| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 415010 | A. Building<br>B. Wing | 04/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Saint Elizabeth Home East Greenwich | 1 Saint Elizabeth Way<br>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 0730<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Observe each nurse aide's job performance and give regular training.<br><br>Based on record review and staff interview, the facility failed to complete an annual performance review for every nurse aide (NA), at least once every 12 months, for 3 of 3 NA personnel records reviewed, Staff B, C, and D.Findings are as follows:Record review of the personnel file for Staff B revealed she was hired in January of 2000. Further review revealed her last annual performance review was completed on 4/8/2024.Record review of the personnel file for Staff C revealed she was hired in January of 2008. Further review revealed her last annual performance review was completed on 2/13/2024.Record review of the personnel file for Staff D revealed she was hired in February of 2023. Further review revealed her last annual performance review was completed on 3/11/2024.During a surveyor interview on 4/22/206 at 10:22 AM with the Director of Nursing Services, she acknowledged that the above-mentioned NA's have not had a yearly performance review since 2024. |

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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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observation, clinical record review, and staff interview, the facility failed to ensure that each resident received adequate supervision and assistance devices to prevent accidents, for 1 of 1 resident reviewed with a wanderguard (a wearable tag, often in a bracelet or anklet form, used to prevent individuals with cognitive impairments from eloping or wandering from a secured area), Resident ID #113. Findings are as follows:Review of a facility policy titled, Wanderguard System and Assessments; Checks, last revised 4/2/2026, states in part, .The bracelet will be checked each shift to assure placement; the nurse will sign this as checked in the treatment record. The functionality of the bracelet is also to be tested routinely (weekly) and documented in the medical record.Wanderguard bracelets do expire and must be checked and replaced accordingly.Record review revealed the resident was admitted to the facility in November of 2025 with a diagnosis including, but not limited to, dementia.During surveyor observations on the following dates and times, the resident was noted to have a wanderguard on his/her walker:-4/20/2026 at 9:35 AM-4/21/2026 at 11:38 AM -4/22/2026 at 1:25 PMReview of an Elopement assessment dated [DATE] revealed a score of 3, indicating the resident is at risk for elopement.Review of a care plan focus area initiated on 11/17/2025 revealed the resident is at risk for elopement, related to recent wandering and verbalizing wanting to go home. Interventions include, but are not limited to, wanderguard in place and staff to check placement and functionality per physician's order.Record review failed to reveal evidence of a physician's order for the wanderguard device, an order to check for placement each shift, or an order to check for functionality weekly. Additional record review failed to reveal documentation that the resident's wanderguard was being monitored for placement and functionality, per the facility policy.During a surveyor interview on 4/22/2026 at 1:25 PM, with Registered Nurse, Unit Manager, Staff A, she acknowledged that there were no active physician's orders for the resident's wanderguard to include the checking for placement and functionality of the device and indicated that there should be.During a surveyor interview on 4/22/2026 at 1:33 PM, with the Director of Nursing Services, she revealed that there should be physician's orders in place for the wanderguard to include checking for placement and functionality of the device. |