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	ALR01426	A. BUILDING: _____ B. WING	09/19/2025

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THE PHYLLIS SIPERSTEIN TAMARISKALR	3 SHALOM DRIVE WARWICK, RI 02886

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S 003	Initial Comments An unannounced biennial State Licensure survey and a complaint/incident investigation survey (KF3911, 09/19/2025) were conducted at this residence. Deficiencies were identified relative to the State Licensure survey.	S003	Revised Received NOV 17 2025 Facilities Regulation	
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. J"he 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; sha'll maintain records of all quality improvement activities; and shall keep records of committee meetings that shall be available to the Department during any onsite visit. 4. The quality improvement committee shall review and approve the quality improvement plan for the residence at intervals not to exceed twelve (12) months. Said plan shall be available to the	S 055	Facilities Regulation 11/28/25 Received OCT 18 2025 Facilities Regulation	

Facilities Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X5)DATE
Melayne A Ramirez	Executive Director	10/17/25

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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 ID 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 with program objectives and methods to identify, evaluate, and correct identified problems. Findings are as follows: Record review of the August 2025 quarterly quality assurance (QA) program minutes failed to reveal evidence that the residence was identifying, evaluating, and correcting areas of needed improvement relative to the required components of the memory care unit and/or limited health service license, which include prevention and treatment of pressure ulcers, nutritional status and dehydration, and changes in mental status. Additionally, the plan failed to reveal evidence of a plan for dietary personnel shortages. During a surveyor interview on 9/19/2025 at 2:45 PM with the Executive Director, she could not provide evidence that the QA plan for August of 2025 included all required components relative to	S 055	**S055 Corrective Action:** The facility will review the following at every QA Meeting. If there are no instances of necessary prevention and treatment of decubitus ulcers, changes in nutritional status (weight loss or gain), or changes in mental status we will document in the meeting minutes that our systems are working to prevent any changes in the above issues. 1. Nutritional status -weight loss or gain 2. Prevention of decubitus ulcers 3. Mental status change **Identification of Others at Risk**: To identify any potential new concerns, we run a weight loss-gain report monthly. With any situations that require a care plan change, these issues are reviewed as part of the care plan change assessment. Otherwise, at a minimum, they are reviewed quarterly. **Preventative Changes**: To prevent the deficiency from re-occurring, as stated above, if there are no instances of a problem, we will note in the QA minutes that there are no concerns and our practices in resident care are effective. **Compliance/Sustaining Change**: Corrective action will be monitored quarterly at the safe patient handling and QA meetings via an updated statement from the Resident Care Director to the team. The residence will proactively include **staffing shortages**, particularly in critical departments such as dining services, in the QA agenda. QA meeting minutes will reflect discussion and follow-up actions related to all required components and staffing concerns. HR/Recruitment will be notified immediately of staffing needs identified at QA and take appropriate action.	10/17/2025

RI Department of Health

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S 055	Continued From page 3 the memory care unit/limited health services license and the concerns identified in the dietary department.	S 055	S165 We are requiring that all staff submit copies of their active CPR cards to be kept on file on site as well as uploaded to our payroll/HRsystem. **Corrective Action:** • We have held two CPR courses since 9/192025 in which we certified 16 staff. • We will be holding CPR courses annually to ensure ease in compliance of maintaining current CPR certification. • Employees will be required to upload certification during on boarding into Payroll system. **Identification of others at Risk:** • Review the full staffing roster (all shift schedules, part-time staff, per diem) to identify any person with current CPR certification to ensure that there is a certified employee on all shifts. • HR will acquire this information upon hire and it will be the responsibility of the Operations Manager to maintain thereafter. **Preventative Changes:** • Manager of Operations to oversee and monitor recertification due dates as well as communicate with staff members regarding their compliance. • Monthly compliance audit: Manager of Operations will run a report of all staff certification dates and ensure that each staff is notified of the 90 and 30 day to expiration window. • Hiring Managers to ensure that documentation of CPR certification has been uploaded into Paycom prior to first shift. **Ongoing Monitoring** • Operations Manager will present compliance quarterly to the QA Team.	10/17/2025
S 165	Organization And Management 2.4.12.D Administrative Management 2.4.12 (D) Cardiopulmonary Resuscitation 1. At all times, one person on-site shall have successfully completed instruction by the American Heart Association, the American Red Cross, or the National Safety Council at the minimal ("Heartsaver") level to perform cardiopulmonary resuscitation. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined that the residence failed to have, at all times, one person on-site that has successfully completed instruction by the American Heart Association, the American Red Cross, or the National Safety Council at the minimal ("Heartsave(') level to perform cardiopulmonary resuscitation (CPR). Findings are as follows: Review of the staffing schedule for the weeks of 9/7/2025 through 9/20/2025 revealed there were twenty-eight staff members, eighteen of these staff members did not have active CPR certification in their personnel records, resulting in numerous shifts not being appropriately staffed. During a surveyor interview on 9/17/2025 at approximately 12:40 PM with the Resident Care Director, she acknowledged the staff CPR	S 165	11/28/25	

