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 _____	C 12/03/2025

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 003	Initial Comments An unannounced complaint/incident investigation survey, ACTS reference numbers 102484, 102461, and 102378, was conducted at this residence on 12/03/2025 to determine compliance with state regulations. Deficiencies were identified as a result of the survey.	S 003		
S 250	Organization And Management 2.4.14.A Management Of Services 2.4.14 (A) Management of Services 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. This Requirement is not met as evidenced by: Based on observation, record review, and resident and staff interviews, it has been determined that the residence failed to provide services to all residents in accordance with the prevailing community standard of care for the singular resident reviewed for oxygen therapy, Resident ID #1 and for the singular resident reviewed for diabetes management, Resident ID #2. Findings are as follows:	S 250		

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

Maryann Grace — Executive Director — 12/23/25

RI Department of Health

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S 250	Continued From page 1 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." 1. Resident ID #1 was admitted to the residence in January of 2025 with a diagnosis that includes, but is not limited to, chronic obstructive pulmonary disease (COPD). During a surveyor interview on 12/3/2025 at approximately 1:00 PM, Resident ID #1 was observed to be receiving oxygen therapy. The resident revealed that she/he receives 2 liters (L) of oxygen. Observation of the oxygen concentrator revealed the setting to be on 3 L of oxygen, not 2 L. Record review of the resident's active physician's orders the residence provided failed to reveal that the resident has a physician's orders for oxygen therapy. 2. Resident ID #2 was admitted to the residence in June of 2022 with a diagnosis that includes, but is not limited to, type 2 diabetes. Record review of the October Medication Administration Record (MAR) revealed finger sticks were being documented as completed two times a week for glucose monitoring. Record review of the October physician's orders failed to reveal an active order for finger sticks to be done two times per week. Additionally, there was no record of finger stick values being communicated to the physician. During a surveyor interview on 12/3/2025 at 2:00	S 250	**A. With Respect to the Specific Regulation Cited: S250** 2.4.14 (A) Management of Services **B. With Respect to how the Facility Will identify and Take Corrective Action:** In reference to Resident ID#1, a physician's order for oxygen was obtained on 12/3/25. In reference to Resident ID#2, attached is an order dated 11/22/2021 for FBS twice weekly. **C. With Respect to What Systemic Measures to be Put in Place to Address the Stated Concern:** Physician order to set parameters. If pulse oximeter result is less than 90% increase flow to 1 liter. In reference to Resident ID#2, blood sugars will be communicated to the physician when outside of the parameters.	

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S 250	Continued From page 2 PM with the Resident Care Director, she acknowledged that Resident ID #1 did not have a physician's order for oxygen therapy and that Resident ID #2 did not have a physician's order for finger sticks.	S 250	**D. With Respect to How the Plan of Corrective Measures will be Monitored:** Training will be provided by Four Winds Senior Care Consultants for 30 days, twice a week for 2 hours.	2/2/26
S 335	Residency Requirements 2.4.16.A Resident Records 2.4.16 (A) Resident Records A. Each residence shall, at a minimum, maintain the following information for each resident: 1. The resident's name; 2. The resident's last address; 3. The name of the person or agency referring the resident to the home; 4. The name, specialty (if any), telephone number, and emergency telephone number of each physician who is currently treating the resident; 5. The date the resident began residing in the home; 6. A list of medications taken by the resident, including dosage, and specific records of medication administration as required by the Department; a. In residences licensed at the M2 level, if a resident refuses to provide the information cited in § 2.4.15(A)(6) of this Part, this fact shall be documented in the resident ' s service agreement.	S 335		

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S 335	Continued From page 3 7. Written acknowledgments that the resident has signed and received copies of the rights as provided in R.I. Gen. Laws § 23-17.4-16; 8. Information about any specific health problems of the resident, which may be useful in a medical emergency, including diagnostic and/or therapeutic orders; 9. A record of personal property and funds which the resident has entrusted to the residence; 10. The name, address, and telephone number of a person identified by the resident who should be contacted in the event of an emergency or death of the resident and the name, address, and telephone number of the legal guardian; 11. Any other health-related emergency, or pertinent information which the resident requests the residence to keep on record; 12. A copy of the initial and periodic assessments described in § 2.4.16 of this Part; 13. A copy of the service plan and nurse review as described in § 2.4.16 of this Part; 14. A copy of the residency agreement as described in § 2.4.14(C) of this Part. This Requirement is not met as evidenced by: Based on observation, record review, and resident and staff interviews, it has been determined that the residence failed to maintain information about specific health problems,	S 335		

