RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01487	A. BUILDING: _____ B. WING _____	06/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VILLA MEMORY CARE	59 PLEASANT STREET WEST WARWICK, RI 02893

(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 (S4G111, 06/13/2023) were conducted at this residence. Deficiencies were identified relative to the State Licensure survey.	S 003		
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	S 055 We have added additional members to our Quality Assurance Committee-Quality Improvement (see attached committee member list) which now includes the Administrator, the Nurse, and a member of Dietary Services as well as other staff members. The Quality Assurance Committee will be meeting quarterly. Scheduled meeting months are as follows: 7/23, 9/23, 12/23, 2/24 The Quality Improvement & Personal Care & Resident Services sheets (see attached) will be completed at every meeting.	7/31/23

Facilities Regulation

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

adm — 7/6/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01487	A. BUILDING: _____ B. WING _____	06/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VILLA MEMORY CARE	59 PLEASANT STREET WEST WARWICK, RI 02893

(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	Continued From page 1 public upon request. 5. Each assisted living residence shall establish a written quality improvement plan that includes: 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: (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. 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: a. Prevention and treatment of decubitus	S 055		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01487	A. BUILDING: _____ B. WING _____	06/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VILLA MEMORY CARE	59 PLEASANT STREET WEST WARWICK, RI 02893

(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	Continued From page 2 ulcers; b. Dehydration, and nutritional status and weight loss or gain; and c. Changes in mental or psychological status. 1. Quality improvement documentation shall be kept on file for a minimum of five (5) years. 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. Findings are as follows: Record review of the quality assurance meeting minutes revealed there was not a registered nurse in attendance or serving on the committee as required on the following dates: 1/31/2022, 4/14/2022, 8/8/2022, and 10/17/2022. Further 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: 1/31/2022, 4/14/2022, 8/8/2022, 10/17/2022 and 5/4/2023. During a surveyor interview on 6/13/2023 at approximately 9:45 AM with the Administrator, he could not provide evidence as to why the quality assurance committee did not have the required participants as indicated in the regulations.	S 055		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01487	A. BUILDING: _____ B. WING _____	06/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VILLA MEMORY CARE	59 PLEASANT STREET WEST WARWICK, RI 02893

(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 075	Continued From page 3	S 075		
S 075	Licensure Requirements 2.4.5.A Safe Resident Handling 2.4.5 (A) Safe Resident Handling A. Each licensed assisted living residence with an "Alzheimer ' s Dementia Special Care Unit or Program" license and/or offers to provide or provides coordination of hospice services for residents who are bed-bound or in need of assistance from more than one staff person for ambulation shall comply with the provisions of §§ 2.4.5(B) through (E) of this Part as a condition of licensure. 1. Notwithstanding the requirements of § 2.4.5(A) of this Part, assisted living residences licensed for an "Alzheimer ' s Dementia Special Care Unit or Program" prior to 1 June 2015 shall be in compliance with the requirements of §§ 2.4.5(B) through (E) of this Part not later than 1 July 2015. 2. A currently licensed assisted living residence who applies for a new level of licensure on or after 1 June 2015 will be required to meet the requirements of §§ 2.4.5(B) through (E) of this Part prior to a new license level being approved. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined the residence failed to ensure that the safe resident handling program was compliant with regulations.	S 075	S 075 A Safe Handling Policy was created and will be evaluated annually. The Safe Handling Committee members have been updated to now include 50% of hourly non-managerial employees who provide direct resident care (see attached). The Safe Handling Committee will meet quarterly. The next meeting will be in August 2023 and again in November 2023, February 2024, May 2024, and thereafter. A Quarterly Meeting sheet will be completed during each meeting. Concord Health was contacted on 6/29/23 regarding providing Safe Handling training workshops (as well as other training sessions) annually at Spring Villa. 3 training sessions will be held this year: -Fall Prevention in the Elderly -Lifting Safety -Safe Resident Handling (see attached list) [redacted] from Concord Health, is contacting the trainer who will be providing the training for us. [redacted] will be getting back to Spring Villa shortly with the dates that are available. Sessions will then be set up immediately.	6/29/23

RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01487	A. BUILDING: _____ B. WING _____	06/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VILLA MEMORY CARE	59 PLEASANT STREET WEST WARWICK, RI 02893

