STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415014	A. Building B. Wing	07/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grace Barker Nursing Center	54 Barker Avenue Warren, RI 02885

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 - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	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** 46338 Based on surveyor observation, record review, resident, and staff interview, it has been determined that the facility failed to keep a resident free from sexual abuse by a staff member for 1 of 2 residents reviewed, Resident ID #1. Findings are as follows: According to the State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities, last revised February 2023, indicates that sexual abuse is defined as .any sexual contact of any type with a resident .Sexual abuse includes, but is not limited to unwanted intimate touching of any kind especially of breasts or perineal area .forced observation of masturbation .Generally, sexual contact is nonconsensual if the resident .does not want the contact to occur . Review of the facility policy titled Abuse prohibition last revised on 10/31/2022 states in part, .it is the policy of this facility to ensure that all residents are treated with respect and dignity and that all residents are free from abuse .Examples of abuse includes sexual harassment, coercion or assault . Record review revealed that the alleged victim, Resident ID #1, was readmitted to the facility in November of 2022 with diagnoses including, but not limited to, anxiety disorder, major depressive disorder, and difficulty in walking. Review of Resident ID #1's Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicating intact cognition. Record review revealed that Resident ID #2 was admitted to the facility in February of 2024 with diagnoses including, but are not limited to, dementia, Alzheimer's disease, and anxiety disorder. Record review of Resident ID #2's quarterly MDS dated [DATE], revealed a BIMS score of 9 out of 15, indicating moderately impaired cognition. Review of a facility reported incident submitted to the Rhode Island Department of Health on 7/5/2024 alleges in part, that Resident ID #1 reported to the Physical Therapy Assistant, Staff A, that Nursing Assistant (NA), Staff B, touched him/her inappropriately. Resident ID #1 reported that Staff B was on top of him/her with his clothes on. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415014	A. Building B. Wing	07/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grace Barker Nursing Center	54 Barker Avenue Warren, RI 02885

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 - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During a surveyor interview on 7/12/2024 at approximately 10:00 AM with Staff A she revealed that on 7/4/2024 at 10:30 AM, Resident ID #2 reported to her that Staff B had tried to come on to him/her. After Staff A completed her therapy session with Resident ID #2, she had a therapy session scheduled with Resident ID #1. During the therapy session Resident ID #1 had shared with Staff A that Staff B had touched his/her chest and perineal area the night before. Staff A indicated that after she heard this, she went to report both sexual allegations made by Resident ID #1 and 2 to the charge nurse. Review of Staff A's daily skilled note for Resident ID #1 dated 7/4/2024 revealed that during a physical therapy session, Resident ID #1 had asked her if she was familiar with any of the overnight staff members. Additionally, Resident ID #1 mentioned Staff B by name and then stated that he was weird because last night he touched his/her chest and perineal area. Further, Resident ID #1 stated s/he had asked Staff B to stop but he did not which made him/her feel uncomfortable. Review of Staff A's, daily skilled note for Resident ID # 2 dated 7/4/2024 revealed that during a physical therapy session, Resident ID #2 had asked her, if she knows Staff B. Additionally, the note indicated that Staff B jumped on top of Resident ID #2 while s/he was in bed, but s/he told him s/he is not interested. Review of the Social Worker's written statement dated 7/4/2024 revealed Resident ID #1's description of the incident He wanted to, he was on top of me, I told him to stop, when he was done, he cleaned himself up . During a surveyor interview on 7/12/2024 at 12:51 PM with Resident ID #2, s/he revealed that on the night of 7/4/2024 s/he was asleep when s/he felt his/her bed move. When s/he woke up, Staff B, was sitting on his/her bed then stood very close to the bed. Additionally, s/he indicated that s/he told him that s/he does not need help and asked him to go away. Further, s/he revealed that he left after s/he had told him s/he does not do that business. During a surveyor interview on 7/12/2024 at 10:24 AM with Resident ID #1, s/he revealed that on the night of 7/4/2024, s/he had a male NA who came into his/her room to take care of him/her while s/he was wearing a shirt and a brief (adult diaper). Additionally, s/he revealed that he touched him/her between his/her legs and performed the motion of having sex with him/her. He was pushing himself up against him/her simulating sex up and down. The resident indicated that s/he told Staff B to stop and at one point was pounding on his chest but he didn't stop. Resident ID #1 revealed that he never took his clothes off and when he was done, he cleaned up himself in the bathroom. She indicated he didn't go inside me. Surveyor review of the security video footage revealed that on 7/4/2024 Staff B peeked his head into the room that shares the bathroom with Resident ID #1. Immediately after peeking his head into that room Staff B was observed entering Resident ID #1's room on 7/4/2024 at 5:32 AM. He then closed the door behind him. He was observed to be wearing a gait belt (transfer belt) around his waist with his clothes neat and orderly. Staff B was then seen exiting the room at 5:48 AM. His shirt was bunched up in the back exposing the skin of his lower back and the waist band of his underwear. The gait belt was no longer visible as it was before he entered the room. It appeared that the gait belt was under his clothes. Furthermore, Staff B was observed fixing and pulling his pants up as they appeared to be sagging. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415014	A. Building B. Wing	07/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grace Barker Nursing Center	54 Barker Avenue Warren, RI 02885

