STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01425	A. BUILDING: _____ B. WING _____	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ELIZABETH COURT	109 MELROSE STREET PROVIDENCE, RI 02907

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S 003	Initial Comments An unannounced biennial State Licensure survey and a complaint/incident investigation survey (Q36511, 12/19/2023) were conducted at this residence. Deficiencies were identified relative to the State Licensure survey.	S 003	RECEIVED JAN 05 2024 FACILITIES REGULATION	
S 180	Organization And Management 2.4.12.G.1 Administrative Management 2.4.12 (G) (1) Employee Training 1. The administrator shall ensure that all new employees shall receive at least two (2) hours of orientation and training within ten (10) days of hire and prior to beginning work alone in the assisted living residence, in addition to any training that may be required for a specific job classification at the residence. Such areas include: a. Fire prevention; b. Recognition and reporting of abuse, neglect, and mistreatment; c. Assisted living philosophy (goals/values: dignity, independence, autonomy, choice); d. Resident's rights; e. Confidentiality. f. Emergency preparedness and procedures; g. Medical emergency procedures; h. Infection control policies and procedures; and	S 180	(POC) for S180 A) Staff A was hired on 06/30/22. The required orientation and training was completed on 06/30/22. The binder containing the evidence of the training and orientation was missing on the day of the survey. It has since been located. B) An audit of all personnel records was completed. There was evidence of orientation and training within 10 days of hire for each employee. C) The HR Manager will develop a checklist of all employees, their date of hire and the date of the training/orientation. The HR Manager will review this list on a monthly basis to ensure the required training/orientation is completed on time. D) On a quarterly basis, the HR Manager will provide a summary of the above findings to the Administrator at the Quality Assurance meeting. 1/10/24	12/22/23 12/22/23 12/22/23

Facilities Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Adminstrator	1/4/2024

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S 180	Continued From page 1 i. Resident elopement. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined the residence failed to ensure all new employees received at least two hours of orientation and training within ten days of hire and prior to beginning work alone in the residence, in the areas specific to job classification and stipulated in §2.4.12(G)(1) of the regulations for 1 of 2 new employees reviewed, Staff A. Findings are as follows: Record review revealed Staff A was hired on 6/30/2022. This employee was hired as a Certified Medication Technician (CMT). Record review of the personnel record for the above-mentioned staff failed to reveal evidence that the staff received at least two hours of orientation and training within ten days of hire and prior to beginning work alone in the residence. During an interview on 12/19/2023 at approximately 1:40 PM, the Director of Wellness could not provide evidence that the above employee had received the required training.	S 180		
S 200	Organization And Management 2.4.12.I.2 Administrative Management 2.4.12 (I) (2) Personnel Records 2. Said personnel records shall be reviewed and updated at intervals not to exceed twelve (12)	S 200		

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S 200	Continued From page 2 months and shall include, but not be limited to, all of the following components: a. Completed job application and/or resume; b. Written statements of references or documentation of verbal reference check; c. Written functional job descriptions; (1) These descriptions shall be updated at intervals not to exceed twelve (12) months and shall include, but not be limited to, minimal qualifications for the position, major duties and responsibilities, and shall be signed and dated by the individual employee. d. Evidence of credentials, current professional licensure and/or certification; e. Documentation of education and/or continuing training, including continuing education units (CEUs) related to administrator certification, food management, etc., medication administration, and dementia care; f. Documentation of attendance at in-service training and/or orientation; g. Documentation of at least one (1) performance evaluation at intervals not to exceed twelve (12) months; h. Signed copy of employee's awareness of resident's rights; i. Results of the criminal record (BCI) check.	S 200	(POC) for S 200 A) Reference Checks were requested for staff B,C and D. B) An Audit of all personnel records was completed. There was evidence of reference checks for most of the employees. In the files where it was missing, a request for reference checks was sent. C) The HR Manager has developed a checklist to use as new employees are hired. As the required tasks are completed, she will check it off. D) On a quarterly basis, HR Manager will provide a summary of the findings to the Administrator at the Quality Assurance meeting. 12/10/24	12/26/2023 12/26/2023 12/26/2023

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S 200	Continued From page 3 This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined that the residence failed to ensure that personnel records contain written statements of references or documentation of verbal reference checks for 3 of 6 sample staff reviewed, Staff B, C, and D. Findings are as follows: 1. Record review of Staff B revealed a hire date of 10/16/2023. This staff was hired as a Licensed Practical Nurse. 2. Record review of Staff C revealed a hire date of 6/17/2023. This staff was hired as a Certified Medication Technician (CMT). 3. Record review of Staff D revealed a hire date of 12/9/2008. This staff was hired as a CMT. Record review failed to reveal evidence that written statements of references or documentation of verbal reference checks were obtained for the above-mentioned staff, as required. During a surveyor interview on 12/19/2023 at approximately 12:41 PM with the Human Resource Coordinator, she was unable to provide evidence that reference checks were obtained for the above-mentioned staff.	S 200		
S 365	Residency Requirements 2.4.16.D Resident Assessment/Service Plans 2.4.16 (d) Resident Assessments and Service	S 365		

