RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01515	A. BUILDING: _____ B. WING _____	C 05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HALCYON AT WEST BAY LLC	2783 WEST SHORE ROAD WARWICK, RI 02889

(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 A complaint investigation, ACTS references numbers 103264, 102911, and 103737, was conducted at this residence on 05/28/2026 through 05/29/2026 to determine compliance with state laws and regulations. Deficiencies were identified.	S 003	The facility identified gaps in the process used to ensure service plans were updated following changes in condition. The Compliance Nurse and nursing leadership team were re-educated on regulatory requirements, facility expectations, and documentation standards. A comprehensive audit of all resident records has been initiated as of 6/1/2026 to ensure assessments, documentation, and service plans accurately reflect each resident's current status, needs, and any changes in condition. Any discrepancies identified during the audit will be corrected immediately, including updating service plans as necessary to ensure compliance with regulatory requirements and facility standards. A "Change in Condition" tracking form has been implemented as of 6/1/2026 requiring the nurse on shift to document changes in condition. The Wellness Director will second check the change and ensure that it is documented in the resident's service plan and assessment. The nurse will then document as a progress note in the residents EMAR that a change in condition has happened and that the Service Plan and Appendix C have been updated. Staff have been re-educated on proper reporting to nursing for changes in residents. The Wellness Director has implemented a Weekly Chart Audit Tracking Log. Resident charts will be selected weekly for review to ensure documentation is thorough and that changes in condition are accurately reflected in assessments and service plans. The audit log will document charts reviewed, findings, and any corrective actions taken. Results will be reviewed on an ongoing basis to identify trends, provide staff education, and ensure continued compliance with facility policy and regulatory requirements.	
S 390	Residency Requirements 2.4.17.D Resident Assessment/Service Plans 2.4.17 (D) Resident Assessments and Service Plans D. The assessment shall be reviewed and at intervals not to exceed twelve (12) months and each time a resident's condition changes significantly. Received JUN 29 2026 Facilities Regulation This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined the residence failed to update the comprehensive assessment each time a resident's condition changed significantly relative to outside services and behaviors for 6 of 6 residents reviewed, Resident ID #s 1, 2, 3, 4, 5, and 6. Findings are as follows: 1) Record review revealed Resident ID #1 moved into the residence in April of 2025 with a diagnosis including Alzheimer's disease. a) Review of the comprehensive assessment, dated 3/31/2025, revealed the resident was receiving physical therapy (PT) services with a	S 390		

Facilities Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Melissa Stark — Executive Director — 6/29/26

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S 390	Continued From page 1 start of care (SOC) date of 8/13/2025 and occupational therapy (OT) services with a start of care (SOC) date of 8/15/2025. Further review of the comprehensive assessment failed to be updated with an end of care (EOC) dates for PT and OT services. During a surveyor interview with the Health and Wellness Director (HWD) on 5/29/2026 at approximately 12:30 PM, she revealed the resident's EOC dates for PT and OT services were on 9/13/2025. Additionally, she acknowledged the comprehensive assessment failed to be updated to document the EOC date for PT and OT services. b) Review of the progress notes revealed the following entries: - 4/12/2026, staff reported that resident has been spending time with another resident who is of the opposite sex, in his/her room. The resident revealed they were just talking. The manager notified the resident's family. The resident's family indicated they had seen them kiss on the video monitor in the apartment and does not want them in the apartment together. - 4/29/2026, the resident was observed sitting on the bed with another resident, who is of the opposite sex, they were asked to visit outside of the bedroom. Further review of the comprehensive assessment, updated on 3/31/2026, failed to document the resident's behavior. During a surveyor interview on 5/29/2026 at approximately 12:30 PM with the HWD, she could	S 390		

