RI DeDartment of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVJDER/SUPPLIER/CLIA IDENTIFICATIONNUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01521	A BUILDING: _____ a.WING	04/30/2026

Received
MAY 18 2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 003	Initial Comments A biennial survey and a complaint investigation (26ZF11), was conducted at this residence on 4/28/2026 through 4/30/2026 to determine compliance with state laws and regulations. Deficiencies were identified.	S 003	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.	
S 335	Residency Requirements 2.4.16.A Resident Records 2.4.16 (A) Resident Records A. Each residence shall, at a minimum, maintain the following information for each resident: 1. The resident's name; 2. The resident's last address; 3. The name of the person or agency referring the resident to the home; 4. The name, specialty (if any), telephone number, and emergency telephone number of each physician who is currently treating the resident; 5. The date the resident began residing in the home; 6. A list of medications taken by the resident, including dosage, and specific records of medication administration as required by the Department; a. In residences licensed at the M2 level, if a resident refuses to provide the information cited in § 2.4.15(A)(6) of this Part, this fact shall be documented in the resident ' s service agreement.	S335	**As a Plan of Correction (POC)** a) Resident ID #1 and Resident ID #3 continue to reside in the facility. Resident's COC, Physicians orders, initial comprehensive assessment, and dietary allergy list were immediately reviewed and updated. Resident ID #2 no longer resides at the facility.	5/1/26
			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 COC, Facesheet, Physicians Orders, Initial comprehensive assessment and dietary allergy list.	5/15/26
			c) Education will be completed with Wellness Director to educate on resident record compliance (See appendix A).	5/8/26
			d) Random audits will be conducted for resident record accuracy each month. These audits will be with QA committee quarterly (See appendix B).	Ongoing
			e) The DOW/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 QA committee to review progress and ensure ongoing compliance. This process will take place for no less than 3 months; after which time our QA committee will determine if our level of compliance is conducive to discontinuing the formal checks. (See appendix C).	Ongoing

5/19/26

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

Jeni L. Sylvia LCSW, LNHA 5/20/26

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s 335	Continued From page 1 7, Written acknowledgments that the resident has signed and received copies of the rights as provided in R.I. Gen. Laws §.23-17.4-16; 8. Information about any specific health problems of the resident, which may be useful in a medical emergency, including diagnostic and/or therapeutic orders; 9. A record of personal property and funds which the resident has entrusted to the residence; 10. The name, address, and telephone number of a person identified by the resident who should be contacted in the event of an emergency or death of the resident and the name, address, and telephone number of the legal guardian; 11. Any other health-related emergency, or pertinent information which the resident requests the residence to keep on record; 12. A copy of the initial and periodic assessments described in § 2.4.16 of this Part; 13. A copy of the service plan and nurse review as described in § 2.4.16 of this Part; 14. A copy of the residency agreement as described in§ 2.4.14(C) 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 maintain, at a minimum, information about any specific	S335		

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S 335	Continued From page 2 health problems of the resident, which may be useful in a medical emergency, for three of eight residents reviewed, Resident ID #s 1, 2 and 3. Findings are as follows: 1) Record review revealed Resident ID #1 moved into the residence in February of 2026 with a diagnosis including, but not limited to, Alzheimers disease. Review of a Continuity of Care (COC) form, dated 2/17/2026, revealed the resident has allergies to the following: -latex -sweeteners -aspartame -fish Review of the resident's face sheet revealed the resident is allergic to the following: -latex/natural rubber -sweeteners -aspartame -fish -vancomycin Review of the initial comprehensive assessment, dated 2/12/2026, revealed the resident has allergies to the following: -latex -sweeteners -aspartame The resident's "Physician Orders" list the following allergies:	S 335		

