RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01482	A. BUILDING: _____ B. WING _____	C 09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOCKWOTTON ON THE WATERFRONT	500 WATERFRONT DRIVE EAST PROVIDENCE, RI 02914

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S 003	Initial Comments An unannounced complaint/incident investigation survey, ACTS reference numbers 101674, 101711, 101842, 101777, 101880, and 101989, was conducted at this residence on 9/29/2025-9/30/2025 to determine compliance with state regulations. Deficiencies were identified.	S 003	Received OCT 24 2025 Facilities Regulation	
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 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 orders for weight obtainment for one of five residents reviewed, Resident ID# 5. 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	S 230	**As of 10/25/25, Resident ID #5's PCP was aware of the weight variance for the date that was missed and discontinued the daily weights order going forward.** **As of 10/25/25, The Director of Wellness or his/her designee will conduct an audit of all residents in the Courtyard Memory Care program and the River's Edge Assisted Living program to identify any other residents with a daily weight order to determine if follow up with physician has been done. If orders are found, doctors will be notified and orders will be discontinued as appropriate. No additional residents were affected.** **As of 10/25/25, any daily vital check doctor order with an end date will be placed on the nurse MAR to prompt the nurse to ask the med tech about the vital taken to ensure compliance.**	10-25-25

10/31/25

Facilities Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE 10/25/25

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S 230	Continued From page 1 clients..." 1. Record review revealed Resident ID #5 was admitted to the residence in January of 2024 with a diagnosis including, but not limited to, congestive heart failure. Record review of a physician's order dated 7/2/2025 revealed in part,"...Daily weights, notify nurse if increase in 3 pounds in one day or 5 pounds in 1 week..." Record review of a document titled; "Vitals" revealed the following: 8/4/2025 weight 168.6 8/5/2025 weight 171.6 8/9/2025 weight 165.6 8/10/2025 weight 168.6 8/18/2025 weight 167.6 8/19/2025 weight 170.6 8/26/2025 weight 166.8 8/27/2025 weight 170.2 9/24/2025 weight 162.4 9/25/2025 weight 166.6 Record review of progress notes failed to reveal that the nurse was notified of the three-pound weight gains in one day and that the physician was notified of the weight gains. During a surveyor interview on 9/30/2025 at 2:45 PM with the Director of Wellness, she acknowledged that the physician should have been notified of the three-pound weight gains in a day.	S 230	**On a weekly basis, remarkable weight increase/decrease will be discussed at the weekly risk meeting. Proper follow up will be audited including physician notification.** **As of 10/25/25, audits of the nurse MAR will be done on a monthly basis to ensure compliance with physician orders. These monthly audits and weekly risk meetings will be brought to the quarterly Quality Improvement Committee meetings for at least three months.**	
S 390	Residency Requirements 2.4.16.G.3 Resident Assessment/Service Plan	S 390		

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S 390	Continued From page 2 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 resident's service plan with a description of the services and interventions needed for three of six residents reviewed for outside services, Resident ID #s 1, 2, and 6. Findings are as follows: 1. Resident ID #1 moved into the residence in March of 2023 with a diagnosis that includes, but is not limited to, Alzheimer's disease. Record review of the resident's physician's orders revealed an admission to hospice in July of 2025. Record review of the resident's service plan failed to reveal an update was made upon admission to hospice services. 2. Record review revealed Resident ID #2 moved into the residence in August of 2025 with a diagnosis that includes, but is not limited to, Alzheimer's disease. Record review of the physician orders revealed that the resident had physician orders for speech therapy, physical therapy, and occupational	S 390	**As of 10/25/25, Resident ID #1's service plan has been updated to reflect hospice services, resident ID #2's service plan has been updated to reflect PT/OT services, and resident ID #6's service plan has been updated to reflect PT services.** **As of 10/25/25, The Director of Wellness or his/her designee will conduct an audit of all service plans of residents in the Courtyard Memory Care program and the River's Edge Assisted Living program who are on outside services, to ensure all service plans contain accurate and up to date information on outside services being provided. If discrepancies are found, service plans will be updated.** **As of 10/25/25, an interdisciplinary weekly Risk meeting will be held to review all outside services of residents and the corresponding updating of service plans.** **As of 10/25/25 monthly audits of the weekly risk meetings will be brought to the quarterly QI committee meetings for at least three months.**	10-25-25

