RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01378	A. BUILDING: _____ B. WING _____	C 05/06/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 003	Initial Comments A complaint investigation, ACTS references numbers 102991, 103379, and 103471, was conducted at this residence on 05/06/2026 to determine compliance with state laws and regulations. Deficiencies were identified.	S 003	Received JUN 03 2026 Facilities Regulation	
S 310	Residency Requirements 2.4.15.A Residency Requirements 2.4.15 (A) Residency Requirements A. Each licensee, or his/her designee, through the assessment and evaluation procedures delineated in these Regulations (see § 2.4.16(C) of this Part) shall be responsible to ensure that admission to and residency in an assisted living residence be limited to those individuals who meet the definition of "resident" in accordance with § 2.3(A)(34) of this Part. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined that the residence retained a resident that does not meet the definition of a "resident" for 2 of 3 sample residents reviewed for appropriateness of residency, Resident ID #s 1 and 2. Findings are as follows: Per the Rules and Regulations for Licensing Assisted Living Residences, the definition of a resident states in part, "'Resident' means an individual not requiring medical or nursing care as provided in a health care facility but who as a result of choice and/or physical or mental limitation requires personal assistance..." The	S 310 6/4/26	**A. With respect to the specific Regulation cited:** **S 310** Residency Requirements 2.4.15.A **B. With respect to how the facility will identify and take corrective action:** All residents will have an updated BIMS on file	6/30/26

Facilities Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Maryann Grace — TITLE: Executive Director — (X6) DATE: 6/3/26

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S 310	Continued From page 1 facility is not licensed to provide a secure memory care unit. A. A facility reported incident sent to the Rhode Island Department of Health on 4/15/2026 revealed the police arrived at the residence to inform them that Resident ID #1 is naked, soaked in urine, and in a wheelchair in the street. The report further revealed that when the police asked the resident why s/he was outside s/he replied that s/he needed to use the bathroom. Record review revealed Resident ID #1 moved into the residence in December of 2012 with a diagnosis including, but not limited to, Wernicke's encephalopathy (caused by a deficiency in thiamine (vitamin B1)), typically resulting in a classic triad of confusion, ophthalmoplegia (eye movement abnormalities), and ataxia (unsteady gait). Review of the resident's BIMS (Brief Interview for Mental Status), dated 7/23/2024, revealed a score of 11, indicating moderate cognitive impairment and the resident's BIMS on 4/4/2025, 6/3/2025, and 12/3/2025, revealed a score of 3.0, indicating severe cognitive impairment. Review of the progress notes revealed the following entries: - 6/4/2025, fall, resident found lying on the floor in the hallway on the 4th floor. The resident wanted to lay down on the sofa in the hallway. The resident did not utilize her/his pendant to ask for assistance. - 6/24/2025, fall, the resident was found lying on her/his bed and her/his wheelchair was in the living room tipped over. The resident revealed	S 310	**C. With respect to what systemic measures to be put in place to address the stated concern:** A weekly retention meeting is held weekly with the resident care director and executive director to review all falls and behaviors occurring within the week. **D. With respect to how the plan of Corrective measures will be Monitored:** Resident #1 and #2 have been discharged to memory care units.	ongoing

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S 310	Continued From page 2 s/he fell out of the wheelchair and crawled into bed. - 7/1/2025, fall, the resident was found in her/his apartment sitting on the bathroom floor with her/his legs crossed. The resident was reminded to lock her/his wheelchair before making any transfers. - 7/3/2025, the resident was lethargic during dinner and sent to the hospital. - 9/2/2025, the resident had another lethargic episode at dinner. The resident was not sent to the hospital after this incident. - 9/3/2025, fall, at about 3:30 PM the resident was found near the second-floor door, incontinent of urine and difficult to redirect. When asked what s/he was doing s/he mentioned that s/he was going to the store. - 9/8/2025, fall, resident was found in her/his living room by staff. The resident mentioned s/he slipped after using the toilet and s/he crawled into the living room where s/he was found. Resident did not use her/his call pendant for assistance after the fall. - 9/27/2025, the resident was lethargic at times, incontinent, unaware of voiding on the floor. The resident went to the hospital for an evaluation. - 10/2/2025, fall, the resident was on the fifth floor of the common bathroom sitting on the floor due to slidding out of her/his wheelchair because s/he forgot to lock it. The resident resides on the third floor. - 10/30/2025, the resident was "very aggressive"	S 310		

