RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01520	A. BUILDING: _____ B. WING _____	03/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAPEL HILL.	10 OLD DIAMOND HILL ROAD CUMBERLAND, RI 02864

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S 003	Initial Comments An unannounced State Licensure survey and a complaint/incident investigation survey (ACTS M61N11, 99956) were conducted at this residence on 3/20/2025 through 3/24/2025. Deficiencies were identified relative to the State Licensure survey.	S 003	The filing of this plan of correction does not constitute an admission of the allegations set forth in this statement of deficiencies. This plan of correction is prepared and executed as evidence of the facility's continued compliance with applicable law.	5/1/25
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	S 055	1. The assnual QA plan has been revised to include education on prevention and treatment of decubitus ulcers, dehydration and nutritional status and weight loss or gain, and recognizing a significant change in mental or psychological status. 2. All staff working in the Dementia unit will receive education on prevention and treatment of decubitus ulcers, dehydration and nutritional status and weight loss or gain, and recognizing a significant change in mental or psychological status by 5/1/25. 3. Education will then be incorporated in Quarterly QA starting in the 3rd quarter. 4. WD and/or Designee will audit 20% of staff weekly x 8 weeks then monthly x 4 months to ensure all staff have received appropriate training. 5. WD will bring audit to results to quarterly QA x6 months to ensure continued compliance with staff training. Received APR 14 2025 Facilities Regulation	

Facilities Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: EXECUTIVE DIRECTOR — (X6) DATE: 4-14-25

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S 055	Continued From page 1 (12) months. Said plan shall be available to the public upon request. 6. 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:	S 055		

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S 055	Continued From page 2 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. 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 for the Dementia Special Care Unit. Findings are as follows: Record review of the residence quality assurance written plan failed to reveal evidence that the residence included the required components (prevention and treatment of decubitus ulcers, dehydration, nutritional status, weight loss/gain, and changes in mental status) related to the Dementia Special Care Unit. During a surveyor interview on 3/24/2025 at 12:48 PM with the Administrator, he could not provide evidence that the quality improvement plan had all of the required components.	S 055		
S 190	Organization And Management 2.4.12.H Administrative Management	S 190		

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S 190	Continued From page 3 2.4.12 (H) In-service Training 1. Employees shall have on-going, at intervals not to exceed twelve (12) months, in-service training as appropriate for their job classifications and including the topics cited in § 2.4.12(G) of this Part. 2. All new employee orientation and on-going in-service training shall be documented in the employee's personnel file, and maintained onsite at the licensed residence. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined the residence failed to ensure all new employees received at least ten hours of orientation and training within thirty days of hire and prior to beginning work alone in the residence, in the areas stipulated in § 2.4.12(G) of the regulations for 2 of 2 newly hired employees, Staff A and B. Findings are as follows: 1) Record review of the personnel record for Staff A revealed a hire date of 12/21/2024, this employee was hired as a certified nursing assistant (CNA). Review of the record failed to reveal Staff A received all of the required trainings within 10 days of hire and prior to beginning work alone in the assisted living residence (ALR) such as: fire prevention; recognition and reporting of abuse, neglect, and mistreatment; assisted living philosophy; resident rights; confidentiality, emergency preparedness and procedures;	S 190	1. Staff A, B, and C will all be re-educated by 4/18 to cover all training required on hire as outlined in the regulation. 2. Audit of all employee records will be completed by 5/1 to identify and complete required trainings. 3. In-service to be completed by 4/18 with ED/WD/and BOM on education needed for employees that needs to be completed within 10 days of hire and prior to working alone. 4. ED and/or Designee will audit 100% of new employee files weekly x 8 weeks and monthly x4 months to ensure employee training is completed and within the appropriate timeframe. 5. ED and/or Designee will bring results of audits to quarterly QA x 6 months to ensure continued compliance of employee trainings.	

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S 190	Continued From page 4 resident elopement. The record further failed to reveal Staff A received all of the required trainings within thirty days of hire and prior to beginning work alone in the ALR in the areas of basic sanitation; food service; cultural differences, basic knowledge of aging-related behaviors including dementia and Alzheimer's disease; personal assistance; assistance with medications; record-keeping; service plans; and internal reporting. Additionally, the record failed to reveal Staff A received all of the required trainings for the dementia care unit prior to beginning work alone in the ALR in the areas of understanding various dementias; communicating effectively with dementia residents; managing behaviors; elopement procedures for the unit/program; creating a safe environment for residents; and medications commonly prescribed for resident residing in the unit/program and potential side effects. 2) Record review of the personnel record for Staff B revealed a hire date of 11/15/2024, this employee was hired as a CNA. Review of the record failed to reveal Staff B received all of the required trainings within 10 days of hire and prior to beginning work alone in the ALR such as: fire prevention; confidentiality, emergency preparedness and procedures; and resident elopement. The record further failed to reveal Staff B received all of the required trainings within thirty days of hire and prior to beginning work alone in the ALR in the areas of basic sanitation; food service; cultural differences; personal assistance; assistance with medications; record-keeping; service plans; and internal reporting. Additionally, the record failed to reveal Staff B received all of the required trainings for the dementia care unit prior to	S 190		

