RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01494	A. BUILDING: _____ B. WING _____	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CLARE - NEWPORT	309 SPRING STREET NEWPORT, RI 02840

(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 An unannounced biennial State Licensure survey and a complaint/incident investigation survey (RD7W11, 01/08/2026) were conducted at this residence. Deficiencies were identified relative to the State Licensure survey.	S 003	Received JAN 23 2026 Facilities Regulation	
S 385	Residency Requirements 2.4.17.C Resident Assessment/Service Plans 2.4.17 (C) Resident Assessment and Service Plans C. The Department-approved assessment form, or such other assessment form as approved by the Department, shall be utilized in completing the assessment on each resident who is admitted to the residence. (Approved Department form is available for downloading online at http://health.ri.gov/forms/assessment/AssistedLivingResident.pdf). 1. Assisted living residences not intending to use the Department ' s assessment form shall submit their proposed assessment forms with a cover letter of intent to the Center for Health Facilities Regulation as specified in §2.4.6(A) of this Part. 2. All assessment forms shall report information appropriate to determine compatibility and compliance with the residency criteria, and shall indicate that the resident ' s needs can be met by the assisted living residence within its licensure level, and shall gather information appropriate for the development of an individualized service plan. a. The assessment form shall be designed to demonstrate compliance with the	S 385	Resident ID #1 Comprehensive Assessment has been updated to accurately reflect the resident's current needs and abilities in order to formulate the service plan. Resident ID #2 Comprehensive Assessment has been updated to accurately reflect the resident's current needs and abilities in order to formulate the service plan. Resident ID #3 Comprehensive Assessment has been updated to accurately reflect the resident's current needs and abilities in order to formulate the service plan. Random audits were conducted of Comprehensive Assessments to ensure these accurately reflect the resident's current needs and abilities. Education was provided to the Program Director on the completion of Comprehensive Assessments. Audits of the Comprehensive Assessments will be conducted by the Clinical Services Director/designee monthly and presented to QAPI committee until it is determined compliance is achieved.	01/26/26

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

Executive Director 1/23/26

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S 385	Continued From page 1 assisted living residence ' s criteria for residency. b. The assessment form shall also be designed to demonstrate that the assisted living residence can meet the resident's needs and preferences. 3. The assessment form shall also be designed to provide information appropriate for the development of an individualized service plan in accordance with § 2.4.16(G)(1) of this Part. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined that the residence failed to accurately reflect the resident's needs and abilities on the comprehensive assessment, to accurately formulate the service plan, for 3 out of 5 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 March of 2024 with a diagnosis including, but not limited to, dementia. Record review of the resident's comprehensive assessment updated on 12/5/2025, revealed under "Section Two-Activities of Daily Living," the following: Toileting: minimal assist Dressing: moderate assist Bathing: minimal assist	S 385	The Executive Director is responsible to ensure compliance.	

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S 385	Continued From page 2 Record review of the resident's service plan dated 12/8/2025, revealed the following: Toileting: extensive assist Dressing: extensive assist Bathing: dependent/total assistance 2. Record review revealed Resident ID #2 moved into the residence in April of 2025 with a diagnosis including, but not limited to, epilepsy (a neurological disorder characterized by recurrent seizures). Record review of the resident's comprehensive assessment, dated 12/2/2025, revealed under "Section Two-Activities of Daily Living," the following: Toileting: minimal assist Dressing: minimal assist Bathing: left blank Record review of the resident's service plan dated 12/4/2025, revealed the following: Toileting: extensive assist Dressing: extensive assist Bathing: extensive assist 3. Record review revealed Resident ID #3 moved into the residence in October of 2025 with a diagnosis including, but not limited to, dementia. Record review of the resident's comprehensive	S 385		

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S 385	Continued From page 3 assessment dated 9/22/2025, revealed under "Section Two-Activities of Daily Living," the following: Toileting: moderate assist Bathing: left blank Record review of the resident's service plan dated 10/10/2024, revealed the following: Toileting: extensive assist Bathing: extensive assist During a surveyor interview with the Administrator on 1/8/2026 at approximately 11:30 AM, she could not provide evidence that the above-mentioned assessments accurately reflected the resident's needs to formulate the service plan accurately.	S 385		
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 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	S 390	Resident ID #2 Comprehensive Assessment has been updated to accurately reflect any outside services being provided to the resident. Resident ID #3 Comprehensive Assessment has been updated to accurately reflect resident's current needs and abilities and any outside services being provided to the resident.	01/26/26