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S 165	Continued From page 4 certifications were not in their personnel records and was unable to provide evidence of active certifications or evidence the facility had been appropriately staffed at all times.	S 165	S230 **Corrective Action:** • Resident review: Upon notification of the question regarding checking BG readings, the resident's chart, discharge paperwork from the SNF and AL admission assessment were all re-reviewed. The COC discharge documentation from [redacted] SNF did not include an active physician order for staff to perform blood glucose monitoring. Attachment A: COC ID#2 • The Director of Resident Care confirmed with the resident and [redacted] physician that [redacted] remains independent with glucose monitoring. The resident's [redacted] was responsible for bringing h[redacted] personal glucometer from home and has since done so. Saw PCP 10/15/25 with no BG order. **Identification of others at Risk:** • The DRC completed a comprehensive audit of all newly admitted residents from July through present who were admitted from a SNF. • Each admission's COC and physician orders were reviewed to verify that all required treatments, monitoring, and medications were properly transcribed onto the resident's admission record and service plan. • No additional discrepancies were found. **Preventative Changes:** Each new admission assessment will have a second nurse verification prior to admission which will be performed using a newly developed checklist tool to include:	10/17/2025
S 230	Organization And Management 2.4.13.A Management Of Services 2.4.13 (A/B) Management of Services A. Each residence shall provide services with adequate professional and ancillary employees and in accordance with applicable state law. Further, the residence shall assure that all services are rendered in a safe and effective manner and consistent with the requirements herein. The [esidence shall provide all care and services to all residents in accordance with the prevailing community standard of care. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined the residence failed to provide care and services in accordance with the prevailing community standard of care relative to following the physician's written orders, upon admission, for the singular newly admitted resident reviewed, Resident ID#2 Findings are as follows: Record review of the resident revealed s/he was admitted to the residence in July of 2025 with a diagnosis that includes, but is not limited to, diabetes mellitus. Record review revealed prior to admission she/he was residing at a skilled nursing facility for rehabilitation after sustaining a fall.	S 230	11/28/25	

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S 230	Continued From page 5 Further record review revealed she/he had a physician's order while at the skilled nursing facility for finger sticks to be done two times a day for blood sugar monitoring. Record review of the document, "Assisted Living Resident Assessment", dated 7/21/2025, stated in part, "...Independent for glucose monitoring..." Record review failed to reveal glucose monitoring was being done since admission to the residence in July. During a surveyor interview on 9/18/2025 at 11:45 AM with the resident, she/he revealed since admission she/he has not been doing glucose monitoring because his/her glucometer is at home and the residence is not doing finger sticks to check blood glucose levels. During a surveyor interview on 9/19/2025 at approximately 3:00 PM with the Resident Care Director, she acknowledged the residence is not doing glucose monitoring nor is the resident. Additionally, she acknowledged the discharge paperwork indicated the resident should be monitored for blood glucose levels.	S230	230 continues from page 5 • Verification of all physician orders from COC paperwork prior to move-in • Direct communication between the admitting nurse and the resident's provider for clarification of any ambiguous or discontinued orders • Documentation of the resident self-management abilities (e.g., diabetes, BP monitoring, etc.) in both the assessment and service plan. • All nursing staff have been re-educated on the importance of order reconciliation during admission, including how to document self-administered care and to ensure that the resident has the means necessary of following through on-said care. Attachment B: Nurse verification Checklist **Sustaining Compliance:** • Director of Resident Care and a second nurse will audit each new admission for the next 6 months. • Audit results will be presented to the QA committee and incorporated into ongoing QA tracking. • The QA committee will continue to review for any discrepancies in admission orders reconciliation as part of a continuous improvement program.	
S 235	Organization And Management 2.4.13.C Management Of Services 2.4.13 (C) Management of Services C. The residence shall develop and maintain written admission procedures that shall include no less than the following components: 1. Procedures for informing residents of	S235		

