PRINTED: 12/29/2025
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RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01467	A. BUILDING: _____ B. WING _____	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA BAY SPRING	147 BAY SPRING AVENUE BARRINGTON, RI 02806

(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 biennial State licensure survey and a complaint/incident investigation survey (30Q011, 12/16/2025 through 12/18/2025) were conducted at this residence. Deficiencies were identified relative to the State licensure survey.	S 003	Received JAN 13 2026 Facilities Regulation	
S 055	Licensure Requirements 2.4.3 Quality Assurance 2.4.3 Quality Assurance A. In accordance with R.I. Gen. Laws § 23-17.4-10.1, each assisted living residence shall develop, implement and maintain a documented, ongoing quality assurance program. 1. The purpose of this program shall be to attain and maintain a high quality assisted living residence through an on-going process of quality improvement that monitors quality, identifies areas to improve, methods to improve them, and evaluates the progress achieved. 2. Each licensed residence shall establish a quality improvement committee which shall include at least the following: assisted living administrator, registered nurse and a representative of dietary services. 3. The quality improvement committee shall meet at least quarterly; shall maintain records of all quality improvement activities; and shall keep records of committee meetings that shall be available to the Department during any on-site visit. 4. The quality improvement committee shall review and approve the quality improvement plan for the residence at intervals not to exceed twelve (12) months. Said plan shall be available to the	S 055	ID Tag S 055 Licensure Requirements 2.4.3 Quality Assurance As set forth from License Requirements 2.4.3 Quality Assurance within the state of Rhode Island Regulations, the community will ensure that the Quality Assurance program will include all of the required components, and the committee will include all of the The Executive Director will audit all Quality Assurance meetings every 90 days to verify that all required committee members are present, ensure that plans of correction from Rhode Island Department of Health inspections are being monitored, and confirm that all reportable incidents are tracked in compliance with the Quality Assurance Program requirements. The Executive Director will review and ensure compliance at the Quarterly Quality Assurance	1/31/2026

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

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S 055	Continued From page 1 public upon request. 5. Each assisted living residence shall establish a written quality improvement plan that includes: a. Program objectives; b. Oversight responsibility (e.g., reports to the governing body, QI records); c. Includes methods to identify, evaluate, and correct identified problems; d. Provides criteria to monitor personal assistance and resident services, including, but not limited to: (1) Resident/family satisfaction; (2) Medication administration/errors; (3) Reportable incidents as specified in § 2.4.17 of this Part; (4) Resident falls; (5) Plans of correction developed in response to the Department ' s inspection reports. B. In addition to the requirements of §§ 2.4.3(A)(1) through (5) of this Part, all assisted living residences with a "dementia care" license and/or a "limited health services license" shall also address the following areas in their quality improvement plan: 1. Prevention and treatment of decubitus	S 055		

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S 055	Continued From page 2 ulcers; 2. Dehydration, and nutritional status and weight loss or gain; and 3. Changes in mental or psychological status. 4. Quality improvement documentation shall be kept on file for a minimum of five (5) years. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined that the residence failed to establish a quality assurance committee which shall include at least the following: the Administrator, a registered nurse, and a representative of dietary services. Additionally, the written quality assurance program failed to include all required components. Findings are as follows: Record review of the quality assurance meeting minutes failed to reveal evidence that a representative from dietary was in attendance as required, on the following dates: 3/26/2025, 6/25/2025, and 9/24/2025. Further record review of the quality assurance meeting minutes failed to reveal evidence that a registered nurse was in attendance on 9/24/2025. Record review of the written plan failed to monitor reportable incidents. Additionally, the plan failed to include monitoring plans of correction in response to Rhode Island Department of Health's inspections.	S 055		

