RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01347	A. BUILDING: _____ B. WING _____	C 08/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE AT WATERMAN LAKE-LP	715 PUTNAM PIKE SMITHFIELD, RI 02828

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 003	Initial Comments An unannounced complaint/incident investigation survey was conducted at this residence. Deficiencies were identified.	S 003	The Filing of this Plan of Correction (POC) is not intended to constitute an admission that the deficiencies alleged did in fact exist; rather this POC is filed as evidence of the community's continuing commitment to high quality resident care in full compliance with State regulations.	
S 415	Residency Requirements 2.4.17.D Reporting Requirements 2.4.17 (D) Licensure Requirements D. Any employee of an assisted living residence who has reasonable cause to believe that a resident has been abused, exploited, neglected, or mistreated shall within twenty-four (24) hours of the receipt of said information, transfer such to the Director and to the Office of the Long- Term Care Ombudsman. Any person required to make a report pursuant to this section shall be deemed to have complied with these requirements if a report is made to a high managerial agent. Once notified, said agent shall be required to meet the above reporting requirements. The residence shall establish a written policy or procedure for reporting abused, exploited or neglected residents that complies with the provisions of this section. The report may be submitted by telephone but shall be followed up in writing. 1. Upon receipt of such information or allegation, the Director shall forthwith conduct such investigation as may be necessary and submit a report of findings of the investigation(s) to the Attorney General of the State of Rhode Island. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined the residence failed to ensure employees of an assisted living residence who	S 415		

Facilities Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPI Oliver Harvey Chief Operating Officer October 17, 2023

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S 415	Continued From page 1 have reasonable cause to believe that a resident has been abused, exploited, neglected, or mistreated shall within twenty-four (24) hours of the receipt of said information make a report to a high managerial agent and to the appropriate state agency for 2 of 2 sample residents reviewed, Resident ID #s 1 and 2. Findings are as follows: According to 2.4.17 (D) of The Rules and Regulations for Licensing Assisted Living which states in part, "...Any employee of an assisted living residence who has reasonable cause to believe that a resident has been abused, exploited, neglected, or mistreated, shall within twenty-four (24) hours of the receipt of said information, transfer such to the Director and to the Office of the Long-Term Care Ombudsman...1. Upon receipt of such information or allegation, the Director shall forthwith conduct such investigation as may be necessary and submit a report of findings to the investigation(s) to the Attorney General of the State of Rhode Island..." Record review revealed a community reported complaint sent to the Rhode Island Department of Health (RIDOH) on 8/16/2023 which states in part, "...Resident to Resident Abuse...Sexual ..." This form reported that two residents on the Special Care Unit (SCU) were involved, one who was the alleged victim, Resident ID #1, and the other who was the alleged perpetrator, Resident ID #2. 1. Record review revealed Resident ID #1 moved into the residence's SCU in August of 2023 with a diagnosis of dementia.	S 415	Resident ID # 1 has experienced no untoward effects as a result of the surveyor findings. No other residents are currently involved in physical relationships that extend beyond handholding. Effective October 6, 2023, The Village has amended our policy entitled "Sexual Relations Between Residents in Memory Care", which we believe was effective in this instance as it relates to our determining in real time whether the two individuals involved were capable of sufficiently consenting to the physical relationship on which they were embarking, to include the following statement: "Even in situations where the physical relationship is determined to be mutually consensual, if the physical relationship has extended to include anything beyond hand holding, then The Village will report that relationship to the Department of Health within 24 hours of our learning of it." A copy of the revised policy is attached and has been circulated and reviewed with all members of the Team.	10/10/23