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S 235	Continued From page 6 house rules (e.g., necessary information, tour of residence); 2. A resident assessment process; 3. Provision of information to each resident related to: a. Results of initial assessment; b. Procedures for involuntary transfer within the residence; c. Procedures for involuntary discharge; d. Procedures for advanced directives; e. Grievance procedures; f. Availability of nursing services, if any. 4. Policies and procedures on elopement; 5. Procedures to be followed, including those for referral (in those cases where an applicant is found to be ineligible for admission); This Requirement is not met as evidenced by: Based on record review and staff interview, ii has been determined that the residence failed to observe the standards stated in the RI Law 23-17.29 allowing residents in assisted living facilities to install electronic monitoring devices in the resident's room, Resident ID #3.	S 235		

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S 235	Continued From page 7 Findings are as follows: Resident ID #3 had a camera installed in his/her room prior to the umplimentation of the law with an effective date of 1/30/2025. Record review failed to reveal that the residence had a document with the device information as required by law and the required consent form signed by the resident's power of attorney (POA). During a surveyor interview on 9/17/2025 at 11:30 AM, with the Executive Director, she was unable to provide evidence that the consent form for the camera use was signed by the POA and the facility had the required device information.	S235	**S235 Corrective Action:** We were provided with the forms for consent and withdrawal of consent. All parties who have cameras have completed the form. A memo was sent to all staff regarding the policy and the need for consent. **Identification of others at Risk:** Notice was sent out to all families/responsible parties and staff to inform them of the regulation as well as the need for a health care provider to sign in agreement if the resident is not capable of providing consent. **Preventative Changes/Sustaining Compliance** Going forward this form will be added to our admission package for review and signature. The resident handbook has been updated with an amendment to include the regulatory requirements. A list of all residents using a camera will be reviewed quarterly with the QA team. Attachment C: Id # 3 consent form	10/17/2025
S 285	Residency Requirements.2.4.14.A Residency Requirements 2.4.14 (A) Residency Requirements A Each licensee, or his/her designee, through the assessment and evaluation procedures delineated in these regulations (see§ 2.4.16(C) of this Part) shall be responsible to ensure that admission to and residency in an assisted living residence be limited to those individuals who meet the definition of "resident" in accordance with§ 2.3(A)(32) of this Part. This Requirement is not met as evidenced by: Based on record review, surveyor observation, and staff interview, it has been determined that the residence retained a resident that does not meet the definition of a resident for one of five sample residents reviewed, Resident ID #1. Finding are as follows:	S 285		

