RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01495	A. BUILDING: _____ B. WING _____	C 11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AMERICAN ASSISTED LIVING	55 TOLL GATE FARM ROAD WARWICK, RI 02886

(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 97942, 98218, 98226, 98256, and 98283, was conducted at this residence on 11/13/2024 to determine compliance with state regulations. Deficiencies were identified.	S 003	S365 Resident assessments and service plans Resident #2 chart will be reconciled and corrected to reflect all available information; OT, SP and hospice reflected. Targeted Completion 12/10/24 Resident ID #3 chart will be recoiled and corrected to reflect all available information: between the time frame 8/7/24-8/31/24. 10/23/24 for PT. Targeted Completion 12/10/24	
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 the residence failed to review the resident's comprehensive assessment at intervals not to exceed (12) months and each time a resident's condition changed significantly for 2 of 3 residents reviewed for outside services, Resident ID #s 2 and 3. Findings are as follows: 1. Record review revealed Resident ID #2 moved into the residence in February of 2024 with a diagnosis including, but not limited to, dementia, hypertension, and osteopenia. Record review of the resident's comprehensive assessment dated 2/10/2024 failed to be updated to reflect that the resident received occupational	S 365	1-: Director of Nursing /Wellness nurses will Receive in-services on proper procedure for adding dates of services to the 90 Day Assessment for all outside services; Included will be; VNA services type (OT, PT, ST, Hospice, VNA), VNA name, the start date and end date. 2- Director of Nursing / Wellness nurses will add notes in Yardi with dates of service to reconcile with the 90-day Assessment, the Resident Care Director/ Wellness nurses will check notes weekly in Yardi to ensure the 90 day assessment are updated and match the dates of services for outside providers 3- Outside VNA services will give the Wellness Department a list of our residents on services with VNA services on a weekly basis and VNA will give updates to the Wellness department to ensure proper communication 4- To ensure state regulation compliance; a minimum of 10% of charts will be audited monthly RECEIVED NOV 27 2024 FACILITIES REGULATION	

Facilities Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Elizabeth A. Lamm — TITLE: Admnstor — (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01495	A. BUILDING: _____ B. WING _____	C 11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AMERICAN ASSISTED LIVING	55 TOLL GATE FARM ROAD WARWICK, RI 02886

(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 365	Continued From page 1 therapy (OT) services and speech therapy (ST) services from 2/20/2024 through 4/20/2024. The assessment further failed to document that the resident started on hospice services with a start of care date of 5/3/2024. 2. Record review revealed Resident ID #3 moved into the residence in August of 2024 with a diagnosis of atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow). Record review of the resident's comprehensive assessment dated 8/7/2024 failed to be updated to document that the resident received physical therapy (PT) services from 8/31/2024 through 10/23/2024. During a surveyor interview on 11/13/2024 at approximately 3:15 PM with the Executive Director, in the presence of the Resident Care Director, she acknowledged that Resident ID #2 received OT, ST, and hospice services and Resident ID #3 received PT services. She could not provide evidence the comprehensive assessments for Resident ID #s 2 and 3 were updated to reflect the above-mentioned outside services.	S 365	S375 Resident assessments and service plans; Nurse review: Residents ID # 2, #4, #5 charts will be recoiled and corrected to reflect 90-day nurse review. If residents are now deceased 90-day review will reflect that. 1- Director of Nursing (RN)/Wellness Nurses (RN) will schedule all 90 assessments in Yardi to reflect due dates. 2-The scheduled Yardi assessments will be reviewed by the Director of Nursing /Wellness Nurses weekly and completed on a weekly basis. 3- Director of Nursing /Wellness Nurses will write notes for all Residents on MLOA, when the resident is back in the building the 90-day assessment will be completed or a change of condition will be completed if applicable. 4-Yardi 90-day assessments will be audited monthly by Director of Nursing (RN) Targeted date of completion: 1/10/25	
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	S 375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01495	A. BUILDING: _____ B. WING _____	C 11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AMERICAN ASSISTED LIVING	55 TOLL GATE FARM ROAD WARWICK, RI 02886

(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 375	Continued From page 2 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 medication container is current with physician orders (M-1 level only); (EE) Physical assessment identifying symptoms of illness and/or changes in mental or	S 375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01495	A. BUILDING: _____ B. WING _____	C 11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AMERICAN ASSISTED LIVING	55 TOLL GATE FARM ROAD WARWICK, RI 02886

(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 375	Continued From page 3 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 quarterly nurse reviews were completed at least once every ninety (90) days for 3 of 3 sample residents, Resident ID #s 2, 4, and 5. Findings are as follows: 1. Record review revealed Resident ID #2 moved into the residence in February of 2024 with diagnoses including, but not limited to, dementia, hypertension, and osteopenia. Record review failed to reveal that a nurse review was completed for this resident. 2. Record review revealed Resident ID #4 moved into the residence in May of 2024 with a diagnosis including, but not limited to, depression.	S 375		

RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01495	A. BUILDING: _____ B. WING _____	C 11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AMERICAN ASSISTED LIVING	55 TOLL GATE FARM ROAD WARWICK, RI 02886