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S 335	Continued From page 3 -latex/natural rubber -sweeteners -aspartame -fish -vancomycin During a surveyor interview with the Director of Wellness (DOW) on 4/30/2026 at approximately 2:30 PM, she could not provide evidence that the comprehensive assessment accurately reflected the residents' allergies. 2) Record review revealed Resident ID #2 moved into the residence in March of 2025 with a diagnosis including, but not limited to, Alzheimer's disease. Review of the resident's face sheet revealed the resident is allergic to the following: -atorvastatin -donepezil -hydroxychloroquine -pollen -ragweed -rosuvastatin Review of the initial comprehensive assessment dated 3/20/2025, revealed the resident has allergies to the following: -ragweed Review of the resident's "Physician Orders" revealed the resident has allergies that are consistent with those listed on the resident's face sheet. During a subsequent interview with the Director of Wellness (DOW), she could not provide evidence	S 335		

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S 335	Continued From page 4 that the comprehensive assessment accurately reflected the residents' allergies. 3) Record review revealed Resident ID #3 moved into the residence in February of 2025 with a diagnosis including, but not limited to, Alzheimer's disease. Review of the resident's face sheet revealed the resident is allergic to amoxicillin. Review of the comprehensive assessment, updated on 2/18/2025, revealed the resident has NKA (No Know Allergies). Review of the resident's "Physician Orders" revealed the resident has an allergy to amoxicillin. During a subsequent interview with the DOW, she could not provide evidence the comprehensive assessment accurately reflected the residents' allergies.	S 335		
S 390	Residency Requirements 2.4.17.D Resident Assessment/Service Plans 2.4.17 (D) Resident Assessments and Service 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 detennined that the residence failed to	S 390		

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S 390	Continued From page 5 review the residents' comprehensive assessment at intervals not to exceed (12) months and each time a resident's condition changes significantly for 6 of 8 residents reviewed, Resident ID #s,1, 3, 4, 5, 6, and 7. Findings are as follows: 1) Record review revealed Resident ID #1 moved into the residence in February of 2026 with a diagnosis including, but not limited to, Alzheimer's disease. Review of the "Addendum Appendix C and Service Plan" form revealed that the resident started receiving physical therapy (PT) services on 2/20/2026, occupational therapy (OT) services on 2/26/2026, and speech therapy (SLP) services on 3/24/2026. Review of the comprehensive assessment, dated 2/17/2026, failed to be updated to include a start of care date for PT, OT, and SLP services. During a surveyor interview with the Director of Wellness (DOW) on 4/30/2026 at approximately 2:30 PM, she could not provide evidence that Resident ID #1's comprehensive assessment was updated to include the start of care dates for PT, OT, and SLP services. 2) Record review revealed Resident ID #3 moved into the residence in February of 2025 with a diagnosis including, but not limited to, Alzheimer's disease. Review of the "Addendum Appendix C and Service Plan" form revealed that the resident had a fall on 4/11/2025, 4/18/2025, 4/24/2025, 6/4/2025, and on 6/6/2025. Additionally, it is noted	S 390	As a Plan of Correction (POC) a) Resident ID #1 , #3, #5, #6,#7 continue to reside in the facility. Resident's service plan and appendix C was immediately reviewed and updated. Resident ID #4 no longer resides at the facility. 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 Service Plan and comprehensive assessments to ensure accuracy. c) Education will be completed with Wellness Director to educate on appendix C and Service plan requirements (See appendix D). d) Random audits will be conducted for service plan accuracy. These audits will be quarterly. (See appendix E). e) The DOW/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).	5/1/26 5/15/26 5/8/26 Ongoing 5/1/27

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S 390	Continued From page 6 that on 2/6/2026 the resident was sent out to the hospital due to an increase in behaviors. Furthermore, the form revealed that the resident received PT services from 3/26/2025 through 9/3/2025 and OT services from 2/25/2025 through 4/22/2025. Review of the comprehensive assessment, dated 2/18/2025, failed to be updated with the above-mentioned fall dates. Additionally, the comprehensive assessment failed to be updated to include that the resident had behaviors. Furthermore, the comprehensive assessment failed to reveal the above-mentioned PT and OT start of care and end of care dates. During a subsequent interview with the DOW, she could not provide evidence that Resident ID #3's comprehensive assessment was updated to include the resident falls, behaviors, and the start of care and end of care dates for PT and OT services. 3) Record review revealed Resident ID #4 moved into the residence in September of 2024 with a diagnosis including, but not limited to, Alzheimer's disease. Review of the "Addendum Appendix C and Service Plan" form revealed an annual review completed on 9/9/2025. Review of the comprehensive assessment, updated on 6/2/2025, failed to be reviewed annually. During a subsequent interview with the DOW, she could not provide evidence that the comprehensive assessment was updated yearly.	S390		