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S 335	Continued From page 4 including diagnostic and/or therapeutic orders, for the singular resident reviewed for oxygen therapy, Resident ID #1 and the singular resident reviewed for blood sugar monitoring, Resident ID #2. Findings are as follows: 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." According to Brunner and Sudarth's textbook, Medical and Surgical Nursing, 7th Edition, 1992, p.524, "as with other medications, oxygen is administered with care, and its effects on each patient are carefully assessed. Oxygen is a drug and except in emergency situations is prescribed by a physician." Record review of a publication in the National Library of Medicine, states in part, "...medical grade oxygen is classified as a drug and needs to be prescribed by a qualified healthcare professional..." 1. Resident ID #1 was admitted to the residence in January of 2025 with a diagnosis that includes, but is not limited to, chronic obstructive pulmonary disease (COPD). During a surveyor observation on 12/3/2025 at approximately 1:00 PM of the resident, she/he was receiving oxygen therapy. Record review of the active physician's orders for ID #1 provided by the residence failed to reveal an order for oxygen therapy.	S 335	**A. With Respect to the Specific Regulation Cited: S335** 2.4.16A Resident Records **B. With Respect to how the Facility Will identify and Take Corrective Action:** Resident ID#1 had an order to self-medicate. The staff was not notified by the resident that [redacted] was prescribed Vicodin. Staff was not notified of any other medications that resident was taking outside of the current orders. Resident ID#2 did have an order for FBS twice weekly.	

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S 335	Continued From page 5 Additionally, Resident ID #1 was transferred to an acute care hospital on 11/8/2025 due to a change in mental status, and the hospital records stated that the hospital did not receive an at home medication list for the resident when she/he sent to the hospital, per transfer requirements. Further review of the hospital admission toxicology screenings drawn on 11/8/2025 at approximately 4:30 PM revealed that she/he tested positive for the following medications in his/her urine: -Benzodiazepine (medications that slow down your nervous system and treat anxiety, insomnia, seizures and other conditions) -Fentanyl (a powerful opioid drug used in the treatment of severe pain, can be found in both prescription and illicit drugs) -Opiates (an alkaloid substance derived from opium) ID #1 had indicated to the staff at the acute care hospital that she/he had taken "Vicodin (acetaminophen/ hydrocodone; used to treat pain)" due to recent oral surgery. Additionally, the record indicated the resident had been provided the order for oxygen during a hospital stay in February of 2025, after the resident's admission to the residence. Record review failed to reveal that the resident had an active mediction list at the residence containing any of the above-mentioned identified substances in the toxicology screening. The medication list that the residence had on file was provided in January of 2025, upon move-in, and did not include the medications that were present in his/her urine when she/he was admitted to the acute care hospital, or that ID #1 identified as	S 335	**C. With Respect to What Systemic Measures to be Put in Place to Address the Stated Concern:** Resident ID#1 was readmitted from the hospital on 11/13/25. Upon return, resident was placed on medication administration. Resident ID#2 did have an order for fingersticks twice a week. Upon residents' return from rehab, fingersticks will be done by the nursing staff and recorded. Readings outside of the normal readings will be relayed to the physician. **D. With Respect to How the Plan of Corrective Measures will be Monitored:** Four Winds Senior Care Consultants to oversee for 30 days, twice a week for 2 hours. A weekly audit to be completed by RCD x 4 to verify blood sugars are being recorded. The QMPI POC PIP will review blood sugar recording to verify compliance for the next 3 months and then randomly thereafter.	3/1/26

