STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415085	A. Building B. Wing	06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount St Rita Health Centre	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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **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 involving an accident resulting in serious injury was reported to the appropriate authorities, including the State Survey Agency, as required by State law. This deficient practice was identified for 1 of 3 residents reviewed, Resident ID #1.Findings are as follows:Review of a community reported complaint received by the Rhode Island Department of Health on 6/9/2026 alleged that Resident ID #1 sustained a dislocated right shoulder and bruising to the right upper arm. Additionally, it indicated that the facility was unaware of the cause of the injury.Record review revealed the resident was admitted to the facility in January of 2025 with diagnoses including, but not limited to, Alzheimer's disease and polyosteoarthritis (a form of arthritis that simultaneously affects multiple joints throughout the body).Record review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that the resident has a Brief Interview for Mental Status score of 4 out of 15, indicating severely impaired cognition. The MDS also indicated that the resident is totally dependent on staff for bed mobility.Record review of a nursing progress note dated 6/6/2026 at 11:00 PM authored by Registered Nurse (RN), Staff A, revealed a Nursing Assistant reported bruising to the resident's right armpit and right posterior arm. The resident was unable to recall how s/he sustained the bruising due to his/her cognitive impairment.Record review of a nursing progress note dated 6/7/2026 at 11:45 AM authored by RN, Staff B, revealed the resident was sent to the emergency room (ER) for an evaluation and returned to the facility with a sling on his/her right arm.Record review of the ER hospital progress notes dated 6/7/2026 revealed s/he was diagnosed with a closed traumatic right posterior (the back) dislocation of the shoulder joint.Record review of the facility's internal investigation documents revealed a signed statement authored by the former Director of Nursing Services (DNS) dated 6/9/2026. The statement indicated, in part: [Resident ID #1] was found to have a bruise on [his/her] right forearm. The bruise appeared to be shaped like the side rail on [his/her] bed with striations that match the bars on the side rail. [S/he] sleeps on [his/her] right side with [his/her] arm around the side rail. It appears that [his/her] arm got caught in the side rail and when [s/he] rolled over it was stuck, resulting in [his/her] shoulder being dislocated when [s/he] tried to pull it out.During a surveyor interview on 6/24/2026 at 2:00 PM with the Administrator, in the presence of the current Director of Nursing Services, he acknowledged that the resident sustained a dislocated right shoulder that was not observed by any person, could not be explained by the resident, and was suspicious due to the location of and type of injury. Additionally, he was unable to provide evidence that the facility reported the incident to the appropriate authorities, including the State Survey Agency, as required under applicable State law governing long-term care facilities.Cross reference to citations F610, F689, and F700.

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **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 injury of unknown origin was thoroughly investigated in accordance with federal regulations for 1 of 1 resident reviewed for who was discovered to have bruising to his/her right armpit and was subsequently diagnosed with a closed traumatic right posterior dislocation of the shoulder joint, Resident ID #1.Findings are as follows:Record review revealed the resident was admitted to the facility in January of 2025 with diagnoses including, but not limited to, Alzheimer's disease and polyosteoarthritis (a form of arthritis that simultaneously affects multiple joints throughout the body).Record review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that the resident has a Brief Interview for Mental Status score of 4 out of 15, indicating severely impaired cognition. The MDS also indicated that the resident is totally dependent on staff for bed mobility.Record review of a nursing progress note dated 6/6/2026 at 11:00 PM authored by Registered Nurse (RN), Staff A, revealed a Nursing Assistant reported bruising to the resident's right armpit and right posterior arm. The resident was unable to recall how s/he sustained the bruising.During a surveyor interview on 6/24/2026 at 1:30 PM, Staff A stated that she did not identify any witnesses to the injury and acknowledged that the resident lacked the cognitive capacity to report how it occurred. She revealed that she did not initiate an investigation upon the discovery of the resident's bruising. Furthermore, she stated she was unaware if the incident was ever investigated.Record review of a nursing progress note dated 6/7/2026 at 11:45 AM authored by RN, Staff B, revealed the resident was sent to the emergency room (ER) for evaluation and came back with a sling on his/her right arm.Record review of the ER hospital progress notes dated 6/7/2026 revealed s/he was diagnosed with a closed traumatic right posterior dislocation of the shoulder joint.During a surveyor interview on 6/24/2026 at 11:29 AM, RN Staff B stated she worked the 11:00 PM to 7:00 AM shift on 6/5/2026 and 6/6/2026. Staff B stated the bruising was not present on 6/5/2026 but was noted on 6/6/2026. Staff B revealed that she did not initiate an investigation upon the discovery of the bruise to the resident's right armpit. Furthermore, she revealed that management did not interview or obtain a statement from her regarding the resident's injury.Record review of the internal investigation documents provided by the Administrator on 6/24/2026 at approximately 11:00 AM failed to demonstrate that a complete investigation was conducted, as the record lacked interviews or statements from all direct care staff regarding the resident's injury of unknown source.During a surveyor interview on 6/24/2026 at 2:00 PM, the Administrator, in the presence of the Director of Nursing Services, acknowledged that Resident ID #1 sustained a dislocated right shoulder that was unobserved, could not be explained by the resident, and was suspicious due to its location and type of injury. Additionally, he was unable to provide evidence that the facility completed a thorough investigation regarding this injury of unknown source, to endure no further potential incidents occurred.Cross reference to citations F609, F689, and F700.

