

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  10/01/2024
NAME OF PROVIDER OR SUPPLIER  Oakland Grove Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0600</p> <p>Level of Harm - 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>46715</p> <p>Based on record review and staff interview, it has been determined that the facility failed to keep a resident free from sexual abuse for 1 of 5 residents reviewed, Resident ID #1.</p> <p>Findings are as follows:</p> <p>Review of a facility policy titled, Abuse Prohibition Policy dated September 2020, states in part, .It will be the facility's responsibility to identify, correct and intervene in situations where abuse, mistreatment, neglect, exploitation and/or misappropriation of resident property occur .sexual abuse includes, but is not limited to, sexual harassment, sexual coercion or sexual assault. Sexual abuse is non-consensual sexual contact of any type with a resident .</p> <p>Review of a facility reported incident submitted to the Rhode Island Department of Health on 9/30/2024 revealed that Resident ID #s 1 and 2 reported to a supervisor on 9/26/2024 that they were engaging in a consensual sexual relationship. On the morning of 9/30/2024, Resident ID #1 reported to the Director of Social Services that s/he had sex with Resident ID #2 three times since 9/27/2024 and all of these instances were without his/her consent.</p> <p>Record review revealed that Resident ID #1 (the alleged victim) was admitted to the facility in September 2022 with diagnoses including, but not limited to, paranoid personality disorder and anxiety.</p> <p>Review of a Minimum Data Set (MDS) Assessment for Resident ID #1 dated 8/26/2024 revealed a Brief Interview for Mental Status (BIMS) score of 14 out of 15 indicating intact cognition.</p> <p>Review of a progress note dated 9/27/2024, authored by the Director of Social Services, revealed that he met with Resident ID #1 relative to him/her being involved in a physical relationship with Resident ID #2. Resident ID #1 indicated that s/he felt safe and is happy with the relationship. Additionally, the progress note indicated that the Director of Social Services informed Resident ID #1 that if s/he ever felt unsafe or uncomfortable that staff are available to support him/her.</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 - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a progress note dated 9/30/2024, authored by the Director of Social Services, revealed that Resident ID #1 reported to him that Resident ID #2 had gotten into bed with him/her although s/he told him/her not to. Additionally, the progress note revealed that Resident ID #1 reported sexual activity occurred on Friday (9/27/2024), Saturday (9/28/2024), and Sunday (9/29/2024) without his/her consent.</p> <p>Further record review revealed that Resident ID #1 was transferred to an acute care hospital for an evaluation related to genital pain.</p> <p>Review of emergency room documentation dated 9/30/2024 revealed Resident ID #1 was being treated for a potential sexual assault. Additionally, it revealed that Resident ID #1 reported being penetrated with an object but was unable to identify what the object was. Additional review revealed that Resident ID #1 was forced to wear outfits and role play with Resident ID #2. The document further revealed that Resident ID #1 was experiencing dysuria (painful or difficulty with urination), pelvic pain and pain to his/her genital area. Lastly the documentation revealed that, while in the emergency room, Resident ID #1 was noted to be anxious and tremulous.</p> <p>Review of a facility provided statement authored by a laundry aide, Staff A revealed that on Sunday 9/29/2024 at around 10:30 AM Resident ID #1 was crying and told her that Resident ID #2 was trying to get into bed with him/her and s/he felt like Resident ID #2 was moving too fast. The statement further revealed that Resident ID #1 felt uncomfortable around Resident ID #2 because s/he was moving so fast and Resident ID #1 showed Staff A hickeys on his/her neck. The statement revealed that Staff A encouraged Resident ID #1 to speak to a Nursing Assistant and talk to the Director of Social Services on Monday.</p> <p>During a surveyor interview on 10/1/2024 at 12:11 PM with Staff A, she acknowledged that Resident ID #1 did tell her that s/he was uncomfortable with Resident ID #2 on Sunday 9/29/2024. Staff A acknowledged that she told Resident ID #1 to talk to the Director of Social Services the following day. Additionally, she revealed that she did not identify Resident ID #1's concerns as potential abuse at the time.