STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415010	A. Building B. Wing	11/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saint Elizabeth Home East Greenwich	1 Saint Elizabeth Way East Greenwich, RI 02818

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it has been determined that the facility failed to keep residents free from abuse for 1 of 3 residents reviewed relative to a resident-to-resident incident, Resident ID #1.Findings are as follows:Review of a facility reported incident submitted to the Rhode Island Department of Health on 10/19/2025 revealed in part, Upon entering room [ROOM NUMBER]A at 7a, [Nursing Assistant (NA), Staff A] observed [Resident ID #2] on top of [Resident ID #1]. [Resident ID #2] was disrobed on [his/her] bottom half. [Resident ID #1] was fully clothed with brief intact and fastened.Record review revealed Resident ID #1 was admitted to the facility in July of 2025 with diagnoses including, but not limited to, Alzheimer's disease with late onset, unspecified psychosis, dementia with behavioral disturbances, and primary insomnia.Review of an admission Minimum Data Set (MDS) assessment dated [DATE] revealed, the resident has a Brief Interview for Mental Status (BIMS) score of 99, indicating s/he could not complete the assessment due to severe cognitive impairment. Additionally, the MDS revealed s/he exhibited wandering behaviors in the lookback period.Record review of Resident ID #1's care plan revealed a focus area initiated on 7/31/2025 and revised on 10/21/2025 indicating that Resident ID #1 has a tendency to wander throughout the neighborhood and into other's rooms. The resident was found in another resident's room with his/her hands in their groin area. The resident also has a tendency to wander into Resident ID #2's room. Interventions include, but are not limited to, monitoring his/her whereabouts as s/he tends to lay on other residents' beds, monitoring his/her wandering on the unit, directing him/her away, and a stop sign has been placed across Resident ID #2's door to deter him/her away.Record review revealed Resident ID #2 was admitted to the facility in November of 2024 with diagnoses including, but not limited to, dementia, unspecified hearing loss, and cognitive communication deficit.Review of a Quarterly MDS assessment dated [DATE] revealed the resident has a BIMS score of 15 out of 15, indicating s/he is cognitively intact.Record review of a care plan last revised on 10/20/2025 revealed a focus area which indicates the resident dislikes when other elders enter his/her room. An intervention includes placing a motion sensor at his/her door to alert staff that someone has entered the room.Record review revealed the following nursing progress notes: - 8/7/2025 at 3:41 PM, another resident was found in Resident ID #2's room touching him/her in the groin area. The other resident was redirected out of the room. - 8/8/2025 at 2:34 PM, the facility spoke to Resident ID #2's family member and was agreeable to putting a motion sensor on his/her door to alert staff that someone has gone into his/her room. - 8/21/2025 at 5:43 AM, the resident is currently resting comfortably in bed, the motion sensor is plugged in as ordered. - 8/26/2025 at 2:12 PM, a stop sign was placed in the doorway to deter elders from entering Resident ID #2's room. - 10/19/2025 at 7:26 AM, Resident ID #2 was observed in bed with a resident of the opposite sex, Resident ID #1. Resident ID #2 was not wearing any pants or brief. Resident ID #1 was fully clothed. The residents were separated, and a full assessment was completed with no new findings. - 10/20/2025 at 4:26 PM, the Social Worker was aware that Resident ID #2 was involved in a resident-to-resident incident on 10/19. Resident ID #2 was pleasant and smiling with no concerns relative to the incident. A stop sign and doorbell were in place in efforts to alert staff when other elders are entering his/her private room.Additional record review revealed physician's orders to plug in the motion sensor alarm at 6:00 AM and to unplug the motion sensor alarm at 10:00 PM.Record review of the October 2025 Treatment Administration Record (TAR) failed to reveal evidence that the order to plug in the motion sensor at 6 AM was signed off as completed on 10/19/2025.During a surveyor interview with Nursing Assistant, Staff A, on 10/21/2025 at 11:39 AM, she revealed that on 10/19/2025, she started her shift at 7:00 AM and started to do rounds at approximately 7:15 AM when she noticed Resident ID #1 was not in his/her bed. She indicated that s/he frequently wanders up and down the hallway, so she began checking other residents' rooms. She revealed she found Resident ID #1 in Resident ID #2's bed, with Resident ID #2 making thrusting motions above Resident ID #1. Additionally, she indicated that Resident ID #2 was undressed below the waist while Resident ID #1 had his/her pants on and brief intact. Further, she indicated that Resident ID #2 has a motion alarm in his/her doorway that typically makes a sound when someone enters his/her room. However, she indicated that it did not sound when she entered the room to separate the two residents.During a surveyor interview with Registered Nurse (RN), Staff B, on 10/21/2025 at 3:01 PM, she indicated that on 10/19/2025 at approximately 7:00 AM when she came in for her shift, she observed Resident ID #1 sitting in the small common area at the end of the hallway. While she was receiving report