RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01378	A. BUILDING: _____ B. WING _____	C 01/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGE AT CHERRY HILL, THE	ONE CHERRY HILL ROAD JOHNSTON, RI 02919

(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 102670, 102713, 102760, and 102879, was conducted at this residence on 01/27/2026 through 01/28/2026 to determine compliance with state regulations. A deficiency was identified.	S 003	Received FEB 19 2026 Facilities Regulation	
S 210	Organization And Management 2.4.13.H Administrative Management 2.4.13 (H) In-service Training 1. Employees shall have on-going, at intervals not to exceed twelve (12) months, in-service training as appropriate for their job classifications and including the topics cited in § 2.4.12(G) of this Part. 2. All new employee orientation and on-going in-service training shall be documented in the employee's personnel file, and maintained onsite at the licensed residence. 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 employees shall have on-going, at intervals not to exceed twelve (12) months, in-service training in all required topics for 2 of 2 staff reviewed for on-going training, Staff A and B. Findings are as follows: Review of a facility reported incident sent to the Rhode Island Department of Health on 1/15/2026 revealed issues with documentation and insulin	S 210	Received FEB 19 2026 Facilities Regulation **A. With Respect to the Specific Regulation Cited:** S 210 Organization and Management 2.4.13.H Administrative Management **B. With Respect to how the Facility will identify and take correction action:** All associates will have on-going in-service training during the 12 month interval. New associates will be in compliance upon finishing orientation.	ongoing

Facilities Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: MaryAnn Grace — TITLE: Executive Director — (X6) DATE: 2/18/26

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S 210	Continued From page 1 administration by Licensed Practical Nurse (LPN) Staff A. These issues were identified due to a previous survey that resulted in weekly audits of documentation of fingersticks and insulin administration. Record review of personnel records and facility in-service training documents failed to reveal the following staff were in-serviced on all required topics identified in 2.4.13G1 and 2.4.13G2: a. Fire prevention; b. Recognition and reporting of abuse, neglect, and mistreatment; c. Assisted living philosophy (goals/values: dignity, independence, autonomy, choice); d. Resident's rights; e. Confidentiality; f. Emergency preparedness and procedures; g. Medical ~~emergency procedures~~; h. Infection control policies and procedures; i. Resident elopement; j. Basic sanitation; k. Food service; l. Basic knowledge of cultural differences; m. Basic knowledge of aging-related behaviors including dementia and Alzheimer's disease; n. Personal assistance; o. Assistance with medications; p. Safety of residents; q. Body Mechanics; i. Resident Transfers (required for residences licensed at the F1 level for fire safety); j. Record-keeping; k. Service plans; and l. Internal reporting. 1. Staff A was hired on 6/6/2018 as a LPN. Record review revealed one training on code of	S 210	**C. With Respect to What Systemic measures to be put in place to address the stated concern:** All associates will be required to sign an in-service sheet and placed in their personnel file. If the associate is unable to associate is unable to attend the inservice, the associate will make arrangements to ensure compliance. **D. With Respect to How the Plan Of Corrective Measures will Be monitored:** The in-services will be held in intervals not to exceed 12 months. An audit will take place on a quarterly basis and be made part of the QMPI process. 2/19/26	on-going on-going

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S 210	Continued From page 2 conduct, dated 6/25/2025, which is not required. 2. Staff B was hired on 5/23/2024 as an LPN. Record review failed to reveal required in-service trainings for the year of 2025. During a surveyor interview with the Administrator on 1/28/2026 at approximately 3:15 PM, she acknowledged the annual trainings for the above-mentioned staff had not been completed, as required.	S 210		