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RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01509	A. BUILDING: _____ B. WING _____	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STILLWATER ASSISTED LIVING AND SKILLED	20 AUSTIN AVENUE GREENVILLE, RI 02828

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S 003	Initial Comments An unannounced biennial State Licensure survey and a complaint/incident investigation survey (RL1H11, 08/27/2025) were conducted at this residence. Deficiencies were identified relative to the State Licensure survey.	S 003	The filing of this Plan of Correction (POC) does not constitute that the deficiencies 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 and federal regulations. Completion date for optimal compliance with the POC will be October 2, 2025	
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	**As a Plan of Correction (POC) for Tag S055:** a)There were no specified residents identified in this tag. b) We recognize that although there were no residents affected by the issue related to Quality Assurance, there is potential risk to all residents (including those on the Dementia Special Care Unit), who may be affected by the Quality Assurance Plan not including the required components. We have since corrected the issue. c)The Quality Assurance Plan has been revised to ensure all of the required elements/ components are listed within the Plan (for all units). The Quality Assurance Committee will meet no less than quarterly to review our overall status related to the elements within the Plan. The Committee will be sure to include evidence of this review in the quarterly d)The Executive Director/designee is responsible for implementing this plan. The Quality Assurance Committee will review the annual plan for assurances of thoroughness and effectiveness. The Committee will review the Plan no less than annually and revise the Plan as indicated.	

Received
SEP 17 2025
Facilities Regulation

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

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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		

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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 written quality improvement plan that included all required components. Findings are as follows: Record review of the quality assurance program written plan failed to reveal evidence that the residence included the required components related to the Dementia Special Care Unit: a. Prevention and treatment of decubitus ulcers. b. Dehydration, and nutritional status and weight loss or gain. c. Changes in mental or psychological status. The plan further failed to include resident and family satisfaction and reportable incidents, as required. During a surveyor interview on 8/27/25 at 11:45 AM with the Executive Director and the Director of Wellness, they could not provide evidence that	S 055		

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S 055	Continued From page 3 the quality improvement plan had all of the required components.	S 055		
S 085	Licensure Requirement 2.4.5.C Safe Resident Handling 2.4.5 (C) Safe Resident Handling C. Shall have a written safe resident handling program, with input from the safe handling committee, to prevent musculoskeletal disorders among health care workers and injuries to residents. As part of this program, each licensed assisted living shall: 1. Implement 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 of all or most of a resident's weight, except in emergency, life-threatening, or otherwise exceptional circumstances; 2. Conduct a resident handling hazard assessment. This assessment should consider such variables as handling-handling tasks, types of units, resident populations, and the physical environment of resident care areas; 3. Develop a process to identify the appropriate use of the safe resident handling policy based on the resident ' s physical and mental condition, the resident's choice, and the availability of lifting equipment or lift teams. The policy shall include a means to address circumstances under which it would be medically contraindicated to use lifting or transfer aids or assistive devices for particular residents;	S 085	**As a POC for Tag S085 :** a) The Safe Resident Handling assessments have been completed for Residents ID#3, 4 and 5. b) We have since reviewed all residents safe resident handling assessments to ensure they have been reviewed/revised quarterly per our facility policy. C) Our safe resident handling committee meets on a quarterly basis to review residents' status related to safe resident handling and any concerns related to transfer status/safety noted from one quarter to the next. At these meetings, we will review the residents' safe a resident handling status and assessments to ensure they are current and accurate. The Wellness Director/designee will confirm there is evidence of the quarterly assessment completed per resident. d)The Wellness Director/designee is responsible for implementing this plan. We will conduct audits of safe resident handling assessments on a routine basis and the results will be shared with the Quality Assurance Committee each quarter for a period of no less than 3 quarters; at which time we will determine the need/frequency to continue formal audits based on our level of improvement in this area.	

