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	07/31/2025

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

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observation, record review, staff, and resident representative interview, it has been determined that the facility failed to treat each resident with respect and dignity for 1 of 1 resident reviewed relative to incontinence care prior to a leave of absence (LOA), Resident ID #18. Findings are as follows:Review of a facility policy titled, Resident Rights last revised February 2021 states in part, .Employees shall treat all residents with kindness, respect and dignity.Federal and state laws guarantee certain basic rights to all residents of the facility. These rights include the resident's right to.a dignified existence .Record review revealed the resident was admitted to the facility in June of 2025 with a diagnosis including, but not limited to, Alzheimer's disease.Record review of the Minimum Data Set (MDS) assessment dated [DATE] revealed s/he had a Brief Interview for Mental Status score of 3 out of 15, indicating severely impaired cognition. Additional review of the MDS revealed the resident was incontinent of bowel and dependent on staff for toileting and hygiene.Review of his/her care plan revealed a focus area dated 6/21/2025 indicating that the resident is incontinent of bowel related to advanced dementia. During a surveyor observation on 7/29/2025 at 8:42 AM, Certified Medication Technician, Staff A, was seen escorting the resident from the elevator. A strong odor of fecal incontinence was immediately noticeable through a surgical mask. Further observation showed Staff A, continuing to lead the resident toward the lobby, ultimately escorting the resident out through the main entrance to a family member before promptly walking away. The resident's family member immediately returned to the door, urgently calling for staff assistance. When this surveyor approached the family member and resident, it was observed that the resident had loose stool running down the resident's pants, into his/her shoes and dripping onto the floor. At this time the receptionist was asked to call for staff to come assist.During a surveyor interview on 7/29/2025 immediately following the above observation with the resident representative, s/he revealed that s/he called the facility earlier to have the resident ready to go to the hospital to visit with his/her dying spouse. S/he was extremely upset, crying and stated, Why would they give [the resident] to me like that?During a surveyor interview on 7/29/2025 at approximately 9:30 AM with Staff A, she acknowledged that she transported the resident from the unit to the main lobby to go on a LOA with his/her family. She would not acknowledge that the resident was incontinent of bowels. During a surveyor interview with the Director of Nursing Services on 7/29/2025 at 11:57 AM, she revealed that the resident had two episodes of loose stool and may not be feeling well. She further revealed that it would be the expectation that a resident is clean, and that incontinence care would have been provided prior to leaving the facility. Additionally, she was unable to provide evidence that the resident was treated with respect and dignity.

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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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice, relative to 1 of 1 resident reviewed for a urology consult, Resident ID #1, and for 1 of 1 resident reviewed for dietary restrictions, Resident ID #103.Findings are as follows:According to Mosby's 4th Edition, Fundamentals of Nursing, page 314 states in part, The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe that the orders are in error or would harm the clients.1) Record review revealed Resident ID #1 was readmitted to the facility in May of 2025 with a diagnosis including, but not limited to, fibromyalgia (chronic pain syndrome).Review of a Continuity of Care (COC) form dated 7/25/2025 revealed the resident attended a urology consult and returned with a recommendation including, but not limited to, increase fluid intake.Record review failed to reveal evidence of a physician's order to encourage fluids.During a surveyor interview on 7/31/2025 at 8:43 AM, with Unit Manager, Licensed Practical Nurse, Staff B, she revealed that if a resident requires extra fluids, it should be documented on the Medication Administration Record as a task. She acknowledged that there was not a current physician's order in place to encourage fluids and indicated that there should be. Record review revealed a physician's order dated 7/31/2025 at 8:48 AM, entered by Staff B, to encourage an extra 240 milliliters (ml) of fluid, per shift. This order was entered after the surveyor interviewed Staff B. During a surveyor interview on 7/31/2025 at 10:47 AM, with Nurse Practitioner (NP), Staff C, she revealed that she was aware of the urology recommendation from 7/25/2025 and revealed that she would not approve the recommendation, due to the resident's current sodium levels. Additionally, when asked about the physician's order entered by Staff B, she revealed that she did not give the order to encourage 240 ml of fluid every shift.During a surveyor interview on 7/31/2025 at 11:05 AM, with Staff B, she acknowledged