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S 310	Continued From page 3 and refused her/his nighttime medications. - 11/8/2025, the resident was found at approximately 3:30 PM in front of the facility attempting to wheel her/himself in the street to "get my brothers car.' Resident with poor safety awareness..." - 12/29/2025, fall, the resident fell in the shower. Her/his clothing was found bunched up in the back of her/his shower wet. It was also noted that s/he had thrown her/his personal care items (soap, shampoo, etc.) across the floor of the bathroom. The resident went to the hospital as s/he had pain in both of her/his legs. "Hospital made aware that this is resident's second time performing self destructive behaviors as resident is not a self shower and can barely stand up on his own..." - 1/3/2026, fall, resident found sitting on the floor of her/his bedroom with her/his back against the bed. The wheelchair was noted to be unlocked. - 2/5/2026, fall, unwitnessed in room 519. - 2/11/2026, fall, the resident was found on the floor of her/his bathroom while s/he was self-transferring from the toilet back to her/his wheelchair and lost her/his balance. Review of a "Ninety (90) Day Nurse Review Report to Administrator" form, dated 9/3/2025, states in part, "...[Resident ID #1] presents with increased confusion and behaviors..." Further review of the form asks if resident is suitable for assisted living and the answer indicated "yes," questioning possible memory care unit. Review of a "Ninety (90) Day Nurse Review	S 310		

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S 310	Continued From page 4 Report to Administrator" form, dated 3/3/2026, states in part, "...[Resident ID #1] has had 3 falls for this quarter, all [without] injury...has no safety awareness...continues to self transfer [without] assistance.." Further review of the form asks if residents is suitable for assisted living and the answer indicated "yes," questioning possible memory care unit. Review of the Assisted Living Residence 5-day report, dated 4/16/2026, revealed that the resident was found outside the building at 11:30 PM. The resident was naked, soaked in urine, and in her/his wheelchair. The police arrived at the residence to notify the staff that the resident was outside. The resident was then transported to the hospital for an evaluation and returned with a diagnosis of a mild urinary tract infection. The resident revealed s/he exited the building through a back door and revealed to police that s/he was going to a Friars game. The resident revealed to the Executive Director (ED) and the Resident Care Director that s/he was trying to escape. After this incident the facility reported they determined that the resident requires a secured memory care unit. During a surveyor interview with Nursing Assistant (NA), Staff A, in the presence of the Resident Care Coordinator on 5/6/2026 at approximately 12:15 PM, she revealed the resident seemed more confused within the last couple of months. She further revealed the resident wanted to go to their car; s/he didn't have a car. S/he would have periods of disorientation. S/he has gotten worse with confusion by going on different floors and to other resident rooms. Additionally, they revealed a couple of months ago the resident started staring at her/his food, appearing that s/he didn't know what to do with it.	S 310		

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S 310	Continued From page 5 B. A facility reported incident sent to the Rhode Island Department of Health on 1/30/2026 revealed Resident ID #2 was concealing utensils in her/his shirt during lunch. The report further alleges staff asked her/him for the utensils and s/he became agitated and aggressive and began throwing the utensils. A knife thrown narrowly missing the head of another resident. Record review revealed Resident ID #2 moved into the residence in June of 2025 with a diagnosis including, but not limited to, unspecified dementia with behavioral disturbance. Review of the residents' BIMS, dated 1/5/2026, revealed a score of 99, indicating the resident was unable to complete the interview. Review of the progress notes revealed the following entries: - 7/4/2025, the resident used her/his shower to pass a bowel movement rather than the toilet. When the resident was asked why s/he didn't use the toilet, s/he revealed s/he didn't know why. - 7/5/2025, the resident has been urinating in the closet of her/his apartment. - 8/7/2025, the resident "...refused care, hallucinating..." - 8/26/2025, "...resident had come into the front office crying, stating, I ran away from home because my mother is a...and I don't know where I am...I'm just a kid, I had to run away from home because my mother is a...offered to assist resident to (her/his) apartment. Resident said, I have an apartment here? How did I manage	S 310		

