

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415071	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2024
NAME OF PROVIDER OR SUPPLIER South County Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 740 Oak Hill Road North Kingstown, RI 02852	

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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Respond appropriately to all alleged violations.</p> <p>39496</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 thoroughly investigated, relative to staff observing a resident putting another resident's pants on of the opposite sex. Resident ID #s 3 and 8.</p> <p>Findings are as follows:</p> <p>Record review of a facility policy titled Abuse prohibition revealed in part, Examples of abuse include but are not limited to the following .Sexual- includes sexual harassment, coercion or assault .Investigation It is the DNS [Director of Nursing Services]/designee's responsibility to act immediately to .Begin the initial investigation .Obtain statements from witnesses .Notify the appropriate administrative personnel so that a comprehensive internal facility investigation can be carried out .It is also the responsibility Director of Nursing to ensure that .the incident reports are accurately and completely filled out .personnel and witness statements are obtained timely .the investigation is comprehensive and timely and documented appropriately .It is the responsibility of the Nursing Home Administrator to .Notify the appropriate agencies in writing . Submit the report of the allegations and results of the internal investigation to the Department of Health within 5 working days of the original filing .</p> <p>Record review of a facility reported incident submitted to the Rhode Island Department of Health revealed that on 7/3/2024, Resident ID #3 was seen by a staff member with Resident ID # in the dining room putting his/her hands on the shoulders of Resident ID #4 and was gyrating [his/her] hips in an inappropriate manner behind Resident ID #4.</p> <p>While at the facility investigating the above-mentioned incident the following progress note was discovered in the medical record of Resident ID #3:</p> <p>6-15-2024 at 11:38 AM- CNA [Certified nursing assistant] reported to this writer resident was seen in another resident [Resident ID #8's] room assisting [him/her] put [his/her] pants on. This writer interview [Resident ID # 8's] roommate who stated [s/he] saw [Resident ID #3] helping [Resident ID #8] putting pants [on] and witnessed resident[s] giving a kiss to each other. Resident educated not [to] enter other resident's room. Call placed to on call supervisor to make them aware. [New order] to add both residents on 15 min check .On call [practitioner's name redacted] aware, family [name redacted] aware.</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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review revealed Resident ID #3 was admitted to the facility in April of 2023 with diagnoses including, but not limited to, Human Immunodeficiency Virus (virus that damages the immune system), chronic viral Hepatitis B (viral infection that effects your liver), chronic viral Hepatitis C (virus that effects the liver). These viruses can be spread though contact with blood, or through sexual contact.</p> <p>Review of a Minimum Data Set (MDS) Assessment for Resident ID #3 dated 6/1/2024 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating intact cognition.</p> <p>Record review revealed a care plan initiated on 7/17/2023 with a focus area of [Resident ID #3] does exhibit behaviors .change in mental status, cognitive deficits .sexualized comments, sexual gestures in attempt to be humorous .</p> <p>Record review of documents titled Resident Monitoring Sheet 15-minute checks revealed that the facility initiated 15-minute checks on both residents following the above-mentioned incident.</p> <p>Record review revealed Resident ID #8 was admitted to the facility in September of 2020 with diagnoses including, but not limited to, neurocognitive disorder (decreased mental function), dementia, and cognitive communication deficit (difficulties with communication caused by deficits in cognitive processes).</p> <p>Review of a MDS Assessment for Resident ID #8 dated 6/4/2024 revealed a BIMS score of 9 out of 15, indicating moderate cognitive impairment.</p> <p>Record review revealed a care plan initiated on 1/17/2023 with a focus area of [Resident ID #8] has history of poor decision making, issues with personal boundaries-especially in intimate relationships-which put [him/her] at risk of negative outcomes .</p> <p>During a surveyor interview on 8/29/2024 at 3:50 PM with the DNS she was unable to provide evidence that the above incident, where Resident ID #3 was found putting pants on and kissing Resident ID #8, was reported to the Department of Health. She was further unable to provide evidence of a comprehensive investigation, including witness statements from the residents involved in the incident and Resident ID #8's roommate who was said to have been a witness to the incident.</p> <p>Record review of a document received via e-mail on 8/29/2024 at 5:23 PM after the surveyor had exited the facility revealed two handwritten statements by staff who witnessed or were informed of the incident that took place on 6/15/2024 between Resident ID #s 3 and 8.</p>		