RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01526	A. BUILDING: _____ B. WING _____	02/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AMERICAN ASSISTED LIVING AT WARWI(	55 TOLL GATE FARM ROAD WARWICK, RI 02886

(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 (XT7S11, 02/10/2026) were conducted at this residence. Deficiencies were identified relative to the State Licensure survey.	S 003		
S 220	Organization And Management 2.4.13.I.2 Administrative Management 2.4.13 (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; 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;	S 220	Received MAR 06 2026 Facilities Regulation 3/1/26	

Facilities Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Elizabeth A. Lamontagne	Executive Director	2/26/26

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S 220	Continued From page 1 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 that the residence failed to ensure that personnel records contained at least one (1) performance evaluation at intervals not to exceed twelve (12) months for 2 of 6 staff reviewed, Staff A and B. Findings are as follows: 1. Record review of Staff A revealed a hire date of 3/20/2024; this staff was hired as a Certified Nursing Assistant (CNA). 2. Record review of Staff B revealed a hire date of 4/9/2024; this staff was hired as a CNA. Record review failed to reveal evidence that a performance evaluation for the year 2025 was completed for the above-mentioned staff, as required. During a surveyor interview on 2/6/2026 at approximately 3:00 PM with the Administrator, in the presence of the Resident Care Director, she could not provide evidence that a performance	S 220	S220 Organization and management adminstrative managment. Staff A and Staff B file will be reviewed and a performance review will be completed to reflect the past 12 months. To prevent this from occuring all employees files will be audited to ensure that 12 months performance reviews are in compliance. Date of completion: 3/30/26	

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S 220	Continued From page 2 evaluation was completed for the year 2025 for the above-mentioned staff.	S 220		
S 295	Organization And Management 2.4.14.J Management Of Services 2.4.14 (J) Smoking Policy 1. If the residence permits smoking, it shall have a policy that includes the following: a. Location of designated smoking area(s) separate from the common area; b. Prohibition of smoking in any area other than the designated area(s); c. Adequate ventilation in smoking areas; d. Assessment (upon admission, quarterly, and when a significant change in function occurs) of all residents that smoke to ensure safe smoking capabilities. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined that the residence failed to follow their policy relative to smoking and failed to complete a smoking assessment upon admission and quarterly for a singular resident reviewed for smoking, Resident ID #1. Findings are as follows: Record review of the residence's smoking policy dated 1/14/2026 states in part, "...Residents who wish to smoke must have a safe-smoking	S 295		

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S 295	Continued From page 3 assessment completed by an RN..." Record review revealed Resident ID #1 moved into the residence in May of 2025 with a diagnosis including, but not limited to, alcoholic cirrhosis of the liver. During the entrance conference on 2/6/2026 at approximately 8:30 AM, it was revealed that this resident is a smoker. During a surveyor interview with the resident on 2/9/2026 at 10:00 AM, s/he revealed s/he has been smoking since admission. Record review failed to reveal evidence of a smoking assessment being completed upon admission and quarterly, as required. During a surveyor interview on 2/10/2026 at approximately 2:00 PM with the Resident Care Director, she was unable to provide evidence of the smoking assessment upon admission and quarterly.	S 295	S295 Smoking Policy Residents ID 1 chart will be reviewed and a smoking assessment will be completed by our RN to ensure safety and capalilities. Going forward residents that are smokers upon admission will have a smoking assessment completed each quarter. Date of completion: 3/10/26	
S 390	Residency Requirements 2.4.17.D Resident Assessment/Service Plans 2.4.17 (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	S 390		

