Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415110	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakland Grove Health Care Center	560 Cumberland Hill Road Woonsocket, RI 02895

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 - Minimal harm or potential for actual harm Residents Affected - Few	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** 37158 Based on surveyor observation, record review and staff interview it has been determined that the facility failed to protect and keep residents free from physical abuse relative to an incident that occurred between Resident ID #1 and Resident ID #5. Findings are as follows: Record review of a facility reported incident submitted to the Rhode Island Department of Health on 5/9/2024 revealed a nursing assistant (NA) entered Resident ID #5's room at 4:00 PM and observed Resident ID #1 with his/her hands around Resident ID #5's neck. The residents were immediately separated, and Resident ID #1 was sent to the hospital for an evaluation. Record review of the facility policy titled Resident Abuse, Neglect, Mistreatment and Misappropriation Prevention Policy dated April, 2015 states in part, Policy: Each resident has the right to be free from abuse . Abuse means the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting harm, pain or mental anguish . Record review revealed Resident ID #1 (the perpetrator) was admitted to the facility in March of 2022 with diagnoses including, but not limited to Alzheimer's disease, generalized anxiety disorder and major depressive disorder. Record review of a Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 0 out of 15, indicating the resident has severe cognitive impairment. Further review of the assessment revealed the resident requires moderate assistance for functional abilities such as showering, dressing, toileting and limited assistance with personal hygiene. Additionally, the assessment indicates that s/he ambulates with a walker. Record review of Resident ID #1's care plan developed on 12/27/2023 and revised on 5/9/2024 states in part, [Resident] has potential to be physically aggressive r/t [related to] increase in confusion secondary to Alzheimer's dementia. [Resident] had an actual episode of physical aggression towards another resident . (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 - Minimal harm or potential for actual harm Residents Affected - Few	Record review revealed Resident ID #1 has been followed by psychiatric services, last assessed on 5/3/2024 in which s/he was noted to be alert, confused, and cooperative per baseline. Further review of the assessment revealed that staff had reported that the resident had increased confusion which could also be related to his/her diagnosis and a medical workup was completed with normal findings. Medication recommendations were made to start Buspar (medication to treat anxiety disorders) 5 mg daily, which was initiated on 5/4/2024. Record review revealed Resident ID #5 (the victim) was admitted to the facility in August of 2020 with diagnoses including, but not limited to, stroke, aphasia following a stroke, anxiety disorder and major depressive disorder. Record review of Resident ID #5's Quarterly MDS assessment dated [DATE] revealed a Brief Interview for Mental Status score of 2 out of 15, indicating severe cognitive impairment. Further review of the MDS assessment revealed the resident is dependent for most functional abilities, except for eating, which s/he can do independently. Additionally the assessment indicates that s/he is able to self-propel in his/her wheelchair on the unit. Record review of Resident ID #5's care plan developed on 12/27/2023 states in part, .[Resident] was involved in a resident to resident incident, interventions include room transfer and social services to provide support as needed . During a surveyor interview on 5/14/2024 at 9:16 AM with the Director of Nursing Services (DNS) she revealed Resident ID #1 is generally sweet, pleasantly confused and keeps to himself/herself, it is not his/her usual behavior to walk into another resident's room. She further revealed Resident ID #1 and Resident ID #5 had previously resided together as roommates until December of 2023. The residents were separated after Resident ID #1 hit Resident ID #5 with his/her walker and Resident ID #5 was moved into a different room. On the day of the incident, 5/9/2024 she revealed Resident ID #1 was observed by a staff member in Resident ID #5's room with his/her hands around Resident ID #5's neck. She further revealed staff intervened immediately and separated both residents. Resident ID #5 was placed in another room on the other end of the unit. Resident ID #1 was sent to the hospital for an evaluation where s/he was diagnosed with a urinary tract infection and received the first dose of a course of antibiotics before returning to the facility. Additionally, the DNS revealed on the following day Resident ID #5 was observed with a bruise to his/her left shoulder, an x-ray was ordered by the provider which resulted in negative findings. Furthermore, the DNS acknowledged the bruise on Resident ID #5's shoulder was from the incident on 5/9/2024. Record review of a progress note dated 5/9/2024, authored by the nurse that responded to the incident, revealed Resident ID #5 was observed with a superficial nail mark to his/her neck and a reddened area on his/her neck. During a surveyor interview on 5/14/2024 at 11:54 AM with the NA Staff A, who observed the incident between the two residents, she revealed Resident ID #1 is usually pleasantly confused and Resident ID #5 is sweet and keeps to himself/herself. Staff A revealed on the day of the incident she observed Resident ID #1 with her hands around Resident ID #5's neck, she immediately removed Resident ID #1 from Resident ID #5 and called for the nurse. Staff A took Resident ID #1 to his/her room and stayed with him/her until s/he left for the hospital. Resident ID #5 was moved to a room on the other side of the unit and then moved to a different floor. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a surveyor interview with the DNS on 5/14/2024 at 9:16 AM, she was unable to provide evidence that Resident ID #5 was kept free from abuse.