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| BRIGHTVIEW COMMONS | 57 GRANDEVILLE COURT WAKEFIELD, RI 02879 |

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| S 003 | Initial Comments<br><br>An unannounced biennial State Licensure survey was conducted at this residence on 01/12/2026 though 01/13/2026. Deficiencies were identified relative to the State Licensure survey. | S 003 | Received<br>FEB 11 2026<br>Facilities Regulation | |
| S 055 | Licensure Requirements 2.4.3 Quality Assurance<br><br>2.4.3 Quality Assurance<br><br>A. In accordance with R.I. Gen. Laws § 23-17.4-10.1, each assisted living residence shall develop, implement and maintain a documented, ongoing quality assurance program.<br><br>1. The purpose of this program shall be to attain and maintain a high quality assisted living residence through an on-going process of quality improvement that monitors quality, identifies areas to improve, methods to improve them, and evaluates the progress achieved.<br><br>2. Each licensed residence shall establish a quality improvement committee which shall include at least the following: assisted living administrator, registered nurse and a representative of dietary services.<br><br>3. The quality improvement committee shall meet at least quarterly; shall maintain records of all quality improvement activities; and shall keep records of committee meetings that shall be available to the Department during any on-site visit.<br><br>4. The quality improvement committee shall review and approve the quality improvement plan for the residence at intervals not to exceed twelve (12) months. Said plan shall be available to the public upon request. | S 055 | The Brightview Quality Assurance (QAPI) meeting was conducted in January 2026 following the RIDOH biannual licensure survey completed on January 28, 2026. During the meeting, the following areas were reviewed and addressed:<br><br>A. Prevention and treatment of decubitus ulcers – We will review any resident who currently has or is at risk of skin breakdown; We will discuss potential interventions that can be added to the service plan to minimize the risk of future skin breakdown. We will review treatment plan of outside agency handling said skin injury and review the response to treatment.<br><br>B. Hydration status, nutritional status, and resident weight loss or gain – We will discuss interventions planned to ensure residents are always offered appropriate hydration but | 1/28/2026 |

2/13/26

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

Kathleen M. LaPore — Sr. Ex. Director — 2/10/26

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| S 055 | Continued From page 1<br><br>5. Each assisted living residence shall establish a written quality improvement plan that includes:<br><br>a. Program objectives;<br><br>b. Oversight responsibility (e.g., reports to the governing body, QI records);<br><br>c. Includes methods to identify, evaluate, and correct identified problems;<br><br>d. Provides criteria to monitor personal assistance and resident services, including, but not limited to:<br><br>(1) Resident/family satisfaction;<br><br>(2) Medication administration/errors;<br><br>(3) Reportable incidents as specified in § 2.4.17 of this Part;<br><br>(4) Resident falls;<br><br>(5) Plans of correction developed in response to the Department's inspection reports.<br><br>B. In addition to the requirements of §§ 2.4.3(A)(1) through (5) of this Part, all assisted living residences with a "dementia care" license and/or a "limited health services license" shall also address the following areas in their quality improvement plan:<br><br>1. Prevention and treatment of decubitus ulcers; | S 055 | especially when risk of dehydration is elevated (illness, and higher temperatures). We will discuss any resident who has a significant weight loss or gain, and interventions that can be offered to ensure their health status is not at risk. This will be done in partnership with physician who will be requested to weigh in for appropriate medical intervention if indicated (example- Increased dosing of Lasix for CHF exacerbation).<br><br>C. Changes in residents' mental and psychological status – We will discuss concerns in changes of mental status as it is related to safety of each resident, including if they are in the appropriate neighborhood/level of care.<br><br>These focus areas will continue to be monitored and addressed on an ongoing basis in all future Quality Assurance meetings, in accordance with Assisted Living Facility (ALF) regulations and within the scope of regulatory limitations. | |

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| S 055 | Continued From page 2<br><br>2. Dehydration, and nutritional status and weight loss or gain; and<br><br>3. Changes in mental or psychological status.<br><br>4. Quality improvement documentation shall be kept on file for a minimum of five (5) years.<br><br>This Requirement is not met as evidenced by:<br>Based on record review and staff interview, it has been determined that the residence failed to establish a written quality improvement plan that included all required components.<br><br>Findings are as follows:<br><br>Record review of the quality assurance program written plan failed to reveal evidence that the residence included the required components related to the Dementia Special Care Unit:<br><br>a. Prevention and treatment of decubitus ulcers;<br><br>b. Dehydration, and nutritional status and weight loss or gain; and<br><br>c. Changes in mental or psychological status.<br><br>The plan further failed to include resident and family satisfaction, as required.<br><br>During a surveyor interview with the Health Service Director on 1/13/2026 at approximately 2:00 PM, she could not provide evidence that the quality improvement plan had all of the required components. | S 055 | | |

