

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415098	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/30/2026
NAME OF PROVIDER OR SUPPLIER Harris Health Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 833 Broadway East Providence, RI 02914	

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** Based on surveyor observation, clinical record review, and staff interview, the facility failed to protect the residents' right to be free from abuse for 1 of 1 resident reviewed for abuse, relative to a physical altercation between Resident ID #s 24 and 28. Findings are as follows: Review of a facility policy titled, Abuse prohibition dated August of 2020 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 to be free from abuse. DEFINITIONS. Abuse: Willful infliction of injury resulting in physical harm. Examples of abuse. Physical-Hitting. Review of a facility reported incident submitted to the Rhode Island Department of Health on 11/9/2025 revealed that Resident ID #28 struck Resident ID #24 with his/her fist causing an abrasion to his/her forehead. Record review revealed that the victim, Resident ID #24, was admitted to the facility in July of 2024 with a diagnosis including, but not limited to, dementia. Review of a Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 7 out of 15, indicating severe cognitive impairment. Review of a care plan focus area dated 12/16/2024 revealed the resident has had increased episodes of sexually inappropriate behavior towards other residents. Additionally, interventions include, but are not limited to, seat the resident away from residents of the opposite gender when s/he is in the dining room. Record review revealed that the perpetrator, Resident ID #28, was readmitted to the facility in April of 2025 with diagnoses including, but not limited to, dementia with mood and behavioral disturbance and unspecified psychosis not due to a substance or known physiological condition. Review of an MDS assessment dated [DATE] revealed a BIMS score of 1 out of 15, indicating severe cognitive impairment. Additionally, it revealed s/he has verbal behavioral symptoms directed towards others that occurred 1 to 3 days of a 7-day review period. Record review of a progress note dated 11/9/2025 at 8:36 PM revealed that Resident ID #24 was involved in an altercation with Resident ID #28. Review of an Event Report dated 11/9/2025 revealed that Resident ID #s 24 and 28 were sitting in the community room. Resident ID #24 attempted to touch Resident ID #28's genital area and in response was struck in the eye and forehead by Resident ID #28. Additionally, Resident ID #24 sustained a small laceration to his/her left forehead and a scratch under his/her right eye that was bleeding. During a surveyor observation on 1/28/2026 at approximately 2:30 PM of surveillance video footage, in the presence of another surveyor, the Director of Nursing Services (DNS), and the Administrator, revealed the following:-11/9/2025 at 2:05 PM: Resident ID #24 was observed to be seated in the middle of two residents of the opposite gender, one being Resident ID #28. Additionally, two staff members were observed to be present in the area and failed to separate Resident ID #24 from the residents of the opposite gender as indicated in his/her care plan. During a surveyor interview on 1/28/2026 at approximately 2:55 PM, with the DNS in the presence of another surveyor, the Social Worker, and the Administrator, the DNS acknowledged that Resident ID #24 was seated between two residents of the opposite gender</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>while two staff members were present. Additionally, they were unable to provide evidence that Resident ID #24's care plan was followed thus resulting in Resident ID #28 striking and injuring Resident ID #24. During a surveyor interview on 1/28/2026 at approximately 2:10 PM with Nursing Assistant, Staff A, she revealed that she was working the day the altercation occurred. She further revealed that she did not witness the altercation between the residents, however, she did observe Resident ID #24 with a cut to his/her forehead that was bleeding. Additionally, she revealed that she was told that Resident ID #24 attempted to touch Resident ID #28's groin, but after the facility staff had reviewed the surveillance video footage, it was determined that Resident ID #24 did not attempt to touch Resident ID #28 at all. During a surveyor interview on 1/29/2026 at 10:25 AM with Registered Nurse, Staff B, she revealed that Resident ID #s 24 and 28 don't mix. She revealed that staff try to keep both residents separated. Additionally, she revealed that Resident ID #24 is to be kept away from residents of the opposite gender which has been in effect for a long time. During a surveyor interview on 1/29/2026 at 9:53 AM with the Administrator, he was unable to provide evidence that Resident ID #24 was kept free from physical abuse. Cross reference F-657</p>		