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S 415	Continued From page 2 2. Record review revealed Resident ID #2 moved into the residence's SCU in July of 2023 with a diagnosis of a stroke. Review of a "Nurses Notes" in Resident ID #1's record dated 8/14/2023 states in part, "Staff reported to DNS (Director of Nursing Services) that on 8/13/23 [ID #1] was often found in [ID #2's] room...this staff member then walked into [ID #2's] apt (apartment) and witnessed [ID #2]...leaning over kissing [ID #1]...with [his/her] hand down [ID #1] pants...at this time the incident was reported to the MOD (manager on duty)..." A similar note was found in Resident ID #2's record. Record review failed to reveal evidence that the above-mentioned incident was reported to the state agency, as required. During a surveyor interview with the Courtyard Director of Nursing on 8/17/2023 at approximately 2:45 PM, she acknowledged that the above-mentioned incident was not reported to the state agency, as required.	S 415		
S 815	Special Care License Requirements 2.5.2.G Specific Requirements 2.5.2 (G) Specific Requirements G. The Alzheimer Dementia Special Care Unit/Program shall operate and provide services to all residents of the unit/program in accordance with the prevailing community standard of care for residents with the particular needs and behaviors with dementia This Requirement is not met as evidenced by:	S 815		

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S 815	Continued From page 3 Based on record review and staff interview, it has been determined the residence failed to operate and provide services to all residents in accordance with the prevailing community standard of care for residents on the special care unit, Resident ID #s 1 and 2. Findings are as follows: According to the Licensing Assisted Living Residences definition, an "Alzheimer Dementia Special Care Unit/Program" means "a distinct living environment within an assisted living residence that has been physically adapted to accommodate the needs and behaviors of those with dementia. The unit provides increased staffing, therapeutic activities designed specifically for those with dementia, and trains its staff on an ongoing basis on the effective management of the physical and behavioral problems of those with dementia. The residents of the unit or program have had a standard medical diagnostic evaluation and have been determined to have a diagnosis of Alzheimer's dementia or another dementia." Record review revealed a community reported complaint sent to the Rhode Island Department of Health (RIDOH) on 8/16/2023 which states in part, "...Resident to Resident Abuse...Sexual ..." This form reported that two residents on the Special Care Unit (SCU) were involved, one who was the alleged victim, Resident ID #1, and the other who was the alleged perpetrator, Resident ID #2. 1. Record review revealed Resident ID #1 moved into the residence in August of 2023 with a diagnosis of dementia due to Alzheimer's disease.	S 815	10/10/23 Residents # 1 and # 2 have experienced no untoward effects as a result of the surveyor findings. Resident ID # 2 no longer resides in our Memory Care Building. Residents 1 and 2 are no longer in contact with each other, and Resident # 1 has not developed any relationships that are beyond platonic in nature. All other residents living in the Memory Care Building currently have a diagnosis of dementia. Going forward, we will utilize our assessment tool for any new admission to The Village at Waterman Lake, which will prevent us from accepting a resident who does not have a diagnosis of dementia. In situations where the resident is experiencing dementia-like symptoms or cognitive issues that affect his or her safety (i.e. elopement risk), as was the case with resident #2, The Village will attempt to secure a diagnoses of dementia from a qualified medical professional, and if unsuccessful, will reach out to The Department of Health for consult prior to accepting/rejecting him or her.	

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S 815	Continued From page 4 Record review of a comprehensive assessment dated 08/07/2023, the date the resident moved to the SCU from traditional assisted living, revealed the reason for the transfer was to have a safe, secure environment due to increased cognitive impairment and wandering behaviors. Further record review of a mini mental exam dated 06/30/2023 revealed a score of 15 out of 30 which indicates s/he has moderate cognitive impairment. A new cognitive score was not obtained after the change in condition which prompted the move to the SCU. During a surveyor interview with the alleged victim, ID #1 on 08/17/2023 at 9:15 AM, the resident presented as alert and oriented to person only. The resident was unable indicate where he/she was and had no recognition of the people on the unit. Additionally, the resident indicated he/she has a significant other in the community and was able to recall that individual's name. 2. Record review revealed Resident ID #2 moved into the special care unit in July of 2023 with a diagnosis of a stroke. Record review of a comprehensive assessment dated 07/21/2023 revealed the resident has a diagnosis of a nontraumatic intracerebral hemorrhage (a type of stroke). Further record review failed to revealed this resident was appropriate for the SCU, as he/she does not have a diagnosis of dementia. Additional record review of a mini mental exam dated 07/24/2023 revealed a score of 24 out of	S 815	Should another resident begin exhibiting a fondness for a resident of the opposite sex that becomes affectionate, (i.e. physical contact beyond hand holding), The Village will report this to the Department of Health. Furthermore, our monitoring and observation of the relationship's development will be documented not just in the nurse's notes, but in the actual care plan as well.	