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S 285	Continued From page 8 Record review revealed Resident ID #1 was admitted to the residence in August of 2020 with a diagnosis that includes, but is not limited to, Alzheimer's disease. Per the Rules and Regulations for Licensing Assisted Living Residences the definition of a resident states in part "... persons who are bedbound or in need of the assistance of more than one (1) person for ambulation are not appropriate to reside in assisted living residence..." The regulation further states, "...Any assisted living residence that offers to provide or provides services for residents receiving hospice services who are bed-bound or in need of assistance from more than one staff person for ambulation is required to be licensed at the F1 level, as defined in§ 2.4.2(A)(1)(a) of this Part, and must have a license endorsement, issued pursuant to these regulations, to provide limited health services, and shall, at a minimum provide services for stage I and stage II pressure ulcer treatment and prevention and meet the requirements of§ 2.6 of this Part..." The regulations indicate team lifts are to be utilized, as mechanical lifting is not permitted as it is • "requiring medical or nursing care as provided in a health care facility." Record review of a document titled, "Dementia and Limited Health Safe Resident Handling and Movement Assessment" dated 6/19/2025, revealed that the resident is transferred from bed to chair with the use of a Hoyer lift (a mechanical lift that utilizes a sling for non-weightbearing residents). During a surveyor observation on 9/19/2025 at 11:00 AM, two nursing assistants were assisting	S285	S285 In review of the following regulations 2.3(A)(32)... "residents who are bedbound or in need of assistance of more than 1 staff person for ambulation may reside in residence if they are receiving hospice care in accordance with these regulations" 2.4.5 (C)(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"..."Address circumstances under which it would be medically contraindicated to use lifting or transfer aids or assistive devices" 2.4.5 (C) (1) " Implement a safe resident handling policy...that will achieve the maximum reasonable reduction of manual lifting, transferring, and repositioning, of all or most of a resident's weight" In addition to the aforementioned, our community is licensed at the F1 and M1 levels, holds a current Limited Heatlh Services Licenses, has available lifting equipment and the resident ID # 1 is on Hospice Services. At the time of the survey, one year of safe resident handling documentation was provided which was directly correlated to our safe resident handing policy as required by regulation. **Corrective Action:** Our ongoing plan is to increase our safe resident handling to a monthly basis for all hospice residents. **Identification of others at Risk.** Review all other residents for safe resident handling issues quarterly **Preventative Changes**: Incident reviews daily and anyone identified as at risk will generate an ad hoc safe residentt handling review. **Sustaining Change**: Safe resident handling documentation will be reviewed at quarterly QA.	10/17/2025

RI Department of Health

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S 285	Continued From page 9 the resident in a transfer from his/her bed to chair with the use of a Hoyer lift. During a surveyor interview on 9/18/2-025 at 3:00 PM with the Director of the Memory Support Program, she revealed that the resident requires a Hoyer lift with the assistance of two staff members for transfers. During a surveyor interview on 9/19/2025 at 3:00 PM with the Executive Director and the Resident Care Director, they acknowledged that the resident utilizes a Hoyer lift for transfer.	S285	285 Updated Plan of Correction. **Corrective Action:** Resident Id #1 was given a 30 day notice of intent to discharge. Mechanical lifts will not longer be used. (see attached Notice) **Identification of others at risk:** Our ongoing plan is to increase our safe resident handling to a monthly basis for all hospice residents **Preventive measures:** Incident reviews daily and anyone identified as at risk will generate an ad hoc safe resident handling review. There will be no mechanical lift use. If a resident requires a lift, they will be given a 30 day notice of intent to discharges. **Sustaining Change:** Safe resident handling documentation will be reviewed at quarterly QA.	11/17/2025
S 360	Residency Requirements 2.4.16.C Resident Assessment/Service Plans 2.4.16 (C) ResidentAssessments and Service Plans C. The Department-approved assessment form, or such other assessment form as approved by the Department, shall be utilized in completing the assessment on each resident who is admitted to the residence. (Approved Department form is available for downloading online at http://health.ri.gov/forms/assessmenl/AssistedLivingResident.pdf). 1. Assisted living residences not intending to use the Department's assessment form shall submit their proposed assessment forms with a cover letter of intent to the Center for Health Facilities Regulation as specified in § 2.4.6(A) of this Part. 2. All assessment forms shall report information appropriate to determine compatibility and compliance with the residency criteria, and	S 360	Received NOV 17 2025 Facilities Regulation S360 **Corrective Action:** The RIDOH APPC form was thoroughly reviewed and updated to match the resident's current plan of care. **Identification of others at risk:** A full audit of memory care residents' initial APP C forms and current care plans was completed; any	10/17/2025

Theresa C Ramos 11/17/25 Ex. Dir.

