RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01308	A. BUILDING: _____ B. WING _____	05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST FARM ASSISTED LIVING	191 FOREST AVENUE MIDDLETOWN, RI 02842

(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 (TKXS11, 05/14/2025) were conducted at this residence. Deficiencies were identified relative to the State Licensure survey.	S 003	The filing of this Plan of Correction does not constitute that the deficiency alleged did in fact exist, rather this POC is filed as evidence of the facility's continuing commitment to high quality resident care in full compliance with state regulations.	
S 230	Organization And Management 2.4.13.A Management Of Services 2.4.13 (A/B) Management of Services A. Each residence shall provide services with adequate professional and ancillary employees and in accordance with applicable state law. Further, the residence shall assure that all services are rendered in a safe and effective manner and consistent with the requirements herein. The residence shall provide all care and services to all residents 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 failed to provide care and services in accordance with the prevailing community standard of care relative to administering medications in accordance with written physician's orders for the singular resident reviewed for self-administration, Resident ID #1.	S 230	Received JUN 03 2025 Facilities Regulation	

Facilities Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jennifer Mello — TITLE: Administrator — (X6) DATE: 06/02/2025

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S 230	Continued From page 1 Findings are as follows: According to Mosby's 4th Edition, Fundamentals of Nursing, page 314 states in part, "...The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm the clients..." During the entrance conference on 5/13/2025 at approximately 8:00 AM, the Executive Director indicated the residents that self-administer their medications. Record review revealed Resident ID #1 moved into the residence in March of 2021 with diagnoses including, but not limited to: hypertension, atrial fibrillation (a-fib), and osteoarthritis. Review of the medical information form dated 4/8/2021 revealed the resident is able to self-administer his/her medications. During a surveyor observation of the resident on 5/14/2025 at 2:26 PM, he/she was receiving oxygen through a nasal canula. He/she revealed that he/she has been on oxygen for years. Record review of the resident's active physician's orders failed to reveal an order for oxygen. During a surveyor interview on 5/14/2025 at approximately 2:40 PM with the Executive Director, she was unable to provide evidence that the resident has an active physician's order for oxygen.	S 230	Physician's orders for self-administration of medications will be obtained. A consent form will be obtained upon admission and will be updated by the PCP upon resident significant change. Audits for physician's orders will be conducted on all resident records. Orders will be compared to the EMR as well as the PCP after-visit paperwork for accuracy. Medications and medication orders wil be reconciled following physician appointments and during quarterly/yearly assessments and upon significant change. Audits will be conducted monthly x3 and quarterly x2 or until compliance has been met. The DNS or designee will report results at the quarterly QAPI meeting x4.	07/15/25

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S 365	Continued From page 2	S 365		
S 365	Residency Requirements 2.4.16.D Resident Assessment/Service Plans 2.4.16 (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 twelve (12) months and each time a resident's condition changes significantly for 4 of 4 sample residents reviewed, Resident ID #s 1, 2, 3, and 4. Findings are as follows: 1) Record review revealed Resident ID #1 moved into the residence in March of 2021 with diagnoses including, but not limited to: hypertension, atrial fibrillation (a-fib), and osteoarthritis. The last comprehensive assessment in the resident's chart was dated 2/24/2021. 2) Record review revealed Resident ID #2 moved into the residence in November of 2018 with diagnoses including, but not limited to: autism spectrum disorder, anemia, and bladder cancer.	S 365	Yearly resident assessments will be completed uon admission and annually thereafter. The Administrator and DNS will pull a report monthly from the EMR to ensure completion of assessments for accuracy. The report will be reviewed at the quarterly QAPI meeting. Audits will be conduced monthly x3, quarterly x3, or until compliance has been met. The DNS or designee will report results at the quarterly QAPI meeting x4.	07/15/25