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S 390	Continued From page 4 relative to outside services for 2 out of 4 residents reviewed, Resident ID #s 2 and 3. 1. Record review revealed Resident ID #2 moved into the residence in April of 2025 with a diagnosis including, but not limited to, epilepsy (a neurological disorder characterized by recurrent seizures). Review of the entrance conference form revealed the resident is receiving physical therapy (PT). Review of the resident's progress notes, revealed a note dated 12/4/2025 that the resident returned to the assisted living residence from a skilled facility. Record review of the resident's comprehensive assessment, dated 12/2/2025, indicated that the resident was receiving PT and occupational therapy (OT). The assessment failed to accurately reflect the resident's receipt of OT and add a start of care date for PT. During a surveyor interview with the Administrator on 1/8/2026 at approximately 11:30 AM, she could not provide evidence the assessment was updated to reflect outside services accurately. 2. Record review revealed Resident ID #3 moved into the residence in October of 2025 with a diagnosis including, but not limited to, dementia. Review of the entrance conference form revealed the resident is receiving wound care services. Review of the record revealed notes from an outside provider. The resident was receiving PT from 12/24/2025 to present.	S 390	Random audits were conducted of Comprehensive Assessments to ensure these accurately reflect the resident's current needs and abilities. Including outside services received. Education was provided to the Program Director on the completion of Comprehensive Assessments. Audits of the Comprehensive Assessments will be conducted monthly by the Clinical Services Director/designee monthly and presented to QAPI committee until it is determined compliance is achieved. The Executive Director is responsible to ensure compliance.	

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S 390	Continued From page 5 During a surveyor interview with the Administrator on 1/8/2026 at approximately 11:00 AM, she revealed the resident is receiving wound care and PT services with a start of care of 11/17/2025 and 12/24/2025, respectively. Record review of the resident's comprehensive assessment dated 9/2/2025 failed to be updated to reflect the resident is receiving wound care and PT services. Additionally, the comprehensive assessment, "Section Six-Medications," was not fully completed and "Section Seven-Assessment Summary," was not completed. During a surveyor interview with the Administrator on 1/8/2025 at approximately 11:30 AM, she acknowledged the assessment was not updated to reflect the resident receiving wound care and PT services. She further acknowledged Section Six of the assessment was not completed in its entirety and Section Seven was not completed, as required.	S 390		
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: Based on record review and staff interview, it has been determined the residence failed to review	S 415	Resident ID #1 Resident service plan has been updated to reflect current care and services provided. In addition, service plan has been signed by RN and Administrator. Resident ID #2 Resident service plan has been updated to reflect current care and services provided. In addition, service plan has been signed by the Administrator.	01/26/26

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S 415	Continued From page 6 the resident's service plan at intervals not to exceed (12) months and each time a resident's condition changes significantly, requiring outside services, for 3 of 4 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 March of 2024 with a diagnosis including, but not limited to, dementia. Review of the record revealed the resident is receiving palliative care with a start of care date of 12/5/2025. Record review of the resident's service plan, dated 12/8/2025, failed to reflect the resident is receiving palliative care. Additionally, the service plan failed to reveal the Registered Nurse (RN) and Administrator's signature. During a surveyor interview with the Administrator on 1/8/2026 at approximately 11:30 AM, she could not provide evidence the service plan reflected the above-mentioned service. Additionally, she could not provide evidence of the RN or Administrator's signatures. 2. Record review revealed Resident ID #2 moved into the residence in April of 2025 with a diagnosis including, but not limited to, epilepsy (a neurological disorder characterized by recurrent seizures). Review of the entrance conference form revealed the resident is receiving physical therapy (PT).	S 415	Resident ID #3 Resident service plan has been updated to reflect current care and services provided. In addition, service plan has been signed by the Administrator. Random audits were conducted of Service Plans to ensure they accurately reflect the resident's current needs, outside services received and have required signatures by the RN and Administrator. Education was provided to the Program Director on the completion and accuracy of Service Plans. Audits of the Service Plans will be conducted monthly by the Clinical Services Director/designee monthly and presented to QAPI committee until it is determined compliance is achieved. The Executive Director is responsible to ensure compliance.	

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S 415	Continued From page 7 Record review of the service plan, dated 12/4/2025, failed to reveal that the resident is receiving PT. Additionally, the service plan failed to reveal the Administrator's signature. During a surveyor interview with the Administrator on 1/8/2026 at approximately 11:30 AM, she could not provide evidence the service plan was updated to include the resident is receiving PT services. Additionally, she could not provide evidence of her signature on the service plan. 3. Record review revealed Resident ID #3 moved into the residence in October of 2025 with a diagnosis including, but not limited to, dementia. Review of the entrance conference form revealed the resident is receiving wound care services. Review of the record revealed notes from an outside provider. The resident was receiving PT from 12/24/2025 to present. During a surveyor interview with the Administrator on 1/8/2026 at approximately 11:00 AM, she revealed the resident is receiving wound care and PT services with a start of care of 11/17/2025 and 12/24/2025, respectively. Record review of the service plan, dated 10/10/2025, failed to reflect it was updated relative to the above-mentioned services. Additionally, the service plan failed to reveal the Administrator's signature. During a surveyor interview with the Administrator on 1/8/2026 at approximately 11:30 AM, she	S 415		