that she entered the above-mentioned physician's order without speaking to the resident's provider, Staff C.During a surveyor interview on 7/31/2025 at 11:41 AM, with the Director of Nursing Services (DNS) she revealed that she would expect staff to speak with the resident's provider prior to entering any orders. Further, she revealed the order has been discontinued, as it was not approved by Staff C.2) Record review revealed Resident ID #103 was admitted to the facility in August of 2024 with a diagnosis including, but not limited to, dysphagia (difficulty swallowing).Record review revealed a physician's order dated 8/3/2024 for a regular diet with special instructions that state, NO PAPER PRODUCTS ON TRAY-REMOVE MENU, TRAY MAT, NAPKIN.Record review revealed a progress note dated 8/20/2024 which states in part, Resident noticed to be biting into [his/her] paper ticket at breakfast this morning.Removed tray ticket and napkin from tray. Resident redirected back to food.Nursing, NP and Dietary Department notified. Tray ticket modified to include instructions for no paper products on tray. Care plan updated.During a surveyor observation on 7/28/2025 at 12:24 PM, Resident ID #103 was noted to be in his/her room eating lunch, with the tray ticket, tray mat, and napkin in front of him/her on the table.During a surveyor interview on 7/28/2025 at 1:10 PM, with Nursing Assistant, Staff D, she acknowledged the special instructions on the resident's meal ticket and acknowledged the resident still had the ticket, mat and napkin in front of him/her. Additionally, she revealed that she was unsure why the resident's meal ticket included removing the ticket, mat, and napkin.During a surveyor interview on 7/29/2025 at 8:19 AM, with Registered Nurse, Staff E, she acknowledged that the diet order instructions specified to remove paper products from the meal tray.During a surveyor interview on 7/29/2025 at 1:18 PM, with the DNS, she revealed that she would expect nursing to review a resident's meal ticket prior to distributing their meal. Further, she revealed that she would have expected Resident ID #103 to not have received any paper products, per the physician's order.

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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. Based on record review and staff interview, it has been determined that the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan for 1 of 1 resident reviewed for daily weights, Resident ID #192. Findings are as follows:Record review revealed that the resident was admitted to the facility in May of 2025 with a diagnosis including, but not limited to, congestive heart failure (CHF, a condition where the heart struggles to pump blood effectively, leading to excess fluid in the body). Additionally, the record revealed that s/he was transferred to an acute care hospital on 6/3/2025 due to an exacerbation of CHF.Record review of a care plan that was initiated on 5/12/2025, revealed a focus area for CHF. Interventions included to monitor for signs and symptoms of CHF, such as weight gain unrelated to meal intake.Record review of the hospital Continuity of Care documents which were received upon admission to the facility on 5/11/2025, revealed the following physician's order:- Weigh daily, call the provider if weight is greater than 3 pounds (lbs.) in a day or 5 lbs. in a week.Further record review failed to reveal evidence that the above physician's order was accepted or declined by a facility provider.Record review of a progress note dated 5/23/2025, authored by Nurse Practitioner, Staff F, states in part, .Patient's weight has continued to increase. Patient should be receiving daily weights.Additional record review revealed that a physician's order for daily weights to be obtained, was implemented on 5/28/2025, 17 days after the resident was admitted to the facility.Additionally, the record failed to reveal evidence that the resident's weights were documented daily on the following dates:5/14, 5/16, 5/17, 5/18, 5/21, 5/22, 5/24, 5/25, 5/26, 5/27, and 5/31/2025 which indicates his/her weight was not obtained for 11 out of 24 opportunities. During a surveyor interview on 7/31/2025 at 2:12 PM, Nurse Practitioner, Staff F declined to confirm whether the order for daily weights should have been implemented on 5/11/2025, despite documentation in her previously noted progress note entry.During a surveyor interview on 7/31/2025 at 11:41 AM with the Director of Nursing Services, she was unable to provide evidence that the resident's weight was monitored daily since his/her admission to the facility on 5/11/2025.