

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415031	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/13/2024
NAME OF PROVIDER OR SUPPLIER Silver Creek Rehab & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Creek Lane Bristol, RI 02809	

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)
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>46715</p> <p>Based on record review and staff interview, it has been determined that the facility failed to keep a resident free from physical abuse for 2 of 4 residents reviewed, Resident ID #s 2 and 3.</p> <p>Findings are as follows:</p> <p>Review of a 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, mistreatment, neglect .Abuse: willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain or mental anguish .</p> <p>Review of a facility reported incident received by the Rhode Island Department of Health on 8/2/2024 states in part, On 8/1/24 at or around 9pm staff were made aware of an incident when they heard screaming . [Resident ID #1] was found on top of [Resident ID #2] with a sheet over [his/her] head .</p> <p>Record review revealed that Resident ID #1 (perpetrator) was admitted to the facility in September of 2023 with diagnoses including, but not limited to, dementia, anxiety and depression.</p> <p>Review of a Minimum Data Set (MDS) Assessment for Resident ID #1 dated 7/5/2024 revealed a Brief Interview for Mental Status (BIMS) Score of 4 out of 15 indicating severe cognitive impairment. Additional review of the MDS revealed s/he transfers and ambulates independently.</p> <p>Record review revealed that Resident ID #2 (victim) was admitted to the facility in September of 2022 with diagnoses including, but not limited to, breast cancer and anxiety.</p> <p>Review of an MDS Assessment for Resident ID #2 dated 7/12/2024 revealed a BIMS score of 0 indicating severe cognitive impairment. Further review of the MDS revealed Resident ID #2 is non-ambulatory and is dependent for all activities of daily living. Additionally, it revealed that s/he is receiving hospice services.</p> <p>During a surveyor interview via telephone on 8/8/2024, at 10:44 AM with Nursing Assistant (NA) Staff B, she revealed that on 8/1/2024 she witnessed Resident ID #1 in Resident ID #2's bed. Resident ID #1 was on top of Resident ID #2 holding a sheet over his/her face, Resident ID #2 was screaming.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of second facility reported incident received by the Rhode Island Department of Health dated 8/2/2024 states in part, During our initial investigation the facility was made aware of another resident incident. [Resident ID #3] made a supervisor aware [s/he] was afraid of [Resident ID#1] and said something was put over [his/her] head .</p> <p>Record review revealed that Resident ID #3 (victim) was admitted to the facility in June of 2024 with diagnoses including, but not limited to, dementia, anxiety and depression.</p> <p>Review of an MDS Assessment for Resident ID #3 dated 6/11/2024 revealed a BIMS score of 15 out of 15 indicating intact cognition. Additional review of the MDS revealed s/he requires supervision or touching assistance with transfers and ambulation.</p> <p>Review of a facility provided statement authored by Licensed Practical Nurse, Staff A, dated 8/2/2024 revealed that on 7/31/2024 Resident ID #3 reported feeling scared of his/her roommate (Resident ID #1) and felt like s/he was trying to kill him/her and had put a blanket over his/her face. The statement further revealed that the facility moved Resident ID #3 to another room for safety reasons.</p> <p>During a surveyor interview on 8/8/2024 at approximately 10:00 AM with the Assistant Director of Nursing (ADNS) she revealed that she was made aware of the accusations that Resident ID #3 had made against Resident ID #1 on 7/31/2024. Additionally, she revealed that a room change was made for Resident ID #3. The ADNS further revealed that no additional investigation was completed regarding this allegation on 7/31/2024 or 8/1/2024. The ADNS revealed that she was too busy to investigate the allegation any further.</p> <p>During a surveyor interview on 8/8/2024 at 10:22 AM with the Social Worker, Staff C, she revealed that she was made aware of the accusations by Resident ID #3 against Resident ID #1 on 7/31/2024 and that she made a room change for Resident ID #3. Staff C acknowledged moving Resident ID #2 into same room as Resident ID #1, even though there had been an accusation of abuse made against Resident ID #1. Staff C further revealed that she did not interview Resident ID #1 or Resident ID #3 on the day the allegation was made, as she was too busy to investigate the allegation any further.</p> <p>Review of the census report revealed Resident ID #3 and Resident ID #2 switched beds on 7/31/2024.</p> <p>During a surveyor interview on 8/8/2024 at approximately 10:40 AM with the Regional Director of Nursing, she acknowledged that Resident ID #2 was moved into a room with Resident ID #1, even though Resident ID #1 was accused of being abusive on that same day. Additionally, she was unable to provide evidence that Resident ID #2 had been kept free of abuse.