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S 335	Continued From page 6 having taken prior to the change in mental status. 2. Resident ID #2 was admitted to the residence in June of 2022 with a diagnosis that includes, but is not limited to, type 2 diabetes. Record review failed to reveal the following: - a self-administration assessment for finger sticks - a physician's order for finger sticks two times a week - notification to the physician of finger stick readings, as applicable Record review of the October Medication Administration (MAR) revealed entries for "FBS (fasting blood sugar) twice weekly in the morning every [Tuesday] and [Saturday] for blood sugar monitoring..." Blood sugar values were documented as completed on the following dates without values: -10/4 -10/7 -10/11 -10/14 -10/21 -10/26 Additional record review of the MAR revealed the following abnormal blood sugar values (normal fasting blood sugar range 70-100) were documented by the residence's nursing staff: -10/18 FBS 598 -10/25 FBS 600 During a surveyor interview on 12/3/2025 at approximately 11:30 AM with the Resident Care	S 335		

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S 335	Continued From page 7 Director (RCD), she revealed that the resident does his/her own fasting blood sugar monitoring. The staff only document that the finger sticks were completed. She acknowledged that on 10/18/2025 and 10/25/2025 a staff member did the finger sticks and recorded the values. During a surveyor interview on 12/3/2025 at approximately 2:00 PM with the RCD, she acknowledged that Resident ID #2's physician was not made aware of the blood sugar readings that were outside the normal blood sugar range and that the resident did not have an order for finger sticks. Additionally, she revealed that Resident ID #1 did not have a physician's order for oxygen therapy.	S 335		
S 380	Residency Requirements 2.4.17.B Resident Assessment/Service Plans 2.4.17 (B) Resident Assessment and Service Plans B. This assessment shall be used to determine if the resident's needs and preferences can be met by the assisted living residence within the range of services offered by the residence at its licensure level. The conclusions shall be shared with the resident or the resident's representative. If a reasonable accommodation can enable a resident to live in an assisted living residence, the nature of that accommodation and a plan for implementation or reason for denial should be included in the assessment. Provided, however, any reasonable accommodation provided to a resident shall be provided within the range of services offered by the residence at its licensure level.	S 380	**A. With Respect to the Specific Regulation Cited: S380 2.4.17 B Resident Assessment and Service Plans** CM 12/29/25	

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S 380	Continued From page 8 1. As part of the initial resident admission and assessment process, the residence shall review and consider any notice provided to the facility as required in R.I. Gen. Laws § 42-56-10(23) concerning the resident's or prospective resident's status on parole and recommendations, if any, from the Department of Corrections regarding safety and security measures. This Requirement is not met as evidenced by: Based on observation, record review, and staff interview, it has been determined the residence failed to provide accurate information on the comprehensive assessment for the appropriate development of an individualized service plan for the singular resident reviewed for oxygen therapy, Resident ID #1 and for the singular resident reviewed for blood sugar monitoring, Resident ID #2. Findings are as follows: 1. Resident ID #1 was admitted to the residence in January of 2025 with a diagnosis that includes, but is not limited to, chronic obstructive pulmonary disease (COPD). Record review of a document titled, "Assisted Living Resident Assessment," dated 11/13/2025, reveals the following: Section Six Medication: -assesses the resident as needing medication administration -assesses the resident as not using over-the-counter medications -assesses the resident as not having the cognitive abilities to self-administer medication	S 380	**B. With Respect to how the Facility Will identify and Take Corrective Action:** Resident ID #1 has an order for Oxygen. Regarding Resident ID #1, a thorough sweep of unit was done. Any and all OTC medications were removed. Resident has been notified that [redacted] can no longer have medications in room to self-administer. **C. With Respect to What Systemic Measures to be Put in Place to Address the Stated Concern:** Weekly room audits to be completed with resident consent x 4 to ensure that prescriptions/OTC medications are not in resident room. **D. With Respect to How the Plan of Corrective Measures will be Monitored:** Through the 90 Day Reviews.	ongoing

