RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01482	A. BUILDING: _____ B. WING _____	C 05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOCKWOTTON ON THE WATERFRONT	500 WATERFRONT DRIVE EAST PROVIDENCE, RI 02914

(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	RECEIVED JUN 18 2024 FACILITIES REGULATION	
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 interviews, it has been determined that facility staff failed to report suspected or known abuse, exploitation,	S 415	The family member who is the alleged perpetrator has been issued a no trespass order and the Power of Attorney can only have supervised visits with their loved one. A staff meeting was held with the Courtyard Memory Care staff members to ask them if they had any suspicions of any other family members in the program. No staff members had any concerns or suspicions of any other family members. Staff were also immediately re-trained on reporting requirements related to abuse. Once a month the staff educator or his/her designee will conduct re-training with all staff on abuse reporting requirements. This will continue for three months and then quarterly thereafter. This re-training documentation will be reviewed at the quarterly Quality Improvement Committee meetings. Weekly Risk meetings held by the Administrator or his/her designee will now include suspicions of abuse. These weekly Risk meeting minutes will be reviewed at the quarterly Quality Improvement Committee meetings.	6/15/24 6/15/24 6/15/24 6/15/24

Facilities Regulation

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

AL Admin 6/15/24

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S 415	Continued From page 1 neglect, or mistreatment which resulted in bodily injury immediately, but not later than four hours from discovery, for the singular resident reviewed relative to abuse, Resident ID #1. Findings are as follows: According to 2.4.17 D of the Assisted Living Residences Regulation, 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 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..." The residence's "Policy on Abuse and Neglect" states in part, "...Any employee or consultant who has reasonable cause to believe that a resident has been abused, exploited or neglected shall immediately report such an incident to the senior member of the nursing staff on duty..." Record review revealed that Resident ID #1 was admitted to the residence in 2020 with a diagnosis of dementia and currently resides on the special care unit. The resident was enrolled in hospice services on 05/15/2024 for a decline in functioning due to dementia; he/she is alert to person only, demonstrating extensive cognitive impairment. According to an "Assisted Living Residence Required Incident Reporting" form sent to the Department of Health on 05/21/2024, Staff A observed Resident ID #1's visitor "laying on top of	S 415		

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S 415	Continued From page 2 resident", kissing him/her with a hand in his/her brief, at approximately 8:15 PM on 05/20/2024. Record review revealed the abuse was reported to senior facility staff on 05/21/2024 at approximately 3:00 PM by Staff A. Once alerted to the incident, the residence's senior nursing staff called the police, and the resident was sent to the hospital for an evaluation. Resident ID #1's evaluation at the hospital revealed evidence of sexual assault and bruising to the genitalia. According to the police report dated 05/24/2024, the staff were suspicious of this visitor prior to this incident. During a surveyor interview on 05/23/2024 at approximately 4:45 PM, Staff A revealed that he observed the visitor in Resident ID #1's room on top of the resident and kissing him/her, the visitor's hand was beneath a blanket in the resident's brief. He further revealed that the staff has had odd interactions with this visitor. Staff A acknowledged he did not report the incident to senior management until the following day when he came into work for his next shift. During an interview on 05/23/2024 at approximately 2:00 PM, the Administrator acknowledged Staff A did not report the abuse immediately, according to facility policy and the regulation, as required.	S 415		