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 _____	10/16/2025

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 biennial State Licensure survey and a complaint/incident investigation survey (7OMG11, 10/16/2025) were conducted at this residence. Deficiencies were identified relative to the State Licensure survey.	S 003	Received NOV 13 2025 Facilities Regulation	
S 285	Residency Requirements 2.4.14.A Residency Requirements 2.4.14 (A) Residency Requirements A. Each licensee, or his/her designee, through the assessment and evaluation procedures delineated in these regulations (see § 2.4.16(C) of this Part) shall be responsible to ensure that admission to and residency in an assisted living residence be limited to those individuals who meet the definition of "resident" in accordance with § 2.3(A)(32) of this Part. This Requirement is not met as evidenced by: Based on record review, observation, and staff interview, it has been determined the residence retained a resident that that does not meet the definition of a resident as the staff utilizes a Hoyer lift for a singular resident reviewed for Hospice, Resident ID #1. Findings are as follows: The definition of a Resident states in part,"...means an individual not requiring medical or nursing care as provided in a health care facility but who as a result of choice and/or physical or mental limitation requires personal assistance, lodging and meals and may require the administration of medication and/or limited health services. A resident must be capable of self-preservation in emergency situations, unless	S 285	As of 10/22/25, Resident ID #1 transferred to Tockwotton's Nursing Home. As of 10/16/25, The Director of Wellness or his/her designee conducted an audit of all residents in the Courtyard Memory Care program and the River's Edge Assisted Living program to identify any other residents not meeting the criteria of a resident in Assisted Living residences. There were no other residents identified. As of 11/13/25, transfer and ambulation status of each resident will be added to the weekly Risk meetings to ensure each resident meets the definition of a resident in Assisted Living residences. To prevent re-occurrence moving forward, we are reviewing remarkable acuity issues both daily at morning meeting and weekly at our enhanced risk meetings, which will cover residents that either need a variance or elevated level of care or service. If during those meetings a resident needs a higher level of care than we can comfortably, safely, or legally provide, we will initiate those transition conversations with residents and/or POA, as appropriate.	10-22-25 10-16-25 11-13-25

11/28/25

Facilities Regulation

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

AL Admin 11/13/25

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S 285	Continued From page 1 the facility meets a more stringent Life Safety Code as required under R.I. Gen. Laws § 23-17.4-6(b)(3). Persons needing medical or skilled nursing care, including daily professional observation and evaluation, as provided in a health care facility, and/or persons who are bedbound or in need of the assistance of more than one (1) person for ambulation are not appropriate to reside in assisted living residences..." Record review revealed the resident moved into the residence in May of 2023 with a diagnosis including, but not limited to, vascular dementia. The resident resides on the secured memory unit and is receiving hospice services. Record review of the comprehensive assessment dated 6/26/2025 revealed the resident was admitted to hospice services on 1/20/2026. Further review of the assessment revealed the following: -Ambulation: total assist, bedbound -Transferring: total assist, Hoyer lift Record review of the care plan, last reviewed on 6/15/2025, reveals the resident requires the assist of two nursing assistants for transfers using the Hoyer lift. Record review of the progress note dated 4/30/2025 reveals a Hoyer lift manual with sling was delivered on this date, from the hospice agency. Record review failed to reveal the resident was appropriate for placement in an assisted living, as she/he "requires medical or skilled nursing care,	S 285 11/28/25	As of 11/13/25, the weekly Risk meeting minutes will be discussed and reviewed at the quarterly Quality Improvement Committee for at least three months.	11-13-25

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S 285	Continued From page 2 including daily professional observation and evaluation, as provided in a health care facility." During surveyor observations of the resident at approximately noon time on 10/14/2025 and on 10/15/2025 the resident was sleeping in bed. During a surveyor interview on 10/16/2025 at 11:40 AM with the Administrator, she acknowledged the resident is receiving limited health services, hospice services, is bed bound, and requires a Hoyer lift for transfers.	S 285		
S 375	Residency Requirements 2.4.16.F Resident Assessment/Service Plans 2.4.16 (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;	S 375	As of 10/16/25, the most recent 90-day reviews of resident ID #'s 2, 3 and 4 were updated to include vitals. The 90-day reviews on all other residents in the Courtyard Memory Care program and the River's Edge Assisted Living program dated from 10/16/25 to current, have been updated to include vitals. As of 10/16/25, the 90-day review form has been updated to include vitals. As of 11/13/25, the Administrator or his/her designee will review 90-day forms weekly at Risk meetings, corrections will be made as discovered, and remarkable issues will be discussed at quarterly QI meetings for at least three months.	10-16-25 11-13-25