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S 190	Continued From page 5 beginning work alone in the ALR in the areas of elopement procedures for the unit/program; creating a safe environment for residents; and medications commonly prescribed for resident residing in the unit/program and potential side effects. During a surveyor interview with the Director of Wellness on 3/21/2025 at approximately 10:00 AM, she could not provide evidence the above-mentioned staff had all of the required trainings prior to beginning work alone in the ALR.	S 190		
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;	S 200	1. Employee record for staff A will be updated with all required documentation by 4/18/25. 2.Audit of all employee files will be completed by 5/1 using new hire checklist to identify that all necessary paperwork is presen. 3. In-service completed with BOM on new hire checklist will be completed by 4/18. 4. ED and/or Designee will audit 10% of employee files weekly x8 weeks and then monthly x 4 months to ensure all new hire paperwork is present. 5. ED and/or Designee will review results of audits in quarterly QA x 6 months to ensure continued compliance.	

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S 200	Continued From page 6 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; 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 one of two newly hired employees reviewed, Staff A. Findings are as follows: Record review of the personnel record for Staff A revealed a hire date of 12/21/2024, this employee was hired as a certified nursing assistant (CNA). The record failed to reveal a BCI check prior to or within 1 week of hire. The record further failed to reveal the Staff's job application/resume, reference checks, job	S 200		

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S 200	Continued From page 7 description, and a signed copy of the resident's rights. During a surveyor interview with the Director of Wellness on 3/21/2025 at approximately 10:00 AM, she could not provide evidence that Staff A's personnel record contained all required components.	S 200	1. Resident ID#2 medications were corrected to ensure blister pack and EMAR matched iections	
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 d. The resident's requested and/or therapeutically needed recreational and social activities.	S 380	1. Resident ID #3 was re-assessed on 4/7 and the service plan was updated to reflect current smoking status. 2. WD and/or Designee will complete audit of all residents who smoke by 4/18 to ensure assessment and service plan reflect accurate smoking status. 3. WD and/or Designee will re-educate nursing staff on smoking policy and reporting any changes in status to WD to be completed by 4. WD and/or Designee will audit all residents who smoke weekly x 4 weeks then monthly x4 months to ensure the smoking status is being captured on the assessment and service plan. 5. Results of audits will be reviewed in quarterly QA x 6 months to ensure continued compliance.	

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S 360	Continued From page 8 This Requirement is not met as evidenced by: Based on record review 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 a singular resident reviewed relative to smoking, Resident ID #3. Findings are as follows: Record review revealed the resident moved into the residence in March of 2024 with diagnoses including, but not limited to, cognitive impairment and delusional disorder. During a surveyor interview on 3/24/2025 at 10:20 AM with the resident, he/she revealed that he/she has been smoking for about 40 years and that he/she currently smokes 1 pack of cigarettes every 3-4 days. Review of the record further revealed smoking assessments dated 4/19/2024, 7/15/2024, 10/15/2024, and 1/15/2025, indicating that the resident is a smoker. Review of a progress note dated 4/19/2024 reveals the resident was found to be outside smoking. The resident was educated that he/she needs to smoke 50 feet away from the building. Record review of the resident's service plan initiated on 3/18/2024 failed to indicate that the resident is a smoker and therefore failed to reveal smoking interventions to keep the resident and other residents safe. During a surveyor interview with the Director of Wellness on 3/24/2025 at approximately 1:00 PM, she could not provide evidence smoking was	S 360		

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S 380	Continued From page 9 listed on the resident's service plan, as required.	S 380		
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 observations, record review, and staff interview, it has been determined that the residence failed to comply with the appropriate standards of the Rhode Island Food Code relative to the main kitchen. Findings are as follows: Record review of the Rhode Island Food Code 2018 edition, Section 3-602.11 Food Labels states, "...(B) Label information shall include: (1) The common name of the food..." During the initial tour of the main kitchen with the Food Service Director (FSD) the following was revealed: - two handwashing sinks, one sink did not have hand soap in the soap dispenser. The other handwashing sink, when turned on, started leaking from the pipe underneath.	S 490	1. On 3/20/25, the handwashing sink leaking from the pipe underneath was fixed and the soap added to the hand washing sink that did not have hand soap. On 3/20/25, the patties, veggie burgers, slices of cherry pie, garden salad, bags of raisin bran, cheerios, and bottle of molasses were discarded. 2. In-service conducted 3/25/25 for staff on food labeling and procedures for reporting leaks in sinks and soap. 3. Audit completed on 3/20/25 of refrigerator, dry storage and freezer to ensure all outdated or non-labeled food was discarded. 4. To enhance current compliant operations, the Director of Dining Services and/or Designee will conduct weekly audits for 3 months then quarterly audits for 3 months on the handwashing sinks soap and handwashing sink operation for leaks. To enhance current compliant operations the Director of Dining Services and/or designee will conduct daily audits for 3 months then quarterly x3 months on the labeling & datung of food items. 5. The Director of Dining services and/or Designee will report audit results to the QA Committee x 6 months and follow up, as necessary to ensure ongoing compliance.	

