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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415080	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayberry Commons	181 Davis Drive Pascoag, RI 02859

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** 46539 Based on record review and staff and resident interview, it has been determined that the facility failed to ensure that residents are free from sexual abuse, for 1 of 2 residents reviewed, Resident ID #1. Findings are as follows: Review a facility reported incident submitted to the Rhode Island Department of Health on 12/13/2024, revealed that Resident ID #1 and Resident ID #2 were found in a room where they appeared to be engaging in an act that was sexual in nature. Review of a policy titled Abuse prohibition last reviewed on 12/4/2024, 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 and or misappropriation of their personal property .Residents have the right to be free of sexual abuse. However, a resident may desire to engage in consensual sexual activity. In this case, the facility needs to perform an evaluation as to the resident's capacity to consent to sexual activity . Record review revealed that Resident ID #1, the victim, was admitted to the facility in September of 2024 with diagnoses including, but not limited to, dementia, major depressive disorder, and adjustment disorder. Resident ID #1 resides on a secured unit. Review of a Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 5 out of 15 indicating severe cognitive impairment and the inability to form consent for sexual activity. Further review of the resident's MDS Assessment revealed that his/her ability to make themselves understood or the ability to understand was documented as Sometimes understands responds adequately to simple, direct communication only and is Sometimes understood, the ability is limited to making concrete requests. Record review revealed that Resident ID #2, the perpetrator, was admitted to the facility in May of 2024 with diagnoses including, but not limited to, dementia, altered mental status, and adjustment disorder. Resident ID #2 resides on a secured unit. (continued on next page)

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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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Review of a MDS assessment dated [DATE] revealed a BIMS score of 99 out of 15. This score indicates that the resident was unable to complete the assessment due to his/her impaired cognitive abilities which also leaves him/her unable to form consent for sexual activity. Further review of the resident's MDS Assessment revealed that his/her ability to make decisions regarding tasks of daily life was documented as severely impaired and that s/he had a short term and long-term memory problem. Record review of Resident ID #2 revealed the following progress notes: - 12/13/2024 at 9:36 PM - Resident ID #2 was noted by staff to kiss Resident ID #1 prior to dinner being passed while sitting in the bistro area. The residents were separated. After dinner, the staff were picking up meal trays in the hallways and a staff member observed Resident ID #2 with Resident ID #1 in a room. Both residents had their pants and briefs down. Resident ID #1 was lying down on the bed while Resident ID #2 was noted to have his/her mouth on Resident ID #1's genitals. The residents were separated, and 15-minute checks were initiated. A couple of hours later, while conducting the 15-minute checks both residents were found to be in another room in the same situation as earlier. The residents were again separated. Upon separating the residents, Resident ID #2 became very upset and became aggressive towards staff, yelling [s/he] would kill us, shaking [his/her] fingers at staffs face. A call was placed to the physician regarding the situation and a new order was obtained for a one time dose of Trazadone (an medication used to treat behaviors) 50 milligrams (mg). The Trazadone 50 mg was administered to Resident ID #2 and s/he was assisted to bed. The residents will continue to be monitored for 72 hours, and the 15-minute checks will be continued. - 12/15/2024 at 10:00 PM, Resident ID #2 was attempting to grab at a nurse's front side and followed the nurse throughout the unit. Also, s/he was noted with another resident's feces in his/her hands, and when nursing staff intervened to clean the resident, the resident became angry, shouting loudly, and attempting to strike out at the nursing staff. Record review failed to reveal an intervention was implemented related to the increased sexual behaviors on 12/15/2024. A surveyor interview was attempted with Resident ID #2 on 12/16/2024 at 12:18 PM, but was unsuccessful due to his/her cognition. A surveyor interview was attempted with Resident ID #1 on 12/16/2024 at 12:29 PM and 12/17/2024 at 10:06 AM, but were unsuccessful due to his/her cognition. During a surveyor interview on 12/16/2024 at 12:38 PM with Licensed Practical Nurse (LPN), Staff A, she revealed before dinner Resident ID #s 1 and 2 were observed kissing in a common area and separated. She then revealed that a Nursing Assistant (NA) found Resident ID #1 laying in bed with his/her pants and brief down. Resident ID #2 was found with his/her mouth on Resident ID #1's genitals. Both residents were placed on 15-minute checks. She further revealed that later in the shift while on the 15-minute checks, Resident ID #1 was found in bed again with his/her pants down and Resident ID #2 was stroking Resident ID #1's genitals. The residents were then separated, and Resident ID #1's room was changed. