RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01378	A. BUILDING: _____ B. WING _____	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGE AT CHERRY HILL, THE	ONE CHERRY HILL ROAD JOHNSTON, RI 02919

(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 from 9/9/2024 through 9/10/2024 at this residence. A deficiency was identified as a result of this survey.	S 003		
S 450	Licensure Requirements 2.4.18 Rights of Residents 2.4.18 Rights of Residents A. Every assisted living residence for adults licensed pursuant to these regulations shall observe the standards stated in R.I. Gen. Laws § 23-17.4-16, "Rights of Residents" and such other appropriate standards as may be prescribed in rules and regulations promulgated by the Department with respect to each resident of the residence. B. For purposes of the following standards stated in §§ 2.4.18(B)(1) through (7) of this Part the term "resident" shall also mean the resident's agent as designated in writing or legal guardian. 1. Upon request have access to all records pertaining to the resident, including clinical records, within the next business day or immediately in emergency situations; 2. Upon admission and during the resident's stay be fully informed in a language the resident understands, of all resident rights and rules governing resident conduct and responsibilities; a. Each resident shall receive a copy of their rights. b. Each resident shall acknowledge receipt in writing; and	S 450	RECEIVED SEP 30 2024 FACILITIES REGULATION	

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S 450	Continued From page 1 c. Each resident shall be informed promptly of any changes. 3. Be informed in writing, prior to, or at the time of admission or at the signing of a residential contract or agreement of: a. The scope of the services available through the residence's service program, including health services, and of all related fees and charges, including charges not covered either under federal and/or state programs by other third party payers or by the residence's basic rate; b. The residence's policies regarding overdue payment including notice provisions and a schedule for late fee charges; c. The residence's policy regarding acceptance of state and federal government reimbursement for care in the residence both at time of admission and during the course of residency if the resident depletes his or her own private resources; d. The residence's criteria for occupancy and termination of residency agreements; e. The residence's capacity to serve residents with physical and cognitive impairments; f. Support any health services that the residence includes in its service package or will make appropriate arrangements to provide these services; 4. Upon provision of at least thirty (30) days notice, if a resident chooses to leave a residence,	S 450		

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S 450	Continued From page 2 the resident shall be refunded any advanced payment made provided that the resident is current in all payments; 5. The residence can discharge a resident only for the following reasons and within the following guidelines: a. Except in life-threatening emergencies and for nonpayment of fees and costs, the residence gives thirty (30) days' advance written notice of termination of residency agreement with a statement containing the reason, the effective date of termination, the resident's right to an appeal under state law, and the name/address of the State Ombudsperson's office; b. If resident does not meet the requirements for residency criteria stated in the residency agreement or requirements of state or local laws or regulations; c. If resident is a danger to self or the welfare of others; and the residence has attempted to make a reasonable accommodation without success to address resident behavior in ways that would make termination of residency agreement or change unnecessary; which would be documented in the resident's records; d. For failure to pay all fees and costs stated in the contract, resulting in bills more than thirty (30) days outstanding. A resident who has been given notice to vacate for nonpayment of rent has the right to retain possession of the premises, up to any time prior to eviction from the premises, by tendering to the provider the entire amount of fees for services, rent, interest, and costs then due. The provider may impose reasonable late	S 450		

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S 450	Continued From page 3 fees for overdue payment; provided that the resident has received due notice of such charges in accordance with the residence's policies. Chronic and repeated failure to pay rent is a violation of the lease covenant. However the residence must make reasonable efforts to accommodate temporary financial hardship and provide information on government or private subsidies available that may be available to help with costs; and e. The residence makes a good faith effort to counsel the resident if the resident shows indications of no longer meeting residence criteria or if service with a termination notice is anticipated; 6. To be able to share a room or unit with a spouse or other consenting resident of the residence in accordance with terms of the resident contract; 7. To live in a safe and clean environment. C. In addition to the standards stated in R.I. Gen. Laws § 23-17.4-16, residents are entitled to the following: 1. Receive dental services from a dentist of his/her choice; 2. Each resident shall be given, in writing, the names, addresses, and telephone numbers of: the Department; the Medicaid Fraud and Patient Abuse Unit of the Department of Attorney General; the State Ombudsperson; and local police offices. D. The residence must:	S 450		