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S 490	Continued From page 10 - Ice machine, red splatter on the inside ledge and brown splatter on the inside left side. During a surveyor interview with the FSD on 3/20/2025 at approximately 8:30 AM, he acknowledged one of the handwashing sinks had a soap dispenser without hand soap. He further acknowledged the other handwashing sink's pipe was leaking. He indicated he put in a work order for it a few weeks ago. Additionally, he could not provide evidence that the ice machine was clean. A. Reach-in freezer: - contained 4 unidentifiable patties that were not wrapped. No label or date. - contained veggie burgers, taken out of the original packaging, no date. - contained at least 10 unidentifiable patties in a plastic bag. No label or date. During a surveyor interview with the FSD, he could not provide evidence that the 4 veggie burgers were wrapped and labeled with dates. He further could not provide evidence that the burgers were labeled and dated. B. Reach-in refrigerator: - 2 slices of cherry pie with a use by date of 3-18 - a garden salad wrapped without a date. During a surveyor interview with the FSD, he could not provide evidence that expired food was discarded. C. Storage area: - 7 clear plastic bags of Raisin bran, taken out of the original packaging, no expiration date.	S 490	1. On 3/21/25, the ice machine was cleaned. An in-service was conducted on 3/20 with staff on cleaning the ice machine. 2. To enhance current compliant operations, the Director of Dining Services and/or designee will conduct weekly audits x 3 weeks then monthly x 3 months on the ice machine. To enhance current compliant operations, monthly cleaning tasks have been added to TELS, our maintenance work order system. On a monthly basis the Facilities Director and/or designee will clean the ice machine and document the task. 3. The Director of Dining Services and/or designee will report audit results to the QA Committee x 6 months and follow up as necessary to ensure ongoing compliance.	

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S 490	Continued From page 11 - 1 clear plastic bag of Cheerios, taken out of the original packaging, no expiration date - 3 1/2 clear plastic bags of Cornflakes, taken out of the original packaging, no expiration date. - a bottle of molasses, the bottle had leaked from the cap, as there was dried brown matter down the sides of the bottle. Additionally, the best buy date was covered. During a surveyor interview with the FSD following the above observations, he could not provide evidence of the expiration dates of the cereals; he further could not provide evidence that the bottle of molasses was kept clean and within its best by date. D. The walk-in freezer was stacked to the ceiling with boxes of food items. Air circulation was not feasible. During a surveyor interview following the above, the FSD acknowledged the walk-in freezer had packages stacked to the ceiling not allowing for proper air circulation.	S 490	1. On 3/21/25, the food boxes in the freezer were removed and distributed to other kitchen freezers, allowing for feasible air circulation. 2. An in-service was conducted with staff on 3/27/25 on proper food storage in the walk-in freezer. 3. Audit completed on 3/27/25 to ensure all freezers were in compliance with storage to allow adequate air circulation. 4. To enhace current compliant operations, the Director of Dining Services and/or designee will conduct weekly audits x 3 weeks then monthly x 3 months on the walk-in freezer. 5. The Director of Dining Services and/or designee will report audit results to the QA commitee quarterly x 6 months and follow up as necessary to ensure ongoing compliance.	
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.	S 565		

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S 565	Continued From page 12 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. 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.	S 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01520	A. BUILDING: _____ B. WING _____	03/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAPEL HILL	10 OLD DIAMOND HILL ROAD CUMBERLAND, RI 02864

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S 565	Continued From page 13 (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. (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 §	S 565		