MENT OF DEFICIENCIES AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(5) Follow up on previous recommendations;

(6) Provide a signed, written report in the residence documenting:

(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 or more licensed registered nurses (i.e., at least one full-time equivalent equal to thirty-five (35) hours) on- site, the nurse review shall be completed at

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S 375	Continued From page 4 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 the residence failed to ensure that nurse reviews held the required components for 4 of 4 sample residents with nurse reviews, Resident ID #s 1, 2, 3, and 4. Findings are as follows: 1. Record review revealed Resident ID #1 moved into the residence in May of 2023. A "Nurse Review" was completed on 8/13/2025. 2. Record review revealed Resident ID #2 moved into the residence in July of 2025. A "Nurse Review" was completed on 10/8/2025. 3. Record review revealed Resident ID #3 moved into the residence in May of 2025. A "Nurse Review" was completed on 8/19/2025. 4. Record review revealed Resident ID #4 moved into the residence in November of 2024. "Nurse Reviews" were completed on 5/30/2025, 8/29/2025, and 10/15/2025. Record review of the above residents' "Nurse Review(s)" failed to reveal evidence of a physical assessment of each resident, as required. During a surveyor interview on 10/14/2025 at approximately 12:40 PM, with the Wellness Director, in the presence of the Administrator, she was unable to provide evidence that the "Nurse Reviews" were completed with all required components.	S 375		

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S 565	Residential Care Services 2.4.24.B.1 Medication Services 2.4.24 (B) (1) Administration of Medications 1. Residences licensed at the M1 level may administer medications to residents including, but not limited to, removing medication containers from storage, assisting with the removal of a medication from a container for residents with disability which prevents independence in this act, and/or administering the medication directly to the resident. a. The resident or guardian must provide written authorization for the residence to provide administration of medications. b. Medications shall be administered in accordance with written orders of a physician. The residence must provide in writing, a description of services provided by the residence to each physician, including limitations on service. c. All medications must be checked against a physician's orders by a licensed nurse, or pharmacist. d. The resident must be identified prior to administration of any medication. e. The medication must be in the original pharmacy-dispensed container with proper label and directions attached and be administered in accordance with such label. f. Injectable medications, including but not limited to insulin, which cannot be self-administered by the resident, must be administered by a licensed nurse.	S 565 11/28/25	Resident ID #5's medications, including PRN medication are available and all physician orders match the medication label and the Medication Administration Record. As of 10/16/25, Resident ID #1'S Humalog pen has been dated, the Breo Ellipta inhaler was discarded, and Resident ID #'s 1 and 2 physician orders match the medication label and the Medication Administration Record. From 10/27/25- 10/31/25, A Pharmerica Nurse consultant was hired to do an audit of all medication carts for both River's Edge Assisted Living and the Courtyard Memory Care program. All findings are currently being corrected. The overnight medication technicians will continue to do weekly cart audits by floor. In addition to this, as of 11/13/25, the Wellness Director or his/her designee will audit 4 resident MAR's weekly to ensure compliance, as well as perform daily checks of the medication technicians reconciliation form located on each cart. In addition, a med tech meeting will be held on 11/14 to re-educate all medication technicians on the proper standard for medication administration procedures. As of 11/13/25, the cart audits will be brought to the Quality Assurance Committee for three months.	10-16-25 11-13-25

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S 565	Continued From page 6	S 565		

g. There shall be written a policy/procedure for the disposal of hypodermic needles, syringes and other such instruments that is in compliance with rules and regulations governing Hypodermic Needles, Syringes & Other Such Instruments (Part 20-15-6 of this Title).

(1) The legal destruction of hypodermic needles, syringes or other such instruments is the responsibility of the last entitled or authorized possessor.

(AA) All personnel or residents legally authorized to use disposal syringes and needles, shall destroy them after one (1) use.

(BB) Excess and undesired needles, syringes and other such instruments shall be stored in impervious, rigid, puncture- resistant container for disposal. Intact needles shall be placed directly into the collection containers.