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S 310	Continued From page 6 something like that..." - 9/15/2025, the resident was wandering the hallway going to other resident's apartments and redirected. The resident revealed s/he was trying to help everybody. - 11/25/2025, the resident had a bowel movement on the fourth-floor hallway. - 12/28/2025, the resident wandered into another resident's room. The other resident went to report it as it made the resident anxious. - 1/12/2026, it was reported by other residents on the fourth floor that Resident ID #2 continues to walk into other resident's apartments in the middle of the night. - 1/18/2026, the resident was verbally aggressive with residents in the dining room during supper stating, "I will kill someone." The resident was escorted out of the dining room and brought to her/his apartment. It was then reported s/he was out on the fourth-floor walking into other residents' apartments. - 1/19/2026, the resident was agitated and anxious, trazodone given for anxiety. - 1/29/2026, the resident had an outburst where s/he started throwing metal utensils and a knife missed another resident's head by a narrow margin. 911 was called. The residents' daughter was called and told if the resident came back the resident would need 1:1 supervision twenty-four hours a day. - 1/30/2026, the resident was diagnosed with agitation and altered mental status.	S 310		

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S 310	Continued From page 7 - 2/2/2026, the plan is for the resident to go to a memory care unit. - 2/4/2026, the resident was in the dining room eating pudding with her/his fingers. Review of the Assisted Living Residence 5-day report, dated 2/5/2026, revealed that 911 was called when the resident started to throw metal utensils in the dining room swearing and yelling at staff. When the resident returned from the hospital the resident's family had to provide the resident with a 24/7 private duty aide until the resident could be moved to a secure memory care facility on 2/9/2026. During a surveyor interview with Nursing Assistant, Staff A, on 5/6/2026 at approximately 11:00 AM, she revealed the resident needed explicit instructions for activities of daily living, if not, for example s/he would put her/his toothbrush through her/his hair or put her/his deodorant in her/his mouth. During a surveyor interview with the Resident Care Director, in the presence of the Executive Director, on 5/6/2026 at approximately 3:00 PM, she could not provide evidence that Resident ID #1 or Resident ID #2 met the definition of a resident for a facility that was unable to provide a secure memory care unit to ensure the safety of all residents residing in the facility.	S 310		
S 335	Residency Requirements 2.4.16.A Resident Records 2.4.16 (A) Resident Records	S 335		

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S 335	Continued From page 8 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. 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	S 335	**A. With respect to the specific regulation cited:** **S 335** Residency Requirements 2.4.26 A Resident Records **B. With respect to how the facility Will identify and take corrective Action:** An audit is being conducted to review the code status on all residents to ensure physician orders are documented accordingly on all pertinent documents. A report is run daily to monitor any and all missed medications.	6/30/26

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S 335	Continued From page 9 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 record review and staff interview, it has been determined the residence failed to maintain, at a minimum, information about any specific health problems of the resident, which may be useful in a medical emergency, for two of three residents reviewed, Resident ID #s 2 and 3. Findings are as follows: 1) Record review revealed Resident ID #2 moved into the residence in June of 2025 with a diagnosis of unspecified dementia with other behavioral disturbances.	S 335	**C. With respect to what systemic Measures be put in place to Address the stated concern:** Code status will be reviewed upon change of condition and/or at resident semi-annual care conference An inservice will be held to educate the CMT's and LPN's on the missed medication policy Including the notification of the ordering physician when three or more doses have been missed. **D. With respect to how the plan of corrective measures will be monitored:** [redacted] Consultants will oversee and train the department for 3 months to be in compliance with policy and procedures and offer recommendations where needed.	6/30/26

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S 335	Continued From page 10 Review of the resident's face sheet revealed the resident is allergic to cat dander. Review of the comprehensive assessment, dated 6/3/2025, revealed the resident has NKA (No Known Allergies). Review of the resident's "Physician Orders" revealed the resident has an allergy to cat dander. During a surveyor interview with the Resident Care Director (RCD) on 5/7/2026 at 9:30 AM, she could not provide evidence the comprehensive assessment accurately reflected the resident's allergy. 2) Record review revealed Resident ID #3 moved into the residence in March of 2026 with a diagnosis including, but not limited to, unspecified dementia with agitation. a. Review of the resident's face sheet revealed the advanced directive was documented as "CPR" (Cardiopulmonary resuscitation). Review of the comprehensive assessment, dated 3/16/2026, revealed the resident's advance directive was documented as "DNR" (Do Not Resuscitate). Review of the resident's "Physician Orders" revealed the resident's advance directives was documented as CPR. b. Review of the residents' April 2026 Medication Administration Record (MAR) revealed the following: 1. Quetiapine fumarate 25 mg (milligrams) take a	S 335		