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S 085	Continued From page 4 4. Designate and train a registered nurse or other appropriate licensed health care professional to serve as an expert resource, and train all direct care staff on safe resident handling policies, equipment, and devices before implementation, and at intervals not to exceed twelve (12) months, or as changes are made to the safe handling policies, equipment and/or devices being used; and 5. Conduct a performance evaluation of the safe resident handling policy at intervals not to exceed twelve (12) months, with the results of the evaluation reported to the safe resident handling committee or other appropriately designated committee. The evaluation shall determine the extent to which implementation of the program has resulted in a reduction in musculoskeletal disorder claims and days of lost work attributable to musculo-skeletal disorder caused by resident handling, and include recommendations to increase the program's effectiveness. This Requirement is not met as evidenced by: Based on record review and staff interview, the residence failed to conduct a safe resident handling evaluation at intervals not to exceed 12 months for 3 of 3 residents that reside on an Alzheimer's-Dementia Special Care Unit, Resident ID #s 3, 4, and 5. Findings are as follows: Record review of a residence policy titled "Safe Resident Handling", that was revised in February of 2017, states in part, "...residents will be assessed quarterly for changes in transfer requirements..."	S 085		

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S 085	Continued From page 5 1. Resident ID #3 was readmitted to the residence in January of 2021 with a diagnosis that includes, but is not limited to, dementia. Record review failed to reveal that safe resident handling assessments were performed per the residence's policy of quarterly or that they were completed with each comprehensive assessment as required by regulation. 2. Resident ID #4 was admitted to the residence in May of 2024 with a diagnosis that includes, but is not limited to, dementia. Record review failed to reveal that a safe resident handling assessment was performed quarterly per the residence's policy or completed with each comprehensive assessment as required by regulation. 3. Resident ID #5 was admitted to the residence in June of 2022 with a diagnosis that includes, but is not limited to, dementia. Record review failed to reveal that safe resident handling assessments were performed per the residence's policy of quarterly or that they were completed with each comprehensive assesment as required by regulation. During a surveyor interview on 8/26/2025 at approximately 3:00 PM with the Director of Wellness, she was unable to provide evidence that safe handing performance evaluations were done quarterly per the residence's policy or with each comprehensive assesment, as required.	S 085		
S 310	Residency Requirements 2.4.15.A Resident Records	S 310		

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S 310	Continued From page 6 2.4.15 (A) Resident Records A. Each residence shall, at a minimum, maintain the following information for each resident: 1. The resident's name; 2. The resident's last address; 3. The name of the person or agency referring the resident to the home; 4. The name, specialty (if any), telephone number, and emergency telephone number of each physician who is currently treating the resident; 5. The date the resident began residing in the home; 6. A list of medications taken by the resident, including dosage, and specific records of medication administration as required by the Department; a. In residences licensed at the M2 level, if a resident refuses to provide the information cited in § 2.4.15(A)(6) of this Part, this fact shall be documented in the resident's service agreement. 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	S 310	**As a POC for Tag S310:** a) We now have the required wound measurements and descriptions in the medical record for Resident ID#2. There was no negative outcome to Resident ID#2. b) We recognize that any and all residents who may receive services from an outside (wound) agency may be at risk for a similar occurrence. We have not identified any further concerns in this regard. c) We have identified that there can be a bit of a delay at times in getting the reports/ measurements & descriptions from the wound agency service; this does not mean that the services were not provided timely and/or properly. We have had recent conversation with the agency and our nurses to ensure these results and the necessary information related to wound care is evident in the medical record timely. We are not anticipating any further issues and will monitor the situation routinely. d) The Wellness Director/designee is responsible for implementing this plan. We will conduct audits of those residents receiving wound services from an outside agency to ensure the measurements and descriptions (when indicated) are in the medical record timely. The audits will be conducted on a routine basis and the results shared with the Quality Committee quarterly for a period of 3 quarters at which time we will determine the need/frequency to continue formal audits based on our level of improvement in this area.	