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to ensure that each resident's medication regimen is free from medication error rates of 5% or greater. Based on 28 opportunities for error observed during the medication administration task, there were 3 errors resulting in a 10.71% error rate involving Resident ID #s 24 and 135.Findings are as follows:Review of the facility's policy titled, Administering Medications states the following in part, .Medications are administered in accordance with prescriber orders.Residents may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team, has determined that they have the decision-making capacity to do so safely.1. Record review revealed Resident ID #24 had a physician's order with start date of 7/28/2025 for Keppra oral tablet give 1250 milligrams (mg) by mouth two times a day to treat epilepsy (seizure disorder).During a surveyor observation of the medication administration task on 7/30/2025 at 8:27 AM, with Licensed Practical Nurse (LPN), Staff H, she retrieved a bottle of liquid Keppra oral liquid solution 100 mg/milliliters (mL) from the medication cart and poured an unmeasured amount of the medication into a 30 mL medicine cup that lacked a 12.5 mL measurement mark. The liquid medication was observed to be between the 10 mL and 15 mL measurement marks.During a surveyor interview with Staff H, immediately following the above-mentioned observation, she acknowledged that she was ready to administer the medication to Resident ID #24. Additionally, she stated that she poured the medication above the 10 mL and below the 15 mL marks. She then acknowledged that the medication should be measured accurately. Additionally, Staff H confirmed that the order was for a tablet, but she was administering the medication in liquid form. 2. Record review revealed Resident ID #135 had the following physician's orders:A. An order dated 7/28/2025, for GlycoLax Powder give 17 grams by mouth two times a day for constipation, mix powder in 6 ounces (oz) of fluid of choice.During a surveyor observation of the medication administration task on 7/31/2025 at 8:28 AM, with LPN, Staff I, she was observed mixing the 17 grams of GlycoLax powder into a 120 mL cup (approximately 4 oz) of water. Additionally, Staff I did not measure or provide 6 oz of fluid as prescribed.During a surveyor interview with Staff I, immediately following the above observation, she stated she was ready to administer the medication to Resident ID #135. When the surveyor asked her how much water was in the cup, she stated it was about 6 oz. She then proceeded to calculate using her cellphone and showed the surveyor that 6 oz is approximately 177 mL but acknowledged that she did not measure 6 oz. She then proceeded to get a second 120 mL cup and poured and unmeasured amount of water into that cup. Staff I proceeded to transfer the fluids back and forth from the first cup into the second cup several times. The surveyor then asked again if she was ready to administer the medication which Staff I stated yes. The surveyor then asked if the facility had a different size cup to which Staff I indicated that she would get a larger cup and proceeded to start the preparation over.B. An order dated 7/23/2025, for Fluticasone Propionate Nasal Suspension 50 micrograms/activated one spray in both nostrils two times a day for allergies.During a surveyor observation on 7/31/2025 at approximately 8:52 AM, Staff I handed the Fluticasone nasal spray to Resident ID #135 without asking the resident if s/he wanted to self-administer. Additionally, the resident was observed to administer two sprays in each nostril instead of one, as ordered. During a surveyor interview with Resident ID #135 immediately following the above observation, s/he indicated that s/he always administers two sprays in each nostril.Further record review failed to reveal evidence of an order for the resident to self-administer medications.During a surveyor interview with Staff I, immediately following the above observation, she acknowledged that the resident self-administered two sprays and not one per the physician's order. Additionally, Staff I acknowledged that the order does not indicate self-administration and indicated she would notify the provider.During a surveyor interview with Director of Nursing Services (DNS) on 7/31/2025 at approximately 9:07 AM, the DNS indicated that she would expect the nurses to administer medications according to the physician's order and allow a resident to self-administer if the order and an assessment indicates such.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on surveyor observation and staff interview, it has been determined that the facility failed to ensure that food is stored and distributed in accordance with professional standards for food service safety, relative to the main kitchen. Findings are as follows:1) Record review of the manufacturer's label for a Vital Cuisine Mighty Shake states in part, .use within 14 days of thawing.During a surveyor observation on 7/28/2025 at 8:53 AM, of the main kitchen, revealed thirty-four Vital Cuisine Mighty Shakes in the walk-in refrigerator, without a use-by date to identify when the product was thawed.During a surveyor interview immediately following the above observation with the Food Service Director (FSD), he acknowledged the Mighty Shakes were not dated and revealed that they are dated when they are delivered to the unit.2) Record review of The Rhode Island Food Code 2022 Edition 4.601.11 reads in part, .(A) equipment food contact surfaces .shall be clean to sight .During a surveyor observation on 7/28/2025 at 8:53 AM of the ice machine located in the main kitchen, revealed an accumulation of a pink wipeable substance located on the ice dispenser shield.During a surveyor interview immediately following the above observation with the Regional FSD, she acknowledged the pink wipeable substance in the ice machine and revealed it had been professionally cleaned three weeks prior.During a follow up surveyor observation of the main kitchen on 7/30/2025 at 9:42 AM, after the above concerns were identified by the surveyor, the ice machine was cleaned, and all of the Mighty Shakes were dated when thawed.