(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 075	Continued From page 4 Findings are as follows; The residence failed to develop and maintain a safe resident handling program including; 1. Maintaining a safe resident handling committee which is chaired by a professional nurse or other appropriate licensed healthcare professional. An assisted living may utilize any appropirately configured committee to perform the responsibilities of this section. At least half of the members of the committee shall be hourly, non-managerial employees who provide direct resident care. 2. A written safe resident handling program to include the following: - a safe resident handling policy for all shifts and units of the residence that will achieve the maximum reasonable reduction of manual lifting, transferring, and repositioning residents. - a resident handling hazard assessment. - a process to identify the appropriate use of the safe resident handling policy. - a trained registered nurse or other appropriate licensed health care professional to act as the expert resource and train all direct care staff on safe resident handling policies, equipment, and devices before implementation, and at intervals not to exceed 12 months, or as needed. - a performance evaluation of the safe resident handling policy at intervals not to exceed 12 months with the results of the evaluation reported to the safe resident handling committee or other designated committee.	S 075		

RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01487	A. BUILDING: _____ B. WING _____	06/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VILLA MEMORY CARE	59 PLEASANT STREET WEST WARWICK, RI 02893

(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 075	Continued From page 5 During a surveyor interview with the Director of Wellness on 6/12/2023 at approximately 1:00 PM, she acknowledged that the residence did not have a safe resident handling program.	S 075		
S 200	Organization And Management 2.4.12.I.2 Administrative Management 2.4.12 (I) (2) Personnel Records 2. Said personnel records shall be reviewed and updated at intervals not to exceed twelve (12) months and shall include, but not be limited to, all of the following components: a. Completed job application and/or resume; b. Written statements of references or documentation of verbal reference check; c. Written functional job descriptions; (1) These descriptions shall be updated at intervals not to exceed twelve (12) months and shall include, but not be limited to, minimal qualifications for the position, major duties and responsibilities, and shall be signed and dated by the individual employee. d. Evidence of credentials, current professional licensure and/or certification; e. Documentation of education and/or continuing training, including continuing education units (CEUs) related to administrator certification, food management, etc., medication administration, and dementia care;	S 200	S 200 All employee records are being reviewed for compliance. All personnel records will also be reviewed annually to maintain compliance. We have updated our National BCI policy to reflect that a BCI screening is mandatory within 1 week of employment or employment will be suspended until the BCI has been completed. (see attached) Notification regarding a mandatory National BCI requirement has been added to the Spring Villa employee application. (See attached) A Pre-Screening form has been created to use as a quick reference check for all new applicants. Pre-screening checks are done utilizing the RI Criminal Database and the RI License Verification web page. (see attached) A verbal "Employee Reference Check" will comply for all new employee applicants and will be documented in the employee file.	8/31/23

RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01487	A. BUILDING: _____ B. WING _____	06/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VILLA MEMORY CARE	59 PLEASANT STREET WEST WARWICK, RI 02893

(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 200	Continued From page 6 f. Documentation of attendance at in-service training and/or orientation; g. Documentation of at least one (1) performance evaluation at intervals not to exceed twelve (12) months; h. Signed copy of employee's awareness of resident's rights; i. Results of the criminal record (BCI) check. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined that the residence failed to ensure that personnel records contain written statements of references or documentation of verbal reference checks for 2 of 6 sample staff reviewed, Staff A and Staff B and 6 of 6 sample staff reviewed for criminal record (BCI) checks. Findings are as follows: Per 2.4.12.J.1 all employees of assisted living residences licensed under the Act, hired after September 30,2014, and having routine contact with a resident or having routine contact with a resident or having access to a resident's belongings or funds shall undergo a national criminal background records check which shall include fingerprints submitted to the Federal Bureau of Investigation (FBI) by the Bureau of Crinimal Identification (BCI) of the Department of Attorney General. The national criminal records check shall be processed, prior to, or within one (1) week of employment.	S 200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01487	A. BUILDING: _____ B. WING _____	06/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VILLA MEMORY CARE	59 PLEASANT STREET WEST WARWICK, RI 02893