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S 310	Continued From page 7 therapeutic orders; 9. A record of personal property and funds which the resident has entrusted to the residence; 10. The name, address, and telephone number of a person identified by the resident who should be contacted in the event of an emergency or death of the resident and the name, address, and telephone number of the legal guardian; 11. Any other health-related emergency, or pertinent information which the resident requests the residence to keep on record; 12. A copy of the initial and periodic assessments described in § 2.4.16 of this Part; 13. A copy of the service plan and nurse review as described in § 2.4.16 of this Part; 14. A copy of the residency agreement as described in § 2.4.14(C) of this Part. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined the residence failed to include, at a minimum, information about any specific health problems of the resident, which may be useful in a medical emergency, including diagnostic and/or therapeutic orders, for one of one resident reviewed for receiving outside nursing services for wound care, Resident ID #2. Findings are as follows: Record review revealed Resident ID #2 moved	S 310		

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S 310	Continued From page 8 into the residence in May of 2025 with a diagnosis that includes, but is not limited to, spinal stenosis. Record review revealed the resident received skilled nursing services from an outside agency for wound care on 8/20/2025, 8/22/2025, and 8/24/2025. Record review of the provider notes by the skilled nursing service agency on the above-mentioned dates failed to reveal evidence that wound measurements were documented in order to assess if the wound was improving. During a surveyor interview on 8/26/2025 at 10:00 AM with the Director of Wellness, she acknowledged the skilled nursing provider notes for the above-mentioned dates did not have the measurements documented of the wound.	S 310		
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 update the service plan and implement interventions for residents receiving outside services for 2 of 2 residents receiving outside services and the singular resident reviewed receiving dialysis	S 390	As a POC for S390: a) We have since updated the service plans for Residents ID#1,2, and 6 to include the changes that were indicated on the 2567 per resident. b) We have since reviewed all other residents' service plans to ensure that any changes in condition and/or new services (i.e. PT) have been noted in the service plans timely. c) The nurses have been educated regarding the need to update the resident service plan as changes in status/services are identified so that the service plan is current and resident specific. The Wellness Director reviews the resident assessments every 90 days to confirm accuracy and thoroughness however, the Wellness Director/designee will now confirm these updates have been added to the resident service plan timely.	

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S 390	Continued From page 9 services, Resident ID #s 1, 2, and 6. Findings are as follows: 1. Resident ID #1 was admitted to the residence in October of 2024 with a diagnosis that includes, but is not limited to, back pain. Record review of a physician's orders revealed a physical therapy consult on 8/13/2025 and treatment was initiated. Record review of a service plan that was completed on 4/28/2025 failed to reveal the service plan was updated to reflect the new service of physical therapy that was initiated on 8/13/2025. 2. Resident ID #2 was admitted to the residence in May of 2025 with a diagnosis that includes, but is not limited to, spinal stenosis. Record review of a physician's orders dated 8/16/2025 revealed a wound consult was ordered. Record review of a service plan that was completed on 5/5/25 failed to reveal the service plan was updated to reflect the new service of skilled nursing for wound care that was initiated on 8/16/2025. 3. Resident ID #3 was admitted to the residence in April of 2021 with a diagnosis that includes, but is not limited, to end stage kidney disease. Record review of a service plan dated 3/3/2023 failed to reveal evidence that the resident went to an outpatient dialysis center two times a week on an ongoing basis.	S 390	d) The Wellness Director/designee is responsible for implementing this plan. Audits of service plans will be conducted on a routine basis to confirm any changes in condition or services ordered have been noted on the service plan timely. The results will be shared with the Quality Assurance Committee quarterly for a period of no less than 3 quarters; at which time we will determine the need/frequency to continue formal audits based on our level of improvement in this area	

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S 390	Continued From page 9 services, Resident ID #s 1, 2, and 6. Findings are as follows: 1. Resident ID #1 was admitted to the residence in October of 2024 with a diagnosis that includes, but is not limited to, back pain. Record review of a physician's orders revealed a physical therapy consult on 8/13/2025 and treatment was initiated. Record review of a service plan that was completed on 4/28/2025 failed to reveal the service plan was updated to reflect the new service of physical therapy that was initiated on 8/13/2025. 2. Resident ID #2 was admitted to the residence in May of 2025 with a diagnosis that includes, but is not limited to, spinal stenosis. Record review of a physician's orders dated 8/16/2025 revealed a wound consult was ordered. Record review of a service plan that was completed on 5/5/25 failed to reveal the service plan was updated to reflect the new service of skilled nursing for wound care that was initiated on 8/16/2025. 3. Resident ID #3 was admitted to the residence in April of 2021 with a diagnosis that includes, but is not limited, to end stage kidney disease. Record review of a service plan dated 3/3/2023 failed to reveal evidence that the resident went to an outpatient dialysis center two times a week on an ongoing basis.	S 390		