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| S 250 | Continued From page 3 | S 250 | | |
| S 250 | Organization And Management 2.4.14.A Management Of Services<br><br>2.4.14 (A) Management of Services<br><br>A. Each residence shall provide services with adequate professional and ancillary employees and in accordance with applicable state law. Further, the residence shall assure that all services are rendered in a safe and effective manner and consistent with the requirements herein. The residence shall provide all care and services to all residents in accordance with the prevailing community standard of care.<br><br>This Requirement is not met as evidenced by:<br>Based on record review and staff interview, it has been determined the residence failed to provide care and services in accordance with the prevailing community standard of care relative to following the physician's orders for a singular resident reviewed for self-administration of medication, Resident ID #1.<br><br>Findings are as follows:<br><br>Mosby's 4th Edition, Fundamentals of Nursing, page 314 states, "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm the clients."<br><br>During a surveyor interview with the Health Service Director on 1/12/2026 at approximately 11:30 AM, she revealed Resident ID #1 | S 250 | On the first day of the survey, January 12, 2026, during discussion regarding residents who self-administer medications, it was identified that there is one resident within the community who self-administers medications. At that time, it was determined that the required documentation was incomplete.<br><br>The deficient practice was corrected on January 12, 2026. Nursing staff obtained a current and accurate medication list from the residents outside provider, along with a written letter signed by the physician stating that it is their professional opinion that the resident *"is capable of safely and independently self-administering his prescribed medications as directed. At this time, no assistance or supervision is required for medication administration."*<br><br>Moving forward, all residents who are capable of safely self-administering medications and who choose to do so will have appropriate physician orders and supporting documentation on file prior to self-administration. This process will be monitored on an ongoing basis, during regular assessment schedule including the 90 Day RN Review to ensure continued compliance. | 1/12/2026 |

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| S 250 | Continued From page 4<br>self-administers all of his/her medications, at this time she was asked to provide the physician's order for the resident to self-administer his/her medications.<br><br>Record review revealed Resident ID #1 was admitted to the residence in August of 2017 with diagnoses including, but not limited to, hypertension (HTN), coronary artery disease (CAD), and gastroesophageal reflux disease (GERD).<br><br>Record review of the resident's comprehensive assessment, dated 10/6/2025, revealed the resident has the cognitive ability to self-administer his/her medications.<br><br>Review of the physician's orders revealed the resident is prescribed the following medications:<br><br>-vitamin C (supplement).<br>-aspirin (used to relieve pain, and in low doses, to prevent blood clots).<br>-Lipitor (used to lower cholesterol).<br>-calcium carbonate and magnesium carbonate (supplement used in treating heartburn).<br>-Cardura (used to treat HTN).<br>-Imdur (used to prevent chest pain).<br>-Cozaar (used to treat HTN).<br>-Hiprex (used to prevent urinary tract infections).<br>-toprol-xl (used to treat HTN).<br>-omega 3 fatty acids/fish oil (supplement).<br>-Prilosec (used to treat GERD).<br>-Brilinta (antiplatelet medication used to prevent blood clots).<br><br>During a surveyor interview with the Health Service Director on 1/13/2026 at approximately 2:00 PM, she acknowledged the resident did not have a physician's order to self-administer the | S 250 | | |

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| S 250 | Continued From page 5<br>above-mentioned medications until brought to her attention on 1/12/2026. | S 250 | | |
| S 495 | Licensure Requirements 2.4.19.D Rights of Residents<br><br>2.4.19 (D) Rights of Residents<br><br>D. The residence must:<br><br>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;<br><br>2. Have prominently displayed a posting of the most recent State licensing survey of the assisted living residence; and<br><br>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."<br><br>This Requirement is not met as evidenced by:<br>Based on surveyor observation and staff interview, it has been determined that the residence failed to post the most recent state licensure survey results.<br><br>Findings are as follows:<br><br>During a surveyor observation of the residence on 1/12/2026 at approximately 9:00 AM, the surveyor was unable to locate the most recent survey results.<br><br>During a surveyor interview with the Executive | S 495<br><br>CM<br>2/18/26 | A binder will be created and kept for those who wish to see the most recent state licensure survey results from this day and ongoing. | 1/13/2026 |