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S 365	Continued From page 4 Plans D. The assessment shall be reviewed and at intervals not to exceed twelve (12) months and each time a resident's condition changes significantly. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined the residence failed to review the resident's comprehensive assessment at intervals not to exceed (12) months and each time a resident's condition changes significantly for 2 of 4 sample residents reviewed, ID #s 2 and 3. Findings are as follows: 1. Record review revealed Resident ID #2 moved into the residence in October of 2021 with a diagnosis of arthritis. Record review revealed the resident received outside services for physical therapy and occupational therapy with a start of care date of 10/26/2023. Record review of the resident's comprehensive assessment dated 12/28/2022 failed to reveal evidence the assessment was updated to reflect that the resident received the above-mentioned outside services. 2. Record review revealed Resident ID #3 moved into the residence in July of 2017 with a diagnosis of Alzheimer's disease. Record review revealed the resident received physical therapy and occupational therapy with a	S 365	(POC) S365 A) The comprehensive assessment for Resident ID#2 was updated to refelct that the resident received outside services for physical therapy and occupational therapy. A review of the comprehensive assessment for Resident ID#3 was completed. The assessment reflects the outside services of physical therapy and occupational therapy. B) An audit of all resident records was completed to ensure that the assessments were being reviewed every 12 months and the assessments were updated to ensure that any outside services were reflected in the assessment. C) Nursing staff were educated about the need to review the assessment at an interval not to exceed 12 months. In addition, nursing staff were educated about the need to update the assessment each time a resident's condition changes significantly, including when a resident receives outside services for physical therapy and occupational therapy.	12/20/2023 12/20/2023 12/20/2023

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S 365	Continued From page 5 start of care date of 12/6/2023. Record review of the resident's comprehensive assessment dated 3/4/2022 failed to reveal evidence the assessment was reviewed at an interval not to exceed (12) months. Additionally, the assessment was not updated to reflect that the resident is receiving outside services. During a surveyor interview on 12/18/2023 at approximately 11:36 AM with the Director of Wellness, she could not provide evidence the assessments were updated to reflect the outside services for Resident ID #2 and 3, as required. Additionally, she acknowledged Resident ID #3's assessment was not reviewed at intervals not to exceed 12 months.	S 365	continued D) Nursing staff will conduct random routine audits to ensure that assessments are being reviewed timely and they are being updated to reflect any significant changes in condition including when a resident receives outside services for physical therapy and occupational therapy. This report will be presented at the quarterly Quality Assurance meeting. 12/19/23	
S 390	Residency Requirements 2.4.16.G.3 Resident Assessment/Service Plan 2.4.16 (G)(3) Service Plans 3. The service plan shall be reviewed by both parties at intervals not to exceed twelve (12) months and each time a resident's condition changes significantly and all changes shall be acknowledged in writing by both parties. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined the residence failed to review the service plan each time a resident's condition changes significantly, and the plan accurately reflects the care the resident is receiving for 1 of 4 sample resident reviewed, ID #1. Findings are as follows:	S 390	(POC) S390 A) The service plan for Resident ID#1 was updated to reflect the hopice services being provided. 12/19/2023 B) An audit of all resident records was completed to ensure the service plans accurately reflect the care the resident is receiving. Where needed the service plans were updated. 12/22/2023 C) Nursing staff were educated about the need to review the service plans at an interval not to exceed 12 months and each time a residents condition changes significantly and all changes acknowledged in writing by both parties. 12/22/2023	

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S 390	Continued From page 6 Record review of the list of residents receiving an outside service, including hospice services, provided by the Director of Wellness on 12/18/2023 revealed Resident ID #1 is receiving hospice services. Record review revealed the resident moved into the residence in April of 2013 with a diagnosis of hypertension. Record review revealed the resident was admitted to hospice services on 9/13/2023. Record review of the resident's service plan dated 4/4/2023 failed to reveal evidence that the service plan was updated to reflect the resident received the above-mentioned outside services. During an interview on 12/18/2023 at 11:32 AM with the Director of Wellness, she acknowledged Resident ID #1 is receiving hospice services and that his/her service plan did not reflect the outside services.	S 390	continued D) Nursing staff will conduct random routine audits to ensure that service plans are being reviewed timely and they are being updated to reflect any significant changes in condition. This report will be presented at the quarterly Quality Assurance meeting. 1/10/24	
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.	S 490	(POC) S 490 A) Any food item missing an appropriate label and date was discarded. B) An audit of all food storage areas was completed. Any food improperly stored (labeled & dated) was discarded. All non food contact surfaces of equipment were inspected to ensure they were free of an accumulation of dirt and other debris.	12/19/2023 12/20/2023

