

RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ALR01308	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/27/2023
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 003	Initial Comments An unannounced biennial State Licensure survey and a complaint/incident investigation survey (OPHY11, 07/27/2023) were conducted at this residence. Deficiencies were identified relative to the State Licensure survey.	S 003	The filing of this Plan of Correction does not constitute that the deficiency alleged did in fact exist, rather this POC is filed as evidence of the facility's continuing commitment to high quality resident care in full compliance with state regulations.	
S 055	Licensure Requirements 2.4.3 Quality Assurance 2.4.3 Quality Assurance 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. 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. 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. 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 onsite visit. 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	S 055		



Facilities Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Jennifer Mello</i>	TITLE Administrator	(X6) DATE 08/14/2023
---	-----------------------------------	------------------------------------

RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ALR01308	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/27/2023
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 055	<p>Continued From page 1 public upon request.</p> <p>5. Each assisted living residence shall establish a written quality improvement plan that includes:</p> <ul style="list-style-type: none"> a. Program objectives; b. Oversight responsibility (e.g., reports to the governing body, QI records); c. Includes methods to identify, evaluate, and correct identified problems; d. Provides criteria to monitor personal assistance and resident services, including, but not limited to: <ul style="list-style-type: none"> (1) Resident/family satisfaction; (2) Medication administration/errors; (3) Reportable incidents as specified in § 2.4.17 of this Part; (4) Resident falls; (5) Plans of correction developed in response to the Department ' s inspection reports. <p>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:</p> <ul style="list-style-type: none"> a. Prevention and treatment of decubitus 	S 055		

RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ALR01308	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/27/2023
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 055	<p>Continued From page 2</p> <p>ulcers;</p> <p>b. Dehydration, and nutritional status and weight loss or gain; and</p> <p>c. Changes in mental or psychological status.</p> <p>1. Quality improvement documentation shall be kept on file for a minimum of five (5) years.</p> <p>This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined that the residence failed to establish a quality improvement committee which shall include at least the administrator, registered nurse, and a representative of dietary services.</p> <p>Findings are as follows:</p> <p>Record review of the quality assurance meeting minutes revealed there was not a representative of dietary services in attendance or serving on the committee as required on the following dates: 4/19/2023, 1/26/2023, and on 7/21/2022.</p> <p>During a surveyor interview on 7/27/2023 at approximately 9:55 AM with the Administrator, she acknowledged that the quality assurance meetings on the above-mentioned dates did not have the required participant as indicated in the regulations.</p>	S 055	Every effort is made to schedule meetings for full committee attendance. If a committee member cannot attend a scheduled meeting, they must send a designee in their place. If that is not possible the meeting will be rescheduled.	08/14/23
S 390	Residency Requirements 2.4.16.G.3 Resident Assessment/Service Plan 2.4.16 (G)(3) Service Plans	S 390		

Handwritten: 08/21/23

RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ALR01308	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/27/2023
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 390	<p>Continued From page 3</p> <p>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.</p> <p>This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined that the residence failed to review the service plan at intervals not to exceed twelve (12) months, each time a resident's condition changes significantly, and accurately reflects the services provided by the residence for 3 of 7 sample residents received, Resident ID #'s' 1, 2, and 7.</p> <p>Findings are as follows:</p> <p>1. Record review revealed Resident ID #1 moved into the residence in January of 2018. S/he has diagnosis including cirrhosis of the liver.</p> <p>Record review revealed a service plan dated 1/18/2018. Further record review failed to reveal evidence that the service plan was reviewed at an interval not to exceed 12 months, as required.</p> <p>2. Record review revealed Resident ID #2 moved into the residence in September of 2014. S/he has diagnosis including diabetes.</p> <p>Record review revealed the resident is receiving outside service for wound care with a start of care date of 3/3/2023.</p> <p>Record review revealed a service plan dated 9/23/2014. Further record review failed to reveal evidence that the service plan was updated to reflect the outside service the resident is</p>	S 390		

RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ALR01308	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/27/2023
NAME OF PROVIDER OR SUPPLIER FOREST FARM ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 191 FOREST AVENUE MIDDLETOWN, RI 02842		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 390	Continued From page 4 receiving and failed to reveal the service plan was reviewed at an interval not to exceed 12 months, as required. 3. Record review revealed Resident ID #7 moved into the residence in February of 2021. S/he has diagnosis including adult failure to thrive. Record review revealed a service plan dated 1/31/2021. Further record review failed to reveal evidence that the service plan was reviewed at an interval not to exceed 12 months, as required. During a surveyor interview on 7/27/2023 at approximately 11:37 AM with the Administrator, she could not provide evidence as to why the residents' service plans were not reviewed as required.	S 390 <i>OW</i> <i>8/21/23</i>	Resident Service Plans will be completed upon admission, quarterly, upon change in condition and annually through our EMR. The Administrator and DNS will pull a report monthly from the EMR to ensure completion of assessments and service plans for accuracy. The report will be reviewed at the quarterly QAPI meeting. Audits will be conducted monthly x3, quarterly x2, or until compliance has been met. The Administrator or designee will report results at the quarterly QAPI meetings x4. No resident was affected by the deficient practice cited.	08/14/23
S 450	Licensure Requirements 2.4.18 Rights of Residents 2.4.18 Rights of Residents A. Every assisted living residence for adults licensed pursuant to these regulations shall observe the standards stated in R.I. Gen. Laws § 23-17.4-16, "Rights of Residents" and such other appropriate standards as may be prescribed in rules and regulations promulgated by the Department with respect to each resident of the residence. B. For purposes of the following standards stated in §§ 2.4.18(B)(1) through (7) of this Part the term "resident" shall also mean the resident's agent as designated in writing or legal guardian.	S 450		

RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ALR01308	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/27/2023
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 450	<p>Continued From page 5</p> <ol style="list-style-type: none"> 1. Upon request have access to all records pertaining to the resident, including clinical records, within the next business day or immediately in emergency situations; 2. Upon admission and during the resident's stay be fully informed in a language the resident understands, of all resident rights and rules governing resident conduct and responsibilities; <ol style="list-style-type: none"> a. Each resident shall receive a copy of their rights. b. Each resident shall acknowledge receipt in writing; and c. Each resident shall be informed promptly of any changes. 3. Be informed in writing, prior to, or at the time of admission or at the signing of a residential contract or agreement of: <ol style="list-style-type: none"> a. The scope of the services available through the residence's service program, including health services, and of all related fees and charges, including charges not covered either under federal and/or state programs by other third party payers or by the residence's basic rate; b. The residence's policies regarding overdue payment including notice provisions and a schedule for late fee charges; c. The residence's policy regarding acceptance of state and federal government reimbursement for care in the residence both at time of admission and during the course of residency if the resident depletes his or her own private 	S 450		

RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ALR01308	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/27/2023
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 450	<p>Continued From page 6</p> <p>resources;</p> <p>d. The residence's criteria for occupancy and termination of residency agreements;</p> <p>e. The residence's capacity to serve residents with physical and cognitive impairments;</p> <p>f. Support any health services that the residence includes in its service package or will make appropriate arrangements to provide these services;</p> <p>4. Upon provision of at least thirty (30) days notice, if a resident chooses to leave a residence, the resident shall be refunded any advanced payment made provided that the resident is current in all payments;</p> <p>5. The residence can discharge a resident only for the following reasons and within the following guidelines:</p> <p>a. Except in life-threatening emergencies and for nonpayment of fees and costs, the residence gives thirty (30) days' advance written notice of termination of residency agreement with a statement containing the reason, the effective date of termination, the resident's right to an appeal under state law, and the name/address of the State Ombudsperson's office;</p> <p>b. If resident does not meet the requirements for residency criteria stated in the residency agreement or requirements of state or local laws or regulations;</p> <p>c. If resident is a danger to self or the welfare of others; and the residence has attempted to make</p>	S 450		

RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ALR01308	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/27/2023
NAME OF PROVIDER OR SUPPLIER FOREST FARM ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 191 FOREST AVENUE MIDDLETOWN, RI 02842		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 450	Continued From page 7 a reasonable accommodation without success to address resident behavior in ways that would make termination of residency agreement or change unnecessary; which would be documented in the resident's records; d. For failure to pay all fees and costs stated in the contract, resulting in bills more than thirty (30) days outstanding. A resident who has been given notice to vacate for nonpayment of rent has the right to retain possession of the premises, up to any time prior to eviction from the premises, by tendering to the provider the entire amount of fees for services, rent, interest, and costs then due. The provider may impose reasonable late fees for overdue payment; provided that the resident has received due notice of such charges in accordance with the residence's policies. Chronic and repeated failure to pay rent is a violation of the lease covenant. However the residence must make reasonable efforts to accommodate temporary financial hardship and provide information on government or private subsidies available that may be available to help with costs; and e. The residence makes a good faith effort to counsel the resident if the resident shows indications of no longer meeting residence criteria or if service with a termination notice is anticipated; 6. To be able to share a room or unit with a spouse or other consenting resident of the residence in accordance with terms of the resident contract; 7. To live in a safe and clean environment.	S 450		

RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ALR01308	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/27/2023
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 450	<p>Continued From page 8</p> <p>C. In addition to the standards stated in R.I. Gen. Laws § 23-17.4-16, residents are entitled to the following:</p> <ol style="list-style-type: none"> 1. Receive dental services from a dentist of his/her choice; 2. Each resident shall be given, in writing, the names, addresses, and telephone numbers of: the Department; the Medicaid Fraud and Patient Abuse Unit of the Department of Attorney General; the State Ombudsperson; and local police offices. <p>D. The residence must:</p> <ol style="list-style-type: none"> 1. Implement written policies and procedures to ensure that all residence employees are aware of and protect the resident's rights contained in these regulations; 2. Have prominently displayed a posting of the most recent state licensing survey of the assisted living residence; and 3. Provide each resident or his or 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." <p>This Requirement is not met as evidenced by: Based on surveyor observation and staff interview, it has been determined the residence failed to implement written policies and procedures to ensure that all the residence's employees protect the resident's rights contained in these regulations and to observe the standards</p>	S 450		

RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ALR01308	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/27/2023
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 450	<p>Continued From page 9</p> <p>stated in R.I. Gen. Laws § 23-17.4-16 (a)(2)(ix) relative to identifying information for the three residents listed in the facility's survey results document located in the main hallway, Resident ID #s 8, 9, and 10.</p> <p>Findings are as follows:</p> <p>During a surveyor observation on 7/26/2023 at approximately 10:20 AM of the residence's main entrance area, revealed a copy of the most recent state licensing survey of the assisted living residence.</p> <p>Located on this document revealed a "Resident/Staff Roster" form dated 8/23/2021 with three residents identified.</p> <p>During a surveyor interview on 7/26/2023 at approximately 2:20 PM with the Administrator, she could not provide evidence as to why the resident identifiers were posted in a location that the resident's privacy was not protected.</p>	S 450	Residents listed in the posted facility most recent survey results were immediately removed upon notification. When posting survey results in the future, any resident and/or employee identifying information will be omitted from the prominently displayed copy posted.	07/27/23
S 490	<p>Residential Care Services 2.4.21.C Dietetic Services</p> <p>2.4.21 (C) Dietetic Services</p> <p>C. The food service in each residence shall comply with the appropriate requirements of R.I. Gen. Laws Chapters 21-27 and 21-31, Rhode Island Food Code (Part 50-10-1 of this Title), and such other applicable statutory or regulatory provisions.</p> <p>This Requirement is not met as evidenced by:</p>	S 490		

