

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415084	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/07/2026
NAME OF PROVIDER OR SUPPLIER Elmhurst Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, the facility failed to ensure that the resident was free from misappropriation of property, specifically a prescribed dose of Mounjaro (a medication prescribed to treat 2 diabetes mellitus), for 1 of 3 residents reviewed for medication administration, Resident ID #1. Findings are as follows: Record review of a community-reported complaint submitted to the Rhode Island Department of Health on 4/3/2026 alleged that the resident did not receive a scheduled dose of Mounjaro; however, the medication was documented by nursing staff as administered. Review of the facility policy titled Identifying Exploitation, Theft and Misappropriation of Resident Property defined misappropriation, in part, as the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings without the resident's consent. Record review revealed the resident was admitted in November 2025 with a diagnosis including, but not limited to, type 2 diabetes mellitus. The Minimum Data Set (MDS) assessment dated [DATE] indicated a Brief Interview for Mental Status (BIMS) score of 15/15, confirming the resident was cognitively intact. During a surveyor interview on 4/7/2026 at approximately 12:20 PM, the resident stated that s/he did not receive a scheduled Mounjaro injection on a Friday (later identified as 3/13/2026). The resident reported notifying nursing staff on 3/15/2026 and was informed that the medication had already been documented as administered. The nursing staff identified Licensed Practical Nurse (LPN), Staff A, as the nurse who documented the administration. Record review revealed a physician's order with a start date of 11/28/2025 for Mounjaro 5 milligrams (mg)/0.5 milliliters (ml) inject 5 mg once every 7 days. During a surveyor interview on 4/7/2026 at 12:32 PM, the Director of Nursing Services (DNS) revealed that facility practice is for Mounjaro to be counted in the narcotic book to ensure ongoing accountability of the medication due to its high cost. Review of pharmacy records and the narcotic count book indicated that four Mounjaro injection pens were delivered to the facility on 3/6/2026 and a total of four doses were available for Resident ID #1. Review of the March Medication Administration Record (MAR) revealed that Staff A documented administration of the resident's Mounjaro dose on 3/13/2026. During a surveyor interview on 4/7/2026 at 2:00 PM, Registered Nurse, Staff C, stated that on 3/15/2026 the resident reported not receiving the 3/13/2026 dose. Staff C verified that the narcotic count book did not reflect the removal or administration of a dose on 3/13/2026. Additionally, Staff B and C verified that all four Mounjaro injection pens remained in the refrigerator on 3/15/2026, confirming that no dose had been removed or administered as documented. During a surveyor interview on 4/7/2026 at 1:36 PM, Staff B corroborated that both the narcotic count record and physical count on 3/15/2026 confirmed four remaining pens, directly contradicting the MAR documentation of administration on 3/13/2026. During a telephone interview on 4/7/2026 at 2:34 PM, Staff A stated that he administered the medication on 3/13/2026 but acknowledged he did not document the removal of the dose in the narcotic book until 3/15/2026. Staff A was unable to explain how the medication count remained at four on 3/15/2026 if a dose had been administered on 3/13/2026, nor could he explain the subsequent reduction in count from four to three after his late documentation. During a surveyor interview on 4/7/2026 at 1:22 PM, the Assistant Director of Nursing (ADON) revealed that on the morning of 3/16/2026, the narcotic count revealed only three Mounjaro (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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, the facility failed to ensure that an allegation of misappropriation and/or medication diversion involving a resident's prescribed Mounjaro (a medication prescribed to treat type 2 diabetes mellitus) injection was reported to the State Survey Agency, in accordance with regulatory requirements, for 1 of 3 residents reviewed, Resident ID #1. Findings are as follows: Record review of a community-reported complaint submitted to the Rhode Island Department of Health on 4/3/2026 alleged that the resident did not receive a scheduled dose of Mounjaro, although nursing staff documented the medication as administered. Record review revealed the resident was admitted to the facility in November of 2025 with a diagnosis including but not limited to, type 2 diabetes mellitus. Record review of the Minimum Data Set assessment dated [DATE] revealed the resident had a Brief Interview for Mental Status score of 15 out of 15, indicating that the resident is cognitively intact. During a surveyor interview on 4/7/2026 at approximately 12:20 PM, the resident stated that he/she did not receive a scheduled Mounjaro injection on a Friday (later identified as 3/13/2026). The resident reported notifying nursing staff on Sunday and was informed that the medication had been documented as administered. The resident identified Licensed Practical Nurse (LPN) Staff A as the nurse who signed for the medication. Record review revealed a physician's order with a start date of 11/28/2025 for Mounjaro 5 milligrams (mg)/0.5 milliliters (ml) inject 5 mg once every 7 days. During a surveyor interview on 4/7/2026 at 12:32 PM, the Director of Nursing Services (DNS) revealed that facility practice is for Mounjaro to be counted in the narcotic book to ensure ongoing accountability of the medication due to its high cost. Review of the narcotic count record showed that four Mounjaro injection pens were delivered by the pharmacy on 3/6/2026 