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S 390	Continued From page 2 not provide evidence the comprehensive assessment documented the resident's behaviors. 2) Record review revealed Resident ID #2 moved into the residence in June of 2025 with a diagnosis including dementia. a) Review of the comprehensive assessment, dated 5/31/2025, revealed the resident was receiving physical therapy (PT) services with a start of care (SOC) date of 8/20/2025. During a subsequent interview with the HWD she revealed that the resident's EOC date for PT services was 9/15/2025. Additionally, she acknowledged the comprehensive assessment failed to be updated to document the EOC date for PT services. b) Review of the progress notes revealed the following entries: - 12/24/2025, resident is behavioral and upsetting other residents, keeps screaming help and trying to grab onto everyone passing by. - 1/13/2026, resident constantly yelling out, "Nurse" and "Help" had agitated the aggressor in a resident to resident involving him/her. - 1/19/2026, "resident continues to yell loudly throughout the day and night frequently upsetting other residents..." - 1/27/2026, resident transferred to the hospital for behavioral problems. - 1/31/2026, "...still yelling out every second disturbing residents..."	S 390		

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S 390	Continued From page 3 - 2/9/2026, screaming, disturbing other residents, putting himself/herself on the floor. - 2/28/2026, still screaming out disturbing other residents and family all day. - 3/4/2026, resident standing over this resident yelling that he/she will make him/her shut up. Further review of the comprehensive assessment failed to be updated to document the resident's behaviors. During a subsequent interview with the HWD, she could not provide evidence the comprehensive assessment documented the resident's behaviors. 3) Record review revealed Resident ID #3 moved into the residence in February of 2026 with a diagnosis including Alzheimer's disease. a) Review of a progress note, dated 5/15/2026, revealed that the resident was discontinued from skilled nursing (SN) services due to a wound on the resident's buttock which is now healed. Record review of the comprehensive assessment, dated 1/28/2026, failed to be updated to document a SOC date and EOC date for SN services. During a subsequent surveyor interview with the HWD, she revealed the resident received SN services with a SOC date of 3/30/2026 and an EOC date of 5/15/2026. Additionally, she acknowledged the comprehensive assessment failed to be updated to document the SOC and EOC date for SN services.	S 390		

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S 390	Continued From page 4 b) Review of the progress notes revealed the following entries: - 3/20/2026, the resident had been found in an intimate situation with another resident. The resident was found in the shower of another resident's bathroom of the opposite sex. This resident only had a pull up on and the other resident had no clothes on. The progress note further revealed they are consistently with one another holding hands and meeting each other throughout the day. Staff will monitor with supportive supervision that the relationship remains "consensual." - 5/22/2026, reaching out to the resident's primary care physician due to the resident's hypersexual behavior. Further review of the comprehensive assessment failed to be updated to document the resident's behaviors. During a subsequent interview with the HWD, she could not provide evidence the comprehensive assessment documented the resident's behaviors. 4) Record review revealed Resident ID #4 moved into the residence in October of 2025 with a diagnosis including a traumatic subdural hemorrhage. Review of the progress notes revealed the following entries: - 1/27/2026, resident heard another resident yelling out while sitting on the bench in the hall across from the resident's room. Resident came	S 390		

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S 390	Continued From page 5 out of his/her room with his/her arm raised and revealed he/she was "going to kill" and does not care if he/she goes to jail. - 3/4/2026, resident pushed another resident with his/her walker last night in other resident's room. - 3/25/2026, resident was seen by the nurse practitioner for an increase in aggressive behaviors. - 5/11/2026, resident noted to easily become agitated with other residents will use profanity and aggressive jesters. Review of the comprehensive assessment, dated 11/6/2025, failed to be updated to document the resident's behaviors. During a subsequent interview with the HWD, she could not provide evidence the comprehensive assessment documented the resident's behaviors. 5) Record review revealed Resident ID #5 moved into the residence in November of 2025 with a diagnosis including, Alzheimer's disease. Review of the progress notes revealed the following entries: - 2/9/2026, the nurse was called to the unit due to resident being agitated, attempting to pull another resident out of his/her chair and attempting to throw his/her walker at residents and staff. Additionally, he/she was banging and pushing on the emergency exit/stairwell. The resident was sent out. - 2/20/2026, the resident is combative and	S 390		

