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	07/03/2025

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it has been determined that the facility failed to ensure that the comprehensive care plan was reviewed and revised by the interdisciplinary team after an incident of resident-to-resident abuse for 2 of 3 residents reviewed, Resident ID #s 3 and 4.Findings are as follows: Review of a facility reported incident submitted to the Rhode Island Department of Health on 6/27/2025 revealed that while rounding on 6/26/2025 at approximately 8:45 PM, staff observed Resident ID #4 in Resident ID #3's room. Staff witnessed Resident ID #4 holding Resident ID #3's arm and striking his/her side, arm, and legs. The report further revealed that after Resident ID #4 was removed from the room, s/he was then sent to the emergency department for an evaluation. Resident ID #3 was observed to be teary and upset during the nursing assessment.Review of an undated document titled, Special care unit disclosure, states in part, .The mission of [facility name redacted] Special care unit is to help the residents live a life of dignity, love, respect, in an environment that is best suited to their needs .the environment is designed to promote and encourage independence while promoting safety .1. Record review revealed Resident ID #3, the victim, was admitted to the facility in December of 2023 with diagnosis including, but not limited to, Alzheimer's disease.Record review of a Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 5 out of 15, indicating the resident has severely impaired cognition. Further review revealed the resident is totally dependent on staff for his/her activities of daily living.Record review of the care plan dated 9/20/2024 revealed that Resident ID #3 is unable to care for him/herself related to his/her cognitive impairment. Further, the care plan revealed s/he is non ambulatory and requires a Hoyer lift (a device that aids in the transfer a resident with challenged mobility from one place to another) for transfers by two caregivers.Record review revealed a progress note dated 6/27/2025 authored by Licensed Practical Nurse (LPN), Staff A, which revealed Resident ID #4 (the perpetrator) grabbed Resident ID #3's arm and s/he hit him/her all over his/her body. Additionally, the progress note indicated that both residents were separated. Further review of the note revealed that all safety precautions were applied.Review of Resident ID #3's care plan failed to reveal evidence the care plan was updated or revised to include interventions to promote the resident's safety after the incident that took place on 6/26/2025.2. Record review revealed Resident ID #4, the perpetrator, was admitted to the facility in April of 2025 and readmitted in June of 2025 with diagnoses including, but not limited to, dementia and anxiety disorder. Review of the admission MDS assessment dated [DATE] revealed a BIMS score of 4 out of 15, indicating the resident has severely impaired cognition. Further review revealed the resident is independent with transfers and utilizes a walker for mobility. Record review revealed a progress note dated 6/26/2025 authored by LPN, Staff B, which revealed Resident ID #4 went into Resident ID #3's room while s/he was asleep, grabbed his/her arm and hit him/her all over his/her body. Additionally, the progress note indicated Resident ID #4 was transferred to the hospital because s/he was a danger to others. Further review of the note revealed that all safety precautions were applied.Additional review revealed a progress note dated 6/27/2025 that revealed Resident ID #4 returned to the facility with a diagnosis of a urinary tract infection and new orders for keflex (an antibiotic), ativan (an anti-anxiety medication), and trazodone (a medication prescribed to treat depression, anxiety and insomnia). Further review of the note revealed all safety precautions applied.Record review of Resident ID #4's care plan last revised on 6/30/2025 revealed the resident exhibits periods of increased anxiety and agitation. S/he often reaches out to touch objects, which may include other residents. S/he attempted to bite his/her spouse, has pinched others, grabbed another resident's hand on 5/31 and grabbed another resident's nose on 6/3/2025. Interventions include, monitoring for increase in agitation as evidenced by loud tone, clenched fists, and argumentative behaviors. Additional review of the care plan revealed a problem start date of 6/30/2025 as the resident experienced signs and symptoms of an acute urinary tract infection which will resolve in 14 days with an intervention to administer medications as ordered.Record review failed to reveal evidence that the resident's care plan was revised to include updated safety interventions to prevent further incidents until 7/6/2025, 10 days after the resident was readmitted to the facility following his/her hospital admission. During a surveyor interview on 7/7/2025 at 1:03 PM with Staff A, she revealed that Resident ID #4 was transferred to the hospital following the incident with Resident ID #3. Additionally, she indicated that there were no additional safety measures put in place upon his/her return to the facility.During a surveyor interview on 7/7/2025 at approximately 2:30 PM with the