</p> <p>Review of a facility provided statement authored by Nursing Assistant, Staff B revealed that on Sunday 9/29/2024 Resident ID #1 told her that Resident ID #2 was moving too fast and s/he wanted him/her to slow down. It further revealed that Resident ID #1 was having mixed emotions and did not know what to do. The statement revealed that Resident ID #1 wanted to tell Resident ID #2 but s/he was afraid and showed Staff B hickeys on his/her neck.</p> <p>During a surveyor interview via telephone on 10/1/2024 at 1:04 PM with Staff B, she revealed that Resident ID #1 told her that s/he felt that Resident ID #2 was moving too fast but s/he was afraid to talk to him/her about it. Staff B acknowledged that she encouraged Resident ID #1 to talk to the Director of Social Services the following day. Staff B revealed that she did tell Licensed Practical Nurse (LPN), Staff C about the concerns Resident ID #1 had with Resident ID #2.</p> <p>During a surveyor interview on 10/1/2024 at 1:45 PM with Staff C, she revealed that she did hear that Resident ID #1 felt that Resident ID #2 was moving too fast on 9/29/2024. Additionally, she acknowledged that she did not talk to Resident ID #1 and did not investigate his/her concerns.</p> <p>Resident ID #1 was unavailable for a surveyor interview due to being discharged to the hospital.</p> <p>(continued on next page)</p>		

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F 0600  Level of Harm - Actual harm  Residents Affected - Few	<p>Record review revealed that Resident ID #2 (the alleged perpetrator) was admitted to the facility in July of 2024 with a diagnosis including, but not limited to, bipolar disorder.</p> <p>Review of an MDS Assessment for Resident ID #2 dated 7/31/2024 revealed a BIMS score of 13 out of 15 indicating intact cognition.</p> <p>Resident ID #2 was unavailable for a surveyor interview due to the resident requesting to be discharged home on 9/30/2024.</p> <p>Record review failed to reveal evidence that the facility staff initiated any interventions to ensure Resident ID #1's safety from Sunday 9/29/2024 at approximately 10:00 AM, when staff were made aware by Resident ID #1 that s/he was uncomfortable with Resident ID #2, as s/he was moving too fast for him/her within their relationship, until Monday 9/30/2024 when Resident ID #1 alleged that s/he was sexually assaulted. Resident ID #1 alleged that s/he was sexually assaulted on Sunday night 9/29/2024 after s/he expressed concerns to staff.</p> <p>During a surveyor interview on 10/1/2024 at approximately 12:05 PM with the Administrator he acknowledged that Resident ID #1 communicated concerns to the facility staff but that they did not identify it as abuse. Additionally, he was unable to provide evidence that the facility kept Resident ID #1 free from abuse on the evening of 9/29/2024.</p> <p>Cross reference F610</p>		

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<p>F 0610</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>46715</p> <p>Based on record review and staff interview it has been determined that the facility failed to ensure that allegations made by residents are recognized as possible abuse by staff, all allegations are investigated, and that residents are kept free from experiencing further abuse during investigations for 1 of 1 Resident reviewed who expressed concerns to staff members regarding a consensual sexual relationship with another resident, Resident ID #1 (the alleged victim).</p> <p>Findings are as follows:</p> <p>Review of a facility policy titled, Abuse Prohibition Policy dated September 2020, states in part, .each resident has the right to be free from abuse .Procedure .identifying events, occurrences, patterns and trends of potential abuse for residents. Performing internal facility investigations of alleged violations and identification of staff members responsible for investigating incidents and reporting of the same to proper authorities. Protecting residents from harm during an investigation of alleged abuse .</p> <p>Review of a facility in-service on abuse dated 3/6/2023 states in part, .Identification of abuse .Sudden or unexplained changes in behaviors and/or activities such as fear of a person or place or feelings of guilt or shame .