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S 390	Continued From page 6 agitated and unable to redirect. The resident banging and kicking on the main door trying to elope. - 3/11/2026, the resident has been increasingly agitated, aggressive, and possessive of other residents or spaces. He/she had verbal aggression towards another resident of the opposite sex that thought he/she was stealing his/her boyfriend/girlfriend. He/she was observed kissing a resident of the opposite sex who did not want to be kissed. - 3/15/2026, staff reports frequent redirection during meals as resident has been standing over a resident of the opposite sex trying to attempt to kiss him/her. - 3/18/2026, the resident was found leaning over other residents, who were sitting on the bench in the hall, and difficult to redirect. - 3/20/2026, the resident has been observed exhibiting increased sexually disinhibited behaviors toward multiple residents of the opposite sex. Their behavior includes approaching residents of the opposite sex, attempting to kiss them without invitation, and lifting clothing in common areas. Staff have observed consistent interaction between this resident and one specific resident of the opposite sex. Interactions between the two "appear mutual," with both residents engaging in affectionate behaviors like holding hands, spending time together, and being in each other's rooms. Further review of the progress note later in the day, revealed the resident was found in the shower of his/her room with no clothes on and the other resident only had on a pull-up.	S 390		

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S 390	Continued From page 7 - 3/23/2026, staff reports bruising to chest during care. Staff had observed a resident of the opposite sex with his/her hands on the resident's chest under his/her shirt. Writer informed his/her power of attorney and primary care physician. - 3/28/2026, resident keeps entering other residents' rooms. Review of the comprehensive assessment, dated 11/17/2025, failed to be updated to document the resident's behaviors. During a subsequent interview with the HWD, she could not provide evidence the comprehensive assessment documented the resident's behaviors. 6) Record review revealed Resident ID #6 moved into the residence in November of 2023 with a diagnosis including Alzheimer's disease. Review of the progress notes revealed the following entries: - 10/28/2026, resident noted to have increased aggression with other residents when he/she feels as though they have entered his/her personal space or are irritating him/her. - 12/04/2025, resident came out of his/her room and revealed that if the resident in the hall didn't stop talking loudly he/she would punch his/her face. - 12/9/2025, resident in the doorway yelling at another resident that was across the hall. - 12/19/2025, resident raised his/her voice at another resident who was in the hallway and was	S 390		

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S 390	Continued From page 8 redirected to go into his/her room. Review of the comprehensive assessment, dated 8/25/2025, failed to be updated to document the resident's behaviors. During a subsequent interview with the HWD, she could not provide evidence the comprehensive assessment was updated to document the resident's behaviors.	S 390		
S 395	Residency Requirements 2.4.17.E Resident Assessment/Service Plans 2.4.17 (E) Resident assessments and Service Plans E. In the event a resident has an admission to a health care facility and is scheduled to return to the residence without a significant change in status, then the assessment shall be updated within five (5) working days of readmission. 1. In case of an emergency admission, the required assessment shall take place within five (5) working days and shall include the following: a. An immediate admission necessitated by natural disaster, crisis, or threat to public safety at another licensed assisted living residence, independent living situation, community residential facility, or private residence; b. An immediate admission necessitated by the unanticipated incapacitation of the primary caregiver of the person to be admitted; c. Conditions or circumstances	S 395		

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S 395	Continued From page 9 warranting emergency admission and as approved by Center for Health Facilities Regulation staff within forty-eight (48) hours. This Requirement is not met as evidenced by: Based on record review and staff interview, the residence failed to update the comprehensive assessment for the singular resident reviewed who was admitted to a health care facility within five (5) working days of readmission to the residence, Resident ID #5. Findings are as follows: Record review revealed Resident ID #5 moved into the residence in November of 2025 with a diagnosis including Alzheimer's disease. Review of the progress notes revealed the following entries: - 2/9/2026, the nurse was called to the unit due to resident being agitated, attempting to pull another resident out of his/her chair and attempting to throw his/her walker at residents and staff. Additionally, he/she was banging and pushing on the emergency exit/stairwell. The resident was sent out. - 2/16/2026, the resident returned from the hospital. Record review revealed a comprehensive assessment was last reviewed on 11/17/2025. Record review failed to reveal that a comprehensive assessment was completed within five (5) working days of readmission on 2/9/2026, as required.	S 395	Resident #5 has since discharged from our facility. Going forward a Medical Leave of Absence Return Tracking Log has been implemented and will be maintained by the Wellness Department. A Medical Leave of Absence (MLOA) Tracker was implemented on 6/5/2026. The tracker is initiated at the time a resident is sent out to a hospital or healthcare facility and documents the date of departure, receiving facility, and return date. Upon return, the Wellness Department ensures completion of a post-hospital reassessment and updates to the service plan and Appendix C as indicated, with all updates documented in the tracker and reviewed and signed by the Wellness Director to confirm completion The MLOA Tracker is reviewed routinely by the Wellness Director to ensure all residents returning from leave of absence have completed required reassessments and service plan updates."	

