

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415085	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/30/2025
NAME OF PROVIDER OR SUPPLIER Mount St Rita Health Centre		STREET ADDRESS, CITY, STATE, ZIP CODE 15 Sumner Brown Road Cumberland, RI 02864	

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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
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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 0689 Level of Harm - Actual harm Residents Affected - Few	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observation, review of the clinical record, and staff interviews, the facility failed to ensure adequate supervision to prevent an accident for 1 of 1 resident reviewed. The resident disengaged the alarm system, exited the facility, remained outside for an unknown period of time, sustained an unwitnessed fall, and was unable to re-enter the building, resulting in hospital admission for treatment of frostbite to the resident's bilateral hands, Resident ID #1. Findings are as follows: Record review of a community reported complaint submitted to the Rhode Island Department of Health on 12/29/2025, states in part, that a resident wandered outside of the facility during a snowstorm, believed to be outside for at least one hour, was found yelling for help while holding onto a metal bar with both hands. S/he had large blisters on both palms, blisters on all 5 digits on the left hand and 3 digits on the right hand. The resident reported to the emergency medical personnel that s/he fell outside after his/her cane fell and that s/he held onto the metal bar for stability and called for help. 1. Record review of a facility policy titled Elopements and wandering Residents states in part, this facility ensures that residents who exhibit wandering behavior and or are at risk of elopement receive adequate supervision to prevent accidents, and receive care in accordance to their person-centered plan of care addressing unique factors contributing wandering or elopement risk. Wandering is random or repetitive locomotion that may be goal-directed (e.g., the person appears to be searching for something such as an exit). Record review revealed Resident ID #1 was admitted to the facility in December of 2024 with diagnoses including, but not limited to, type 2 diabetes mellitus, complete traumatic amputation of left foot, and insomnia (inability to sleep). Review of an Annual Minimum Data Set assessment dated [DATE], revealed the resident had a Brief Interview for Mental Status score of 15 out of 15, indicating intact cognition. Record review of a care plan revised on 9/25/2025 revealed that the resident was at risk of falls, was unsteady on his/her feet, s/he was partial weight bearing to his/her left lower leg and required the use of an orthopedic shoe and rolling walker for ambulation. Record review of a progress note dated 11/26/2025 at 11:48 PM, revealed that the resident had attempted to exit the building from the lobby. S/he indicated that s/he wanted to go home and was waiting for a friend to pick him/her up. The receptionist had called the unit to assist the resident however the resident had refused to return to the unit. A nurse and supervisor went to the lobby, yet the resident continued to refuse. The supervisor reached out to residents family, who revealed that there was not anyone coming to get the resident, however the resident insisted that a friend from out of state was coming. After multiple attempts the resident agreed to return to the unit with the supervisor. Further review of his/her care plan failed to reveal evidence of a focus area for going outdoors without staff notification and wandering prior to 12/26/2025. Record review failed to revealed evidence that an elopement evaluation was completed following the incident on 11/26/2025, when the resident exhibited wandering behavior and potential risk for elopement. Additionally, the care plan was not updated after the 11/26/2025 incident to reflect this change in this residents condition. During a surveyor interview on 12/30/2025 at 3:25 PM with Receptionist, Staff A, she recalled the incident on 11/26/2025 and revealed that when the resident arrived in the lobby independently without a rolling walker or wheelchair, s/he was visibly unsteady when walking. She noted that it was cold and dark outside, and she was concerned that the resident would fall. She then called the nurse on the unit as the resident was insisting on leaving the facility and refusing to return to the unit. She revealed that she had witnessed the resident exit the facility using the emergency exit button, located by the main door, to disengage the alarm on multiple occasions. Additionally, she indicated that the resident would come down the stairs of the lobby without his/her wheelchair or rolling walker as s/he was unable to navigate the stairs with anything other than a cane. During a surveyor interview on 12/30/2025 at 8:22 AM with the Administrator, he revealed that the facility has a receptionist in the lobby daily until 6:00 PM, the front doors automatically lock at approximately 4:30 PM daily and doorbells attached to the building are then used. He revealed that when someone rings the doorbell, a notification and video is sent to a cellular phone that the nursing supervisor has, they can then unlock the door for the individual to enter. When questioned by the surveyor regarding the incident that occurred on 11/26/2025, he stated that he was not aware of the incident until it was brought to her attention by the surveyor. During a surveyor interview on 12/30/2025 at 9:48 AM with the Director of Nursing Services, she revealed that it was not unusual for the resident to go outside for fresh air and that the resident had previously resided in an assisted living facility and was struggling to adjust to a restricted environment. Additionally, she revealed that the resident wakes</p>		