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	03/09/2026

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews with the home care agency staff, the complainant, and facility staff, the facility failed to ensure that the appropriate resident information was communicated to the receiving health care providers at the time of discharge for 1 of 1 resident reviewed for discharge, Resident ID #1. Specifically, the facility failed to communicate that the resident's primary care physician (PCP) was a new provider who would be unable to sign home health orders until the resident was established as a patient in that practice. Additionally, the facility failed to respond to requests of the home care agency to have the facility's Medical Director sign homecare orders to enable to resident to receive skilled nursing and therapy services as ordered, following his/her discharge.Findings are as follows:Review of a community-reported complaint submitted to the Rhode Island Department of Health on 3/4/2026 by Resident ID #1's family member, alleged that the resident experienced an unsafe and poorly coordinated discharge which resulted in the resident not receiving ordered home care services following his/her discharge from the facility on 2/15/2026.Record review revealed the resident was admitted to the facility in January of 2026 with diagnoses including, but not limited to, dementia and heart failure (a chronic condition in which the heart muscle is unable to pump blood efficiently).Review of a Brief Interview for Mental Status (BIMS) evaluation dated 2/3/2026 revealed a score of 9 out of 15, indicating moderate cognitive impairment.Review of a Discharge summary dated [DATE], authored by the facility's Medical Director (MD) revealed that home health services were medically necessary for the resident, including skilled nursing and therapy services.Further record review revealed the resident was discharged home on 2/15/2026 with services from a home care agency.Review of progress notes obtained from the home care agency revealed that the resident had an initial assessment by the home care agency on 2/17/2026; however, the new primary care physician (PCP) would not sign the orders until the resident was seen in their office on 2/26/2026, and established as their patient.Additional review of progress notes dated 2/18/2026 revealed the agency contacted the facility and left a voicemail for the facility's social worker inquiring whether the facility's MD would be willing to sign home care orders until the resident could be seen by their new PCP in the community. Further review of the home care agency progress notes dated 2/26/2026 and 2/27/2026 revealed the agency again contacted the facility and left voicemails requesting that the facility's MD sign the orders so home care services could be provided to the resident prior to the 2/26/2026 appointment. Further record review revealed the facility did not return these calls until 3/5/2026.Record review failed to reveal evidence that the facility communicated with the homecare agency that the resident's primary care physician (PCP) was a new provider who would not sign home health orders until the resident was seen in the office and failed to respond to requests from the home care agency to have the facility's MD sign homecare orders. As a result, the resident did not receive skilled nursing and therapy services as ordered following his/her discharge.During surveyor interviews on 3/9/2026 at 11:15 AM and 3:57 PM with the Quality Manager from the home care agency, she stated that the agency received and accepted the referral from the facility for services beginning on 2/15/2026. She indicated the facility informed the agency the resident had a PCP (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	appointment scheduled for 2/26/2026 but did not inform the agency that this PCP was a new provider who had never seen the resident. She further stated that on 2/17/2026, following the agency's first visit with the resident, staff contacted the PCP to obtain signed orders, but were informed the PCP would not sign orders until the resident was seen in the office on 2/26/2026. She indicated agency staff contacted the facility three times beginning on 2/18/2026 requesting that the facility MD sign the orders so services could begin prior to the PCP appointment; however, the facility did not return the calls until 3/5/2026. She confirmed the resident had not received home health services since 2/17/2026.During a surveyor interview on 3/9/2026 at 11:45 AM with the complainant, the resident's family member, s/he stated that s/he informed the facility a few days after the resident's admission that the resident did not have a PCP in the community. S/he stated the resident was discharged home on 2/15/2026 with skilled nursing and therapy services from a home care agency but had not received those services because the facility failed to relay accurate information to him/her or the home care agency. The complainant stated that after learning from the home care agency that services could not begin because the PCP would not sign orders until the 2/26/2026 appointment, s/he attempted to contact the facility's social worker on 2/24/2026 at 3:08 PM, 2/25/2026 at 2:41 PM, and again on 2/27/2026 using the telephone number provided by the facility. S/he stated s/he did not receive a return call until 3/5/2026. S/he further stated that the facility's social worker had previously assured him/her that the new PCP had agreed to sign the home care orders prior to the 2/26/2026 appointment.During surveyor interviews on 3/9/2026 at 12:16 PM and 1:07 PM with the facility social worker, Staff A, she stated the facility was aware shortly after admission that the resident did not have a PCP. Staff A stated a PCP was obtained and an appointment was scheduled for 2/26/2026. She confirmed the resident was discharged home on 2/15/2026 with skilled nursing and therapy services. Staff A acknowledged that she was aware that the new PCP would not sign the home care orders until the resident was seen on 2/26/2026. She was unable to provide evidence that the PCP had agreed to sign orders prior to that appointment. Additionally, she was also unable to provide evidence that the home care agency had been informed that this was a new PCP who had not previously seen the resident. When asked by the surveyor whether she had received calls from the home care agency or the resident's family member following the discharge, she denied receiving calls; however, she acknowledged the telephone number provided to the surveyor by the home care agency and the complainant to leave the voicemails was her correct telephone number.During an interview on 3/9/2026 at 2:26 PM with the MD, he stated that he had been informed by facility staff that the new PCP had agreed to sign the home care orders when the resident was discharged . He stated he was not aware the home care agency had requested that he sign the orders due to the PCP's refusal until 3/6/2026. He further indicated that although he does not usually sign home care orders, he would have signed the orders in this situation if he had been made aware that the new PCP would not sign them, and the resident was unable to receive services.