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S 365	Continued From page 3 The last comprehensive assessment in the resident's chart was dated 8/21/2018. 3) Record review revealed Resident ID #3 moved into the residence in October of 2019 with diagnoses including, but not limited to: a-fib and chronic obstructive pulmonary disease (COPD). The last comprehensive assessment in the resident's chart was dated 10/3/2019. 4) Record review revealed Resident ID #4 moved into the residence in December of 2018 with diagnoses including, but not limited to: a-fib, COPD, and congestive heart failure. The last comprehensive assessment in the resident's chart was dated 11/29/2018. During a surveyor interview with the Executive Director on 5/14/2025 at 2:30 PM, she acknowledged that the above-mentioned residents failed to have comprehensive assessments completed upon change of condition or at intervals not to exceed 12 months in their charts.	S 365		
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:	S 375		

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S 375	Continued From page 4 (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: (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;	S 375		

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S 375	Continued From page 5 (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 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 nurse reviews were completed at least once every ninety (90) days for four of four sample residents reviewed, Resident ID #s 1, 2, 3, and 4. Findings are as follows: The following resident records failed to have evidence of nurse reviews: 1) Record review revealed Resident ID #1 moved into the residence in March of 2021 with diagnoses including, but not limited to: hypertension, atrial fibrillation (a-fib), and osteoarthritis. 2) Record review revealed Resident ID #2 moved into the residence in November of 2018 with diagnoses including, but not limited to: autism spectrum disorder, anemia, and bladder cancer.	S 375	90-Day resident assessments will be completed every quarter and upon any change in condition. The Administrator and DNS will pull a report monthly from the EMR for accuracy to ensure completion of assessments. The report will be reviewed at the quarterly QAPI meeting. Audits will be conducted monthly x3, quarterly x2 or until compliance has been met. The DNS or designee will report results at the quarterly QAPI meeting x4.	07/28/25

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S 375	Continued From page 6 3) Record review revealed Resident ID #3 moved into the residence in October of 2019 with diagnoses including, but not limited to: a-fib and chronic obstructive pulmonary disease (COPD). 4) Record review revealed Resident ID #4 moved into the residence in December of 2018 with diagnoses including, but not limited to: a-fib, COPD, and congestive heart failure. During a surveyor interview on 5/14/2025 at 2:30 PM with the Executive Director, she was unable to provide evidence that the above-mentioned residents' nurse reviews were completed at least once every ninety days, as required.	S 375		
S 555	Residential Care Services 2.4.24.A.3.a Medication Services 2.4.24 (A) (3) (a) Medication Services 3. Each residence shall provide medication services only in accordance with the appropriate level of licensure for which the residence is licensed, which shall be as follows: a. For assisted living residences licensed at the M2 Level, assistance with self- administration by unlicensed employees means that the residence shall only be responsible for reminding residents to take medications, and: (1) The resident or guardian must provide written authorization for the residence to provide assistance with the self-administration of medications; (2) The residence must provide, in writing, a description of services provided by the	S 555		

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S 555	Continued From page 7 residence to each physician prescribing for a resident, including limitations on services; (3) Employees may only remind the resident and observe the self- administration of medication; (4) The resident shall not require nursing assessment of health status before receiving the medication, nor nursing assessment of the therapeutic or side effects after the medication is taken; (5) Except as provided in § 2.4.24(A)(3)(a)(7) of this Part, the medication shall be in the original pharmacy-dispensed container with proper label and directions attached; (6) Unlicensed employees shall not monitor health indicators, make medication decisions, adjust medications or provide other medical or nursing decisions; (7) For residents capable of self-administration of medication but who wish to ask assisted living residence employees to use a medi-set (pre-poured packaging distribution system), only registered medication aide, licensed nurse, or pharmacist shall organize the medications for up to one (1) week; (8) All medication in the residence, regardless of whether controlled by employees or by the resident, shall be stored securely. All medications shall be stored in a manner to prevent spoilage, dosage errors, administration errors or inappropriate access by other residents, visitors, or unauthorized employees. Provisions for safe storage may include lockable containers,	S 555		