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 - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During a surveyor interview on 7/12/2024 at 11:42 AM with NA, Staff C, she revealed that she worked with Staff B on the night of 7/4/2024. She indicated that Staff B does not normally work the overnight shift and she was explaining to him that they usually work together to complete resident care. Staff C indicated that Staff B was agitated and wanted to independently. Additionally, she indicated Staff B asked to take one side of the hallway and she would take the other. Staff C indicated to the surveyor that Resident ID #1 and his/her roommate do not receive full assistance with care so Staff B should not have been in the room for long. An interview was attempted with Staff B on multiple occasions, but he was unable to be reached. During a surveyor interview on 7/12/2024 at approximately 10:00 AM and at approximately 3:00 PM with the Administrator in the presence of the Director of Nursing Services, he was unable to provide evidence that Resident ID #1 was kept free from sexual abuse. Further record review revealed that Staff B was arrested by the local police department on 7/16/2024. This failure resulted in Resident ID #1 being sexually abused by a staff member. This failure had the potential to cause more than minimal harm to Resident ID #1.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415014	A. Building B. Wing	07/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grace Barker Nursing Center	54 Barker Avenue Warren, RI 02885

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 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** 46338 Based on record review, resident and staff interview, it has been determined that the facility failed to ensure that all alleged violations involving sexual abuse are thoroughly investigated for 1 of 2 residents reviewed, Resident ID #2. Findings are as follows: Record review revealed that the resident was admitted to the facility in February of 2024 with diagnoses including, but are not limited to, dementia, Alzheimer's disease, and anxiety disorder. Record review of the quarterly Minimum Data Set assessment dated [DATE], revealed a Brief Interview for Mental Status score of 9 out of 15, indicating that s/he had moderately impaired cognition. Review of Physical Therapy Assistant, Staff A's, daily skilled note dated 7/4/2024 revealed that during a physical therapy session, the resident had asked her, if she knows Nursing Assistant (NA), Staff B. Additionally, the note indicated that Staff B jumped on top of Resident ID #2 while s/he was in bed, but s/he told him s/he is not interested. During a surveyor interview on 7/12/2024 at approximately 10:30 AM with Staff A, she revealed that on 7/4/2024 at 10:30 AM, during a physical therapy session, Resident ID #2 reported to her that Staff B was weird because he had tried to come on to him/her during the previous overnight shift. Additionally, Staff A indicated that she did not immediately report this allegation. Staff A revealed after finishing her therapy session with Resident ID #2 she went to work with Resident ID #1. At this time Resident ID #1 also reported a sexual allegation by Staff B. She indicated that at this time she went and reported both sexual allegations of Resident ID #s 1 and 2 to the charge nurse. Record review failed to reveal evidence that the allegation of sexual abuse by Staff B to Resident ID #2 was investigated by the facility. During a surveyor interview on 7/12/2024 at 12:51 PM with Resident ID #2, s/he revealed that on the night of 7/4/2024 s/he was asleep when s/he felt his/her bed move. When s/he woke up, Staff B, was sitting on his/her bed then stood very close to the bed. Additionally, s/he indicated that s/he told him that s/he does not need help and asked him to go away. Further, s/he revealed that he left after s/he had told him s/he does not do that business. During a surveyor interview on 7/12/2024 at 10:36 AM with the Administrator, he was unable to provide evidence that this sexual allegation against Staff B was thoroughly investigated then reported to the State Survey Agency in accordance with State law. Cross Reference F 600