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S 450	Continued From page 4 1. Implement written policies and procedures to ensure that all residence employees are aware of and protect the resident's rights contained in these regulations; 2. Have prominently displayed a posting of the most recent state licensing survey of the assisted living residence; and 3. Provide each resident or his or her representative upon admission, a copy of the provisions of § 2.4.18 of this Part and shall display in a conspicuous place on the premises a copy of the "Rights of Residents." This Requirement is not met as evidenced by: Based on surveyor observation, record review, and resident and staff interviews, it has been determined the residence failed to observe the standards stated in R.I. Gen. Laws § 23-17.4-16, "Rights of Residents" for the singular resident reviewed relative to abuse and restraints, Resident ID #1. Findings are as follows: According to the R.I. Gen. Laws § 23-17.4-16, "Rights of Residents", states in part that each resident is entitled, "...(ii)To be free from verbal, sexual, physical, emotional, and mental abuse, corporal punishment, and involuntary seclusion; (iii) To be free from physical or chemical restraints for the purpose of discipline or convenience and not required to treat the resident's medical symptoms. No chemical or physical restraints will be used except on order of a physician..."	S 450		

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S 450	Continued From page 5 A community reported complaint, from the hospital to the Rhode Island Department of Health (RIDOH) on 9/3/2024, revealed that the resident obtained a hematoma (a collection of blood that pools outside of a blood vessel, usually due to an injury or trauma) to the left wrist with soft tissue swelling of the dorsal radius (dorsal refers to the back side of a structure as the knuckle side of the hand; the radius is a bone located on the thumb side of the forearm). An additional community reported complaint to the RIDOH on 9/5/2024 alleges that the resident was assaulted by an employee leading to the resident needing to go to the emergency room. The report further alleges that the resident's arm was twisted behind his/her back and that the resident asked the nurse to stop, and the nurse kept twisting his/her wrist. An initial reportable incident form to the RIDOH on 9/3/2024 reveals an incident occurred with Resident ID #1 on 9/2/2024 and states in part, "...Resident went into the kitchen and started grabbing food from the line and throwing them. Resident threatened to punch associate...The floor was set [sic] in the kitchen as coffee had spilled. Associate was afraid the resident would slip and fall. One of the CNAs (Certified Nursing Assistants) [Staff B] got a wheelchair to transport resident out of the kitchen. [Resident ID #1] grabbed a bottle of relish and threw it. [Resident ID #1] was transported to the Bistro...Resident got up and followed associate to the wellness department and started banging the door with [his/her] phone on the glass door." Record review reveals the resident moved into the residence in June of 2023 with diagnoses including, but not limited to: type 2 diabetes	S 450	**A. With Respect to the Specific Regulation Cited:** S450 Licensure Requirements 2.4.18 Rights of Residents **B. With Respect to how the Facility will identify and take corrective action:** An inservice will be conducted by Four Winds Senior Care Consultants on the following Topics: Conflict Resolution; Descalating Techniques and Dealing with Difficult Residents In a Crisis for all staff.	10/8/24

