RI Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | ALR01493 | A. BUILDING: _____ B. WING _____ | 07/21/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| COMMONWEALTH HOUSE | 655 COMMONWEALTH AVENUE WARWICK, RI 02886 |

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| S 003 | Initial Comments<br><br>A biennial licensure survey was conducted at this residence on 07/20/2026 through 07/21/2026 to determine compliance with state laws and regulations. Deficiencies were identified. | S 003 | **S 003**<br><br>This plan of correction constitutes a written allegation of the non-compliance for deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists, or that it was cited correctly. This plan of correction is submitted to meet requirements established by state and federal laws. | |
| S 390 | Residency Requirements 2.4.17.D Resident Assessment/Service Plans<br><br>2.4.17 (D) Resident Assessments and Service Plans<br><br>D. The assessment shall be reviewed and at intervals not to exceed twelve (12) months and each time a resident's condition changes significantly.<br><br>This Requirement is not met as evidenced by:<br>Based on record review and staff interview, it has been determined the residence failed to update the comprehensive assessment each time a resident's condition changed significantly relative to outside services for 2 of 3 residents reviewed, Resident ID #s 1 and 2.<br><br>Findings are as follows:<br><br>Review of the Assisted Living Residence (ALR) Entrance Conference form revealed Resident ID #s 1 and 2 are receiving outside services for physical therapy (PT) and occupational therapy (OT).<br><br>1. Record review revealed Resident ID #1 moved into the residence in June of 2025 with a diagnosis including, but not limited to, dementia. | S 390 | **S 390**<br><br>Residency Requirements 2.4.17.D Resident Assessment/Service Plans<br><br>The survey found that comprehensive assessments were not updated when outside physical therapy or occupational therapy services started or ended for Resident IDs 1 and 2.<br><br>1. **Corrective action for residents affected**<br>The DON reviewed Resident IDs 1 and 2 and updated each comprehensive assessment to accurately reflect the start-of-care and end-of-care dates for all current and recently discontinued outside PT and OT services. The DON verified the information against provider orders, progress notes, and available outside-service documentation and placed the corrected assessments in the residents' records.<br><br>2. **Identification and correction for other residents potentially affected**<br>The DON completed a 100% audit of all current residents to identify anyone | 8/11/2026 Ongoing |

Received
AUG 11 2026
Facilities Regulation

8/14/26

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



Amanda Willoughby - Administrator

Amanda Willoughby 8/11/2026

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| S 390 | Continued From page 1<br>Record review of the progress notes revealed the following entries:<br><br>- PT SOC (start of care) date 06/24/2026.<br><br>- OT SOC date 06/26/2026.<br><br>- OT discontinued on 07/08/2026.<br><br>Record review of the comprehensive assessment, dated 06/20/2026, under "Treatments and Therapies" states in part, "PT COURSE MET GOALS." The comprehensive assessment failed to be updated to document a SOC date for PT services on 6/24/2026. Additionally, the comprehensive assessment failed to be updated to document a SOC date and an end of care (EOC) date for OT services.<br><br>During a surveyor interview with the Director of Nursing (DON) on 07/20/2026 at approximately 10:30 AM, she could not provide evidence the comprehensive assessment was updated to document a SOC date for PT services. She further could not provide evidence the comprehensive assessment was updated to document a SOC date and an EOC date for OT services.<br><br>2. Record review revealed Resident ID #2 moved into the residence in June of 2026 with a diagnosis including, but not limited to, Alzheimer's disease.<br><br>Review of the progress note, dated 07/08/2026, revealed that OT services was discontinued.<br><br>Review of the Entrance Conference form revealed the resident started PT services on 06/10/2026 and is currently receiving services. | S 390 | Continued From page 1<br>**S 390**<br>receiving, beginning, changing, or ending outside services, including PT, OT, speech therapy, skilled nursing, hospice, and other contracted clinical services. No other discrepancies or omissions were found. Any assessment that did not accurately reflect the service, provider, start date, status, or end date was corrected promptly, with required review and acknowledgment completed.<br><br>3. **Systemic changes to prevent recurrence**<br>The residence revised its resident-assessment procedure to require a comprehensive-assessment review whenever an outside service begins, changes, or ends, or whenever a significant change in condition occurs. Nursing staff were educated to notify the DON upon receipt of an order, start-of-care notice, status change, discharge notice, or end-of-care notice. The DON or designee will reconcile outside-service documentation with the assessment and service plan within 2 business days and document completion on an Outside Services Tracking Log.<br><br>4. **Monitoring and quality assurance**<br>The DON or designee will audit all residents with active or recently discontinued outside services weekly for 4 weeks, then monthly for 3 months. The audit will verify that assessments contain accurate service details and dates and are consistent with orders, progress notes, and provider communications. Identified omissions will be corrected immediately | |