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S 360	Continued From page 10 shall indicate that the resident's needs can be met by the assisted living residence within its licensure level, and shall gather information appropriate for the development of an individualized service plan. a. The assessment form shall be designed to demonstrate compliance with the assisted living residence's criteria for residency. b. The assessment form shall also be designed to demonstrate that the assisted living residence can meet the resident's needs and preferences. 3. The assessment form shall also be designed to provide information appropriate for the development of an individualized service plan in accordance with § 2.4.16(G)(1) of this Part. This Requirement is not met as evidenced by: Based on surveyor observation, record review, and staff interview, it has been determined the residence failed to review the resident assessment at intervals not to exceed (12) months and each time a resident's condition changes significantly for one of four sample residents, Resident ID #1 Findings are as follows: Record review revealed the resident was admitted to the residence in August of 2020, with a diagnosis that includes, but is not limited to,	S 360		

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S 360	Continued From page 11 Alzheimer's disease. Record review revealed the resident was admitted to hospice services in July of 2025. Record *review* of the comprehensive assessment dated 6/15/2025 revealed the following: -needs cueing for eating -ambulation can be unsteady at time -bladder control; occasional incontinence -bowel control; continent -treatment/therapies; 1/22/2025 evaluated by an outside agency During surveyor observations on 9/17/2025, 9/18/2025, and 9/19/2025 at 12:15 PM, the resident was sitting in a Broda chair and was being provided one to one assistance from a private duty aide for eating his/her lunch. During a surveyor observation on 9/19/2025 at 11:00 AM, the resident was being transferred from his/her bed with an assist of two nursing assistants with the use of a Hoyer lift During a surveyor interview on 9/19/2025 at approximately 11:15 AM with the Director of Renaissance Memory Support Program, she revealed the resident is not ambulatory, is incontinent of bladder and bowel, is dependent on a staff member for eating, and requires the assistance of two staff members with a Hoyer lift for transfers. During a surveyor interview on 9/19/2025 at 3:00 **PM** with the Executive Director and the Resident Care Director, they were unable to provide evidence the resident's comprehensive assessment had been updated with the decline in the resident's functional and health status.	S 360		

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	ALR01426	A. BUILDING: _____ B. WING	09/19/2025

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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 and staff interview, it has been determined that the residence failed to comply with the appropriate requirements of the R.I General Laws Chapters 21-27 and 21-31, Rhode Island Food Code (Part 50-10-1 of this Title) relative to the main kitchen and the memory care kitchenette. Findings are as follows: 1. Record review of the 2022 Food Code published by the U.S Food and Drug Administration 3-509.19 states in part, "...food shall have an initial temperature of 5 degrees C (41 degrees F) or less when removed from cold holding temperature control or 57 degrees (135 degrees **F)** or greater when removed from hot holding temperature control..." During a surveyor observation on 9/19/2025 at a 12:05 **PM,** in the presence of the Food Service Director (FSD), the seafood bisque had a hot holding temperature of 130 degrees **F.**, and the fried fish had a hot holding temperature of 125 degrees **F.**	S490	S490 **Corrective Action** 1. Immediate Temperature Control Measures • Retrain kitchen staff on hot holding temperature requirements (≥135°F). • Review process for temperature logs for hot-held foods. 2. Labeling and Identification of Food Containers • All contents of unlabeled containers were discarded. • Staff were retrained on FDA labeling standards. • After each meal, the daily labeling checklist is completed. 3. Expired Food Disposal • Expired milk and other items were discarded. • Staff were instructed to check expiration dates prior to use and at the end of each shift. 4. Date Marking for Prepared Foods • All improperly dated items were discarded. • Staff retrained on 7-day discard rule (Day 1 = prep date).	10/17/2025