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S 055	Continued From page 3 During a surveyor interview on 12/18/2025 at 2:30 PM with the Administrator, she could not provide evidence the quality assurance committee had the required participants and components.	S 055		
S 090	Licensure Requirement 2.4.6.C Safe Resident Handling 2.4.6 (C) Safe Resident Handling C. Each licensed assisted living residence must have a written safe resident handling program, with input from the safe handling committee, to prevent musculoskeletal disorders among health care workers and injuries to residents. As part of this program, each licensed assisted living residence shall: 1. Implement a safe resident handling policy for all shifts and units of the residence that will achieve the maximum reasonable reduction of manual lifting, transferring, and repositioning of all or most of a resident's weight, except in emergency, life-threatening, or otherwise exceptional circumstances; 2. Conduct a resident handling hazard assessment. This assessment should consider such variables as handling-handling tasks, types of units, resident populations, and the physical environment of resident care areas; 3. Develop a process to identify the appropriate use of the safe resident handling policy based on the resident ' s physical and mental condition, the resident's choice, and the availability of lifting equipment or lift teams. The policy shall include a means to address circumstances under which it would be medically	S 090	ID Tag S 090 Licensure Requirement 2.4.6.(C) Safe Resident Handling As set forth on Licensure Requirements 2.4.6 (C) Safe Resident Handling within the state of Rhode Island regulations, the community will ensure to conduct a resident handling hazard assessment on admission and quarterly on the special care unit. 1) In response to Resident ID #1, a resident handling hazard assessment was completed for the resident. 2) In response to Resident ID #2, a resident handling hazard assessment was completed for the resident. 3) In response to Resident ID #3, a resident handling hazard assessment was completed for the resident.	1/9/2026 1/9/2026 1/9/2026

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S 090	Continued From page 4 contraindicated to use lifting or transfer aids or assistive devices for particular residents; 4. Designate and train a registered nurse or other appropriate licensed health care professional to serve as an expert resource, and train all direct care staff on safe resident handling policies, equipment, and devices before implementation, and at intervals not to exceed twelve (12) months, or as changes are made to the safe handling policies, equipment and/or devices being used; and 5. Conduct a performance evaluation of the safe resident handling policy at intervals not to exceed twelve (12) months, with the results of the evaluation reported to the safe resident handling committee or other appropriately designated committee. The evaluation shall determine the extent to which implementation of the program has resulted in a reduction in musculoskeletal disorder claims and days of lost work attributable to musculo-skeletal disorder caused by resident handling, and include recommendations to increase the program's effectiveness. This Requirement is not met as evidenced by: Based on record review and staff interview, the residence failed to conduct a resident handling hazard assessment for three of three sample residents residing on the special care unit, Resident ID #'s 1, 2, and 3. Findings are as follows: Review of the facility policy titled, "Safe Resident Handling" states in part, "...Residents will be assessed quarterly for changes in transfer	S 090	All resident handling hazard assessments will be audited every 90 days at at admission by Resident Service Director or designee. The community will Inservice nursing staff on Licensure Requirements 2.4.6 (C) Safe Resident Handling. Resident Service Director or designee and Executive Director will review compliance at quarterly Quality Assurance Meeting.	1/14/2026

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S 090	Continued From page 5 requirements..." 1) Record review revealed Resident ID #1 was admitted to the special care unit in April of 2025 with a diagnosis that includes, but is not limited to, ataxia (a neurological sign of poor muscle control, causing clumsy, awkward movements, balance problems, and difficulty with coordination). Record review failed to reveal evidence that an initial resident handling hazard assessment was completed for the resident. Further review of the record failed to reveal July's quarterly assessment was completed, per policy. 2) Record review revealed Resident ID #2 was admitted to the special care unit in September of 2023 with a diagnosis that includes, but is not limited to, major neurocognitive disorder. Record review failed to reveal evidence that an initial safe resident handling hazard assessment was completed for the resident. Further review of the record failed to reveal July's quarterly assessment was completed, per policy. 3) Record review revealed Resident ID #3 was admitted to the special care unit in November of 2025. Record review failed to reveal evidence that a safe resident handling hazard assessment was completed for the resident upon admission. During a surveyor interview on 12/18/2025 at approximately 1:30 PM with the Resident Service Director, she acknowledged that the residents' initial safe handling hazard assessments are not being completed for the residents. She further	S 090		