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S 390	Continued From page 10 During a surveyor interview on 8/26/2025 at approximately 2:30 PM with the Director of Wellness, she was unable to provide evidence of skilled nursing services, physical therapy services, and dialysis were being addressed on the service plans.	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 the residence failed to comply with the appropriate requirements of the Rhode Island Food Code related to the main kitchen and the satellite kitchenettes. Findings are as follows: 1. Record review of the 2022 Food Code published by the U.S Food and Drug Administration Section 4-501.110, states in part," ...temperature of the wash solution in spray type dishwashers that use hot water to sanitize may not be less than for a stationary rack, single temperature machine, 74 degrees C (Celsius) 165 degrees F (Fahrenheit)..."	S 490	**As a POC for Tag S490:** a) Although no residents were specifically identified in this tag, we recognize the risk to our residents if dietetic service standards are not being met/followed consistently. All of the areas and items identified have been corrected. The dish machine was serviced on 8/27/25; there were no negative findings or concerns with the temperature readings. Paper products were used for the next meal until assurances of proper cleaning and sanitizing of plates and other utensils could be confirmed. Also-regarding the turkey sandwiches holding temperature of 59 degrees Farenheit; those sandwiches were not served and were replaced with grilled cheese sandwiches for that meal. b) Although no specific residents were identified in this tag, we recognize the potential risk to our residents related to any issues with dietetic services and sanitation. We have since taken another look at the main kitchen and unit kitchenettes to ensure compliance in all areas related to dietetic service requirements.	

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(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 11 During a surveyor observation of the main kitchen on 8/25/2025 at approximately 10:45 AM, the dish machine did not register at a surface temperature of 160 degrees F (Fahrenheit) or higher. Immediately following the above observation, the Assistant Food Service Director acknowledged the dishmachine was not reaching the acceptable temperature range for sanitation. 2. Record review of the 2022 Food Code published by the U.S Food and Drug Administration Section 3-303.11 states in part, "...Ice that has been in contact with unsanitized surfaces may contain pathogens and other contaminants..." During a surveyor observation of the Memory Lane Unit kitchenette on 8/25/2025 at 11:40 AM, the refrigerator's freezer had three ice cube trays stored, uncovered. During a surveyor observation of the Camelot Unit kitchenette on 8/25/2025 at 12:10 PM, the refrigerator's freezer had one ice cube tray stored, uncovered. During a surveyor interview with the Executive Director on 8/27/2025 at 11:30 AM, he acknowledged the ice cube trays were not to be stored uncovered in the unit kitchenettes. 3. Record review of the 2022 Food Code published by the U.S Food and Drug Administration Section 2-402.11 reads in part, "...food employees shall wear hair restraints such as...hair coverings...beard restraints..." During a surveyor observation on 8/25/2025 at 10:20 AM, dietary staff, Staff A, was observed	S 490	C) We have provided education to the Food Service Director (FSD), Assistant Food Service Director and the kitchen staff regarding the regulatory requirements under this tag. The dish machine in the main kitchen has been serviced and is running properly with proper temperatures being met. Staff are aware of the required temperatures for sanitation. The ice cube trays mentioned on Memory Lane and Camelot kitchenettes have been discarded and will not be used; staff have been made aware of this. Dietary staff have also been (re) educated regarding the need to wear a beard guard when applicable and hairnets to cover hair fully. They have also received re-education regarding hand hygiene and the proper way to transport clean items such as dishes and glasses (so as not to potentially contaminate them). Dietary staff have also been (re) educated regarding the proper cold holding temperatures and will ensure the sandwiches are maintained at the proper cold holding temperature; the bread and other food products used for any sandwiches will be refrigerated just prior to leaving the kitchen. Food temperatures will be checked to ensure proper holding temperatures have been met. The temperatures for the dish machine will also be checked and recorded daily. Dietary staff will also be observed routinely to ensure beard guards and hair nets are in place and effectively covering hair. The dietary team will be responsible for ongoing compliance with food sanitation and safety.	

