RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01466	A. BUILDING: _____ B. WING _____	C 06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA HARBORHILL	159 DIVISION STREET EAST GREENWICH, RI 02818

(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, ACTS reference numbers 100923, 101119, and 101169, was conducted at this residence on 06/18/2025 to determine compliance with state regulations. A deficiency was identified.	S 003	Preparation, execution, and submission of this Plan of Correction does not constitute an admission of fault or liability on the part of Atria Harborhill as to the truth of the facts alleged or conclusions drawn in the Statement of Deficiencies or any specific statement of n on-compliance. Atria Harborhill prepares and submits this Plan of Correction to comply with state laws and regulatory provisions.	
S 815	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 provide all care and services in accordance with the prevailing community standard of care for residents with particular needs and behaviors related to dementia relative to supervision for a singular resident reviewed, Resident ID #1. Findings are as follows: An initial reportable incident form submitted to the Rhode Island Department of Health on 6/5/2025 alleges that a friend of Resident ID #1 was visiting him/her in his/her apartment when Certified Medication Technician (CMT), Staff A, went to check on the resident and witnessed the visitor putting his/her hand down the resident's shirt and then went to report it. CMT, Staff B,	S 815	On 6/4/25, a visitor and family friend came to visit the resident. The visitor is in [redacted] mid-80s and is well known to the resident and the resident's family (who said it was fine for [redacted] to visit). A staff member (Staff Member A) observed the resident and the visitor kissing in the resident's apartment and the visitor had [redacted] hand down the resident's shirt. The resident was not exhibiting distress, but per policy, Staff Member A relayed the information to the Life Guidance Director "LGD" (her supervisor).	8/1/2025

Received
JUL 08 2025
Facilities Regulation

Facilities Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Robert Ingram
TITLE
Executive Director
(X6) DATE
7/7/2025

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S 815	Continued From page 1 went to check on the resident and observed them kissing. The Life Guidance Director (LGD) then went to check in on the resident and observed the visitor standing over the resident and when she knocked on the door, the visitor was adjusting his/her pants. The residence's "Preventing, Detecting and Reporting Abuse, Neglect and Exploitation" policy states in part, "...4.0 Procedure:...C. Reporting and Immediate Response:...1. Any employee who suspects, witnesses or has knowledge about any incident or allegation that may concern abuse...must report that incident or allegation immediately to a supervisor. 2. The supervisor must immediately communicate any such report to the Executive Director (ED)...3. The supervisor shall ensure the resident is safe and is removed from any situation that could place the resident in harm's way..." Record review revealed the resident was admitted to the secure memory care unit in March of 2025 with diagnoses including, but not limited to, Alzheimer's disease and aphasia (a language disorder that affect the ability to communicate). During a surveyor interview with the LGD in the presence of the Executive Director on 6/18/2025 at 9:40 AM, she revealed that Staff A came to her indicating that the resident was in his/her room with a visitor, and that it looked like the visitor had his/her hand down the resident's shirt. She further indicated that while Staff A was revealing this information, she had Staff B go check in on the resident as she didn't want him/her alone. Staff B came back to report what she saw; CMT, Staff C went to the room while Staff B's statement was taken.	S 815	Continued When the LGD first heard Staff Member A's concerns, she sent a second staff member to the apartment so the resident would not be alone while the LGD spoke with Staff Member A and assessed next steps. The LGD went to the apartment appx. 3-4 minutes after gathering the information to address the situation. When the LGD walked in the apartment, the visitor was departing. The resident was evaluated by [redacted] nurse practitioner and the police were contacted so they could follow-up accordingly regarding the visit	8/1/2025

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S 815	Continued From page 2 The LGD revealed that is when she went to the room to see what was happening. She noticed the visitor in front of the resident and nothing else due to the angle of the room. She then knocked on the door and indicated that is when the visitor turned away and it looked like the visitor was adjusting his/her pants. Additionally, she revealed the visitor left immediately while she was talking to the resident. Review of the written witness statements revealed the following regarding the incident on 6/4/2025: 1) Staff A indicated that around 2:30 PM several residents were outside doing an activity when Resident ID #1's visitor arrived and asked the resident if they could go inside to his/her apartment. The two went to the resident's room, the door was left open. She further revealed that when she brought the other residents inside, she went to Resident ID #1's room to see if they wanted to go to the TV room with the other residents to get them out of the apartment. Additionally, she revealed that when she walked into the room fully, she saw the visitor's hands inside the resident's shirt. Furthermore, she revealed she went to her supervisor, the LGD, to inform her what she witnessed. 2) Staff C indicated a few minutes after Staff A saw the visitor touching the resident's chest, Staff C then went into the room and witnessed the visitor in front of the resident. The resident was on his/her bed leaning forward near the visitor's waist. 3) The LGD indicated Staff A came to her office to report that Resident ID #1 had a visitor in the resident's apartment and that the visitor had	S 815	Continued The community has and continues to have training that requires staff to report suspected abuse to their supervisor, so that steps can be taken to remove a resident from a situation that could place them in harm's way. All staff and management will be in-serviced regarding reporting and acting on suspected abuse, including notifying their supervisor and promptly removing residents from situations that could place them in harm's way. All in-services will be completed by 8/1/2025 The Executive Director, Life Guidance Director and their designees will be responsible for continued compliance.	8/1/2025 8/1/2025

Robert Ingram 8/1/2025

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S 815	Continued From page 3 his/her hand down the resident's shirt touching him/her. Staff B was sent to go check on the resident while the LGD was speaking with Staff A. Staff B came back down the hall and revealed the resident and visitor were kissing. Staff C then went to stand outside the apartment as the LGD went down the hall and stood in the resident's doorway and witnessed the visitor in front of the resident who was sitting on the bed. She revealed she knocked on the door and entered the room. She indicated that she saw the visitor fixing his/her pants. During a surveyor interview with Staff C on 6/18/2025 at 1:14 PM, she revealed she went into the resident's room after Staff A indicated to her that the visitor was fondling and kissing the resident. She indicated that when she went to the resident's apartment she witnessed the resident sitting on the bed, and the visitor was in front of him/her. She indicated that she then went to tell her supervisor. During a surveyor interview with the ED at approximately 2:25 PM, he could not provide evidence that the resident had adequate supervision to keep him/her safe and was removed from a situation where the resident was at risk after Staff A gave her statement to the LGD regarding inappropriate touching of Resident ID #1 by a visitor.	S 815		