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S 090	Continued From page 6 could not produce evidence that Resident ID #2 and 3's July's assessments were completed, per their policy.	S 090		
S 255	Organization And Management 2.4.14.B Management Of Services 2.4.14 (B) Management Of Services B. The residence shall have a policy and procedure manual that is reviewed and updated by the administrator at intervals not to exceed twelve (12) months, and shall include, but not be limited to, the following items: 1. A written description of all services available to residents that shall be designed to promote the resident ' s efforts to maintain independence; 2. A written statement of admission criteria that shall include, at a minimum, the following information regarding the resident population: a. Nature and extent of disabling condition(s) served; and b. Restrictions (if any). (1) The statement of admission criteria shall include a statement that no otherwise qualified applicant shall be denied admission to the residence solely on the basis of age, sex, gender identity or expression, race, creed, color, religion, sexual orientation, marital status, familial status, disability, source of income, source of payment or profession, or national origin.	S 255	Tag ID S 255 Organization and Management 2.4.14. (B) Management Of Services As set forth on Organization and Management 2.4.14 (B) Management of Services within the state of Rhode Island regulations, the community will ensure a policy and procedure manual is reviewed and updated by the administrator at intervals not to exceed (12) twelve months as required. The policy and procedure manual will be reviewed and updated by the administrator as required. The Executive Director will audit and review the policy and procedure manual at the quarterly Quality Assurance Meeting to ensure compliance.	1/31/2026

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S 255	Continued From page 7 This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined that the residence failed to have a policy and procedure manual that is reviewed and updated by the residence at intervals not to exceed twelve months. Findings are as follows: Record review of the policy and procedure manual titled, "Policy and Procedure Manual Senior Living Group Atria" failed to reveal evidence that residence policies had been reviewed yearly. During a surveyor interview with the Administrator on 12/18/2025 at approximately 3:00 PM, she could not provide evidence that the policy and procedure manual's contents had been updated at intervals not to exceed twelve months, as required.	S 255		
S 390	Residency Requirements 2.4.17.D Resident Assessment/Service Plans 2.4.17 (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 review the assessment at intervals not to exceed	S 390	ID Tag S 390 Residency Requirements Resident Assessment/Services Plans As set forth by Residency Requirements 2.4.16 (D) Assessment and Service Plans within the state of Rhode Island Regulations, the community will ensure that the assessment shall be reviewed and at intervals not to exceed twelve (12) months and each time a resident's condition changes significantly.	2.4.16.(D)

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S 390	Continued From page 8 (12) months and each time a resident's condition changes significantly for 5 of 6 residents reviewed, Resident ID #s 3, 4, 5, 6, and 7. Findings are as follows: 1) Record review revealed Resident ID #3 moved into the residence in October of 2021 with a diagnosis including, but not limited to, Alzheimer's disease. Review of the entrance conference form revealed the resident had a start of care for speech therapy on 11/30/2025. Review of the outside agency note revealed that on 12/11/2025 the resident was discharged from speech. Record review of the resident's comprehensive assessment, dated 11/13/2025, failed to reveal the assessment was updated to discontinue speech therapy. During a surveyor interview with the Resident Service Director on 12/18/2025 at approximately 8:30 AM, she acknowledged the assessment was not updated to discontinue speech therapy. 2) Record review revealed Resident ID #4 moved into the residence in February of 2024 with a diagnosis including, but not limited to, thrombocytopenia (a condition with abnormally low platelet levels, reducing the blood's ability to clot). Review of the entrance conference form revealed the resident had a start of care for skilled nursing on 9/26/2025.	S 390	1) For Resident ID # 3 the community will update the resident's assessment to reflect the resident received speech therapy from 11/30/2025-12/11/2025 2) For Resident ID # 4, the community will update the resident's assessment to reflect the resident received physical therapy services 11/1/2024-12/4/2024 & 9/27/2025-11/21/2025 speech therapy services 9/29/2025-10/22/25 skilled nursing services from 3) For Resident ID #5 the community will update the resident's assessment to reflect resident received physical therapy services 12/27/2024-1/30/2024 & 2/14/2025-4/25/2025; evaluated for occupational therapy services and not admitted on 1/6/2024 & 4) For Resident ID #6 the community will update the resident's assessment to reflect the resident's paranoid, intrusive, and aggressive behaviors. 5) For Resident ID #7 the community will update the resident's assessment to reflect the resident received physical therapy services from 9/5/2025-	1/9/2026 1/9/2026 1/9/2026 1/9/2026 1/9/2026

