RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01477	A. BUILDING: _____ B. WING _____	11/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE CENTRE OF NEW ENGLAND	600 CENTRE OF NEW ENGLAND COVENTRY, RI 02816

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S 003	Initial Comments An unannounced State licensure survey, was conducted at this facility on 11/03/2025 through 11/04/2025 to determine compliance with state regulations. Deficiencies were identified.	S 003	Received NOV 21 2025 Facilities Regulation	
S 295	Organization And Management 2.4.14.J Management Of Services 2.4.14 (J) Smoking Policy 1. If the residence permits smoking, it shall have a policy that includes the following: a. Location of designated smoking area(s) separate from the common area; b. Prohibition of smoking in any area other than the designated area(s); c. Adequate ventilation in smoking areas; d. Assessment (upon admission, quarterly, and when a significant change in function occurs) of all residents that smoke to ensure safe smoking capabilities. 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 smoking assessments were completed upon admission, quarterly, and/or when a significant change in function occurs to ensure safe smoking capabilities, for two of two residents reviewed who smoke, Resident ID #s 5 and 6. Findings are as follows:	S 295	12/11/25 The following is the Plan of Correction for Brookdale Centre of New England regarding the Statement of Deficiencies from the community biannual survey investigation on November 4, 2025. This Plan of Correction is not to be construed as an admission of, or agreement with the findings and conclusions in the Statement of Deficiencies. Rather, it submitted as confirmation of our ongoing efforts to comply with statutory regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We remain committed to delivery of quality health	

Facilities Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Thomas Faccione	Executive Director	11-20-25

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S 295	Continued From page 1 1. Record review revealed Resident ID #5 moved into the residence in December of 2022, with a diagnosis including, but not limited to, unspecified lung/bronchus malignant neoplasm (lung cancer). The resident was identified as being a smoker upon admission. Record review revealed the resident had his/her initial smoking assessment completed on 7/11/2023, which was seven months after his/her admission, instead of upon admission, as required. Additional record review revealed the resident had smoking assessments on 4/30/2024, 3/20/2025, and 9/8/2025. Record review failed to reveal evidence of smoking assessments being completed quarterly, as required. 2. Record review revealed Resident ID #6 moved into the residence in June of 2023 with a diagnosis including, but not limited to, chronic obstructive pulmonary disease (a condition that causes damage to the lung restricting the airway). The resident was not identified as being a smoker upon admission. Record review revealed the resident had his/her initial smoking assessment completed on 11/1/2023, when s/he indicated to the residence that s/he was a smoker. Record review revealed the next smoking assessment was not completed until 5/13/2024. Additional record review failed to reveal evidence smoking assessments were being completed quarterly after 11/1/2023 and after 5/13/2024, as required. During a surveyor interview on 11/4/2025 at 1:17 PM with the Assisted Living Director of Nursing, she acknowledged the smoking assessment was not completed upon admission for Resident ID	S 295	2.4.14 (j) Smoking Policy S295 The residents #5 and #6 were re-assessed All residents who smoke are at risk of deficient practice. Community will assess residents following Rhode Island Guidelines which state to include quarterly and on change of condition status. All admissions identified as smokers,will be assessed upon admission, quarterly and/or change of condition. The community's Safety committee will meet monthly to review and monitor for compliance. Quarterly Quality Assurance compliance & review will be conducted by the Health and Wellness Director and/or Executive Director to verify compliance.	11/18/25 11/18/25 Ongoing 11/12/25 Ongoing 11/18/25 Ongoing 1/13/26 Ongoing