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| S 495 | Continued From page 6<br>Director on 1/13/2026 at approximately 3:15 PM, she could not provide evidence that the survey results were posted, as required. | S 495 | | |
| S 540 | Residential Care Services 2.4.22.C(1-5) Illness And Emergencies<br><br>2.4.22 (C) (1-5) Reporting of Communicable Diseases<br><br>C. Reporting of Communicable Diseases<br><br>1. Each residence shall report promptly to the Center for Acute Infectious Diseases Epidemiology (IDE), cases of communicable diseases designated as "reportable diseases" when such cases are diagnosed in the residence in accordance with Part 30-05-1 of this Title, Reporting and Testing of Infectious, Environmental and Occupational Diseases.<br><br>2. When infectious diseases present a potential hazard to residents or personnel, these shall be reported to the Center for Acute Infectious Diseases Epidemiology (IDE) even if not designated as "reportable diseases."<br><br>3. When outbreaks of food-borne illness are suspected, such occurrences shall be reported immediately to the Center for Acute Infectious Diseases Epidemiology (IDE) or to the Center for Food Protection.<br><br>4. Residences must comply with the provisions of R.I. Gen. Laws § 23-28.36-3, which requires notification of fire fighters, police officers and emergency medical technicians after exposure to infectious diseases. | S 540<br><br>AM 2/3/26 | Please see attached Communicable Disease Management and Infection Control Policy. Note on page 5, lines (V) and (W) address discharging any resident with active communicable disease. Also attached is our updated move in/move out policy to include discharging residents with communicable disease. | 2/6/2026 |

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| S 540 | Continued From page 7<br>5. Infection Control<br><br>Infection control provisions shall be established for the mutual protection of residents, employees, and the public. The residence shall be responsible for no less than the following:<br><br>a. Establishing and maintaining a residence-specific infection prevention program;<br><br>b. Establishing policies governing the admission and isolation of residents with known or suspected infectious diseases;<br><br>c. Developing, evaluating and revising on a continuing basis infection control policies, procedures and techniques for all appropriate areas of the residence;<br><br>d. Developing and implementing protocols for:<br><br>(1) Discharge planning to home that include full instructions to the family or caregivers regarding necessary infection control measures; and<br><br>(2) Hospital and/or nursing facility transfer of residents with infectious diseases which may present the risk of continuing transmission. Examples of such diseases include, but are not limited to, tuberculosis (TB), Methicillin resistant staphylococcus aureus (MRSA), vancomycin resistant enterococci (VRE), and clostridium difficile;<br><br>This Requirement is not met as evidenced by: | S 540 | | |

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| S 540 | Continued From page 8<br><br>Based on record review and staff interview, it has been determined the facility failed to establish infection control provisions for the mutual protection of residents, employees, and the public relative to developing and implementing protocols for transfer/discharge to home, hospitals, and/or nursing facilities, of residents with infectious diseases which may present the risk of continuing transmission such as tuberculosis (TB), Methicillin resistant staphylococcus aureus (MRSA), vancomycin resistant enterococci (VRI), and clostridium difficile.<br><br>Findings are as follows:<br><br>Review of the residence's infection control policies failed to include protocols for transfer/discharge to home, hospitals, and/or nursing facilities of a resident with infectious diseases.<br><br>During a surveyor interview with the Executive Director, in the presence of the Health Services Director, on 1/13/2026 at approximately 2:30 PM, she could not provide evidence of the discharge planning protocols of residents with infectious diseases to home, the hospital, and/or a nursing facility. | S 540 | | |
| S 560 | Residential Care Services 2.4.23.C Dietetic Services<br><br>2.4.23 (C) Dietetic Services<br><br>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 | S 560 | | |