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S 390	Continued From page 9 Record review of the resident's comprehensive assessment, dated 9/25/2025, revealed the resident was receiving outside services with the following start of care dates: -"PT (physical therapy) 11/1/24" -"SN (skilled nursing) 11/1/24" The assessment failed to indicate the end of service dates for the above-mentioned services. During a surveyor interview with the Resident Service Director on 12/18/2025 at approximately 8:30 AM, she acknowledged the assessment did not reflect which therapy the resident was receiving. 3) Record review revealed Resident ID #5 moved into the residence in October of 2023 with diagnoses including, but not limited to, arthritis and chronic pulmonary edema (where excess fluids fills the air sacs in the lungs, making it hard to breathe). Review of an outside agency note revealed that on 8/29/2025 the resident started PT (physical therapy) twice per week for four weeks. Record review of the resident's comprehensive assessment, dated 12/27/2024, listed "PT" under "therapies" without a start of care date or discharge date. During a surveyor interview with the Resident Service Director on 12/17/2025 at approximately 1:00 PM, she acknowledged the comprehensive assessment did not accurately reflect the above service. 4) Record review revealed Resident ID #6 moved	S 390	The community will Inservice nursing staff on Residency Requirements 2.4.17 (D) Resident Assessment and Service Plans. The Resident Services Director will audit all new and current residents receiving outside services and ensure that any documented behaviors are accurately reflected in their assessments. Resident Service Director or designee and Executive Director will review compliance at the quarterly Quality Assurance Meetings.	1/14/2026 1/31/2026

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S 390	Continued From page 10 into the residence in October of 2025 with a diagnosis including, but not limited to, lactose intolerance. Record review of the resident's comprehensive assessment, dated 11/25/2025, revealed Section Four titled, "Behavioral Information" failed to reveal this section was updated to reflect the resident's paranoid, intrusive, and aggressive behaviors. The assessment failed to document a diagnosis that reflects these behaviors or their occurences. During a surveyor interview with the Resident Service Director on 12/18/2025 at approximately 8:30 AM, she acknowledged the assessment did not accurately reflect the resident's behaviors. 5) Record review revealed Resident ID #7 moved into the residence in May of 2025 with a diagnosis including, but not limited to, deep vein thrombosis (where a blood clot forms in a deep vein, usually in the legs, causing pain, swelling, and redness). Record review of a progress note, dated 10/2/2025, revealed the resident was discharged from nursing services. Further review of a progress note, dated 10/10/2025, revealed the resident was discharged from all outside services. Record review of the resident's comprehensive assessment, dated 5/7/2025, revealed under therapies, follow through with PT and OT (occupational therapy). Additionally, skilled nursing not documented. During a surveyor interview with the Resident Service Director on 12/18/2025 at approximately	S 390		

