STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415084	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elmhurst Rehabilitation and Healthcare Center	50 Maude Street Providence, RI 02908

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 - 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. **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 a resident free from physical abuse for 1 of 3 residents reviewed, Resident ID #2. Findings are as follows: Review of a facility reported incident submitted to the Rhode Island Department of Health on 6/9/2025 revealed that staff over heard Resident ID #3, the perpetrator, yelling from his/her room. Resident ID #2, the victim, had wandered into Resident ID #3's room and was found lying on the floor next to Resident ID #3's bed. The report further revealed that when staff assisted Resident ID #2 off of the floor, Resident ID #3 struck Resident ID #2 in the face, causing a bloody nose. Review of a policy titled, Abuse, Neglect, Exploitation, and Misappropriation Prevention Program last revised in April of 2021 states in part, .Residents have the right to be free from abuse .the resident abuse .prevention program consists of a facility-wide commitment and resource allocation to support the following objectives: Protect residents from abuse .by anyone including .other residents . Record review revealed Resident ID #2, the victim, was admitted to the facility in April of 2021 with diagnoses including, but not limited to, dementia, age-related physical debility, and fractures of the nasal bones. Record review of a Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 0 out of 15, indicating the resident has severely impaired cognition. Further review revealed the resident was able to ambulate independently. Record review revealed a progress note dated 6/8/2025 indicating that Resident ID #2 was found on the floor in Resident ID #3's room. Further review revealed while the nurse was helping the resident off of the floor, the other resident struck Resident ID #2 in the face causing a bloody nose. Record review of an MQS: Interim Pain Evaluation completed after the above incident revealed the resident exhibited pain non-verbally through facial expressions, sounds, actions or behaviors. Record review revealed that Resident ID #3, the perpetrator, was admitted to the facility in May of 2020 with a diagnosis including, but not limited to, traumatic brain injury and mood disorder. (continued on next page)

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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of a MDS assessment dated [DATE] revealed a BIMS score of 7 out of 15, indicating the resident has severely impaired cognition. Further review revealed the resident is independent with transfers and mobility in his/her wheelchair. Record review of a care plan dated 5/7/2025 revealed that Resident ID #3 does not like people entering his/her room or personal space and can become combative and agitated when such instances occur. Record review revealed the following progress notes involving Resident ID #3 and altercations related to resident's wandering into his/her room. -5/13/2025- resident became verbally upset related to a resident entering his/her room and went into the hallway yelling and cursing. Another resident told Resident ID #3 not to speak that way, but Resident ID #3 continued to yell and move his/her hands around. The other resident touched Resident ID #3's wrist and staff intervened. No injuries were noted. -6/1/2025- Resident had an episode of yelling and cursing related to another resident entering his/her room. Record review failed to reveal evidence that new interventions had been put into place in an attempt to prevent a resident-to-resident altercation until after the third incident, which resulted in injuries to Resident ID #2. Record review revealed a stop sign was placed on Resident ID #3's door and then his/her room was moved to another unit on 6/10/2025. Further record review revealed a social service note dated 6/11/2025 indicating that the social worker spoke with the resident's mother regarding .looking into a group home or a facility that has a behavioral unit . Further review revealed the resident's mother was .in agreement to look into these options . During a surveyor observation on 6/11/2025 at approximately 1:40 PM, Resident ID #2 was observed with a bruise which was blue and yellow in color under the resident's left eye, and a dark bruise to the right side of his/her lower lip. During a surveyor interview following the above observation with Licensed Practical Nurse, Staff A, she acknowledged the bruising to the resident's face was a result of the resident-to-resident physical altercation between Resident ID #s 2 and 3. During a surveyor interview on 6/11/2025 at 1:54 PM with the Director of Nursing Services, she indicated that Resident ID #3 has behaviors related to his/her traumatic brain injury. She acknowledged that the resident had verbal altercations related to other residents entering his/her room on 5/13/2025 and 6/1/2025. She further acknowledged that no new interventions were put into place following those two incidents. Additionally, she acknowledged that Resident ID #3 hit Resident ID #2 in the face with his/her hand out of anger, resulting in Resident ID #2 sustaining a bloody nose. