

RECEIVED

NOV 24 2023

PRINTED: 11/08/2023  
FORM APPROVED

RI Department of Health

|                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                    |                                                     |
|-------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>ALR01474</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br>B. WING: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                    | (X3) DATE SURVEY COMPLETED<br><br><b>10/27/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BROOKDALE SAKONNET BAY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1215 MAIN ROAD<br/>TIVERTON, RI 02878</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                    |                                                     |
| (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<br><br>An unannounced biennial State Licensure survey and a complaint/incident investigation survey (PHQE11, 10/26/2023) were conducted at this residence. A deficiency was identified relative to the State Licensure survey.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | S 003                                                                     | Enclosed is the Plan of Correction for Brookdale Sakonnet Bay in response to the SOD. While this document is being submitted as confirmation of the facilities on-going efforts to comply with all statutory and regulatory requirements, it should not be construed as an admission or agreement with the findings and conclusion in the SOD.                                                                                                                                                                                                                                           |                    |                                                     |
| S 490                                                             | Residential Care Services 2.4.21.C Dietetic Services<br><br>2.4.21 (C) Dietetic Services<br><br>C. The food service in each residence shall comply with the appropriate requirements of R.I. Gen. Laws Chapters 21-27 and 21-31, Rhode Island Food Code (Part 50-10-1 of this Title), and such other applicable statutory or regulatory provisions.<br><br>This Requirement is not met as evidenced by: Based on surveyor observations, record review, and staff interview, it has been determined that the residence failed to comply with the appropriate requirements of the Rhode Island Food Code.<br><br>Findings are as follows:<br><br>1. According to Section 2-301.14 of the Rhode Island Food Code states in part "...FOOD EMPLOYEES shall clean their hands and exposed portions of their arms as specified under §2-301.12 immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS...(E). After handling soiled EQUIPMENTS or UTENSILS..." | S 490                                                                     | Per community policy of Brookdale Sakonnet Bay is to comply with the requirements of RI General Laws Chapters 21-27, RI Food Code (Part 50-10-1 this Title), and such other applicable statutory regulatory provisions<br><br>1. Employee A was educated on Section 2-301.14 as well as 2-301-1210/27/23 pertaining to infection control, clean and dirty techniques.<br><br>Dining staff members including other staff identified handling food will be educated on above Sections noted in SOD. Audits will be completed weekly Exhibit A and brought to QA/reviewed monthly x3 months |                    |                                                     |

Facilities Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

6899

4Z5F11

If continuation sheet 1 of 3

RI Department of Health

|                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                          |                                                        |
|-------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>ALR01474</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>10/27/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BROOKDALE SAKONNET BAY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1215 MAIN ROAD<br/>TIVERTON, RI 02878</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X5)<br>COMPLETE<br>DATE |                                                        |
| S 490                                                             | <p>Continued From page 1</p> <p>During surveyor observations of the main kitchen on 10/26/2023 at approximately 10:40 AM and 10:50 AM in the presence of the Dining Room Manager, a dishwasher, Staff A, was placing soiled dishes into the dishwasher with his bare hands. Without washing his hands, Staff A then removed the clean dishes from the dishwasher and put them away.</p> <p>2. According to Section 4-601.11 of the Rhode Island Food Code requires that "... (C) Non FOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris..."</p> <p>During a surveyor observation of the ice machine on 10/26/2023 at approximately 10:55 AM in the presence of the Dining Room Manager, a black substance on the shield of the machine where the ice is dispensed was revealed.</p> <p>3. According to Section 3-501.17 of Rhode Island Food Code states in part, "... (A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under § 3-502.12, and except as specified in (E) and (F) of this section, refrigerated, READY-TO-EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5°C (41°F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. (B) Except as specified in (E) -(G) of this section, refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at</p> | S 490                                                                        | <p>To be monitored by FSD/RD and/or designee</p> <p>To be completed by 11/20/2023</p> <p>2. It is community policy of Brookdale Sakonnet Bay to follow Section 4-601.11 that non food contact surfaces of equipment shall be kept free of dust, dirt, food residue and other debris.</p> <p>Non food contact surfaces are at risk and have been cleaned 10/27/2023 as well as daily ongoing included in daily check list (See exhibit B)<br/>Daily checklist will be brought to daily stand-up and discussed as well as presenting data to QA monthly for compliance review.</p> <p>Staff will be educated on new daily check sheet.</p> <p>To be monitored by FSD/RD and/or designee</p> <p>To be completed 11/20/2023</p> <p>3. It is the policy of Brookdale to follow RI food code 3-501.17. The containers identified in the SOD we discarded on 10/27/2023 and all food items were checked for manufacture use by date as all food items were identified and assessed including all deliveries. Documentation shall be collected (See Exhibit C) and reviewed daily as well as discussed in QA monthly</p> |                          |                                                        |

RI Department of Health

|                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                       |                                                                                                                          |                                                        |
|-------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>ALR01474</b>          | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>10/27/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BROOKDALE SAKONNET BAY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1215 MAIN ROAD<br/>TIVERTON, RI 02878</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                                                                   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| S 490                                                             | <p>Continued From page 2</p> <p>the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the FOOD ESTABLISHMENT shall be counted as Day 1; and (2) The day or date marked by the FOOD ESTABLISHMENT may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on FOOD safety..."</p> <p>During a surveyor observation of the walk-in refrigerator on 10/26/2023 at approximately 10:58 AM, six containers of cooked butternut squash dated 10/22/2021 were revealed.</p> <p>During a surveyor interview on 10/26/2023 at approximately 11:00 AM with the Dining Room Manager, she acknowledged Staff A did not wash his hands after handling the soiled dishes before handling the cleaned dishes. Additionally, she acknowledged the black substance on the ice machine and could not provide evidence the above-mentioned food was stored appropriately.</p> | S 490                                                                                 | <p>To be monitored by FSD/RD and/or designee</p> <p>To be completed by 11/20/2023</p>                                    |                                                        |