(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 375	Continued From page 4 Record review failed to reveal that a nurse review was completed for this resident. 3. Record review revealed Resident ID #5 moved into the residence in April of 2024 with a diagnosis including, but not limited to, Alzheimer's disease. Record review failed to reveal that a nurse review was completed for this resident. During a surveyor interview on 11/13/2024 at 12:39 PM with the Resident Care Director, in the presence of the Executive Director, she was unable to provide evidence that the above-mentioned nurse reviews were completed, as required.	S 375	S385 Service Plan: Resident ID 1# Service plan will be reviewed for 10/17/24 and signed by Director of nursing and Executive Director. Targeted Date of completion:12/20/24 Resident ID 2# Service plan will be reviewed for 2/14/24 and signed by Director of nursing and Executive Director. Targeted Date of completion:12/20/24 Resident ID 3# Service plan will be reviewed for 8/7/24 and signed by Director of nursing and Executive Director. Targeted Date of completion: 12/20/24 Resident ID 5# Service plan will be reviewed for 4/17/24 and signed by Director of nursing and Executive Director. Targeted Date of completion:12/20/24	
S 385	Residency Requirements 2.4.16.G.2 Resident Assessment/Service Plan 2.4.16 (G)(2) Service Plans 2. The service plan shall be developed by a registered nurse and/or the certified assisted living residence administrator, and shall be signed, approved, and dated 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 have the service plan signed, approved, and dated by a registered nurse and/or the certified assisted living residence administrator for 4 of 5 sample residents reviewed, Resident ID #s 1, 2, 3, and 5. Findings are as follows:	S 385	1- Director of Nursing (RN)/ Wellness nurses(RN) will review the dashboard daily on Yardi and complete all scheduled Service Plans 2- When Service Plans are completed the Wellness Nurse will call families to set up servie Plan meetings 3- Director of Nursing (RN) and Executive Director will sign and review Service plan with residents and/or families 4- Director of Nursing (RN)will perform monthly Q & A auditing at least 10% of the charts Targeted completion:1/31/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01495	A. BUILDING: _____ B. WING _____	C 11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AMERICAN ASSISTED LIVING	55 TOLL GATE FARM ROAD WARWICK, RI 02886

(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 385	Continued From page 5 1. Record review revealed Resident ID #1 moved into the residence in April of 2022 with a diagnosis including, but not limited to, dementia. Record review revealed a service plan dated 10/17/2024. Record review failed to reveal evidence that the service plan was signed and approved by the Executive Director (ED), as required. 2. Record review revealed Resident ID #2 moved into the residence in February of 2024 with diagnoses including, but not limited to, dementia, hypertension, and osteopenia. Record review revealed a service plan dated 2/15/2024. Record review failed to reveal evidence that the service plan was signed and approved by the ED, as required. 3. Record review revealed Resident ID #3 moved into the residence in August of 2024 with a diagnosis of atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow). Record review revealed a service plan dated 8/7/2024. Record review failed to reveal evidence that the service plan was signed and approved by the ED, as required. 4. Record review revealed Resident ID #5 moved into the residence in April of 2024 with a diagnosis including, but not limited to, Alzheimer's disease. Record review revealed a service plan dated 4/17/2024. Record review failed to reveal evidence that the service plan was signed and	S 385		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01495	A. BUILDING: _____ B. WING _____	C 11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AMERICAN ASSISTED LIVING	55 TOLL GATE FARM ROAD WARWICK, RI 02886

(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 385	Continued From page 6 approved by the ED, as required. During a surveyor interview on 11/13/2024 at approximately 3:15 PM with the ED, in the presence of the Resident Care Director, she could not provide evidence the service plans for Resident ID #s 1, 2, 3, and 5 were signed, as required.	S 385		
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 that the residence failed to update the service plan each time a resident's condition changed significantly for 2 of 3 residents reviewed for outside services, Resident ID #s 2 and 3. Findings are as follows: 1. Record review revealed Resident ID #2 moved into the residence in February of 2024 with diagnoses including, but not limited to, dementia, hypertension, and osteopenia. Record review revealed the resident was receiving hospice services with a start of care date of 5/3/2024.	S 390	S390 Resident assessment / service plan Resident ID #2 service plan will be recoiled and corrected to reflect receiving hospice services 5/3/24. Targeted completion: 12/20/24 Resident ID #3 service plan will be recoiled and corrected to reflect receiving PT service on 8/7/24. 1-: Director of Nursing /Wellness nurses will Receive in-services on proper procedure for adding dates of services to the 90 Day Assessment for all outside services; Included will be; VNA services type (OT, PT, ST, Hospice, VNA), VNA name, the start date and end date. 2- Director of Nursing / Wellness nurses will add notes in Yardi with dates of service to reconcile with the 90 day Assessment, the Resident Care Director/ Wellness nurses will check notes weekly in Yardi to ensure the 90 day assessment are updated and match the dates of services for outside providers 3- Outside VNA services will give the Wellness Department a list of our residents on services with VNA services on a weekly basis and VNA will give updates to the Wellness department to ensure proper communication 4- To ensure state regulation compliance; a minimum of 10% of charts will be audited monthly Targeted completion: 1/31/25 To ensure all residents' service plan are meeting state regulations a chart audit will be conducted. All residents that have received services, had a change of condition, annual reviews or are new resident will have a service plan created by RN that reflects any changes to care. Targeted completion: 1/31/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01495	A. BUILDING: _____ B. WING _____	C 11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AMERICAN ASSISTED LIVING	55 TOLL GATE FARM ROAD WARWICK, RI 02886

