RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01473	A. BUILDING: _____ B. WING _____	C 04/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE SOUTH BAY	1959 KINGSTOWN ROAD SOUTH KINGSTOWN, RI 02879

(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)	(XS) COMPLETE DATE
S 003	Initial Comments An unannounced State Licensure survey was conducted at this residence. State deficiencies were identified. RECEIVED MAY 26 2023 FACILITIES REGULATION	S 003	The following is the Plan of Correction for Brookdale South Bay regarding the Statement of Deficiencies dated April 25, 2023. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identical issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health services and will continue to make changes and improvement to satisfy that objective.	
S 190	Organization And Management 2.4.12(H) Administrative Management 2.4.12 (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 the residence failed to ensure employees received 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) for four of six sample employees, Staff ID's A,B,C, and D. Findings are as follows: 1)Record review of Staff A revealed a hire date of 02/10/2020. This employee was hired as a Registered Nurse. 2) Record review for Staff B revealed a hire date of 03/23/2009. This employee was hired as a	S 190	1. The required in-service trainings that were incomplete for employees A, B, C and D will be completed by 6/16/2023. 2. An audit was completed by the Human Resources Manager on 5/24/2023 to identify any additional licensed nurses, certified nurse's aides and certified medication assistants that had not completed all of their on-going in-service trainings. 3. On 5/16/2023, the Human Resources Manager re-in serviced the Department managers on the regulations for the on-going in-service training for employees. 4. The Human Resource Manager or designee will audit monthly for three months licensed nurses, certified nurse's aides, and certified medication assistants for completion of their assigned monthly training to include in-service training as appropriate for their job classifications. The Human Resources Manager will communicate to the Health and Wellness Director on a monthly basis what clinical associates need to complete their assigned training. The Human Resource Manager or designee will report results of the audit in the monthly Quality Assurance	6/16/23

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S 190	Continued From page 1 Certified Medication Technician (CMT)/Certified Nursing Assistant (CNA). 3) Record review for Staff C revealed a hire date of 10/13/2015. This employee was hired as a CMT/CNA. 4) Record review for Staff D revealed a hire date of 12/04/2000. This employee was hired as a CNA. Record review failed to reveal evidence that the above employees had received all required in-service training in the following areas on an annual basis: 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;	S 190		

RI Department of Health

		Performance Improvement (QAPI) Meeting for 3 months.	

Facilities Regulation

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

Executive Director | 5-20-2023

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S 190	Continued From page 2 I. Internal reporting. -Staff A's record failed to reveal on-going in-service training in 2021. -Staff B's record failed to reveal on-going in-service training in 2020 and 2021. -Staff C's record failed to reveal on-going in-service training in 2020, 2021, and 2022. -Staff D's record failed to reveal on-going in-service training in 2020 and 2022. During an interview on 04/25/2023 at approximately 3:45 PM, the Director of Financial Services was unable to provide evidence that the above employees had received all required in-service training annually, as required.	S 190		
S 365	Residency Requirements 2.4.16(0) 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 the residence failed to review the resident assessment at intervals not to exceed (12) months and each time a resident's condition changes significantly for three of six sample residents, Resident ID #s 1,2, and 3. Findings are as follows: Review of a list of residents receiving outside services provided by the Director of Wellness	S 365	1. The comprehensive assessments were updated by the Health & Wellness Director to reflect the outside services provided by 6/8/2023 for Residents # 1, and 3. Resident #2 passed on 4/30/2023. 2. An audit was completed by the Health & Wellness Director on 5/25/2023 to identify any additional residents whose comprehensive assessments did not reflect outside services provided. 3. The District Director of Clinical Services re-trained the Health and Wellness Director on 5/24/2023 on updating the comprehensive assessments to reflect outside services provided. 4. The Health & Wellness Director or designee will audit twice weekly for 3 months to identify residents with new orders for outside services. The Health & Wellness Director or designee will report results of the audit in the monthly Quality Assurance Performance Improvement (QAPI) Meeting for 3 months.	6/8/23