STATEMENT OF DEFICIENCIES ANO PIAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATIONNUMBER:	(X2) MULTIPLE CONSTRUCTION	0(3) DATE SURVEY COMPLETED
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S390	Continued From page 7 4) Record review revealed Resident ID #5 moved into the residence in July of 2024 with a diagnosis including, but not limited to, Alzheimer's disease. Review of the "Addendum Appendix C and Service Plan" form revealed the resident received OT services from 10/21/2025 through 2/9/2026. Additionally, the form revealed the resident received SLP services from 10/14/2025 through 3/9/2026. Furthermore, the form revealed the wanderguard was discontinued on 1/17/2025. Review of the comprehensive assessment, dated 7/23/2025, failed to be updated to include the above-mentioned services. The assessment further failed to document that the resident's wanderguard was discontinued. During a subsequent interview with the DOW, she could not provide evidence the comprehensive assessment was updated to include SLP services. Additionally, she could not provide evidence the assessment documented that the wanderguard was discontinued. 5) Record review revealed Resident ID #6 moved into the residence in February of 2026 with a diagnosis including, but not limited to, dementia. Review of the "Addendum Appendix C and Service Plan" form revealed the resident received PT services from 3/3/2026 through 3/30/2026 and OT services from 3/4/2026 through 3/30/2026. Review of the comprehensive assessment, dated 2/2/2026, failed to be updated to include the above-mentioned services. During a subsequent interview with the DOW, she could not provide evidence the above-mentioned	S390		

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s 390	Continued From page 8 services were updated on the comprehensive assessment. 6) Record review revealed Resident ID #7 moved into the residence in February of 2025 with senile degeneration of the brain. Review of the "Addendum Appendix C and Service Plan" form revealed the resident with a start of care date for PT services on 3/19/2025, a start of care date for OT services on 3/4/2025, and a start of care date for SLP services on 3/19/2025. Additionally, the form revealed the resident received a wanderguard on 2/3/2026. Review of the comprehensive assessment, dated 2/3/2025, failed to reveal the resident is receiving the above-mentioned services. Additionally, the assessment failed to reveal that the resident utilizes a wanderguard. During a subsequent interview with the DOW, she could not provide evidence the above-mentioned services were updated on the comprehensive assessment.	S390		
S 415	Residency Requirements 2.4.17.G.3 Resident Assessment Service Plan 2.4.17 (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:	S 415		

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S 415	Continued From page 9 Based on record review and staff interview, it has been determined that the residence failed to update the service plan each time a resident's condition changed significantly for 4 of 8 residents reviewed, Resident ID #s 1, 3, 5, 6, and 7 and the residence failed to address the party responsible for arranging and/or providing the service for 8 of 8 sample residents reviewed, Resident ID #s 1, 2, 3, 4, 5, 6, 7, and 8. Findings are as follows: 1) Record review revealed Resident ID #1 moved into the residence in February of 2026 with a diagnosis including, but not limited to, Alzheimer's disease. Review of the "Addendum Appendix C and Service Plan" form revealed that the resident started receiving physical therapy (PT) services on 2/20/2026, occupational therapy (OT) services on 2/26/2026, and speech therapy (SLP) services on 3/24/2026. Additionally, review of the form revealed the resident had a fall on 2/20/2026. Review of the comprehensive assessment, dated 2/17/2026, revealed under history of falls that the resident had some falls. It was documented on 1/22/2026 that the falls were while in an assisted living facitliy. Review of the service plan, dated 2/17/2026, failed to be updated to include a start of care date for PT, OT, and SLP services. Additionally, the service plan failed to be updated to include the resident is a fall risk with interventions in place. Furthermore, the service plan failed to provide the	S 415	As a Plan of Correction (POC) a) Resident ID #1, #3, #5, #6, #7 continue to reside in the facility. Resident's service plan was immediately reviewed and updated with fall risk and interventions, behavior symptoms and interventions and therapy services initiation and discharge dates, and diet changes. Resident #2 no longer residents at the facility. 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 service plan was reviewed and updated with fall risk and interventions, behavior symptoms and interventions and therapy services initiation and discharge dates. c) Education will be completed with Wellness Director to educate on change in condition being updated on service plan requirements (See appendix D). d) Random audits will be conducted for service plan accuracy. These audits will be annually during residents annual review. (See appendix E). e) The DOW/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).	5/1/26 5/15/26 5/8/26 Ongoing 5/1/27