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S 295	Continued From page 2 #5. Additionally, she acknowledged the smoking assessments were not completed quarterly for Resident ID #s 5 and 6, as required.	S 295		
S 495	Licensure Requirements 2.4.19.D Rights of Residents 2.4.19 (D) Rights of Residents D. The residence must: 1. Implement written policies and procedures to ensure that all residence employees are aware of and protect the resident's rights contained in these Regulations; 2. Have prominently displayed a posting of the most recent State licensing survey of the assisted living residence; and 3. Provide each resident or his/her representative upon admission, a copy of the provisions of § 2.4.18 of this Part and shall display in a conspicuous place on the premises a copy of the "Rights of Residents." This Requirement is not met as evidenced by: Based on surveyor observation and staff interview, it has been determined that the residence failed to ensure that the most recent State licensing survey results of the assisted living residence was prominently displayed, as required. Findings are as follows: During a surveyor observation of the main entrance/lobby area on 11/3/2025 at 9:50 AM, the residence failed to reveal evidence of the most	S 495 12/1/25	2.4.19 D Rights of Residents S495 Notice of Survey results and protocol on how to obtain survey results is displayed in lobby for resident/visitor access. All resident/visitors residing in the community can be affected by deficient practice. Copy of most recent survey has been stored behind the reception desk and available at any time for viewing. HWD/ED at Safety Meeting committee to monitor for compliance. And HWD/ED at QA committee to review for compliance	11/4/25 11/4/25 Ongoing 11/18/25 Ongoing 1/13/26 Ongoing

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S 495	Continued From page 3 recent State licensing survey results being prominently displayed, as required. During an additional surveyor observation on 11/4/2025 at 1:09 PM, in the presence of the Business Office Manager, she acknowledged that the most recent survey results were not prominently displayed, as required. During a surveyor interview on 11/4/2025 at 1:10 PM with the Executive Director (ED), he acknowledged the most recent State licensing survey results were not prominently displayed, as required. The ED then located the survey results in a cabinet that was not accessible to residents and families.	S 495		
S 560	Residential Care Services 2.4.23.C Dietetic Services 2.4.23 (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, Part 50-10-1 of this Title, Rhode Island Food Code, 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 for the Rhode Island Food Code related to the main kitchen. Findings are as follows:	S 560	2.4.23 C Dietectic Services S560 Food Service Director to inserviced Dining Staff on Food service Codes, sanitation procedures and cleaning schedules All residents at risk for deficient practice.	11/18/25

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S 560	Continued From page 4 1. Record review of the 2022 Food Code published by the U.S. Food and Drug Administration Section 4-601.11 (C) states in part, "...non-contact surfaces of equipment shall be free of an accumulation of...other debris..." During a surveyor observation of the main kitchen on 11/3/2025 at 9:10 AM revealed an accumulation of dusk and debris on the top surface and tubing of the drinks/syrup dispenser. During an additional surveyor observation on 11/4/2025 at 11:53 AM in the presence of the Food Service Director (FSD), he acknowledged the drinks/syrup dispenser had an accumulation of dusk and debris on the top surface and tubing. 2. Record review of the 2022 Food Code published by the U.S. Food and Drug Administration Section 5-202.13 states in part, "...An air gap between the water supply inlet and the flood level rim of the PLUMBING FIXTURE, EQUIPMENT, or nonfood EQUIPMENT shall be at least twice the diameter of the water supply inlet and may not be less than 25 mm (1 inch)..." During a surveyor observation on 11/4/2025 at 11:45 AM in the presence of the FSD, revealed an ice dispenser filled with ice, the drain tubes connected to the ice dispenser were observed lying directly in the drainage without an air gap between the drain tubes and the flood level rim of the plumbing fixture, as required. During a surveyor interview immediately following this observation, the FSD acknowledge the ice dispenser is connected to the beverage system and did not have an air gap. Additionally, he acknowledged the drain tubes from the dispenser were lying directly in the drain.	S 560	2.4.23 C Dietectic Services S560 All dining associates inserviced on proper sanitation procedures for equipment, proper food temp procedure for testing temperature and proper sanitary procedures. Maintnance to correct drain pipes to include gap per US Food Code. Safety committee to review monthly for compliance QA quarterly monitoring by ED/HWD for compliance.	11/18/25 11/18/25 1/13/26 Ongoing