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S 415	Continued From page 8 could not provide evidence the service plan was updated to include the above-mentioned services. Additionally, she could not provide evidence of her signature on the service plan.	S 415		
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, record review, and staff interview, it has been determined that the facility failed to comply with all appropriate standards of the Rhode Island Food Code relative to the main kitchen, Bailey's kitchenette, third floor kitchen, and the Sachuest kitchenette. Findings are as follows: Record review of the 2022 Food Code published by the U.S. Food and Drug Administration Section 4-601.11A states in part,"...Equipment food contact surfaces...shall be clean to sight and touch..." 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..."	S 560	1. Can opener was cleaned of debris. Salt scattered on the inside bottom of a white container was emptied and container was cleaned. Three cutting boards were disposed of and replaced with new cutting boards. A. Shelf with spilled sugar and yellow cake mix was cleaned. Pest control plan in place for flies. B. Deli unit inside lid was cleaned for the accumulation of crumbs. Butter package that was opened was disposed of. C. Walk-in freezer was swept and cleaned. 2. Bailey's kitchen microwave was cleaned. 3. Third floor kitchenette under sink was cleaned. Area near ice machine was cleaned.	01/26/26

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S 560	Continued From page 9 Record review of the 2022 Food Code published by the U.S. Food and Drug Administration Section 5.501.113 states in part, "receptables and waste handling units for refuse...shall be kept covered..." Record review of the 2022 Food Code published by the U.S Food and Drug Administration Section 3-501.16 (A) (2) states in part, "...except during preparation, cooking, or cooling... time/temperature control for food safety shall be maintained at 51 degrees C. (Celsius) 41 degrees F(Fahrenheit)..." 1. During a surveyor observation of the main kitchen on 1/6/2026 at approximately 8:45 AM, in the presence of the Director of Culinary, the following was observed: -can opener with an accumulation of debris. -salt scattered on the inside bottom of a white container that contains a bottle of honey and waffle syrup. -three cutting boards (green, light green, and red) were scored. During a surveyor interview with the Director of Culinary, following the above observations, he acknowledged the can opener and the container were not clean. He further acknowledged the above cutting boards were scored. A. Surveyor observation of the dry storage area, in the presence of the Director of Culinary, the following was observed: -a shelf with a pile of spilled sugar and yellow	S 560	Ice cream was disposed of and frost removed. Hood slats were cleaned. Red and green cutting boards were replaced. Underneath the hood of the deli bar was cleaned. Lid was placed on trash container when not in use. 4. Seafood salad and coleslaw was disposed of. The Food Service Director conducted a full house sanitation audit. Dietary staff education was provided on sanitation and proper food temperatures. The Food Service Director/Designee will conduct monthly audits and findings will be brought to QAPI committee until compliance is determined. The Executive Director is responsible to ensure compliance.	

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S 560	Continued From page 10 cake mix. -flies were noted to be flying in the area. During a surveyor interview with the Director of Culinary, following each observation, he acknowledged the shelf needed to be cleaned. He further acknowledged the flies. B. Surveyor observation of the deli unit, in the presence of the Director of Culinary, the following was observed: -along the inside of the lid had an accumulation of crumbs. -a butter package that was opened, half of it dried out. During a surveyor interview with the Director of Culinary, following the observation, he acknowledged inside the deli unit needed cleaning and he discarded the butter. C. Surveyor observation of the walk-in freezer, in the presence of the Director of Culinary, the following was observed: -behind and underneath the shelves was an accumulation of food matter, small pieces of paper, and tape. During a surveyor interview with the Director of Culinary, following the observation, he acknowledged the floor in the freezer was not kept clean. 2. During a surveyor observation of the Bailey's kitchen on 1/6/2026 at 9:45 AM the following was observed:	S 560		

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S 560	Continued From page 11 -inside the microwave had dried liquid and food matter. During a surveyor interview on 1/6/2026 at 9:45 AM, Culinary Aide, Staff A, could not provide evidence that the microwave was clean. 3. During a surveyor observation of the third-floor kitchenette at approximately 10:25 AM, the following was observed: -under the sink were wrappers, bottle caps, and debris. -next to the ice machine on the floor were a bunch of sugar packets and plastic wrappers. -the ice cream freezer with 4 large containers of ice cream not covered tightly and the inside of the freezer had a build-up of frost. -hood slats with a heavy accumulation of debris. -red and green cutting boards stored with food matter on them. -underneath the hood of the deli bar along the back edge and corners, had an accumulation of crumbs. -no lid on the trash container when not in use. During a surveyor interview with the Service Manager, Staff B, on 1/6/2026 at 10:40 AM, she acknowledged under the sink and next to the ice machine was not kept clean, she further acknowledged the hood slats had a heavy accumulation of debris, the cutting boards and underneathe the hood of the deli bar was not kept	S 560		

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S 560	Continued From page 12 clean, and the trash container did not contain a lid. 4. During a surveyor observation on 1/7/2026 at approximately 12:40 PM of the Sachuest kitchenette on the second floor, was a pan of seafood salad and a pan of coleslaw sitting out on the counter during service, not on ice. During a surveyor interview with Nursing Assistant (NA), Staff C, following the above observation, she was asked to take the temperature of the above items at the end of service. The temperatures of the above items were 54 degrees Fahrenheit and 53 degrees Fahrenheit respectively. During a surveyor interview with the Director of Culinary Services on 1/7/2026 at approximately 2:00 PM, he could not provide evidence the above items were kept out of the temperature danger zone.	S 560		