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S 395	Continued From page 10 During a surveyor interview on 5/28/2026 at approximately 2:45 PM with the Health and Wellness Director she was unable to provide evidence that Resident ID #5's comprehensive assessment was updated within five (5) working days from readmission, as required.	S 395		
S 415	Residency Requirements 2.4.17.G.3 Resident Assessment/Service Plan 2.4.17 (G)(3) Service Plans 3. The service plan shall be reviewed by both parties at intervals not to exceed twelve (12) months and each time a resident's condition changes significantly and all changes shall be acknowledged in writing by both parties. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined that the residence failed to update the service plan each time a resident's condition changed significantly, related to outside services and behaviors, and failed to complete the service plan in its entirety for 6 of 6 residents reviewed, Resident ID #s 1, 2, 3, 4, 5, and 6. Findings are as follows: Review of a facility policy titled, "Person-Centered Service Plans" revealed "...12. The Service Plan includes a description of the condition that is directly proportional to the assessed need, data and information to support ongoing effectiveness of the intervention, time limits for periodic reviews to determine the ongoing necessity of the	S 415		

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S 415	Continued From page 11 modification, informed Resident consent..." 1) Record review revealed Resident ID #1 moved into the residence in April of 2025 with a diagnosis including Alzheimer's disease. a) Review of the service plan, dated 4/21/2025, revealed the resident was receiving physical therapy (PT) services with a start of care (SOC) date of 8/13/2025 and occupational therapy (OT) services with a start of care (SOC) date of 8/15/2025. Further review of the service plan failed to be updated with an end of care date (EOC) date for PT and OT services. During a surveyor interview with the Health and Wellness Director (HWD) on 5/29/2026 at approximately 12:45 PM, she revealed the resident's EOC dates for PT and OT services were on 9/13/2025. Additionally, she acknowledged the service plan failed to be updated to document the EOC date for PT and OT services. b) Review of the progress notes revealed the following entries: - 4/12/2026, staff reported that resident has been spending time with another resident who is of the opposite sex, in his/her room. The resident revealed they were just talking. The manager notified the resident's family. The resident's family indicated they had seen them kiss on the video monitor in the apartment and does not want them in the apartment together. - 4/29/2026, the resident was observed sitting on the bed with another resident, who is of the	S 415		

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S 415	Continued From page 12 opposite sex, they were asked to visit outside of the bedroom. Further review of the service plan failed to document the resident's behavior. Additionally, the service plan failed to contain recreational activities, code status, and the frequency of services. During a subsequent interview with the HWD, she could not provide evidence the service plan contained the resident's behaviors and interventions to protect the resident and other residents. She acknowledged the service plan failed to be completed in its entirety. 2) Record review revealed Resident ID #2 moved into the residence in June of 2025 with a diagnosis including dementia. a) Review of the service plan, dated 6/19/2025, revealed the resident was receiving PT services with a start of care (SOC) date of 8/20/2025. During a subsequent interview with the HWD she revealed that the resident's EOC date for PT services was 9/15/2025. Additionally, she acknowledged the service plan failed to be updated to document the EOC date for PT services. b) Review of the progress notes revealed the following entries: - 12/24/2025, resident is behavioral and upsetting other residents, keeps screaming help and trying to grab onto everyone passing by. - 1/13/2026, resident constantly yelling out,	S 415		