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S 555	Continued From page 8 secure spaces, or lockable units, as appropriate to the residence and the resident population. (9) There shall be documented policies or procedures regarding medication disposal and inventory procedures in the policies and procedures manual. (10) Each person assisting residents with self-administration of medications shall: (AA) Be an employee of the residence; (BB) Be literate in English; and (CC) Receive orientation, instruction and on-the-job training regarding relevant policies and procedures; or (DD) Be a licensed nurse. (EE) M2 level facilities may limit record keeping for residents who retain possession and control of medications to the requirements of § 2.4.15(A)(6) of this Part. This Requirement is not met as evidenced by: Based on surveyor observation and staff interview, it has been determined the residence failed to ensure that medications shall be stored securely and in such a manner to prevent spoilage, dosage errors, administration errors, and/or inappropriate access for the singular medication cart observed.	S 555	The med cart will be inspected weekly x4 bi-weekly x4, monthly x4 and quarterly thereafter. All results will be reported at the quarterly QAPI meeting x4.	07/15/25

6/3/25

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S 555	Continued From page 9 Findings are as follows: During a surveyor observation of the medication cart on 5/13/2025 at 9:06 AM in the presence of Certified Medication Technician, Staff B, the following was revealed: -senna plus with an expiration date of 2/2025. -tylenol PM bottle, without a resident identifier and directions for use. -melatonin bottle, without a resident identifier and directions for use. -chest congestion relief with a faded label, unable to be read. Immediately following the observation, Staff B, acknowledged that the senna plus was expired, the tylenol and melatonin bottles did not have a resident identifier or directions for use, and the chest congestion relief, had a faded label that was unable to be read. During a surveyor interview on 5/13/2025 at approximately 11:00 AM with the Executive Director, she could not provide evidence the above-mentioned medications were stored appropriately, as required.	S 555		
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	S 705		

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S 705	Continued From page 10 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. 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;	S 705		

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S 705	Continued From page 11 (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; (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 record review and staff interview, it has been determined the residence failed to ensure documentation of the person conducting the drill as defined in Fire Safety Code-General Provisions (R.I. Gen. Laws Chapter 23-28.1). Findings are as follows: Record review revealed fire drills were conducted on the following dates in 2024 and 2025: 3/23/2024, 4/25/2024, 6/10/2024, 7/26/2024, 10/10/2024, 12/20/2024, 1/25/2025, and 3/21/2025. Further record review of the fire drill documentation failed to reveal who conducted the	S 705	Although fire drills were conducted as required, upon notification the form was changed to include a line for the name of the person conducting the drill. The Administrator or designee will report compliance at the quarterly QAPI meetings x4.	05/20/25

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S 705	Continued From page 12 drills on the above-mentioned dates. During a surveyor interview on 5/13/2025 at 12:32 PM with the Executive Director, she acknowledged the fire drill documentation failed to contain all required components. She further indicated that she conducts the drills during the hours she is present; however, she could not identify which staff conducted the drills on the other dates.	S 705		

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S 003	Initial Comments An unannounced complaint/incident investigation survey and a biennial State licensure survey (H7CG11, 05/14/2025) were conducted at this residence. A deficiency was identified relative to the complaint/incident survey.	S 003		
S 275	Organization And Management 2.4.13.K Management Of Services 2.4.13 (K) Advance Directives 1. The residence shall have written policies and procedures that address advanced directives that shall include, but not be limited to, sufficient instructions for employees to follow in the event of emergencies and the resuscitation of residents. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined the residence failed to have written policies and procedures that address advanced directives with sufficient instructions for employees to follow relative to the singular resident reviewed for emergency medical care, Resident ID #2. Findings are as follows: Record review of an initial report sent to the Rhode Island Department of Health on 2/5/2025 revealed that Resident ID #2 was found unresponsive. According to the Springhouse Illustrated Manual of Nursing Practice, 2002, which states in part, "you must initiate CPR (cardiopulmonary resuscitation) as soon as possible after cardiac	S 275	Policies/procedures for advance directives will be reviewed and edited if needed, to include clear and sufficient instructions for employees to follow. All staff will be retrained on the use of the AED as well as re-educated on the Emergency Response instructions. Over the next 30 days an audit will be conducted of all resident records. Upon their annual PCP visit, a request will be sent to the PCP to address code status for any resident without a code status identified. An audit will be conducted to ensure all facesheets and code status paperwork are placed in resident apartments as well as the Wellness Office. Results of all audits will be reported at the quarterly QAPI meeting x4.	07/15/25

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

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and respiratory arrest begin. If you have any doubt about how long the patient's pulse and respirations have been absent, you should still go ahead and perform CPR."