</p> <p>Review of a facility reported incident submitted to the Rhode Island Department of Health on 9/30/2024 revealed that Resident ID #s 1 and 2 reported to a supervisor on 9/26/2024 that they were engaging in a consensual sexual relationship. On the morning of 9/30/2024, Resident ID #1 reported to the Director of Social Services that s/he had sex with Resident ID #2 (the alleged perpetrator) three times since 9/27/2024 and all of these instances were without his/her consent.</p> <p>Record review revealed that Resident ID #1 was admitted to the facility in September 2022 with diagnoses including, but not limited to, paranoid personality disorder and anxiety.</p> <p>Review of a Minimum Data Set (MDS) Assessment for Resident ID #1 dated 8/26/2024 revealed a Brief Interview for Mental Status (BIMS) score of 14 out of 15 indicating intact cognition.</p> <p>Review of a facility provided statement authored by a laundry aide, Staff A revealed that on Sunday 9/29/2024 at around 10:30 AM Resident ID #1 was crying and told her that Resident ID #2 was trying to get into bed with him/her and s/he felt like Resident ID #2 was moving too fast. The statement further revealed that Resident ID #1 felt uncomfortable around Resident ID #2 because s/he was moving so fast. The statement revealed that Staff A encouraged Resident ID #1 to speak to a Nursing Assistant and talk to the Director of Social Services on Monday.</p> <p>During a surveyor interview on 10/1/2024 at 12:11 PM with Staff A, she acknowledged that Resident ID #1 did tell her that s/he was uncomfortable with Resident ID #2 on Sunday 9/29/2024. Staff A acknowledged that she told Resident ID #1 to talk to the Director of Social Services the following day. Additionally, she revealed that she did not identify Resident ID #1's concerns as potential abuse at the time nor did she investigate any further.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a facility provided statement authored by Nursing Assistant, Staff B revealed that on Sunday 9/29/2024 Resident ID #1 told her that Resident ID #2 was moving too fast and s/he wanted him/her to slow down. It further revealed that Resident ID #1 was having mixed emotions and did not know what to do. The statement revealed that Resident ID #1 wanted to tell Resident ID #2 but s/he was afraid.</p> <p>During a surveyor interview via telephone on 10/1/2024 at 1:04 PM with Nursing Assistant (NA), Staff B, she revealed that Resident ID #1 told her that s/he felt that Resident ID #2 was moving to fast but s/he was afraid to talk to him/her about it. Staff B acknowledged that she encouraged Resident ID #1 to talk to the Director of Social Services the following day. Staff B revealed that she told Licensed Practical Nurse (LPN), Staff C about the concerns Resident ID #1 had with Resident ID #2.</p> <p>During a surveyor interview on 10/1/2024 at 1:45 PM with LPN, Staff C she revealed that she was made aware of Resident ID #1 telling Staff B about his/her concerns about Resident ID #2 moving too fast. Additionally, she acknowledged that she did not go talk to Resident ID #1 and did not further investigate any concerns.</p> <p>Review of emergency room documentation dated 9/30/2024 revealed Resident ID #1 was being treated for potential sexual assault. Additionally, it revealed that Resident ID #1 reported being penetrated with an object but was unable to identify what the object was. Further review revealed that Resident ID #1 was experiencing dysuria (pain or difficulty with urination), pelvic pain and pain to his/her genital area. While in the emergency room Resident ID #1 was noted to be anxious and tremulous.</p> <p>Resident ID #1 was unavailable for a surveyor interview due to being discharged to the hospital.</p> <p>Record review revealed that Resident ID #2 was admitted to the facility in July of 2024 with a diagnosis including, but not limited to, bipolar disorder.</p> <p>Review of an MDS Assessment for Resident ID #2 dated 7/31/2024 revealed a BIMS score of 13 out of 15 indicating intact cognition.</p> <p>Resident ID #2 was unavailable for a surveyor interview as the resident requested to be discharged home on 9/30/2024.</p> <p>During a surveyor interview on 10/1/2024 at approximately 12:05 PM with the Administrator he acknowledged that Resident ID #1 communicated concerns to the facility staff but that they did not identify it as potential abuse. Additionally, he was unable to provide evidence that the facility prevented further potential abuse from occurring to Resident ID #1 while an investigation was being conducted or that the facility initiated an investigation to determine if Resident ID #1 had been abused.</p> <p>Cross reference F600</p>		