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| S 390 | Continued From page 2<br><br>Record review of the comprehensive assessment, dated 06/09/2026, under "Treatments and Therapies" states in part, "...PT/OT EVAL AND TREAT..." Further review of the comprehensive assessment failed to be updated to document an EOC date for OT services.<br><br>During a subsequent interview with the DON, she could not provide evidence the comprehensive assessment was updated to document an EOC date for OT services. | S 390 | Continued From page 2<br>**S 390**<br><br>and staff will be re-educated as needed. Results will be reported to the Administrator and reviewed through quality assurance; sustained compliance will be demonstrated by 100% accuracy during the monitoring period.<br><br>Responsible persons: Director of Nursing and Administrator<br><br>Date of full compliance: August 11, 2026 | |
| S 415 | Residency Requirements 2.4.17.G.3 Resident Assessment/Service Plan<br><br>2.4.17 (G)(3) Service Plans<br><br>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.<br><br>This Requirement is not met as evidenced by:<br>Based on record review and staff interview, it has been determined that the residence failed to update the service plan each time a resident's condition changed significantly for 2 of 3 residents reviewed for outside services, Resident ID #s 1 and 2. Additionally, the residence failed to have the party responsible for arranging and/or providing the services relative to the need of assistance for Activities of Daily Living (ADL) and medication management for 4 of 4 residents reviewed, Resident ID #s 1, 2, 3, and 4. | S 415 | **S 415**<br><br>Residency Requirements 2.4.17.G.3 Resident Assessment/Service Plan<br><br>The survey found that service plans were not updated when outside OT services ended for Resident IDs 1 and 2, and service plans for Resident IDs 1 through 4 did not identify the party responsible for arranging or providing assistance with activities of daily living and medication management.<br><br>1. **Corrective action for residents affected**<br>The DON reviewed and revised the service plans for Resident IDs 1 and 2 to reflect the current status and end-of-care dates of outside OT services. The DON also reviewed and revised the service plans for Resident IDs 1 through 4 to identify the person, discipline, agency, or residence staff responsible for arranging and/or providing each required ADL and medication-management service. All | 8/11/2026<br>Ongoing |

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| S 415 | Continued From page 3<br><br>Findings are as follows:<br><br>Review of the Assisted Living Residence (ALR) Entrance Conference form revealed Resident ID #s 1 and 2 are receiving outside services for physical therapy (PT) and occupational therapy (OT).<br><br>1. Record review revealed Resident ID #1 moved into the residence in June of 2025 with a diagnosis including, but not limited to, dementia.<br><br>Record review of the progress notes revealed the following entries:<br><br>- PT SOC (start of care) date on 06/24/2026.<br><br>- OT SOC date on 06/26/2026.<br><br>- OT discontinued on 07/08/2026.<br><br>Record review of the service plan, dated 06/20/2026, revealed under "Outside Services" that the resident is receiving PT and OT services. The service plan failed to be updated to document an End of Care (EOC) date for OT services. Additionally, the service plan failed to provide the party responsible for arranging and/or providing the services relative to ADLs and medication management.<br><br>During a surveyor interview with the Director of Nursing (DON) on 07/20/2026 at approximately 10:30 AM, she could not provide evidence the service plan was updated to document an EOC date for OT services. Additionally, she could not provide evidence the service plan provided the party responsible for arranging and/or providing the services relative to ADLs and medication | S 415 | Continued From page 3<br>**S 415**<br><br>revisions were reviewed with the resident and/or authorized representative and acknowledged in writing as required.<br><br>2. **Identification and correction for other residents potentially affected**<br>The DON completed a full audit of all resident service plans for outside-service accuracy and for clear identification of the responsible party for every assessed need, including ADLs and medication management. No additional discrepencies or omissions were found. Missing, outdated, or unclear information was corrected, and updated plans were reviewed and acknowledged by the resident and/or authorized representative.<br><br>3. **Systemic changes to prevent recurrence**<br>The service-plan process and template were revised to include required fields for the service, frequency, provider or responsible party, start date, current status, and end date when applicable. A service-plan review is now required within 2 business days of a significant change, including the start, change, or discontinuation of an outside service. Licensed nursing staff were educated on the revised process, documentation expectations, and written-acknowledgment requirements. The DON or designee will use the Outside Services Tracking Log to reconcile assessments, service plans, orders, progress notes, and provider notices. | |