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S 390	Continued From page 4 update the comprehensive assessment each time a resident's condition changed significantly for 3 of 5 residents reviewed for outside services, Resident ID #s 2, 3, and 4; the singular resident who smokes, Resident ID #1; and the singular resident reviewed relative to oxygen use, Resident ID #5. Findings are as follows: A. Review of the list of residents receiving outside services given during the entrance conference on 2/6/2026 at approximately 10:00 AM, revealed Resident ID #2 is receiving skilled nursing (SN) services and Resident ID #3 is receiving physical therapy (PT) and occupational therapy (OT) services. Resident ID #4 was not listed as currently receiving outside services. 1. Record review revealed Resident ID #2 moved into the residence in July of 2024 with diagnoses including, but not limited to, gangrene (death of body tissue caused by a lack of blood supply or a bacterial infection commonly affecting the limbs, fingers, and toes) and necrosis (death of cells and living tissue caused by infection or trauma that cut off blood supply) of the right toe(s). Record review of the resident's comprehensive assessment, dated 6/17/2025, failed to be updated to document that the resident is receiving SN services for wound care, with a start of care date of 6/23/2025. 2. Record review revealed Resident ID #3 moved into the residence in April of 2025 with a diagnosis including, but not limited to, Alzheimer's disease. Record review of the resident's comprehensive	S 390		

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S 390	Continued From page 5 assessment, dated 5/17/2025, failed to be updated to document that the resident started receiving PT and OT services on 1/15/2026. 3. Record review revealed Resident ID #4 moved into the residence in January of 2025 with a diagnosis including, but not limited to, dementia. Record review of the resident's comprehensive assessment, dated 4/25/2025, revealed that the resident was receiving PT and OT services; there were no dates provided for the end of care. The entrance conference worksheet did not reveal this resident was receiving PT or OT services. During a surveyor interview with the Resident Care Director (RCD), in the presence of the Administrator, on 2/10/2026 at approximately 2:15 PM, she could not provide evidence the comprehensive assessment was updated to discontinue these services, nor could she provide the date PT was discontinued. OT therapy had been discontinued on 5/20/2025. During a subsequent interview with the RCD, in the presence of the Administrator, she could not provide evidence of updates to the comprehensive assessments for the above-mentioned outside services for Resident ID #s 2, 3, and 4. B. Additionally, during the entrance conference Resident ID #1 was listed as a smoker. During initial observations of the facility Resident ID #5 was identified as utilizing oxygen. 4. Record review revealed Resident ID #1 moved into the residence in May of 2025 with a diagnosis including, but not limited to, alcoholic cirrhosis of the liver.	S 390		

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S 390	Continued From page 6 Record review of the resident's comprehensive assessment, dated 5/6/2025, failed to reveal the resident is a smoker. During a surveyor interview with the RCD, in the presence of the Administrator, on 2/10/2026 at approximately 2:30 PM, she could not provide evidence smoking was listed on the resident's comprehensive assessment. 5. Record review revealed Resident ID #5 moved into the residence in May of 2025 with a diagnosis including, but not limited to, chronic obstructive pulmonary disease (COPD). During a surveyor observation of the building on 2/6/2026 at 8:18 AM, an oxygen sign outside of the resident's door was observed. During a surveyor interview with the resident on 2/9/2026 at 10:30 AM, s/he revealed s/he is on oxygen at night. Review of a physician's order, dated 11/21/2025, reveals the resident is able to self-administer her/his own oxygen. Record review of the resident's assessment, dated 7/23/2025, reveals "...Oxygen Use Not Applicable: Resident does not require supplemental oxygen..." During a subsequent interview with the RCD, in the presence of the Administrator, she could not provide evidence that the comprehensive accurately reflected that the resident is on oxygen.	S 390		

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S 400	Continued From page 7	S 400		
S 400	Residency Requirements 2.4.17.F Resident Assessments/Service Plans 2.4.17 (F) Nurse Review 1. Nurse review is necessary for all levels of licensure. a. A registered nurse shall visit the residence at least once every thirty (30) days except as provided in § 2.4.16(F)(1)(b) of this Part and shall complete a review to include the following: (1) Monitor the medication regimen for all residents; (2) Review any new physician orders and evaluate the health status of all residents by identifying symptoms of illness and/or changes in mental/physical health status; (3) Evaluate the appropriateness of placement for each resident; (4) Make any necessary recommendations to the administrator; (5) Follow up on previous recommendations; (6) Provide a signed, written report in the residence documenting: (AA) Date and time of assessment; (BB) Recommendations for follow-up; (CC) Progress on previous	S 400	S400 Nurse review Resident ID #1, 2, 3, 4, 5, 6, 7, 8 charts will be reviewed and nurse reviews will be performed for each resident ID listed above. To prevent from occuring in the future, nursing will audit all resident charts and ensure that nurse reviews are completed and reflect residents needs. Date of completion: 6/30/26	