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S 365	Continued From page 3 (DOW) on 04/25/2023 indicated ID #1 is receiving hospice services from an outside agency. Additional review revealed ID #2 is receiving skilled nursing (SN) services, physical therapy (PT) services, and occupational therapy (OT) services and ID #3 is receiving "wound care." 1) Record review revealed ID #1 was admitted to the residence in February of 2022, with diagnoses including, but not limited to: chronic kidney disease, hypertension, and sleep apnea. The resident was readmitted to the residence in April of 2022 after a medical leave of absence. Further record review reveals he/she was admitted to palliative nursing services, a skilled nursing service provided by an outside agency, on 08/11/2022 and transitioned to hospice services on 04/10/2023 from palliative care services. ID #1's comprehensive assessment dated 11/28/2022 failed to reveal the assessment was updated to reflect admission to hospice services. 2) Record review revealed ID #2 was admitted to the residence in April of 2014 with diagnoses including, but not limited to: type II diabetes, hypertension, and Parkinson's disease. Record review revealed he/she was hospitalized on 03/10/2023 with a subsequent skilled nursing facility admission, returning to the residence on 04/13/2023. ID #2's comprehensive assessment dated 02/22/2023 failed to reveal the assessment was updated to include SN, PT, and OT services provided by an outside agency beginning 04/15/2023.	S 365		

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S 365	Continued From page 4 3)Record review revealed ID #3 was admitted in April of 2022, with diagnoses including, but not limited to: Polyosteoarthritis, hypertension, and an intellectual disability. Record review revealed ID #3 was receiving PT from 02/01/2023-03/18/2023 and skilled nursing services for wound care beginning on 04/20/2023. ID #3's comprehensive assessment dated 02/28/2023 failed to be updated to reflect these outside service provisions. During an interview on 04/25/2023 at approximately 5:25 PM, the Executive Director was unable to produce evidence that the comprehensive assessments were updated to reflect the outside services provided to Resident ID #s 1,2, and 3, as required.	S 365		
S 370	Residency Requirements 2.4.16(E) Resident Assessment/Service Plans 2.4.16 (E) Resident assessments and Service Plans E. In the event a resident has an admission to a health care facility and is scheduled to return to the residence without a significant change in status, then the assessment shall be updated within five (5) working days of readmission. 1. In case of an emergency admission, the required assessment shall take place within five (5) working days and shall include the following: a. An immediate admission necessitated by	S 370	1. Resident #2 passed at the hospital on 4/30/2023 and he did not return to the community. 2. An audit was completed by the Health and Wellness Director on 5/25/2023 to identify if there were any additional residents whose comprehensive assessments had been updated within (5) working days of readmission from admission to a health care facility. 3. The District Director of Clinical Services re-trained the Health and Wellness Director on the policy on 5/24/2023 for completing comprehensive assessments within (5) working days of readmission from admission to a health care facility.	5/26/23

			Staring on 5/26/2023 the Health & Wellness Director or designee with complete a comprehensive assessment within 5 working days for residents that are readmitted. 4. Health & Wellness Director or designee will audit readmissions from the hospital twice weekly for three months and complete a comprehensive assessment within 5 days of return. The Health & Wellness Director or designee will report results of the audit in the monthly Quarterly Assurance Performance Improvement (QAPI) Meeting for 3 months	

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S 370	Continued From page 5 natural disaster, crisis, or threat to public safety at another licensed assisted living residence, independent living situation, community residential facility, or private residence; b. An immediate admission necessitated by the unanticipated incapacitation of the primary caregiver of the person to be admitted; c. Conditions or circumstances warranting emergency admission and as approved by Center for Health Facilities Regulation staff within forty-eight (48) hours. This Requirement is not met as evidenced by: Based on record review and staff interview it has been determined the residence failed to ensure the resident's comprehensive assessment was updated within five (5) working days of readmission from admission to a health care facility for the singular resident reviewed for readmission, ID #2. Findings are as follows: Record review revealed ID #2 was admitted to the residence in April of 2014 with diagnoses including, but not limited to: type II diabetes, hypertension, and Parkinson's disease. Record review revealed he/she was hospitalized on 03/10/2023 with a subsequent skilled nursing facility admission. The record revealed the last comprehensive assessment to be dated 02/22/2023, failing to reflect an assessment was completed prior to or within five working days from readmission to the residence on 04/13/2023.	S 370		