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of the 15-minute checks sheets for Resident ID #1 failed to reveal evidence that the checks were completed every 15 minutes from 8:00 PM on 12/15/2024 through 6:45 AM on 12/16/2024. The 15-minute checks sheets also failed to reveal evidence that the checks were completed every 15 minutes from 11:45 AM through 12:15 PM on 12/16/2024. Record review of the 15-minute checks sheets for Resident ID #2 failed to reveal evidence that the checks were completed every 15 minutes from 4:15 PM on 12/15/2024 through 6:45 AM on 12/16/2024. The 15-minute checks sheets also failed to reveal evidence that the checks were completed every 15 minutes from 11:45 AM through 12:15 PM on 12/16/2024. Further review of the 15-minute checks sheets revealed that the third incident where Resident ID #1 was found in bed with his/her pants down and Resident ID #2 had his/her hand stroking Resident ID #1's genitals occurred at 8:15 PM on 12/13/2024. During a surveyor interview on 12/16/2024 at 1:52 PM with LPN, Staff B, she revealed that that an NA found Resident ID #s 1 and 2 with their pants and briefs down. Resident ID #2's mouth was on Resident ID #1's genitals. Both residents were placed on 15-minute checks. She further revealed that later in the shift while on the 15-minute checks, a similar situation occurred involving both residents. Additionally, she revealed that Resident ID #2 believed that Resident ID #1 was his/her spouse, indicating that s/he was unaware of with whom s/he was having sexual contact with and what Resident ID #1's relationship was to him/her. During a surveyor interview on 12/17/2024 at 2:43 PM with NA, Staff C, she revealed that prior to dinner she saw Resident ID #'s 1 and 2 in the common area kissing and that they were separated immediately. She then revealed that after supper she was cleaning up the meal trays when she saw Resident ID #1 lying in bed with his/her pants and brief down. Resident ID #2 was sitting on the side of the bed with his/her pants and brief down. Resident ID #2 was observed leaning down with his/her mouth on Resident ID #1's genitals. Staff C revealed that staff intervened and separated the residents. Furthermore, later in the shift while on the 15-minute checks, Resident ID #1 was found in bed again with his/her pants down and Resident ID #2 had his/her hand stroking Resident ID #1's genitals. Further record review revealed a progress noted dated 12/16/2024 at 8:01 PM revealed, prior to the supper meal, it was noted that Resident ID #2, the perpetrator, was in the common area standing next to a table with a resident of the opposite sex sitting there. Resident ID #2 attempted to get the attention of this resident, though the resident did not respond. Resident ID #2 then proceeded to expose his/her chest, causing nursing staff to quickly intervene and separate these residents. During the separation of the residents, Resident ID #2 began to shout loudly at the nursing staff and attempted to strike out at the nursing staff. Resident ID #2 was placed on a 1:1 observation at this time. A call was placed to the physician to update them regarding this event. An order was received to send Resident ID #2 out for an evaluation secondary his/her hypersexual behaviors. During a surveyor interview on 12/17/2024 at 10:31 AM, with LPN, Staff D, he revealed that Resident ID #2 was sent to the hospital where s/he was diagnosed with a urinary tract infection on 12/16/2024 and is still in the hospital at this time. During a surveyor interview on 12/16/2024 at 2:12 PM with the Director of Nursing Services (DNS), he acknowledged that the 15-minute check sheets were not documented in their entirety. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Record review revealed that following the incident where Resident ID #s 1 and 2 were found kissing, the staff separated the residents, but no additional interventions or monitoring were put into place. Additional review revealed that the residents were then placed on 15-minute checks following a second incident where Resident ID #2 was putting Resident ID #1's genitals in his/her mouth. Further review revealed a third incident while on 15-minute checks Resident ID #s 1 and 2 were found again engaging in another act that was sexual in nature. Following this incident, Resident ID #1's room was changed to a new room which was directly across the hall from where the third incident occurred. Following this incident the 15-minute checks failed to be completed in their entirety. Resident ID #2 continued to have increased sexual behaviors on 12/15/2024, and the record review failed to reveal evidence that a new intervention was implemented. It was not until after the immediate jeopardy was identified on 12/16/2024 that Resident ID #2 was sent to the hospital, after showing his/her chest, where s/he was found to have a urinary tract infection. During a surveyor interview on 12/16/2024 at 3:47 PM and 12/18/2024 at approximately 10:40 AM with the DNS and the Administrator, they acknowledged that Resident ID #s 1 and 2 engaged in sexual behaviors multiple times on 12/13/2024. Additionally, they were unable to provide evidence that the facility kept Resident ID #1 free from sexual abuse on 12/13/2024.