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The facility's failure to implement interventions on 5/13 and 6/1/2025 after two witnessed incidences of Resident ID #3 becoming upset at other residents entering his/her room placed Resident ID #2 at risk for physical abuse. This abuse resulted in Resident ID #2 sustaining a bloody nose and facial bruising.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. Based on record review and staff interview it has been determined that the facility failed to provide and document sufficient preparation and orientation to residents to ensure a safe and orderly discharge from the facility for 1 of 1 resident reviewed who left the facility, Resident ID #1. Findings are as follows: Review of a community reported complaint submitted to the Rhode Island Department of Health on 6/5/2025 alleged that a resident had gone missing from the facility the week prior, and the facility's management did not take appropriate action. The complaint further alleged that the resident said s/he wanted to go home, and it took hours for the facility to find him/her. Review of a facility policy titled, Discharging a Resident Without a Physician's Approval states in part, . Regardless of the resident or resident's representative's request to leave the facility against medical advice, the facility will provide a Notice of Discharge, discharge orientation, and a Discharge Summary .before the resident leaves the facility. Record review revealed Resident ID #1 was admitted to the facility in May of 2025 with diagnoses including, but not limited to, aftercare following a hip replacement, post-traumatic stress disorder, and osteoarthritis. Review of a Brief Interview for Mental Status evaluation dated 5/25/2025 revealed a score of 14 out of 15, indicating intact cognition. Review of a Nurse Practitioner's (NP) note with a service date of 5/29/2025 at 9:45 AM revealed the resident informed the NP that s/he is leaving the facility today and had discussed leaving against medical advice. Further review revealed the NP wrote that the resident is safe and medically cleared for discharge home. Record review failed to reveal evidence of a physician's order for the discharge from the facility, a discharge plan involving the interdisciplinary team, a notice of discharge, a discharge summary, or a medication reconciliation. During a surveyor interview via telephone on 6/11/2025 at 11:34 AM with the resident, s/he indicated that s/he told staff that s/he wanted to leave the facility and they had asked him/her to wait so s/he agreed to stay, but s/he left the facility around 11:00 AM on 5/29/2025 with his/her friend. Additionally, the resident indicated that s/he was not given any paperwork, medications, or a referral to home care services. During a surveyor interview on 6/11/2025 at 9:45 AM with Licensed Practical Nurse, Staff B, she indicated that she was the unit nurse on 5/29/2025 when the resident left the facility. She further acknowledged that she did not complete any discharge planning, complete a discharge summary, or conduct a medication reconciliation for the resident. (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a surveyor interview on 6/11/2025 at approximately 10:04 AM with the Assistant Director of Nursing Services, she indicated that the unit nurse is responsible for starting the discharge summary and the discharge process. Additionally, she could not provide evidence that the resident received an appropriate discharge. Cross reference F-684

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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 record review and staff interview, it has been determined that the facility failed to ensure that residents receive adequate supervision to ensure the safety of 1 of 1 resident reviewed who left the facility, Resident ID #1. Findings are as follows: Review of a community reported complaint submitted to the Rhode Island Department of Health on 6/5/2025 alleges that a resident had gone missing from the facility the week prior, and the facility's management did not take appropriate action. The complaint further alleged that the resident said s/he wanted to go home and it took hours for the facility to find him/her. Review of the facility policy titled, Wandering and Elopements states in part, .If a resident is missing, initiate the elopement/missing resident emergency procedure .If the resident is not located, notify .law enforcement officials . Record review revealed Resident ID #1 was admitted to the facility in May of 2025 with diagnoses including, but not limited to, aftercare following a hip replacement, post-traumatic stress disorder, and osteoarthritis. Review of a Brief Interview for Mental Status evaluation dated 5/25/2025 revealed a score of 14 out of 15, indicating intact cognition. Review of a Nurse Practitioner's (NP) note with a service date of 5/29/2025 at 9:45 AM revealed the resident informed the NP that s/he is leaving the facility today and had discussed leaving against medical advice. Further review revealed the NP wrote that the resident is safe and medically cleared for discharge home. Record review revealed the following progress notes: - 5/29/2025 at 10:21 AM- authored by the Minimum Data Set (MDS) assessment Nurse, Staff C, the resident is not available for quality of life rounds. - 5/29/2025 at 12:19 PM- social worker and case manager went to see the resident to discuss his/her wishes to discharge, resident was not in his/her room at the time of the visit today. Will follow up. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 5/29/2025 at 6:11 PM- Resident is alert oriented x3 and expressed desire to discharge to home today. Resident met with NP who stated she would sign off on discharge if resident insisted on going home. Resident encouraged by staff to speak to social services and wait for discharge plan to be put into place. Resident had a friend visiting at the time. Resident stated to nurse [s/he] would stay until discharge could be set up but that [s/he] was leaving. Activity aid went into room and resident told activity aid [s/he] was leaving today and was observed packing [his/her] room. Resident also stated to activities [s/he] had a ride arranged today to go home and [s/he] told [his/her] friend in the room to go get [him/her] a wheelchair. Resident stated to staff [s/he] was going to go outside with [his/her] friend for 'air' Social services went into see resident in [his/her] room but [s/he] was not in room. Resident's wheelchair found left outside rehab gym. All resident's belongings were not in room. Resident did not wait for discharge paperwork or sign AMA (against medical advice) form. Message left for resident to call facility to obtain paperwork and medications needed for discharge. MD (medical doctor) made aware. Record review failed to reveal a physician's order for the resident's discharge from the facility. Record review failed to reveal evidence of signed AMA paperwork, a discharge summary or a medication reconciliation. Record review failed to reveal evidence that the police were notified of an elopement. During a surveyor interview on 6/10/2025 at 12:43 PM with the MDS assessment Nurse, Staff C, she revealed that she entered the resident's room for a routine interview on 5/29/2025 at approximately 11:00 AM and the resident was not in his/her room at that time. She further indicated that she thought the resident was being discharged later that week and had planned to return later to complete the MDS interview. Additionally, she indicated that during the facility's end of day meeting, around 3:30 PM, it was realized that the resident hadn't been seen in the building for a while and an Elopement Code was announced over the intercom. Furthermore, she indicated that the staff searched the building for the resident and when s/he was not located, staff assumed s/he left AMA. During a surveyor interview on 6/10/2025 at 12:53 PM with the Social Worker, Staff D, she indicated that the resident had said that s/he wanted to go home and she went to speak with the resident about discharge on [DATE] around 12:00 PM. She indicated that the resident was not in his/her room at that time; however, she believed his/her belongings were still in the room, so she planned to follow up later that day. She further indicated that an Elopement Code was called at approximately 3:00 PM and a search of the facility was conducted. Additionally, she indicated that when the resident wasn't located, s/he was called multiple times with no return phone call received. Furthermore, she indicated that she spoke with the resident via telephone the following day, 5/30/2025 to offer to set up outside services; however, the resident indicated that s/he would do it him/herself. During a surveyor interview on 6/11/2025 at 10:04 AM with the Assistant Director of Nursing Services, she indicated that it was brought to her attention during her morning meeting that the resident wanted to leave so she went to speak with him/her around 8:00-9:00 AM. She further indicated that the resident told her that s/he wanted to leave; however, s/he would stay until s/he saw social services, physical therapy (PT), and the provider. Additionally, she indicated that during the afternoon meeting it was discussed that the resident hadn't been seen in his/her room and when they realized s/he was not with PT, an Elopement Code was called, and the facility was searched. Furthermore, she indicated that she called the resident, did not receive a response, and did not notify the police. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a surveyor interview on 6/10/2025 at approximately 1:15 PM with the Director of Nursing Services, she indicated that the resident had said that s/he wanted to go home on 5/29/2025 and was evaluated by the NP who indicated that she would sign off if s/he really wanted to go home. She further indicated that throughout the day some staff thought s/he was at an appointment however s/he was not. Additionally, she indicated that an unknown staff member called an Elopement Code during the afternoon meeting around 3:30 PM but when the resident was not located, the code was cleared, and it was assumed s/he had gone home with a friend. Furthermore, she could not identify when the resident left the facility or where s/he went until the resident returned her phone call on 5/30/2025, the day after s/he unknowingly left the facility. During a surveyor interview on 6/11/2025 at 10:41 AM with the Administrator, she indicated that she was told that the resident wanted to leave on 5/29/2025 and when she heard the Elopement Code over the facility's over head paging system, she cleared the code because she thought the resident had been discharged from the facility earlier that day. She further indicated that she called the