RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01426	A. BUILDING: _____ B. WING _____	C 06/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PHYLLIS SIPERSTEIN TAMARISK ALR	3 SHALOM DRIVE WARWICK, RI 02886

(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 complaint investigation, ACTS references numbers 103877, 103912, and 103904, was conducted at this residence on 06/18/2026 through 6/22/2026 to determine compliance with state laws and regulations. Deficiencies were identified. 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 ensure that the comprehensive assessments were completed in their entirety and were accurate for 5 of 5 residents reviewed, Resident ID #s 1, 2, 3, 4, and 5. Findings are as follows: 1. Record review revealed Resident ID #1 moved into the residence in May of 2024 with a diagnosis including, but not limited to, a history of a myocardial infarction (heart attack). Record review of the resident's service plan, dated 3/8/2026, revealed the resident is a moderate assist for bathing and dressing, a	S 003 S 390 7/10/26	S 390 Corrective Action Resident ID #1 is out of the facility on leave of absence; the App C Assessment will be updated prior to return. Resident ID #2 is out of the facility on leave of absence; the App C Assessment will be updated prior to return including and updated code status and ADL needs. Resident ID #3's App C Assessment has been updated to reflect current ADL needs, medical diagnosis, and psychological history as it reflects currently in the EMR and the electronic service plan. Resident ID #4's App C Assessment has been updated to reflect current ADL needs as it reflects currently in the EMR and the electronic service plan Resident ID #5's App C Assessment has been updated to reflect current ADL needs, and the medication section was updated to reflect current medications and name/dose/frequency of medications as it reflects currently in the EMR and the electronic service plan. Received JUL 09 2026 Facilities Regulation	

Facilities Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Executive Director | (X6) DATE: 7/9/26

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S 390	Continued From page 1 minimal assist for transfers, and for ambulation an assistive device is needed. Record review of the resident's comprehensive assessment, updated on 6/12/2026, revealed the resident is independent with dressing and transferring, bathing is checked as being independent and a minimal assist, and ambulation revealed no device is needed. The comprehensive assessment failed to accurately document the resident's above-mentioned ADL needs. 2. Record review revealed Resident ID #2 moved into the residence in February of 2026 with a diagnosis including, but not limited to, dementia. Record review of the service plan, dated 6/18/2026, revealed the resident is a moderate assist for bathing, a minimal assist for dressing and hygiene, and for toileting needs assistance with peri care. Record review of the comprehensive assessment, updated on 6/6/2026, revealed the resident is a minimal assist for bathing, independent for dressing and toileting, and a moderate assist for hygiene. Additionally, the comprehensive assessment was not completed in its entirety, "Code Status" was left blank and parts of "Section Five-Health Information" were left blank, including: "Current Medical Diagnoses," "Psychosocial History," "Dementia and Cognitive Assessment Score," and "Other Problems." The comprehensive assessment failed to be updated to accurately reflect the resident's above-mentioned ADL needs. Additionally, the	S 390	ID Residents A review of all residents' App C Assessments has been conducted to be sure that the ADLs reflected on the service plan match the ADLs in the assessments. Any discrepancies were assessed and updated. Additionally, all the sections of the assessments were reviewed to be sure they were completed. Systematic changes Going forward, each time the resident service plan is updated, the resident App C Assessment will also be updated to reflect the changes. Monitor The RCD or designee will do random monthly reviews of resident App C Assessments to confirm they match the service plans and are completed in their entirety.	8/31/26

7/10/26 DMS

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S 390	Continued From page 2 comprehensive assessment was not completed in its entirety. 3. Record review revealed Resident ID #3 moved into the residence in July of 2025 with a diagnosis including, but not limited to, dementia. Record review of the service plan, dated 6/3/2026, revealed the resident is a moderate assist for bathing and a full assist for hygiene. Record review of the comprehensive assessment, dated 1/23/2026, revealed the resident is a minimal assist for bathing and hygiene. Additionally, the comprehensive assessment was not completed in its entirety, parts of "Section Five-Health Information" were left blank, including: "Current Medical Diagnoses" and "Psychosocial History." The comprehensive assessment failed to be updated to accurately reflect the resident's above-mentioned ADL needs. Additionally, the comprehensive assessment was not completed in its entirety. 4. Record review revealed Resident ID #4 moved into the residence in March of 2024 with a diagnosis including, but not limited to, Alzheimer's disease. Record review of the service plan, dated 6/3/2026, revealed the resident needs assistance with bathing and toileting. Record review of the comprehensive assessment, dated 6/9/2025, revealed the resident is independent with bathing and toileting. The comprehensive assessment failed to	S 390		

