STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01383	A. BUILDING: _____ B. WING _____	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWS ASSISTED LIVING	47 BARKER AVENUE WARREN, RI 02885

(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 An unannounced biennial State Licensure survey was conducted at this residence on 2/26/2025 through 2/27/2025. Deficiencies were identified relative to the State Licensure survey.	S 003	Received MAR 14 2025 Facilities Regulation	

S 190	Organization And Management 2.4.12.H Administrative Management
	
	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:
	
	2.4.12 G 1 Employee Training includes:
	a. Fire prevention;
	b. Recognition and reporting of abuse, neglect, and mistreatment;
		S 190	**S 190 In-Service Training** **3/12/2025**
			• The corrective action that will be in place for new hire employees will have at least ten hours of orientation and training within the thirty days of hire prior to working alone.
			• The corrective action which will be accomplished of those staff members found to have been affected by the deficient practice, will be to immediately adding the following topics to the orientation check list for all new employees hired
			  • Assisted Living Philosophy/Dignity
			  • Emergency Preparedness and Procedures
			  • Basic Knowledge of aging-related behaviors including Alzheimer's and Dementia
			  • Personal Assistance
			  • Medical emergency procedures
			• The corrective action will be monitored to ensure the deficient practice will not reoccur through periodic audit review of personnel charts and updating annually all in-services that are required.
			• The corrective action will be to monitor to ensure the deficient practice will not recur through periodic audits on random staff charts and through inclusion in our QA/QI at each quarterly meeting.	

Facilities Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Director — (X6) DATE: 3/14/25

RI Department of Health

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S 190	Continued From page 1 c. Assisted living philosophy (goals/values: dignity, independence, autonomy, choice); d. Resident's rights; e. Confidentiality. f. Emergency preparedness and procedures; g. Medical emergency procedures; h. Infection control policies and procedures; and i. Resident elopement. 2.4.G 2 Employee Training includes: a. Basic sanitation; b. Food service; c. Basic knowledge of cultural differences; d. Basic knowledge of aging-related behaviors including dementia and Alzheimer's disease; e. Personal assistance; f. Assistance with medications; g. Safety of residents; h. Body Mechanics; i. Resident Transfers (required for residences licensed at the F1 level for fire safety); j. Record-keeping; k. Service plans; and l. Internal reporting. Record review of the following staff revealed they did not receive initial training in the following areas: - Assisted living philosophy (goals/values: dignity, independence, autonomy, choice) - Emergency preparedness and procedures - Medical emergency procedures - Basic knowledge of aging-related behaviors including dementia and Alzheimer's disease - Personal assistance	S 190		

RI Department of Health

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S 190	Continued From page 2 1) Staff A was hired as a certified medication aide in November of 2024. 2) Staff B was hired as a certified medication aide in November of 2024. During a surveyor interview on 2/27/2025 at approximately 12:00 PM, the Executive Director was unable to produce evidence the above employees received initial training in the above stated areas within 30 days of hire or prior to working alone.	S 190		
S 310	Residency Requirements 2.4.15.A Resident Records 2.4.15 (A) Resident Records A. Each residence shall, at a minimum, maintain the following information for each resident: 1. The resident's name; 2. The resident's last address; 3. The name of the person or agency referring the resident to the home; 4. The name, specialty (if any), telephone number, and emergency telephone number of each physician who is currently treating the resident; 5. The date the resident began residing in the home; 6. A list of medications taken by the resident, including dosage, and specific records of medication administration as required by the	S 310	**Residency Requirements : Resident Records** **3/12/2025** • The corrective action which will be accomplished of those Residents found to have been affected by the deficient practice will be to document confirming all residents receiving outside services. Each Assessment and Service Plan of those affected residents have been updated immediately. All agencies providing outside services to The Willows Residents' will provide The Willows with service notes at each visit in a communication of care (binder). Provided by The Willows or by the outside service team. • All residents have the potential to be affected by the deficient practice so the the above corrective action will affect all residents receiving outside services. • The corrective action will be The Willows will provide a binder for all agencies providing outside services to chart in at each visit. • The corrective action will be to monitor all residents charts to ensure that the deficient practice will not recur through periodic audits on random residents charts and through inclusion in our QA/QI at each quarterly meeting . 3/19/25	