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S 490	Continued From page 13 Immediately following the above-mentioned observation, the FSD acknowledged the temperatures were not within the appropriate temperature range. 2. Record review of the 2022 Food Code published by the U.S. Food and Drug Administration Section, 3-302.12 Food Storage containers, identified with common name of food, states in part, "...except for containers holding food that can be readily and unmistakably recognized, working containers of food holding food that are removed from their original packages shall be identified with a common name of the food..." During a surveyor observation on 9/19/2025 at approximately 11:15 **AM** of the memory care kitchenette, the refrigerator had stored the following: -a container with a white-yellow substance without a label. -a container with a white colored substance without a label. -two containers with a red colored liquid without a label. -two containers with a caramel-colored liquid without a label. -two containers with an orange-colored liquid without a label. 3. Record review of the 2022 Food Code published by the U.S Food and Drug Administration Section 3.501.17, states in part, "the day marked by the food establishment may not exceed the manufacturer's use by date..." During a surveyor observation on 9/17/2025 at 12:15 PM of the memory care kitchenette, the	S490	S490 Continued form previous page 5. Cleaning of Non-Food Contact Surfaces • Deep cleaning of all listed equipment completed. • Daily and Weekly cleaning schedule updated and documented. • Food Service Director to verify cleanliness, Executive Director to oversee compliance. 6. Cleaning of Food Contact Surfaces • Ice machine chute cleaned and sanitized. • Staff retrained on cleaning protocols for food contact surfaces. 7. Trash Receptacle Compliance • All uncovered trash containers replaced with covered units. • Staff instructed to keep lids closed at all times. • Daily kitchen walkthroughs added to cleaning checklist. 8. Chemical Labeling Compliance • Unlabeled sanitizer bottles discarded. • New bottles labeled per OSHA standards. • Staff re-trained on chemical safety and labeling.	

11/26/25

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S 490	Continued From page 14 refrigerator had stored a gallon of whole milk with a use by date of 9/15/2025. Immediately following the above-mentioned observation, the Director-of the Memory Support Program acknowledged that the milk was stored beyond its expiration date. 4. Record review of the 2022 Food Code published by the U.S.Food and Drug Administration states in part, "...food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date by which the food shall be consumed or discarded for a maximum of 7 days, the day of preparation shall be counted as Day 1..." During a surveyor observation on 9/17/2025 at 9:45 AM of the main kitchen, in the presence of the Executive Director, the reach-in refrigerator had a pan of turkey bacon stored that had Day 1 labeled as 9/17/2025 and a discard date of 9/27/2025. An additional surveyor observation on 9/19/2025 at 11:15 AM of the memory care kitchenette, the refrigerator had a container of vanilla pudding stored that had Day 1 labeled as 9/11/2025 and a discard date of 9/18/2025. 5. Record review of the 2022 Food Code published by the U.S. Food and Drug Administration Section 4-601.11 (C) reads in part,"...non-contact surfaces of equipment shall be free of an accumulation of...other debris..." During a surveyor observation on 9/17/2025 at 9:45 AM, in the presence of the Executive Director, the following was revealed: -grates on lower portion of the reach in	S490	S490 Continued from prior page **Identification of Others at Risk** • A facility-wide audit was conducted to ensure no other food safety violations existed, including the main kitchen, memory care and the bistro. **Preventative Changes** • Policy Updates: Food safety policies reviewed and all dietary staff retrained. All new staff will be trained during onboarding and all staff again annually. • Labeling System: Assured availability of standardized labels for all food containers. **Sustaining Compliance** • Internal Audits: Monthly audits by the Executive Director and Food Service Director. • Resident Council Feedback: Monthly meetings to gather feedback on food service quality. • FSD will implement the RIDOH (available from RIALA) survey prep checklist sections weekly for the dietary department. • Documentation from above items 1-8 (Corrective Action) will be presented at QA meetings quarterly, non-compliance will be addressed immediately. Attachment E: logs,education, etc	