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	ALR01509	A. BUILDING: _____ B. WING _____	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STILLWATER ASSISTED LIVING AND SKILLED	20 AUSTIN AVENUE GREENVILLE, RI 02828

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S 490	Continued From page 12 working in the main kitchen without a beard net. During a surveyor observation on 8/27/2025 at 12:05 PM, dietary staff, Staff B, was observed serving the lunch meal with her hair not fully covered by a hair restraint, her bangs were hanging out of the hair restraint. Immediately following the above observation, dietary staff, Staff C, was observed washing pots and pans without a beard restraint. During a surveyor interview on 8/27/2025 at 11:45 AM with the Executive Director, he was unable to provide evidence that the dietary staff were wearing the appropriate hair restraints. 4. Record review of the 2022 Food Code published by the U.S Food and Drug Administration Section, 2-301.14 states in part, "...when to wash...food employees shall clean their hands...after handling soiled equipment or utensils..." During a surveyor observation on 8/25/2025 at 10:20 AM, dietary staff, Staff D, failed to wash his hands after handling soiled dishes and proceeded to touch clean dishes and glasses and held them against his body during transport to the storage area. During a surveyor interview on 8/27/2025 at 11:45 AM with the Executive Director, he was unable to provide evidence that the dietary staff were washing their hands prior to touching clean dishware. 5. Record review of the 2022 Food Code published by the U.S Food and Drug Administration 3-509.19 states in part, "...food	S 490	d) The FSD/designee is responsible for implementing this plan. The FSM/designee will complete routine audits of all of these items. The results will be shared with the Quality Assurance Committee quarterly. We will review our progress with the Quality Committee for no less than 3 quarters at which time we will determine the need/frequency to continue formal audits based on our level of improvement in this area.	

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	ALR01509	A. BUILDING: _____ B. WING _____	08/27/2025

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STILLWATER ASSISTED LIVING AND SKILLED	20 AUSTIN AVENUE GREENVILLE, RI 02828

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S 490	Continued From page 13 shall have an initial temperature of 5 degrees C (41 degrees F) or less when removed from cold holding temperature control..." During a surveyor observation on the Camelot Unit on 8/25/2025 at 12:20 PM, in the presence of the Assistant Director of Food Service, the turkey sandwich that was served for lunch had a cold holding temperature of 59 degrees F. Immediately following the observation, the Assistant Director of Food Service acknowledged the temperature of the turkey sandwich was not within the acceptable parameters.	S 490		
S 665	Physical Plant 2.4.30.B Safety Requirements 2.4.30 (B) Safety Requirements B. All locks on bedrooms shall be operable by a master key, under the control of the person in charge in accordance with §§ 2.4.12(B) and (C) of this Part. This Requirement is not met as evidenced by: Based on surveyor observation and staff interview, the residence failed to have locks on bedroom doors that are operable by a master key. Findings are as follows: During a surveyor observation on 8/25/2025 at approximately 11:00 AM the following was revealed:	S 665	**As a POC for Tag S665:** a) The locks have been removed and replaced (with a lock that is operable with a master key) for those bedrooms identified in the 2567; room 105, 106, 121, 303, 307, and 308. b) Our Maintenance team is replacing all of the locks for all rooms identified to have the issue of locking on the inside without an operable master key to open the door from the outside. c)The Director of Maintenance and team are assessing all resident bedroom door locks in the facility for assurances they are safe and capable of being opened from the outside. The door locks had not been replaced in quite some time but are now being replaced to ensure optimal safety for our residents. Our staff are being educated regarding any new door locks for the knowledge and awareness that the doors can be unlocked form the outside.	