(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 200	Continued From page 7 1. Record review of personnel records for Staff A and Staff B failed to reveal that reference checks were completed as required. During a surveyor interview with the Administrator on 6/13/2023 at 9:45 AM, he could not provide evidence that reference checks were completed for the above-mentioned staff. 2. Record review of personnel records failed to provide evidence that a BCI check was processed prior to or within one week of employment for the following employees: - Director of Wellness, revealed a hire date of 8/29/2022 and a Background Criminal Investigation (BCI) date of 10/17/2022. - Dietary server, Staff B, revealed a hire date of 6/27/2022 and a BCI date of 7/25/2022. - Nursing Assistant, Staff C, revealed a hire date of 7/1/2022 and a BCI date of 8/12/2022. - Nursing Assistant, Staff D, revealed a hire date of 3/6/2022 and a BCI date of 3/28/2023. - Certified Medication Technician, Staff E, revealed a hire date of 6/17/2020 and a BCI date of 7/2/2020. - Certified Medication Technician, Staff F, revealed a hire date of 3/9/2015 and a BCI date of 4/2/2015. During a surveyor interview with the Administrator on 6/13/2023 at 9:45 AM, he acknowledged that the above staff members did not have a BCI check prior to or within one week of hire.	S 200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01487	A. BUILDING: _____ B. WING _____	06/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VILLA MEMORY CARE	59 PLEASANT STREET WEST WARWICK, RI 02893

(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 270	Continued From page 8	S 270		
S 270	Organization And Management 2.4.13.J Management Of Services 2.4.13 (J) Smoking Policy 1. If the residence permits smoking, it shall have a policy that includes the following: a. Location of designated smoking area(s) separate from the common area; b. Prohibition of smoking in any area other than the designated area(s); c. Adequate ventilation in smoking areas; d. Assessment (upon admission, quarterly, and when a significant change in function occurs) of all residents that smoke to ensure safe smoking capabilities. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined that the residence failed to follow their policy relative to smoking and failed to complete a smoking assessment upon admission and quarterly for 2 of 2 sample residents reviewed for smoking, Resident ID #s 2 and 7. Findings are as follows: Record review of the residence's smoking policy dated 2/6/2021 states in part, "...Upon admission, quarterly, and when a significant change occurs in a Resident's function, a smoking assessement will be conducted to ensure safe smoking capabilities..."	S 270	S 270 Spring Villa's RN will include a Smoking Assessment for all Residents upon admission, quarterly and/or when a significant change has occurred. Resident #2 is no longer a smoker and [redacted] file has been updated. Assessment completed on 6/12/23. An update Smoking Assessment was done for Resident #7 on 6/12/23 and will continue quarterly and/or when a significant change occurs.	7/6/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01487	A. BUILDING: _____ B. WING _____	06/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VILLA MEMORY CARE	59 PLEASANT STREET WEST WARWICK, RI 02893

(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 270	Continued From page 9 1. Record review revealed Resident ID #2 moved into the residence in March of 2023. S/he has diagnoses including neurocognitive disorder and anxiety. Record review of the residence census provided to the surveyor revealed the resident is a smoker. Further record review failed to reveal evidence of a smoking assessment being completed for the resident since s/he moved into the residence. 2. Record review revealed Resident ID #7 moved into the residence in July of 2021. S/he has diagnoses including dementia with behavior disturbance and bipolar disorder. Record review of the residence census provided to the surveyor revealed the resident is a smoker. Further record review failed to reveal evidence of a smoking assessment being completed upon admission and quarterly as required. Additional record review revealed the resident has had one smoking assessment since his/her admission which was dated on 8/31/2022. During a surveyor interview on 6/12/2023 at 1:05 PM and at 2:25 PM with the Director of Wellness, she acknowledged both residents are smokers. She could not provide evidence as to why the smoking assessments were not completed for the residents.	S 270		
S 310	Residency Requirements 2.4.15.A Resident Records 2.4.15 (A) Resident Records	S 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01487	A. BUILDING: _____ B. WING _____	06/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VILLA MEMORY CARE	59 PLEASANT STREET WEST WARWICK, RI 02893

(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 310	Continued From page 10 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 310	S 310 The nurse has created a binder for Nurse Placement. The information in the binder contains physician orders & measurement of wound care. Resident ID#3's wound resolved and was discharged from Nursing Placement on 6/27/23	7/6/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01487	A. BUILDING: _____ B. WING _____	06/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VILLA MEMORY CARE	59 PLEASANT STREET WEST WARWICK, RI 02893