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S 335	Continued From page 11 half tablet three times a day. Indications for use: behaviors. - The resident refused this medication on 4/10 and 4/11 (morning and afternoon doses), and on 4/12 (refused all 3 doses). Record review failed to reveal that the physician was notified of the missed doses. -4/18 and 4/19 the afternoon dose revealed no documentation by staff administering medications. -4/21 the morning dose revealed no documentation by the staff administering medications; the resident refused the afternoon and evening dose. Record review failed to reveal that the physician was notified of the missed doses. -4/22 the resident refused the afternoon dose and on 4/23 it was documented that the resident refused the afternoon and evening dose. Record review failed to reveal that the physician was notified of the missed doses. - Record review revealed the resident went to the hospital on 4/24/2026 and did not return. The MAR revealed the resident was hospitalized on 4/24/2026 through 4/27/2026 but then on 4/28/2026 the morning and afternoon dose was documented as a "1." The code "1" is used for "absent from home without meds." 2. All morning medications on the MAR for 4/21/2026 failed to reveal any documentation by the staff administering medications for the following medications: -amlodipine	S 335		

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S 335	Continued From page 12 -aspirin -ferrous sulfate -levothyroxine -metoprolol tartrate -mirtazapine -omeprazole -quetiapine fumarate During a subsequent interview with the RCD, she could not provide evidence that the comprehensive assessment accurately reflected the resident's code status. She further could not provide evidence the resident's April 2026 MAR provided accurate documentation, and that the physician was notified of the above-mentioned refused doses.	S 335		
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 update the comprehensive assessment each time a resident's condition changed significantly for 2 of 3 sample residents reviewed, Resident ID #s 1 and 2; and Nurse and Administrator signatures were provided on the comprehensive assessment	S 390	**A. With respect to the specific Regulation cited:** **S 390** **2.14.17 (D) Resident Assessments and Service Plans** **B. With respect to how the facility will identify and take corrective action:** The comprehensive assessment plan will be updated when there is a change in condition and semi-annually. The update will be reviewed by both the resident care director and executive director.	6/4/26 ongoing

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 390	Continued From page 13 forms for 3 of 3 sample residents reviewed, Resident ID #s 1, 2, and 3. Findings are as follows: A. A facility reported incident sent to the Rhode Island Department of Health on 4/15/2026 revealed the police arrived at the residence to inform them that Resident ID #1 is naked, soaked in urine, and in a wheelchair in the street. The report further revealed that when the police asked the resident why s/he was outside s/he replied that s/he needed to use the bathroom. Record review revealed Resident ID #1 moved into the residence in December of 2012 with a diagnosis including, but not limited to, Wernicke's encephalopathy (caused by a deficiency in thiamine (vitamin B1)), typically resulting in a classic triad of confusion, ophthalmoplegia (eye movement abnormalities), and ataxia (unsteady gait). Review of the resident's BIMS (Brief Interview for Mental Status), dated 7/23/2024, revealed a score of 11, indicating moderate cognitive impairment and the resident's BIMS on 4/4/2025, 6/3/2025, and 12/3/2025, revealed a score of 3.0, indicating severe cognitive impairment. Review of the comprehensive assessment, dated 12/3/2025, revealed the following sections: -"Section Four-Behavioral Information:" "Wandering," revealed the resident "...wanders within residence or facility. May wander outside; health or safety may be jeopardized, but resident is not combative about returning and does not require professional consultation and/or	S 390	**C. With respect to what systemtic Measures be put in place to Address the stated concern:** Daily review of dashboard/report to identify any change in status/ condition of resident. Any significant change of condition will be addressed in the comprehensive assessment and also when a resident has been out of the community. Residents will be reviewed also at the weekly retention meeting, **D. With respect to how the plan of Corrective measured will be Monitored:** [redacted] Consultants will oversee and train the department for 3 months to be in compliance with policy and procedures. All residents will be reviewed for appropriate level of care by [redacted] with the Administrator, Wellness Director and caregivers.	ongoing 7/2/26 and ongoing