According to the residence's policy titled, "MEDICAL EMERGENCY RESPONSE PROCEDURE" updated on 9/8/2024, states in part,"...THE FIRST PERSON AT THE SCENE OF A MEDICAL EMERGENCY Will initiate call for assistance...If there are no staff members within hearing distance, Call staff on walkie talkie and give location. Call 911. If needed, obtain code status. Begin immediate assistance to the resident as required by situation and code status. THE NEXT LICENSED PERSON ARRIVING AT THE SCENE Will assist as needed Record details of the emergency..."

According to the residence's policy titled, "ADVANCE DIRECTIVE/MOLST POLICY" updated on 5/29/2022, states in part, "...The advance directives are indicated on the Resident Face Sheet in the Wellness Office. The Face Sheet is also in the resident's apartment. In the event of an emergency, the staff and the rescue personnel can consult this document for advance directives...Staff will respond to emergency situations as indicated by advance directives..."

Record review revealed the resident moved into the residence in November of 2018 with diagnoses including, but not limited to: autism spectrum disorder, anemia, and bladder cancer.

Further review of the record revealed the resident's face sheet, which indicated the resident is a full code (a medical term that indicates a patient's wishes to receive all possible medical interventions, including CPR, in the event of a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01308	A. BUILDING: _____ B. WING _____	C 05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST FARM ASSISTED LIVING	191 FOREST AVENUE MIDDLETOWN, RI 02842

(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 275	Continued From page 2 cardiac or respiratory arrest). During a surveyor interview on 5/14/2025 at 9:46 AM with Staff A, Nursing Assistant (NA), she indicated the resident was walking outside up and down as he/she normally does. She indicated the resident was short of breath (SOB) when he/she came back into the residence. She indicated that she asked Staff B, Certified Medication Technician, if she thought the resident was ok. She indicated Staff B made reference that the SOB could have been from him/her walking outside and that they would keep an eye on him/her. Staff A indicated she went to check on him/her during lunch. She revealed she found him/her in the sunroom unresponsive. Additionally, she indicated that she assumed the resident was a Do Not Resuscitate (DNR) when she encountered the resident unresponsive and further indicated that she did not and would not do CPR on him/her without the resident having a pulse. She further indicated that she let Staff B know that the resident was downstairs and did not call 911. Staff A did not know the resident's code status. During a surveyor interview on 5/14/2025 at 10:10 AM with Staff B, she revealed that during lunch, she realized the resident had not come upstairs. She had Staff A go downstairs to check on him/her when there was a lull in service. She revealed Staff A through the walkie stated, "can you come downstairs?" She revealed that she could not go downstairs right away because someone had to remain in the dining room during service. She indicated Staff A came back upstairs to let her know that the resident was unresponsive. She indicated that she let the Director of Nursing know and she immediately went downstairs to the resident and found	S 275		

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S 275	Continued From page 3 him/her unresponsive. 911 was called. She indicated the resident didn't look good and was drooling from the side of the mouth. Staff B did not know the resident's code status. During a surveyor interview on 5/14/2025 at 10:59 AM with the Executive Director, she acknowledged the residence's staff did not follow their medical emergency response policy or the policy for advanced directives. Additionally, she could not provide evidence that staff followed the resident's code status of full code, resulting in a delay of treatment to the resident. She indicated that the residents' face sheet is where the code status information would be located, and indicated the area on Resident ID #2's Face Sheet that stated "Full Code."	S 275	Type text here	