RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01378	A. BUILDING: _____ B. WING _____	10/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGE AT CHERRY HILL, THE	ONE CHERRY HILL ROAD JOHNSTON, RI 02919

(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 and a complaint/incident investigation survey (OUJ011, 10/16/2025) were conducted at this residence. Deficiencies were identified relative to the State Licensure survey.	S 003	Received NOV 13 2025 Facilities Regulation	
S 080	Licensure Requirements 2.4.5.B Safe Resident Handling 2.4.5 (B) Safe Resident Handling B. Shall maintain a safe resident handling committee, which shall be chaired by a professional nurse or other appropriate licensed health care professional. An assisted living may utilize any appropriately configured committee to perform the responsibilities of this section. At least half of the members of the committee shall be hourly, non-managerial employees who provide direct resident care. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined the residence failed to establish a safe resident handling committee, chaired by a Registered Nurse or other appropriate licensed healthcare professional and ensure that at least half of the members are hourly non-managerial employees who provide direct resident care. Findings are as follows: Record review revealed the residence is licensed to provide limited health services as of November 2024, and is required to establish and maintain a safe resident handling committee, as a requirement for this license.	S 080	**A. With Respect to the Specific Regulation Cited: S080** Safe Resident Handling 2.4.5 (B) **B. With Respect to how the Facility Will identify and Take Corrective Action:** The Resident Care Director will chair the committee of employees who provide direct resident care with at least ½ being hourly, non-managerial staff to be in compliance with the current Limited Health Care License.	

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

MaryAnn Grace — Executive Director — 11/12/25

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S 080	Continued From page 1 Record review failed to reveal evidence the residence has establish a safe resident handling program and failed to maintain a safe resident handling committee, as required. During a surveyor interview on 10/16/2025 at 8:51 AM with the Resident Care Director, she acknowledged the residence has had a limited health services license since November 2024. Additionally, she acknowledged the residence has not establish a safe resident handling committee, as required.	S 080	**C. With Respect to What Systemic Measures to be Put in Place to Address the Stated Concern:** Physical therapy provider will continue to educate direct care staff on safe resident handling and will report to the Resident Care Director and implement any additional training.	12/1/25
S 185	Organization And Management 2.4.12.G.2 Administrative Management 2.4.12 (G) (2) Employee Training 2. The administrator shall ensure that all new employees who will have regular contact with residents and provide residents with personal care shall receive at least ten (10) hours of orientation and training within thirty (30) days of hire and prior to beginning work alone in the assisted living residence, in addition to the areas stipulated in § 2.4.12(G) of this Part. Such areas include: 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;	S 185	**D. With Respect to How the Plan of Corrective Measures will be Monitored:** This will be part of the QMPI Process. **A. With Respect to the Specific Regulation Cited:** **2.4.12 (G) (2) Employee Training** **B. With Respect to how the Facility Will identify and Take Corrective Action:** Staff A, B and C were identified as not receiving training in food service. The staff identified will be trained to meet the requirements in food service.	

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S 185	Continued From page 2 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. This Requirement is not met as evidenced by: Based on record review and staff interview it has been determined the Administrator 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 three of three sample new employees, Staff A, B, and C. Findings are as follows: Per 2.4.G 2 of the regulation 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;	S 185 11/28/25	**C. With Respect to What Systemic Measures to be Put in Place to Address the Stated Concern:** A check off list will be utilized to ensure that all new employees will receive the required training within 30 days of hire and prior to working alone in the community. **D. With Respect to How the Plan of Corrective Measures will be Monitored:** The ED and BOD will work with the various departments to ensure that all training has been completed within the required time frame. This will be made part of QMPI.	12/1/25 + ongoing

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S 185	Continued From page 3 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. 1. Record review of Staff A revealed a hire date of 4/24/2025. This employee was hired as a Licensed Practical Nurse. 2. Record review of Staff B revealed a hire date of 7/25/2025. This employee was hired as a Nursing Assistant (NA). 3. Record review of Staff C revealed a hire date of 8/8/2025. This employee was hired as a NA and Certified Medication Technician. Record review failed to reveal evidence that the above-mentioned employees had received in-service training in food service, as required. During a surveyor interview with the Business Office Director on 10/16/2025 at 9:07 AM, she was unable to provide evidence that the above-mentioned employees had received the appropriate in-service training, as required.	S 185		
S 450	Licensure Requirements 2.4.18 Rights of Residents 2.4.18 Rights of Residents A. Every assisted living residence for adults licensed pursuant to these regulations shall observe the standards stated in R.I. Gen. Laws §	S 450		

