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	ALR01347	A. BUILDING: _____ B. WING _____	07/15/2025

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VILLAGE AT WATERMAN LAKE-LP	715 PUTNAM PIKE SMITHFIELD, RI 02828

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S 003	Initial Comments An unannounced biennial State Licensure survey and a complaint/incident investigation survey (6SYI11, 07/15/2025) were conducted at this residence. Deficiencies were identified relative to the State Licensure survey.	S 003	The Filing of this plan of Correction (POC) does not constitute that the deficiencies alleged did in fact exist; rather this POC is filed as evidence of the community's continuing commitment to high quality resident care in full compliance with State regulations. Completion date for optimal compliance is 8/13/25.	
S 055	Licensure Requirements 2.4.3 Quality Assurance 2.4.3 Quality Assurance A. In accordance with R.I. Gen. Laws § 23-17.4-10.1, each assisted living residence shall develop, implement and maintain a documented, ongoing quality assurance program. 1. The purpose of this program shall be to attain and maintain a high quality assisted living residence through an on-going process of quality improvement that monitors quality, identifies areas to improve, methods to improve them, and evaluates the progress achieved. 2. Each licensed residence shall establish a quality improvement committee which shall include at least the following: assisted living administrator, registered nurse and a representative of dietary services. 3. The quality improvement committee shall meet at least quarterly; shall maintain records of all quality improvement activities; and shall keep records of committee meetings that shall be available to the Department during any onsite visit. 4. The quality improvement committee shall review and approve the quality improvement plan for the residence at intervals not to exceed twelve (12) months. Said plan shall be available to the	S 055	8/13/25 Facilities Regulation AUG 13 2025 Received Received AUG 13 2025 Facilities Regulation	

Facilities Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Oliver Harvey — COO — (X6) DATE 8/13/25

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S 055	Continued From page 1 public upon request. 5. Each assisted living residence shall establish a written quality improvement plan that includes: a. Program objectives; b. Oversight responsibility (e.g., reports to the governing body, QI records); c. Includes methods to identify, evaluate, and correct identified problems; d. Provides criteria to monitor personal assistance and resident services, including, but not limited to: (1) Resident/family satisfaction; (2) Medication administration/errors; (3) Reportable incidents as specified in § 2.4.17 of this Part; (4) Resident falls; (5) Plans of correction developed in response to the Department ' s inspection reports. B. In addition to the requirements of §§ 2.4.3(A) (1) through (5) of this Part, all assisted living residences with a "dementia care" license and/or a "limited health services license" shall also address the following areas in their quality improvement plan: a. Prevention and treatment of decubitus	S 055		

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S 055	Continued From page 2 ulcers; b. Dehydration, and nutritional status and weight loss or gain; and c. Changes in mental or psychological status. 1. Quality improvement documentation shall be kept on file for a minimum of five (5) years. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined that the residence failed to establish a written quality improvement plan that included all required components. Findings are as follows: Record review of the quality assurance program written plan failed to reveal evidence that the residence included the required components related to the Dementia Special Care Unit: a. Prevention and treatment of decubitus ulcers; b. Dehydration, and nutritional status and weight loss or gain; and c. Changes in mental or psychological status. The plan further failed to include medication administration, medication errors, and reportable incidents, as required. During a surveyor interview on 7/15/2025 at 2:14 PM with the Administrator, he could not provide evidence that the quality improvement plan had	S 055	The Quality Assurance Meeting Minutes will now include a more detailed summary of discussions that take place in the QA meeting regarding residents residing in memory care; specifically the prevention of decubitus ulcers, dehydration, nutritional status and weight loss or gain, as well as changes in mental or psychological status. Medication Administration, errors and reportable incidents will continued to be reviewed in QA meetings, with documentation reflecting this review included in each meeting's minutes accordingly. In order to ensure continued compliance in this area, assigned members of the managerial team (the VP Mktg Communication and the Courtyard Director of Nursing) will review the meeting minutes to ensure the aforementioned discussion topics are reflected on the minutes prior to the minutes being circulated and/or filed.	8/13/25

