STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415106	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Antoine Residence	10 Rhodes Avenue North Smithfield, RI 02896

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46539 Based on record review and staff interview, it has been determined that the facility failed to keep a resident free from abuse 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 (RIDOH) on 3/31/2025, revealed in part, that Resident ID #1 became combative with staff and was escorted to his/her room and that the resident was held down in his/her bed to avoid him/her from falling. Additionally, the incident report dated 3/31/2025, revealed that a follow up call was placed from RIDOH to the facility, where the Director of Nursing Services (DNS), revealed that Registered Nurse (RN), Staff A, and Licensed Practical Nurse (LPN), Staff B, restrained Resident ID #1. Review of the facility policy titled, Abuse Prevention Plan reviewed 10/23 states in part, .Abuse is defined as . the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish .It includes verbal abuse, sexual abuse, physical abuse, and mental abuse . convenience is defined as the result of any action that has the effect of altering a resident's behavior such that the resident requires a lesser amount of effort or care, and is not in the resident's best interest .freedom of movement means any change in place or position for the body or any part of the body that the person is physically able to control .manual method means to hold or limit a resident's voluntary movement by using body contact as a method of physical restraint .physical restraint is defined as any manual method, physical or mechanical device, equipment, or material that meets all the following criteria .Restricts the resident's freedom of movement or normal access to his/her body . Record review revealed Resident ID #1 was readmitted to the facility in January of 2025 with diagnoses that include, but are not limited to, dementia and anxiety disorder. Review of an Admission Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status score of 0 out of 15, indicating the resident has severely impaired cognition. Review of the resident's care plan revealed that s/he is at risk for selfcare deficit related to weakness and deconditioning related to advanced dementia with the following interventions in place; if resistive to care, redirect and reapproach at a later time and approach the resident in a calm friendly manner for daily care. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's progress notes revealed that on 3/31/2025, at approximately 7:30 PM, RN, Staff C, was on the unit when Resident ID #1 was noted to be agitated and aggressively attempting to enter the room of another resident. Staff A, was assisting him/her out of the other resident's room and escorted Resident ID #1 to the common area. RN, Staff C, left the unit and was called back for Resident ID #1 being out of control and that s/he was combative and was attempting to fight everyone. Staff C, and Staff B, went back to the unit to assist. Resident ID #1 was found sitting in the common area, extremely agitated and combative, throwing his/her walker at staff, kicking, biting, and punching anyone that was in his/her reach. Staff were told to back away from him/her; however, the resident got up and was attempting to head in the direction of other residents. Staff C removed the other residents from the immediate situation and called Emergency Medical Services (EMS) for assistance. At this time LPN, Staff B, and Nursing Assistants (NA), Staff D and E, escorted Resident ID #1 out of the common area and into his/her bed. The NA's left the room and Staff C stayed behind with the resident while Staff B attempted to keep him/her safe until help arrived. Resident ID #1 began kicking and spitting. Staff C, and Staff B, tried to calm the resident down by offering him/her ice cream and music, to which s/he took a mouthful of and spit it across the room. Police and EMS arrived shortly after and without incident, the resident was transferred to the hospital for a work-up. During a surveyor interview on 4/7/2025 at 11:05 AM, with RN, Staff C, she revealed that on 3/31/2025 she received a call from a staff member on Resident ID #1's unit who indicated that the resident was out of control. She further revealed that she and LPN, Staff B, went to the unit to assist. She revealed that upon arrival to the unit she found Resident ID #1 sitting in a chair in the common area with his/her walker in front of him/her and the resident appeared terrified. She revealed that the resident attempted to throw his/her walker at her, so she removed the other residents from the area. She revealed that when she went back to the resident s/he was being assisted from the chair in the common area to his/her room by