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S 450	Continued From page 4 23-17.4-16, "Rights of Residents" and such other appropriate standards as may be prescribed in rules and regulations promulgated by the Department with respect to each resident of the residence. B. For purposes of the following standards stated in §§ 2.4.18(B)(1) through (7) of this Part the term "resident" shall also mean the resident's agent as designated in writing or legal guardian. 1. Upon request have access to all records pertaining to the resident, including clinical records, within the next business day or immediately in emergency situations; 2. Upon admission and during the resident's stay be fully informed in a language the resident understands, of all resident rights and rules governing resident conduct and responsibilities; a. Each resident shall receive a copy of their rights. b. Each resident shall acknowledge receipt in writing; and c. Each resident shall be informed promptly of any changes. 3. Be informed in writing, prior to, or at the time of admission or at the signing of a residential contract or agreement of: a. The scope of the services available through the residence's service program, including health services, and of all related fees and charges, including charges not covered either under federal and/or state programs by other third party	S 450		

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S 450	Continued From page 5 payers or by the residence's basic rate; b. The residence's policies regarding overdue payment including notice provisions and a schedule for late fee charges; c. The residence's policy regarding acceptance of state and federal government reimbursement for care in the residence both at time of admission and during the course of residency if the resident depletes his or her own private resources; d. The residence's criteria for occupancy and termination of residency agreements; e. The residence's capacity to serve residents with physical and cognitive impairments; f. Support any health services that the residence includes in its service package or will make appropriate arrangements to provide these services; 4. Upon provision of at least thirty (30) days notice, if a resident chooses to leave a residence, the resident shall be refunded any advanced payment made provided that the resident is current in all payments; 5. The residence can discharge a resident only for the following reasons and within the following guidelines: a. Except in life-threatening emergencies and for nonpayment of fees and costs, the residence gives thirty (30) days' advance written notice of termination of residency agreement with a statement containing the reason, the effective	S 450		

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S 450	Continued From page 6 date of termination, the resident's right to an appeal under state law, and the name/address of the State Ombudsperson's office; b. If resident does not meet the requirements for residency criteria stated in the residency agreement or requirements of state or local laws or regulations; c. If resident is a danger to self or the welfare of others; and the residence has attempted to make a reasonable accommodation without success to address resident behavior in ways that would make termination of residency agreement or change unnecessary; which would be documented in the resident's records; d. For failure to pay all fees and costs stated in the contract, resulting in bills more than thirty (30) days outstanding. A resident who has been given notice to vacate for nonpayment of rent has the right to retain possession of the premises, up to any time prior to eviction from the premises, by tendering to the provider the entire amount of fees for services, rent, interest, and costs then due. The provider may impose reasonable late fees for overdue payment; provided that the resident has received due notice of such charges in accordance with the residence's policies. Chronic and repeated failure to pay rent is a violation of the lease covenant. However the residence must make reasonable efforts to accommodate temporary financial hardship and provide information on government or private subsidies available that may be available to help with costs; and e. The residence makes a good faith effort to counsel the resident if the resident shows	S 450		

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S 450	Continued From page 7 indications of no longer meeting residence criteria or if service with a termination notice is anticipated; 6. To be able to share a room or unit with a spouse or other consenting resident of the residence in accordance with terms of the resident contract; 7. To live in a safe and clean environment. C. In addition to the standards stated in R.I. Gen. Laws § 23-17.4-16, residents are entitled to the following: 1. Receive dental services from a dentist of his/her choice; 2. Each resident shall be given, in writing, the names, addresses, and telephone numbers of: the Department; the Medicaid Fraud and Patient Abuse Unit of the Department of Attorney General; the State Ombudsperson; and local police offices. D. The residence must: 1. Implement written policies and procedures to ensure that all residence employees are aware of and protect the resident's rights contained in these regulations; 2. Have prominently displayed a posting of the most recent state licensing survey of the assisted living residence; and 3. Provide each resident or his or her representative upon admission, a copy of the provisions of § 2.4.18 of this Part and shall	S 450		