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S 055	Continued From page 3 all of the required components.	S 055		
S 230	Organization And Management 2.4.13.A Management Of Services 2.4.13.(A/B) Management of Services A. Each residence shall provide services with adequate professional and ancillary employees and in accordance with applicable state law. Further, the residence shall assure that all services are rendered in a safe and effective manner and consistent with the requirements herein. The residence shall provide all care and services to all residents in accordance with the prevailing community standard of care. This Requirement is not met as evidenced by: Based on surveyor observation, record review, and staff interview, it has been determined that the residence failed to provide care and services in accordance with prevailing community standards of care relative to following physician's orders relative to 2 of 2 residents whom self-administer medication, Resident ID #s 1 and 2. Findings are as follows: Mosby's 4th Edition, Fundamentals of Nursing, page 314 states, "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm the clients." 1. Record review revealed Resident ID #1 moved into the residence in June of 2017 with a diagnosis including, but not limited to, insulin dependent diabetic mellitus.	S 230		

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S 230	Continued From page 4 During a surveyor interview on 7/15/2025 at 8:30 AM with the resident, s/he revealed that s/he has a concentrator in her/his room and that s/he receives insulin that is brought to her/him by staff and that s/he injects it herself/himself. Record review of the comprehensive assessment "Section Five - Health Information" reveals that on 5/18/2024 the resident had a watchman's procedure (used to reduce the risk of stroke) and later became short of breath and needed to use more oxygen. Further review of the record revealed an assessment for medication, dated 6/2/2025, which indicates the resident can self-administer her/his insulin. Additionally, the resident was evaluated to self-administer her/his oxygen on 6/11/2025. Review of the service plan dated 10/7/2024 reveals the resident self-injects her/his insulin pen and is independent with oxygen. Review of a "Physical Assessment Physician's Orders for New Resident" dated 6/14/2017, reveals that the resident requires administration of medications. Record review revealed the following current physician's orders for insulin: -Lyumjev (a fast acting insulin) 1000units/1ml. Inject 42 units subcutaneously three times daily with meals. -Tresiba (a long acting insulin) 1000 units/1ml. Inject 42 units subcutaneously at bedtime.	S 230		

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S 230	Continued From page 5 Further review of the physician's orders failed to reveal an order for oxygen. Resident ID #1's physician's orders failed to reveal the medications were to be self-administered. During a surveyor interview with the Nurse, Staff A, on 7/15/2025 at approximately 10:30 AM, she could not provide evidence the resident had orders to self-administer insulin and oxygen. 2. Record review revealed Resident ID #2 moved into the residence in July of 2024 with a diagnosis of chronic obstructive pulmonary disease. Record review of the comprehensive assessment, dated 7/8/2025, reveals the spouse will be administering her/his medications. Record review of a service plan, dated 7/26/2024, failed to reveal the resident is independent with oxygen. Review of the hospital outpatient physician order summary, dated 5/23/2025, revealed an order for the resident to be "...using continuous oxygen at 3 liters at rest and 5 liters with exertion/personal care..." The resident's record failed to reveal a self-administration assessment. The record failed to reveal evidence the residence obtained all of the resident's current orders. During a surveyor interview with the resident's spouse on 7/15/2025 at approximately 11:00 AM, s/he revealed that s/he administers the resident's	S 230	Resident ID's # 1 and # 2 have experienced no untoward effects as a result of the surveyor findings. An order for oxygen was obtained and added to Resident # 1's chart. Orders were obtained from the PCP approving both residents for self-administration of the medication identified. The orders are now in each resident's chart. All medication sheets have been audited to identify other residents requiring orders to self-administer. Any orders required have been obtained and added to the resident charts. To ensure ongoing compliance, Medication sheets will be audited monthly to ensure the deficient practice does not recur. These corrective actions will be monitored through reporting at QAPI meetings to ensure that the actions continue to be effective and that the deficient practice will not recur.	8/13/25