and documented as four total pens were available for the resident. During a surveyor interview on 4/7/2026 at 1:36 PM, Registered Nurse (RN), Staff B, stated that on 3/15/2026, the resident reported to RN, Staff C, that the 3/13/2026 dose had not been administered. Staff B stated that the narcotic count record did not reflect removal of a dose on that date. Additionally, she and Staff C verified that four Mounjaro pens remained in the refrigerator, which was consistent with the 3/6/2026 delivery count. During a surveyor interview on 4/7/2026 at 1:22 PM, the Assistant Director of Nursing (ADON) revealed that on 3/16/2026, a narcotic count confirmed three pens were present, and the narcotic record also reflected three. After administering a dose to the resident on 3/16/2026, the ADON identified that Staff A had documented that he administered a dose of Mounjaro to the resident on 3/13/2026, which was not reflected in the narcotic book when both Staff B and C reviewed the entries for the medication on 3/15/2026. During a telephone interview on 4/7/2026 at 2:34 PM, Staff A was unable to explain the discrepancy between the documented administration on 3/13/2026 and the unchanged narcotic count of four pens through 3/15/2026, nor the subsequent decrease in count following his documentation on 3/15/2026. During a surveyor interview on 4/7/2026 at 2:30 PM, the DNS and Administrator were unable to provide evidence that the allegation of potential misappropriation was reported to the State Survey Agency as required. Cross reference F602, and F842</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, and resident and staff interview, the facility failed to maintain accurate and complete medical records in accordance with accepted professional standards and practices for 1 of 3 residents reviewed related to medication administration, Resident ID #1. Specifically, the facility failed to ensure accurate, timely, and consistent documentation of the administration of Mounjaro, a medication prescribed to treat type 2 diabetes mellitus. Findings are as follows:Record review of a community-reported complaint submitted to the Rhode Island Department of Health on 4/3/2026 alleged that the resident did not receive a scheduled dose of Mounjaro; however, nursing staff documented the medication as administered.Review of a facility policy titled Documentation of Medication Administration (November 2022) indicated, in part, that medications are to be documented immediately after administration and that documentation must include reasons when a medication is withheld, not administered, or refused.Record review indicated the resident was admitted in November 2025 with diagnoses including, but not limited to, type 2 diabetes mellitus. The Minimum Data Set (MDS) assessment dated [DATE] reflected a Brief Interview for Mental Status (BIMS) score of 15/15, indicating the resident was cognitively intact.During a surveyor interview on 4/7/2026 at approximately 12:20 PM, the resident reported not receiving the scheduled Mounjaro injection on 3/13/2026 and stated that s/he was later informed the dose had been documented as administered by Licensed Practical Nurse (LPN), Staff A.Record review revealed a physician's order with a start date of 11/28/2025 for Mounjaro 5 milligrams (mg)/0.5 milliliters (ml) inject 5 mg once every 7 days.Review of the March 2026 Medication Administration Record (MAR) indicated that LPN Staff A documented administration of Mounjaro on 3/13/2026.During a surveyor interview on 4/7/2026 at 12:32 PM, the Director of Nursing Services (DNS) revealed that facility practice is for Mounjaro to be counted in the narcotic book to ensure ongoing accountability of the medication due to its high cost. Record review of pharmacy records and the narcotic count book revealed that four Mounjaro injection pens were delivered on 3/6/2026 and a total of four were available for administration.Record review of a written statement authored by Registered Nurse (RN) Staff B, Unit Supervisor, indicated that on 3/15/2026 the resident reported not receiving the scheduled dose. RN Staff B and Staff C verified that both the narcotic count record and physical inventory in the refrigerator remained unchanged from 3/6/2026 through 3/15/2026, indicating that the medication had not been administered as documented in the MAR.During a surveyor interview on 4/7/2026 at 1:22 PM, the Assistant Director of Nursing (ADON) revealed that on 3/16/2026, the narcotic count reflected three remaining Mounjaro injection pens, and the narcotic book was updated accordingly. The ADON later identified that Staff A had documented administration of a dose on 3/13/2026; however, this documentation was inconsistent with prior verification on 3/15/2026 that no dose had been removed or administered.During a telephone interview on 4/7/2026 at 2:34 PM, Staff A acknowledged that although the narcotic book entry was dated 3/13/2026, the documentation was not completed until 3/15/2026, which is not consistent with facility policy requiring documentation immediately after medication administration.Record review of the conflicting documentation between the MAR, narcotic count records, and staff interviews, demonstrates that the facility failed to ensure that the resident's medical record accurately reflected whether the medication was administered. Additionally, the delayed documentation in the narcotic record further reflects failure to adhere to accepted standards of timely documentation.During a surveyor interview, the DNS and Administrator were unable to provide evidence that the documentation supporting administration of the 3/13/2026 Mounjaro dose was accurate or reliable.These findings demonstrate the facility's failure to maintain accurate, complete, and timely medical records in accordance with professional standards of practice.Cross Reference F602 and F609</p>		