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	ALR01509	A. BUILDING: _____ B. WING _____	08/27/2025

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S 490	Continued From page 13 shall have an initial temperature of 5 degrees C (41 degrees F) or less when removed from cold holding temperature control..." During a surveyor observation on the Camelot Unit on 8/25/2025 at 12:20 PM, in the presence of the Assistant Director of Food Service, the turkey sandwich that was served for lunch had a cold holding temperature of 69 degrees F. Immediately following the observation, the Assistant Director of Food Service acknowledged the temperature of the turkey sandwich was not within the acceptable parameters.	S 490		
S 665	Physical Plant 2.4.30.B Safety Requirements 2.4.30 (B) Safety Requirements B. All locks on bedrooms shall be operable by a master key, under the control of the person in charge in accordance with §§ 2.4.12(B) and (C) of this Part. This Requirement is not met as evidenced by: Based on surveyor observation and staff interview, the residence failed to have locks on bedroom doors that are operable by a master key. Findings are as follows: During a surveyor observation on 8/25/2025 at approximately 11:00 AM the following was revealed:	S 665		

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	ALR01609	A. BUILDING: _____ B. WING _____	08/27/2025

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S 665	Continued From page 14 -Room 105 is a shared 2-bedroom apartment and each bedroom door has a lock that locks on the inside without an operable master key that opens the outside lock. -Room 106 the bedroom door lock that locks on the inside and without an operable master key that opens the outside lock. -Room 121 is a shared 2-bedroom apartment, and each bedroom door has a lock that locks on the inside and without an operable master key that opens the outside locks. -Room 303 is a shared bedroom and each bedroom door has a lock that locks on the inside and without an operable master key that opens the outside lock. -Room 307 is a shared 2-bedroom apartment, and each bedroom door has a lock that locks on the inside and without an operable master key that opens the outside lock. -Room 308 is a shared 2-bedroom apartment and each bedroom has a door lock that locks on the inside and without an operable master key that opens the outside lock. During a surveyor interview on 8/25 /2025 at approximately 1:00 PM with the Executive Director and the Director of Maintenance, they acknowledged the locks were not the appropriate locks for the bedroom doors.	S 665	d) The Executive Director is responsible for implementing this plan with the assistance of the Maintenance Director to complete the project. Safety rounds to include checking the door locks of the residents' bedrooms, will be completed routinely by the Maintenance team/ designee and the results shared with the Quality Committee quarterly. We will review our progress with the Quality Committee for no less than 3 quarters; at which time, we will determine the need/frequency to continue formal audits based on our level of improvement in this area.	
S 675	Physical Plant 2.4.30.D Safety Requirements 2.4.30 (D) Safety Requirements	S 675	As a POC for Tag S675: next page	

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S 675	Continued From page 15 D. Every bathroom door shall be designed to permit the opening of the locked door from outside in an emergency. This Requirement is not met as evidenced by: Based on observation and staff interview, the residence failed to have bathroom doors that are designed to permit the opening of the locked door from outside in an emergency. Findings are as follows: During a surveyor observation on 8/25/2025 at 11:00 AM the following rooms revealed they did not have a master key lock to open from the outside in an emergency: -Room 105 -Room 213 -Room 302 -Room 307 -Room 308 During a surveyor interview on 8/25/2025 at 11:30 AM with the Executive Director and the Director of Maintenance, they acknowledged the bathroom doors were not able to be opened from the outside in the event of an emergency.	S 675	As a POC for Tag S675: a) The bathroom door locks for rooms 105, 213, 302, 307,and 308 have since been replaced with a door lock that can be unlocked from the outside. b) Our Maintenance team is replacing all of the door locks for all bathrooms identified to have the issue of locking on the inside without a means to unlock it from the outside. c) The Director of Maintenance and team are assessing all resident bathroom door locks in the facility for assurances they are safe and capable of being opened from the outside. The door locks had not been replaced in quite some time but are now being replaced to ensure optimal safety for our residents. Our staff are being educated regarding any new door locks for the knowledge and awareness that the doors can be unlocked form the outside. d) The Executive Director is responsible for implementing this plan with the assistance of the Maintenance Director to complete the project. Safety rounds to include checking the door locks of the residents' bathrooms, will be completed routinely by the Maintenance team/ designee and the results shared with the Quality Committee quarterly. We will review our progress with the Quality Committee for no less than 3 quarters; at which time, we will determine the need/frequency to continue formal audits based on our level of improvement in this area.	