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S 390	Continued From page 11 8:30 AM, she could not provide evidence that the resident's assessment was accurate for outside services. She further revealed that the resident was receiving skilled nursing services from 9/5/2025 through 10/2/2025, which was not indicated on the assessment.	S 390		
S 400	Residency Requirements 2.4.17.F Resident Assessments/Service Plans 2.4.17 (F) Nurse Review 1. Nurse review is necessary for all levels of licensure. a. A registered nurse shall visit the residence at least once every thirty (30) days except as provided in § 2.4.16(F)(1)(b) of this Part and shall complete a review to include the following: (1) Monitor the medication regimen for all residents; (2) Review any new physician orders and evaluate the health status of all residents by identifying symptoms of illness and/or changes in mental/physical health status; (3) Evaluate the appropriateness of placement for each resident; (4) Make any necessary recommendations to the administrator; (5) Follow up on previous recommendations; (6) Provide a signed, written report in the residence documenting:	S 400	ID Tag S 400 Residency Requirements 2.4.17.F Resident Assessments/Services Pans 2.4.17 (F) As set forth on Residency Requirements 2.4.17 (F) Resident Assessments/Service Plans 2.4.17 (F) Nurse Review within the state of Rhode Island regulations the community will ensure nurse reviews will be completed every 90 days and contain all required components for a physical assessment. All resident's nurse reviews will be audited every 90 days by the Resident Service Director or designee to ensure resident's weight is in included in the physical assessment section of " Nurse Review" as required.	1/9/2026 1/31/2026

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S 400	Continued From page 12 (AA) Date and time of assessment; (BB) Recommendations for follow-up; (CC) Progress on previous recommendations; (DD) Verification that the medication listed by the pharmacist on the mediset, blister pack or medication container is current with physician orders (M-1 level only); (EE) Physical assessment identifying symptoms of illness and/or changes in mental or physical health status and appropriateness of placement; (FF) Such reports shall be on file at the residence. (7) Complete the quarterly evaluation of the residence ' s registered medication aide(s) administration of medication. (Approved Department form is available for downloading online). b. In those residences that have one (1) or more licensed registered nurses (i.e., at least one (1) full-time equivalent equal to thirty-five (35) hours) on-site, the nurse review shall be completed at least once every ninety (90) days. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined that the residence failed to ensure that nurse reviews held the required	S 400	The community will Inservice nursing staff on Residency Requirements Section 2.4.17 (F) Nurse Reviews. Resident Service Director or designee and Executive Director will review compliance at the quarterly Quality Assurance Meetings.	1/14/2026

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	ALR01467	A. BUILDING: _____ B. WING _____	12/18/2025

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S 400	Continued From page 13 components for 6 out of 6 sample residents with nurse reviews, Resident ID #s 2, 3, 4, 5, 7, and 8. Findings are as follows: 1) Record review revealed Resident ID #2 moved into the residence in June of 2021. A "Nurse Review" was completed on 12/24/2024, 3/4/2025, 6/10/2025, 9/17/2025, and 12/8/2025. 2) Record review revealed Resident ID #3 moved into the residence in October of 2021. A "Nurse Review" was completed on 2/28/2025, 6/30/2025, and 9/6/2025. 3) Record review revealed Resident ID #4 moved into the residence in February of 2024. A "Nurse Review" was completed on 2/21/2026, 6/22/2026, 8/11/2026, and 9/25/2025. 4) Record review revealed Resident ID #5 moved into the residence in October of 2023. A "Nurse Review" was completed on 11/24/2024, 2/13/2025, 4/30/2025, 6/30/2025, and 9/7/2025. 5) Record review revealed Resident ID #7 moved into the residence in May of 2025. A "Nurse Review" was completed on 7/17/2026 and 10/10/2025. 6) Record review revealed Resident ID #8 moved into the residence in January of 2024. A "Nurse Review" was completed on 2/24/2025, 5/3/2025, 8/8/2025, and 11/21/2025. Record review of the above resident's "Nurse Review(s)" failed to reveal evidence of a physical assessment of each resident, as required. During a surveyor interview with the Director of	S 400		