(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 310	Continued From page 11 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, including therapeutic orders for 1 of 3 sample residents reviewed that are receiving outside services, Resident ID #3. Findings are as follows: Record review revealed the resident moved into the residence in January of 2023. S/he has diagnoses including schizophrenia and a stage 2 pressure ulcer (open wound) to the left heel.	S 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01487	A. BUILDING: _____ B. WING _____	06/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VILLA MEMORY CARE	59 PLEASANT STREET WEST WARWICK, RI 02893

(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 310	Continued From page 12 Record review revealed the resident is receiving outside service for skilled nursing care related to a pressure ulcer with a start of care date of 5/2/2023. Record review of the resident's record failed to reveal evidence of a physician's order for wound care. Additional record review failed to reveal evidence of communication between the outside service and the residence including, details of care being provided to the resident until it was brought to the residence attention by the surveyor on 6/12/2023. During a surveyor interview on 6/12/2023 at approximately 12:35 PM with the Director of Wellness, she acknowledged the resident's record failed to document a current physician's order for wound care and failed to document communication with the outside service including details of the care being provided.	S 310		9/30/23
S 375	Residency Requirements 2.4.16.F Resident Assessment/Service Plans 2.4.16 (F) Nurse Review 1. Nurse review is necessary for all levels of licensure. a. A registered nurse shall visit the residence at least once every thirty (30) days except as provided in § 2.4.16(F)(1)(b) of this Part and shall complete a review to include the following: (1) Monitor the medication regimen for all residents;	S 375	S 375 With the excessive amount of duties that our wonderful Nurse/Wellness Director is responsible for on a daily basis, we realize that [redacted] is in need of an assistant RN to help [redacted]. We are going to hire another RN for an additional 16+ hours per week to assist the Wellness Director. The RN who will be helping the Wellness Director will assist [redacted] with catching up on all 90-day nursing reviews among other tasks. assigned by the Wellness Director.	

7/23/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01487	A. BUILDING: _____ B. WING _____	06/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VILLA MEMORY CARE	59 PLEASANT STREET WEST WARWICK, RI 02893

(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 375	Continued From page 13 (2) Review any new physician orders and evaluate the health status of all residents by identifying symptoms of illness and/or changes in mental/physical health status; (3) Evaluate the appropriateness of placement for each resident; (4) Make any necessary recommendations to the administrator; (5) Follow up on previous recommendations; (6) Provide a signed, written report in the residence documenting: (AA) Date and time of assessment; (BB) Recommendations for follow-up; (CC) Progress on previous recommendations; (DD) Verification that the medication listed by the pharmacist on the mediset, blister pack or medication container is current with physician orders (M-1 level only); (EE) Physical assessment identifying symptoms of illness and/or changes in mental or physical health status and appropriateness of placement; (FF) Such reports shall be on file at the residence.	S 375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01487	A. BUILDING: _____ B. WING _____	06/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VILLA MEMORY CARE	59 PLEASANT STREET WEST WARWICK, RI 02893

(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 375	Continued From page 14 (7) Complete the quarterly evaluation of the residence's registered medication aide(s) administration of medication. (Approved Department form is available for downloading online). b. In those residences that have one or more licensed registered nurses (i.e., at least one full-time equivalent equal to thirty-five (35) hours) on- site, the nurse review shall be completed at least once every ninety (90) days. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined the residence failed to complete nurse reviews every ninety-day (90) days as required for 2 of 6 residents reviewed, Resident ID #s 3 and 7. Findings are as follows: 1. Record review revealed Resident ID #3 moved into the residence in January of 2023. S/he has diagnoses including schizophrenia and a stage 2 pressure ulcer to the left heel. Record review failed to reveal evidence of a 90-day nurse review being completed as required since the resident moved into the residence in January of 2023. 2. Record review revealed Resident ID #7 moved into the residence in July of 2021. S/he has diagnoses including, dementia with behavior disturbance and bipolar disorder. Record review revealed the resident had a 90-day nurse review on 1/30/2023. Further record review failed to reveal evidence of a 90-day nurse review	S 375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01487	A. BUILDING: _____ B. WING _____	06/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VILLA MEMORY CARE	59 PLEASANT STREET WEST WARWICK, RI 02893