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S 230	Continued From page 6 medications. During a surveyor interview with the Staff A on 7/15/2025 at approximately 11:40 AM, she could not provide evidence that the resident has a physician's order to self-administer her/his oxygen.	S 230		
S 490	Residential Care Services 2.4.21.C Dietetic Services 2.4.21 (C) Dietetic Services 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. This Requirement is not met as evidenced by: Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to comply with all appropriate standards of the Rhode Island Food Code relative to the Courtyard and the Lodge kitchens. Findings are as follows: Record review of the Rhode Island Food Code 2022 edition, Section 4-501.12 states in part, "Cutting Surfaces. Surfaces such as cutting blocks and boards that are subject to scratching and scoring shall be resurfaced if they can no longer be effectively cleaned and sanitized, or discarded if they are not capable of being resurfaced."	S 490		

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S 490	Continued From page 7 Record review of the Rhode Island Food Code 2022 edition, Section 4-601.11 states in part, "... (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris..." Record review of the Rhode Island Food Code 2022 edition, Section 4-501.112 states in part, "Mechanical Warewashing Equipment, Hot Water Sanitization Temperatures.(A)...(2) For all othe machines, 82°C (celcius) (180°F (fahrenheit))..." Record review of the Rhode Island Food Code 2022 edition, Section 3-602.11 states in part, "Food Labels states in part...(B) Label Information shall include: (1) The common name of the food..." Record review of the Rhode Island Food Code 2022 edition, Section 3-501.17 states in part"...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..." Record review of the Rhode Island Food Code 2022 edition, Section 5-501.113 states in part, "Covering Receptacles. Receptacles and waste handling units for Refuse, recyclables, and returnable shall be kept covered:(A) Inside the Food Establishment if the receptacles and units: (1) Contain food residue and are not in continuous use..."	S 490		

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S 490	Continued From page 8 Record review of the Rhode Island Food Code 2022 edition, Section 2-402.11 states in part, "(A)...FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed FOOD; clean EQUIPMENT, UTENSILS..." 1. During the initial tour of the Courtyard kitchen on 7/11/2025 at 9:15 AM, the following was revealed: -5 cutting boards scored and scratched; this may harbor bacteria. -Can opener with soft white matter hanging down. -Dried orange substance spots inside the microwave throughout the top and bottom. -The hot temperature dish machine dials were cracked and contained spots of brown, making it difficult to read the temperature on the dials. Additionally, the test strip used to test the dish machine had expired in May of 2025. Furthermore, review of the dish machine temperature logs failed to reveal the machine reached a sanitary temperature on numerous times logged. During a surveyor interview with the Food Service Director (FSD) on 7/11/2025 at 10:11 AM, the above-mentioned concerns were brought to his attention. He acknowledged the cutting boards were scratched, the can opener had soft white matter hanging from the tip, the microwave needed to be cleaned, and the hot temperature dish machine dials needed to be replaced.	S 490	S 490 8/13/25 1. Cutting boards have been replaced (see attached). Review of cutting boards has been added to weekly kitchen and dining inspections. Both can opener and microwave were washed and team reminded to keep these items clean. Both items are checked in weekly inspections to ensure compliance. 8/13/25 Glass on dials have been cleaned are now able to be read. New glass dials have been ordered and will be replaced as soon as they arrive. New strips were added and are being used. 2.Food in question was labeled immediately. Review of labeling is done during weekly kitchen and dining inspections. Turkey salad was discarded. Team have been reminded not to keep the lid of deli bar open too long as it can affect internal temp. Italian grinder was discarded. Team reminded to store sandwiches being held for later deeper in deli bar.	

