RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01519	A. BUILDING: _____ B. WING _____	C 04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITHFIELD WOODS	171 PLEASANT VIEW AVENUE SMITHFIELD, RI 02917

(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. A deficiency was identified.	S 003	Reassessment of resident ID#1 completed on 4/25/24. Resident at baseline behaviorly.	5/24/24
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	1. In-service completed 5/10/24 with staff on managing difficult behaviors in residents with dementia. 2. In-service to be completed by 5/4/24 on Abuse, Neglect, and reporting incidents timely. 3. ED or designee will audit all incidents weekly x4 weeks, then 20% of incidents monthly x3 months. Review of audits will be completed in QA Quarterly x6 months to ensure compliance. 4. ED or designee will interview 10% of the staff to ensure understanding of the reporting process and expectations weekly. Review of audits will be completed in QA quarterly x6 months to ensure compliance.	

5/24/24

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FACILITIES REGULATION

Facilities Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: ALRA — (X6) DATE: 5/16/24

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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 1 of 2 sample residents reviewed, Resident ID #1. 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 an "Assisted Living Residence Required Incident Reporting" form sent to the Rhode Island Department of Health (RIDOH) on 3/21/2024 which states in part, "Date of Alleged Event: 03/01/2024 Time: 3:46 PM ...ALRA (Assisted Living Residence Administrator) notified 3/20 of statements produced late reporting accusation of verbal abuse by LPN (Licensed Practical Nurse) DD [Staff A] to resident [ID #1]. Two witnesses (staff and vendor) observed [Staff A] speaking loudly to [ID #1]..." Record review revealed Resident ID #1 moved	S 415		

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S 415	Continued From page 2 into the residence in December of 2022 with diagnoses including, but not limited to, dementia and anxiety. Record review of a staff witness statement obtained from the Memory Care Director, Staff B, dated 3/5/2024 which states in part, "On Friday, March 1st, I was walking on the unit...[ID #1] was feeling very anxious and wanting to speak with his/her mom and [Staff A] yelled at him/her...Go away...I need you to do something with him/her [ID #1] before I lose it..." Further record review of another witness statement obtained from an outside agency occupational therapist, dated 3/5/2024, which states in part, "On 3/1/2024, I witnessed [Staff A] yelling at [ID #1] at the nurse's station. [ID #1] was in a stressed state and was in obvious need of de-escalation due to increased anxiety..." Record review failed to reveal evidence that the above incident was reported to the state agency within the required time frame. This alleged incident occurred on 3/1/2024 and was not reported to the state agency until 3/21/2024. During a telephone interview on 4/24/2024 at approximately 10:54 AM with Staff A, she indicated that on 3/1/2024, at the change of shift, Resident ID #1 was exhibiting increased behaviors and was difficult to redirect. Staff A stated, "I yelled at him/her [ID #1] to stop it." Staff A further acknowledged that she spoke to the resident inappropriately and should not have used that tone of voice to the resident. During an interview on 4/24/2024 at approximately 9:51 AM with the Executive Director, she acknowledged the above-mentioned	S 415		

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S 415	Continued From page 3 incident happened on 3/1/2024 but was not reported until 3/21/2024, when she became aware of the allegation of abuse.	S 415		