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S 310	Continued From page 3 Department; a. In residences licensed at the M2 level, if a resident refuses to provide the information cited in § 2.4.15(A)(6) of this Part, this fact shall be documented in the resident's service agreement. 7. Written acknowledgments that the resident has signed and received copies of the rights as provided in R.I. Gen. Laws § 23-17.4-16; 8. Information about any specific health problems of the resident, which may be useful in a medical emergency, including diagnostic and/or therapeutic orders; 9. A record of personal property and funds which the resident has entrusted to the residence; 10. The name, address, and telephone number of a person identified by the resident who should be contacted in the event of an emergency or death of the resident and the name, address, and telephone number of the legal guardian; 11. Any other health-related emergency, or pertinent information which the resident requests the residence to keep on record; 12. A copy of the initial and periodic assessments described in § 2.4.16 of this Part; 13. A copy of the service plan and nurse review as described in § 2.4.16 of this Part; 14. A copy of the residency agreement as	S 310		

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S 310	Continued From page 4 described in § 2.4.14(C) of this Part. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined the residence failed to include, at a minimum, information about any specific health problems of the resident in the resident's record, for 2 of 3 residents reviewed, Resident ID #s 1 and 3. Findings are as follows: 1. Record review revealed Resident ID #1 moved into the residence in August of 2024 with a diagnosis including, but not limited to, leukemia. Further record review revealed the resident was admitted to an outside agency for occupational therapy (OT) services and physical therapy (PT) services, beginning on 1/14/2025 and 1/17/2025 respectively. Record review failed to reveal documentation from the outside services agency indicating the services provided and the resident's current health status. 2. Record review revealed Resident ID #3 moved into the residence in December of 2018 with diagnoses including, but not limited to: diabetes, osteopenia, and squamous cell carcinoma of the soft palate right side. Further record review revealed the resident was admitted to an outside agency for PT services, beginning on 2/11/2025. Record review failed to reveal documentation from the outside services agency indicating the	S 310		

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S 310	Continued From page 5 services provided and the resident's current health status. During a surveyor interview on 2/26/2025 at approximately 12:45 PM with the Executive Director, she could not provide evidence of outside agency service notes for Resident ID #s 1 and 2.	S 310		
S 365	Residency Requirements 2.4.16.D Resident Assessment/Service Plans 2.4.16 (d) Resident Assessments and Service Plans D. The assessment shall be reviewed and at intervals not to exceed twelve (12) months and each time a resident's condition changes significantly. 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 comprehensive assessment each time a resident's condition changed significantly for 3 of 3 residents reviewed, Resident ID #s 1, 2, and 3. Findings are as follows: 1. Record review revealed Resident ID #1 moved into the residence in August of 2024 with a diagnosis including, but not limited to, leukemia. Record review of the resident's comprehensive assessment dated 9/9/2024 revealed the resident was on physical therapy (PT) and occupational	S 365	**S 365 Resident Assessment/Service Plans 3/12/2025** • The corrective action which will be accomplished of those Residents found to have been affected by the deficient practice will be to document confirming all residents receiving outside services. Each Assessment and Service Plan of those affected residents have been updated immediately. • All residents have the potential to be affected by the deficient practice so the the above corrective action will affect all residents receiving outside services. • The corrective action will be to monitor all residents charts to ensure that the deficient practice will not recur through periodic audits on random residents charts and through inclusion in our QA/QI at each quarterly meeting. 3/17/25	

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S 365	Continued From page 6 (OT) therapy services. The assessment was not updated to reveal the resident was discharged from those services shortly after moving into the residence. The assessment further failed to be updated to document that the resident was readmitted to OT therapy services beginning on 1/14/2025 and PT therapy services beginning on 1/17/2025. Further review of the assessment, under "Self Medication Assessment," reveals that the resident does not have the cognitive ability to self-administer. Additional review of the record revealed a physician's order dated 8/28/2024 for the resident to self-administer insulin lispro 100 units/milliliter pen three times daily with meals. During a surveyor interview on 2/27/2025 at approximately 12:15 PM with the Executive Director, she was unable to provide evidence that the comprehensive assessment accurately reflected the resident's receipt of OT and PT services. Additionally, she acknowledged the resident has a physician's order to self-administer her/his insulin and the comprehensive assessment inaccurately indicates the resident is unable to self-administer her/his medication. 2. Record review revealed Resident ID #2 moved into the residence in June of 2020 with diagnoses including, but not limited to: Alzheimer's disease with dementia, dysphagia, and malignant neoplasm of the left cheek. Record review of the resident's comprehensive assessment, dated 6/3/2024, failed to be updated to document that the resident is receiving hospice services beginning on 12/21/2024.	S 365		