resident a couple of times with no answer and had assumed that s/he went home with a friend. Additionally, she was unable to provide evidence that the resident had been discharged from the facility, left AMA, or that the police were notified of an elopement per the facility policy. During a surveyor interview on 6/11/2025 at 11:34 AM with Residnet ID #1, s/he stated that his/her stay at the facility was awful, s/he didn't feel safe, and that s/he had escaped. The resident indicated that s/he told staff that s/he wanted to leave the facility and they had asked him/her to wait so s/he agreed to stay. The resident indicated s/he left the facility around 11:00 AM on 5/29/2025 with his/her friend. Additionally, the resident indicated that s/he was not given any paperwork, medications, or a referal to homecare services. Cross reference F-627

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on record review and staff interview it has been determined that the facility failed to be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident relative to 1 of 1 resident reviewed who left the facility, Resident ID #1. Findings are as follows: Review of a community reported complaint submitted to the Rhode Island Department of Health on 6/5/2025 alleges that a resident had gone missing from the facility the week prior, and the facility's management did not take appropriate action. The complaint further alleged that the resident said s/he wanted to go home and it took hours for the facility to find him/her. Record review revealed Resident ID #1 left the facility at an unknown time on 5/29/2025. During a surveyor interview via telephone on 6/11/2025 at 11:34 AM with the resident, s/he stated that s/he left the facility around 11:00 AM on 5/29/2025 with his/her friend. Additionally, the resident indicated that s/he was not given any paperwork, medications, or had any homecare services set up. During a surveyor interview on 6/10/2025 at approximately 3:00 PM with the Director of Nursing Services, she indicated that an Elopement Code was called around 3:30 PM when staff realized the resident had not been seen for a while at the facility. She further indicated that because the resident had said that s/he wanted to go home that morning and because his/her belongings were not in the resident's room, staff assumed that s/he left the facility to go home and the Elopement Code was cleared. Additionally, she could not indicate when the resident left the facility and could not be sure where the resident went because the resident did not return the multiple phone calls from the facility until the next morning. During a surveyor interview on 6/11/2025 at 10:41 AM with the Administrator, she indicated that she was told that the resident was being discharged that day so when she heard the Elopement Code, she assumed that the resident had been discharged and cleared the code. Additionally, she could not indicate when the resident left and could not provide evidence that the resident was safely discharged from the facility on 5/29/2025. Cross reference F 684 & 627

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review and staff interview, it has been determined that the facility failed to ensure that resident records are complete and accurately documented, relative to medication administration, for 1 of 1 resident reviewed who left the facility, Resident ID #1. Findings are as follows: Record review revealed Resident ID #1 was admitted to the facility in May of 2025 with diagnoses including, but not limited to, aftercare following a hip replacement, post-traumatic stress disorder, and osteoarthritis. Review of a Brief Interview for Mental Status evaluation dated 5/25/2025 revealed a score of 14 out of 15, indicating intact cognition. Record review revealed a physician's order dated 5/23/2025 for Acetaminophen 325 milligrams (mg) give two tablets three times a day. Record review of the May 2025 Medication Administration Record (MAR) revealed the Acetaminophen dose scheduled for 2:00 PM was documented as administered on 5/29/2025 by Licensed Practical Nurse (LPN), Staff B. During a surveyor interview via telephone on 6/11/2025 at 11:34 AM with the resident, s/he indicated that s/he left the facility around 11:00 AM on 5/29/2025 with his/her friend and did not return to the facility again. During a surveyor interview on 6/11/2025 at 9:45 AM with LPN, Staff B, she indicated that she thought that she last saw the resident in his/her room around 2:00 PM on 5/29/2025. She further indicated that she thought the resident ate lunch in his/her room that day because the Nursing Assistants didn't tell her that the resident didn't eat. During a subsequent interview on 6/11/2025 at 12:29 PM with Staff B, she indicated that she was unaware that the resident had left the facility around 11:00 AM on 5/29/2025. She further acknowledged that she documented that she administered the resident's 2:00 PM Acetaminophen; however, this was inaccurate since the resident was not in the facility. During a surveyor interview on 6/11/2025 at 12:38 PM with the Director of Nursing Services, she indicated that she would expect that a medication is only documented as administered if it was administered. Additionally, she could not explain the 2:00 PM dose of Acetaminophen being documented as administered when the resident had left the facility hours prior. Cross reference F 627 and 684