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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415056	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evergreen House Health Center	1 Evergreen Drive East Providence, RI 02914

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **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 the resident was treated with dignity and in a manner that maintained his/her quality of life. Specifically, the facility did not ensure the resident received a meal prior to departure for a scheduled medical appointment. The resident was transported without breakfast and had not received nourishment since dinner the previous evening, resulting in an excessive and avoidable period of approximately 20 hours without food for 1 of 1 resident reviewed, Resident ID #1. Findings are as follows:Record review of a community-reported complaint received by the Rhode Island Department of Health on 4/20/2026 alleges, that on 4/15/2026, Resident ID #1 was sent out to an early morning appointment and was not provided with breakfast. It further alleges that following the resident's appointment at approximately 11:00 AM, no return transportation had been arranged or made available. Despite multiple calls placed to the facility requesting assistance, an ambulance was not arranged until much later. As a result, the resident did not return to the facility until after 1:00 PM.Record review revealed the resident was readmitted to the facility in November of 2025 with diagnoses including, but not limited to, contractures (a permanent tightening of muscles and surrounding tissues that causes joint stiffness and significantly reduced movement) of the right and left hip and contractures of the right and left knee.Record review of a Quarterly Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status score of 14 out of 15, indicating intact cognition.Record review of a care plan initiated on 4/8/2025 revealed the resident is at risk for malnutrition (a severe condition caused by the body not getting the nutrients it needs) with interventions including in part, to serve the ordered diet: regular with large portions.Record review of the electronic medical record documentation completed by the nursing assistants revealed the resident t did not receive breakfast or lunch on 4/15/2026.Record review of the progress notes dated 4/15/2026, authored by the Unit Manager, Staff B, revealed the resident was sent to a dermatology appointment during this shift and that at 11:50 AM, the dermatology provider called to report that his/her procedure was finished. During a surveyor interview on 4/21/2026 at approximately 2:00 PM, with the resident, s/he revealed that on the day of the appointment s/he was at the dermatology office for a long time and had not received any breakfast or bagged lunch and that s/he was hungry when they returned to the facility. During a surveyor interview on 4/21/2026 at 2:15 PM, with Staff A, she revealed that she was the NA assigned to provide care to the resident on 4/15/2026 and acknowledged that the resident was not provided with breakfast or lunch at the facility. During a surveyor interview on 4/22/2026 at approximately 11:05 AM, the Director of Nursing Services acknowledged that the resident was not provided breakfast or lunch by the facility while the resident was out at their appointment. Additionally, she acknowledged no meal was prepared for the resident to take along with them to the appointment.

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **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 the resident received treatment and care in accordance with professional standards of practice for 1 of 1 resident reviewed with a percutaneous drainage catheter (a thin, flexible tube surgically placed into the abdomen used to drain fluid), Resident ID #2.Findings are as follows:Record review of a facility policy titled Percutaneous Drainage Catheter Management issued on 1/27/2026 revealed in part, .Policy: The facility will provide Percutaneous Drainage Catheter Management in accordance with professional standards of practice, as outlined by [NAME].Position the patient so that you can clearly see and access the percutaneous drainage catheter. Trace the drainage catheter from the patient to its point of origin to ensure that you're managing the correct catheter. Ensure that the drainage bag or system is below the level of the fluid collection to ensure optimal fluid removal .Completing the procedure Secure the drainage bag. to the patient's gown, as necessary, to prevent it from pulling, ensuring that it's below the level of the fluid collection. Perform securement with a safety pin or a tube holder through the plastic loop at the neck of the bulb or bag.Documentation.drainage catheter integrity and securement.Record review of a community-reported complaint received by the Rhode Island Department of Health on 4/20/2026 alleges, that Resident ID #2 was hospitalized for a severe gallbladder infection with an abscess, and was treated with the placement of a drain (an opening designed to remove fluid). Further review of the complaint revealed that on 4/11/2026, the drain bag (an external pouch connected to a tube that drains bile, pus, or infected fluid from the gallbladder) was secured to a call light using a safety pin. Record review revealed that the resident was admitted to the facility in January of 2026 with diagnoses including, but not limited to, perforation of the gallbladder (a medical emergency where a hole forms in the gallbladder), cholecystitis (inflammation of the gallbladder), and dementia.Record review of a Quarterly Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status score of 11 out of 15, indicating moderate impaired cognition.Record review of a care plan initiated on 4/16/2026 revealed the resident has a surgical incision for a percutaneous cholecystostomy drain (a tube placed through the skin into the gallbladder to remove bile) with interventions including to empty and monitor drainage. Record review revealed a physician's order with a start date of 4/10/2026 to keep the bag secure, drain to gravity and monitor drainage every shift.During surveyor interviews on 4/22/2026 at 1:00 PM and 4/23/2026 at 12:30 PM with Licensed Practical Nurse (LPN), Staff C, he reported observing that on 4/12/2026 the resident was in bed with the percutaneous drainage bag improperly secured to the call light, which was in turn attached to an elevated bed rail, preventing the system from draining by gravity as intended.During a surveyor interview on 4/23/2026 at 12:10 PM with Nurse Practitioner, Staff D, she indicated that it is her expectation for the drain not to be attached to the call light.During a surveyor interview on 4/22/2026 at 12:47 PM with the Director of Nursing Services, she acknowledged the resident's drain was attached to the call light and stated that it is her expectation for the drain not to be pinned to the call light. Additionally, she was unable to provide evidence that the facility implemented their policy relative to Percutaneous Drainage Catheter Management.