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S 490	Continued From page 9 2. During the initial tour of the Lodge kitchen on 7/11/2025 at 9:15 AM in the presence of the FSD, the following was revealed: -No labels on food that were non distinguishable, examples as yellow muffin mix and white meat salad. -Turkey salad held at a temperature of 42 degrees Fahrenheit. -Italian grinder held at a temperature of 47 degrees Fahrenheit. -Trash containers, located near the ice machine, were not covered when not in use. -Dishwashers, Staff A and B, were not wearing beard nets and Waitstaff, Staff C, was not wearing a hair restraint. On 7/14/2025, the Cook, Staff D, was not wearing a beard net and Waitstaff, Staff E, was not wearing a hair restraint. -Walk in freezer was found to have ice build-up at the bottom lower door which defrosted with water leakage onto the floor. -Black substance on the wall behind the dish machine. -During the initial tour of the kitchen, the test strip for the low temperature dish machine was not registering at a minimum of 50 ppm (parts per million). The sanitizer container was empty and staff was unaware until the surveyor brought it to the attention of the FSD. Additionally, a test strip was not used that morning to test if the dish machine was sanitizing the breakfast dishes.	S 490	New covers have been ordered and are now in use. (see attached) All waitstaff were reminded to wear hair restraints. Staff persons A, B, and D have been provided beard guards, as were all other kitchen staff with facial hair. The door sweep to the walk-in freezer has been replaced. (see attached) The black substance was cleaned and will be maintained by service staff. Area reviewed as part of weekly kitchen and dining inspections. Team was reminded to test the dish machine to ensure proper sanitizing before each service. Ecolab has installed an alarm to alert when the sanitizer on the low temp machine has been depleted. (see attached)	8/1/25 8/13/25 8/4/25 7/14/25 7/21/25

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S 490	Continued From page 10 During a surveyor interview with the FSD following the observations, he could not provide evidence that the muffin mix and meat salad were labeled, the turkey salad and Italian grinder were held at a temperature of 41 degrees or less, trash containers were covered when not in use, the kitchen staff wore beard nets and hair restraints while preparing food. He acknowledged that the walk-in freezer had ice build-up at the bottom lower door, as well as water. He further acknowledged there was no sanitizer solution for the low-temperature dish machine to sanitize the dishes.	S 490		
S 565	Residential Care Services 2.4.24.B.1 Medication Services 2.4.24 (B) (1) Administration of Medications 1. Residences licensed at the M1 level may administer medications to residents including, but not limited to, removing medication containers from storage, assisting with the removal of a medication from a container for residents with disability which prevents independence in this act, and/or administering the medication directly to the resident. a. The resident or guardian must provide written authorization for the residence to provide administration of medications. b. Medications shall be administered in accordance with written orders of a physician. The residence must provide in writing, a description of services provided by the residence to each physician, including limitations on service.	S 565		

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S 565	Continued From page 11 c. All medications must be checked against a physician's orders by a licensed nurse, or pharmacist. d. The resident must be identified prior to administration of any medication. e. The medication must be in the original pharmacy-dispensed container with proper label and directions attached and be administered in accordance with such label. f. Injectable medications, including but not limited to insulin, which cannot be self-administered by the resident, must be administered by a licensed nurse. g. There shall be written a policy/procedure for the disposal of hypodermic needles, syringes and other such instruments that is in compliance with rules and regulations governing Hypodermic Needles, Syringes & Other Such Instruments (Part 20-15-6 of this Title). (1) The legal destruction of hypodermic needles, syringes or other such instruments is the responsibility of the last entitled or authorized possessor. (AA) All personnel or residents legally authorized to use disposal syringes and needles, shall destroy them after one (1) use. (BB) Excess and undesired needles, syringes and other such instruments shall be stored in impervious, rigid, puncture- resistant container for disposal. Intact needles shall be placed directly into the collection containers.	S 565		

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S 565	Continued From page 12 (CC) Personnel handling disposal waste materials such as needles, syringes, and other such instruments may treat and destroy such waste by a DEM-approved alternative treatment/destruction technology or prepare the regulated medical waste for off-site transport by a DEM-permitted medical waste transporter. h. Individual medication records must be retained for each resident to whom medications are being administered and each dose administered to the resident must be properly recorded. i. Any medication administered by the residence and refused by a resident shall be documented and reported, as appropriate. j. Medications shall be stored securely and in such a manner to prevent spoilage, dosage errors, administration errors, and/or inappropriate access. Provisions for safe storage may include lockable containers, secure spaces, or lockable units, as appropriate to the residence and the resident population. k. All medication in the residence, regardless of whether controlled by employees or by the resident, shall be stored securely as stated in § 2.4.24(A)(3)(a)(8) of this Part. l. All centrally stored medications shall be maintained in accordance with manufacturer's labeling and administered by authorized personnel. This Requirement is not met as evidenced by:	S 565		