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S 400	Continued From page 8 recommendations; (DD) Verification that the medication listed by the pharmacist on the mediset, blister pack or medication container is current with physician orders (M-1 level only); (EE) Physical assessment identifying symptoms of illness and/or changes in mental or physical health status and appropriateness of placement; (FF) Such reports shall be on file at the residence. (7) Complete the quarterly evaluation of the residence ' s registered medication aide(s) administration of medication. (Approved Department form is available for downloading online). b. In those residences that have one (1) or more licensed registered nurses (i.e., at least one (1) full-time equivalent equal to thirty-five (35) hours) on-site, the nurse review shall be completed at least once every ninety (90) days. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined the residence failed to complete nurse reviews every 90 days as required for 8 of 9 sample residents reviewed, Resident ID #s 1, 2, 3, 4, 5, 6, 7, and 8. 1. Record review revealed Resident ID #1 moved into the residence in May of 2025 with a diagnosis including, but not limited to, alcoholic cirrhosis of the liver.	S 400		

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S 400	Continued From page 9 Record review failed to reveal evidence of a nurse review completed every ninety days after the comprehensive assessment dated 5/6/2025. 2. Record review revealed Resident ID #2 moved into the residence in July of 2024 with diagnoses including, but not limited to, gangrene (death of body tissue caused by a lack of blood supply or a bacterial infection commonly affecting the limbs, fingers, and toes) and necrosis (death of cells and living tissue caused by infection or trauma that cut off blood supply) of the right toe(s). Record review failed to reveal evidence of a nurse review completed every ninety days after the comprehensive assessment dated 6/17/2025. 3. Record review revealed Resident ID #3 moved into the residence in April of 2025 with a diagnosis including, but not limited to, Alzheimer's disease. Record review failed to reveal evidence of a nurse review completed every ninety days after the comprehensive assessment dated 5/17/2025 and prior to the nurse review dated 11/13/2025. 4. Record review revealed Resident ID #4 moved into the residence in January of 2025 with a diagnosis including, but not limited to, dementia. Record review failed to reveal evidence of a nurse review completed every ninety days after 8/21/2025. 5. Record review revealed Resident ID #5 moved into the residence in May of 2025 with a diagnosis including, but not limited to, chronic obstructive pulmonary disease (COPD).	S 400		

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S 400	Continued From page 10 Record review failed to reveal evidence of a nurse review completed every ninety days after the comprehensive assessment dated 7/23/2025. 6. Record review revealed Resident ID #6 moved into the residence in October of 2024 with a diagnosis including, but not limited to, frontotemporal neurocognitive disorder. Record review failed to reveal evidence of a nurse review completed every ninety days after the comprehensive assessment dated 4/30/2025. 7. Record review revealed Resident ID #7 moved into the residence in October of 2024 with a diagnosis including, but not limited to, dementia. Record review failed to reveal evidence of a nurse review completed every ninety days after the comprehensive assessment dated 1/14/2025 and prior to 8/14/2025. 8. Record review revealed Resident ID #8 moved into the residence in July of 2025 with a diagnosis including, but not limited to, senile dementia. Record review failed to reveal evidence of a nurse review completed every ninety days after the comprehensive assessment dated 7/23/2025 and prior to the nurse review dated 12/30/2025. During a surveyor interview with the Resident Care Director in the presence of the Administrator on 2/10/2026 at approximately 2:30 PM, she acknowledged the above-mentioned nurse reviews were not completed for the above-mentioned residents.	S 400		