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S 365	Continued From page 7 During a surveyor interview on 2/27/2025 at approximately 12:15 PM with the Executive Director, she was unable to provide evidence that the comprehensive assessment accurately reflected the resident's receipt of hospice services. 3. Record review revealed Resident ID #3 moved into the residence in December of 2018 with diagnoses including, but not limited to: diabetes, osteopenia, and squamous cell carcinoma of the soft palate right side. Record review revealed the resident's comprehensive assessment, dated 12/21/2024, failed to be updated to document that the resident is receiving PT services beginning on 2/11/2025. During a surveyor interview on 2/27/2025 at approximately 12:15 PM with the Executive Director, she was unable to provide evidence that the comprehensive assessment accurately reflected the resident's receipt of PT services.	S 365		
S 390	Residency Requirements 2.4.16.G.3 Resident Assessment/Service Plan 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	S 390		

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S 390	Continued From page 8 been determined that the residence failed to update the service plan each time a resident's condition changed significantly for 2 of 3 residents reviewed, Resident ID #s 2 and 3. Findings are as follows: 1. Record review revealed Resident ID #2 moved into the residence in June of 2020 with diagnoses including, but not limited to: Alzheimer's disease with dementia, dysphagia, and malignant neoplasm of the left cheek. Record review revealed the resident is receiving hospice services beginning on 12/21/2024. Record review revealed the resident's service plan, dated 6/4/2024, failed to be updated to reflect that the resident is receiving hospice services. During a surveyor interview on 2/26/2025 at approximately 12:45 PM with the Executive Director (ED), she could not provide evidence that the service plan was updated to reflect that the resident is receiving hospice services. 2. Record review revealed Resident ID #3 moved into the residence in December of 2018 with diagnoses including, but not limited to: diabetes, osteopenia, and squamous cell carcinoma of the soft palate right side. Record review revealed the resident is receiving physical therapy services beginning on 2/11/2025. Record review revealed the resident's service plan, dated 12/2/2024, failed to be updated to reflect that the resident is receiving physical therapy services.	S 390	**S 390 Service Plans** **3/12/2025** • The corrective action which will be accomplished of those residents found to have been affected by the deficient practice will be to immediately update all residents Services Plans and Assessments to reflect outside services. • All residents have the potential to be affected by the deficient practice, so the above corrective action will affect all residents. • The corrective action will be to monitor to ensure the deficient practice will not recur through periodic audits of all residents charts and through inclusion in our QA/QI at each quarterly meeting. Residents Service Plans and Assessments will be updated annually if any outside services has been updated the service plans will be immediately updated with any significant change in condition. 3/7/25	

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S 390	Continued From page 9 During a surveyor interview on 2/26/2025 at approximately 12:45 PM with the ED, she could not provide evidence that the service plan was updated to reflect that the resident is receiving physical therapy services.	S 390		
S 560	Residential Care Services 2.4.24.A.3.b Medication Services 2.4.24 (A) (3) (b) Medication Services b. For assisted living residences licensed at the M1 level, licensed employees (registered medication aides, registered nurses, licensed practical nurses) may administer oral or topical drugs and monitor health indicators. However, schedule II medications shall only be administered by licensed personnel. The physician or nurse supervisor shall conduct and document quarterly evaluations of the registered medication aides who are administering drugs and place a copy in the employee's personnel record. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined the residence failed to have a physician or nurse supervisor conduct and document monthly evaluations, for the first three months of hire of the registered medication aides who are administering drugs, and place a copy in the employee's personnel record, for 2 of 2 recently hired medication aides, Staff A and B. Findings are as follows: 1. Record review revealed Staff A was hired on	S 560	**S 560 Residential Care Services / Medication Services 3/12/2025** • The corrective action will be all new employees hired will have monthly Medication Aide evaluations, for the first three months of hire. • The corrective action which will be accomplished of those staff members found to have been affected by the deficient practice, for the first three months Medication Aide evaluations will be to immediately added to the orientation check list for all new employees hired. • The corrective action will be monitored to ensure the deficient practice will not reoccur through periodic audit review of personnel charts and updating annually all in-services that are required. • The corrective action will be to monitor to ensure the deficient practice will not recur through periodic audits on random staff charts and through inclusion in our QA/QI at each quarterly meeting. OM 3/7/25	