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CHAPEL HILL	10 OLD DIAMOND HILL ROAD CUMBERLAND, RI 02864

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S 565	Continued From page 14 2.4.24(A)(3)(a)(8) of this Part. I. 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: Based on surveyor observation, and resident and staff interviews, 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 1 of 2 residents observed that self-administer their medications, Resident ID #1, and the medication cart on the special care unit. Findings are as follows: A. Record review of Resident ID #1's assessment dated 12/9/2024 revealed the resident self-administers his/her medications. During a surveyor observation of the resident's room on 3/21/2025 medications were stored on an open shelf. During a surveyor interview with the resident in the presence of his/her daughter on 3/21/2025 at approximately 11:50 AM, he/she revealed that a lockable container or a locked cabinet was never offered for him/her to store his/her medications. During a surveyor observation in the presence of the Director of Wellness (DOW) on 3/21/2025 at 12:40 PM, the resident's apartment was left unlocked, and the resident was not in his/her room.	S 565	1. Resident ID #1 provided a lock box and re-educated on keeping medication secured in room. 2. Audit of all residents who self-medicate to be completed by 4/18/25 to ensure all medications are kept secure in their apartments. 3. ED and/or Designee to re-educate nursing staff on med-policy and expectations on securing medications in resident apartments to be completed by 4/18/25. 4. WD and/or Designee to complete education with residents on securing medications in their apartments. To be completed by 4/18/25. 5. WD and/or Designee will audit 25% of residents who self-medicate to ensure medications are kept secure weekly x 8 weeks, and then monthly x4 months. 6. WD will report audit results in the quarterly QA meeting x 6 months to ensure continued compliance.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAPEL HILL	10 OLD DIAMOND HILL ROAD CUMBERLAND, RI 02864

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S 665	Continued From page 15 During a surveyor interview with the DOW following the above observation, she acknowledged the resident's apartment did not have a locked cabinet or a lock box for the resident to put his/her medications in. She further could not provide evidence that the resident's medications were stored securely. B. During a surveyor observation of the medication cart on the special care unit on 3/20/2025 at 2:54 PM in the presence of Certified Medication Technician, Staff C, the following medications for Resident ID #2 were revealed: 1. A medication card of Docusate Sodium 100 milligram (mg) caps to be administered twice per day. Review of the resident's physician's order revealed Docusate Sodium 100 mg to be administered daily, dated 3/18/2025. 2. A medication card of Gabapentin 100 mg caps to be administered in the morning and afternoon. Review of the resident's physician's order revealed Gabapentin 300 mg caps by mouth daily at bedtime, dated 12/15/2024. During a surveyor interview immediately following the above observations, Staff C acknowledged the medication card directions did not match the physician's orders for the above-mentioned medications. During a surveyor interview on 3/24/2025 at 8:48 AM with the Director of Wellness, she could not provide evidence the above-mentioned medications were stored to prevent dosage	S 665	1. Resident ID#2 medications were corrected to ensure blister pack and EMAR matched in directions. 2. Education completed with all nursing staff who administer medications on notifying the nurse of conflicting information on blister pack to be completed by 4/18/25. 3. Audit of all residents medications to ensure EMAR and blister pack coincide to be completed by 5/1/25. 4. WD and/or Designee will audit 10% of residents orders to ensure accuracy wwekly x 8 weeks then monthly x 4 months. 5. WD will bring audit results to quarterly QA x 6 months to ensure continued compliance.	

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	ALR01520	A. BUILDING: _____ B. WING _____	03/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAPEL HILL	18 OLD DIAMOND HILL ROAD CUMBERLAND, RI 02864

(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 665	Continued From page 16 errors, as required.	S 665		
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 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	S 705	1. An in-service was conducted with staff on 3/24/25 to review the regulation on obstructed vs. unobstructed fire drills and amount of time taken to complete the drill. 2. 110 residents have the potential to be affected by this alleged deficient practice. 3. To enhance current compliant operations, the ED and/or Designee will conduct monthly audits on fire drills and a yearly schedule developed planning obstructed fire drills to ensure at least fifty percent (50%) are obstructed. 4. The ED and/or Designee will report audit results to the QA committee quarterly x 12 months and follow up as necessary to ensure ongoing compliance. 5. The next scheduled drill by 4/15.	

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S 705	Continued From page 17 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 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 that the residence's documentation of fire drills failed to include all the necessary components, including the amount of time taken to evacuate the building or unit, the documentation further failed to provide at least	S 705		

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S 705	Continued From page 18 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). Findings are as follows: Record review revealed fire drills were conducted on 1/31/2024, 2/29/2024, 3/29/2024, 4/29/2024, 5/30/2024, 6/27/2024, 7/30/2024, 8/28/2024, 9/11/2024, 10/15/2024, 11/13/2024, and 12/27/2024. Record review revealed obstructed drills were documented on 2/29/2024, 5/30/2024, and 11/13/2024, which is 25% of the drills conducted. Further review of the fire drills dated 1/31/2024, 7/30/2024, 10/15/2024, and 12/27/2024, failed to include the amount of time taken to evacuate the building or unit, as required. During a surveyor interview on 3/21/2025 at approximately 2:00 PM with the Administrator, he could not provide evidence the obstructed fire drills were conducted as required and the documentation of fire drills was complete.	S 705		