(CC) Personnel handling disposal waste materials such as needles, syringes, and other such instruments may treat and destroy such waste by a DEM-approved alternative treatment/destruction technology or prepare the regulated medical waste for off-site transport by a DEM-permitted medical waste transporter.

h. Individual medication records must be retained for each resident to whom medications are being administered and each dose administered to the resident must be properly recorded.

i. Any medication administered by the residence and refused by a resident shall be

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S 565	Continued From page 7 documented and reported, as appropriate. j. Medications shall be stored securely and in such a manner to prevent spoilage, dosage errors, administration errors, and/or inappropriate access. Provisions for safe storage may include lockable containers, secure spaces, or lockable units, as appropriate to the residence and the resident population. k. All medication in the residence, regardless of whether controlled by employees or by the resident, shall be stored securely as stated in § 2.4.24(A)(3)(a)(8) of this Part. l. All centrally stored medications shall be maintained in accordance with manufacturer's labeling and administered by authorized personnel. This Requirement is not met as evidenced by: Based on surveyor observation, record review, and staff interview, it has been determined that the residence failed to ensure medications shall be stored securely and in such a manner to prevent spoilage, dosage errors, administration errors, and/or that medications were appropriately reconciled, administered, and disposed of in accordance with regulations for Resident ID #s 1, 2, 5, and 6. Findings are as follows: According to Basic Nursing, Mosby 3rd edition, "the registered nurse checks all transcribed orders against the original order for accuracy and	S 565		

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S 565	Continued From page 8 thoroughness. If an order seems incorrect or inappropriate, the nurse consults the physician." 1) Resident ID #5's Medication Administration Record (MAR) reveals the following medication: a. CoQ10 (coenzyme supplement) take 30 milligrams (mg) daily. During a surveyor observation on 10/15/2025 at 12:20 PM, the CoQ10 bottle in the medication cart read CoQ10 100 mg daily. During a surveyor interview with Licensed Practical Nurse, Staff A, following the above observation, he acknowledged the MAR read CoQ10 30 mg daily and the residence was administering 100 mg daily to the resident. During a surveyor interview with the Wellness Director on 10/15/2025 at approximately 2:00 PM, she was unable to provide evidence the residence reconciled the medications available to the physician's orders b. Calcium Citrate (a form of dietary supplement that provides calcium, an essential mineral for bone health) 250 mg daily. Record review of the MAR revealed this medication was unavailable on 10/11/2025, 10/12/25, 10/14/2025, and 10/15/2025; however, it was documented as given on 10/13/2025. During a surveyor interview on 10/15/2025 at 12:30 PM with Certified Medication Technician, Staff B, she could not provide evidence that Calcium Citrate was available to the resident, as prescribed.	S 565		

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S 565	Continued From page 9 c. Loratadine (used to treat symptoms of allergies) 10 mg daily. Record review of the MAR revealed this medication was unavailable on 10/11/2025, 10/12/2025, and 10/14/2025: however, it was documented as given on the 13th and 15th. During a surveyor observation of the medication cart, there was no evidence the resident's Loratadine was available to be administered. During a surveyor interview on 10/15/2025 at 12:30 PM with Staff B, she could not provide evidence that Loratadine was available to the resident on the above-mentioned dates. d. Muscle rub (methyl salicylate-menthol) [OTC] (over the counter) cream 15-10% for pain, administer every 8 hours as needed. During a surveyor observation of the medication cart, there was no evidence of the resident's muscle rub being available to be administered. During a surveyor interview on 10/15/2025 at 12:30 PM with Staff B, she could not provide evidence that muscle rub was available to the resident. e. Senna 8.6 milligram tablet, administer 2 tablets every 8 hours as needed. During a surveyor observation of the medication cart, there was no evidence of the resident's Senna being available to be administered. During a surveyor interview on 10/15/2025 at 12:30 PM with Staff B, she could not provide evidence that the Senna tablets were available to	S 565		

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S 565	Continued From page 10 the resident. 2) During a surveyor observation on 10/14/2025 at 11:45 AM of the 4th floor medication refrigerator revealed a Humalog insulin KwikPen opened and not dated. Manufacturer's instructions state once opened it is good for up to 28 days. During a surveyor interview following the above observation with Licensed Practical Nurse, Staff A, he could not provide evidence that the insulin pen was dated when opened. 3) During a surveyor observation on 10/14/2025 at approximately 12:15 PM of the overstock closet on the second floor, a Breo Ellipta inhaler was opened and not dated. Manufacturer's directions indicate to discard the inhaler 6 weeks after opening. During a surveyor interview on 10/14/2025 at approximately 12:15 PM with Staff B, she could not provide evidence that the inhaler was dated after being opened. 4) Record review of Resident ID #2 's MAR revealed the resident is prescribed Acetaminophen 325 mg tablet, take 2 tablets every 4 hours as needed. During a surveyor observation of the resident's Acetaminophen card, it stated Acetaminophen 325 mg tablet, take 1 tablet every 4 hours as needed. During a surveyor interview with CMT, Staff C, on 10/14/2025 at approximately 12:15 PM, she acknowledged the order for the acetaminophen did not match the label on the medication.	S 565		