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S 415	Continued From page 11	S 415	S415 Residency Requirements: resident assessment/ service plan.	
S 415	Residency Requirements 2.4.17.G.3 Resident Assessment/Service Plan 2.4.17 (G)(3) Service Plans 3. The service plan shall be reviewed by both parties at intervals not to exceed twelve (12) months and each time a resident's condition changes significantly and all changes shall be acknowledged in writing by both parties. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined that the residence failed to update the service plan each time a resident's condition changed significantly for 5 of 5 residents reviewed for outside services, Resident ID #s 2, 3, 4, 6, and 7; the singular resident who smokes, Resident ID #1; and the singular resident reviewed relative to oxygen use, Resident ID #5. Findings are as follows: A. Review of the list of residents receiving outside services given during the entrance conference on 2/6/2026 at approximately 10:00 AM, revealed Resident ID #2 is receiving skilled nursing (SN) services, Resident ID #3 is receiving physical therapy (PT) and occupational therapy (OT) services, Resident ID #4 was not listed as currently receiving outside services, Resident ID #6 is receiving OT services, and Resident ID #7 is receiving palliative care services. 1. Record review revealed Resident ID #2 moved into the residence in July of 2024 with diagnoses including, but not limited to, gangrene (death of body tissue caused by a lack of blood supply or a bacterial infection commonly affecting the limbs,	S 415	Resident ID2 serivce plan will be reviewed and updated to reflect skilled nursing services for wound care from an outside agency. Resident ID 3 service plan will be reviewed and updated to reflect the service that is being provided PT and OT. Resident ID 4 service plan will be reviewed and corrected for the dates for end of care for PT or OT from 4/25/25. Resident ID 1 service plan will be reviewed and updated to reflect is a smoker. Resident ID 5 service plan will be reviewed and updated to reflect that resident is on oxygen and self manages. Resident 6 service plan will be reviewed and updated to reflect service, OT being provided to the resident. Resident ID7 service plan will be reviewed and updated to reflect palliative services that are being provided. To prevent in the future nursing will audit all resident charts and ensure that the resident services plans are updated when residents assessment changes to ensure all care is on the service plans. Date of completion: 6/30/26	

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S 415	Continued From page 12 fingers, and toes) and necrosis (death of cells and living tissue caused by infection or trauma that cut off blood supply) of the right toe(s). Record review of the resident's service plan, dated 10/14/2025, failed to document that the resident is receiving SN services for wound care, with a start of care date of 6/23/2025. 2. Record review revealed Resident ID #3 moved into the residence in April of 2025 with a diagnosis including, but not limited to, Alzheimer's disease. Record review of the resident's service plan, dated 5/17/2025, failed to be updated to document that the resident started receiving PT and OT services on 1/15/2026. 3. Record review revealed Resident ID #4 moved into the residence in January of 2025 with a diagnosis including, but not limited to, dementia. Record review of the resident's service plan, dated 5/10/2025, revealed that the resident was receiving PT and OT services; there were no dates provided for the end of care. The entrance conference worksheet did not reveal this resident was receiving PT or OT services. During a surveyor interview with the Administrator on 2/10/2026 at approximately 11:00 AM, she could not provide evidence the service plan was updated to discontinue these services, nor could she provide the date PT was discontinued. OT therapy had been discontinued on 5/20/2025. 4. Record review revealed Resident ID #6 moved into the residence in October of 2024 with a diagnosis including, but not limited to,	S 415		

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S 415	Continued From page 13 frontotemporal neurocognitive disorder. Record review of the resident's service plan, dated 5/10/2025, failed to be updated to document that the resident started receiving OT services on 12/2/2025. 5. Record review revealed Resident ID #7 moved into the residence in October of 2024 with a diagnosis including, but not limited to, dementia. Record review of the resident's service plan, dated 1/14/2025, failed to accurately reflect that the resident started receiving palliative services on 12/9/2024. During a surveyor interview with the Resident Care Director (RCD), in the presence of the Administrator, on 2/10/2026 at approximately 2:15 PM, she could not provide evidence of updates or accurate documentation on the service plans for the above-mentioned outside services for Resident ID #s 2, 3, 4, 6, and 7. B. Additionally, during the entrance conference Resident ID #1 was listed as a smoker. During initial observations of the facility Resident ID #5 was identified as utilizing oxygen. 6. Record review revealed Resident ID #1 moved into the residence in May of 2025 with a diagnosis including, but not limited to, alcoholic cirrhosis of the liver. Record review of the resident's service plan, dated 5/17/2025, failed to reveal the resident is a smoker. The plan further failed to reveal interventions to keep the resident and the other residents safe.	S 415		