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S 815	Continued From page 5 30 which indicates s/he has mild cognitive impairment. Review of "Nurses Notes" in Resident ID #1's record dated 08/07/2023 indicates he/she was moved to the SCU due to poor short-term memory and decreased safety awareness. Resident ID #1's "Nurses Notes" on 08/07/2023, 08/08/2023, and 08/09/2023 indicate confusion as baseline. Review of "Nurses Notes" in Resident ID #1's record dated 08/09/2023, 08/10/2023, and 08/11/2023 indicate the residence is to "monitor" the interactions between Resident ID #s 1 and 2 and "redirect" the residents when they seek private areas. Review of a "Nurses Notes" in Resident ID #1's record dated 08/14/2023 states in part, "Staff reported to DNS (Director of Nursing Services) that on 8/13/23 [ID #1] was often found in [ID #2's] room...this staff member then walked into [ID #2's] apt (apartment) and witnessed [ID #2]...leaning over kissing [ID #1]...with [his/her] hand down [ID #1] pants...at this time the incident was reported to the MOD (manager on duty)..." A similar note was found in Resident ID #2's record. Review of a "Behavior Tracking Record" for Resident ID #1 indicates numerous instances of confusion and restlessness from 08/07/2023-08/17/2023. Record review of a staff statement by the Manager on Duty, Staff B, on the date of the alleged incident, which states in part, "On Sunday, August 13, 2023, The CMT [Staff A]...came to us and said she personally	S 815		

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S 815	Continued From page 6 witnessed [ID #1 and 2]...engaging in sexual intercourse...[ID #1] has in the past failed to recognize [ID #2]. For this reason, along with the consideration of [his/her] level of dementia, which is more advanced than [ID #2]...I felt it necessary to inform [ID #1's] POA (power of attorney)...We informed the Director of Nursing...of our intentions, and [she] agreed...[POA] suspects that [ID #1] would not actually be choosing to engage in this behavior were [s/he] not memory impaired...we agreed it was in [ID #1's] best interest for the team to deter [him/her] from engaging in further sexual relation with [ID #2]..." Additional record review of a staff witness statement by a Certified Medication Technician (CMT), Staff A, dated 08/17/2023 states in part, "I noticed about a week ago that [ID #1 and 2]...would talk and sit together frequently. Then they started holding hands and would go into each other rooms. I would go in and sometimes they would be sitting on the bed, sometimes they would be kissing...the above was reported to DNS (Director of Nursing Services)." The record failed to reveal Resident ID #1 was sufficiently monitored to prevent numerous sexual encounters between themselves and Resident ID #2. Resident ID #1 did not readily recognize Resident ID #2 and at times indicated she/he did not know him/her or was waiting or searching for a different person. Resident ID #1's POA indicated that Resident ID #1 was potentially confusing Resident ID #2 with their significant other referenced in the interview with the surveyor. During a surveyor interview with the Courtyard Director of Nursing on 08/17/2023 at approximately 2:50 PM, she indicated that	S 815		

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S 815	Continued From page 7 Resident ID #1 has dementia and is more cognitively impaired than Resident ID #2 who does not have a diagnosis of dementia. She further indicated that Resident ID #2 moved into the Special Care Unit due to some cognitive impairment following a stroke and moved back to the traditional assisted living unit on 08/14/2023 after his/her cognition had improved. She could not provide evidence the residents' behaviors were monitored and managed effectively, as required.	S 815		