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| S 560 | Continued From page 9<br>provisions.<br><br>This Requirement is not met as evidenced by:<br>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, the assisted living servery, and the Wellspring kitchenette.<br><br>Findings are as follows:<br><br>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..."<br><br>Record review of the 2022 Food Code published by the U.S. Food and Drug Administration Section 5-202.13 states in part, "...An air gap between the water supply inlet and the flood level rim of the PLUMBING FIXTURE, EQUIPMENT, or nonfood EQUIPMENT shall be at least twice the diameter of the water supply inlet and may not be less than 25 mm (1 inch)..."<br><br>Record review of the 2022 Food Code published by the U.S. Food and Drug Administration Section 4-501-114 states in part, "...a chemical Sanitizer used in a Sanitizing solution for a manual or mechanical operation shall (C)(2) have a concentration as indicated by the manufacturer..."<br><br>Record review of the 2022 Food Code published by the U.S. Food and Drug Administration Section 3-501.16 states in part, "...Time/Temperature Control for Safety Food, Hot and Cold Holding. (A) Except during preparation, cooking, or | S 560 | | |

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| S 560 | Continued From page 10<br>cooling, or when time is used as the public health control as specified under §3-501.19, and except as specified under ¶ (B) and in ¶ (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57°C (135°F) or above..."<br><br>1. During a surveyor observation of the main kitchen on 1/12/2026 at 8:10 AM, the following was observed:<br><br>-under the serving area table a plastic cover to a container that had scattered crumbs and dried up white liquid.<br><br>-three white bins (one containing salt, one containing sugar, and one containing flour) that contained brown splatter throughout the outside of the bins.<br><br>-in the four-door refrigerator, the condenser fan had an accumulation of debris and the bottom of the refrigerator had dried brown and white liquid.<br><br>~~-the ice machine failed to have an air gap, the pipe to the ice machine was on an angle to the floor with water occasionally coming out onto the floor.~~<br><br>During a surveyor interview with Dining Server, Staff A, following the observations, she acknowledged the plastic cover, the three white bins, the condenser fan in the refrigerator, and the bottom of the refrigerator needed cleaning. She further acknowledged the ice machine did not have an air gap.<br><br>a. During a follow up visit to the main kitchen on 1/13/2026 at 11:00 AM, the surveyor asked the | S 560 | Plastic lids under the service line in the kitchen had accumulated debris. This was corrected at time of inspection; This area and all non-contact food surfaces shall be free of accumulation of debris ongoing<br><br>Sugar/salt/flour bins in back prep area to be kept clean ongoing. This was corrected at time of inspection. This area will be kept clean ongoing<br><br>The whole refrigerator including the condenser fan was cleaned and sanitized at the time of inspection; All ~~areas listed will be kept clean and always sanitized ongoing~~<br><br>Air gap for ice machine drain: Vendor scheduled for 2/9/2026 – completed on this date | 1/12/2026<br><br>1/12/2026<br><br>1/12/2026<br><br>2/9/2026 |

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| S 560 | Continued From page 11<br>Senior Dining Service Director to test the chemical dish machine. The test strip used did not register, he repeated this twice. He could not provide evidence the dish machine was sanitizing the dishes.<br><br>2. During a surveyor observation of the servery on 1/12/2026 at 10:25 AM, the following was observed:<br><br>-the inside of the microwave had brownish-orange dried liquid on the sides and top of the microwave.<br><br>-the bottom of the cart containing cereals, had dried up brown liquid.<br><br>Following the above observations the Senior Dining Server, Staff B, acknowledged that the microwave and the bottom of the cart were not clean.<br><br>3. During a surveyor interview with Nursing Assistant, Staff C, in the Wellspring kitchenette on 1/13/2026 at 8:30 AM, the surveyor asked her to take the temperature of the sausage, this was near the end of the meal service. The temperature of the sausage read 124.2 degrees Fahrenheit.<br><br>During a surveyor interview with the Senior Dining Service Director on 1/13/2026 at 10:30 AM, he acknowledged the sausage was not at the hot holding temperature of 135 degrees Fahrenheit (required to keep cooked foods safe for service). | S 560 | Sanitizer solution for dish machine not dispensing correctly: This was corrected before then end of the day, on the day of inspection.<br><br>The microwave was cleaned at time of inspection and will be kept clean ongoing.<br><br>The cart was cleaned at time of inspection, and the carts will be kept clean moving forward and ongoing.<br><br>Time and temperature control WSV (Sausage not up to correct temp). Lids to be used more efficiently during service to maintain correct temperature.<br><br>See attached cleaning schedule that will be utilized moving forward. | 1/13/2026<br><br>1/12/2026<br><br>1/12/2026<br><br>1/13/2026 |
| S 640 | Residential Care Services 2.4.26.B.1 Medication Services | S 640 | | |