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s 415	Continued From page 10 responsible party for arranging and providing services for the following: personal care, housekeeping, laundry, and diet. During a surveyor interview with the Director of Wellness (DOW) on 4/30/2026 at approximately 2:30 PM, she could not provide evidence that Resident ID #1's service plan was updated to include the start of care dates for PT, OT, and SLP services. Additionally, she could not provide evidence the service plan included the resident was a fall risk with interventions in place. Furthermore, she could not provide evidence of the responsible party for providing the services mentioned above. 2) Record review revealed Resident ID #2 moved into the residence in March of 2025 with a diagnosis including, but not limited to, Alzheimer's disease. Review of the service plan, dated 3/26/2025, failed to provide the responsible party for arranging and providing services for the following: personal care, housekeeping, laundry, and diet. 3) Record review revealed Resident ID #3 moved into the residence in February of 2025 with a diagnosis including, but not limited to, Alzheimer's disease. Review of the "Addendum Appendix C and Service Plan" form revealed that the resident had a fall on 4/11/2025, 4/18/2025, 4/24/2025, 6/4/2025, and on 6/6/2025, Additionally, it is noted that on 2/6/2026 the resident was sent out to the hospital due to an increase in behaviors. Furthermore, the form revealed that the resident received PT services from 3/26/2025 through 9/3/2025 and OT services from 2/25/2025	S415		

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S 415	Continued From page 11 through 4/22/2025. Review of the service plan, dated 2/18/2025, failed to be updated to include that the resident is a fall and behavior risk with interventions in place. The service plan further failed to be updated to include the start of care dates and end of care dates for PT and OT services. Furthermore, the service plan failed to provide the responsible party for arranging and providing services for the following: personal care, housekeeping, laundry, and diet. During a subsequent interview with the DOW, she could not provide evidence that Resident ID #3's service plan was updated to include resident falls and behaviors with interventions in place. Additionally, she could not provide evidence of the start of care and end of care dates for PT and OT services. Furthermore, she could not provide evidence of the responsible party for providing the services mentioned above. 4) Record review revealed Resident ID #4 moved into the residence in September of 2024 with a diagnosis including, but not limited to, Alzheimer's disease. Review of the service plan, dated 9/9/2025, failed to provide the responsible party for arranging and providing services for the following: personal care, housekeeping, laundry, and diet. During an interview with the DOW, she acknowledged the service plan failed ot designate the responsible party for providing the above-mentioned services. 5) Record review revealed Resident ID #5 moved	S 415		