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| S 415 | Continued From page 4<br>management.<br><br>2. Record review revealed Resident ID #2 moved into the residence in June of 2026 with a diagnosis including, but not limited to, Alzheimer's disease.<br><br>Review of the progress note, dated 07/08/2026, revealed that OT was discontinued.<br><br>Record review of the service plan, dated 06/08/2026, failed to be updated to document an EOC date for OT services.<br><br>During a subsequent interview with the DON, she could not provide evidence the service plan was updated to document an EOC date for OT services. Additionally, she could not provide evidence the service plan provided the party responsible for arranging and/or providing the services relative to ADLs and medication management.<br><br>3. Record review revealed Resident ID #3 moved into the residence in May of 2022 with a diagnosis including, but not limited to, dementia.<br><br>Record review of the service plan, dated 05/09/2026, failed to provide the party responsible for arranging and/or providing the services relative to ADLs and medication management.<br><br>During a subsequent interview with the DON, she could not provide evidence the service plan provided the party responsible for arranging and/or providing the services relative to ADLs and medication management.<br><br>4. Record review revealed Resident ID #4 moved | S 415 | Continued From page 4<br>**S 415**<br><br>4. **Monitoring and quality assurance**<br>The DON or designee will audit all revised service plans and a sample of at least 5 service plans, or 100% when fewer than 5 apply, weekly for 4 weeks and monthly for 3 months. Audits will verify current outside-service information, identification of responsible parties for ADLs and medication management, consistency across the record, and required written acknowledgment. Deficiencies will be corrected immediately and followed by staff re-education. Results will be reviewed by the Administrator and quality assurance committee, with a goal of 100% compliance.<br><br>Responsible persons: Director of Nursing and Administrator<br>Date of full compliance: August 11, 2026 | |

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| S 415 | Continued From page 5<br>into the residence in November of 2021 with a diagnosis including, but not limited to, Alzheimer's disease.<br><br>Record review of the service plan, dated 01/22/2026, failed to provide the party responsible for arranging and/or providing the services relative to ADLs and medication management.<br><br>During a subsequent interview with the DON, she could not provide evidence the service plan provided the party responsible for arranging and/or providing the services relative to ADLs and medication management. | S 415 | | |
| S 540 | Residential Care Services 2.4.22.C(1-5) Illness And Emergencies<br><br>2.4.22 (C) (1-5) Reporting of Communicable Diseases<br><br>C. Reporting of Communicable Diseases<br><br>1. Each residence shall report promptly to the Center for Acute Infectious Diseases Epidemiology (IDE), cases of communicable diseases designated as "reportable diseases" when such cases are diagnosed in the residence in accordance with Part 30-05-1 of this Title, Reporting and Testing of Infectious, Environmental and Occupational Diseases.<br><br>2. When infectious diseases present a potential hazard to residents or personnel, these shall be reported to the Center for Acute Infectious Diseases Epidemiology (IDE) even if not designated as "reportable diseases." | S 540 | **S 540**<br><br>Residential Care Services 2.4.22.C(1-5) Illness And Emergencies<br><br>The survey found that the residence's infection-control policies did not include protocols for transferring or discharging residents with infectious diseases to home, hospitals, or nursing facilities when continued transmission may be possible.<br><br>1. **Corrective action for residents affected**<br>No specific affected resident was identified in the survey finding. The Administrator and DON reviewed current residents for known or suspected communicable diseases and confirmed that any resident requiring transfer or discharge will have an individualized infection-control handoff and discharge plan. Any current transfer or discharge involving an infectious condition | 8/11/2026 Ongoing |