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S 415	Continued From page 13 "Nurse" and "Help" had agitated the aggressor in a resident to resident involving him/her. - 1/19/2026, "resident continues to yell loudly throughout the day and night frequently upsetting other residents..." - 1/27/2026, resident transferred to the hospital for behavioral problems. - 1/31/2026, "...still yelling out every second disturbing residents..." - 2/9/2026, screaming, disturbing other residents, putting himself/herself on the floor. - 2/28/2026, still screaming out disturbing other residents and family all day. - 3/4/2026, resident standing over this resident yelling that he/she will make him/her shut up. Further review of the service plan failed to be updated to document the resident's behaviors. Additionally, the service plan failed to contain recreational activities, code status, and the frequency of services. During a subsequent interview with the HWD, she could not provide evidence the service plan contained the resident's behaviors and interventions to protect the resident and other residents. She acknowledged the service plan failed to be completed in its entirety. 3) Record review revealed Resident ID #3 moved into the residence in February of 2026 with a diagnosis including Alzheimer's disease.	S 415		

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S 415	Continued From page 14 Review of a progress note, dated 5/15/2026, revealed that the resident was discontinued from skilled nursing (SN) services due to a wound on the resident's buttock which is now healed. Record review of the service plan, dated 2/4/2026, failed to be updated to document a SOC date and EOC date for SN services. During a subsequent surveyor interview with the HWD, she revealed the resident received SN services with a SOC date of 3/30/2026 and an EOC date of 5/15/2026. Additionally, she acknowledged the service plan failed to be updated to document the SOC and EOC date for SN services. b) Review of the progress notes revealed the following entries: - 3/20/2026, the resident had been found in an intimate situation with another resident. The resident was found in the shower of another resident's bathroom of the opposite sex. This resident only had a pull up on and the other resident had no clothes on. The progress note further revealed they are consistently with one another holding hands and meeting each other throughout the day. Staff will monitor with supportive supervision that the relationship remains "consensual." - 5/22/2026, reaching out to the resident's primary care physician due to the resident's hypersexual behavior. Further review of the service plan failed to be updated to document the resident's behaviors. Additionally, the service plan failed to contain	S 415		

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S 415	Continued From page 15 recreational activities, code status, the frequency of services, and a signature from the Executive Director (ED). During a subsequent interview with the HWD, she could not provide evidence the service plan contained the resident's behaviors and interventions to protect the resident and other residents. She acknowledged the service plan failed to be completed in its entirety and signed by the ED. 4) Record review revealed Resident ID #4 moved into the residence in October of 2025 with a diagnosis including a traumatic subdural hemorrhage. Review of the progress notes revealed the following entries: - 1/27/2026, resident heard another resident yelling out while sitting on the bench in the hall across from the resident's room. Resident came out of his/her room with his/her arm raised and revealed he/she was "going to kill" and does not care if he/she goes to jail. - 3/4/2026, resident pushed another resident with his/her walker last night in other resident's room. - 3/25/2026, resident was seen by the nurse practitioner for an increase in aggressive behaviors. - 5/11/2026, resident noted to easily become agitated with other residents will use profanity and aggressive jesters. Additionally, the service plan failed to contain recreational activities, code status, the frequency	S 415		

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S 415	Continued From page 16 of services, and a signature from the resident and/or representative. During a subsequent interview with the HWD, she could not provide evidence the service plan contained the resident's behaviors and interventions to protect the resident and other residents. She acknowledged the service plan failed to be completed in its entirety and signed by the resident and/or representative. 5) Record review revealed Resident ID #5 moved into the residence in November of 2025 with a diagnosis including Alzheimer's disease. Review of the progress notes revealed the following entries: - 2/9/2026, the nurse was called to the unit due to resident being agitated, attempting to pull another resident out of his/her chair and attempting to throw his/her walker at residents and staff. Additionally, he/she was banging and pushing on the emergency exit/stairwell. The resident was sent out. - 2/20/2026, the resident is combative and agitated and unable to redirect. The resident banging and kicking on the main door trying to elope. - 3/11/2026, the resident has been increasingly agitated, aggressive, and possessive of other residents or spaces. He/she had verbal aggression towards another resident of the opposite sex that thought he/she was stealing his/her boyfriend/girlfriend. He/she was observed kissing a resident of the opposite sex who did not want to be kissed.	S 415		