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S 415	Continued From page 14 During a surveyor interview with the RCD in the presence of the Administrator on 2/10/2026 at approximately 2:30 PM, she could not provide evidence smoking with interventions to protect the resident and other residents were listed on the service plan. 7. Record review revealed Resident ID #5 moved into the residence in May of 2025 with a diagnosis including, but not limited to, chronic obstructive pulmonary disease (COPD). During a surveyor observation of the building on 2/6/2026 at 8:18 AM, an oxygen sign outside of the resident's door was observed. During a surveyor interview with the resident on 2/9/2026 at 10:30 AM, s/he revealed s/he is utilizing oxygen at night. Review of a physician's order, dated 11/21/2025, revealed the resident is able to self-administer her/his own oxygen. Record review of the resident's service plan, dated 5/3/2025, revealed "...Medication: Total Resident is not able to take medication without assistance..." During a subsequent interview with the RCD, in the presence of the Administrator, she could not provide evidence that the service plan accurately reflected that the resident is able to self-administer her/his own oxygen.	S 415		
S 495	Licensure Requirements 2.4.19.D Rights of Residents 2.4.19 (D) Rights of Residents	S 495		

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S 495	Continued From page 15 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/her representative upon admission, a copy of the provisions of § 2.4.18 of this Part and shall 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 observation and staff interview, it has been determined the residence failed to implement procedures to ensure that all of the residence's employees protect the resident's rights contained in these regulations and to observe the standards stated in R.I. Gen. Laws § 23-17.4-16 (a)(2)(ix) relative to identifying information for the residents listed in the facility's survey results binder. Findings are as follows: During a surveyor observation on 2/6/2026 at approximately 9:30 AM of the residence's survey binder, a copy of the "Resident/Staff Roster(s)," dated 11/13/2024, 12/19/2024, 2/5/2025, and 10/2/2025 was identified. During a surveyor interview with the Administrator on 2/6/2026 following the observation, she could not provide evidence the residents' privacy was	S 495	S495 Resident Rights Our state citation binder will be reviewed and all resident/ staff roster sheets will be removed. To protect the residents privacy. To prevent this from occuring in the future, the adminstrator will ensure the state citation binder is updated with state surveys and the resident/ staff roster will be removed from the suvery due to resident privacy. Date of completion: 3/15/26	

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S 495	Continued From page 16 protected.	S 495	S 560 Dietetic services All non contract areas will be intital deep cleaned which includes, ice machine, walk in fridge. counters, can opener, ect. The food service director will create cleaning list for daily tasks for staff to follow and monthly deep cleaning. The food service director will oversee and ensure areas are cleaned properly daily and deep cleaned monthly. The ice machine will be deep cleaned on a quartly basis by an outside company. And spot cleaned as needed by the Food service Director. All maintance tools for cleaning such as brooms, vaccums will be store in the housekeeping closet outside of the kitchen. To prevent similar issues in the future the Food serivce Director will create check list for cleaning schedule for the staff to complete for cleaning equiment. The Food Service Director will ensure that all cleaning supplies are stored in the houskeeping closet outside of the kitchen. Date of completion: 3/30/26	
S 560	Residential Care Services 2.4.23.C Dietetic Services 2.4.23 (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, Part 50-10-1 of this Title, Rhode Island Food Code, and such other applicable statutory or regulatory provisions. This Requirement is not met as evidenced by: Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to comply with all appropriate standards of the Rhode Island Food Code relative to the main kitchen. Findings are as follows: Record review of the 2022 Food Code published by the U.S. Food and Drug Administration Section 4-601.11 (C) states in part,"...non-contact surfaces of equipment shall be free of an accumulation of...other debris..." Record review of the 2022 Food Code published by the U.S. Food and Drug Administration Section 6-501.113 Storing Maintenance Tools states in part, "...Maintenance tools such as brooms, mops, vacuum cleaners, and similar items shall be: (A) Stored so they do not contaminate FOOD, EQUIPMENT, UTENSILS, LINENS..." During a surveyor observation of the main kitchen	S 560		