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S 380	Continued From page 9 During a surveyor observation on 12/3/2025 at approximately 1:00 PM, the resident had over-the-counter medications stored in his/her room. Additionally, Resident ID #1 was observed to be receiving oxygen therapy. The resident revealed that she/he receives 2 liters (L) of oxygen. Observation of the oxygen concentrator revealed the setting to be on 3 L of oxygen, not 2 L. During an interview with the resident, immediately following the above observation, she/he indicated that she/he administers his/her own oxygen. 2. Resident ID #2 was admitted to the residence in June of 2022 with a diagnosis that includes, but is not limited to, type 2 diabetes. Record review of a document titled, "Assisted Living Resident Assessment," dated 7/9/2025, reveals the following: Section Six Medications: -assesses the resident as not being an insulin dependent diabetic -assesses the resident as needing glucose monitoring and that she/he needs full assistance for the monitoring -assesses the resident as choosing to have staff administer medications Record review of the October Medication Administration Record (MAR) revealed that the resident did his/her own finger sticks twice weekly on Tuesdays and Saturdays, with no recorded values on the following dates: -10/4 -10/7	S 380		

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S 380	Continued From page 10 -10/11 -10/14 -10/21 Additional review of the MAR revealed that a staff member obtained the the finger stick values on 10/18/2025 and 10/25/2025. During a surveyor interview on 12/3/2025 at 2:00 PM with the Resident Care Director, she acknowledged that the above-mentioned comprehensive assessments are not accurate related to self-administration of medications, blood sugar monitoring, the use of over-the-counter medications, and oxygen therapy.	S 380		
S 405	Residency Requirements 2.4.17.G.1. Resident Assessment/Service Plans 2.4.17 (G) (1) Service Plans 1. Within a reasonable time after move-in, not to exceed seven (7) days, the Administrator shall be responsible for the development of a written service plan based on the initial assessment. The service plan shall include at least: a. The services and interventions needed, including all services provided by outside healthcare agencies (e.g., home nursing care, hospice); b. Description, frequency, duration relating to the service or intervention, including personal assistance, medication, special diets, recreational activities, and other similar services rendered; c. Party responsible for arranging and/or	S 405	**A. With Respect to the Specific Regulation Cited: S405** 2.4.17.G.1 Resident Assessment Service Plans 12/29/25	

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S 405	Continued From page 11 providing the service; and d. The resident ' s requested and/or therapeutically needed recreational and social activities. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined that the residence failed to accurately reflect the services and interventions needed on the service plan for two of three residents reviewed, Resident ID #s 1 and 2. Findings are as follows: 1. Resident ID #1's service plan, dated 11/13/2025, stated the following: -"will recieve medications safely and as prescribed" -"medications are provided by [pharmacy]" During a surveyor observation on 12/3/2025 at approximately 1:00 PM, the resident had over-the-counter medications stored in his/her room. Additionally, Resident ID #1 was observed to be receiving oxygen therapy. The resident revealed that she/he receives 2 liters (L) of oxygen. Observation of the oxygen concentrator revealed the setting to be on 3 L of oxygen, not 2 L. During an interview with the resident, immediately following the above observation, she/he indicated that she/he administers his/her own oxygen. Record review failed to reveal that the resident was assessed as having the cognitive abilities to administer his/her own medication oxygen and	S 405	**B. With Respect to how the Facility Will identify and Take Corrective Action:** With respect to Resident ID#1, a physician's order for O2 has been obtained for resident to self-administer. With respect to Resident ID#2, a physician's order for FBS twice weekly was obtained on 11/23/21. Service plans will be updated to reflect current orders. All residents to be reviewed to ensure self administration and blood sugar monitoring have been obtained and added to service plans as applicable.	

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S 405	Continued From page 12 that a physician's order was obtained for over-the-counter medications or oxygen. 2. Resident ID #2 's service plan stated "blood sugar checks as ordered by MD." The resident's comprehensive assessment indicated the resident prefers staff to administer medications and requires full assistance for glucose monitoring. Additional record review revealed that the physician's orders failed to reveal an active order for blood sugar monitoring. Record review of the October Medication Administration Record revealed that the resident does his/her own finger sticks for glucose monitoring two times a week. The record failed to reveal "full asssitance" was being provided relative to glucose monitoring on the service plan. During a surveyor interview on 12/3/2025 at 2:00 PM with the Resident Care Director, she acknowledged that the service plans were not accurate for the use of over-the-counter medications, the monitoring of blood sugars for ID #2, and for oxygen therapy being managed by ID #1.	S 405	**C. With Respect to What Systemic Measures to be Put in Place to Address the Stated Concern:** An audit will be conducted to ensure service plans, physician orders are reflected in the service plans. **D. With Respect to How the Plan of Corrective Measures will be Monitored:** A list of residents who self-administer medications and require diabetic management will be reviewed and made part of the QMPI process.	ongoing
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,	S 640		