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S 415	Continued From page 12 into the residence in July of 2024 with a diagnosis including, but not limited to, Alzheimer's disease. Review of the "Addendum Appendix C and Service Plan" form revealed the resident received OT services from 10/2112025 through 2/9/2026. Further review of the form revealed the resident received SLP services from 10/14/2025 through 3/9/2026. Review of the service plan, dated 7/25/2024, failed to be updated yearly and to include the above-mentioned services. Furthermore, the service plan failed to provide the responsible party for arranging and providing services for the following: personal care, housekeeping, laundry, and diet. During a subsequent interview with the DOW, she could not provide evidence the service plan was updated yearly, Additionally, she could not provide evidence that the service plan was updated to include SLP services. Furthermore, she could not provide evidence of the responsible party for providing the services mentioned above. 6) Record review revealed Resident ID #6 moved into the residence in February of 2026 with a diagnosis including, but not limited to, dementia. Review of the "Addendum Appendix C and Service Plan" form revealed the resident received PT services from 3/3/2026 through 3/30/2026 and OT services from 3/4/2026 through 3/30/2026. Additionally, the form revealed the diet was downgraded relative to proteins from regular to pureed. Review of the service plan, dated 2/2/2026, failed	S 415		

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	ALR01521	A BUILDING: _____ B.WING	04/30/2026

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S 415	Continued From page 13 to be updated to include the above-mentioned services. Additionally, the plan further failed to provide evidence the resident's diet changed to pureed proteins. Furthermore, the service plan failed to provide the responsible party for arranging and providing services for the following: personal care, housekeeping, laundry, and diet. During a subsequent interview with the DOW, she could not provide evidence the above-mentioned services were updated on the service plan. Additionally, she could not provide evidence that the resident was receiving a pureed diet. Furthermore, she could not provide evidence of the responsible party for providing the services mentioned above. 7) Record review revealed Resident ID #7 moved into the residence in February of 2025 with senile degeneration of the brain. Review of the "Addendum Appendix C and Service Plan" form revealed the resident with a start of care date for PT services on 3/19/2025, a start of care date for OT services on 31412025, and a start of care date for SLP services on 3/19/2025. Review of the service plan, dated 21312025, failed to be updated to include the above-mentioned services. Additionally, the service plan failed to provide the responsible party for arranging and providing services for the following: personal care, housekeeping, laundry, and diet. During a subsequent interview with the DOW, she	S415	As a Plan of Correction (POC) a) Resident ID #1 , #3, #5, #6,#7 continue to reside in the facility. Resident's service plan and appendix C was immediately reviewed and updated. Resident ID #4 no longer resides at the facility. 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 Service Plan and comprehensive assessments to ensure accuracy. c) Education will be completed with Wellness Director to educate on appendix C and Service plan requirements (See appendix D). d) Random audits will be conducted for service plan accuracy. These audits will be quarterly. (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).	5/1/26 5/15/26 5/8/26 Ongoing 5/1/27

5/19/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATIONNUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 415	Continued From page 14 could not provide evidence the above-mentioned services were updated on the service plan. Furthermore, she could not provide evidence of the responsible party for providing the services mentioned above. 8) Record review revealed Resident ID #8 moved into the residence in June of 2024 with a diagnosis including, but not limited to, dementia. Review of the service plan, dated 6/24/2025, failed to provide the responsible party for arranging and providing services for the following: personal care, housekeeping, laundry, and diet. During a subsequent interview with the DOW, she could not provide evidence of the responsible party for providing the services mentioned above.	S415		
S 480	Licensure Requirements 2.4.19.A Rights of Residents 2.4.19 (A) Rights of Residents A. Every assisted living residence for adults licensed pursuant to these Regulations shall observe the standards stated in R.I. Gen. Laws § 23-17.4-16, "Rights of Residents" and such other appropriate standards as may be prescribed in Rules and Regulations promulgated by the Department with respect to each resident of the residence. This Requirement is not met as evidenced by: Based on surveyor observation and staff interview, it has been determined the residence failed to implement procedures to ensure that all	S480	As a Plan of Correction (POC) a) Residence Survey Binder was immediately removed, reviewed and updated to hold only ALF licensed survey and roster removed. 5/1/26	4/26/26