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S 390	Continued From page 3 therapy. Record review of the resident's service plan dated 8/1/2025 failed to reveal evidence of the services the outside agency was providing to the resident. 3. Record review revealed Resident ID #6 moved into the residence with a diagnosis that includes, but is not limited to, restless leg syndrome. Record review of the physician's order revealed that the resident had a physician's order for physical therapy and a palliative care consult. Record review of the service plan initiated on 9/2/2024 failed to reveal evidence the resident was receiving physical therapy. During a surveyor interview on 9/30/2025 at 3:15 PM with the Director of Wellness, she acknowledged the service plans failed to have evidence of the services that the outside agencies provided.	S 390		
S 405	Residency Requirements 2.4.17.B Reporting Requirements 2.4.17 (B) Reporting Requirements B. Accidents, incidents, and medication errors resulting in out-of-residence emergency medical services resulting in a hospital admission of any resident shall be reported to the Center for Health Facilities Regulation in writing, via facsimile or electronic transmission to doh.ofr@health.ri.gov by the end of the next working day. A copy of each report shall be retained by the residence for review during subsequent inspections by the Department.	S 405	**As of 10/25/25 incident was reported. The Director of Wellness received retraining on the reporting protocol.** **As of 10/25/25 a review of all incidents and hospital transfers from the past 30 days confirmed all other required reports were submitted timely.** **As of 10/25/25, The Director of Wellness or his/her designee will call the hospital within 24 hours of a resident being sent out to determine admission status of resident.**	10-25-25

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S 405	Continued From page 4 This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined the residence had failed to report an incident resulting in out-of-residence emergency medical services and a hospital admission by the end of the next working day for one of six who were admitted to the hospital after a fall, Resident ID #2. Findings are as follows: Record review revealed the resident had a fall on 9/12/2025 and was sent to the hospital for an evaluation, and was admitted on 9/12/2025 and discharged on 9/16/2025. This resident's fall with hospitalization was not reported to the Center for Health Facilities Regulation in writing as of 9/30/2025. During a surveyor interview on 9/30/2025 at 3:00 PM with the Director of Wellness, she acknowledged she did not report the fall that occurred on 9/12/2025 in writing to the Center for Health Facilities Regulations.	S 405	**As of 10/25/25, a daily clinical review at stand-up meetings will be done to review any incidents resulting in hospital visit. These daily clinical reviews will be added to the weekly risk meetings.** **As of 10/25/25 monthly audits of the weekly risk meetings will be brought to the quarterly QI committee meetings for at least three months.**	
S 535	Residential Care Services 2.4.22 Housekeeping 2.4.22 Housekeeping The residence shall maintain a comfortable, safe, clean, sanitary and orderly environment, free of litter, rubbish and offensive odors. This Requirement is not met as evidenced by:	S 535	**Resident ID #5's raised toilet seat was fixed immediately upon investigation of the facility on 8/4/25.**	**10-25-25**

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S 535	Continued From page 5 Based on record review and staff interview it has been determined that the residence failed to maintain a comfortable, safe, clean sanitary environment as evidenced by a toilet grab bar that was not securely attached to the wall. Findings are as follows: The Rhode Island Department of Health received an facility reported incident on 8/5/2025 alleging a resident sustained a bruise to his/her left upper arm due to a broken toilet apparatus. Resident ID #5 was admitted to the memory care unit of the residence in March of 2022 with a diagnosis that includes, but is not limited, to Alzheimer's disease. During a surveyor interview on 9/30/2025 at approximately 12:30 PM with the resident, s/he did not recall the incident. During a surveyor interview with the Executive Director on 9/30/2025 at approximately 3:00 PM, he acknowledged that the toilet grab bar was loose and that it was not affixed to the wall thereby causing the bruise to the resident's arm.	S 535	**As of 10/25/25, The Director of Maintenance or his/her designee, will do an audit of all toilet apparatuses in the Courtyard Memory Care Program and the River's Edge Assisted Living Program to determine they are safe and stable for resident use. No additional hazards were identified.** **As of 10/25/25, The Director of Maintenance or his/her designee will place all toilet apparatuses on a Bathroom Safety Checklist to be checked on a quarterly basis.** **As of 10/25/25, the Administrator or his/her designee will bring the completed quarterly Bathroom Safety. Checklist to the quarterly QI meetings for at least three months.**	