RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01518	A. BUILDING: _____ B. WING _____	C 05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLA VILLA ASSISTED LIVING	336 WILLETT AVENUE RIVERSIDE, RI 02915

(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 reference numbers 103459 and 103116, was conducted at this residence on 4/30/2026 to determine compliance with state laws and regulations. Deficiencies were identified.	S 003	Received MAY 29 2026 Facilities Regulation	
S 355	Residency Requirements 2.4.16.E Resident Records 2.4.16 (E) Resident Records E. Confidentiality of resident records shall be governed by the provisions of R.I. Gen. Laws Chapter 5-37.3 and the following; 1. Only authorized personnel shall have access to the records. 2. The residence shall release resident's medical information only with the written consent of the resident, parent, guardian or legal representative in accordance with R.I. Gen. Laws Chapter 5-37.3. This Requirement is not met as evidenced by: Based on record review, and resident and staff interviews, the residence failed to have written consent when releasing medical information to state and or local entities relative to health records for Resident ID #2 Findings are as follows: The Rhode Island Department of Health received a complaint from the Alliance for Better Long Term Care Office on 4/22/2026 alleging that a 30-day eviction notice is being issued to Resident ID #1. Resident ID #2's medical record is being	S 355	As part of showing evidence to a report of resident-to-resident abuse filed by Bella Villa on 02/14/26 to the DOH, the facility requested information from a resident's therapist for documentation of therapy sessions as a result of her encounter with another resident. The report was one of the reasons why another resident was served a 30-day notice for discharge. The therapist's documentation was turned in during hearing since resident with 30-day notice appealed the notice. The resident gave [redacted] verbal consent prior to the release of these documents to the Alliance and the EOHHS Appeals Office as evidence.The consent was sought twice however no written consent pertaining to the actual document to be released was acquired. A written document confirming verbal consent of the resident prior to release of document by fax signed by the resident and was given to the surveyor. A signed HIPAA form on admission of resident is attached informing the resident of Bella Villa's need to release certain information for reporting abuse, neglect or domestic violence when required by law. Corrective Action:A form was developed by Bella Villa to document consent release that specifies the purpose for release of information prior to the release of information to any entity.Review of documents by Administrator or Wellness Director will be done prior to release. 05/13/26	

Facilities Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: R K Sasmena — TITLE: ADMINISTRATOR — (X6) DATE: 05/22/26

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S 355	Continued From page 1 utilized as supporting documentation for the eviction process. The residence provided medical and psychiatric information to the Alliance for Better Long-Term Care and the Executive Office of Health and Human Services (EOHHS) without the written consent of Resident ID #2. Record review of Resident ID #2 revealed a written consent letter was signed by the resident for the release of his/her medical information to the residence. Record review failed to reveal evidence that a written consent letter was signed by the resident to provide medical and psychiatric information from the residence to the Alliance for Better Long Term Care Office and the EOHHS. During a surveyor interview on 5/6/2026 at approximately 11:15 AM with the resident, s/he indicated that s/he gave consent to the behavioral health provider to release information to the residence. She was unable to recall if s/he gave consent to release his/her medical information to the Alliance for Better Long Term Care Office and EOHHS. During a surveyor interview on 5/6/2026 at approximately 12:30 PM with the Administrator, she was unable to provide evidence of a written release of information to the above stated entities, as required by regulation. She acknowledge she had provided the information to those entities. Additionally, she acknowledged the information that was sent to the above-mentioned agencies was not redacted to include only the required information that was needed.	S 355		

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S 440	Continued From page 2	S 440		
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 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	S 440	Resident-to-resident abuse was filed on 02/14/26 to the DOH and with the filing was included documentation of other numerous complaints from other residents. The Alliance, as the advocate for all residents was made aware of the complaints. The facility addressed the incidents however it did not send the DOH a copy of the complaints. Corrective Action: Bella Villa will review the regulation regarding Reporting Requirements 2.4.18 (D). An inservice to staff will be conducted to review existing policy of facility regarding allegations of abuse and reporting requirements.	5/8/26