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S 490	Continued From page 7 This Requirement is not met as evidenced by: Based on surveyor observation, record review, and staff interview, it has been determined that the residence failed to comply with the appropriate requirements of the Rhode Island Food Code. Findings are as follows: 1) According to Section 3-501.17 of Rhode Island Food Code states in part" (A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under § 3-502.12, and except as specified in (E) and (F) of this section, refrigerated, READY-TO -EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5°C (41°F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. (B) Except as specified in (E) -(G) of this section, refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the FOOD ESTABLISHMENT shall be counted as Day 1; and (2) The day or date marked by the FOOD ESTABLISHMENT may not exceed a manufacturer's use-by date if the manufacturer	S 490	continued C) Education was provided to staff about the need to label and date in accordance with the Food Code. In addition, staff were educated about the need to ensure that all nonfood contact surfaces of equipment are clean and free from any accumulation of dirt and other debris... D) The Food Service Director will conduct random and routine audits of the kitchen to ensure that all food is labeled and dated appropriately, and all non food contact surfaces of equipment are clean. The results of the audit will be presented at the quarterly Quality Assurance meeting. 1/10/24 CS	12/22/2023 12/23/2023

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S 490	Continued From page 8 determined the use-by date based on FOOD safety..." A) During a surveyor observation of a standup refrigerator in the kitchen in the presences of the Food Service Director (FSD) on 12/18/2023 at approximately 11:00 AM the following was revealed: - A Ziploc bag of muffins, without a label and not dated. - A Ziploc bag of Danish, without a label and not dated. - A Ziploc bag of biscuit, without a label and not dated. - A Ziploc bag of cookies, dated "11/30." - A Ziploc bag of 13 boiled eggs, without a label and not dated. B) During a surveyor observation of the storage room in the presence of the FSD, on 12/18/2023 at approximately 11:15 AM revealed 42 pie crusts without a label and not dated. 2) According to the Rhode Island Food Code 2018 Edition 4-601.11 states in part, "...nonfood contact surfaces of equipment shall be kept free of an accumulation of dirt...and other debris..." A) During a surveyor observation of the main kitchen on 12/18/2023 at approximately 11:20 AM in the presence of the FSD, the hood compartments above the stove were observed to have a heavy accumulation of black substance. During an interview immediately following these observations with the FSD, he acknowledged the above-mentioned food items were not stored appropriately and the hood compartments had an accumulation of debris.	S 490		

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S 565	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 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.	S 565	(POC) S565 A) 1st floor-A resident identifier and directions for use were placed on the bottle of Multi Plus omega- 3 gummies multi vitamin and the bottle of Tylenol Extra Strength 500MG (milligram) 2nd floor-A resident identifier and directions for use was placed on the bottle of Tums Antacid 500mg. A date was placed on the Anoro Ellipta 62.5MCG/25MCG (microgram) inhaler. 3rd floor-A resident identifier and directions for use were placed on the bottle of Calcium 1200 mg suppliment. A date was placed on the Anora Ellipta 62.5/25MCG (microgram) inhaler. B) An inspection of all the medication carts was done to ensure medications were appropriately labeled and stored C. The CMT's and nurses were educated about the importance of appropriate labeling, dating and storing of medications D. The Wellness Director will conduct random and routine audits to ensure medications are properly labeled dated and stored. The results of the audit will be presented at the quarterly Quality Assurance meetings	12/18/2023 12/18/2023 12/18/2023 12/20/2023 12/22/2023 12/23/2023

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S 565	Continued From page 10 g. There shall be written a policy/procedure for the disposal of hypodermic needles, syringes and other such instruments that 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 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	S 565		

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S 565	Continued From page 11 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)(8) 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 interview, it has been determined 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 the 3 of 3 medication carts observed. Findings are as follows: 1. During a surveyor observation of the first-floor medication cart on 12/18/2023 at approximately 10:23 AM in the presence of a Certified Medication Technician (CMT), Staff E revealed a bottle of Multi Plus Omega-3 gummies multi vitamin and a bottle of Tylenol Extra Strength 500 MG (milligram) without a resident identifier and directions for use.	S 565		