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S 480	Continued From page 15 of the residence's employees protect the resident's rights contained in these regulations and to observe the standards stated in R.I. Gen. Laws§ 23-17.4-16 (a)(2){ix) relative to identifying information for the residents listed in the facility's survey results binder. Findings are as follows: During a surveyor observation on 4/28/2026 at approximately 8:45 AM of the residence's survey binder, a copy of the "Resident/Staff Roster" dated 10/8/2025 from the survey was revealed. Additionally, "Resident/Staff Roster(s), from the previously licensed nursing home, dated 12/14/2023, 10/19/2022, and 7/22/2021, from the surveys were revealed. During a surveyor interview with the Administrator on 4/28/2026 at approximately 9:00 AM, she could not provide evidence the residents' privacy was protected.	S480		
s 595	Residential Care Services 2.4.23.G(7) Dietetic Services 2.4.23 (G) (7) Dietetic Services 7. No person shall use the title "Manager Certified in Food Safety," or in any way represent himself as a manager certified in food safety unless they hold a current certificate pursuant Part 50-10-2 of this Title, Certification of Managers in Food Safety. This Requirement is not met as evidenced by: Based on record review and staff interview, it has	S 595		

RI Deoartment of Health

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S 595	Continued From page 16 been determined the facility failed to ensure that all food services are conducted in accordance with the rules and regulations pertaining to Certification of Managers in Food Safety (Part 50-10-2 of this Title) that include, but are not limited to the following provisions, residences that primarily serve the elderly and individuals with diminished immune systems shall have a manager certified in food safety present during preparation of all hot potentially hazardous foods. Findings are as follows: Record review revealed the only staff licensed as a manager certified in food safety is the Food Service Director (FSD) and Cook, Staff A. Record review of the residence's menu revealed meals containing hot potentially hazardous foods were prepared on the following dates and times when there are no staff licensed as managers certified in food safety: 3/9/2026, 6:00 AM-11:00 AM 3/23/2026, 6:00 AM-11:00 AM 4/5/2026, 2:30 PM-7:00 PM 4/6/2026, 6:00 AM-10:30 AM 4/20/2026, 6:00 AM-11:00 AM During a surveyor interview with the FSD on 4/30/2026 at 8:00 AM, he could not provide evidence that the facility had a staff member who held the Certification of Managers in Food Safety scheduled on the above dates and times when hot, potentially hazardous food was prepared.	S595	As a Plan of Correction (POC) a) Culinary Department wide evaluation conducted on cook staff. Schedule reviewed and ensured all meals are prepared by staff with Certification in Food Safety when hot and potentially hazardous food is prepared. b) Audit conducted and all cook staff, certification and application sent to department of health immediately. Education provided to Director of Culinary (appendix G). d) Random audits will be conducted for license certification on an annual basis. e) The Director of Culinary 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 H).	5/1/26 5/1/26 Ongoing
S 640	Residential Care Services 2.4.26.B.1 Medication Services	S 640		

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S640	Continued From page 17 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. 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	S640	As a Plan of Correction (POC) a) Resident ID #1, continue to reside in the facility. Resident's physicians' orders reviewed, family notified of urgency and importance to deliver authorized medication in timely manner. Medication obtained from family and present for administration as needed. Resident's over the counter medications labeled with directions for use. Resident ID #6 currently resides in the facility. Resident's physician orders reviewed and all discontinued medications removed.	5/1/26
			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 Medication Storage Cart.	5/18/26
			c) Education will be completed with CMT staff to educate on proper medication storage, disposal of medication and educated on process for family notification and education on the importance and urgency for timely receipt of medications (See appendix I). Staff member D receive a med pass evaluation and obtain education on the 5 Rights of Medication Administration.	5/18/26
			d) Random audits will be conducted on medication storage cart. These audits will be conducted monthly.	Ongoing
			e) The DOW/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 J).	5/1/27

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S 640	Continued From page 18 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, (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	S640		

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S 640	Continued From page 19 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 § 2.4.25(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 three of three sample residents reviewed, Resident ID #s 1, 6, and 7. Findings are as follows: A. During a surveyor observation of the third floor medication cart on 4/30/2026 at approximately B:50 AM, the following was revealed relative to Resident ID #s 1 and 6's medications. 1) Record review of Resident ID #1's physician's order revealed the resident is prescribed the following medications:	S640		