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S 566	Continued From page 13 Based on surveyor observation, record review, and staff interview, it has been determined that 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 one of two memory care medication carts and a medication cart for the first-floor residents. Findings are as follows: 1) Resident ID #3's Medication Administration Record indicates the resident is prescribed the following medications: -Milk of Magnesia 400 mg (milligram)/5 ml (milliliter). Give 30 ml by mouth once daily as needed for constipation. -Diclofenac Sodium 1% gel. Apply to left knee topically four times daily. Max dose of two grams for upper extremities and max dose of four grams for lower extremities as needed. During a surveyor observation of the memory care cart on 7/15/2025 at approximately 9:45 AM in the presence of Certified Medication Technician (CMT), Staff F, the following was revealed: a. Resident ID #1's Milk of Magnesium and Diclofenac Sodium gel were unavailable on the cart. b. Acetaminophen 500 mg with a discard date of 7/13/2024. c. Bayer low dose 81 mg with an expiration date of 6/2025. During a surveyor interview on 7/15/2025 at 10:05	S 566	1. Resident ID # 3 has experienced no untoward effects as a result of the surveyor findings. The PRN medications that were unavailable have been re-ordered. Medications that were discontinued and/or expired have been removed from the supply and re-ordered as appropriate. 2. Carts were audited to ensure no other meds were discontinued and/or expired and any found to be have been removed from the supply and re-ordered as appropriate. 3. Audit of the medication carts will be performed on a monthly basis to ensure all residents on the med program have PRN medications available, that expired medications are re-ordered timely, and that discontinued medications are removed from supply. Any identified issues will be immediately addressed. 4. These corrective actions will be monitored through reporting at QAPI meetings to ensure that the corrective actions continue to be effective and that the deficient practice will not recur.	8/13/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01347	A. BUILDING: _____ B. WING _____	07/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE AT WATERMAN LAKE-LP	715 PUTNAM PIKE SMITHFIELD, RI 02828

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S 565	Continued From page 14 AM with the Director of Nursing, she acknowledged that the residence did not have the resident's medications for the above prn orders. She further acknowledged that the Acetaminophen and Bayer had expired. 2) During a surveyor observation of the medication cart for the first floor on 7/15/2025 at 11:30 AM in the presence of CMT, Staff G, the following was revealed: -2 bubble packs of Senna with expiration dates of 2/2025 and 3/2025. -2 bubble packs of Acetaminophen 500 mg with discard dates of 4/18/2025 and 6/14/2025. During a surveyor interview following the above observations Staff G, acknowledged the above medications have expired and should have been discarded.	S 565		
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 the effectiveness of the fire evacuation plan shall	S 705		

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S 705	Continued From page 15 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 resident's ability to carry out evacuation	S 705		

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S 705	Continued From page 16 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 the length of time. Findings are as follows: 1. Record review revealed the Lodge fire drills were conducted on the following dates in 2024 and 2025: 1/31/2024, 2/29/2024, 3/31/2024, 4/30/2024, 5/30/2024, 6/28/2024, 7/30/2024, 8/29/2024, 9/10/2024, 10/31/2024, 12/30/2024, 1/19/2025, 2/27/2025, 3/31/2025, 4/30/2025, 5/30/2025, and 6/30/2025. Review of the fire drill documentation failed to reveal the length of time of the drills. 2. Record review revealed the Courtyard fire drills were conducted on the following dates in 2024 and 2025: 1/31/2024, 2/27/2024, 3/22/2024, 4/30/2024, 5/30/2024, 7/30/2024, 8/16/2024, 9/27/2024, 10/15/2024, 11/29/2024, 2/28/2025, 3/28/2025, 4/30/2025, 5/20/2025, and 6/4/2025.	S 705 8/18/25	The Fire drill tracking sheet located in the monthly quality assurance maintenance log has been revised to include "end time" of the drill. This aspect of the drill will be audited when the fire drills logs are audited bi-monthly.	8/13/25

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S 705	Continued From page 17 Review of the fire drill documentation failed to reveal the length of time of the drills. During a surveyor interview on 7/15/2025 at approximately 12:30 PM with the Administrator, he could not provide evidence that the fire drill documentation contained the length of time of the drills, as required.	S 705		