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S 370	Continued From page 6 During an interview on 04/25/2023 at approximately 5:20 PM, the Executive Director was unable to provide evidence a comprehensive assessment was completed prior to or upon readmission to the residence within five working days.	S 370		
S 375	Residency Requirements 2.4.16(F) Resident AssessmenUService 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; (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	S 375	1. Resident's #1 was assessed by the Health & Wellness Director on 5/26/2023. Resident #5 was assessed by the Health & Wellness Director by 6/8/2023 and Resident's #4, and 6 were assessed by the Health & Wellness Director by 6/8/2023. Resident #2 passed on 4/30/2023. 2. An audit was completed by the Health & Wellness Director on 5/25/2023 to identify any additional residents whose 90 day assessments were not completed. 3. The District Director of Clinical Services re-trained on 5/24/2023 the Health and Wellness Director on the policy for completing 90 day assessments. 4. The Health & Wellness Director or designee will audit 5 residents a month for 3 months to verify to identify if any residents due for their 90 day assessment are completed. The Health & Wellness Director or designee will report results of the audit in the monthly Quarterly Assurance Performance Improvement (QAPI) Meeting for 3 months.	6/8/23

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S 375	Continued From page 7 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 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 five of six sample residents, Resident ID #s 1,2,4,5, and 6. Findings are as follows: 1) Record review revealed ID #1 was admitted to the residence in February of 2022, with diagnoses including, but not limited to: chronic kidney disease, hypertension, and sleep apnea. The resident was readmitted to the residence in April of 2022 after a medical leave of absence. Record review revealed an initial assessment of ID #1 on 02/28/2022 and a reassessment on 11/28/2022.	S 375		

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S 375	Continued From page 8 2) Record review revealed ID #2 was admitted to the residence in April of 2014 with diagnoses including, but not limited to: type II diabetes, hypertension, and Parkinson's disease. Record review revealed a change of condition assessment of ID #2 on 05/28/2021 and reassessments on 06/01/2022, 11/15/2022, and 02/22/2023. 3) Record review revealed ID #4 was admitted in May of 2016, with diagnoses including, but not limited to: chronic kidney disease, hypertension, and osteoporosis. The resident was readmitted to the residence in December of 2019 after a medical leave of absence. Record review failed to reveal an assessment of ID #4 from 04/02/2021 - 03/07/2022. 4) Record review revealed ID #5 was admitted in November of 2021, with diagnoses including, but not limited to: seizure disorder, chronic kidney disease, and cognitive communication deficit. Record review revealed an assessment of ID #5 on 01/24/2022 and reassessments on 06/09/2022 and 11/01/2022. 5) Record review revealed ID #6 was admitted to the residence in November of 2018, with diagnoses including, but not limited to: pulmonary fibrosis, chronic obstructive pulmonary disease (COPD), and congestive heart failure (CHF). The resident was readmitted to the residence in August of 2022 after a medical leave of absence. Record review revealed an initial assessment of ID #6 on 01/20/2021 and reassessments on 02/24/2022, 08/30/2022, and11/28/2022.	S 375		

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S 375	Continued From page 9 During an interview on 04/25/2023 at approximately 5:30 PM, the Executive Director was unable to produce evidence the residents above were assessed at least once every ninety (90) days by a registered nurse, as required.	S 375		
S 390	Residency Requirements 2.4.16(G)(3) Resident Assessment/Service Plan 2.4.16 (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 the residence failed to review the service plan each time a resident's condition changes significantly and the plan accurately reflects the services provided by the residence for three of six sample residents reviewed, ID #s 1,2, and 3. Findings are as follows: Review of a list of residents receiving outside services provided by the Director of Wellness (DOW) on 04/25/2023 indicated ID #1 is receiving hospice services from an outside agency. Additional review revealed ID #2 is receiving skilled nursing (SN) services, physical therapy (PT) services, and occupational therapy (OT) services and ID #3 is receiving "wound care." 1) Record review revealed ID #1 was admitted to the residence in February of 2022, with diagnoses	S 390	1. Resident #1 and #3 were completed by the Health & Wellness Director to reflect the services provided for the resident's change of condition by 6/8/2023. Resident #2 passed on 4/30/2023. 2. An audit was completed by the Health & Wellness Director on 5/25/2023 to identify any additional residents with a change of condition. 3. The District Director of Clinical Services re-trained the newly hired Health and Wellness Director on the policy on reflecting the services provided for a resident's change of condition on 5/24/2023. 4. The Health & Wellness Director or designee will audit 5 residents a month to identify if any residents due for their 90 day assessment are completed. The Health & Wellness Director or designee will report results of the audit in the monthly Quarterly Assurance Performance Improvement (QAPI) Meeting for 3 months.	6/8/23