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s 640	Continued From page 20 -guaifenesin liquid 100 mg (milligrams)/5 ml (milliliters). Take every 4 hours as needed (prn). This medication was not available to be administered, -acetaminophen 500 mg tablet. Take 2 tablets for hip pain twice a day prn (as needed). This medication bottle had no directions for use, During a surveyor interview with Certified Medication Technician (GMT), Staff B, on 4/30/2026 at approximately 8:50 AM, she acknowledged the resident's guaifenesin medication was not in the medication cart and acknowledged the acetaminophen bottle did not have directions for use. 2) Record review of Resident ID #6's physician's order revealed the following medications were discontinued on the following dates: -Iron 65 mg, 3/17/2026 -donepril 10 mg, 3/30/2026 -simvastatin 40 mg, 3/30/2026 -folic acid 1 mg, 3/30/2026 The above-mentioned medications were observed in the medication cart on 4/30/2026 at approximately 9:00 AM. During a surveyor interview with GMT, Staff C, on 4/30/2026 at approximately 9:00 AM, she acknowledged the above-mentioned medications were in the medication cart. She further revealed the resident is no longer prescribed these medications. B. During a surveyor observation of the second floor medication cart on 4/28/2026 at approximately 9:10 AM, the following was	S640		

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s 640	Continued From page 21 revealed relative to Resident ID #*Ts* medications: 1) Record review revealed Resident ID #7's physician's order revealed the resident is prescribed the following medications: -acetaminophen 325 mg tablet Take every 8 hours pm. The medication in the cart read acetaminophen 500 mg, with no directions for use, -aspirin 81 mg. Take 1 tablet every morning. This medication bottle had no directions for use. During a surveyor interview with CMT, Staff D, on 4/30/2026 at approximately 9:10 AM, she acknowledged the above-mentioned medications had no directions for use and the acetaminophen order for 325 mg tablet did not match the bottle of acetaminophen that was in the medication cart.	S 640		
S 771	Physical Plant 2.4.32.1 Safety Requirements 2.4.32 (I) Safety Requirements I. Each residence shall develop and maintain a written plan and procedure for the evacuation of the premises in case of fire or other emergency, based on F1/F2 licensure requirements, Fire Safety Code - General Provisions (R.I. Gen. Laws Chapter 23-28.1) requirements. 1. Emergency steps of action shall be clearly outlined and posted in conspicuous locations throughout the residence. 2. Drills simulating fire emergencies, testing the effectiveness of the fire evacuation plan shall be conducted at least six (6) times per year on a bimonthly basis with a minimum of two (2) drills	S 775		

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S 775	Continued From page 22 conducted during the night when residents are sleeping with documentation of observed ability of residents to carry out evacuation procedures. At least fifty percent (50%) of these drills shall be obstructed drills, as defined in Fire Safety Code - General Provisions (R.I. Gen. Laws Chapter 23-28.1). 3. The drills shall be permitted to be announced in advance to the residents. The drills shall involve the actual evacuation of all residents to an assembly point as specified in the emergency plan and shall provide residents with experience in egressing through all exits and means of escape required by the Fire Safety Code - General Provisions (R.I. Gen. Laws Chapter 23-28.1), Exits and means of escape not used in any fire drill shall not be credited in meeting the requirements of the Fire Safety Code - General Provisions (R.I. Gen. Laws Chapter 23-28.1). a. Documentation offire drills shall be maintained and shall include no less than the following information: (1) Name of the person conducting the drill; (2) Date and time of the drill; (3) Amount of time taken to evacuate the building or unit; (4) Type of drill (i.e., obstructed or unobstructed); (5) Record of problems encountered and steps taken to rectify them;	S775	As a Plan of Correction (POC) a) Facility reviewed and updated policy and procedure for fire drill. b) Education will be completed with Director of Environmental Services safey requirements (See appendix K). d) Fire Drill evaluation review will be conducted quarterly for compliance with QA Committee. e) The Director of Environment Services 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 L).	5/1/26 5/8/26 Ongoing 5/1/27