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S 415	Continued From page 17 - 3/15/2026, staff reports frequent redirection during meals as resident has been standing over a resident of the opposite sex trying to attempt to kiss him/her. - 3/18/2026, the resident was found leaning over other residents, who were sitting on the bench in the hall, and difficult to redirect. - 3/20/2026, the resident has been observed exhibiting increased sexually disinhibited behaviors toward multiple residents of the opposite sex. Their behavior includes approaching residents of the opposite sex, attempting to kiss them without invitation, and lifting clothing in common areas. Staff have observed consistent interaction between this resident and one specific resident of the opposite sex. Interactions between the two "appear mutual," with both residents engaging in affectionate behaviors like holding hands, spending time together, and being in each other's rooms. Further review of the progress note later in the day, revealed the resident was found in the shower of his/her room with no clothes on and the other resident only had on a pull-up. - 3/23/2026, staff reports bruising to chest during care. Staff had observed a resident of the opposite sex with his/her hands on the resident's chest under his/her shirt. Writer informed his/her power of attorney and primary care physician. - 3/28/2026, resident keeps entering other residents' rooms. Review of the service plan, dated 11/20/2025, failed to be updated to document the resident's behaviors.	S 415		

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S 415	Continued From page 18 Additionally, the service plan failed to contain recreational activities, code status, the frequency of services, and a signature from the resident and/or representative. During a subsequent interview with the HWD, she could not provide evidence the service plan contained the resident's behaviors and interventions to protect the resident and other residents. She acknowledged the service plan failed to be completed in its entirety and signed by the resident and/or representative. 6) Record review revealed Resident ID #6 moved into the residence in November of 2023 with a diagnosis including Alzheimer's disease. Review of the progress notes revealed the following entries: - 10/28/2026, resident noted to have increased aggression with other residents when he/she feels as though they have entered his/her personal space or are irritating him/her. - 12/04/2025, resident came out of his/her room and revealed that if the resident in the hall didn't stop talking loudly he/she would punch his/her face. - 12/9/2025, resident in the doorway yelling at another resident that was across the hall. - 12/19/2025, resident raised his/her voice at another resident who was in the hallway and was redirected to go into his/her room. Review of the service plan, dated 8/28/2025, failed to be updated to document the resident's behaviors.	S 415	The facility identified gaps in the process used to ensure service plans were updated following changes in condition. The Compliance Nurse and nursing leadership team were re-educated on regulatory requirements, facility expectations, and documentation standards. A comprehensive audit of all resident records has been initiated as of 6/1/2026 to ensure start of care and end of care dates are added to any outside skilled services the resident is currently. Service plans and Assessments will be updated as necessary to ensure compliance with regulatory requirements and facility standards. Start of Care and End of Care forms were implemented on 6/1/2026. When outside service providers initiate or discontinue services, they are required to document visits on the facility's visit forms. These forms include resident name, date, and service provided. Receipt of this documentation triggers completion of an internal Start of Care/End of Care form by the Wellness Department, which captures the resident name, agency, type of service, start/end dates, and verification that the service plan and assessment were updated as indicated. A progress note is completed, and the form is signed by nursing and the Wellness Director to confirm completion. The Wellness Director is the final signature on the Start of Care and End of Care form. The Wellness Director must sign their name that the form has been completed look to confirm the service plan and assessment have been completed in the chart.	

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S 415	Continued From page 19 Additionally, the service plan failed to contain recreational activities, code status, the frequency of services, and a signature from the resident and/or representative. During a subsequent interview with the HWD, she could not provide evidence the service plan contained the resident's behaviors and interventions to protect the resident and other residents. She acknowledged the service plan failed to be completed in its entirety and signed by the resident and/or representative.	S 415		
S 440	Residency Requirements 2.4.18.D Reporting Requirements 2.4.18 (D) Reporting 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 immediately, but not later than four (4) hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than twenty-four (24) hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, report 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	S 440		

