STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01372	A. BUILDING: _____ B. WING _____	05/20/2025

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S 003	Initial Comments An unannounced biennial State Licensure survey and a complaint/incident investigation survey (YZMJ11, 05/20/2025) were conducted at this residence. Deficiencies were identified relative to the State Licensure survey.	S 003		
S 200	Organization And Management 2.4.12.I.2 Administrative Management 2.4.12 (I) (2) Personnel Records 2. Said personnel records shall be reviewed and updated at intervals not to exceed twelve (12) months and shall include, but not be limited to, all of the following components: a. Completed job application and/or resume; b. Written statements of references or documentation of verbal reference check; c. Written functional job descriptions; (1) These descriptions shall be updated at intervals not to exceed twelve (12) months and shall include, but not be limited to, minimal qualifications for the position, major duties and responsibilities, and shall be signed and dated by the individual employee. d. Evidence of credentials, current professional licensure and/or certification; e. Documentation of education and/or continuing training, including continuing education units (CEUs) related to administrator certification, food management, etc., medication administration, and dementia care;	S 200	Received JUL 07 2025 Facilities Regulation	

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

Sandra Cullen — COO — 7/7/2025

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S 200	Continued From page 1 f. Documentation of attendance at in-service training and/or orientation; g. Documentation of at least one (1) performance evaluation at intervals not to exceed twelve (12) months; h. Signed copy of employee's awareness of resident's rights; i. Results of the criminal record (BCI) check. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined the residence failed to ensure personnel records contained all required documentation for 6 of 6 sample staff reviewed, Staff A, B, C, D, E, and F. Findings are as follows: The following personnel records failed to reveal evidence of a signed copy of the employee's awareness of resident's rights: 1) Record review of Staff A revealed a hire date of 11/9/2023. This employee was hired as a Certified Medication Technician (CMT). 2) Record review of Staff B revealed a hire date of 5/3/2024. This employee was hired as a CMT. 3) Record review of Staff C revealed a hire date of 5/30/2023. This employee was hired as a CMT. 4) Record review of Staff D revealed a hire date of 3/31/2023. This employee was hired as a	S 200	The residence shall maintain signed residents rights in their personnel file upon hire and annual inservcing. All new employees will sign a copy of the resident rights upon hire and be kept in the HR department in their personnel file. A copy of the resident's rights will be added to the new hire packet. All new employee records will be monitored within 30 days of hire.	To start imm-ediately

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S 200	Continued From page 2 Certified Nursing Assistant (CNA). 5) Record review of Staff E revealed a hire date of 7/6/2023. This employee was hired as a CNA. 6) Record review of Staff F revealed a hire date of 11/20/2019. This employee was hired as a Registered Nurse/Director of Wellness. During a surveyor interview on 5/19/2025 at 1:20 PM with the Payroll Manager, she was unable to provide evidence the personnel records for Staff A, B, C, D, E, and F, contained the required documentation.	S 200		
S 380	Residency Requirements 2.4.16.G.1 Resident Assessment/Service Plan 2.4.16 (G) (1) Service Plans 1. Within a reasonable time after move-in, not to exceed seven (7) days, the Administrator shall be responsible for the development of a written service plan based on the initial assessment. The service plan shall include at least: a. The services and interventions needed, including all services provided by outside healthcare agencies (e.g., home nursing care, hospice); b. Description, frequency, duration relating to the service or intervention, including personal assistance, medication, special diets, recreational activities, and other similar services rendered; c. Party responsible for arranging and/or providing the service; and	S 380		

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S 380	Continued From page 3 d. The resident's requested and/or therapeutically needed recreational and social activities. This Requirement is not met as evidenced by: Based on record review, observation, and staff interview, it has been determined that the residence failed to document a description of the services and interventions needed on the service plan for 6 of 6 sample residents reviewed, Resident ID #s 1, 2, 3, 4, 5, and 6. Findings are as follows: 1) Record review revealed Resident ID #1 moved into the residence in March of 2020 with diagnoses including, but not limited to: anemia, hearing loss, and hypertension. Review of the resident's comprehensive assessment, dated 6/3/2024, revealed the resident had falls on 11/28/2024, 3/2/2025, 4/20/2025, and on 5/12/2025. Further review of the assessment revealed that the resident is on a mechanically altered diet. Review of the resident's fall risk assessments revealed that on 12/2/2024, 3/3/2025, 4/21/2025, and 5/12/2025 the resident scored an 8, 9, 9, and 10 respectively, indicating the resident is at a moderate risk for falls. The resident's service plan, dated 5/12/2025, failed to reveal the resident was at risk for falls with interventions in place to reduce the fall risk. Additionally, the service plan indicated the resident is on a regular diet and failed to indicate accurately that the resident is on a mechanically	S 380		