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S 400	Continued From page 14 Resident Services on 12/16/2025 at approximately 12:00 PM, she was unable to provide evidence that the "Nurse Reviews" were completed with all required components for the above-mentioned residents.	S 400		
S 415	Residency Requirements 2.4.17.G.3 Resident Assessment/Service Plan 2.4.17 (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 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 that the residence failed to update the service plan each time a resident's condition changed significantly for 6 of 7 residents reviewed, Resident ID #s 3, 4, 5, 6, and 8. Findings are as follows: 1) Record review revealed Resident ID #3 moved into the residence in October of 2021 with a diagnosis including, but not limited to, Alzheimer's disease. Review of the entrance conference form revealed the resident started speech therapy on 11/30/2025. Record review of the service plan, dated 11/21/2025, failed to reveal speech therapy and/mission and discharge dates; speech therapy	S 415	ID Tag S 415 Residency Requirements 2.4.17.G.3 Resident Assessment/Service Pan 2.4.17 (G) (3) Service Plans As set forth by Residency Requirements 2.4.17 (G) (3) Service Plans within the state of Rhode Island regulations the community will ensure 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 acknowledged in writing by both parties. 1) For Resident ID #3 the community will update the resident's service plan to reflect the resident received speech therapy service 11/30/2025-12/11/2025. 2) For Resident ID #4 the community will update the resident's service plan to reflect the resident received physical therapy 9/27/2025-11/21/2025	1/9/2026 1/9/2026

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S 415	Continued From page 15 was discontinue on 12/11/2025. During a surveyor interview with the Resident Service Director on 12/18/2025 at approximately 8:45 AM, she acknowledged the service plan was not updated for speech therapy services. 2) Record review revealed Resident ID #4 moved into the residence in February of 2024 with a diagnosis including, but not limited to, thrombocytopenia (a condition with abnormally low platelet levels, reducing the blood's ability to clot). Record review of the resident's service plan, dated 9/25/2025, failed to reveal the resident was receiving PT (physical therapy) services with a start of care date of 9/27/2025. During a surveyor interview with the Resident Service Director on 12/18/2025 at approximately 8:45 AM, she revealed the resident's PT services was discontinued on 11/21/2025. She acknowledged the service plan failed to reveal PT services. 3) Record review revealed Resident #5 moved into the residence in October of 2023 with diagnoses including, but not limited to, arthritis and chronic pulmonary edema (where excess fluids fills the air sacs in the lungs, making it hard to breathe). Review of an outside agency note revealed the resident started PT on 6/29/2025 twice per week for 4 weeks. Record review of the service plan, dated 6/30/2025, revealed the resident had a PT evaluation without a start of care date.	S 415	3) For Resident ID #5 the community will ensure the resident's service plan will be updated to reflect resident received physical therapy services 6/29/2025-7/10/2025. 4) For Resident ID #6 the community will ensure the resident's service plan will be updated to reflect resident's paranoid, intrusive and aggressive 5) For Resident ID # 8 the community will ensure the resident's service plan will be updated to reflect the resident started physical therapy services on 11/22/2025 and started occupational therapy services on 11/22/2025.	1/9/2026 1/9/2026 1/9/2026

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S 415	Continued From page 16 During a surveyor interview with the Resident Service Director on 12/18/2025 at approximately 8:45 AM, she acknowledged there was no start of care or discharge date for PT on the service plan. 4) Record review revealed Resident #6 moved into the residence in October of 2025 with a diagnosis including, but not limited to, lactose intolerance. During a surveyor interview with the Administrator on 12/17/2025 at 2:05 PM, she revealed she gave the resident a 30-day notice due to his/her paranoid and aggressive behaviors. Record review of the service plan, dated 9/26/2025, failed to reveal the service plan was updated to reflect the resident's paranoid, intrusive, and aggressive behaviors. 5) Record review revealed Resident ID #8 moved into the residence in January of 2024 with a diagnosis including, but not limited to, osteoporosis. Record review of the service plan, dated 11/21/2025, failed to reflect that the resident started PT and OT services with a start of care date of 11/22/2025. During a surveyor interview with the Resident Service Director on 12/18/2025 at approximately 8:45 AM, she acknowledged the resident started PT and OT services on 11/22/2025. She further could not provide evidence the service plan was updated to include the above services.	S 416		