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S 450	Continued From page 6 mellitus, depression, anxiety, and disorder of the skin and subcutaneous (under the skin) tissue. Review of a progress note dated 8/30/2024 reveals the resident was diagnosed with a urinary tract infection (can present atypically in older adults as confusion, change in mental status, or delirium) and started on an antibiotic. Record review reveals the resident's Brief Interview for Mental Status (BIMS) Score dated 7/23/2024 was 10 out of 15, indicating that the resident has moderate cognitive impairment. During a surveyor observation of the resident on 9/9/2024 at 10:56 AM he/she was observed to have bruising to his/her left wrist with swelling and also bruising below his/her right elbow to above his/her wrist. During a surveyor interview following the above observation with the resident, he/she revealed that at dinner time he/she had asked for soup. The resident indicated that the kitchen ran out so he/she received pizza. The resident revealed the top of the pizza looked ok to eat but the bottom was burnt. The resident further revealed that he/she went into the kitchen to show the cook that his/her pizza was burnt. The resident does not have a clear recollection of the incident but indicated that he/she was not yelling or throwing dishes. Review of the hospital paperwork report dated 9/3/2024 reveals the resident sustained: "Soft tissue swelling of the dorsal radius suspicious for underlying hematoma...no displaced fracture." Further review of the report reveals his/her Range of Motion (ROM: the amount of movement a joint or body part can make) are normal with the	S 450	**C. With Respect to What Systemic measures to be put in place to address the stated concern:** Change of condition will be noted during morning stand-up with the Department Heads and during daily shift huddle. **D. With Respect to How the Plan Of Corrective Measures will be monitored:** Staff will sign in for the inservice Individual training for the nurse will be conducted quarterly by the regional director of nursing and will be monitored through the QMPI process	on-going on-going

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S 450	Continued From page 7 exception of the left wrist where the patient has swelling and ecchymosis (a bruise, which is a discoloration of the skin caused by broken blood vessels leaking blood into the surrounding tissue) and mild tenderness. Additionally, the note reveals "the patient was calm and collected while [he/she] has been here, x-ray shows no fracture, due to size of hematoma discussed risks and benefits of aspiration which patient and family were amenable to instilled 2 ml [milliliter] of 1% lidocaine with epinephrine to hematoma, attempted aspiration with 18-gauge needle without significant blood return, likely clotted. Wrapped with gentle pressure dressing..." During a surveyor interview on 9/9/2024 at 2:33 PM with Server, Staff C, he indicated that around 5:30 PM the resident came into the kitchen asking, "who's in charge?" The resident was asked to leave the kitchen. He further indicated a couple of nurses came into the kitchen to deescalate and escort the resident out, "it was intense." He revealed he did not see anyone put their hands on the resident. Additionally, he revealed he did not see the resident throw anything. Furthermore, he revealed the resident came back 15 minutes later to show the chef his/her bruise. During a surveyor interview on 9/9/2024 at 5:31 PM with Staff A, the alleged perpetrator, she revealed she went into the kitchen as she heard some commotion. She observed the resident put his/her hand on a piece of pizza. She further revealed the resident was grabbing condiments and threw a bottle of relish. Additionally, she indicated that the resident's arms were flailing, so she held the resident's wrist with one hand, as she was defending herself with the other hand. She further indicated that another staff member	S 450		

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S 450	Continued From page 8 brought in a wheelchair for the resident to sit in, in order to keep the resident safe from slipping on the wet floor. During a surveyor interview on 9/9/2024 at 5:56 PM with Server, Staff D, he revealed he was in the dining room when he saw the resident walk into the kitchen aggressively, he then heard banging. He indicated that he went into the kitchen and saw about 4-5 staff members, including nurses and certified nursing assistants. He further revealed he witnessed a nurse hold the resident's wrists; the resident was stating, "let go." During a surveyor interview on 9/10/2024 at 3:08 PM with Cook, Staff E, he revealed the resident came into the kitchen yelling at him saying his/her pizza was burnt. He indicated that he/she was screaming and then all nursing staff came in. The resident went to go touch the pizza and he/she was restrained from touching the pizza by Staff A by holding his/her arms. He indicated that he did not see the resident throw any food items. He further revealed that the resident kept raising his/her arms and then Staff A kept holding them down, he indicated that this happened for about 5-10 minutes. Additionally, he revealed that once a staff member brought in a wheelchair for the resident, he/she sat down and was escorted out of the kitchen. During a surveyor interview with the Executive Director on 9/9/2024 at approximately 3:05 PM, she was unable to provide evidence that Staff A did not cause the injury to Resident ID #1's wrist.	S 450		