STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415060	A. Building B. Wing	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avalon Nursing Home Inc	57 Stokes Street Warwick, RI 02889

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on clinical record review and staff interview, the facility failed to ensure that alleged violations involving abuse are reported immediately, but not later than 2 hours, after the allegation was made, relative to 1 of 2 residents reviewed for abuse who had a bruise to his/her outer thigh, Resident ID# 1.Findings are as follows:Record review of the facility policy dated 8/2020, titled, Reporting Patient Abuse states in part, .any person that has reason to believe that a patient has been abused.should contact the charge nurse, DNS [Director of Nursing Services] and/or Administrator at the time of the incident .the incident will be reported to the Department of Health.within 2 hours.Record review of a facility reported incident submitted to the Rhode Island Department of Health (RIDOH) on 3/5/2026, alleges that on 3/4/2026, Resident ID #1 reported to the 11:00 PM to 7:00 AM shift nurse that a Nursing Assistant (NA) Staff B, was too rough with him/her on the previous shift, 3:00 PM to 11:00 PM. Upon interview with Resident ID #1, s/he stated that the NA hurried him/her to bed and twisted his/her arms when pivoting him/her from his/her chair to the bed. Additionally, when a skin check was completed on 3/5/2026, a small, blue mark was noted to his/her right outer thigh with an unknown etiology and that the NA will no longer be assigned to care for Resident ID #1. Further review revealed that the incident report was submitted to the RIDOH on 3/5/2026 at 1:39 PM, indicating that the report was not submitted within the required two-hour timeframe from when the allegation was made.Record review of a nursing progress note dated 3/4/2026 at 6:22 AM, authored by Registered Nurse (RN), Staff A, revealed that Resident ID #1 complained that Staff B was being too rough with him/her on the 3:00 PM to 11:00 PM shift. The note further indicated that Staff A would speak to the DNS about the allegation. During a surveyor interview on 3/11/2026 at 8:52 AM with Staff A, she revealed that the resident revealed to her on 3/4/2026 at approximately 1:30 AM, that s/he did not want Staff B, to take care of him/her any longer and that she is just too rough. Additionally, Staff A revealed that she did not report the allegation of abuse to the DNS.During a surveyor interview on 3/10/2026 at 12:23 PM with RN, Staff C, she stated that she had been off from work for several days and returned to the facility on 3/5/2026. Staff C further stated that after being away from the facility for a few days, she typically reviews residents' progress notes for updates. Staff C reported that after reviewing Staff A's progress note regarding the abuse allegation made by Resident ID #1, she then reported the allegation to RIDOH.During a surveyor interview on 3/10/2026 at 3:20 PM with the Administrator, he was unable to provide evidence that the facility reported the allegation of abuse immediately, or within 2 hours, after the allegation of abuse was made.

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 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** Based on clinical record review and staff interview, the facility failed to ensure that an allegation of abuse was thoroughly investigated for 1 of 2 residents reviewed, who had a bruise to his/her outer thigh, Resident ID #1. Additionally, the facility failed to prevent further potential abuse while the investigation was in progress. Findings are as follows:Record review of the facility policy titled, Reporting Patient Abuse dated 8/2020 states in part, .any person that has reason to believe that a patient has been abused.should contact the charge nurse, DNS [Director of Nursing Services] and/or Administrator at the time of the incident .A full investigation will be conducted which may include written statements from witnesses as well as the resident.Record review of a facility reported incident submitted to the Rhode Island Department of Health (RIDOH) on 3/5/2026, alleges that on 3/4/2026, Resident ID #1 reported to the 11:00 PM to 7:00 AM shift nurse that a Nursing Assistant (NA), Staff B, was too rough with him/her on 3/3/2026, the previous shift, 3:00 PM to 11:00 PM. Upon interview with Resident ID #1, s/he stated that Staff B hurried him/her to bed and twisted his/her arms when pivoting him/her from the chair to the bed. Additionally, when a skin check was completed on 3/5/2026, a small, blue mark was noted to his/her right outer thigh with an unknown etiology and that Staff B will no longer be assigned to care for Resident ID #1. Record review revealed the resident was admitted to the facility in June of 2022 with diagnoses including, but not limited to, bipolar disorder (a chronic mental health condition that causes extreme mood swings), anxiety, and insomnia.Record review of the resident's Quarterly Minimum Data Set assessment dated [DATE], revealed a Brief Interview for Mental Status score of 14 out 15, indicating s/he is cognitively intact. A. Record review of a nursing progress note, dated 3/4/2026 authored by Registered Nurse (RN), Staff A, revealed that Resident ID #1 complained to her that Staff B was being too rough with him/her on the 3:00 PM to 11:00 PM shift and that she would speak to the DNS about the allegation.During a surveyor interview on 3/10/2026 at 12:23 PM with RN, Staff C, she stated that she had been off from work for several days and returned to the facility on 3/5/2026. Staff C further stated that after being away from the facility for a few days, she typically reviews residents' progress notes for updates. Staff C reported that after reviewing Staff A's progress note regarding the abuse allegation made by Resident ID #1, she then initiated the investigation. Record review of the investigation failed to reveal evidence of Staff A's statement relative to the abuse allegation and failed to reveal evidence of a statement relative to the abuse allegation from RN, Staff D, who was assigned to the resident on 3/3/2026 during the 3-11 PM shift. Record review of a statement written by the alleged perpetrator, NA, Staff B, revealed that the allegation is false, and she denied twisting the resident's arm and leg. Additionally, there is nothing further written in the NA's statement related to the events of that night.B. Record review of the facility schedule revealed that Staff B worked on the evening of 3/4/2026 and 3/5/2026, indicating that the NA was allowed to work after the allegation of abuse was made by the resident.During a surveyor interview on 3/10/2026 at 1:37 PM with the Administrator, he acknowledged that the facility failed to obtain statements from key staff members involved in the incident, including RNs Staff A and Staff D, and failed to obtain a detailed statement from the alleged perpetrator regarding the events in question. Additionally, the Administrator confirmed that although Staff B was removed from providing care to Resident ID #1, she was permitted to continue working in the facility on 3/4/2026 and 3/5/2026, providing care to other residents after the allegation of abuse had been reported.

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. Based on record review and staff interview, the facility failed to provide training to their staff, that at a minimum educates staff on, abuse and neglect.Findings are as follows:Record review of the most recent abuse in-service training sign-in sheet, dated 1/5/2025, titled Staff Sign Off Sheet for Abuse and Neglect, along with a folder containing abuse post-tests provided by the Director of Nursing Services (DNS), revealed that only 13 of the 28 listed nursing staff had signed indicating attendance at the abuse training. Further review of the post-tests revealed that only three had been completed by staff. Additionally, the in-service sign-in sheet did not include the Social Worker, dietary staff, housekeeping staff, or maintenance staff.During a surveyor interview on 3/10/2026 at 2:07 PM with the housekeeping/dietary aide, Staff E, she stated that she had never received training related to abuse at the facility.During a surveyor interview on 3/11/2026 at 9:30 AM with Nursing Assistant, Staff B, she stated that she had never received training related to abuse at the facility.During a surveyor interview on 3/10/2026 at 3:20 PM with the DNS, he was unable to explain why 10 staff members who had signed the in-service sheet indicating attendance at the abuse training did not have a completed post-test. The DNS was also unable to provide evidence of a completed post-test for Staff B, despite her signature on the in-service sheet indicating attendance at the training. Additionally, the DNS stated he was unaware that abuse training was required for all facility staff, not solely nursing staff, until this requirement was brought to his attention by the surveyor.