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S 565	Continued From page 11 5) Record review of Resident ID #1's MAR revealed the resident is prescribed Senna Plus 8.6-50 mg tablet, administer 2 tablets daily at 8:00 AM. During a surveyor observation of the resident's Senna plus card, it stated Senna Plus take 2 tablets daily at bedtime. During a surveyor interview with Staff C on 10/14/2025 at approximately 12:15 PM, she acknowledged the above-mentioned medication card did not have the correct dosage instructions and should be administered at 8:00 AM and not at bedtime. During a surveyor interview with the Wellness Director on 10/16/2025 at approximately 11:00 AM, she could not provide evidence the medications listed above were transcribed, stored, administered, and reconciled appropriately, as required.	S 565		
S 705	Physical Plant 2.4.30.I Safety Requirements 2.4.30 (I) Safety Requirements I. Each residence shall develop and maintain a written plan and procedure for the evacuation of the premises in case of fire or other emergency, based on F1 / F2 licensure requirements, Fire Safety Code-General Provisions (R.I. Gen. Laws Chapter 23-28.1) requirements. 1. Emergency steps of action shall be clearly outlined and posted in conspicuous locations throughout the residence.	S 705	As of 10/16/25, the emergency floor plans that were taken down when re-painting, have been placed back up on each floor. No residents were affected. As of 11/13/25, weekly visual checks of the emergency floor plans by the Director of Maintenance or his/her designee will be done to ensure compliance. As of 11/13/25, these weekly audits will be brought to the Quality Improvement Committee for three months.	10-16-25 11-13-25

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S 705	Continued From page 12 2. Drills simulating fire emergencies, testing the effectiveness of the fire evacuation plan shall be conducted at least six (6) times per year on a bimonthly basis with a minimum of two (2) drills conducted during the night when residents are sleeping with documentation of observed ability of residents to carry out evacuation procedures. At least fifty percent (50%) of these drills shall be obstructed drills, as defined in Fire Safety Code-General Provisions (R.I. Gen. Laws Chapter 23-28.1). 3. The drills shall be permitted to be announced in advance to the residents. The drills shall involve the actual evacuation of all residents to an assembly point as specified in the emergency plan and shall provide residents with experience in egressing through all exits and means of escape required by the Fire Safety Code-General Provisions (R.I. Gen. Laws Chapter 23-28.1). Exits and means of escape not used in any fire drill shall not be credited in meeting the requirements of the Fire Safety Code-General Provisions (R.I. Gen. Laws Chapter 23-28.1). a. Documentation of fire drills shall be maintained and shall include no less than the following information: (1) Name of the person conducting the drill; (2) Date and time of the drill; (3) Amount of time taken to evacuate the building or unit; (4) Type of drill (i.e., obstructed or unobstructed); (5) Record of problems encountered and steps taken to rectify them;	S 705		

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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 705	Continued From page 13 (6) Employee observation of each resident's ability to carry out evacuation procedures. 4. Residents shall be instructed in all alternative methods of escape since the primary exit may be unusable due to fire and/or smoke. Such instruction shall be documented in the record described in § 2.4.30(l)(3)(a) of this Part. 5. Each new resident shall be oriented to the fire drill procedure on admission, with documentation of the orientation placed in the resident's record. This Requirement is not met as evidenced by: Based on surveyor observation and staff interview, it has been determined the residence failed to post emergency steps of action in conspicuous locations throughout the residence. Findings are as follows: During the initial tour of the residence on 10/14/2025 at 9:25 AM, this surveyor did not observe any posted emergency floor plans on the first floor, the second floor, the fourth floor, and the fifth floor. During a surveyor interview with the Administrator on 10/14/2025 at 9:55 AM, she acknowledged there were no emergency floor plans posted throughout the residence.	S 705		
S 730	Practices and Procedures, Violations, Sa 2.4.32.B Variance Procedure	S 730		

