RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01308	A. BUILDING: _____ B. WING _____	C 06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST FARM ASSISTED LIVING	191 FOREST AVENUE MIDDLETOWN, RI 02842

(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 abbreviated complaint/incident survey was conducted at this residence. Deficiencies were identified as a result of this survey.	S 003	The filing of this Plan of Correction does not constitute that the deficiency alleged did in fact exist, rather this POC is filed as evidence of the facility's continuing commitment to high quality resident care in full compliance with state regulations.	
S 360	Residency Requirements 2.4.16.C Resident Assessment/Service Plans 2.4.16 (C) Resident Assessments and Service Plans C. The Department-approved assessment form, or such other assessment form as approved by the Department, shall be utilized in completing the assessment on each resident who is admitted to the residence. (Approved Department form is available for downloading online at http://health.ri.gov/forms/assessment/AssistedLivingResident.pdf). 1. Assisted living residences not intending to use the Department's assessment form shall submit their proposed assessment forms with a cover letter of intent to the Center for Health Facilities Regulation as specified in § 2.4.6(A) of this Part. 2. All assessment forms shall report information appropriate to determine compatibility and compliance with the residency criteria, and shall indicate that the resident's needs can be met by the assisted living residence within its licensure level, and shall gather information appropriate for the development of an individualized service plan. a. The assessment form shall be designed to demonstrate compliance with the assisted living residence's criteria for residency.	S 360		

Facilities Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jennifer Mello	Administrator	07/12/2024

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S 360	Continued From page 1 b. The assessment form shall also be designed to demonstrate that the assisted living residence can meet the resident's needs and preferences. 3. The assessment form shall also be designed to provide information appropriate for the development of an individualized service plan in accordance with § 2.4.16(G)(1) of this Part. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined that the resident's comprehensive assessment form failed to be completed in its' entirety for 3 of 4 sample residents reviewed, Resident ID #'s 1, 2, and 4, and updated with all relevant information for the development of a service plan for the singular resident reviewed relative to outside services, Resident ID #2. Findings are as follows: 1. Record review of Resident ID #1 revealed s/he moved into the residence in November of 2015 with a diagnosis of stage 3 kidney disease. Record review of the comprehensive assessment dated 1/8/2024 and updated on 4/10/2024 failed to reveal the assessment was signed by the Administrator, as required. 2. Record review of Resident ID #2 revealed s/he moved into the residence in June of 2018 with a diagnosis of transient cerebral ischemic attack (a	S 360	Resident assessments are completed upon admission, quarterly, upon change in condition and annually through our EMR. The Administrator and DNS will pull a report monthly from the EMR to ensure timeliness of assessments. Upon completion, the DNS will notify the Administrator to review for accuracy and signature. The report will be reviewed at the quarterly QAPI Meeting. Audits will be conducted monthly X3, Quarterly X2, or until compliance has been met. The Administrator or designee will report results at the quarterly QAPI Meetings X4. No resident was affected by the deficient practice cited.	7/25/24

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S 360	Continued From page 2 stroke, when the blood supply to the brain is briefly interrupted). Record review of the comprehensive assessment dated 1/5/2024 and updated on 4/12/2024 failed to reveal the assessment was signed by the Administrator, as required. Further review of the assessment failed to reveal that the resident had a start of care for physical therapy on 6/5/2024, a service which is required to be documented on the individual's service plan. 3. Record review of Resident ID #4 revealed s/he moved into the residence in June of 2023 with a diagnosis of stroke. Record review of the comprehensive assessment dated 6/5/2023 failed to reveal the assessment was signed by the Administrator, as required. During an interview on 6/25/2024 at approximately 2:30 PM, the Administrator was unable to provide evidence that the comprehensive assessment was updated to include outside services for Resident ID #2 and that the above-mentioned assessments were signed by her, as required.	S 360		
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.	S 705		

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S 705	Continued From page 3 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 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	S 705		

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S 705	Continued From page 4 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. Findings are as follows: Record review revealed fire drills were conducted on 8/25/2023, 9/30/2023, 11/9/2023, 1/30/2024, 2/6/2024, and 3/23/2024. Review of the fire drill documentation dated 8/25/2023, 9/30/2023, and 11/9/2023, failed to include the amount of time taken to evacuate the building or unit as required. During an interview on 6/25/2024 at	S 705	Although fire drills were conducted as required, the amount of time taken to evacuate the building was not transferred from the resident list used during the drill, onto the document used as proof of the drill for regulation purposes. Once drills are complete all required information will be transferred to the proper documentation. The Administrator or designee will report compliance at the quarterly QAPI Meeting X4.	7/31/24

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S 705	Continued From page 5 approximately 2:30 PM, the Administrator was unable to provide evidence that the length of time was completed on the documentation of fire drills conducted for the above-mentioned dates, as required.	S 705		