RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01521	A. BUILDING: _____ B. WING	C 10/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LOFT AT LINN ASSISTED LIVING MEMOR	30 ALEXANDER AVE EAST PROVIDENCE, RI 02914

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S 003	Initial Comments An unannounced complaint/incident investigation survey, ACTS reference numbers 98716, 100014, 100687, 102212, 102292, and 102311, was conducted at this residence on 10/28/2025 to determine compliance with state regulations. Deficiencies were identified as a result of this survey.	S003	The filing of this Plan of Correction (POC) does not constitute that the deficiencies alleged did in fact exist, rather this POC is filed as evidence of the facility's continuing commitment to high quality resident care in full compliance with state and federal regulations. **As a Plan of Correction (POC)**	
s 405	Residency Requirements 2.4.17.G.1. Resident Assessment/Service Plans 2.4.17 (G) (1) Service Plans 1. Within a reasonable time after move-in, not to exceed seven (7) days, the Administrator shall be responsible for the development of a written service plan based on the initial assessment. The service plan shall include at least: a. The services and interventions needed, including all services provided by outside healthcare agencies (e.g., home nursing care, hospice); b. Description, frequency, duration relating to the service or intervention, including personal assistance, medication, special diets, recreational activities, and other similar services rendered; c. Party responsible for arranging and/or providing the service; and d. The resident ' s requested and/or therapeutically needed recreational and social activities. This Requirement is not met as evidenced by: Based on surveyor observation, record review,	S405	a) Resident ID #1 continues to reside in the facility. Resident service plan was immediately updated. (Please refer to Appendix A). b) We have reviewed our current population to identify those who may be at risk for this issue identified by the survey team; all residents who reside at The Loft may be affected. Facility wide review will be conducted on Resident Service Plans and adding transfer status of all residents. c) Education will be completed with all Loft staff over Resident Service Plans. (See appendix B). d) Random audits will be conducted for service plan accuracy. These audits will be conducted 2x/ month and then 1x/monthly for the next 2 months. (See appendix C). e) The DON/designee is responsible for the implementation of this plan. The plan will be revised as needed to ensure compliance is achieved. The plan will be monitored, and the audits will be reviewed through the QAPI committee to review progress and ensure ongoing compliance. This process will take place for no less than 3 months; after which time our QAPI committee will determine if our level of compliance is conducive to discontinuing the formal checks. (See appendix D) Received NOV 20 2025 Facilities Regulation	10/28/25 11/5/25 11/5/25 11/5/25 2/1/26

Facilities Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE 11/20/25

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S 405	Continued From page 2 "...you have requested physical guidance and verbal cueing for assitance [sic] with bed mobility and transfers..." Additional record review of the service plan that was updated on 8/18/2025 failed to reveal that the resident was a 1-2 person assist to stand/pivot from bed to chair. Record review and staff interviews failed to provide evidence the staff had clear guidance on the appropriate care, relative to transfers, for this resident. During a surveyor interview on 10/28/2025 immediately following the above-mentioned observation with the hospice provider, she revealed that the resident, based on her assessment, is to be a 2 person transfer. During a surveyor interview on 10/28/2025 at approximately 2:30 PM with the DOW, she acknowledged the service plan did not reveal the assistance the resident required for safe transfers.	S405	As a Plan of Correction (POC) a) Resident ID #2 continues to reside in the facility. Resident and family was notified, items including white lotion, white tablets and ear drops are required to have MD order and be centrally stored. b) We have reviewed our current population to identify those who may be at risk for this issue identified by the survey team; all residents may be affected. c) Education provided to residents and their families, reminding all medications, creams and drops require a doctor's order and need to be stored centrally by staff. d) Education provided to all Loft staff to be aware and observe for any medications while in the apartment. (See appendix E). e) The DON/designee is responsible for the implementation of this plan. The plan will be revised as needed to ensure compliance is achieved. The plan will be monitored, and the audits will be reviewed through the QAPI committee to review progress and ensure ongoing compliance. This process will take place for no less than 3 months; after which time our QAPI committee will determine if our level of compliance is conducive to discontinuing the formal checks. (See appendix F)	10/29/25 10/29/25 11/4/25 10/29/25 2/1/26
s 640	Residential Care Services 2.4.26.B.1 Medication Services 2.4.26 (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.	S 640		

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S 640	Continued From page 3	S640		

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.

g. There shall be written a policy/procedure for the disposal of hypodermic needles, syringes and other such instruments that is in compliance with Part 20-15-6 of this Title, Hypodermic Needles, Syringes, and Other Such Instruments.

(1) The legal destruction of hypodermic needles, syringes or other such instruments is the responsibility of the last entitled or authorized possessor.

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s 640	Continued From page 4 {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 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 §	S640		

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S 640	Continued From page 5 2.4.25(A)(3)(a)(8) of this Part. I. 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 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 administering medications in accordance with written physician's orders for one of six residents reviewed for following physician orders, Resident 10#2. Findings are as follows: Record review revealed ID #2 was admitted to the residence in October of 2024 with a diagnosis that includes, but is not limited to, Alzheimer's disease. During a surveyor observation and interview on 10/28/2025 at approximately 2:15 PM, with the resident, in the presence of the Director of Wellness, the following medications were observed sitting on a table in the resident's room: - a tube of a white cream like ointment with the manufacturer's packaging that was written in Korean - a container with a white tablet with the manufacturer's packaging written in Korean - a bottle of ear drops with the manufacturer's packaging written in English	S640		

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S 640	Continued From page 6 A surveyor interview was attempted with the resident immediately following the above-mentioned observations, s/he was unable to communicate with the surveyor because English is not his/her primary language. Record review of the physician's orders for October 2025 failed to reveal evidence that the resident had a prescribed order for ear drops and that s/he was able to self-administer them, Additional record review of the October physician's orders failed to reveal that the resident had physician's orders for medications that were ordered from an overseas manufacturer. Further record review failed to reveal the physician was made aware the resident was taking these medications. Additionally, the observations of medications in the resident's room failed to reveal that the medications were stored securely, posing a potential safety risk to the other residents residing in the special care unit. During a surveyor interview on 10/28/2025 at approximately 2:30 PM with the Director of Wellness, she acknowledged that the physician's orders did not include the medications that were found in the resident's room and that the resident did not have a physician's order to self-administer his/her medications.	S640		