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| S 540 | Continued From page 6<br>3. When outbreaks of food-borne illness are suspected, such occurrences shall be reported immediately to the Center for Acute Infectious Diseases Epidemiology (IDE) or to the Center for Food Protection.<br><br>4. Residences must comply with the provisions of R.I. Gen. Laws § 23-28.36-3, which requires notification of fire fighters, police officers and emergency medical technicians after exposure to infectious diseases.<br><br>5. Infection Control<br><br>Infection control provisions shall be established for the mutual protection of residents, employees, and the public. The residence shall be responsible for no less than the following:<br><br>a. Establishing and maintaining a residence-specific infection prevention program;<br><br>b. Establishing policies governing the admission and isolation of residents with known or suspected infectious diseases;<br><br>c. Developing, evaluating and revising on a continuing basis infection control policies, procedures and techniques for all appropriate areas of the residence;<br><br>d. Developing and implementing protocols for:<br><br>(1) Discharge planning to home that include full instructions to the family or caregivers regarding necessary infection control measures; and | S 540 | Continued From page 6<br>**S 540**<br><br>will be reviewed before departure to ensure that the receiving provider, transport personnel, resident, family, or caregiver receives the necessary precautions and instructions.<br><br>2. **Identification and correction for other residents potentially affected**<br>The DON reviewed all current residents with active or recently resolved infectious conditions and all transfers or discharges occurring during the prior 30 days to determine whether required infection-control information and notifications were documented. No additional discrepencies or omissions were found. Any incomplete documentation was corrected when possible, and responsible staff were counseled or re-educated.<br><br>3. **Systemic changes to prevent recurrence**<br>The residence adopted a written transfer/ discharge infection-control protocol covering discharge to home and transfer to hospitals or nursing facilities. The protocol requires documentation of the infectious condition or suspected condition, transmission-based precautions, required personal protective equipment, cleaning and handling instructions, medication and treatment information, exposure information when applicable, and communication with the receiving setting, transport personnel, resident, and family/ caregiver. It also addresses required reporting to the Rhode Island Center for | |

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| S 540 | Continued From page 7<br>(2) Hospital and/or nursing facility transfer of residents with infectious diseases which may present the risk of continuing transmission. Examples of such diseases include, but are not limited to, tuberculosis (TB), Methicillin resistant staphylococcus aureus (MRSA), vancomycin resistant enterococci (VRE), and clostridium difficile;<br><br>This Requirement is not met as evidenced by:<br>Based on record review and staff interview, it has been determined the facility failed to establish infection control provisions for the mutual protection of residents, employees, and the public relative to developing and implementing protocols for transfer/discharge to home, hospitals, and/or nursing facilities, of residents with infectious diseases which may present the risk of continuing transmission such as tuberculosis (TB), Methicillin resistant staphylococcus aureus (MRSA), vancomycin resistant enterococci (VRE), and clostridium difficile (C-diff).<br><br>Findings are as follows:<br><br>Review of the residence's infection control policies failed to include protocols for transfer/discharge to home, hospitals, and/or nursing facilities of a resident with infectious diseases.<br><br>During a surveyor interview with the Administrator on 07/21/2026 at approximately 8:15 AM, she could not provide evidence of the discharge planning protocols of residents with infectious diseases to home, the hospital, and/or a nursing | S 540 | Continued From page 7<br>**S 540**<br><br>Acute Infectious Diseases Epidemiology or other authorities. A standardized Infectious Disease Transfer/Discharge Checklist was implemented, and all licensed nursing staff and administrators were educated on its use and on applicable reporting requirements.<br><br>4. **Monitoring and quality assurance**<br>The DON or designee will audit 100% of transfers and discharges involving a known or suspected infectious condition for 3 months. If no qualifying event occurs in a month, the DON will conduct a documented mock transfer/discharge drill and audit the completed checklist. Monitoring will confirm required notifications, infection-control instructions, receiving-provider communication, transport communication, and retention of documentation in the resident record. Any deficiency will be corrected immediately and trigger re-education. Results will be reported monthly to the Administrator and quality assurance committee, with a goal of 100% compliance.<br><br>Responsible persons: Director of Nursing and Administrator<br><br>Date of full compliance: August 11, 2026 | |

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