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S 440	Continued From page 20 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, the residence failed to report incidents of abuse and injury of unknown origin to the Rhode Island Department of Health for Resident ID #s 3 and 5. Findings are as follows: Review of an updated policy, dated 5/1/2026, titled, "Abuse, Neglect and Exploitation" revealed "It is the policy of this facility to provide protections for the health, welfare and rights of each resident...sexual abuse is non-consensual sexual contact of any type with a resident...III ...A. Establishing a safe environment that supports, to the extent possible, a resident's consensual sexual relationship and by establishing policies and protocols for preventing sexual abuse, such as the identify when, how, and by whom determinations of capacity to consent to a sexual contact will be made and where this documentation will be recorded ...V11 ...1. Reporting of all alleged violations to the Administrator, state agency..." Review of a facility reported incident sent to the	S 440		

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S 440	Continued From page 21 Rhode Island Department of Health on 5/21/2026 alleged resident-to-resident abuse, involving Resident ID #3. 1. Record review revealed Resident ID #3 was admitted to the residence in February of 2026 with a diagnosis including Alzheimer's disease. Record review of Resident ID #3's progress note, dated 3/20/2026, revealed that the resident had been found in an intimate situation with another resident. The resident was found in another resident's room in the shower with only a pull-up on and the other resident, of the opposite sex, did not have any clothes on. During a surveyor interview with the Health and Wellness Director (HWD) on 5/28/2026 at approximately 2:45 PM, she revealed the other resident was Resident ID #5. She could not provide evidence this incident was reported. She further revealed she didn't think it needed to be reported as it was "consensual," although she could not provide evidence that there was an assessment done that the residents had the capacity to consent. 2. Record review revealed Resident ID #5 moved into the residence with a diagnosis including Alzheimer's disease. Record review of Resident ID #5's progress note, dated 3/23/2026, revealed that staff noted bruising to the resident's chest during care. A resident of the opposite sex was observed with his/her hands on Resident ID #5's chest under the shirt in the dining room. "...Staff will continue residents their privacy with intimate relations as long as consensual, and no harm..."	S 440	The Wellness Department is currently working interdepartmentally and with family and reaching out to resident's providers for interventions to prevent behaviors within memory care. That includes movement of furniture, working with families on room changes if it will benefit the resident, and the activities department stepping in to help keep residents engaged. Staff have been re-educated on the identification and timely reporting of resident behaviors, including new or developing relationships within the memory care unit, mandatory reporting requirements, and the process for conducting and documenting individualized assessments of each resident's cognitive capacity to provide informed consent for romantic or intimate relationships. Determinations regarding consent will be made on a case-by-case basis based on the resident's ability to understand the nature of the relationship and to consistently demonstrate comfort, willingness, and a positive desire to participate in the relationship through observable behaviors and expressed preferences. A New Relationship Form was implemented on 6/9/2026 to document and assess newly identified relationships, with nursing completing an evaluation to determine whether residents involved demonstrate any signs of distress or adverse impact. A Behavioral Tracking Binder was implemented on 6/1/2026 to support real-time staff documentation of observed behaviors. If a behavior requires intervention, nursing will sign off once behavior has been reported appropriately. Nursing and the Wellness Director review the binder daily to identify reportable concerns and ensure timely communication to families and providers as appropriate. Progress notes are completed based on identified behaviors, and 24-hour reports are utilized to maintain continuity of communication and ensure all clinical staff are informed of relevant behavioral changes and reporting needs.	

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S 440	Continued From page 22 Record review of the Rhode Island Department of Health's (RIDOH) database for residence reported allegations of abuse, injury of unknown origin, etc. failed to have the reports of the above-mentioned incidents. During a surveyor interview with the HWD at approximately 2:45 PM, she was unable to provide evidence that this incident was reported to the state agency as an injury of unknown origin. The HWD indicated when Resident ID #5 was questioned about the bruising, he/she had a smile on his/her face, so she felt it didn't need to be reported.	S 440		
S 900	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: Based on record review and staff interview, it has been determined the residence failed to operate and provide services to all residents of the Special Care Unit (SCU) in accordance with the prevailing community standard of care related to documentation for 1 of 6 sample residents reviewed, Resident ID #4, and failed to notify the physician for 1 of 3 reported incidents relative to alleged resident-to-resident abuse, intake #103737.	S 900		