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S 480	Continued From page 17	S 480		
S 480	Licensure Requirements 2.4.19.A Rights of Residents 2.4.19 (A) 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. This Requirement is not met as evidenced by: Based on surveyor observation and staff interview, it has been determined the residence failed to implement procedures to ensure that all of the residence's employees protect the resident's rights contained in these regulations and to observe the standards stated in R.I. Gen. Laws § 23-17.4-16 (a)(2)(ix) relative to identifying information for the residents listed in the facility's survey results binder. Findings are as follows: During a surveyor observation on 12/16/2025 at 8:06 AM of the residence's survey binder, a copy of the "Resident/Staff Roster(s)", dated 2/2/2022 and 1/23/2024, from the surveys were revealed. During a surveyor interview with the Administrator on 12/16/2025 at 12:37 PM, she could not provide evidence the residents' privacy was protected.	S 480	ID Tag S 480 Licensure Requirements 2.4.19.A Rights of Residents 2.4.19 (A) Rights of Residents. As set forth on Licensure Requirements 2.4.19. A Rights of Residents Section 2.4.19 (A) Rights of Residents within the state of Rhode Island regulations the community will ensure all of the employees protect the the resident's rights contained in these regulations and to observe the standards stated in R.I Gen. Laws 23-17-4-16 (a)(2)(ix) relative to identifying information for the residents listed in the facility's survey results binder. In responds to surveyor observation on 12/16/2025 the "Resident/Staff Roster(s)" from survey dated 2/2/2022 & 1/23/2024 will be removed from the facility's survey The Facility's survey binder will be audited by the Executive Director after every inspection results are placed to ensure the " Resident/Staff Roster(s)" is not present and resident's privacy is The community will Inservice administrative staff on Licensure Requirements 2.4.19.A Resident Rights	1/9/2026 1/31/2026 1/14/2026

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S 540	Continued From page 18	S 540	The Executive Director will review compliance at the Quarterly Quality Assurance Meeting.	
S 540	Residential Care Services 2.4.22.C(1-5) Illness And Emergencies 2.4.22 (C) (1-5) Reporting of Communicable Diseases C. Reporting of Communicable Diseases 1. Each residence shall report promptly to the Center for Acute Infectious Diseases Epidemiology (IDE), cases of communicable diseases designated as "reportable diseases" when such cases are diagnosed in the residence in accordance with Part 30-05-1 of this Title, Reporting and Testing of Infectious, Environmental and Occupational Diseases. 2. When infectious diseases present a potential hazard to residents or personnel, these shall be reported to the Center for Acute Infectious Diseases Epidemiology (IDE) even if not designated as "reportable diseases." 3. When outbreaks of food-borne illness are suspected, such occurrences shall be reported immediately to the Center for Acute Infectious Diseases Epidemiology (IDE) or to the Center for Food Protection. 4. Residences must comply with the provisions of R.I. Gen. Laws § 23-28.36-3, which requires notification of fire fighters, police officers and emergency medical technicians after exposure to infectious diseases. 5. Infection Control Infection control provisions shall be established for the mutual protection of residents, employees,	S 540	ID Tag S 540 Residential Care Services 2.4.22.C (1-5) Illness and Emergences Section 2.4.22.C (1-5) Reporting of Communicable As set forth on Residential Care Services 2.4.22.C(1-5) Section 2.4.22 C (1-5) Reporting of Communicable Diseases within the state of Rhode Island Regulations the community will ensure to establish infection control provisions for the mutual protection of residents, employees, and the public relative to developing by including protocols for transfer/discharge to home, hospitals, and/or nursing facilities of a resident with infections The Executive Director and the Resident Service Director will ensure the residence's "Policy and Procedure Manual" includes the protocols for transfer/discharge to home, hospitals, and/or nursing facilities of a resident with infections disease. The Executive Director or designee will review compliance at the quarterly Quality Assurance Meetings.	1/31/2026