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F 0700 Level of Harm - Actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure the correct use and ongoing reassessment of bed siderails for one of one resident, Resident ID #1 reviewed for the use of bed siderails. The facility failed to reassess the continued need for and safety of the resident's bed siderails for approximately 15 months, despite the resident's severely impaired cognition, total dependence for bed mobility, and continued use of the device. Consequently, the facility failed to identify that the bed siderails had become unsafe and were no longer clinically appropriate. As a result, Resident ID #1 sustained a traumatic posterior (the back) dislocation of the right shoulder and significant bruising. Following the injury, the facility's bed siderail assessment determined that the bed siderails were no longer indicated because they created a safety hazard for the resident. Findings are as follows:Record review of the Centers for Medicare & Medicaid Services' Resident Assessment Instrument (RAI) 3.0 Manual, dated October 2025, revealed that the use of bed siderails must be assessed prior to implementation and reassessed at least quarterly (every three months), and with any significant change in condition, to determine whether the continued use of the device remains appropriate and safe for the resident.Review of an undated facility policy titled Proper Use of Bed Rails, provided by the Administrator on 6/25/2026, stated in part, .When bed rails are used, perform an ongoing assessment of the patient's physical and mental status; closely monitor high-risk patients . Re-evaluate and revise the patient's treatment program as needed if an episode of entrapment or near-entrapment occurs with or without serious injury .Review of a community reported complaint received by the Rhode Island Department of Health on 6/9/2026 alleged that Resident ID #1 sustained a dislocated right shoulder and bruising to the right upper arm.Record review revealed Resident ID #1 was admitted to the facility in January 2025 with diagnoses including, but not limited to, Alzheimer's disease and polyosteoarthritis (a form of arthritis affecting multiple joints throughout the body).Record review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed the resident had a Brief Interview for Mental Status (BIMS) score of 4 out of 15, indicating severely impaired cognition. The MDS further revealed the resident was totally dependent on staff for bed mobility.Record review of a nursing progress note dated 6/6/2026 at 11:00 PM, authored by Registered Nurse (RN) Staff A, revealed that a Nursing Assistant reported bruising to the resident's right armpit and right posterior arm. Due to the resident's cognitive impairment, s/he was unable to recall how the injuries occurred.Record review of a nursing progress note dated 6/7/2026 at 11:45 AM, authored by RN Staff B, revealed the resident was transferred to the Emergency Department for evaluation and returned to the facility wearing a sling on the right arm.Record review of the Emergency Department records dated 6/7/2026, revealed the resident was diagnosed with a closed traumatic posterior dislocation of the right shoulder.Record review of the facility's internal investigation revealed a signed statement, authored by the former Director of Nursing Services (DNS), dated 6/9/2026, which stated in part, [Resident ID #1] was found to have a bruise on [his/her] right forearm. The bruise appeared to be shaped like the side rail on [his/her] bed with striations that match the bars on the side rail. [S/he] sleeps on [his/her] right side with [his/her] arm around the side rail. It appears that [his/her] arm got caught in the side rail and when [s/he] rolled over it was stuck, resulting in [his/her] shoulder being dislocated when [s/he] tried to pull it out .Record review failed to reveal evidence Resident ID #1 received the required ongoing reassessments of the continued need for and safety of the bed siderails after 2/4/2025. As a result, the facility failed to reassess whether the bed siderails remained clinically appropriate and safe for Resident ID #1 for approximately 15 months, despite the resident's severely impaired cognition, total dependence for bed mobility, and ongoing use of the device.Further record review revealed a bed siderail assessment (continued on next page)

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F 0700 Level of Harm - Actual harm Residents Affected - Few	completed on 6/8/2026 determined the bed siderails were unsafe for the resident's continued use. The assessment concluded that bed siderails were not indicated because they created an accident hazard for the resident.During a surveyor interview conducted on 6/24/2026 at 2:00 PM, with the Administrator, in the presence of the current DNS, he was unable to provide evidence that the facility completed the required ongoing reassessments to determine whether Resident ID #1's bed siderails remained appropriate and safe.The facility failed to ensure that Resident ID #1's bed siderails were appropriately reassessed, as required, to determine whether their continued use remained clinically appropriate and safe. Despite the resident's severely impaired cognition, total dependence for bed mobility, and continued use of the bed siderails, the facility failed to conduct the required quarterly reassessments for approximately 15 months. Consequently, the facility failed to identify that the bed siderails had become unsafe and no longer appropriate for the resident. As a result, Resident ID #1 sustained a traumatic posterior dislocation of the right shoulder and significant bruising. Following the injury, the facility completed a bed siderail assessment that determined the bed siderails were no longer indicated because they posed a safety hazard.Based on the former Director of Nursing Services' investigation, which concluded that the resident's arm became entrapped in the bed siderail while turning in bed, together with the facility's failure to perform the required ongoing assessments of the continued appropriateness and safety of the bed siderails for approximately 15 months, a reasonable person would conclude that the facility's deficient practice directly contributed to the resident's injury and resulted in actual harm.Cross reference to citations F609 and F610.