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S 390	Continued From page 14 intervention..." "Self-preservation", revealed the resident "...is able to discern situations in which he/she may be in danger but due to physical limitations may need some assistance to self-preserve or evacuate..." -"Section Five-Health Information" History of Falls revealed the date of the resident's last fall was 5/31/2025. -"Section Seven-Assessment Summary" revealed the resident is suitable for ALR (Assisted Living Residence) admission or continued residence: long term. Review of the progress notes revealed the following entries: - 6/4/2025, fall, resident found lying on the floor in the hallway on the 4th floor. The resident wanted to lay down on the sofa in the hallway. The resident did not utilize her/his pendant to ask for assistance. - 6/24/2025, fall, the resident was found lying on her/his bed and her/his wheelchair was in the living room tipped over. The resident revealed s/he fell out of the wheelchair and crawled into bed. - 7/1/2025, fall, the resident was found in her/his apartment sitting on the bathroom floor with her/his legs crossed. The resident was reminded to lock her/his wheelchair before making any transfers. - 7/3/2025, the resident was lethargic during dinner and sent to the hospital.	S 390		

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S 390	Continued From page 15 - 9/2/2025, the resident had another lethargic episode at dinner. The resident was not sent to the hospital after this incident. - 9/3/2025, fall, at about 3:30 PM the resident was found near the second-floor door, incontinent of urine and difficult to redirect. When asked what s/he was doing s/he mentioned that s/he was going to the store. - 9/8/2025, fall, resident was found in her/his living room by staff. The resident mentioned s/he slipped after using the toilet and s/he crawled into the living room where s/he was found. Resident did not use her/his call pendant for assistance after the fall. - 9/27/2025, the resident was lethargic at times, incontinent, unaware of voiding on the floor. The resident went to the hospital for an evaluation. - 10/2/2025, fall, the resident was on the fifth floor of the common bathroom sitting on the floor due to slidding out of her/his wheelchair because s/he forgot to lock it. The resident resides on the third floor. - 10/30/2025, the resident was "very aggressive" and refused her/his nighttime medications. - 11/8/2025, the resident was found at approximately 3:30 PM in front of the facility attempting to wheel her/himself in the street to "'get my brothers car.' Resident with poor safety awareness..." - 12/29/2025, fall, the resident fell in the shower. Her/his clothing was found bunched up in the back of her/his shower wet. It was also noted that	S 390		

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S 390	Continued From page 16 s/he had thrown her/his personal care items (soap, shampoo, etc.) across the floor of the bathroom. The resident went to the hospital as s/he had pain in both of her/his legs. "Hospital made aware that this is resident's second time performing self destructive behaviors as resident is not a self shower and can barely stand up on his own..." - 1/3/2026, fall, resident found sitting on the floor of her/his bedroom with her/his back against the bed. The wheelchair was noted to be unlocked. - 2/5/2026, fall, unwitnessed in room 519. - 2/11/2026, fall, the resident was found on the floor of her/his bathroom while s/he was self-transferring from the toilet back to her/his wheelchair and lost her/his balance. The comprehensive assessment failed to be updated in the following areas: -falls -wandering -self-preservation -ALR suitable residence Furthermore, review of the comprehensive assessment failed to be signed by the Nurse and the Administrator. Review of the Assisted Living Residence (ALR) 5-day report, dated 4/16/2026, revealed that the resident was found outside the building at 11:30 PM. The resident was naked, soaked in urine, and in her/his wheelchair. The police arrived at the residence to notify the staff that the resident was outside. The resident was then transported to the hospital for an evaluation and returned with	S 390		

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S 390	Continued From page 18 throwing the utensils. A knife thrown narrowly missing the head of another resident. Record review revealed Resident ID #2 moved into the residence in June of 2025 with a diagnosis including, but not limited to unspecified dementia with behavioral disturbance. Review of the residents' BIMS, dated 1/5/2026, revealed a score of 99, indicating the resident was unable to complete the interview. Review of the comprehensive assessment, dated 1/5/2026, revealed the following sections: -"Section Four-Behavioral Information:" "Wandering" revealed the resident "...wanders within residence or facility. May wander outside; health or safety may be jeopardized, but resident is not combative about returning and does not require professional consultation and/or intervention...Easily redirected when standing at door verbalizing (her/his) desire to go outside unattended..." "Assaultive/destructive behavior" which includes throwing objects revealed the resident "is not Assaultive or dangerous." "Self-preservation" revealed the resident "...is frequently confused and unable to discern and/or avoid situations in which he/she may be in danger and needs guidance and assistance..." Furthermore, review of the comprehensive assessment failed to be signed by the Nurse and the Administrator. Review of the progress notes revealed the	S 390		

