STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01409	A. BUILDING: _____ B. WING _____	C 11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN COURT ASSISTED LIVING	180 FRANKLIN STREET BRISTOL, RI 02809

(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 complaint/incident investigation survey, ACTS reference numbers 102412, 102457, 102478, and 102512, were conducted at this residence on 11/10/2025 through 11/21/2025 to determine compliance with state regulations. Deficiencies were identified as a result of this survey.	S 003		
S 380	Residency Requirements 2.4.17.B Resident Assessment/Service Plans 2.4.17 (B) Resident Assessment and Service Plans B. This assessment shall be used to determine if the resident's needs and preferences can be met by the assisted living residence within the range of services offered by the residence at its licensure level. The conclusions shall be shared with the resident or the resident's representative. If a reasonable accommodation can enable a resident to live in an assisted living residence, the nature of that accommodation and a plan for implementation or reason for denial should be included in the assessment. Provided, however, any reasonable accommodation provided to a resident shall be provided within the range of services offered by the residence at its licensure level. 1. As part of the initial resident admission and assessment process, the residence shall review and consider any notice provided to the facility as required in R.I. Gen. Laws § 42-56-10(23) concerning the resident's or prospective resident's status on parole and recommendations, if any, from the Department of Corrections regarding safety and security measures.	S 380		

Received
DEC 23 2025
Facilities Regulation

2/9/26

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

ANGELA P. CABRAL ADMINISTRATOR 12/23/25

RI Department of Health

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S 380	Continued From page 1 This Requirement is not met as evidenced by: Based on record review and staff interview it has been determined the residence failed to complete an assessment which shall be used to determine if the resident's needs and preferences can be met by the assisted living residence within the range of services offered by the residence at its licensure level for one of one residents reviewed for initial comprehensive assessments, Resident ID #1. Findings are as follows: Record review revealed Resident ID #1 was admitted to the residence in December of 2024 with a diagnosis of Alzheimer's disease. Review of the initial comprehensive assessment dated 11/22/2024 failed to reveal evidence of the care needs relative to the resident's wandering while residing at an independent living facility, prior to admission. Additional review of the initial comprehensive assessment revealed the resident would go for a walk and forget his/her way back to the facility. Further review of the initial assessment failed to reflect the care services that would be required for wandering, as the residence does not hold a license for a secure special care unit. During an interview on 11/10/2025 at approximately 2:45 PM with the Administrator, she acknowledged that the resident is an elopement risk, the residence does not have a secure special care unit license, and the resident's care needs are outside the range of services able to be provided by the residence at	S 380	S380: Moving forward, our nursing staff will conduct a comprehensive review of an applicant's wandering history as part of the initial assessment for residents diagnosed with Alzheimer's disease. For residents deemed appropriate for our community, we will implement frequent wellness safety checks to mitigate wandering risks. Regarding Resident #1 [redacted] service plan originally required safety checks every two hours. Following the recent incident, we have increased these to one-hour intervals. The family has also provided a tracking device for the resident's safety while we collectively search for a facility capable of providing a higher level of care fo[redacted] declining memory. It should be noted that prior to this, Resident #1 had no history of wandering, behavioral issues, or difficulties with self-preservation during evacuations at our residence.	12/23/25

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S 380	Continued From page 2 their licensure level.	S 380		
S 450	Residency Requirements 2.4.18.F Reporting Requirements 2.4.18 (F) Reporting Requirements F. Any elopement of a resident that results in police being called must be reported in writing to the Department within twenty-four (24) hours or by the end of the next business day. This Requirement is not met as evidenced by: Based on record review and staff interview it has been determined the residence failed to report an elopement that resulted in the police being contacted within twenty-four (24) hours or by the end of the next business day for one of one residents reviewed for an elopement, Resident D #1. Findings are as follows: Resident ID #1 was admitted to the residence in December of 2024 with a diagnosis that includes, but is not limited to, Alzheimer's disease. On 11/17/2025 the Rhode Island (RI) Department of Health received a community reported complaint alleging that a resident had been missing, 12 days after the alleged missing person alert. The social media post that was referenced was dated 11/5/2025 and indicated to contact the police or the facility's Director of Nursing Services. During a surveyor interview on 11/17/2025 at 11:30 AM with the Administrator, she revealed that a family member notified the police and	S 450 CM 2/19/26	S 450 Going forward, the residence will report in writing any elopement resulting in police involvement to the Rhode Island Department of Health (RIDOH) in writing within 24 hours or by the end of the next business day. We are currently collaborating with our Maintenance Department to evaluate the feasibility of installing an alarm system on exterior doors to alert staff of resident exits. For clarification regarding the survey report: The Administrator reported to the RIDOH surveyor that it was the Administrator, not a family member, who contacted the police. On the evening of November 5, 2025, the Administrator observed Resident #1 via surveillance leaving for a walk at 5:00 p.m with [redacted] coat, hat and cane. When [redacted] attempted to return at 5:15 p.m., the front doors had already been locked for the evening. [redacted] did not utilize the call button for the receptionist and she didn't see [redacted] standing there. The resident then turned around and continued with [redacted] walk. Because [redacted] remained outside in the cold and dark, because Daylight Saving Time had just ended on November 2, 2025, the	12/23/25

