RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01439	A. BUILDING: _____ B. WING _____	C 09/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMER VILLA	51 LAUREL AVENUE COVENTRY, RI 02816

(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 9/19/2024 through 9/23/2024. Deficiencies were identified as a result of this survey.	S 003		
S 365	Residency Requirements 2.4.16.D Resident Assessment/Service Plans 2.4.16 (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. 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 comprehensive assessment each time a resident's condition changed significantly for 2 of 2 residents reviewed for behaviors, Resident ID #s 1 and 2. Findings are as follows: 1. Record review revealed Resident ID #1 moved into the residence in August of 2024 with diagnoses including, but not limited to: schizoaffective disorder, adjustment disorder with depressed mood, and anxiety disorder. Review of the resident's progress notes reveal the following entries: - 8/27/2024 a certified medication technician (CMT) at night went to deliver the resident's	S 365		

RECEIVED
OCT 28 2024
FACILITIES REGULATION

Facilities Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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S 365	Continued From page 1 medications, the resident was nowhere to be found. Further record review revealed the resident was found and returned to the facility on 8/29/2024, 2 days later. - 9/6/2024 the resident went missing from the facility. He/she was last seen at 4:15 PM. The police to be called at 9:00 PM if he/she hasn't returned. Further review of the note reveals that at 9:30 PM the police called and said that they found the resident at the bike path. - 9/18/2024 the resident is missing again, the police were called. On 9/19/2024 when a CMT came in for her morning shift, she noted the resident was in bed sleeping. Record review of the resident's comprehensive assessment dated 8/1/2024 reveals Section Four titled, "Behavioral Information" failed to reveal this section was updated to reflect the resident's wandering behaviors. During a surveyor interview on 9/19/2024 with Staff A, CMT, at 8:15 AM, she revealed that the residents have a sign out book and are informed to sign themselves out when they want to leave the residence. During a surveyor interview with the Administrator at 9/23/2024 at 9:50 AM, she could not provide evidence that the comprehensive assessment was updated to include the resident's wandering behaviors. 2. Record review revealed Resident ID #2 moved into the residence in August of 2023 with diagnoses including, but not limited to: schizoaffective disorder, bipolar disorder, and major depressive disorder.	S 365		

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S 365	Continued From page 2 Review of the progress notes reveals the following entries: - 10/24/2023 Resident ID #2 went into another resident's room and was yelled at by the other resident to get out and that's when Resident ID #2 went "to choke and punch" the other resident on the left side of his/her face. Further review of the progress note reveals that Resident ID #2 went into another resident's room looking for cigarettes and when he/she was told to get out, Resident ID #2 assaulted him/her. - 1/24/2024 the resident got into a verbal altercation with another resident. - 2/15/2024 Resident ID #2 was told by another resident that he/she owes them money. The resident got up from his/her chair and became verbally aggressive towards the resident, including threatening language. - 5/30/2024 the resident went up to another resident and started yelling at him/her. Staff had to intervene and redirect; Resident ID #2 continued to berate the other resident when exiting. - 7/24/2024 the resident got into a drunk physical altercation with another resident. Record review of the resident's comprehensive assessment dated 8/27/2023 and updated on 10/25/2023 (to reveal a resident to resident physical altercation), 12/20/2023, 4/13/2024, 7/7/2024, and on 8/29/2024, failed to reveal that the resident had additional resident to resident verbal and physical altercations until 9/3/2024.	S 365		

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S 365	Continued From page 3 On 9/3/2024 the resident had an additional incident. This incident resulted in the resident being sent out to the hospital and not being allowed to return. Further review of the assessment reveals Section Four titled, "Behavioral Information" failed to reveal this section was updated to reflect the residents' assaultive (verbally and physically) behaviors after the incident on 10/24/2023 and before the incident on 9/3/2024. During a surveyor interview on 9/19/2024 with Staff B, CMT, at 3:45 PM, she revealed that the resident has outbursts and that certain things trigger him/her. She further revealed that the resident was given a few warnings about his/her behavior but with this last resident to resident physical altercation on 9/3/2024, the Administrator decided for the safety of the residents not to have Resident ID #2 return. During a surveyor interview with the Administrator on 9/23/2024 at 9:50 AM, she could not provide evidence that the comprehensive assessment was updated to include all of the resident's physical and verbal altercations with other residents or accurately reflect his/her abusive behaviors.	S 365	(1) Both resident charts have been updated care plan and comprehensive assessments. (2) all other resident charts are up to date (3) Both nurses were trained to identify significant changes that warrant updates to charts (4) administrator will check charts when significant changes happen for compliance. all of the above items are up to date 10-15-24 (03) 11/7/24	
S 390	Residency Requirements 2.4.16.G.3 Resident Assessment/Service Plan 2.4.16 (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	S 390		

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S 390	Continued From page 4 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 the residence failed to formulate a service plan with interventions to address a resident's needs, for 1 of 2 residents reviewed for behaviors, Resident ID #2. Findings are as follows: Record review revealed Resident ID #2 moved into the residence in August of 2023 with diagnoses including, but not limited to: schizoaffective disorder, bipolar disorder, and major depressive disorder. Review of the progress notes reveal the following entries: - 10/24/2023 Resident ID #2 went into another resident's room and was yelled at by the other resident to get out and that's when Resident ID #2 went "to choke and punch" the other resident on the left side of his/her face. Further review of the progress note reveals that Resident ID #2 went into another resident's room looking for cigarettes and when he/she was told to get out, Resident ID #2 assaulted him/her. - 1/24/2024 the resident got into a verbal altercation with another resident. - 2/15/2024 Resident ID #2 was told by another resident that he/she owes them money. The resident got up from his/her chair and became verbally aggressive towards the resident, including threatening language.	S 390		

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S 390	Continued From page 5 - 5/30/2024 the resident went up to another resident and started yelling at him/her. Staff had to intervene and redirect; Resident ID #2 continued to berate the other resident when exiting. - 7/24/2024 the resident got into a drunk physical altercation with another resident. - 9/3/2024 the resident was in the bathroom when another resident knocked on the door a few times. Resident ID #2 became upset, opened the bathroom door, and pushed the other resident who ended up falling back and hitting his/her head. 911 was called, and the other resident was taken to the hospital for an evaluation. Resident ID #2 was transported to the hospital for an evaluation due to his/her behaviors. Record review of the resident's service plan dated 8/28/2023 and updated on 10/25/2023 (to reflect the resident went to the hospital due to an assault on another resident), 12/20/2023, and on 12/29/2023 failed to address the resident's threatening and assaultive behaviors after 10/25/2023, as well as interventions to address these behaviors. During a surveyor interview with the Administrator on 9/23/2024 at 9:50 AM, she could not provide evidence that the service plan was updated after 10/25/2023 with interventions to help reduce the risk additional incidences due to numerous verbal and physical altercations with staff and other residents.	S 390	(1) Both residents charts have been updated, care plan + assessments. (2) all other residents charts are up to date. (3) Both nurses were trained to identify significant changes to warrant updates to service plans. (4) admin. will audit charts when significant changes happen for compliance. 10-18-24 (a) 11/7/24	