

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415079	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/20/2024
NAME OF PROVIDER OR SUPPLIER Trinity Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4 St Joseph Street 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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50004</p> <p>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 assessed to be a moderate risk for wandering, previously displayed exit seeing behavior and was able to successfully elope from the facility, Resident ID #1.</p> <p>Findings are as follows:</p> <p>Record review of a facility policy titled Elopement dated 4/10/2018, states in part, .Elopement - leaving the facility without permission and/or notification to the facility .An assessment will be completed within 24-hours of admission. 1. A re-assessment will be completed for any resident who demonstrates any of the following: Verbalizing a desire to leave the building .exit seeking .A resident assesses to be at risk. The following actions may be employed: 1. Application of a wanderguard 2. Initiation of frequent checks 3. Initiate Care Plan 4. Room transfer to a secure area 5. Residents at risk for elopement identified to appropriate staff .</p> <p>Record review of a facility reported incident sent to the Rhode Island Department of Health on 11/12/2024, revealed that on 11/11/2024 Resident ID #1 left the building and was found in the parking lot next door. A neighbor called the police, and the resident was taken to the hospital for safety. Although during the complaint survey it was determined by record review and interview that the resident was located approximately 1.5 miles from the facility, found by a jogger. Emergency services were called and s/he was transported to the hospital.</p> <p>During a surveyor observation on 11/18/2024 at approximately 11:00 AM revealed the facility is equipped with a wander guard system. When a resident wearing bracelet attempts to leave the facility an alarm will go off alerting the staff.</p> <p>Record review revealed the resident was admitted to the facility in October of 2024 with a diagnosis including, but not limited to, dementia. Further review revealed that the resident resides on the facility's secured/locked unit.</p> <p>Review of the Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status score of 6 out of 15, indicating s/he has severely impaired cognition.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of a Wander Risk assessment dated [DATE] revealed the resident scored a 9, indicating s/he is a moderate risk for wandering behaviors.</p> <p>Record review of a nursing progress note dated 11/10/2024 at 12:37 PM states in part, Resident with some agitation this shift .Asks why we are keeping [him/her] here. Trying to get on the elevator x2. Redirected with difficulty.</p> <p>Record review failed to reveal evidence that a Wander Risk Assessment was completed after the resident displayed exit seeking behaviors, that a wanderguard was placed on the resident or that the resident was placed on frequent checks per the facility policy. Additionally, the care plan was not updated with interventions to mitigate the resident's exit seeking behavior following the incident on 11/10/2024.</p> <p>Record review of facility investigation statements for the 11/11/2024 incident indicated that staff last recall seeing the resident between 4:45 PM and 5:15 PM, eating dinner, but no one witnessed the resident exit the facility.</p> <p>Record review of a progress note authored by Registered Nurse, Staff A, on 11/11/2024 at 9:40 PM, revealed that the last time staff saw the resident on the evening of 11/11/2024, prior to his/her elopement was at approximately 5:15 PM, when s/he was observed sitting in the dayroom eating dinner. At approximately 6:58 PM the facility received a phone call from the hospital indicating that the resident was in the emergency room . Additionally, two staff members from the facility went to the hospital to pick up the resident and return him/her to the facility.</p> <p>Record review of hospital documentation titled ED [emergency department] Triage Note dated 11/11/2024, revealed that the resident was brought in by emergency medical services, after a jogger called 911 and reported a Spanish speaking person who was confused about his/her location. The resident was assessed in the ED and was unsure of the date and where s/he was. The resident reported s/he was from [NAME] (a city located approximately 20 miles away from the facility) and lived at a local school. Additionally, the document revealed that the secretary from the hospital called the facility to see if they were missing a resident. Per the report the facility sent staff to the hospital to identify and pick up the resident.</p> <p>The surveyor made two attempts to contact Staff A. Staff A failed to return any of these phone calls.</p> <p>During a surveyor interview on 11/18/2024 at 2:35 PM with the Administrator, she acknowledged that the facility was not aware that Resident ID #1 left the facility on [DATE] until the hospital called to notify them. She further acknowledged that the staff were unaware how the resident made his/her way off of the secured unit and exited the facility. Additionally, the Administrator was unable to determine when the resident had left facility and how long s/he had been gone.</p> <p>The facility's failure to implement interventions for a resident who was identified on their admission assessment as a moderate risk for wandering and to follow their policy relative to wandering behaviors placed a cognitively impaired resident at risk for more than minimal harm, injury, impairment, or death. These failures resulted in this resident making his/her way off of the secured unit, exiting the facility unsupervised and being found by a jogger approximately 1.5 miles away from the facility.</p>		