STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415098	A. Building B. Wing	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harris Health Center LLC	833 Broadway East Providence, RI 02914

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 - Minimal harm or potential for 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 - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observation, record review, staff, and resident interviews, it has been determined that the facility failed to ensure that a resident received adequate supervision to prevent an elopement for 1 of 3 residents reviewed Resident ID #1.Findings are as follows:Review of a facility reported incident submitted to the Rhode Island Department of Health on 9/14/2025 reveals that Resident ID #1 left the facility without following the leave of absence policy and procedure. Record review revealed the resident was admitted to the facility in March of 2023 with diagnoses including, not limited to, bipolar disorder and epilepsy (a neurological disorder characterized by recurrent, unprovoked seizures).Record review of a Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status score of 14 out of 15 indicating the resident's cognition is intact. Additional review of the MDS revealed the resident ambulates independently.Record review revealed a progress note dated 9/13/2025 at 10:38 PM, revealed the resident left the facility and went to the hospital to visit with his/her relative. Record review of a care plan revised on 9/13/2025 after the resident retuned to the facility from visiting his/her relative, revealed the resident is at risk for elopement and staff interventions including, but not limited to, ensuring staff awareness of the resident's wander risk and ensuring that the LOA policy and procedure is being followed. Record review revealed the following nursing progress notes from 9/14/2025, the day after the resident left the facility without following the LOA policy: 9:00 AM- the facility received a call from a police department that was approximately 12 miles from the facility across the state line. The police indicated to the facility that Resident ID #1 was at their station, and they would be accompanying him/her back to the facility.11:53 AM, revealed the resident left the facility without following the LOA policy and procedure, s/he returned to the facility accompanied by the police on 9/14/2025 at approximately 9:20 AM, and the resident was sent to a local hospital for evaluation.A surveyor observation on 9/17/2025 at 10:28 AM of the staff desk area adjacent to the front door revealed a key attached to a wooden pad visible on a shelf that was accessible to the residents. During a simultaneous surveyor observation and interview on 9/17/2025 at 12:45 PM with Staff A, she acknowledged the key on the shelf and that the key is accessible to the residents. She indicated it was the key for the rear door on the first floor. Additionally, she revealed that the key for the rear door is kept either in the desk drawer, at the staff desk, or on the shelf as observed. Staff A revealed that the last time she had seen the resident ambulating in the hall was on 9/15/2025 at approximately 7:50 AM and indicated that this may have been the key the resident used on 9/14/2025 to exit the facility and that the location of the key had not changed since the resident eloped from the facility on 9/14/2025. During a surveyor interview with the resident on 9/17/2025 at 10:40 AM, s/he revealed that on 9/13/2025 s/he had signed the LOA log to go out to see his/her relative at a hospital accompanied by a family member. S/he revealed that they returned to the facility on the night of 9/13/2025 and s/he did not call the facility to notify them that s/he would be out for an extended period. The resident revealed that on 9/14/2025 at approximately 8:10 AM, s/he removed the key from the staff desk, unlocked the rear door, and left the facility via a bus to see his/her relative at the hospital. S/he indicated that after visiting with his/her relative, s/he went to the police station that was approximately a block from the hospital and asked for a ride back to the facility. The resident indicated that s/he was out of the facility for less than two hours and returned to the facility accompanied by the police and is aware that s/he did not follow the facility's LOA policy. Additionally, the resident indicated that since this incident, s/he is not allowed to leave the facility without being accompanied by a family or staff member.During a surveyor interview on 9/17/2025 at 11:00 AM with Registered Nurse, Staff B, she acknowledged that the above-mentioned LOA log entries were not completed in its entirety, as required. Additionally, Staff B acknowledged that the LOA log should have been signed off by the nurse on duty prior to the resident leaving the facility and upon his/her return.Surveyor review of the facility's video surveillance footage on 9/17/2025 at 1:25 PM in the presence of the Administrator, revealed the resident was walking toward the staff desk area adjacent to the front entrance on 9/14/2025 at 8:12 AM and walked back with the key in his/her hand. The resident then opened the exit door at the rear end of the hall on the first floor, left the key in the door, and exited the facility on 9/14/2025 at 8:14 AM. During a surveyor interview on 9/17/2025 at 1:35 PM with the Director of Nursing Services (DNS), she indicated that the resident had been made aware on the evening of 9/13/2025 that s/he was no longer allowed to leave the facility unaccompanied because of his/her non-compliance to the facility's LOA policy. The DNS indicated that on 9/14/2025 the resident left the facility unknown to the staff until they were notified