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observation, record review, resident, and staff interview, it has been determined that the facility failed to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area for 4 of 4 residents observed with their call lights out of reach who were requesting staff assistance, Resident ID #s 1, 105, 162, and 175.Findings are as follows:Review of a facility policy titled, Call System, Resident dated September 2022, states in part, .Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities, and from the floor.1) Record review revealed Resident ID #162 was readmitted to the facility in February of 2024 with diagnoses including, but not limited to, dementia and muscle weakness.Review of a care plan focus area dated 5/12/2025 revealed s/he has Activities of Daily Living (ADL) self-care performance deficits related to physical limitations and medical co-morbidities with an intervention to encourage him/her to use his/her call light for assistance.Surveyor observations revealed the resident's call light was placed out of the resident's reach on the following dates and times:-7/28/2025 at 11:37 AM: The resident was observed in a recliner in the center of his/her room while the call light was noted to be on his/her bed.-7/29/2025 at 12:03 PM: The resident was observed in a recliner in the center of his/her room while the call light was noted to be on the foot of his/her bed.-7/30/2025 at 10:03 AM: The resident was observed in a recliner in the center of his/her room while the call light was noted lying to be lying across the bed and resting on the floor.During a surveyor interview immediately following the above observation on 7/30/2025 with Activity Aide, Staff J, she acknowledged that the resident's call light was out of the resident's reach.During an additional surveyor observation on 7/30/2025 at 10:34 AM, the resident was observed in a recliner in the center of his/her room while the call light was noted lto be [NAME] across the bed and resting on the floor, out the resident's reach.During a surveyor interview immediately following the above observation with Licensed Practical Nurse, Staff B, she acknowledged that the resident's call light was out of the resident's reach.2) Record review revealed Resident ID #105 was readmitted to the facility in April of 2024 with diagnoses including, but not limited to, history of falling and muscle weakness.Review of the care plan revealed s/he has ADL self-care performance deficits and is at risk for falls with interventions that include to ensure his/her call light is within reach and to encourage him/her to use his/her call light for assistance.Surveyor observations revealed the resident's call light was placed out of the resident's reach on the following dates and times:-7/28/2025 at 11:08 AM: The resident was observed in his/her bed while the call light cord was noted to be tied to the bedrail with the call light dangling off the side of the bed.-7/29/2025 at 12:09 PM: The resident was observed in his/her bed while the call light cord was noted to be tied to the bedrail with the call light dangling off the side of the bed.-7/30/2025 at 10:00 AM: The resident was observed in his/her bed while the call light was resting on the floor.During a surveyor interview immediately following the above observation on 7/30/2025 with Nursing Assistant, Staff K, she acknowledged that the resident's call light was on the floor and was out of the resident's reach.3) Record review revealed Resident ID #175 was readmitted to the facility in November of 2022 with diagnoses including, but not limited to, repeated falls and unsteadiness on feet.Review of the care plan revealed s/he has ADL self-care performance deficits and is at risk for falls with interventions that include to ensure his/her call light is within reach and to encourage him/her to use his/her call light for assistance.During a surveyor observation on 7/28/2025 at 10:50 AM, the resident was observed in his/her bed while the call light was noted to be resting on the floor behind the headboard of his/her bed, out of the resident's reach.4) Record review revealed Resident ID #1 was readmitted to the facility in May of 2025 with diagnoses including, but not limited to, muscle weakness and history of falling.Review of a Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status score of 15 out of 15, indicating intact cognition.Review of the care plan revealed s/he has ADL self-care performance deficits and is at risk for falls with interventions that include to ensure his/her call light is within reach and to encourage him/her to use his/her call light for assistance.During a surveyor observation and simultaneous interview on 7/31/2025 at 8:26 AM with Resident ID #1, s/he was observed in his/her bed eating breakfast. S/he revealed that s/he would like sugar packets for his/her cereal but cannot reach his/her call light. Additionally, his/her call light was noted to be resting on his/her nightstand by the foot of his/her bed, out of his/her reach. Further, s/he revealed that the call light is often on the nightstand, and s/he is unable to reach it.During a surveyor interview immediately following the above observation with Staff