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S 560	Continued From page 17 on 2/6/2026 at 7:45 AM, the following was observed: -the can opener and blade with a brown sticky matter. -the inside of the microwave with dried up liquid brown spots. Following the above observation, Cook, Staff C, acknowledged the can opener, the blade, and the microwave, were not kept clean. -5 brooms and a bucket were stored next to the ice machine and next to where cereal in bowls was held for service. -inside the ice machine, on the white plastic piece, was a small build-up of orange matter. Following the above observations with the Maintenance Director, he acknowledged the brooms, and bucket should not be stored where they were in the kitchen and acknowledged the orange matter inside the ice machine. -the door handle to the walk-in refrigerator was sticky. -the middle of the walk-in refrigerator ceiling had an accumulation of brown debris. -the cart in the walk-in refrigerator had an accumulation of white and brown crumbs. Following the above observations with the Food Service Director, he acknowledged the door handle to the walk-in refrigerator was not kept cleaned, as well as the ceiling, and the cart.	S 560		

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S 635	Continued From page 18	S 635		
S 635	Residential Care Services 2.4.26.A.3.C Medication Services 2.4.26 (A) (3) (C) Medication Services c. For the first three (3) months of employment, a licensed nurse designated by the health care facility, adult day care program, or assisted living residence, as appropriate, shall conduct and document monthly evaluations (in accordance with the evaluation checklist on the Department website) of a medication aide who administers medication. After the first three (3) months, the evaluation shall be conducted no less than quarterly. Copies of said evaluations shall be placed in the medication aides' personnel records. 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 evaluations of the Certified Medication Technicians (CMTs) who are administering drugs, and place a copy in the employee's personnel record, for the singular newly hired CMT reviewed, Staff D, and for 2 of 2 CMTs who have worked longer than twelve months, Staff E and F. Findings are as follows: 1. Record review revealed Staff D was hired in April of 2025, as a Certified Medication Technician (CMT).	S 635	S635 Residental care service All new CMT will have a competancy completed by the RN for the first three months after hire, then on quarterly basis. Staff D, E, F will have an evaluation completed by the RN for medication passes. To prevent this from occuring in the future, all CMT files will be audited to ensure CMT competancies are completed every quarter and the RN going forward will ensure that every quarter they will be completed. Date of completion: 3/30/26	

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S 635	Continued From page 19 Record review failed to reveal evidence that monthly evaluations were conducted in May and June of 2025. During a surveyor interview with the Resident Care Director (RCD), in the presence of the Administrator, on 2/6/2026 at approximately 3:15 PM, she could not provide evidence that Staff D had all three-monthly evaluations, as required. 2. Record review revealed Staff E was hired in November of 2023, as a CMT. Record review failed to reveal 2024 quarterly evaluations. Further record review revealed evaluations were completed in April and September of 2025. Quarterly evaluations failed to be completed in January and July of 2025. During a surveyor interview with the Administrator on 2/10/2026 at approximately 11:00 AM, she revealed Staff E went out in September of 2025 and returned in January of 2026. She could not provide evidence Staff E completed any quarterly evaluations in 2024. She further could not provide evidence Staff E completed her January and July 2025 evaluations. 3. Record review revealed Staff F was hired in April of 2021 as a CMT. Record review failed to reveal 2024 quarterly evaluations. Further record review revealed evaluations were completed in April, September, and October of 2025. Quarterly evaluations failed to be completed in January and July of 2025 and January of 2026. During a surveyor interview with the RCD, in the presence of the Administrator, on 2/6/2026 at	S 635		

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S 635	Continued From page 20 approximately 3:00 PM, she could not provide evidence that Staff F completed any quarterly evaluations in 2024. She further could not provide evidence Staff F completed her evaluations in January and July of 2025 and January of 2026.	S 635	S640 Residential care services; medication services All med carts will be audited by a wellness departn ent. Bottles that fail to have orders/ directions per doctor order will be reviewed and have order placed on the bottle.	
S 640	Residential Care Services 2.4.26.B.1 Medication Services 2.4.26 (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. 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	S 640	Labeling over the counter medication with directions from the doctor for all over the counter meds. Meds filled by the pharmacy and prescription bottles already have directions on the medications. To prevent in the future, the wellness department will conduct monthly med cart audits to ensure all medications have the proper instructions per doctor on the bottle. Date of completion: 6/30/26	