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S 565	Continued From page 12 During an interview immediately following this observation with Staff E, she acknowledged the above medications did not have a resident identifier and directions for use. 2. During a surveyor observation of the second-floor medication cart on 12/18/2023 at approximately 10:30 AM in the presence of the Director of Wellness (DOW) a bottle of Tums Antiacid 500 mg without a resident identifier and directions for use was revealed. Additionally, an Anoro Ellipta 62.5 MCG/25 MCG (microgram) inhaler was observed opened and not dated. Manufacturer instructions indicates to discard 6 weeks after opening. During an interview immediately following this observation with the DOW, she acknowledged the above-mentioned observation. 3. During a surveyor observation of the third-floor medication cart on 12/18/2023 at 10:55 AM in the presence of a CMT, Staff F a bottle of Calcium 1200 mg supplement without a resident identifier and directions for use was observed. Additionally, an Anoro Ellipta 62.5 MCG/25 MCG inhaler was observed opened and not dated. Manufacturer instructions indicates to discard 6 weeks after opening. During an interview on 12/18/2023 at approximately 11:00 AM with the DOW, she acknowledged the above-mentioned medications were not stored appropriately, as required.	S 565		
S 730	Practices and Procedures, Violations, Sa 2.4.32.B Variance Procedure	S 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01425	A. BUILDING: _____ B. WING _____	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ELIZABETH COURT	109 MELROSE STREET PROVIDENCE, RI 02907

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S 730	Continued From page 13 2.4.31 (B) Variance Procedure B. A request for a variance shall be filed by a high managerial agent of the assisted living residence in writing, and must set forth in detail the basis upon which the request is made including: 1. Identification of the specific regulatory section(s) herein; 2. Alternative actions, processes, or procedures that through the facility's implementation will facilitate compliance with the specific regulatory intent, and how the Residence will ensure staff awareness and training regarding the variance, when appropriate. 3. A variance period shall not exceed the assisted living residence's license period. An assisted living residence must request renewal of the variance when it submits its annual license renewal application. 4. Upon the filing of each request for variance with the Department, and within a reasonable time thereafter, the Department shall notify the applicant by certified mail of its approval or in the case of a denial, a hearing date, time and place may be scheduled if the residence appeals the denial and held in accordance with the provisions of § 2.4.33 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 obtain a variance for approval from the Department for 1 of 1 sample resident receiving hospice services,	S 730		

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S 730	Continued From page 14 Resident ID #1. Finding are as follows: Per the Rules and Regulations for Licensing Assisted Living Residences, the definition of a resident states in part, "Resident" means "...an individual not requiring medical or nursing care as provided in a health care facility but who as a result of choice and/or physical or mental limitation requires personal assistance, lodging and meals and may require the administration of medication and/or limited health services...Persons needing medical or skilled nursing care, including daily professional observation and evaluation, as provided in a health care facility, and/or persons who are bedbound or in need of the assistance of more than one (1) person for ambulation is not appropriate to reside in assisted living residences. However, an established resident may receive daily skilled nursing care or therapy from a licensed health care provider for a condition that results from a temporary illness or injury for up to forty-five (45) days subject to an extension of additional days as approved by the Department, or if the resident is under the care of a Rhode Island licensed hospice agency provided the assisted living residence assumes responsibility for ensuring that the required care is received. Furthermore, a new resident may receive daily therapy services and/or limited skilled nursing care services, as defined through these Regulations, from a Rhode Island licensed health care provider for a condition that results from a temporary illness or injury for up to forty-five (45) days subject to an extension of additional days as approved by the Department..." Record review of the list of residents receiving	S 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 730	Continued From page 15 outside services, including hospice services, provided by the Director of Wellness on 12/18/2023 revealed Resident ID #1 is receiving hospice services. Record review revealed the resident moved into the residence in April of 2013 with a diagnosis of hypertension. Record review revealed the resident was admitted to hospice services on 9/13/2023. Review of the resident's record failed to reveal evidence a variance was obtained from the Department, as required. During a surveyor interview on 12/18/2023 at approximately 2:00 PM with the Director of Wellness, she acknowledged the above-mentioned resident is receiving hospice services and a variance was not obtained from the Department, as required.	S 730	A. A DOH variance for resident #1 to receive Hospice services was requested B. An audit of medical records was done to ensure that there were not any other situations in which a variance would need to be requested. There was no other need to request a variance C. A review of the situations that would necessitate a request for a variance procedure was done with the Director of Wellness D. The Administrator will conduct random and routine audits to ensure requests for variances are being filed as needed. The results of the audit will be presented at the quaterly Quality Assurance meetings	12/19/2023 12/20/2023 12/19/2023