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S 730	Continued From page 14 2.4.31 (B) Variance Procedure B. A request for a variance shall be filed by a high managerial agent of the assisted living residence in writing, and must set forth in detail the basis upon which the request is made including: 1. Identification of the specific regulatory section(s) herein; 2. Alternative actions, processes, or procedures that through the facility's implementation will facilitate compliance with the specific regulatory intent, and how the Residence will ensure staff awareness and training regarding the variance, when appropriate. 3. A variance period shall not exceed the assisted living residence's license period. An assisted living residence must request renewal of the variance when it submits its annual license renewal application. 4. Upon the filing of each request for variance with the Department, and within a reasonable time thereafter, the Department shall notify the applicant by certified mail of its approval or in the case of a denial, a hearing date, time and place may be scheduled if the residence appeals the denial and held in accordance with the provisions of § 2.4.33 of this Part. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined that the residence failed to submit a variance for approval from the	S 730	As of 11/13/25 variances were sent in for Resident ID #'s 7 and 8. As of 11/13/25, an audit was done of all residents in Courtyard Memory Care and River's Edge Assisted Living who are on outside services to determine if there were any more outstanding variances needed -- no outstanding variances were needed. As of 11/13/25, once outside services start, The Wellness Director or his/her designee, will put an order in the EMAR prompting the nurse to do a variance starting at the 40-day mark. In addition, variances will be discussed in our weekly Risk meetings. To ensure compliance with acuity and variance parameters, updates will be made when discovered or scheduled, either after learning of an issue during Risk audit processes, or when prompted by our variance schedule that has been newly implemented. As of 11/13/25, variance audits and Risk meeting minutes will be brought to the Quality Improvement Committee for three months to ensure system compliance.	11-13-25

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S 730	Continued From page 15 Department for 3 of 3 resident's reviewed for hospice/palliative services, Resident ID #'s 1, 5, and 6. Findings are as follows: Per the Rules and Regulations for Licensing assisted Living Residences, " ...an established resident may receive daily skilled nursing care or therapy from a licensed health care provider for a condition that results from a temporary illness or injury for up to forty-five (45) days subject to an extension of additional days as approved by the Department, or if the resident is under the care of a Rhode Island licensed hospice agency provided the assisted living residence assumes responsibility for ensuring that the required care is received. Furthermore, a new resident may receive daily therapy services and/or limited skilled nursing care services, as defined through these Regulations, from a Rhode Island licensed health care provider for a condition that results from a temporary illness or injury for up to forty-five (45) days subject to an extension of additional days as approved by the Department..." 1) Record review revealed Resident ID #1 moved into the residence in May of 2023 with a diagnosis of vascular dementia. Record review revealed the resident was admitted to hospice services on 1/20/2025. Record review failed to reveal evidence an approved variance for hospice services provided by an outside agency was obtained from the Department, as required. 2) Record review revealed Resident ID #7 moved into the residence in June of 2023 with a	S 730		

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S 730	Continued From page 16 diagnosis of malignant neoplasm of the thyroid gland. Record review revealed the resident was admitted to palliative care services on 6/19/2023. Record review failed to reveal evidence of an approved variance for palliative care services provided by an outside agency was obtained from the Department, as required. 3) Record review revealed Resident ID #8 moved into the residence in December of 2024 with diagnoses including, but not limited to, tight proximal esophageal stricture (a severe narrowing of the upper part of the esophagus that makes swallowing very difficult and can cause pain, regurgitation, and weight loss) and Zenker's diverticulum (food, pills, and even thick mucus can get stuck in the pouch instead of going through the esophagus). Record review failed to reveal evidence of an approved variance for palliative care services provided by an outside agency was obtained from the Department, as required. During a surveyor interview on 10/15/2025 at approximately 2:00 PM with the Administrator, she acknowledged the above-mentioned residents are receiving hospice/palliative services. Additionally, she was unable to provide evidence an approval was obtained from the Department, as required.	S 730	11/26/25	
S 920	Limited Health Services Lincense Require 2.6.2.N Specific Requirements 2.6.2 (N) Specific Requirements	S 920	As of 10/16/25, the Quality Improvement Committee meeting was moved to a Tuesday to allow for the meeting to align with the Nurse Practitioners schedule.	10-16-25

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S 920	Continued From page 17 N. All limited health services shall operate and provide services in accordance with the prevailing community standard of care. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined the residence, which is licensed to provide limited health services, failed to have a licensed physician, a certified nurse practitioner, or a licensed physician assistant as a member of the Quality Improvement Committee. Findings are as follows: Record review of the attendance for the Quality Improvement committee meetings on 1/23/2025, 4/28/2025, and 7/31/2025, failed to reveal a licensed physician, a certified nurse practitioner, or a licensed physician assistant in attendance, as required. During a surveyor interview with the Administrator on 10/16/2025 at 9:20 AM, she could not provide evidence a licensed physician, a certified nurse practitioner, or a licensed physician assistant were in attendance at the Quality Improvement meetings, as required.	S 920	No residents were affected. As of 10/16/25, the Administrator or his/her designee will ensure that the Nurse Practitioner or the Physician, attend the quarterly Quality Improvement Committee meetings.	

11/28/25