(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 375	Continued From page 15 being completed as required since the last review dated 1/30/2023. During a surveyor interview on 6/12/2023 at 12:40 PM with the Director of Wellness, she could not provide evidence as to why the residents did not have the 90-day nurse review completed as required.	S 375		
S 380	Residency Requirements 2.4.16.G.1 Resident Assessment/Service Plan 2.4.16 (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 providing the service; and d. The resident's requested and/or therapeutically needed recreational and social activities.	S 380	S 380 With the excessive amount of duties that our wonderful Nurse/Wellness Director is responsible for on a daily basis, we realize that [redacted] is in need of an assistant RN to help her. We are going to hire another RN for an additional 16+ hours per week to assist the Wellness Director. The RN who will be helping the Wellness Director will assist [redacted] with nursing documentation which will include new admissions. Both the Wellness Director and the assistant RN will confirm all duties on the checklist for new admissions are conducted within 7 days of admission and when resident is discharged from the facility. Resident charts will be reviewed for compliance by the Wellness Director and the assistant RN.	12/15/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01487	A. BUILDING: _____ B. WING _____	06/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VILLA MEMORY CARE	59 PLEASANT STREET WEST WARWICK, RI 02893

(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 380	Continued From page 16 This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined that the residence failed to develop a written service plan within a reasonable time after move-in, not to exceed seven (7) days, for a singular resident reviewed for new admission, Resident ID #5. Findings are as follows: Record review revealed the resident moved into the residence in December of 2022 with diagnosis including neurocognitive disorder with behavioral disturbance. Record review failed to reveal evidence that a written service plan was developed for the resident as required. During a surveyor interview on 6/13/2023 at 10:10 AM with the Director of Wellness, she could not provide evidence as to why a written service plan was not developed for the resident as required.	S 380		
S 390	Residency Requirements 2.4.16.G.3 Resident Assessment/Service Plan 2.4.16 (G)(3) Service Plans 3. The service plan shall be reviewed by both parties at intervals not to exceed twelve (12) months and each time a resident's condition changes significantly and all changes shall be acknowledged in writing by both parties. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined the residence failed to review	S 390	S 390 The service plan for Resident #1 was updated by the Wellness Director during the survey on 6/12/23 to include that the resident was receiving outside physical therapy. The service plan for Resident #3 was updated by the Wellness Director during the survey on 6/12/23 to include that the resident is was receiving outside skilled nursing services related to a pressure ulcer to the left heel.	7/6/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01487	A. BUILDING: _____ B. WING _____	06/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VILLA MEMORY CARE	59 PLEASANT STREET WEST WARWICK, RI 02893

(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 17 the service plan each time a resident's condition changes significantly, and failed to accurately reflect that the resident is receiving outside services for 2 of 6 sample residents reviewed, Resident ID #s 1 and 3. Findings are as follows: 1. Record review revealed Resident ID #1 moved into the residence in April of 2023. S/he has a diagnosis of vascular dementia. Record review revealed the resident is receiving outside service for physical therapy with a start of care date of 6/2/2023. Record review of the resident's service plan dated 4/26/2023 failed to reveal evidence that the service plan was updated to reflect that the resident is receiving the above-mentioned outside service. 2. Record review revealed Resident ID #3 moved into the residence in January of 2023. S/he has diagnoses including, schizophrenia and a stage 2 pressure ulcer to the left heel. Record review revealed the resident is receiving outside service for skilled nursing care related to a pressure ulcer with a start of care date of 5/2/2023. Record review of the resident's service plan dated 1/24/2023 failed to reveal evidence that the service plan was updated to reflect that the resident is receiving the above-mentioned outside service. During a surveyor interview on 6/12/2023 at 12:20 PM with the Director of Wellness, she	S 390	S 390 continued.. Service plans will be reviewed annually and when significant changes occur. The Wellness Director has created a binder for Nurse Placement. The information in the binder contains physician orders & measurement of wound care.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01487	A. BUILDING: _____ B. WING _____	06/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VILLA MEMORY CARE	59 PLEASANT STREET WEST WARWICK, RI 02893