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S 390	Continued From page 10 including, but not limited to: chronic kidney disease, hypertension, and sleep apnea. The resident was readmitted to the residence in April of 2022 after a medical leave of absence. Further record review reveals he/she was admitted to palliative nursing services, a skilled nursing service provided by an outside agency on 08/11/2022 and transitioned to hospice services on 04/10/2023 from palliative care services. ID #1's service plan dated 11/28/2022 failed to reveal being updated to reflect admission to hospice services. 2) Record review revealed ID #2 was admitted to the residence in April of 2014 with diagnoses including, but not limited to: type II diabetes, hypertension, and Parkinson's disease. Record review revealed he/she was hospitalized on 03/10/2023 with a subsequent skilled nursing facility admission, returning to the residence on **04/13/2023.** ID #2's service plan dated 02/15/2023 failed to reveal being updated to include SN, PT, and OT services provided by an outside agency beginning 04/15/2023. The service plan also failed to reflect the medical leave of absence from **03/10/2023-04/13/2023.** 3) Record review revealed ID #3 was admitted in April of 2022, with diagnoses including, but not limited to: polyosteoarthritis, hypertension, and an intellectual disability. Record review revealed ID #3 was receiving PT from 02/01/2023-03/18/2023 and skilled nursing services for wound care beginning on	S 390		

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S 390	Continued From page 11 04/20/2023. ID #3's service plan dated 02/28/2023 failed to be updated to reflect these outside service provisions. During an interview on 04/25/2023 at approximately 5:25 PM, the Executive Director was unable to produce evidence the service plans were updated to reflect the outside services provided to Resident ID #s 1,2, and 3, as required.	S 390		
S 560	Residential Care Services 2.4.24(A)(3)(b) Medication Services 2.4.24 (A) (3) (b) Medication Services b. For assisted living residences licensed at the M1 level, licensed employees (registered medication aides, registered nurses, licensed practical nurses) may administer oral or topical drugs and monitor health indicators. However, schedule II medications shall only be administered by licensed personnel. The physician or nurse supervisor shall conduct and document quarterly evaluations of the registered medication aides who are administering drugs and place a copy in the employee's personnel record. This Requirement is not met as evidenced by: Based on record review and staff interview it has been determined the residence failed to have the physician or nurse supervisor conduct and document quarterly evaluations of the registered medication aides who are administering drugs and place a copy in the employee's personnel record for two of two medications aides reviewed,	S 560	1. On 5/16/2023, quarterly medication aide evaluations were conducted, documented and filed in the personnel record for Staff B and C by the Health & Wellness Director. 2. An audit was completed by Health & Wellness Director on 5/19/2023 for completion of quarterly evaluations for medication aides. No other medication aides were found to be out of compliance. 3. The District Director of Clinical Services re-trained the newly hired Health and Wellness Director on the regulations for quarterly medication aide's evaluations 5/24/2023. 4. The Health and Wellness Director or designee will audit 5 medication aides a month for 3 months to verify that the quarterly medication aide evaluations were conducted, documented and filed in the personnel record. The Health and Wellness Director or designee will report results of the audit in the	5/2623

			monthly Quarterly Assurance Performance Improvement (QAPI) Meeting for 3 months.	

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	ALR01473	A. BUILDING: _____ B. WING _____	C 04/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE SOUTH BAY	1959 KINGSTOWN ROAD SOUTH KINGSTOWN, RI 02879

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S 560	Continued From page 12 Staff B and C. Findings are as follows: 1) Record review for Staff 8 revealed a hire date of 03/23/2009. This employee was hired as a Certified Medication Technician (CMT)/Certified Nursing Assistant (CNA). Record review revealed two evaluations for this staff member, dated 04/26/2021 and 02/10/2023. 2) Record review for Staff C revealed a hire date of 10/13/2015. This employee was hired as a **CMT/CNA.** Record review revealed two evaluations for this staff member, dated 04/28/2021 and 02/15/2023. During an interview on 04/25/2023 at approximately 4:30 PM the Director of Wellness was unable to provide evidence quarterly medication aide evaluations were conducted, documented, and filed in the personnel record for Staff 8 and C, as required.	S 560		
S 705	Physical Plant 2.4.30(1) Safety Requirements 2.4.30 (1) 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	S 705	1. The Maintenance Director conducted a fire drill on 4/28/23 which included the name of the person who conducted the drill, date/ time of drill, amount of time taken to evacuate, type of drill, any problems encountered and steps taken to rectify, and employee observations of residents ability to carry out evacuations. 2. On 5/26/2023 HR completed an audit of recent resident move in from 4/1/23 to 5/26/2023 to verify that they had	5/30/23