NA's, Staff D, E, and ,Staff B. She revealed that while the other staff was assisting Resident ID #1 back to his/her room she left to get the resident an ice cream and mats for the floor in case of a fall and went back to his/her room. Upon entering the resident's room she observed LPN, Staff B, push the resident into bed and held him/her down with her hand on the resident's chest. She revealed that she told Staff B to stop and Staff B responded, No [s/he] is not going to act like that. She further revealed that she continued to tell the Staff B to stop. The resident then began to spit at the staff and she revealed that Staff B, held the resident's head to the side with her palm on the side of the resident's head behind his/her ear. She further revealed that she sent both Staff A and B home on 3/31/2025, following the above incident of witnessed abuse. During a surveyor interview on 4/7/2025 at 12:57 PM with NA, Staff D, she revealed that on 3/31/2025 she witnessed RN, Staff A, dragging Resident ID #1 down the hallway by pulling his/her arm and walker. She then observed Staff A to forcefully push the resident into a chair. She revealed that the resident attempted to hit her with his/her walker and stomp on her foot. She revealed another staff member came over to assist by removing the walker from the resident and then the resident bit that staff member's arm. Staff D, revealed that Staff A, then pushed the resident's head backwards to stop him/her from biting. She revealed that at this point RN, Staff C and LPN, Staff B, arrived on the unit. Staff B, brought the resident to his/her room by pulling the resident towards the room and Staff B, said to the resident, you're going to get hurt more than I will. She revealed that she told the staff to stop and attempted to hold the resident's hands to walk him/her down the hall. However, Staff B, continued to pull the resident aggressively and forced him/her into bed. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During a surveyor interview on 4/8/2025 at 9:42 AM, with NA, Staff E, she revealed that on 3/31/2025 she was coming out of the shower room on the unit when she saw RN, Staff A, dragging the resident down the hallway by pulling his/her arm and walker. She indicated that the resident looked scared. She then observed Staff A pick up the resident and tossed [him/her] into the chair. She stated that she told the nurse to walk away and take a break. She revealed that after she completed care on another resident, she returned to the common area to check on Resident ID #1 where she observed LPN, Staff B, dragging the resident to his/her room, and Staff E, told LPN, Staff B, to leave the resident alone. She revealed that Staff B, continued to bring the resident to his/her room and that the resident attempted to pull away and almost fell . She stated when they got into the room Staff B, threw [him/her] into the bed and pinned [him/her] into the bed by [his/her] head. She further revealed that she continued to tell Staff B, that the resident was in a safe space and to leave him/her alone. Review of a document titled, Employee Disciplinary Record dated 4/3/2025 for RN, Staff A, revealed that he was terminated due to his failure to follow appropriate procedure while trying to seat a combative resident by physically moving a resident to the chair with unnecessary force which was witnessed by multiple co-workers. Review of a document titled, Employee Disciplinary Record dated 4/3/2025 for LPN, Staff B, revealed that she was terminated due to failing to follow the appropriate procedure by physically restraining a combative patient. Staff B was witnessed holding a resident's head down while the resident was in bed to prevent him/her from getting up. Record review of the facility investigation report dated 4/1 and 4/2/2025 revealed that the facility substantiated the allegation of abuse and both Staff A and B were terminated. During a surveyor interview on 4/8/2025 at 10:32 AM with the DNS, she revealed that she substantiated the allegation of abuse. She revealed that she would have expected the staff to redirect the resident and monitor him/her from a distance once s/he was safe. She revealed that she was unsure why the staff continued to attempt to move the resident or remove his/her walker once the resident was in a chair in a common area and would have expected the staff to walk away. Additionally, she revealed that she would have expected the staff to not restrain the resident in bed, but rather leave him/her alone as s/he was safe. Furthermore, she acknowledged that Resident ID #1 was abused on 3/31/2025. The survey team concluded that a reasonable person would not want to be dragged down the hallway, tossed into a chair or thrown and pinned into his/her bed and therefore this was cited at a the harm level due to the probability of psychosocial harm.