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S 440	Continued From page 3 residence failed to report incidents of abuse that did not result in bodily injury to the Rhode Island Department of Health for the singular resident reviewed for perpetuating abuse, Resident ID #1. Findings are as follows: Record review of Resident ID #1 revealed that verbal forms of abuse were reported on the following dates: - 5/27/2024 verbal altercation between Resident ID #1 and another resident and Resident ID #1 challenged the other resident to take it outside and that s/he would beat him/her up. - 11/2/2024 verbal altercation between Resident ID #1 and another resident and Resident ID #1 threatened to hit the other resident. - 2/26/2025 verbal altercation between Resident ID #1 and another resident with Resident ID #1 saying to the other resident s/he was going to "mess [him/her] up". - 6/29/2025 verbal altercation with another resident and stated, "I will kill you when you go to the store." The East Providence police department was contacted and both residents were spoken to by the police officer. - 2/13/2026 a resident approached Administrator indicating that s/he anxiety is increasing due Resident ID #1's behavior and that s/he is managing the anxiety through psychological counseling. - 3/3/2026 The resident was issued a 30-day notice for discharge from the residence.	S 440		

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S 440	Continued From page 4 Record review of the Rhode Island Department of Health's (RIDOH) database for residence reported allegations of abuse failed to have the reports of all the above-mentioned incidents of threatening behaviors and verbal abuse towards other residents perpetuated by Resident ID #1. During a surveyor interview on 5/6/2026 at approximately 11:30 AM with the Administrator, she was unable to provide evidence that RIDOH was notified of the alleged abuse incidents.	S 440	Med cabinet should never be unlocked without staff immediately present providing resident supervised access.	
S 635	Residential Care Services 2.4.26.A.3.C Medication Services 2.4.26 (A) (3) (C) Medication Services c. For the first three (3) months of employment, a licensed nurse designated by the health care facility, adult day care program, or assisted living residence, as appropriate, shall conduct and document monthly evaluations (in accordance with the evaluation checklist on the Department website) of a medication aide who administers medication. After the first three (3) months, the evaluation shall be conducted no less than quarterly. Copies of said evaluations shall be placed in the medication aides' personnel records. This Requirement is not met as evidenced by: Based on record review and staff interview, the residence failed to store medications securely for the singular resident reviewed relative to medication storage, Resident ID #1.	S 635	Quarterly evaluations by RN are done on med techs since all med techs at Bella Villa have worked at the facility for more than 3 months. During evening medpass on 01/09/26, a resident could not wait for [redacted]um to be administered [redacted]meds and went into [redacted]medication bin to take [redacted]meds. Since meds were prepackaged by the pharmacy according to time and date the resident was able to self-administer the correct medications. The incident was addressed by the administrator after breakfast the next morning. The resident promised such incident will not be repeated. On 03/07/26, the same resident went into [redacted]medication bin while next shift staff was putting down [redacted]bag. The medication cabinet was open as the administrator was preparing to give meds because the med tech called to say [redacted]was going to be a few minutes late. Corrective Action: Staff is aware that medication cabinets are to be kept locked at all times except during medpass. In the instances that the resident had access into [redacted]medication bin, a medpass was going on or about to start. Staff will be inserviced to reinforce policy on locking medication cabinets. Residents will be educated on the M1F1 license of the facility, house rules pertaining to medication administration, and need for resident compliance to regulation and policy on medication administration. The resident concerned will be evaluated on [redacted]ability to self-administer [redacted]own meds.	Staff trained 5/16/26 5/14/26

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S 635	Continued From page 5 Findings are as follows:. Record review of the physician's orders for Resident ID #1 revealed that s/he does not have a prescribed physician's order to self-administer his/her own medications. Record review of a service plan dated 5/25/2023 revealed that the residence is responsibe for administering Resident ID #1's medications. Record review of the "Charting Notes" revealed in part the following: - 1/9/2026 the resident going into his/her medication bin and taking his/her own medications; not waiting for staff to administer - 3/7/2026 the resident went into his/her medication bin and took his/her own medications for the evening, as the medication aide was running a few minutes late During a surveyor interview on 5/6/2026 at approximately 12:15 PM with the Administrator, she indicated that the incident that occurred on 1/9/2026 was related to the change of shifts and the Medication Aide moved away from the medication cabinet that was not secured. The second occurrence was related to the medication storage cabinet not being secured during medication administration and the Medication Aide being delayed in administering the evening medications, resulting in the resident accessing the medication cabinet that was unlocked and took his/her medications.	S 635		