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S 390	Continued From page 19 following entries: - 7/4/2025, the resident used her/his shower to pass a bowel movement rather than the toilet. When the resident was asked why s/he didn't use the toilet, s/he revealed s/he didn't know why. - 7/5/2025, the resident has been urinating in the closet of her/his apartment. - 8/7/2025, the resident "...refused care, hallucinating..." - 8/26/2025, "...resident had come into the front office crying, stating, I ran away from home because my mother is a...and I don't know where I am...I'm just a kid, I had to run away from home because my mother is a...offered to assist resident to (her/his) apartment. Resident said, I have an apartment here? How did I manage something like that..." - 9/15/2025, the resident was wandering the hallway going to other resident's apartments and redirected. The resident revealed s/he was trying to help everybody. - 11/25/2025, the resident had a bowel movement on the fourth-floor hallway. - 12/28/2025, the resident wandered into another resident's room. The other resident went to report it as it made the resident anxious. - 1/12/2026, it was reported by other residents on the fourth floor that Resident ID #2 continues to walk into other resident's apartments in the middle of the night. - 1/18/2026, the resident was verbally aggressive	S 390		

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S 390	Continued From page 20 with residents in the dining room during supper stating, "I will kill someone." The resident was escorted out of the dining room and brought to her/his apartment. It was then reported s/he was out on the fourth-floor walking into other residents' apartments. - 1/19/2026, the resident was agitated and anxious, trazodone given for anxiety. - 1/29/2026, the resident had an outburst where s/he started throwing metal utensils and a knife missed another resident's head by a narrow margin. 911 was called. The residents' daughter was called and told if the resident came back the resident would need 1:1 supervision twenty-four hours a day. - 1/30/2026, the resident was diagnosed with agitation and altered mental status. - 2/2/2026, the plan is for the resident to go to a memory care unit. - 2/4/2026, the resident was in the dining room eating pudding with her/his fingers. The comprehensive assessment indicates that the person providing the information was the "resident chart," there is no evidence of a nursing assessment having been completed by an RN. Review of the ALR 5-day report, dated 2/5/2026, revealed that 911 was called when the resident started to throw metal utensils in the dining room swearing and yelling at staff. When the resident returned from the hospital the resident's family had to provide the resident with a 24/7 private duty aide until the resident could be moved to a secure memory care facility on 2/9/2026.	S 390		

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S 390	Continued From page 21 During a surveyor interview with Nursing Assistant, Staff B, on 5/6/2026 at approximately 11:00 AM, she revealed the resident needed explicit instructions for activities of daily living, if not, for example s/he would put her/his toothbrush through her/his hair or put her/his deodorant in her/his mouth. During a surveyor interview with the RCD, in the presence of the ED, on 5/6/2026 at approximately 3:00 PM, she could not provide evidence that the above-mentioned sections on the comprehensive assessment were updated and the form was signed by the Administrator and nurse, as required. Additionally, the nurse could not provide evidence the resident was assessed appropriately. 3) Resident ID #3 moved into the residence in March of 2026 with a diagnosis including, but not limited to, chronic unspecified dementia with agitation. Record review of the comprehensive assessment, dated 3/16/2026, failed to reveal the Nurse and the Administrator's signature, as required. During a subsequent interview with the RCD, in the presence of the ED, she could not provide evidence of the required Nurse and Administrator's signatures were on the resident's assessment.	S 390		
S 415	Residency Requirements 2.4.17.G.3 Resident Assessment/Service Plan 2.4.17 (G)(3) Service Plans	S 415		

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S 415	Continued From page 22 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 2 of 3 sample residents reviewed for behaviors, Resident ID #s 1 and 3. Findings are as follows: A. A facility reported incident sent to the Rhode Island Department of Health on 4/15/2026 revealed the police arrived at the residence to inform them that Resident ID #1 is naked, soaked in urine, and in a wheelchair in the street. The report further revealed that when the police asked the resident why s/he was outside s/he replied that s/he needed to use the bathroom. Review of the ALR 5-day report, dated 4/16/2026, revealed that the resident was found outside the building at 11:30 PM. The resident was naked, soaked in urine, and in her/his wheelchair. The police arrived at the residence to notify the staff that the resident was outside. The resident was then transported to the hospital for an evaluation, and s/he returned with a diagnosis of a mild urinary tract infection. The resident revealed s/he exited the building through a back door and revealed to the police that s/he was going to a Friars game. The resident revealed to the	S 415 CB 6/9/26	**A. With respect to the specific Regulation cited:** **S 415** **2.4.17 (G)(3) Service Plans** **B. With respect to how the facility will identify and take corrective action:** Any and all changes in condition will be noted on the community dashboard as well as discussed and documented at change of shift. Review of the change(s) will be conducted and change in comprehensive assessment as well as service plan will be completed and acknowledged in writing by all parties. **C. With respect to what systemic measures be put in place to address the stated concern:** A weekly random audit will be conducted on a minimum of 5% of the residents at the retention meeting to ensure compliance for the next 60 days.	