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| S 640 | Continued From page 12<br>2.4.26 (B) (1) Administration of Medications<br><br>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.<br><br>a. The resident or guardian must provide written authorization for the residence to provide administration of medications.<br><br>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.<br><br>c. All medications must be checked against a physician's orders by a licensed nurse, or pharmacist.<br><br>d. The resident must be identified prior to administration of any medication.<br><br>e. The medication must be in the original pharmacy-dispensed container with proper label and directions attached and be administered in accordance with such label.<br><br>f. Injectable medications, including but not limited to insulin, which cannot be self-administered by the resident, must be administered by a licensed nurse.<br><br>g. There shall be written a policy/procedure | S 640 | | |

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| S 640 | Continued From page 13<br>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.<br><br>(1) The legal destruction of hypodermic needles, syringes or other such instruments is the responsibility of the last entitled or authorized possessor.<br><br>(AA) All personnel or residents legally authorized to use disposal syringes and needles, shall destroy them after one (1) use.<br><br>(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.<br><br>(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.<br><br>h. Individual medication records must be retained for each resident to whom medications are being administered and each dose administered to the resident must be properly recorded.<br><br>i. Any medication administered by the residence and refused by a resident shall be documented and reported, as appropriate.<br><br>j. Medications shall be stored securely and in | S 640 | On 1/12/2026 at 9:55AM, surveyor requested access to medication cart(s) located on the first floor to assess the medications contained inside of the cart. CMT on duty is actively administering medications at the time of request. CMT unlocked the medication cart and allowed access as requested. The following medications were identified with only OTC label directions for use but all bottles had been labeled with appropriate identification for which resident the medication belonged to:<br><br>One bottle of vitamin D3 1000IU<br><br>One bottle of Vitamin D3 2000IU<br><br>One bottle of Vitamin D3 5000IU<br><br>Two bottles of Vitamin B12 1000mcg<br><br>One bottle of Melatonin 3mg<br><br>One bottle of Imodium<br><br>One bottle of Tylenol regular strength 325mg<br><br>One bottle of Tylenol Extra strength 500mg<br><br>One bottle of beets & coenzyme Q-10<br><br>One bottle of women's daily 50 plus multivitamin/multimineral supplement | 1/12/2026 |

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| S 640 | Continued From page 14<br>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.<br><br>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.<br><br>l. All centrally stored medications shall be maintained in accordance with manufacturer ' s labeling and administered by authorized personnel.<br><br>This Requirement is not met as evidenced by:<br>Based on surveyor observation and staff interview, it has been determined the residence failed to ensure that medications shall be stored securely and in such a manner to prevent spoilage, dosage errors, administration errors, and/or inappropriate access for two of two medication carts observed.<br><br>Findings are as follows:<br><br>1. During a surveyor observation of the first-floor medication cart on 1/12/2026 at 9:55 AM, the medication cart revealed the following medications that did not contain directions for use:<br><br>- one bottle of vitamin D3 1000 IU (international units)<br>- one bottle of vitamin D3 2000 IU | S 640 | A label with "Directions changed refer to chart" was placed on every bottle noted above to indicate ensure that the administration of each medication is based upon Physician Order which is listed in the Electronic Health Record. Ongoing training has occurred to ensure that each OTC bottle received in the future has this label applied.<br><br>On 1/12/2026 at 9:55AM, surveyor requested access to the medication cart(s) located on the second floor to assess the medications contained inside of the cart. Wellness nurse on duty unlocked the door to the medication room and brought surveyor into the room. She then unlocked both medication carts and the refrigerator for surveyor to inspect. The following medications were identified without OTC label directions for use, but all bottles had been labeled with appropriate identification for which resident the medication belonged to:<br><br>One bottle of 3mg melatonin<br><br>One bottle of Melatonin 5mg<br><br>One bottle of bisacodyl 5mg<br><br>Three bottles of acetaminophen 500mg | 1/12/2026 |