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ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 450	Continued From page 8 display in a conspicuous place on the premises a copy of the "Rights of Residents." This Requirement is not met as evidenced by: Based on surveyor observations and staff interview, it has been determined that the residence failed to ensure that the most recent State licensing survey results of the assisted living residence was prominently displayed, as required. Findings are as follows: During a surveyor observation of the main entrance/lobby area on 10/15/2025 at 10:05 AM, the residence failed to reveal evidence of the most recent State licensing survey results being prominently display, as required. During a surveyor interview with the Resident Care Director on 10/15/2025 at 10:07 AM, she acknowledged that the residence's survey results were not accessible and prominently displayed, as required.	S 450	**A. With Respect to the Specific Regulation Cited: S450** Section 2.4.18 Rights of Residents **B. With Respect to how the Facility Will identify and Take Corrective Action:** The survey book that was displayed In the administrative offices under the facility license has been removed and placed in the lobby. **C. With Respect to What Systemic Measures to be Put in Place to Address the Stated Concern:** The recent survey results are located in the main lobby by the kiosk with signage. **D. With Respect to How the Plan of Corrective Measures will be Monitored:** Random checks will take place to ensure the survey result book is located by the kiosk with signage. A PIP has been done to be in compliance.	10/16/25
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.	S 490		

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S 490	Continued From page 9 This Requirement is not met as evidenced by: Based on surveyor observation and staff interviews, it has been determined that the residence failed to comply with the appropriate requirements of the Rhode Island Food Code related to the main kitchen. Findings are as follows: 1. Record review of the 2022 Food Code published by the U.S. Food and Drug Administration, Section 3.501.17 states in part, "...refrigerated ready to eat food and held more than 24 hours...shall be clearly marked to indicate the date the food shall be consumed...discarded... for a maximum of 7 days...Section 3-602.11, Food Labels states in part "...(B) Label information shall include: (1) The common name of the food..." During a surveyor observation of a lowboy refrigerator (a compact refrigeration unit designed to fit underneath a standard kitchen countertop) in the main kitchen in the presence of a cook, Staff D, on 10/14/2025 at 1:40 PM revealed the following: - 1.5-liter (L) container with a yellow-colored liquid without a label and not dated - 3.5 L container with a thick cream-colored liquid without a label and not dated - A container with approximately a dozen of boiled eggs not dated - Three cooked burger patties in a plastic wrap dated "9/24" - Slices of grilled chicken dated "9/19" During a surveyor interview immediately following this observation with Staff D, he acknowledged above-mentioned food items should have been	S 490	**A. With Respect to the Specific Regulation Cited:** Residential Care Services 2.4.21.C Dietetic Services **B. With Respect to how the Facility Will identify and Take Corrective Action:** An inservice was Conducted to review Policy 2-301.14, 3-509.19, 4-702.11 and 7-201.11 regarding labeling, dating, initial temperatures and sanitation of utensils in accordance with the 2022 Food Code. **C. With Respect to What Systemic Measures to be Put in Place to Address the Stated Concern:** A random audit will be conducted daily to ensure compliance with the 2022 Food Code. **D. With Respect to How the Plan of Corrective Measures will be Monitored:** On a weekly basis, audits will be conducted by the ED and/or FSD to ensure compliance and part of the QMPI process.	11/7/25

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S 490	Continued From page 10 dated and labeled, and the burger patties and grilled chicken should have been discarded. 2. Record review of the 2022 Food Code published by the U.S Food and Drug Administration Section, 2-301.14 states in part, "...when to wash...food employees shall clean their hands...after handling soiled equipment or utensils..." During a surveyor observation on 10/15/2025 at 10:28 AM of the main kitchen, a dietary aide, Staff E, was observed handling the soiled dishes while putting them in the dishwasher, she failed to wash her hands after, and instead Staff E wiped her hands on her clothing and proceeded to touch the clean dishes. 3. Record review of the 2022 Food Code published by the U.S Food and Drug Administration Section 3-509.19 states in part, "...food shall have an initial temperature of 5 degrees C (41 degrees Fahrenheit, °F) or less when removed from cold holding temperature control..." During a surveyor observation on 10/15/2025 at 11:22 AM of the lunch meal service in the main kitchen in the presence of a cook, Staff F, revealed the following food items were not at the required cold holding temperature: -A container of tuna salad with a cold holding temperature of 44.4°F. - A bowl of hard boil eggs with a cold holding temperature of 45.6°F. - A bowl of diced peppers, onions, and ham with a cold holding temperature of 56.6°F. 4. Record review of the 2022 Food Code	S 490		

