RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01466	A. BUILDING _____ B. WING _____	C 11/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA HARBORHILL	159 DIVISION STREET EAST GREENWICH, RI 02818

(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 on 11/28/2023. Deficiencies were identified.	S 003	Preparation, Execution, and Submission of this Plan of Correction does not constitute an admission of fault or liability on the part of Atria Harborhill nor agreement by Atria Harborhill as to the truth of the facts alleged or conclusions drawn in the Statement of Deficiencies or any specific statement of non-compliance. Atria Harborhill prepares and submits this Plan of Correctionto comply with state laws and regulatory provisions	
S 380	Residency Requirements 2.4.16.G.1 Resident Assessment/Service Plan 2.4.16 (G) (1) Service Plans 1. Within a reasonable time after move-in, not to exceed seven (7) days, the Administrator shall be responsible for the development of a written service plan based on the initial assessment. The service plan shall include at least: a. The services and interventions needed, including all services provided by outside healthcare agencies (e.g., home nursing care, hospice); b. Description, frequency, duration relating to the service or intervention, including personal assistance, medication, special diets, recreational activities, and other similar services rendered; c. Party responsible for arranging and/or providing the service; and d. The resident's requested and/or therapeutically needed recreational and social activities. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined that the residence failed to document a description of the services and interventions needed on the service plan for one	S 380	ID Tag S 380 Residency Requirements 2.4.16 .G.1 Resident Assessments/Service Plan As set forth by Residency Requirements 2.4.16. G.1 Resident Assessments/Service Plan, Within the State of Rhode Island Regulations. For Resident ID #1 The Resident moved back to California on 9/14/2023. 9/14/2023 The Community will Inservice Nursing Staff on Residency Requirements 2.4.16.G.1 Resident Assessments/Service Plan 1/10/2024 Nursing Staff will audit all new and current residents services plans documentation on the resident's record to accurately reflect the description of services and interventions needed on an ongoing basis. 2/1/2024 Resident Services Director and Executive Director will review compliance at the Quarterly Quality Assurance Meetings 3/31/2024	

@ 1/4/24

RECEIVED
JAN 2 2024
FACILITIES REGULATION

Facilities Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Executive Director	12/22/2023

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S 380	Continued From page 1 of two sample residents reviewed relative to behaviors, ID #1. Findings are as follows: Record review revealed Resident ID #1 was admitted in August of 2023 with a diagnosis of Alzheimer's disease. Review of an additional "Assisted Living Residence Required Incident Reporting" form dated 09/04/2023 indicates Resident ID #1 had a physical altercation with another resident and continued to "punch/kick staff and EMT." Review of an "Assisted Living Residence Required - Five (5) Day Investigation Report" form dated 09/08/2023 revealed Resident ID #1 "was evaluated by psychiatry and started on new medication related to behavior. Resident returned after no behaviors were observed at the hospital Resident has a one to one companion in place until further notice to observe stable behaviors." Resident ID #1's service plan dated 07/25/2023 failed to reveal being updated to include interventions and services needed related to the return of the resident from the hospital, such as the requirement for a one-to-one companion for safety. During an interview on 11/28/2023 at approximately 12:25 PM, the Director of Wellness acknowledged Resident ID #1's service plan does not accurately reflect their behavioral needs and required interventions.	S 380		
S 430	Residency Requirements 2.4.17.G Reporting Requirements	S 430		

12/22/2023

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S 430	Continued From page 2 2.4.17 (G) Reporting Requirements G. The residence shall maintain evidence that all reportable incidents have been thoroughly investigated and that actions have been taken to prevent further incidents while the investigation is in progress. Appropriate corrective action shall be taken, as necessary. The results of said investigation shall be reported to the Department, within five (5) business days, on forms supplied by the Department. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined the residence failed to thoroughly investigate and document an incident relative to any injury(ies) to a resident for one of two residents reviewed relative to abuse, ID #2. Findings are as follows: Record review revealed Resident ID #2 was admitted in October of 2022 with a diagnosis of Alzheimer's disease. Review of an "Assisted Living Residence Required Incident Reporting" form dated 09/04/2023 revealed Resident ID #2 was the alleged victim of a resident-to-resident abuse incident. Review of Resident ID #2's record failed to reveal documentation of the incident, an assessment of the resident by licensed staff, and documented follow-up regarding this incident. During an interview on 11/28/2023 at approximately 12:25 PM, the Director of Wellness	S 430	ID Tag S 430 Reporting Requirements 2.4.17 (G) As set forth by Residency Requirements 2.4.17 (G) Resident Reporting Requirements. Within the State of Rhode Island Regulations For Resident ID #2. The Residence will document the results of a thorough investigation relative to any injury(ies) relative to the abuse incident that occured on 9/4/2023 Documentation of the Incident. Documentation of an assessment by licensed staff and documented follow-up regarding this incident The Community will Inservice Nursing Staff on Residency Requirements 2.4.17 (G) Resident Reporting Requirements Nursing Staff will audit all new and current residents documentation for the results of a thorough investigation relative to any reportable incident. Documentation of the Incident. Documentation of an assessment bylicensed staff and documented follow-up Resident Services Director and Executive Director will review compliance at the Quarterly Quality Assurance Meetings	1/10/2024 1/10/2024 2/1/2024 3/31/2024

12/24/2023

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S 430	Continued From page 3 acknowledged Resident ID #2's record did not appropriately document the incident and a thorough investigation into the incident.	S 430		

12/12/2023