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S 380	Continued From page 4 altered diet. 2) Record review revealed Resident ID #2 moved into the residence in October of 2020 with diagnoses including, but not limited to: dementia, anxiety, and hypertension. Review of the resident's comprehensive assessment, dated 5/2/2025, revealed the resident had falls on 10/7/2024, 3/29/2025, and 5/2/2025. Review of the resident's fall risk assessments dated 10/7/2024, 3/31/2025, and 5/2/2025 revealed that the resident scored a 7, 8, and 9 respectively, indicating the resident is at a moderate risk for falls. Further review of the fall risk assessments revealed the resident started having falls in 2023. The resident's service plan dated 4/17/2025 failed to reveal the resident was at risk for falls with interventions in place to reduce the fall risk. 3) Record review revealed Resident ID #3 moved into the residence in January of 2022 with diagnoses including, but not limited to: dementia, anxiety, and hypertension. Review of the resident's comprehensive assessment, dated 4/27/25, revealed the resident had falls on 3/28/2025, 4/1/2025, 4/12/2025, and 4/26/2025. Review of the resident's fall risk assessments dated 3/28/2025, 4/1/2025, 4/14/2025, and 4/27/2025 revealed that the resident scored a 8, 8, 8, and 9 respectively, indicating the resident is at a moderate risk for falls. Further review of the fall risk assessments revealed the resident	S 380		

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S 380	Continued From page 5 started having falls in 2023. The resident's service plan dated 4/27/2025 failed to reveal the resident was at risk for falls with interventions in place to reduce the fall risk. 4) Record review revealed Resident ID #4 moved into the residence in June of 2022 with a diagnosis including, but not limited to, end stage kidney disease. Review of the comprehensive assessment, dated 6/3/2024, revealed the resident receives dialysis (a treatment that filters waste and excess fluid from the blood when the kidneys are no longer able to). Review of the service plan dated 6/27/2024 failed to reveal the resident is receiving dialysis treatments. 5) Record review revealed Resident ID #5 moved into the residence in November of 2022 with diagnoses including, but not limited to, benign prostatic hyperplasia (BPH, prostate enlargement that can cause urinary difficulty) and nicotine dependence. After the entrance conference on 5/19/2025 a list of smokers was given to this surveyor. Resident ID #5 was on that list. Record review of the comprehensive assessment dated 11/5/2024 revealed the resident has a urinary catheter. Review of the service plan dated 12/11/2024 failed to reveal the resident has a foley catheter and is a smoker, with interventions in place to reduce the risks associated with smoking and	S 380		

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S 380	Continued From page 6 treatments needed relative to the cathether. 6) Record review revealed Resident ID #6 moved into the residence in April of 2024 with a diagnosis including, but not limited to, congestive heart failure. During the initial tour of the building on 5/19/2025 this surveyor observed this resident's door had an oxygen sign on it. Review of the physician's orders revealed the resident had an order to self-administer 2 liters of oxygen via nasal cannula continuously. Review of the service plan dated 2/13/2025 failed to reveal that the resident utilizes oxygen with interventions in place to safely utilize oxygen. During a surveyor interview with the Administrator and with the Director of Wellness on 5/20/2025 at approximately 2:20 PM, they could not provide evidence that Resident ID #s 1, 2, and 3's service plans revealed that they were at risk of falls; Resident ID #1's service plan accurately reflected that the resident is on a mechanically altered diet; Resident ID #4's service plan indicates he/she is on dialysis; Resident ID #5's service plan indicates he/she has a foley catheter and is a smoker; and further could not provide evidence that Resident ID #6's service plan reveals that he/she utilizes oxygen.	S 380	Within seven days of move-in the service plan shall be developed and will reflect all services by outside agencies and interventions. Will aslo include description, frequency, duration of services, including personal care, medication, special diets, smokers, foley catheters and oxygen use and any use of other services rendered. It will include arranging provider and who is providing the service and/or residents request or need for recreational and social activities. Residents identified at risk for falls will be included on service plans with interventions in place to reduce falls. All service plans have been reviewed. Will be updated quarterly and added to Quality Assurance.	To start imm-ediatley
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	S 555		