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S 490	Continued From page 11 published by the U.S Food and Drug Administration Section 4-702.11 states in part, " ...Utensils and Food-Contact Surfaces of Equipment shall be SANITIZED before use after cleaning ..." During a surveyor observation on 10/15/2025 at 11:25 AM of the lunch meal service in the main kitchen in the presence of Staff F, he was observed using a dirty soiled dishtowel to wipe a thermometer, then he put the same thermometer into a prepared ready to serve tray of cooked pasta to check the temperature of the food, when he was stopped by the surveyor. 5. Record review of the 2022 Food Code published by the U.S Food and Drug Administration Section 7-201.11 "...poisonous or toxic materials shall be stored so they cannot contaminate food..." During a surveyor observation on 10/15/2025 at 11:33 AM of the main kitchen, the following items were stored on a shelf with condiments and utensils: - Three spray bottles of liquid glass cleaners - One spray bottle of peroxide glass and surface cleaner - One spray bottle of Ecolab heavy duty chemical resistant spray During a surveyor interview on 10/15/2025 at approximately 11:40 AM with Staff F, he acknowledged the above-mentioned food items cold holding temperatures were above 41°F, as required. Staff F further acknowledged that he used a dirty soiled dishtowel to wipe the thermometer prior to putting it into the prepared ready to serve pasta, as observed by the	S 490		

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S 490	Continued From page 12 surveyor. Additionally, Staff F acknowledged the above-mentioned chemicals were stored in proximity to food items. During a surveyor interview on 10/15/2025 at 2:10 PM with the Resident Care Director, she was unable to provide evidence the main kitchen and food services were maintained, as required by the Food Code. During an additional surveyor interview on 10/16/2025 at 9:32 AM with the Food Service Director (FSD), he was unable to provide evidence the staff was in compliance with the Food Code. The FSD further revealed that the staff are expected to follow all requirements as indicated in the Food Code related to the main kitchen and all food services in the residence.	S 490		
S 710	Physical Plant 2.4.30.J Safety Requirements 2.4.30 (J) Safety Requirements J. Appropriate fire extinguishers shall be installed on each occupied level and maintained in a usable condition, inspected at specified intervals as stipulated by manufacturers and the State Fire Marshal. This Requirement is not met as evidenced by: Based on surveyor observation and staff interview, it has been determined the residence failed to ensure that all Fire Extinguishers are maintained in a usable condition and inspected at specific intervals.	S 710		

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S 710	Continued From page 13 Findings are as follows: Review of the residence policy titled "Maintenance Safety Guide" dated August 2011, states in part, "Fire Extinguishers...Each extinguisher will have a durable tag to show date of monthly inspection..." Surveyor observations on 10/14/2025 of the residence failed to reveal evidence the following fire extinguishers were inspected monthly as per the residence's policy: - 5th floor at 2:07 PM, two extinguishers last inspected on 8/5/2025 and 8/6/2025 - 4th floor at 2:13 PM, two extinguishers last inspected on 8/5/2025 - 3rd floor at 2:16 PM, two extinguishers last inspected on 8/5/2025 - 2nd floor at 2:19 PM, two extinguishers last inspected on 8/5/2025 - 1st floor at 2:22 PM, one extinguisher last inspected on 6/12/2025 and not in July and August, until 10/8/2025. - Main kitchen at 2:25 PM, two extinguishers last inspected on 8/5/2025. During a surveyor interview on 10/15/2025 at 10:08 AM, the Director of Maintenance acknowledged the above-mentioned fire extinguishers were not inspected monthly, as required.	S 710	**A. With Respect to the Specific Regulation Cited:** Physical Plant 2.4.30.J Safety Requirements **B. With Respect to how the Facility Will identify and Take Corrective Action:** A new maintenance director has been hired **C. With Respect to What Systemic Measures to be Put in Place to Address the Stated Concern:** An inservice was held with the Maintenance Department to review the safety requirements of the monthly fire extinguisher policy. **D. With Respect to How the Plan of Corrective Measures will be Monitored:** Monthly documentation in TELS to ensure compliance and part of the QMPI process.	11/4/25

RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01378	A. BUILDING: _____ B. WING _____	10/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGE AT CHERRY HILL, THE	ONE CHERRY HILL ROAD JOHNSTON, RI 02919