(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 18 acknowledged the residents are receiving outside services. Additionally, she acknowledged the service plans were not updated to reflect the outside services provided to the residents.	S 390		
S 490	Residential Care Services 2.4.21.C Dietetic Services 2.4.21 (C) Dietetic Services C. The food service in each residence shall comply with the appropriate requirements of R.I. Gen. Laws Chapters 21-27 and 21-31, Rhode Island Food Code (Part 50-10-1 of this Title), and such other applicable statutory or regulatory provisions. This Requirement is not met as evidenced by: Based on surveyor observation, record review, and staff interview, it has been determined that the residence failed to comply with the appropriate requirements of the Rhode Island Food Code. Findings are as follows: 1. According to the Rhode Island Food Code 2018 Edition 4-501.116 Warewashing Equipment, Determining Chemical Sanitizer Concentration states in part,"Concentration of the SANITIZING solution shall be accurately determined by using a test kit or other device". During a surveyor tour of the kitchen with the Food Service Director (FSD) on 6/12/2023 at 8:40 AM, the dish washer was observed in use. Immediately following the observation, the	S 490	S 490 1. Administrator contacted the dishwasher contractor to request test kits to accurately determine the concentration of the sanitizing solution. A dishwasher testing checklist will be created for kitchen staff to adhere to before the 1st service in the morning. Kitchen staff will be trained on the use of the test kit and instruction will be posted next to the dishwasher.	8/31/23

RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01487	A. BUILDING: _____ B. WING _____	06/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VILLA MEMORY CARE	59 PLEASANT STREET WEST WARWICK, RI 02893

(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	Continued From page 19 surveyor asked the FSD to test the dish machine with a test strip to ensure the concentration of the sanitizing solution was accurately sanitizing the dishes. During a surveyor interview with the FSD immediately following the above observation, the FSD revealed that he was unaware of what method of sanitization the dish machine utilizes. He further acknowledged that the residence has no system in place to ensure the dishes get properly sanitized. 2. According to the Rhode Island Food Code 2018 Edition 4-301.12 Manual Warewashing, Sink Compartment Requirements states in part," ...a sink with at least 3 compartments shall be provided for manually washing, rinsing, and SANITIZING EQUIPMENT and UTENSILS". During a surveyor observation of the three bay sink on 6/12/2023 at approximately 8:50 AM, water was observed at the bottom of the three bay sink. Further observation of the three bay sink failed to reveal that a chemical sanitizing solution was attached to the sink which is necessary to sanitize the dishes. During a surveyor observation and interview with the FSD and the Administrator on 6/12/2023 at 11:20 AM, both staff acknowledged that the three bay sink was not attached to a chemical sanitizing solution which is necessary to sanitize the dishes. 3. 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	S 490	S 490 continued 2. The sanitizing unit had recently not been working properly and wasn't hooked up during the survey. The dishwasher contractor had been contacted and is scheduled a service visit on 7/5/23. [redacted] will be checking the 3 bay compartments for compliance and making all necessary updates so that all equipment is working properly. 3. Hair nets were purchased the same day as the survey was conducted and hair nets or hats are now mandatory for staff when in the kitchen and/or serving food. A notification of hair covering compliance was hung in the kitchen. (see attached). A Food Safety-Hair Restraints policy was also created. (see attached)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01487	A. BUILDING: _____ B. WING _____	06/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VILLA MEMORY CARE	59 PLEASANT STREET WEST WARWICK, RI 02893

(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	Continued From page 20 keep their hair from contacting exposed Food; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES ..." During a follow up visit to the main kitchen on 6/12/2023 at 9:50 AM, Nursing Assistant (NA), Staff F, was observed preparing a salad while Server Staff G was observed slicing apple pie, both staff members were observed not wearing a hair restraint while preparing ready to eat food. During a surveyor interview with Staff G following the above observation at 9:55 AM, she revealed that she works in the kitchen daily preparing desserts and has never worn a hair restraint. During a surveyor interview with the FSD on 6/12/2023 at 8:40 AM, he acknowledged that there were no hair nets in the building.	S 490		
S 510	Residential Care Services 2.4.21.G(1-4) Dietetic Services 2.4.21 (G) (1-4) Dietetic Services G. All food services shall be conducted in accordance with the rules and regulations pertaining to Certification of Managers in Food Safety (Part 50-10-2 of this Title) that include but are not limited to the following provisions: 1. Each residence where potentially hazardous foods are prepared shall employ at least one (1) full-time, on-site manager certified in food safety who is at least eighteen (18) years of age. 2. Residences that primarily serve the elderly	S 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01487	A. BUILDING: _____ B. WING _____	06/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VILLA MEMORY CARE	59 PLEASANT STREET WEST WARWICK, RI 02893

