

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 04/24/2026
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 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** Based on clinical record review and staff interview, the facility failed to provide adequate supervision and failed to ensure an effective elopement prevention system for 1 of 1 resident reviewed, Resident #1. The resident, who resides on a secured unit due to impaired safety awareness and a high risk for elopement, requires a wander guard device (a safety mechanism intended to monitor and prevent at-risk residents from exiting unsupervised). Despite this intervention, the facility failed to prevent unsafe exit-seeking behaviors. The resident was able to self-propel while in his/her wheelchair to a stairwell door, manipulate the handle until it released, and exited into the stairwell, resulting in him/her falling down approximately 10 stairs with the wheelchair positioned over him/her. This represents an immediate and serious breakdown in supervision and safety systems, placing the resident at risk for serious harm, serious injury, serious impairment or death. Findings are as follows: Record review of a facility-reported incident submitted to the Rhode Island Department of Health on 4/13/2026 indicated Resident #1 has a Brief Interview for Mental Status (BIMS) score of 3/15, consistent with severe cognitive impairment. The resident has dementia, poor safety awareness, and self-propels rapidly in his/her wheelchair throughout the unit. The resident was found lying in a stairwell and was subsequently hospitalized and admitted with a subdural hematoma (a collection of blood found between the brain and the outer most covering typically caused by head trauma) and subarachnoid hemorrhage (a type of hemorrhagic that occurs between the brain and the membrane that protects it). Record review revealed Resident ID #1 was initially admitted to the facility in September of 2024 with a diagnosis including but not limited to dementia. Record review of an elopement assessment dated [DATE] identified the resident at high risk for elopement and indicated the use of a wander guard bracelet to his/her right wrist. Record review of a Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed the resident has a BIMS score of 3 out of 15, indicating severe cognitive impairment. Additionally, the record indicates that the resident has the ability to independently wheel him/herself in a wheelchair at least 150 feet down the corridor. During a surveyor interview on 4/21/2026 at 11:25 AM with the Administrator, she confirmed through her investigation on the day of the incident, Resident #1 was self-propelling in his/her wheelchair on the secured unit, approached the stairwell exit door, and held the fire bar until the door released. The resident then exited into the stairwell and fell down a flight of approximately 10 stairs. When staff responded to the door alarm, they found the resident lying on the stairwell landing. Additionally, the Administrator acknowledged that the alarm to the stairwell door was not loud enough to be heard by all the staff located on the secured unit. During a surveyor interview on 4/21/2026 at 3:32 PM with Nursing Assistant, Staff A, she revealed that at the time of the incident she was assisting another resident in the shower room. She indicated that she did not hear the alarm until opening the shower room door, at which time she responded to the exit stairwell door and observed Resident ID #1 lying on the landing. During a surveyor interview on 4/21/2026 at 3:41 PM with the Supervisor, Registered Nurse, Staff B, she revealed that she observed Resident ID #1 in the dining room minutes before s/he fell. Additionally, she revealed that she did not hear the door alarm sounding from the dining room. (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>During a surveyor interview on 4/24/2026 at 9:12 AM with Unit Manager, Licensed Practical Nurse, Staff C, she revealed that she was in her office, located near the dining room, when the incident occurred and she did not hear the alarm from her office. Record review of a nursing progress note dated 4/9/2026 revealed the resident was found in the stairwell and assessed with a bump to the back of his/her head. Emergency Medical Services (EMS) was called to transfer the resident to the hospital for an evaluation and Resident ID #1 was kept in place until their arrival. Record review of the EMS Patient Care Report, dated 4/9/2026 revealed that EMS was dispatched to the facility for a traumatic injury resulting after Resident ID #1 fell down 10-12 stairs. Further review of the report indicated that staff from an adjacent medical office reported hearing a door open and an alarm sounding upstairs from the facility's dementia unit, followed by significant noise and someone screaming for help. The report indicates that the resident managed to open a locked door, rolled down the stairs while in his/her wheelchair, and was found on the stairwell landing with the wheelchair on top of him/her. Upon further assessment, the resident was noted with a hematoma (a collection of clotted or partially clotted blood) to the back of his/her head and a contusion to his/her right forearm. Record review of the hospital documentation, dated 4/9/2026, revealed the resident presented to the Emergency Department with a hematoma to his/her posterior scalp and a contusion (soft tissue injury) to his/her tongue. Additionally, a CT scan (is a diagnostic imaging test that uses X-rays and computer processing to create detailed cross-sectional images of the body) was completed and the results indicated that the resident sustained a subdural hematoma and right-sided subarachnoid hemorrhage and s/he was admitted. The facility failed to provide adequate supervision and elopement protection for Resident ID #1, who was a known high elopement risk. This failure enabled the resident to exit a secured unit door undetected, roll down multiple stairs, falling to the stairwell landing and s/he subsequently sustained a subdural hematoma and subarachnoid hemorrhage from the trauma. This lapse of supervision placed the resident at risk for more than minimal harm, serious injury, or death.</p>		