RI Department of Health

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$490	Continued- From page 15 refrigerator with black substance. -tilt skillet with grease and grime build up in the corner. -gasket on beverage air beverage cooler with black substance. 6. Record review of the 2022 Food Code published by the U.S. Food and Drug Administration Section 4-601.11 (A) states in part, "...equipment food contact surfaces...shall be clean to sight and touch..." During a surveyor observation of the main kitchen on 9/17/2025 at 9:45 AM, in the presence of the Executive Director, the chute of the ice machine had a black, brown substance along the lower end of the chute. 7. Record review of the 2022 Food Code published by the U.S. Food and Drug Administration Section 5.501.113 states in part, "receptables and waste handling units for refuse...shall be kept covered..." During a surveyor observation on 9/17/2025 at 9:45 AM of the main kitchen, in the presence of the Executive Director, revealed the following: -Trash container uncovered by coffee machine worktable. -Trash container uncovered by hand sink. -Trash container uncovered by 3 bay sink. 8. Record review of the Occupational Safety and Health Administration Standard 1910.1200 (1)(1) states in part, "...chemicals are marked with a product identifier, signal word (danger or warning), a statement that the full label information for the chemical is provided on the outside package..."	$490		

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S490	Continued From page 16 During a surveyor's observation on 9/17/2025 at 9:45 AM of the main kitchen, a spray bottle stored above a workstation table had a handwritten label that read "sanitizer." During a surveyor interview on 9/19/2025 at 3:00 PM with the Executive Director, she was unable to provide evidence that the containers in the memory care unit had a product label, that the trash receptables in the kitchen were covered, and that the sanitizer spray bottle had the appropriate label.	S490		
S565	Residential Care Services 2.4.24.B.1 Medication Services 2.4.24 (B) (1) Administration of Medications 1. Residences licensed at the M1 level may administer medications to residents including, but not limited to, removing medication containers from storage, assisting with the removal of a medication from a container for residents with disability which prevents independence in this act, and/or administering the medication directly to the resident. a. The resident or guardian must provide written authorization for the residence to provide administration of medications. b. Medications shall be administered in accordance with written orders of a physician. The residence must provide in writing, a description of services provided by the residence to each physician, including limitations on service. c. All medications must be checked against a physician's orders by a licensed nurse, or	S 565		

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S 565	Continued From page 17 pharmacist. d. The resident must be identified prior to administration of any medication. e. The medication must be in the original pharmacy-dispensed container with proper label and directions attached and be administered in accordance with such label. f. Injectable medications, including but not limited to insulin, which cannot be self-administered by the resident, must be administered by a licensed nurse. g. There shall be written a policy/procedure for the disposal of hypodermic. needles, syringes and other such instrumentsthat is in compliance with rules and regulations governing Hypodermic Needles, Syringes & Other Such Instruments (Part 20-15-6 of this Title). (1) The legal destruction of hypodermic needles, syringes or other such instruments is the responsibility of the last entitled or authorized possessor. (AA) All personnel or residents legally authorized to use disposal syringes and needles, shall destroy them after one (1) use. (BB) Excess and undesired needles, syringes and other such instruments shall be stored in impervious, rigid, puncture- resistant container for disposal. Intact needles shall be placed directly into the collection containers. (CC) Personnel handling disposal waste materials such as needles, syringes, and	S 565	S 565 **Corrective Actions Taken:** • Immediate removal of expired medications; All expired medications identified during the survey were immediately removed and properly disposed of in accordance with the facility policy. • The seven loose pills found in the third floor medication cart were discarded. Staff were re-educated on the importance of ensuring all medications are stored in properly labeled containers and linked to the correct resident. • A full audit of all medication carts was conducted to ensure compliance with secure storage standards. All discrepancies were corrected on the spot. **Preventative Measures:** • Medication cart checks will be performed each shift, by the CMT on the cart, using a newly developed checklist which ensures that all expired medications are disposed of no loose pills are present in the cart, all medications are secure, etc. • A weekly medication cart checklist will be performed by a designated RN to ensure compliance with above stated shift check. • The entire care team is has reviewed the medication storage protocols and expectations. • A Medication Cart daily checklist has been refreshed to include it be completed every shift by the CMT responsible for the care. developed to ensure compliance.	10/17/2025

