STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415044	A. Building B. Wing	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Friendly Home	303 Rhodes Avenue Woonsocket, RI 02895

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - Immediate jeopardy to resident health or safety 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 ensure that a resident received adequate supervision for 1 of 1 resident reviewed who was able to successfully elope from the facility, Resident ID #1.Findings are as follows:Review of a facility reported incident submitted to the Rhode Island Department of Health on 8/1/2025 revealed that Resident ID #1 left the faciity on 7/31/2025 and was seen by a neighbor, who subsequently notified the local police department. The report further revealed that the resident was transported back to the facility by the police.Record review of a facility policy titled, Elopement assessments states in part, .It is the policy of this facility to maintain a safe and secure environment for all our residents. In order to achieve this; residents who are at risk for wandering/elopement need to be identified and a care plan developed to eliminate risk.An assessment is also to be completed whenever the resident exhibits change in behaviors which is a signal a change in the risk, such as. wandering with intent to leave, wandering unsafely, actually attempting to leave the building, etc.Record review revealed that Resident ID #1 was admitted to the facility in April 2025, with diagnoses to include, but are not limited to, traumatic brain injury, status post craniectomy (surgical procedure involving the temporary removal of a portion of the skull), and aphasia (a language disorder that affects a person's ability to communicate).Review of the Minimum Data Set assessment dated [DATE] revealed that the resident has moderately impaired cognition, poor decision-making abilities, and requires supervision and cueing. Record review of a physician's order dated 4/9/2025, revealed that the resident is to wear a helmet at all times, due to post-craniectomy.Record review of a progress note dated 7/17/2025, marked as a Recorded as Late Entry on 07/21/2025 10:37 states in part, [Resident] was seen outside by this writer, noted [s/he] had [his/her] helmet off and did not have [his/her] wheelchair, wheelchair was noted to be in the lobby of the facility.Unit staff was made aware [resident] was outside and needs to have someone with.when outside, staff came to lobby and retrieved.w/c and got [resident] from outside and brought [resident] in. [Resident] was again visually upset and made aware when staff have time they can bring [him/her] out but can't go out alone. Record review failed to reveal evidence that an elopement assessment or risk evaluation was completed following the 7/17/2025 incident.Record review of a Physical Therapy document dated 7/18/2025 revealed that the resident has a traumatic brain injury, craniectomy and is to wear a helmet when out of bed. The resident was referred to physical therapy to reassess functional mobility as the patient is often found walking alone in the facility. Additionally, the report revealed that the resident was discharged from physical therapy on 7/31/2025 and indicated that the staff and resident were educated that s/he cannot go outside on their own. Record review of a progress note dated 7/31/2025 revealed that at 6:55 PM, a call was received by the local police department that a resident was found wandering over one mile from the facility. The resident was returned to the facility by the police and assessed by staff. The provider was updated, and the resident was sent to the emergency room for an evaluation.Record review of the police log dated 7/31/2025 revealed a call to 911 was made at 6:43 PM, requesting a well-being check on a confused person in the area. An officer approached the person and asked if they needed help. The person mumbled incoherently and continued down the road. At approximately 7:03 PM the person was identified as Resident ID #1, and the facility was contacted and confirmed that the resident was missing from the facility. Additionally, the report revealed that at 7:22 PM the resident was escorted back to the facility by police. Review of a hospital document dated 7/31/2025 revealed Resident ID #1 presented to the emergency room for medical clearance. The report states in part, .patient is aphasic at baseline.Per report, patient eloped for [approximately] 2 hours before the facility was aware of the elopement, now requesting medical clearance.Record review of a facility provided document titled, [Resident ID #1] Timeline, revealed that a Nursing Assistant last recalled seeing the resident at approximately 5:45 PM. At 6:58 PM the facility was called and made aware that the local police department had found the resident approximately 1.5 miles from the facility after a neighbor found the resident walking.During a surveyor interview on 8/5/2025 at 11:29 AM, with Certified Medication Technician, Staff A, she revealed that she was working on 7/31/2025 and at approximately 4:55 PM, she delivered the resident his/her medications in his/her room. She further revealed that this was the last time she had seen the resident and at approximately 7:30 PM, she was told by another staff member that the local police had called and found the resident and would be bringing him/her back to the facility.Surveyor observations of the facility's surveillance camera footage on 8/5/2025 at approximately 1:30 PM, in the presence of the Director