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S 555	Continued From page 7 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 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;	S 555		

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S 555	Continued From page 8 (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, 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	S 555		

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S 555	Continued From page 9 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 2 out of 3 medication carts observed, the medication cart for the 6th and 7th floor, and the medication cart for the 2nd and 3rd floor. Findings are as follows: During a surveyor observation for the 6th and 7th floor medication cart on 5/19/2025 at 9:36 AM in the presence of Certified Medication Technician, Staff G, the following were revealed: -fluticasone propionate 50 mcg (micrograms) opened, not dated. Manufacturer's instructions are to discard 6 weeks after opening. -diclofenac sodium topical gel 1%, discard after 1/4/2024. -aspirin 81 mg (milligrams) EC (Enteric Coated: designed to dissolve in the small intestine rather than the stomach), expired 4/13/2025. Immediately following the observation, Staff G, acknowledged that the fluticasone propionate	S 555	To ensure medications are stored securely they will be in their original pharmacy container with proper labeling and dated upon opening. A weekly checklist will be implemented to ensure medications expiration and dating is in compliane with DOH medications regulations. Weekly checklist, attached copy, will be monitored weekly by the Wellness Director. Removed all expired medications immediately and identified and labeled with dates. Added to Quality Assurance.	To start on June 13, 2025.

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S 555	Continued From page 10 was opened and not dated and that the diclofenac gel and the aspirin were expired. During a surveyor observation of the 2nd and 3rd floor medication cart at 10:17 AM in the presence of the Director of Wellness (DOW), the following was revealed: -fluticasone propionate 50 mcg opened, not dated. -fluticasone propionate 50 mcg in a plastic bag, opened, not dated. -incruse ellipta 62.5 mcg opened, not dated. Manufacturers instructions are to discard 6 weeks after opening. Immediately following the above observations, the DOW could not provide evidence the above-mentioned medications were dated when opened.	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 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	S 705		

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S 705	Continued From page 11 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; (6) Employee observation of each	S 705		

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S 705	Continued From page 12 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(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's documentation of fire drills failed to include all the necessary components, including 2 nightly fire drills, and the length of time of the drill, the employee observation of each resident's ability to carry out the drill. Additionally, it has been determined the residence failed to ensure drills simulating fire emergencies, testing the effectiveness of the fire evacuation plan, be conducted at least six (6) times per year on a bimonthly basis and at least fifty percent (50%) of these drills shall be obstructed drills, with a minimum of two drills conducted during the night 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: 2/2/2024, 4/10/2024, 6/14/2024, 8/17/2024, 10/3/2024, 12/9/2024, 1/7/2025, and 3/31/2025.	S 705	Fire drill form shall be altered to include the person conducting fire drills and the length of time of drills. Fire drills will be scheduled every other month, with half being obstructed and at least two conducted during the night. Add to Quality Assurance to be monitored quarterly. The maintenance director to monitor fire drill binder monthly.	To start June 17, 2025

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S 705	Continued From page 13 Review of the fire drill documentation failed to reveal who conducted the drills on the above-mentioned dates, the length of time of the drill, and the employee observation of each resident's ability to carry out the evacuation. Additionally, on 1/7/2025 and on 3/31/2025, it was not noted if the drills were obstructed or unobstructed. Further review of the fire drill documentation revealed that 2 of the drills, 4/10/2024 and 10/3/2024, were recorded as obstructed which is 25%, not the required 50%. Additionally, only 1 drill on 8/17/2024 was conducted during hours of sleep, not meeting the requirement. During a surveyor interview on 5/19/2025 at approximately 12:39 PM with the Administrator, she acknowledged the fire drill documentation failed to contain all of the above-mentioned required components.	S 705		