</p> <p>Cross reference F610</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>46715</p> <p>Based on record review and staff interview it has been determined that the facility failed to provide evidence that an alleged violation of abuse was investigated, relative to an allegation of resident-to-resident abuse between Resident ID #s 1 and 3, which in turn resulted in Resident ID #2 sustaining abuse by the same alleged perpetrator, Resident ID #1.</p> <p>Findings are as follows:</p> <p>Review of a facility policy titled, Abuse Prohibition last revised on 10/31/2022 states in part, .Any instance of actual or suspected abuse, neglect, mistreatment, involuntary confinement, misappropriation of resident property, including injuries of unknown origins including bruises, skin tears, or lacerations must be reported immediately to the DNS [Director of Nursing Services]/designee, i.e., supervisor on duty and an incident report is filled out .immediate response to allegations and/or incidents may include as appropriate but not limited to, examination of the victim for physical injury, trauma assessment for psychosocial injury, increased supervision of the victim and others as needed, room changes as needed, provision of ongoing emotional support during the investigation and ongoing as needed .</p> <p>Review of a facility reported incident received by the Rhode Island Department of Health dated 8/1/2024 states in part, On 8/1/24 at or around 9pm staff were made aware of an incident when they heard screaming . [Resident ID #1] was found on top of [Resident ID #2] with a sheet over [his/her] head .</p> <p>Review of a second facility reported incident received by the Rhode Island Department of Health dated 8/2/2024 states in part, During our initial investigation the facility was made aware of another resident incident. [Resident ID #3] made a supervisor aware [s/he] was afraid of [Resident ID#1] and said something was put over [his/her] head .</p> <p>Record review revealed that Resident ID #3 was admitted to the facility in June of 2024 with diagnoses including, but not limited to, dementia, anxiety, and depression.</p> <p>Review of a Minimum Data Set Assessment for Resident ID #3 dated 6/11/2024 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating intact cognition.</p> <p>Review of a facility provided statement authored by Licensed Practical Nurse, Staff A, dated 8/2/2024 revealed that on 7/31/2024 Resident ID #3 reported feeling scared of his/her roommate (Resident ID #1) and felt like s/he was trying to kill him/her and had put a blanket over his/her face. The statement further revealed that the facility moved Resident ID #3 to another room for safety reasons.</p> <p>During a surveyor interview on 8/8/2024 at approximately 10:00 AM with the Assistant Director of Nursing (ADNS) she revealed that she was made aware of the accusation that Resident ID #3 had made against Resident ID #1 on 7/31/2024. Additionally, she revealed that a room change was made for Resident ID #3. The ADNS further revealed that no additional investigation was completed regarding the allegation Resident ID #3 made on 7/31/2024.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During a surveyor interview on 8/8/2024 at 10:22 AM with the Social Worker, Staff C, she revealed that she was made aware of the accusation of abuse made by Resident ID #3 against Resident ID #1 on 7/31/2024 and that she made a room change for Resident ID #3. Staff C further revealed that she did not interview Resident ID #1 or Resident ID #3 on the day the abuse allegation was made. Additionally, she stated that she and did not initiate any type of investigation regarding this allegation of abuse, because she was too busy.</p> <p>Review of the census report revealed Resident ID #3 and Resident ID #2 switched rooms/beds on 7/31/2024.</p> <p>Review of an MDS Assessment for Resident ID #2 dated 7/12/2024 revealed a BIMS score of 0 indicating severe cognitive impairment. Further review of the MDS revealed Resident ID #2 is non ambulatory and is dependent for all activities of daily living (ADL) and is receiving hospice services.</p> <p>During a surveyor interview via telephone on 8/8/2024, at 10:44 AM with Nursing Assistant (NA) Staff B, she revealed that on 8/1/2024 she witnessed Resident ID #1 in Resident ID #2's bed. Resident ID #1 was on top of Resident ID #2 holding a sheet over his/her face, Resident ID #2 was screaming. Additionally, Staff B revealed that she was unaware of the previous abuse allegation that Resident ID #3 had made against Resident ID #1 and was not made aware of it until after she had witnessed Resident ID #1 on top of Resident ID #2 holding a sheet over his/her face.</p> <p>During a surveyor interview on 8/8/2024 at approximately 10:40 AM with the Regional Director of Nursing she acknowledged that there was not an investigation initiated on 7/31/2024 even though Staff A, Staff C and the ADNS were all aware of the abuse allegation reported by Resident #3.</p> <p>The facility's failure to investigate the allegation of abuse made by Resident ID #3 on 7/31/2024, placed Resident ID #2, a vulnerable resident who was cognitively impaired, unable to ambulate, dependent on staff for all of his/her ADLs and receiving hospice services, placed him/her at risk for serious injury, serious harm, impairment or death.</p> <p>Cross reference F600</p>		