DM
8/21/23

RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ALR01308	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/27/2023
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 490	<p>Continued From page 10</p> <p>Based on surveyor observation, record review, and staff interview, it has been determined that the residence failed to comply with the appropriate requirements of the Rhode Island Food Code.</p> <p>Findings are as follows:</p> <p>1. According to section 4-601.11 of the Rhode Island Food Code requires that "... (C) Non-FOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris."</p> <p>During a surveyor observation of the main kitchen on 7/26/2023 at approximately 9:10 AM and on 7/27/2023 at approximately 10:10 AM in the presence of a cook, Staff A, revealed the following:</p> <ul style="list-style-type: none"> - the hood compartments above the stove was observed with an accumulation of a black substance - a toaster oven with an accumulation of black/brown sticky substance on the surface and dry crusted particles on the rack. <p>During a surveyor interview on 7/27/2023 at approximately 10:12 AM with Staff A, he acknowledged the above observations.</p> <p>2. Record review of the Rhode Island Food Code 2018 Edition 2-402.11 Hair Restraints states in part, "...Food Employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed Food; clean</p>	S 490		

RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ALR01308	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/27/2023
NAME OF PROVIDER OR SUPPLIER FOREST FARM ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 191 FOREST AVENUE MIDDLETOWN, RI 02842		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 705	<p>Continued From page 12</p> <p>outlined and posted in conspicuous locations throughout the residence.</p> <p>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).</p> <p>3. The drills shall be permitted to be announced in advance to the residents. The drills shall involve the actual evacuation of all residents to an assembly point as specified in the emergency plan and shall provide residents with experience in egressing through all exits and means of escape required by the Fire Safety Code-General Provisions (R.I. Gen. Laws Chapter 23-28.1). Exits and means of escape not used in any fire drill shall not be credited in meeting the requirements of the Fire Safety Code-General Provisions (R.I. Gen. Laws Chapter 23-28.1).</p> <p>a. Documentation of fire drills shall be maintained and shall include no less than the following information:</p> <p>(1) Name of the person conducting the drill;</p> <p>(2) Date and time of the drill;</p> <p>(3) Amount of time taken to evacuate the building or unit;</p> <p>(4) Type of drill (i.e., obstructed or</p>	S 705		

RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ALR01308	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/27/2023
NAME OF PROVIDER OR SUPPLIER FOREST FARM ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 191 FOREST AVENUE MIDDLETOWN, RI 02842		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 705	Continued From page 13 unobstructed); (5) Record of problems encountered and steps taken to rectify them; (6) Employee observation of each resident's ability to carry out evacuation procedures. 4. Residents shall be instructed in all alternative methods of escape since the primary exit may be unusable due to fire and/or smoke. Such instruction shall be documented in the record described in § 2.4.30(l)(3)(a) of this Part. 5. Each new resident shall be oriented to the fire drill procedure on admission, with documentation of the orientation placed in the resident's record. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined the residence failed to ensure drills simulating fire emergencies, testing the effectiveness of the fire evacuation plan were 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, and 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). Findings are as follows: Record review revealed fire drills were conducted on 5/24/2023, 3/1/2023, 1/24/2023, 1/19/2023, 11/26/2022, 9/23/2022, 8/11/2022, 6/14/2022, 2/28/2022, and 1/29/2022.	S 705	Although fire drills were conducted as required, 6x/year, 2 during the night with 50% obstructed, upon notification the form was changed to include check-off boxes for obstructed/unobstructed drill. The Administrator or designee will ensure that every other drill conducted is obstructed in order to ensure compliance. In addition, a line was added to the form to include the length of time it took to evacuate the building to the designated areas. The Administrator or designee will report compliance at the quarterly QAPI meeting x4.	07/27/23

(Handwritten)
CMB
8/2/23

RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ALR01308	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/27/2023
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 705	<p>Continued From page 14</p> <p>Further record review revealed obstructed drills were conducted on 3/1/2023 and 6/14/2022 which is 20% of the drills instead of 50%, as required.</p> <p>Additional record review of the fire drill documentation dated 1/19/2023, 9/23/2022, and 6/14/2022 failed to include the amount of time taken to evacuate the building or unit, as required.</p> <p>During a surveyor interview on 7/27/2023 at approximately 9:15 AM with the Administrator, she could not provide evidence as to why the fire drills were not conducted appropriately.</p>	S 705		