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S 560	Continued From page 5 3. Record review of the 2022 Food Code published by the U.S. Food and Drug Administration Section 4-702.11 states in part, "...Utensils and Food-Contact Surfaces of Equipment shall be SANITIZED before use after cleaning..." During a surveyor observation on 11/4/2025 at 11:55 AM of the lunch meal service in the main kitchen in the presence of a cook, Staff A, he was observed using a dirty soiled dishtowel to wipe a thermometer, then he put the same thermometer into a prepared ready to serve tray of mashed sweet potatoes to check the temperature of the food. Staff A then wiped the thermometer with the same soiled dishtowel and proceeded to put the thermometer into a tray of glazed carrots when he was stopped by the surveyor. During a surveyor interview immediately following the above-mentioned observation, Staff A acknowledged he used the dirty soiled dishtowel to wipe the thermometer prior to placing it into the mashed sweet potatoes, as observed. During a surveyor interview on 11/4/2025 at 11:59 AM with the FSD, he acknowledged Staff A should have used an alcohol wipe to sanitize the thermometer instead of a soiled dishtowel, prior to placing it into any ready to serve food.	S 560		
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	S 640		

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S 640	Continued From page 6 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. 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.	S 640 12/1/25	2.4.26.B 1 Medication Services S640 Associates educated on Med cart protocol when Leaving medication cart unattended. All residents are at risk. Inservice to all staff on med cart protocol, to include Protocol leaving locked and all meds inside. Weekly med cart audits and random audits To monitor for compliance Safety committie to review monthly QA review monitor for compliance ED/HWD to monitor for compliance	11/3/25 11/19/25 11/20/25 Ongoing 11/18/25 Ongoing 1/13/26 Ongoing

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S 640	Continued From page 7	S 640		

(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 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

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S 640	Continued From page 8 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 § 2.4.25(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 one of two medication carts observed on the second floor. Findings are as follows: During a surveyor observation on 11/3/2025 from 9:35 AM to 9:43 AM, a medication cart on the second floor was observed unlocked and not in sight or proximity of staff. Additional observation of this cart revealed a Breztri 160 microgram (mcg)-9 mcg/4.8 mcg (a prescription inhaler used to help control symptoms like shortness of breath) was observed lying on the top surface of the unlocked medication cart. During a surveyor observation and interview with Licensed Practical Nurse, Staff B immediately following the above-mentioned observation, she acknowledged the medication cart was left	S 640		

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S 640	Continued From page 9 unlocked and unattended. Additionally, she acknowledged the inhaler was left on the top surface of the medication cart. During a surveyor interview on 11/4/2025 at 2:02 PM with the Assisted Living Director of Nursing, she was unable to provide evidence the medications were stored securely, as required.	S 640	2.6.2 M	
S1005	Limited Health Services License Require 2.6.2.M Specific Requirements 2.6.2 (M) Specific Requirements M. Assisted living residences licensed to provide limited health services are required to have a licensed physician, a certified nurse practitioner or a licensed physician assistant as a member of the Quality Improvement Committee as defined in § 2.4.3 of this Part. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined the residence, which is licensed to provide limited health services, failed to have a licensed physician, a certified nurse practitioner, or licensed physician assistant as a member of the Quality Improvement Committee. Findings are as follows: Record review of the attendance for the Quality Improvement Committee meetings on 4/24/2024, 7/17/2024, 4/15/2025, and 7/29/2025, failed to reveal a licensed physician, a certified nurse practitioner, or licensed physician assistant was in attendance, as required. During an interview on 11/4/2025 at 10:00 AM,	S1005	S1005 Medical professional inserviced on QA attendance All residents have potential to be affected by deficient practice QA committee inserviced on attendance protocol to include medical professional. QA committee to have Medical professional in attendance. Safety meetings to monitor to verify compliance ED / HWD will review at quarterly QA for compliance	11/28/25 11/28/25 1/13/26 Ongoing 11/18/25 Ongoing 1/13/26 Ongoing

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S1005	Continued From page 10 the Executive Director was unable to provide evidence a licensed physician, a certified nurse practitioner, or licensed physician assistant attended the Quality Improvement Committee meetings on the above-mentioned dates, as required.	S1005		