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S 915	Continued From page 14	S 915		
S 915	Limited Health Services License Require 2.6.2.M Specific Requirements 2.6.2 (M) Specific Requirements M. Assisted living residences licensed to provide limited health services are required to have a licensed physician, a certified nurse practitioner or a licensed physician assistant as a member of the Quality Improvement Committee as defined in § 2.4.3 of this Part. This Requirement is not met as evidenced by: Based on record review and staff interview it has been determined the residence which is licensed to provide limited health services (LHS) as of November 2024, failed to have a licensed physician, a certified nurse practitioner, or a licensed physician assistant as a member of the Quality Improvement Committee. Additionally, the residence failed to include in their Quality Improvement (QI) plan all the required areas related to the limited health services license, such as, prevention and treatment of decubitus ulcers (pressure/bed sores), dehydration, nutritional status, weight loss/gain, and changes in mental status. Findings are as follows: Review of an undated residence's Quality Improvement Plan failed to reveal a licensed physician, a certified nurse practitioner, or a licensed physician assistant is included on the committee, as required. Additional record review of the attendance for the QI committee meetings from November 2024	S 915	**A. With Respect to the Specific Regulation Cited: S915** 2.6.2 (M) Specific Requirements **B. With Respect to how the Facility Will identify and Take Corrective Action:** The process for the license was sent to our legal department on or about October 5, 2024. **C. With Respect to What Systemic Measures to be Put in Place to Address the Stated Concern:** Numerous e-mails were sent to our legal department. During the course of time, there were many revisions that were needed. The final contract was executed on July 1, 2025. **D. With Respect to How the Plan of Corrective Measures will be Monitored:** The Limited Health License will not be renewed for the upcoming year.	

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S 915	Continued From page 15 through August 2025, failed to reveal a licensed physician, a certified nurse practitioner, or a licensed physician assistant in attendance. During a surveyor interview on 10/16/2025 at 10:25 AM with the Resident Care Director (RCD), she acknowledged the residence has had a LHS license since November 2024. Additionally, the RCD acknowledged the QI plan did not have all of the required areas related to their LHS licensure, and the QI committee did not include a licensed physician, a certified nurse practitioner, or a licensed physician assistant, as required.	S 915		
S 925	Limited Health Services License Require 2.6.2.O Specific Requirements 2.6.2 (O) Specific Requirements O. Evidence of Pre-employment and Ongoing Health Screening Upon hire and prior to delivering services, employment health screenings shall be required for each individual who has or may have direct contact with a resident receiving limited health services. Such health screening shall be conducted in accordance with the rules and regulations pertaining to Immunization, Testing, and Health Screening for Health Care Workers (Part 20-15-7 of this Title). This Requirement is not met as evidenced by: Based on record review and staff interview it has been determined that the residence failed to obtain proper employment health screenings prior to delivering service for each individual who has	S 925		

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S 925	Continued From page 16 or may have direct contact with a resident receiving limited health services for three of seven sample staff reviewed, Staff G, H, and I. Findings are as follows: Per the Rules and Regulations Pertaining to Immunization, Testing, and Health Screening for Health Care Workers [216-RICR-20-18-7] it states in part, "...any individual who has or may have direct contact with a resident receiving limited health services must have upon hire or prior to delivering service a review of health records, pertinent laboratory results, and other documentation of a health care worker performed by a licensed practitioner is required in order to determine that the health care worker is free of the communicable diseases cited in these Regulations, and is also appropriately immunized, tested, and counseled prior to employment." 1. Record review of Staff G revealed a hire date of 6/6/2018. This employee was hired as a Licensed Practical Nurse. The record failed to reveal evidence that the employee received screenings for Measles Mumps Rubella (MMR), Varicella, Tetanus, Diphtheria and Pertussis (TDAP), and Hepatitis B (Hep B), as required. 2. Record review of Staff H revealed a hire date of 12/15/2003. This employee was hired as a Nursing Assistant (NA). The record failed to reveal evidence that the employee received screenings for MMR, Varicella, TDAP, and Hep B, as required. 3. Record review of Staff I revealed a hire date of 11/12/2008. This employee was hired as a NA and Certified Medication Technician. The record failed to reveal evidence that the employee	S 925	**A. With Respect to the Specific Regulation Cited: S925** 2.6.2 (O) Specific Requirements **B. With Respect to how the Facility Will identify and Take Corrective Action:** Staff G. H and I were identified. Immunization records have been retained. **C. With Respect to What Systemic Measures to be Put in Place to Address the Stated Concern:** An audit will be conducted to Identify those associates who will or will have direct contact with a resident receiving limited health care services. **D. With Respect to How the Plan of Corrective Measures will be Monitored:** All associates, upon hire, will provide the required immuni-zations.	11/6/25

11/28/25 AM

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S 925	Continued From page 17 received screenings for MMR, Varicella, TDAP, and Hep B, as required. During a surveyor interview on 10/15/2025 at 2:26 PM with the Resident Care Director, she could not provide evidence that the health screenings were conducted as required for Staff G, H, and I.	S 925		