(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 510	Continued From page 21 and individuals with diminished immune systems shall have a manager certified in food safety present during preparation of all hot potentially hazardous foods. 3. Residences that have a licensed capacity of twenty-six (26) or more residents and that employ ten (10) or more full-time equivalent employees directly involved in food preparation shall employ at least two (2) full time, on-site managers certified in food safety. 4. Residences that have a licensed capacity of twenty-five (25) or fewer residents and that employ five (5) or fewer full-time equivalent employees involved in preparation and serving of food, shall only be required to employ one (1) full time manager certified in food safety. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined that the residence failed to ensure that all food services be conducted in accordance with the rules and regulations pertaining to certification of managers in food safety. Findings are as follows: Record review of the list of current employees provided by the residence revealed a cook, Staff H was hired on 1/22/2022 and remained a current employee. Record review of the dietary schedule for the week of 6/4/2023 through 6/10/2023 and 6/11/2023 through 6/17/2023 revealed Staff H worked on 6/10/2023 and 6/11/2023 alone.	S 510	S 510 Staff H had taken the Food Safety Training course prior to the survey and was awaiting [redacted] test results from the instructor. [redacted] received [redacted] passing grade and certificate on 6/12/23 (see attached). Spring Villa Memory Care now has three (3) full time, on-site managers certified in food safety.	7/6/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01487	A. BUILDING: _____ B. WING _____	06/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VILLA MEMORY CARE	59 PLEASANT STREET WEST WARWICK, RI 02893

(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 510	Continued From page 22 Additional record review of the dietary schedule revealed there was no employee certified in food safety while hot food was being prepared on these dates. During a surveyor interview on 6/12/2023 at approximately 8:45 AM with the FSD, he acknowledged that Staff H works on the weekends and does not have an active food safety manager certification.	S 510		
S 705	Physical Plant 2.4.30.I Safety Requirements 2.4.30 (I) Safety Requirements I. Each residence shall develop and maintain a written plan and procedure for the evacuation of the premises in case of fire or other emergency, based on F1 / F2 licensure requirements, Fire Safety Code-General Provisions (R.I. Gen. Laws Chapter 23-28.1) requirements. 1. Emergency steps of action shall be clearly outlined and posted in conspicuous locations throughout the residence. 2. Drills simulating fire emergencies, testing the effectiveness of the fire evacuation plan shall be conducted at least six (6) times per year on a bimonthly basis with a minimum of two (2) drills conducted during the night when residents are sleeping with documentation of observed ability of residents to carry out evacuation procedures. At least fifty percent (50%) of these drills shall be obstructed drills, as defined in Fire Safety Code-General Provisions (R.I. Gen. Laws Chapter 23-28.1). 3. The drills shall be permitted to be	S 705	S 705 A fire drill compliance sheet was created to include all of the information that needs to be documented. (see attached) Drills will be held bi-monthly and 50% of the drills will be obstructed and 2 of the drills will be conducted in the evening. A monthly maintenance duties sheet will also be created and required by the maintenance manager to complete. Part of this list will include checking off if a fire drill was completed and the date of drill. All individual fire drill sheets and the monthly maintenance duties sheet will be reviewed by the Administrator.	8/31/23

RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01487	A. BUILDING: _____ B. WING _____	06/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VILLA MEMORY CARE	59 PLEASANT STREET WEST WARWICK, RI 02893

(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 23	S 705		

announced in advance to the residents. The drills shall involve the actual evacuation of all residents to an assembly point as specified in the emergency plan and shall provide residents with experience in egressing through all exits and means of escape required by the Fire Safety Code-General Provisions (R.I. Gen. Laws Chapter 23-28.1). Exits and means of escape not used in any fire drill shall not be credited in meeting the requirements of the Fire Safety Code-General Provisions (R.I. Gen. Laws Chapter 23-28.1).

a. Documentation of fire drills shall be maintained and shall include no less than the following information:

(1) Name of the person conducting the drill;
(2) Date and time of the drill;
(3) Amount of time taken to evacuate the building or unit;
(4) Type of drill (i.e., obstructed or unobstructed);
(5) Record of problems encountered and steps taken to rectify them;
(6) Employee observation of each resident's ability to carry out evacuation procedures.

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(I)(3)(a) of this Part.