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S 540	Continued From page 19 and the public. The residence shall be responsible for no less than the following: a. Establishing and maintaining a residence-specific infection prevention program; b. Establishing policies governing the admission and isolation of residents with known or suspected infectious diseases; c. Developing, evaluating and revising on a continuing basis infection control policies, procedures and techniques for all appropriate areas of the residence; d. Developing and implementing protocols for: (1) Discharge planning to home that include full instructions to the family or caregivers regarding necessary infection control measures; and (2) Hospital and/or nursing facility transfer of residents with infectious diseases which may present the risk of continuing transmission. Examples of such diseases include, but are not limited to, tuberculosis (TB), Methicillin resistant staphylococcus aureus (MRSA), vancomycin resistant enterococci (VRE), and clostridium difficile; This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined the facility failed to establish infection control provisions for the mutual protection of residents, employees, and the public	S 540		

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S 640	Continued From page 20 relative to developing and implementing protocols for transfer/discharge to home, hospitals, and/or nursing facilities, of residents with infectious diseases which may present the risk of continuing transmission such as tuberculosis (TB), Methicillin resistant staphylococcus aureus (MRSA), vancomycin resistant enterococci (VRI), and clostridium difficile. Findings are as follows: Review of the residence's "Policy and Procedure Manual" failed to include protocols for transfer/discharge to home, hospitals, and/or nursing facilities of a resident with infectious diseases. During a surveyor interview with the Administrator, in the presence of the Resident Service Director, on 12/18/2025 at approximately 4:00 PM, she could not provide evidence of the discharge planning protocols of residents with infectious diseases to home, the hospital, and/or a nursing facility.	S 640		
S 560	Residential Care Services 2.4.23.C Dietetic Services 2.4.23 (C) Dietetic Services C. The food service in each residence shall comply with the appropriate requirements of R.I. Gen. Laws Chapters 21-27 and 21-31, Part 50-10-1 of this Title, Rhode Island Food Code, and such other applicable statutory or regulatory provisions. This Requirement is not met as evidenced by:	S 560	ID Tag # S 560 Residential Care Services 2.4.23.C Dietetic Services As set forth by Residential Care Services 2.4.23.C Dietetic Services within the state of Rhode Island regulations the community will ensure the facility complies with all appropriate standards of the Rhode Island Food Code relative to the main	

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S 560	Continued From page 21 Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to comply with all appropriate standards of the Rhode Island Food Code relative to the main kitchen. Findings are as follows: Record review of the 2022 Food Code published by the U.S. Food and Drug Administration Section 2-301.14 When to Wash states in part, "...FOOD EMPLOYEES shall clean their hands and exposed portions of their arms as specified under § 2-301.12 immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS, and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES P and...(E) After handling soiled EQUIPMENT or UTENSILS..." During a surveyor observation, in the presence of the Director of Dining Services, during the initial tour of the main kitchen on 12/16/2025 at approximately 8:15 AM, revealed Dishwasher, Staff A, handling dirty dishes, rinsing his hands for a couple of seconds, then handling clean dishes. The Director of Dining Services acknowledged Staff A did not wash his hands when going from dirty dishes to clean. During a follow-up observation on 12/18/2025 at approximately 9:00 AM, Staff A was again handling dirty dishes, rinsing his hands for a couple of seconds, then handling clean dishes. Following the above observation, the Director of Dining Services could not provide evidence Staff A followed appropriate hand washing requirements.	S 560	The community will ensure all kitchen staff will be in serviced on the appropriate hand washing requirements to comply with the Rhode Island Food Code. The Director of Dining Services will spot check staff members on hand washing requirements weekly and educate as needed x 90 days. The Director of Dining Servies or designee and Executive Director will review compliance at the Quarterly Quality Assurance Meetings.	1/19/2026 4/30/2026

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