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S 565	Continued From page 18 other such instruments may treat and destroy such waste by a DEM-approved alternative treatment/destruction technology or prepare the regulated medical waste for off-site transport by a DEM-permitted medical waste transporter. h. Individual medication records must be retained for each resident to whom medications are being administered and each dose administered to the resident must be properly recorded. i. Any medication administered by the residence and refused by a resident shall be documented and reported, as appropriate. j. Medications shall be stored securely and in such a manner to prevent spoilage, dosage errors, administration errors, and/or inappropriate access. Provisions for safe storage may include lockable containers, secure spaces, or lockable units, as appropriate to the residence and the resident population. k. All medication in the residence, regardless of whether controlled by employees or by the resident, shall be stored securely as stated in § 2.4.24(A)(3)(a)(B) of this Part. l. All centrally stored medications shall be maintained in accordance with manufacturer's labeling and administered by authorized personnel. This Requirement is not met as evidenced by: Based on surveyor observation and staff	S565	S565 continued **Monitoring and Maintaining compliance:** • The designated RN will review the CMT daily checklist on a weekly basis. • The QA committee will review medication cart audit results on a Quarterly basis. • Any non-compliance will trigger immediate retraining and coaching. Attachement F Med Cart daily check list Attachment G: Weekly Nursing med cart compliance 11/28/25	

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s 565	Continued From page 19 interview, it has been determined that the residence failed to ensure that medications shall be stored securely and in such a manner to prevent spoilage, dosage errors, administration errors, and/or inappropriate access for two of three medication carts observed, the third floor and memory care unit medication carts. Findings are as follows: 1. During a surveyor observation on 9/19/2025 at 9:20 AM of the third floor medication cart, seven loose pills were found not stored in a bubble pack or vial. The pills were not identifiable nor was it identified to whom they were prescribed. Additionally, the following was revealed: -one bottle of Atropine, opened, and with a manufacturer's expiration date of 3/31/2025. -one bottle of Atropine, opened and with a manufacturers expiration date of 4/30/2025. -one nasal spray, Sinex Severe, opened and with a manufacturer's expiration date of 8/2025. 2. During a surveyor observation on 9/19/2025 at 11:00AM of the medication cart on the memory care unit, the following was revealed: -Leader dry eye relief drops, opened and with a manufacturer's expiration date of 5/2025. During a surveyor interview with the Resident Care Director on 9/19/2025 at 11:30 AM, she acknowledged the Atropine was stored beyond the manufacturer's expiration date, as were the Sinex Severe and Leader dry eye relief drops. Additionally, she acknowledged the loose pills that were observed on the bottom of the cart.	S 565		

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S 670	Physical Plant 2.4.30.C Safety Requirements 2.4.30 (C) Safety Requirements C. Every closet door latch shall be a type that cannot be locked from the inside. This Requirement is not met as evidenced by: Based on observation and record review, two of five sampled resident rooms had closet doors that locked from the inside, Rooms 303 and 311. Findings are as follows: During surveyor observation on 9/18/2025 at 11:25 AM of Rooms 303 and 311, the closet doors had inside locks that were not able to 13e opened with a master key from the outside of the door. During a surveyor interview with the Executive Director immediately following the above-mentioned observations, she acknowledged the closet doors had inside locks and were not able to be opened from the outside with a master key.	S670	S670 **Corrective Action:** Upon identification of the issue during the survey on 9/19/2025, facility maintenance immediately replaced the closet doorknobs in Rooms 303 and 311 with compliant hardware that cannot be locked from the inside. This corrective action was completed during the survey window while the surveyor was present, ensuring immediate resolution and reconciliation. **Identification of Others at Risk:** A facility-wide audit of all resident room closet doors was conducted to identify any additional rooms with similar non-compliant locking mechanisms. One other room was found, all non-compliant knobs were changed immediately. **Preventative Changes:** To prevent recurrence, the facility has updated its preventative maintenance protocols to include a yearly inspection of all closet door hardware in resident rooms. Any non-compliant or altered hardware will be flagged and replaced immediately. The annual inspection has been added to Residex which automatically produces a "to do" list for maintenance staff daily. **Sustaining Compliance:** Documentation of inspections and corrective actions will be maintained and reviewed during quarterly/safety committee meetings.	10/17/2025