

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415050	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/19/2024
NAME OF PROVIDER OR SUPPLIER The Dawn Hill Home for Rehab & Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 1 Dawn Hill 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 - Minimal harm or potential for actual harm</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49184</p> <p>Based on record review and staff interview, it has been determined that the facility failed to ensure residents are free from abuse for 1 of 3 residents reviewed, Resident ID # 1.</p> <p>Findings are as follows:</p> <p>According to State Operations Manual, Appendix PP - Guidance to Surveyors for Long Term Care Facilities, last revised 2/2023, .Abuse is the willful infliction of injury .with resulting physical harm, pain or mental anguish .Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain .Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm .</p> <p>Resident to Resident Abuse of Any Type</p> <p>A resident to resident altercation should be reviewed as a potential situation of abuse .Also, when investigating an allegation of abuse between residents, the surveyor should not automatically assume that abuse did not occur, especially in cases where either or both residents have a cognitive impairment or mental disorder. Having a mental disorder or cognitive impairment does not automatically preclude a resident from engaging in deliberate or non-accidental actions. In determining whether F 600-Free from Abuse and Neglect should be cited in these situations, it is important to remember that abuse includes the term 'willful'. The word 'willful' means that the individual's action was deliberate (not inadvertent or accidental), regardless of whether the individual intended to inflict injury or harm. An example of a deliberate (willful) action would be a cognitively impaired resident who strikes out at a resident within his/her reach .The facility may provide evidence that it completed a resident assessment and provided care planning interventions to address a resident's distressed behaviors such as physical, sexual or verbal aggression. However, based on the presence of resident to resident altercations, if the facility did not evaluate the effectiveness of the interventions and staff did not provide immediate interventions to assure the safety of residents, then the facility did not provide sufficient protection to prevent resident to resident abuse. For example, redirection alone is not a sufficiently protective response to a resident who will not be deterred from targeting other residents for abuse once he/she has been redirected .</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 - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of a facility reported incident received by the Rhode Island Department of Health on 7/10/2024 indicated that an incident occurred on 7/10/2024 at approximately 6:20 PM in the hallway. The report alleges that Nursing Assistant, Staff A, witnessed Resident ID #2, push Resident ID # 1 into a precaution bin. Then Resident ID #1 fell to the floor. Resident ID #1 complained of pain to the left arm and face and an X-ray was ordered that showed a dislocation of the left shoulder.</p> <p>Record review revealed that the alleged victim, Resident ID #1, was admitted to the facility in March of 2021 with diagnoses that include, but are not limited to, Alzheimer's Disease, and anxiety.</p> <p>Review of the Minimum Data Set Assessment (MDS), dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 3 of 15, which indicates the resident has impaired cognition.</p> <p>Record review revealed that the alleged perpetrator, Resident ID #2, was admitted to the facility in March of 2022 with diagnoses that include, but are not limited to, dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety.</p> <p>Review of the MDS, dated [DATE], revealed a BIMS score of 7 of 15, which indicates the resident has impaired cognition.</p> <p>Record review of the facility's internal investigation revealed that on 7/10/2024 Staff A witnessed Resident ID #2 push Resident ID #1 resulting in Resident ID #1 sustaining a dislocated left shoulder.</p> <p>During an interview with the Administrator and the Director of Nursing Services on 7/19/2024 at 12:30 PM, they acknowledged that Resident ID #2 pushed Resident ID #1 which resulted in Resident ID #2 dislocating Resident ID #1's left shoulder. They were unable to provide evidence that Resident ID #1 was kept free from abuse.</p>