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| S 640 | Continued From page 15<br>- one bottle of vitamin D3 5000 IU<br>- two bottles of vitamin B12 1000 mcg (microgram)<br>- one bottle of melatonin 3 mg (milligrams)<br>- one bottle of Imodium<br>- one bottle of Tylenol regular strength 325 mg<br>- one bottle of Tylenol extra strength 500 mg<br>- one bottle of beets & coenzyme Q-10<br>- one bottle of women's daily 50 plus multivitamin/multimineral supplement<br>- one bottle of PB 8 probiotic<br><br>During a surveyor interview with Certified Medication Technician (CMT), Staff D, following the above observations, he could not provide evidence the above-mentioned bottles had a label with directions for use on them, as required.<br><br>2. During a surveyor observation of the second-floor medication cart on 1/12/2026 at 9:55 AM, the medication cart revealed the following medications that did not contain directions for use:<br><br>- one bottle of melatonin 3 mg<br>- two bottles of melatonin 5 mg<br>- one bottle of bisacodyl 5 mg<br>- three bottles of acetaminophen 500 mg<br>- one bottle of aspirin 81 mg<br>- one bottle of women's formula multivitamin/multimineral supplement<br>- one bottle of docusate sodium 100 mg<br>- one bottle of Spectravite multivitamin/multimineral supplement<br>- three bottles of aspirin 81 mg<br>- one bottle of Osteo Bi-Flex joint health triple strength plus vitamin D<br>- one bottle of vitamin C 1000 mg<br>- two bottles of Miralax | S 640 | One bottle of Aspirin 81mg<br><br>One bottle of women's formula multivitamin/multimineral supplement<br><br>One bottle of docusate sodium 100mg<br><br>One bottle of Spectravite multivitamin/multimineral supplement<br><br>Three bottles of aspirin 81mg<br><br>One bottle Osteo Bi-Flex joint health triple strength plus Vitamin D<br><br>One bottle of vitamin C 1000mg<br><br>Two bottles of MiraLAX<br><br>A label with "Directions changed refer to chart" was placed on every bottle noted above to indicate/ensure that the administration of each medication is based upon Physician Order which is listed in the Electronic Health Record. Ongoing training has occurred to ensure that each OTC bottle received in the future has this label applied.<br><br>All medications listed were always secured in locked medication cart(s) since receiving said medication. The medication carts are secured in locked rooms when not in use. | |

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| S 640 | Continued From page 16<br>During a surveyor interview with the Health Services Director on 1/12/2026 at 11:45 AM, 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, as required. | S 640 | | |
| S 775 | Physical Plant 2.4.32.I Safety Requirements<br><br>2.4.32 (I) Safety Requirements<br><br>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.<br><br>1. Emergency steps of action shall be clearly outlined and posted in conspicuous locations throughout the residence.<br><br>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).<br><br>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 | S 775 | All future fire drills will meet the 50% obstructed criteria as requested by the state surveyor and in accordance with the RI ALF Regulations. Each January the community will use the QAPI Safety Schedule to plan drills for the entire year and 50% of those will be obstructed as required. | 2/4/2026 |

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| S 775 | Continued From page 17<br>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).<br><br>a. Documentation of fire drills shall be maintained and shall include no less than the following information:<br><br>(1) Name of the person conducting the drill;<br><br>(2) Date and time of the drill;<br><br>(3) Amount of time taken to evacuate the building or unit;<br><br>(4) Type of drill (i.e., obstructed or unobstructed);<br><br>(5) Record of problems encountered and steps taken to rectify them;<br><br>(6) Employee observation of each resident ' s ability to carry out evacuation procedures.<br><br>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.<br><br>5. Each new resident shall be oriented to the | S 775 | | |

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| S 775 | Continued From page 18<br>fire drill procedure on admission, with documentation of the orientation placed in the resident ' s record.<br><br>This Requirement is not met as evidenced by:<br>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).<br><br>Findings are as follows:<br><br>Record review revealed fire drills were conducted on the following dates in 2025:<br><br>2/21/2025, 3/19/2025, 4/27/2025, 6/27/2025, 7/31/2025, 8/29/2025, 10/27/2025, 11/25/2025, and 12/31/2025.<br><br>Further review of the fire drill documentation revealed that 3 of the drills, 2/21/2025, 7/31/2025, and 8/29/2025, were recorded as obstructed which is 33.3%, not the required 50%.<br><br>During a surveyor interview with the Maintenance Director on 1/12/2026 at approximately 11:00 AM, he could not provide evidence that 50% of the drills were obstructed. | S 775 | | |