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S 560	Continued From page 10 11/1/2024, as a Certified Medication Technician (CMT). Record review failed to reveal evidence a monthly evaluation for January was conducted. 2. Record review revealed Staff B was hired on 11/26/2024, as a CMT. Record review failed to reveal evidence a monthly evaluation for January was conducted. During a surveyor interview with the Executive Director on 2/27/2025 at approximately 12:00 PM, she could not provide evidence that Staff A and B had medication aide evaluations monthly, upon hire, as required by 216-RICR-40-05-22- Nursing Assistants, Medication Aides, and the Approval of Nursing Assistant and Medication Aide Training Programs.	S 560		
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	S 705	**S 705 Physical Plant Safety Requirement** **3/12/2025** • The corrective action which will be accomplished for those residents found to have been affected by the deficient practice, all Fire Drills will be conducted including 2 overnight drills between the hours (10pm–6am) of which (50%) will be obstructed drills • All residents have the potential to be affected by the deficient practice so the above corrective action will affect all residents. • The corrective action will be to monitor to ensure the deficient practice will not recur through periodic audits no less than annually of all Policy and Procedures and through inclusion in our QA/QI at each quarterly meeting. All Policies and Procedures will be updated immediately.	

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S 705	Continued From page 11 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 procedures.	S 705		

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WILLOWS ASSISTED LIVING	47 BARKER AVENUE WARREN, RI 02885

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S 705	Continued From page 12 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 failed to ensure drills simulating fire emergencies, testing the effectiveness of the fire evacuation plan were 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, and 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). Findings are as follows: Record review revealed fire drills were conducted on 1/23/2024, 2/27/2024, 3/26/2024, 4/29/2024, 5/28/2024, 6/20/2024, 7/25/2024, 8/22/2024, 9/25/2024, 10/28/2024, and 12/24/2024. Further record review revealed obstructed drills were conducted on 3/26/2024, 5/28/2024, 7/25/2024, and 9/25/2024 which is 36% of the drills instead of the required 50% and 1 drill was conducted during the hours of sleep instead of	S 705		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01383	A. BUILDING: _____ B. WING _____	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWS ASSISTED LIVING	47 BARKER AVENUE WARREN, RI 02885

(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 705	Continued From page 13 the required 2 drills. During a surveyor interview on 2/27/2025 at approximately 12:00 PM with the Executive Director, she could not provide evidence the fire drills were conducted per requirements.	S 705		
S 725	Practices and Procedures, Violations, Sa 2.4.32.A Variance Procedure 2.4.32 (A) Variance Procedure A. The Department may grant a variance either upon its own motion or upon request of the applicant from the provisions of any rule or regulation in a specific case if it finds that a literal enforcement of such provision will result in unnecessary hardship to the applicant and that such a variance will not be contrary to the public interest, public health and/or health and safety of residents. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined the residence failed to send a variance for an established resident receiving hospice services from an outside provider for a singular resident reviewed, Resident ID #2. Findings are as follows: Per the Rules and Regulations for Licensing Assisted Living Residences the definition of a resident states in part "...an established resident may receive daily skilled nursing care or therapy from a licensed health care provider for a condition that results from a temporary illness or	S 725	**S 725 Practices and Procedures, Violations, Variance Procedure** • The corrective action which will be accomplished of those Residents found to have been affected by the deficient practice will be to document confirming Variance request for any Skilled Outside Services. Requested Variance will be updated Immediately on the Residents Assessment and Service Plan. All agencies providing outside services to The Willows Residents' will provide The Willows with service notes at each visit in a communication of care (binder). Provided by The Willows or by the outside service team. • All residents have the potential to be affected by the deficient practice, so the above corrective action will affect all residents. • The corrective action will be to monitor to ensure the deficient practice will not recur through periodic audits of all residents charts and through inclusion in our QA/QI at each quarterly meeting. Residents Service Plans and Assessments will be updated annually if any outside services has been updated the service plans will be immediately updated with any significant change in condition. AM 3/7/25	3/12/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01383	A. BUILDING: _____ B. WING _____	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 725	Continued From page 14 injury for up to forty-five (45) days subject to an extension of additional days as approved by the Department, or if the resident is under the care of a Rhode Island licensed hospice agency provided the assisted living residence assumes responsibility for ensuring that the required care is received..." Record review revealed the resident moved into the residence in June of 2020 with diagnoses including, but not limited to: Alzheimer's with dementia, dysphagia, and malignant neoplasm of the left cheek. Further record review revealed s/he was admitted to hospice services on 12/21/2024. Residence records lacked evidence that a variance for hospice care was sent to the Rhode Island Department of Health (RIDOH) for approval. During a surveyor interview on 2/27/2025 at approximately 12:10 PM with the Executive Director, she could not provide evidence that a variance had been sent to RIDOH for this resident to receive hospice care from an outside provider.	S 725		