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S 450	Continued From page 3 posted the "missing person" alert on social media. She further revealed that the residence did not contact the local police department and that the RI Department of Health was not notified of the alleged incident that occurred on 11/5/2025.	S 450	Administrator contacted the police to ensure [redacted] swift and safe return. Upon [redacted] return, the resident was able to identify staff and family and successfully completed a memory questionnaire administered by the police officers and the Director of Nursing (DON).	
S 460	Residency Requirements 2.4.18.H Reporting Requirements 2.4.18 (H) Reporting Requirements H. The residence shall maintain evidence that all reportable incidents have been thoroughly investigated and that actions have been taken to prevent further incidents while the investigation is in progress. Appropriate corrective action shall be taken, as necessary. The results of said investigation shall be reported to the Department, within five (5) business days, on forms supplied by the Department. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined that the residence failed to thoroughly investigate an alleged incident and take action to prevent further occurrences of abuse for the singular resident reviewed relative to a report of staff to resident abuse, Resident ID #2. Findings are as follows: The Rhode Island (RI) Department of Health received a residence reported incident of an alleged staff to resident abuse on 11/04/2025; the allegation indicated the abuse had been perpetrated by Staff A, Certified Nursing Assistant (CNA), and had been occurring for several weeks	S 460	S460 On November 4, 2025, Resident #2 reported the incident to the Administrator and Director of Nursing (DON). They then immediately reported the allegation in-person to the Bristol Police and via telephone and in writing to the RIDOH and the LTC Ombudsman. Following guidance from the Ombudsman's office, we provided a list of residents cared for by the accused staff member. We asked the Ombudsman's representatives if we should conduct interviews as well, but they said that they would conduct the interviews themselves and we did not have to. They did not report any further allegations to us before leaving the building. Going forward we will conduct interviews with residents regarding the care they received from staff who are alleged to have committed abuse. We will also conduct interviews with staff	12/23/25

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S 460	Continued From page 4 prior to it being reported to the residence. Record review of the residence's internal investigation of the alleged incident failed to reveal the following: -interviews with other residents regarding the care they were receiving by Staff A, who is alleged to have committed the abuse -interviews with staff members regarding any reports of abuse or mistreatment of Resident ID #2 or any other residents Additional record review revealed that two RI Longterm Care Ombudsmen (advocates on behalf of residents in care facilities) visited the residence on 11/6/2025 and interviewed other residents; there was no evidence that the administrative staff of the residence received information about those interviews or spoke to residents directly regarding the allegations of abuse. Further record review of a facility reported incident dated 12/22/2022 revealed that the staff member had a prior allegation of abuse against him at the residence. The residence failed to put any corrective actions in place to prevent and monitor further occurrences of abuse towards other residents by Staff A, despite the staff member being issued a final warning at that time. During a surveyor interview on 11/10/2025 at approximately 10:30 AM with the Administrator and the Director of Nursing Services, they were unable to provide evidence that corrective actions were put in place to prevent future occurrences of staff to resident abuse after the 2022 incident involving Staff A.	S 460	members regarding any reports of abuse or mistreatment of any other residents. To ensure ongoing compliance, a question regarding "Abuse, Neglect, and Mistreatment" will be added to the quarterly nurse's review.	