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S 415	Continued From page 23 Executive Director (ED) and the Resident Care Director (RCD) that s/he was trying to escape. 1) Record review revealed Resident ID #1 moved into the residence in December of 2012 with a diagnosis including, but not limited to, Wernicke's encephalopathy, caused by a deficiency in thiamine (vitamin B1)), typically resulting in a classic triad of confusion, ophthalmoplegia (eye movement abnormalities), and ataxia (unsteady gait). Review of the resident's BIMS (Brief Interview for Mental Status), dated 7/23/2024, revealed a score of 11, indicating moderate cognitive impairment and the resident's BIMS on 4/4/2025, 6/3/2025, and 12/3/2025, revealed a score of 3.0, indicating severe cognitive impairment. Review of the progress notes revealed the following entries: - 6/4/2025, fall, resident found lying on the floor in the hallway on the 4th floor. The resident wanted to lay down on the sofa in the hallway. The resident did not utilize her/his pendant to ask for assistance. - 6/24/2025, fall, the resident was found lying on her/his bed and her/his wheelchair was in the living room tipped over. The resident revealed s/he fell out of the wheelchair and crawled into bed. - 7/1/2025, fall, the resident was found in her/his apartment sitting on the bathroom floor with her/his legs crossed. The resident was reminded to lock her/his wheelchair before making any transfers.	S 415	**D. With respect to how the plan of corrective measures will be monitored:** [redacted] Consultants will train and oversee the department for 3 months to be in compliance with policy and procedures.	

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S 415	Continued From page 24 - 7/3/2025, the resident was lethargic during dinner and sent to the hospital. - 9/2/2025, the resident had another lethargic episode at dinner. The resident was not sent to the hospital after this incident. - 9/3/2025, fall, at about 3:30 PM the resident was found near the second-floor door, incontinent of urine and difficult to redirect. When asked what s/he was doing s/he mentioned that s/he was going to the store. - 9/8/2025, fall, resident was found in her/his living room by staff. The resident mentioned s/he slipped after using the toilet and s/he crawled into the living room where s/he was found. Resident did not use her/his call pendant for assistance after the fall. - 9/27/2025, the resident was lethargic at times, incontinent, unaware of voiding on the floor. The resident went to the hospital for an evaluation. - 10/2/2025, fall, the resident was on the fifth floor of the common bathroom sitting on the floor due to slidding out of her/his wheelchair because s/he forgot to lock it. The resident resides on the third floor. - 10/30/2025, the resident was "very aggressive" and refused her/his nighttime medications. - 11/8/2025, the resident was found at approximately 3:30 PM in front of the facility attempting to wheel her/himself in the street to "'get my brothers car.' Resident with poor safety awareness..." - 12/29/2025, fall, the resident fell in the shower.	S 415		

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S 415	Continued From page 25 Her/his clothing was found bunched up in the back of her/his shower wet. It was also noted that s/he had thrown her/his personal care items (soap, shampoo, etc.) across the floor of the bathroom. The resident went to the hospital as s/he had pain in both of her/his legs. "Hospital made aware that this is resident's second time performing self destructive behaviors as resident is not a self shower and can barely stand up on his own..." - 1/3/2026, fall, resident found sitting on the floor of her/his bedroom with her/his back against the bed. The wheelchair was noted to be unlocked. - 2/5/2026, fall, unwitnessed in room 519. - 2/11/2026, fall, the resident was found on the floor of her/his bathroom while s/he was self-transferring from the toilet back to her/his wheelchair and lost her/his balance. Review of the service plan, dated 12/3/2025, revealed that the resident has behaviors including agitation. Interventions include, but are not limited to: administer medications as ordered, allowing her/him to make decisions about treatment regimen and personal care, approach in a calm manner and validate feelings, divert attention, and provide wellness checks on all shifts. The service plan failed to include that the resident's cognitive status had declined (the resident's BIMS score of 3). The service plan further failed to reflect that the resident has poor safety awareness. During a surveyor interview with Nursing Assistant (NA), Staff A, in the presence of the Resident Care Coordinator on 5/6/2026 at	S 415		