			documentation of orientation to fire drills upon move in was completed. 3. The Maintenance Director conducted a training on the fire drill procedures with current assisted living employees on 4/28/23 to include the type of drill (obstructed/ unobstructed), problems encountered and steps taken to rectify them and employee observation of each resident's ability to carry out the evacuation. On 5/25/23 Asset Management revised the community's fire drill form to include all areas required for a fire drill. The Maintenance Director or designee will document the drills and maintain the documentation in the communities building management platform. 4. The Executive Director or designee will audit 1 drill a month for 3 months to verify monthly drills are being conducted. The Executive Director or designee will report results of the audit in the monthly Quarterly Assurance Performance Improvement (QAPI) Meeting for 3 months.

6/2/23

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S 705	Continued From page 13 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 Chapter23-28.1). 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.1. 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; (6) Employee observation of each resident's ability to carry out evacuation procedures.	S 705		

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S 705	Continued From page 14 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(I)(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 fire drill documentation included all necessary components for 12 of 12 monthly fire drills reviewed. Findings are as follows: Fire drills were conducted at the residence on the following dates: 04/03/2022, 04/27/2022, 05/31/2022, 06/30/2022,07/28/2022, 08/29/2022, 09/30/2022, 10/30/2022, 11/26/2022, 12/28/2022, 01/30/2023, 02/22/2023, and 03/28/2023. Fire drill documentation from the above-mentioned dates fails to include the type of drill (i.e., obstructed, or unobstructed); problems encountered, and steps taken to rectify them; and employee observation of each resident's ability to carry out the evacuation. During an interview on 04/25/2023 at approximately 1:00 PM, the Executive Director was unable to provide evidence the fire drill documentation contained all required components.	S 705		

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S 725	Continued From page 15	S 725		
S 725	Practices and Procedures, Violations, Sa 2.4.32(A) Variance Procedure 2.4.32 (A) Variance Procedure A. The Department may grant a variance either upon its own motion or upon request of the applicant from the provisions of any rule or regulation in a specific case if it finds that a literal enforcement of such provision will result in unnecessary hardship to the applicant and that such a variance will not be contrary to the public interest, public health and/or health and safety 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 send a variance for an established resident receiving palliative care and hospice services from an outside provider, Resident ID #1. Findings are as follows: Per the Rules and Regulations for Licensing Assisted Living Residences the definition of a resident states in part"... 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..." Record review revealed ID #1 was admitted to	S 725	1. A variance will be submitted by the Health & Wellness Director for Resident #1 receiving palliative care and hospice services from an outside provider by 6/2/23. 2. An audit will be completed by the Health & Wellness Director by 6/2/23 to identify if there were any additional residents that are need a variance for receiving palliative care and hospice services. 3. The District Director of Clinical Services re-trained the Health and Wellness Director on the policy for obtaining variances for palliative care and hospice services on 5/30/2023. Starting on 5/30/2023 after the training is completed, the Health & Wellness Director or designee will submit a variance request in writing to the Department of Health for residents receiving palliative care or hospice services. 4. The Health & Wellness Director or designee will audit orders weekly for new referrals or orders for hospice or palliative care for 3 months to verify that any additional residents variance were completed. The Health & Wellness Director or designee will report results of the audit in the monthly Quarterly Assurance Performance Improvement (QAPI) Meeting for 3 months.	6/2/23

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S 725	Continued From page 16 the residence in February of 2022, with diagnoses including, but not limited to: chronic kidney disease, hypertension, and sleep apnea. The resident was readmitted to the residence in April of 2022 after a medical leave of absence. Further record review reveals he/she was admitted to palliative nursing services, a skilled nursing service provided by an outside agency on 08/11/2022. Additional record review revealed he/she transitioned to hospice services on 04/10/2023 from palliative care services. The clinical record lacked evidence that a variance for palliative or hospice care was sent to the Rhode Island Department of Health (RIDOH) for approval. During an interview on 04/25/2023 at approximately 5:15 PM, the Director of Financial Services acknowledged that the facility had not been sending variance requests in writing for the residents receiving palliative care, nor had sent one for this resident to receive hospice care from an outside provider.	S 725		