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	ALR01378	A. BUILDING: _____ B. WING _____	C 12/03/2025

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BRIDGE AT CHERRY HILL, THE	ONE CHERRY HILL ROAD JOHNSTON, RI 02919

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S 640	Continued From page 13 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 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	S 640		

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S 640	Continued From page 14 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 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	S 640		

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S 640	Continued From page 15 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. I. 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 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 one of three residents reviewed, Resident ID #1. Findings are as follows: Record review revealed Resident ID #1 moved into the residence in January of 2025 with a diagnosis that includes, but is not limited to, chronic obstructive pulmonary disease (COPD) and was hospitalized from 11/8/2025 through 11/12/2025 due to an episode of altered mental status. During a surveyor interview on 12/3/2025 at approximately 1:00 PM with the resident, she/he was in his/her room, she/he revealed that she/he was recently hospitalized, and that s/he was no longer able to self-administer his/her medication due to a potential suicidal attempt. Review of the hospital admission toxicology screenings drawn on 11/8/2025 at approximately	S 640	**A. With Respect to the Specific Regulation Cited: S 640 2.4.26.B.1 Medication Services** **B. With Respect to how the Facility Will identify and Take Corrective Action:** Resident ID #1 did not disclose the OTC medications or the other medications that were present in her room as [redacted] was self-medicating. A sweep of residents' apartment was done and any and all medications were removed.	

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S 640	Continued From page 16 4:30 PM revealed that she/he tested positive for the following medications in his/her urine: -Benzodiazepine (medications that slow down your nervous system and treat anxiety, insomnia, seizures and other conditions) -Fentanyl (a powerful opioid drug used in the treatment of severe pain, can be found in both prescription and illicit drugs) -Opiates (an alkaloid substance derived from opium) ID #1 had indicated to the staff at the acute care hospital that she/he had taken "Vicodin (acetaminophen/ hydrocodone; used to treat pain)" due to recent oral surgery. Additionally, the record indicated the resident had been provided the order for oxygen during a hospital stay in February of 2025, after the resident's admission to the residence. Record review failed to reveal that the resident had an active mediction list at the residence containing any of the above-mentioned identified substances in the toxicology screening. The medication list that the residence had on file was provided in January of 2025, upon move-in, and did not include the medications that were present in his/her urine when she/he was admitted to the acute care hospital, or that ID #1 identified as having taken prior to the change in mental status. A surveyor's observation of the resident's room on 12/3/2025 revealed the following: -Trelegy Ellipta inhaler lying on the resident's bed -A silver locked box with the following over the counter medications:	S 640	**C. With Respect to What Systemic Measures to be Put in Place to Address the Stated Concern:** Random audits will be conducted in all resident apartments to ensure there are no OTC medications without a self-medication order and evaluation. A letter to be sent to all residents and family members as a reminder regarding bringing in OTC medications. **D. With Respect to How the Plan of Corrective Measures will be Monitored:** An audit of all residents that self-medicate will be conducted to check on orders and evaluations and to be part of the quarterly QMPI process.	ongoing

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S 640	Continued From page 17 -tube of Muscle Rub, -a tube of Walgreen antibiotic cream -a tube of StellaLife gel for pain and swelling -On a side table, the following was observed: -a tube of Biofreeze -StellaLife spray for pain and swelling Record review of the active physician's orders for Resident ID #1 failed to reveal an order for the above listed medications that were observed in his/her room or for the medications that she/he tested positive for at the hospital. During a surveyor interview on 12/3/2025 at 2:00 PM with the Resident Care Director, she acknowledged that the resident did not have active physician's orders for the above-mentioned medications and that the resident was not supposed to have medications in his/her possession after the hospital admission.	S 640		