RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01522	A. BUILDING: _____ B. WING _____	03/31/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANTOINE RESIDENCE PRIMROSE LANE	10 RHODES AVE NORTH SMITHFIELD, RI 02896

(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 was conducted at this residence 3/30/2026 - 3/31/2026; deficiencies were identified.	S 003	Received APR 13 2026 Facilities Regulation	
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. 7. Written acknowledgments that the resident	S 335	Resident #1's allergies were updated on the initial comprehensive assessment and face sheet to include all allergies as per COC. Resident #2's allergies were updated on the comprehensive assessment to include all allergies as per the COC and face sheet. An audit was conducted of all comprehensive assessments and face sheets on all residents to ensure allergies were documented correctly. Education was provided to Wellness Director on documentation of allergies on the comprehensive assessment, physician orders and face sheets. The Wellness Director/designee will conduct monthly audits of comprehensive assessments, physician orders and face sheets to ensure documentation compliance with listed allergies. Audit findings will be presented to the QAPI committee, until determined compliance is achieved. The Executive Director is ultimately responsible to ensure compliance.	4/13/26

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

Jenny Simmons (W, ED) — Exec Director — 4/13/26

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S 335	Continued From page 1 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 health problems of the resident, which may be useful in a medical emergency, for two of three	S 335		

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S 335	Continued From page 2 residents reviewed, Resident ID #s 1 and 2. Findings are as follows: 1) Record review revealed Resident ID #1 moved into the residence in March of 2026 with a diagnosis including, but not limited to, dementia. Review of a Continuity of Care (COC) form, dated 8/14/2025, revealed that the resident has allergies to the following medications: -codeine -gemfibrozil -IV dye/ iodine containing contrast media (chemical substances containing iodine injected or ingested during X-ray and CT (computed tomography) scans to improve the visibility of blood vessels, organs, and tissues). -statin drugs Review of the resident's face sheet revealed the resident is allergic to the following medications: -codeine -gemfibrozil Review of the initial comprehensive assessment, dated 1/7/2026, revealed the resident has allergies that are consistent with those listed on the resident's COC form. The resident's "Physician Orders" list the allergies to medications as follows: -codeine -gemfibrozil During a surveyor interview with the Wellness Director on 3/31/2026 at approximately 2:45 PM,	S 335		

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S 335	Continued From page 3 she could not provide evidence the face sheet and the resident's physician's orders accurately reflected the resident's allergies. 2) Record review revealed Resident ID #2 moved into the residence in December of 2024 with a diagnosis including, but not limited to, Alzheimer's disease. Review of a COC form, dated 7/29/2024, revealed that the resident has allergies to the following medications: -adhesive remover (paper tape and Tegaderm are ok to use) -atorvastatin/Lipitor -codeine/codeine sulfate -lisinopril -penicillins -sulfa antibiotics -tape Review of the resident's face sheet revealed the resident has allergies that are consistent with those listed on the resident's COC form. Review of the comprehensive assessment, dated 12/2/2025, revealed that the resident has "NKA (no known allergies)." 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 Wellness Director on 3/31/2026, she could not provide evidence that the comprehensive assessment accurately reflected the resident's allergies.	S 335		

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S 390	Continued From page 4	S 390		
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 that the residence failed to review the residents' comprehensive assessment at intervals not to exceed (12) months and each time a resident's condition changes significantly for 2 of 2 residents reviewed for outside services, Resident ID #s 1 and 3. Findings are as follows: Review of the list of residents receiving outside services revealed Resident ID #s 1 and 3. 1) Record review revealed Resident ID #1 moved into the residence in March of 2026 with a diagnosis including, but not limited to, dementia. Review of the outside agency notes revealed the resident started receiving physical therapy (PT) services on 3/19/2026. Review of the comprehensive assessment, dated 1/7/2026, failed to be updated to include a start of care date for PT services. During a surveyor interview with the Wellness Director on 3/31/2026 at approximately 2:30 PM, she could not provide evidence that Resident ID	S 390	Resident #1's comprehensive assessment was updated to include start date for PT (physical therapy) services on 3/19/26. Resident #3's comprehensive assessment was updated to include start and end date for OT (occupational therapy) services from 2/12/26 to 3/13/26. An audit was conducted on all comprehensive assessments to ensure PT/OT/outside services' start and end dates were documented correctly. Education was provided to the Wellness Director/designee on documentation of start and end dates for PT/OT/Outside services on comprehensive assessments. The Wellness Director/designee will conduct monthly audits of comprehensive assessments and face sheets to ensure documentation compliance with outside services being provided. Audit findings will be presented to the QAPI committee, until determined compliance is achieved. The Executive Director is ultimately responsible to ensure compliance.	4/13/26

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S 390	Continued From page 5 #1's comprehensive assessment was updated to include the start of care date for PT services. 2) Record review revealed Resident ID #3 moved into the residence in July of 2024 with a diagnosis including, but not limited to, Alzheimer's disease. Review of the resident's service plan, dated 1/23/2026, revealed it was updated to include a start of care date and an end of care date for occupational therapy (OT) 2/12/2026 to 3/13/2026 respectively. Review of the comprehensive assessment, dated 2/11/2026, failed to be updated to include a start and an end of care date for OT services. During a subsequent surveyor interview with the Director of Wellness on 3/31/2026, she could not provide evidence that Resident ID #3's comprehensive assessment was updated to include the start of care date and an end of care date for OT services.	S 390		
S 775	Physical Plant 2.4.32.I 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.	S 775	The "Record of Drills Form" was updated to include a check off box to indicate if the drill is obstructed (yes or no) or not. Education was provided to Maintenance Director/Wellness Director on documentation of obstructed fire/emergency drills. The Executive Director/designee will conduct monthly audits of fire/emergency drills to ensure that at least 50% of drills are obstructed and documented accordingly.	4/13/26

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S 775	Continued From page 6 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 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 of fire 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	S 775	Audit findings will be presented to the QAPI committee, until determined compliance is achieved. The Executive Director is ultimately responsible to ensure compliance.	

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S 775	Continued From page 7 unobstructed); (5) Record of problems encountered and steps taken to rectify them; (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 2024: 11/12/2024 and 12/10/2024. Record review revealed fire drills were conducted on the following dates in 2025:	S 775		

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S 775	Continued From page 8 1/7/2025, 2/10/2025, 3/8/2025, 4/7/2025, 5/9/2025, 6/7/2025, 7/2/2025, 8/7/2025, 9/7/2025, 10/3/2025, 11/14/2025, and 12/10/2025. Record review revealed fire drills were conducted on the following dates in 2026: 1/9/2026, 2/12/2026, and 3/10/2026. Further review of the fire drill documentation failed to reveal that any of the drills were obstructed. During a surveyor interview with the Maintenance Director on 3/30/2026 at approximately 9:50 AM, he could not provide evidence that 50% of the drills were obstructed.	S 775		