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S 415	Continued From page 26 approximately 12:15 PM, she revealed the resident seemed more confused within the last couple of months. She further revealed the resident wanted to go to their car; s/he didn't have a car. S/he would have periods of disorientation. S/he has gotten worse with confusion by going on different floors and to other resident rooms. Additionally, she revealed a couple of months ago the resident started staring at her/his food, appearing that s/he didn't know what to do with it. During a surveyor interview with the Resident Care Director (RCD) in the presence of the Executive Director (ED) on 5/7/2026 at approximately 3:00 PM, she could not provide evidence the service plan was updated to include the resident's accurate cognitive status and lack of safety awareness. B. A facility reported incident sent to the Rhode Island Department of Health on 1/30/2026 revealed Resident ID #2 was concealing utensils in her/his shirt during lunch. The report further alleges staff asked her/him for the utensils and s/he became agitated and aggressive and began throwing the utensils. A knife thrown narrowly missing the head of another resident. Review of the ALR 5-day report, dated 2/5/2026, revealed that 911 was called when the resident started to throw metal utensils in the dining room swearing and yelling at staff. When the resident returned from the hospital the resident's family had to provide the resident with a 24/7 private duty aide until the resident could be moved to a secure memory care facility on 2/9/2026. Record review revealed Resident ID #2 moved into the residence in June of 2025 with a diagnosis including, but not limited to unspecified	S 415		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGE AT CHERRY HILL, THE	ONE CHERRY HILL ROAD JOHNSTON, RI 02919

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 415	Continued From page 27 dementia with behavioral disturbance. Review of the residents' BIMS, dated 1/5/2026, revealed a score of 99, indicating the resident was unable to complete the interview. Review of the progress notes revealed the following entries: - 7/4/2025, the resident used her/his shower to pass a bowel movement rather than the toilet. When the resident was asked why s/he didn't use the toilet, s/he revealed s/he didn't know why. - 7/5/2025, the resident has been urinating in the closet of her/his apartment. - 8/7/2025, the resident "...refused care, hallucinating..." - 8/26/2025, "...resident had come into the front office crying, stating, I ran away from home because my mother is a...and I don't know where I am...I'm just a kid, I had to run away from home because my mother is a...offered to assist resident to (her/his) apartment. Resident said, I have an apartment here? How did I manage something like that..." - 9/15/2025, the resident was wandering the hallway going to other resident's apartments and redirected. The resident revealed s/he was trying to help everybody. - 11/25/2025, the resident had a bowel movement on the fourth-floor hallway. - 12/28/2025, the resident wandered into another resident's room. The other resident went to report it as it made the resident anxious.	S 415		

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S 415	Continued From page 28 - 1/12/2026, it was reported by other residents on the fourth floor that Resident ID #2 continues to walk into other resident's apartments in the middle of the night. - 1/18/2026, the resident was verbally aggressive with residents in the dining room during supper stating, "I will kill someone." The resident was escorted out of the dining room and brought to her/his apartment. It was then reported s/he was out on the fourth-floor walking into other residents' apartments. - 1/19/2026, the resident was agitated and anxious, trazodone given for anxiety. - 1/29/2026, the resident had an outburst where s/he started throwing metal utensils and a knife missed another resident's head by a narrow margin. 911 was called. The residents' daughter was called and told if the resident came back the resident would need 1:1 supervision twenty-four hours a day. - 1/30/2026, the resident was diagnosed with agitation and altered mental status. - 2/2/2026, the plan is for the resident to go to a memory care unit. - 2/4/2026, the resident was in the dining room eating pudding with her/his fingers. Review of the service plan, dated 1/5/2026, revealed the resident with behaviors/psychosocial needs. Interventions include, but are not limited to: allow the resident to make decisions about treatment, establish personal care with activities of daily living routines, and encourage as much	S 415		

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S 415	Continued From page 29 independence during care as possible. During a surveyor interview with Nursing Assistant, Staff A, on 5/6/2026 at approximately 11:00 AM, she revealed the resident needed explicit instructions for activities of daily living, if not, for example, s/he would put her/his toothbrush through her/his hair or put her/his deodorant in her/his mouth. During a surveyor interview with the RCD, in the presence of the ED, on 5/6/2026 at approximately 3:00 PM, she could not provide evidence the service plan documented and updated the resident's above-mentioned behaviors of wandering into other resident's rooms, hallucinating, and increased confusion.	S 415		