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S 900	Continued From page 23 Findings are as follows: Mosby's 4th Edition, Fundamentals of Nursing, page 314 states, "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm the clients." According to Lippincott Nursing Procedures Ninth Edition 2023 page 236 states, "...Documentation is the process of preparing a complete record of a patient's care, and is a vital tool for communication among healthcare team members. Accurate, detailed documentation shows the extent and quality of the care that nurses provide, the outcomes of that care, and treatment and education that the patient still needs. Thorough, accurate documentation decreases the potential for miscommunication and errors..." Review of a policy, dated 5/1/2026, titled, "Compliance with Reporting Allegations of Abuse/Neglect/Exploitation" under "Procedure for Response and Reporting Allegations of Abuse/Neglect/Exploitation...When suspicion of abuse/neglect/exploitation or reports of abuse/neglect exploitation occur, the following procedure will be initiated: 1. The Licensed Nurse will...d. Notify the attending physician..." A. Record review revealed Resident ID #4 moved into the residence in October of 2025 with a diagnosis including a traumatic subdural hemorrhage. Review of the resident's physician order dated 10/3/2025, revealed an order for generic behavior monitoring every shift.	S 900		

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S 900	Continued From page 24 Review of the progress notes failed to identify the behavior demonstrated for the following entries: -5/16/2026 documented at 06:43 and at 07:40, Note text: Was a behavior observed? Yes -5/17/2026 documented at 06:44, Note text: Was a behavior observed? Yes -5/18/2026 documented at 06:10, Note text: Was a behavior observed? Yes -5/23/2026 documented at 05:44, Note text: Was a behavior observed? Yes -5/24/2026 documented at 13:58, Note text: Was a behavior observed? Yes During a surveyor interview with the Health and Wellness Director (HWD) on 5/28/2026 at approximately 2:30 PM, she could not provide evidence of what behaviors were observed for the above-mentioned resident on the above-mentioned dates and shifts. B. Review of a facility reported incident sent to the Rhode Island Department of Health on 5/21/2026 revealed that on 5/19/2026 Resident ID #3 had his/her hand inside Resident ID #1's pants simultaneously Resident ID #1 was rubbing Resident ID #3's private area over his/her clothing. 1. Record review revealed Resident ID #1 moved into the residence in April of 2025 with a diagnosis including Alzheimer's disease. 2. Record review revealed Resident ID #3 moved into the residence in February of 2026 with a	S 900		

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S 900	Continued From page 25 diagnosis including Alzheimer's disease. Review of progress notes, dated 5/19/2026, revealed the residents' powers of attorney were notified; however, the progress notes failed to reveal the primary care physicians (PCPs) were notified. Review of a progress note, dated 5/20/2026, revealed Resident ID #1's PCP was notified; the record revealed a delay in notification to the physician. Review of a progress note, dated 5/22/2026, revealed Residnet ID # 3's PCP was notified; the record revealed a delay in notification to the physician. During a surveyor interview with the HWD on 5/28/2026 at approximately 2:15 PM, she could not provide evidence the physicians were notified the day the incident occurred, indicating there was a delay in notification to the physician.	S 900	The Wellness department is currently auditing resident charts and electronic medical records to identify behaviors in residents so that specific orders can be placed in our EMAR so that staff that cannot assess can check off in the MAR when a certain behavior was notified and if there is more to the behavior, a behaviors binder that is monitored by nursing and the wellness director has been implemented and nursing will document on behaviors. Staff have also been re-educated on reporting procedures for resident behavior. A Behavioral Tracking Binder was implemented on 6/1/2026 to support real-time staff documentation of observed behaviors. If a behavior requires intervention, nursing will sign off once behavior has been reported appropriately. Nursing and the Wellness Director review the binder daily to identify reportable concerns and ensure timely communication to families and providers as appropriate. Progress notes are completed based on identified behaviors, and 24-hour reports are utilized to maintain continuity of communication and ensure all clinical staff are informed of relevant behavioral changes and reporting needs.	