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S 640	Continued From page 21 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 Part 20-15-6 of this Title, Hypodermic Needles, Syringes, and Other Such Instruments. (1) The legal destruction of hypodermic needles, syringes or other such instruments is the responsibility of the last entitled or authorized possessor. (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	S 640		

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S 640	Continued From page 22 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 § 2.4.25(A)(3)(a)(8) of this Part. l. 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, record review, and staff interview, it has been determined that 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 the singular medication cart reviewed on the second floor and for the singular medication cart reviewed on Rose Lane One.	S 640		

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S 640	Continued From page 23 Findings are as follows: 1. During a surveyor observation of the second-floor medication cart, in the presence of Certified Medication Technician (CMT), Staff D, on 2/9/2026 at 11:05 AM, the medication cart revealed the following medications without directions for use: - a bottle of vitamin D3 1000 IU (international units). - a container of Tums - a bottle of Equate extra strength pain reliever. - a bottle of vitamin B12 1000 mcg (micrograms). - a bottle of Clearlax polyethylene glycol. - a bottle of extra strength acetaminophen 500 mg. During a surveyor interview, following the above observations with Staff D, she acknowledged the above-mentioned medications did not have a label with directions for use on them, as required. 2. During a surveyor observation of the medication cart on Rose Lane One, in the presence of CMT, Staff G, on 2/9/2026 at 11:42 AM, the medication cart revealed the following medications without directions for use: - a bottle of women's daily multivitamin. - a bottle of melatonin 1 mg (milligram). - a bottle of iron 65 mg. - a bottle of vitamin D3 1000 IU. - a bottle of vitamin D3 2000 IU. - two bottles of acetaminophen 325 mg. - a bottle of Tylenol extra strength. - a bottle of women's probiotic dietary supplement. - a bottle of age 50 plus multivitamin - a bottle of ferrous sulfate 325 mg.	S 640		

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S 640	Continued From page 24 - two bottles of Miralax. - a bottle of 4 in 1 daily fiber. During a surveyor interview, following the above observations with Staff G, she acknowledged the above-mentioned medications did not have a label with directions for use on them, as required. During a surveyor interview with the Resident Care Director on 2/10/2026 at approximately 2:45 PM, she was unable to provide evidence the above-mentioned medications were stored securely and in such a manner to prevent spoilage, dosage errors, administration errors, and/or inappropriate access.	S 640		
S 775	Physical Plant 2.4.32.I Safety Requirements 2.4.32 (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	S 775	S775 Physical Plant/ safety requirements Fire drills will be held on a monthly basis. Bi monthly fire drills will be held that are obstructed drills to ensure that 50% of fire drills are obstructed. In the future we will continue to conduct fire drills with obstructions. During our monthly QA reviews maintance will document the fire drill and include if the drill was obstructed or not obstructed and ensures 50% are obstructed. Date of completion: 3/15/26	

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S 775	Continued From page 25 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 775		

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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 § 2.4.31(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, be conducted at least six (6) times per year on a bimonthly basis and at least fifty percent (50%) of these drills shall be obstructed drills as 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 the following dates from January of 2025 through January of 2026:

1/7/2025, 2/26/2025, 3/25/2025, 4/9/2025, 5/27/2025, 6/27/2025, 7/7/2025, 8/2/2025, 9/27/2025, 10/30/2025, 11/15/2025, 12/8/2025, and 1/16/2026.

Further review of the fire drill documentation revealed that 1 of the drills, 11/15/2025, was conducted as obstructed which is 7.69%, not the required 50%.

During a surveyor interview with the Administrator on 2/6/2026 at approximately 12:30 PM, she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01526	A. BUILDING: _____ B. WING _____	02/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AMERICAN ASSISTED LIVING AT WARWIC	55 TOLL GATE FARM ROAD WARWICK, RI 02886

(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 775	Continued From page 27 could not provide evidence that 50% of the drills were obstructed.	S 775		