5. Each new resident shall be oriented to the fire drill procedure on admission, with documentation of the orientation placed in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01487	A. BUILDING: _____ B. WING _____	06/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VILLA MEMORY CARE	59 PLEASANT STREET WEST WARWICK, RI 02893

(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 24 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 5/31/2023, 3/22/2023, 1/5/2023, 12/14/2022, 10/19/2022, 8/19/2022, and 6/22/2022. Further record review revealed obstructed drills were conducted on 5/31/2023 and 6/22/2022 which is 20% of the drills instead of 50% as required and 1 drill was conduct during the night on 12/14/2022 instead of 2 drills as required. Additional record review of the fire drill documentation from the above-mentioned dates failed to include the amount of time taken to evacuate the building or unit as required. During a surveyor interview on 6/13/2023 at approximately 9:45 AM with the Administrator, he could not provide evidence as to why the fire drills were not conducted appropriately as required.	S 705		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01487	A. BUILDING: _____ B. WING _____	06/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VILLA MEMORY CARE	59 PLEASANT STREET WEST WARWICK, RI 02893

(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 830	Continued From page 25	S 830		
S 830	Special Care License Requirements 2.5.2.J Specific Requirements 2.5.2 (J) Specific Requirements J. Menus for the Alzheimer Dementia Special Care Unit/Program shall be developed under the direction of a nutritionist or registered dietician licensed by the Department. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined the residence failed to have menus for the Alzheimer Dementia Special Care Unit/Program developed under the direction of a nutritionist or registered dietitian licensed by the department. Findings are as follows: Record review of the residence menu failed to reveal evidence that a registered dietitian developed and reviewed the menu as required. During a surveyor interview with the Administrator on 6/12/2023 at 12:35 PM, he acknowledged that the residence menu was not developed, signed, or reviewed by a registered dietitian since 2020. Additionally, he acknowledged the residence has not had a dietitian on staff since 2020.	S 830	S 830 J.) We have contacted a registered dietitian. [redacted] will first be meeting with the Assistant Administrator on July 7 to go over terms of the contract. Another meeting will take place shortly after with the Kitchen Manager, the Wellness Director/RN, and the Assistant Administrator. They will be creating a plan to meet frequently via in person and/or virtually to develop and review the dining menus together. After the menu is submitted to the dietitian & approved, a copy will be given to the Administrator for review. The dietitian also offers in-service education to facility staff and counsels the resident, staff, and/or family with regard to the resident's needs.	8/31/23
S 835	Special Care License Requirements 2.5.2.K Specific Requirements 2.5.2 (K) Specific Requirements K. All menus including alternate choices shall be	S 835		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01487	A. BUILDING: _____ B. WING _____	06/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VILLA MEMORY CARE	59 PLEASANT STREET WEST WARWICK, RI 02893

(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 835	Continued From page 26 planned at least one (1) week in advance, to meet the standards for nutritional care in accordance with Dietary Reference Intakes: The Essential Guide to Nutrient Requirements, incorporated above at § 2.2(A) of this Part, and to provide for a variety of foods, adjusted for seasonal changes, and reflecting the dietary preferences of residents. 1. Menus shall indicate nourishments available to residents between evening meal and bedtime. 2. Menus shall be posted in a conspicuous place in the dietary department and in resident areas. 3. Records of menus actually served shall be retained for thirty (30) days. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined that the residence failed to indicate nourishments on their menu that are available to residents between the evening meal and bedtime. Findings are as follows: Record review of the residence menu failed to indicate nourishments are available to the residents between the evening meal and bedtime as required. During a surveyor interview with the Administrator on 6/12/2023 at approximately 9:55 AM, he acknowledged that the menus did not indicate nourishments being offered to the residents	S 835	S835 The Spring Villa Admission Agreement states the following regarding nourishments in-between the evening meal and bedtime: "A snack is served after the last meal of the day. Vending machines with snacks and beverages are always available to Residents and are located in the dining room. Meals are served at 7:15am & 8:15am, 11:15am & 12:15pm, and 4:15pm & 5:15pm." Unfortunately, we were not aware that it should also be posted with the monthly menu. We have since created a notice regarding these nourishments and placed it along side the monthly dining menu on all of the information boards throughout the facility. (see attached) The kitchen manager	7/6/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01487	A. BUILDING: _____ B. WING _____	06/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VILLA MEMORY CARE	59 PLEASANT STREET WEST WARWICK, RI 02893

(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 835	Continued From page 27 between the evening meal and bedtime.	S 835	will confirm that this notice will be posted with the dining menu every month.	