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S 775	Continued From page 23 (6) Employee observation of each resident' s ability to carry out evacuation procedures. 4. Residents shall be instructed in all alternative methods of escape since the primary exit may be unusable due to fire and/or smoke. Such instruction shall be documented in the record described in§ 2.4.31(I)(3)(a) of this Part. 5. Each new resident shall be oriented to the fire drill procedure on admission, with documentation of the orientation placed in the resident's record. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined the residence failed to ensure drills simulating fire emergencies, be conducted at least six (6) times per year on a bimonthly basis and at least fifty percent (50%) of these drills shall be obstructed drills as in Fire Safety Code-General Provisions (R.I. Gen. Laws Chapter 23-28.1). Findings are as follows: Record review revealed fire drills were conducted on the following dates in 2025 and 2026: 2/6/2025, 4/1/2025, 6/7/2025, 7/12/2025, 8/26/2025, 9/13/2025, 11/15/2025, 1/9/2026, and 3/13/2026, Further review of the fire drill documentation revealed that 3 of the drills, 7/12/2025, 9/13/2025, and 119/2026, were recorded as obstructed which is 33.3%, not the required 50%.	S 775		

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S 775	Continued From page 24 During a surveyor interview with the Director of Environmental Services on 4/28/2026 at 10:31 AM, he could not provide evidence that 50% of the drills were obstructed.	S 775	As a Plan of Correction (POC) a) Facility wide environmental rounds to ensure all chemicals were secured.	4/30/26
S921	Special Care License Requirements 2.5.2.L Specific Requirements 2.5.2 (L) Specific Requirements L. The Alzheimer Dementia Special Care Unit/Program shall provide a secure distinct living environment appropriate for the resident population. This requirement may include, but not be limited to, a locked unit, secured perimeter, or other mechanism to ensure resident safety and quality of life. The residence shall have elopement policies in place, specific to the Unit/Program. This Requirement is not met as evidenced by: Based on observation and staff interview, it has been determined the residence failed to ensure the Alzheimer dementia Special Care Unit/Program provided a safe distinct living environment relative to chemicals being easily accessed by residents. Findings are as follows: During a surveyor observation on 4/28/2026 at approximately 9:00 AM, the bottom unlocked cabinet in the third-floor kitchenette contained a bottle of Satin Shine (the bottle stated intentional misuse by deliberate inhalation may be harmful or fatal). During a subsequent observation near the	S925	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. c) Education provided to all facility staff on proper storage of hazardous chemicals. (See appendix M). d) Environmental rounds will be conducted monthly to ensure compliance with special care license requirements. These audits will be conducted monthly. e) The Director of Environmental Services 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 N).	5/18/26 Ongoing 5/1/27

5/1/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01521	A. BUILDING: _____ a.WING	04/30/2026

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

(X4)ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 925	Continued From page 25 kitchenette was an unattended activities cart, which contained a bottle of nail polish remover. During a surveyor interview, following the above observations, with the Administrator, she acknowledged the Satin Shine and nail polish remover were not kept secured. During a surveyor observation on 4/28/2026 at approximately 9:25 AM, the bottom unlocked cabinet in the second-floor kitchenette contained a bottle of Satin Shine. Following the above observation Certified Medication Technician, Staff C, acknowledged the bottle of Satin Shine was not in a locked cabinet. During a surveyor observation of the laundry room, on the second floor, at approximately 9:30 AM, the door was opened and no staff were observed nearby, a 39-liter bottle ofTide (laundry detergent) was kept in there as well as a spray bottle of Oxivir (a disinfectant cleaner). During a surveyor interview following the above observation with Housekeeper, Staff E, she revealed she was next door cleaning. During a surveyor interview with the Administrator on 4/30/2026 at approximately 2:30 PM, she could not provide evidence that the residents were in a safe living environment.	S925		