(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 390	Continued From page 7 Record review of the resident's service plan dated 2/15/2024 failed to be updated to reflect that the resident is receiving hospice services. 2. Record review revealed Resident ID #3 moved into the residence in August of 2024 with a diagnosis of atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow). Record review revealed the resident was receiving physical therapy (PT) services with a start of care date of 8/31/2024. Record review of the resident's service plan dated 8/7/2024 failed to be updated to reflect that the resident is receiving PT services. During a surveyor interview on 11/13/2024 at approximately 3:15 PM with the Administrator, in the presence of the Resident Care Director, she acknowledged that Resident ID #2 received hospice services and Resident ID #3 received PT services. She could not provide evidence the service plans for Resident ID #s 2 and 3 were updated to reflect the above-mentioned outside services.	S 390	840 Special Care license requirements Resident ID #2 had a fall on 10/29/24 resulting in injury. Agency worker involved in resident #2 care will not be returning to the facility. To prevent this from occurring in the future agency employees will receive report from shift prior from facility staffing. Service plans will be reviewed with agency staffing to ensure they understand how to provide care to residents. If a resident is a one person assist one staff member will remain with resident through all part of care to ensure resident safety. RN will give an in service to all care staff to ensure safety of residents when providing care. 1- Resident Care Director/Wellness Nurses will complete Introductory Sheet for all Residents in our building. This will include; all ADL needs including if the resident is independent or a 1 person assist for transfers and ambulation . 2- Resident Care Director(RN)/Wellness Nurse will review the Introductory sheet daily at Stand up meeting with floor staff and a copy will be left for all floor staff in the building to review on all shifts Targeted completion: 1/31/25	
S 840	Special Care License Requirements 2.5.2.L Specific Requirements 2.5.2 (L) Specific Requirements L. The Alzheimer Dementia Special Care Unit/Program shall provide a secure distinct living environment appropriate for the resident population. This requirement may include, but not be limited to, a locked unit, secured perimeter, or	S 840		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01495	A. BUILDING: _____ B. WING _____	C 11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AMERICAN ASSISTED LIVING	55 TOLL GATE FARM ROAD WARWICK, RI 02886

(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 840	Continued From page 8 other mechanism to ensure resident safety and quality of life. The residence shall have elopement policies in place, specific to the Unit/Program. 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 Alzheimer Dementia Special Care Unit/Program provided a safe distinct living environment for 1 of 3 residents reviewed for falls, Resident ID #2. Findings are as follows: An initial reportable incident form submitted to the Rhode Island Department of Health on 10/29/2024 alleges that a staff member was assisting Resident ID #2 in the bathroom. The staff member left the bathroom, the resident was left on the toilet, and when s/he returned, the resident was found on the bathroom floor. The Residence's 5-day investigation report dated 11/1/2024 indicates the resident had a negative outcome of a spinal fracture as a result of the fall. Further, it indicates the staff member was an agency staff that was not aware the resident could not be left alone or the residence's policies regarding supervision on the unit. Record review revealed the resident moved into the residence in February of 2024 with a diagnosis including, but not limited to, dementia. Review of the resident's mini mental state exam dated 2/25/2024 reveals a score of 1 out of 30, revealing that the resident has severe cognitive impairment.	S 840		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01495	A. BUILDING: _____ B. WING _____	C 11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AMERICAN ASSISTED LIVING	55 TOLL GATE FARM ROAD WARWICK, RI 02886

(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 840	Continued From page 9 Review of a fall risk review dated 2/25/2024 reveals a score of 55, a score of 25 or greater indicates the resident would be prone to falling. Record review of the comprehensive assessment dated 2/10/2024 reveals that the resident is a moderate assist for toileting, transferring, and ambulation, and an extensive assist for personal hygiene. The assessment further reveals that the resident is frequently confused and unable to discern and/or avoid situations in which s/he may be in danger and needs guidance and assistance. Record review of the service plan dated 2/15/2024 reveals that the resident is an extensive assist for toileting. During a surveyor interview on 11/13/2024 at 9:30 AM with Certified Medication Technician, Staff A, s/he revealed that s/he would expect a staff member to stay with this resident at all times during toileting. During a surveyor interview on 11/13/2024 at 8:45 AM with the Executive Director, she revealed that the resident is an assist for toileting and that staff need to be present at all times when toileting Resident ID #2. She could not provide evidence that this resident was kept safe and appropriately supervised for activities of daily living.	S 840		