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S 390	Continued From page 3 accurately document the resident's above-mentioned ADL needs. 5. Record review revealed Resident ID #5 moved into the residence in December of 2023 with a diagnosis including, but not limited to, Alzheimer's disease. Record review of the service plan, dated 3/8/2026, revealed the resident needs full assistance with bathing and hygiene. Record review of the comprehensive assessment, dated 8/11/2025, revealed the resident is a minimal assist with bathing and hygiene. Additionally, the comprehensive assessment was not completed in its entirety, parts of "Section Six-Medications" were left blank: including: "Total Number of Medications Prescribed" and the" Name/Dosage and Frequency" of medications. The comprehensive assessment failed to be updated to accurately reflect the resident's above-mentioned ADL needs. Additionally, the comprehensive assessment was not completed in its entirety. During a surveyor interview with the Resident Care Director (RCD) on 6/22/2026 at approximately 11:43 AM, she could not provide evidence that the comprehensive assessments for the above-mentioned residents accurately reflected the residents' ADL needs. Additionally, she could not provide evidence that Resident ID #2, 3, and 5's comprehensive assessments were completed in their entirety.	S 390		

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S 395	Continued From page 4	S 395	S 395	
S 395	Residency Requirements 2.4.17.E Resident Assessment/Service Plans 2.4.17 (E) Resident assessments and Service Plans E. In the event a resident has an admission to a health care facility and is scheduled to return to the residence without a significant change in status, then the assessment shall be updated within five (5) working days of readmission. 1. In case of an emergency admission, the required assessment shall take place within five (5) working days and shall include the following: a. An immediate admission necessitated by natural disaster, crisis, or threat to public safety at another licensed assisted living residence, independent living situation, community residential facility, or private residence; b. An immediate admission necessitated by the unanticipated incapacitation of the primary caregiver of the person to be admitted; c. Conditions or circumstances warranting emergency admission and as approved by Center for Health Facilities Regulation staff within forty-eight (48) hours. This Requirement is not met as evidenced by: Based on record review and staff interview, the residence failed to update the comprehensive assessment for the singular resident reviewed who was admitted to a health care facility within five (5) working days of readmission to the residence, Resident ID #1.	S 395	Corrective Action Resident ID #1 is out of the facility on leave of absence, and the App C Assessment will be updated prior to return. ID Residents A review of all residents' with readmissions in the past 6 months will be conducted to confirm that the comprehensive App C Assessment is in place from the date of readmission. Systemic changes Going forward, each instance a resident is readmitted to the facility, the RCD will complete an updated App C Assessment within 5 days of the readmission to the facility. Monitor The RCD will do random monthly reviews of resident App C Assessments to confirm that residents who are readmitted have an updated assessment in place prior to or within 5 days of the readmission.	8/31/26

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S 395	Continued From page 5 Findings are as follows: Record review revealed Resident ID #1 moved into the residence in May of 2024 with a diagnosis including, but not limited to, a history of myocardial infarction (heart attack). Review of the progress notes revealed the following entries: -1/31/2026, the resident was admitted to the hospital with multiple hip fractures. -2/19/2026, the resident was transferred to a skilled nursing facility. -3/11/2026, the resident returned to this residence. Record review revealed the comprehensive assessment was reviewed on 1/20/2025 and then on 4/12/2026. Record review failed to reveal that a comprehensive assessment was completed within five (5) working days of readmission on 3/11/2026, as required. During a surveyor interview with the Resident Care Director on 6/22/2026 at approximately 12:15 PM, she was unable to provide evidence that Resident ID #1's comprehensive assessment was updated within five (5) working days from readmission, as required.	S 395		
S 400	Residency Requirements 2.4.17.F Resident Assessments/Service Plans 2.4.17 (F) Nurse Review	S 400		

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S 400	Continued From page 6 1. Nurse review is necessary for all levels of licensure. a. A registered nurse shall visit the residence at least once every thirty (30) days except as provided in § 2.4.16(F)(1)(b) of this Part and shall complete a review to include the following: (1) Monitor the medication regimen for all residents; (2) Review any new physician orders and evaluate the health status of all residents by identifying symptoms of illness and/or changes in mental/physical health status; (3) Evaluate the appropriateness of placement for each resident; (4) Make any necessary recommendations to the administrator; (5) Follow up on previous recommendations; (6) Provide a signed, written report in the residence documenting: (AA) Date and time of assessment; (BB) Recommendations for follow-up; (CC) Progress on previous recommendations; (DD) Verification that the medication listed by the pharmacist on the mediset, blister pack or medication	S 400	S 400 Corrective Action Resident ID #1 is out of the facility on leave of absence. The physical assessment and medication verification to physician orders will be completed upon return. Resident ID #2 is out of the facility on leave of absence. The physical assessment and medication verification to physician orders will be completed upon return. Resident ID #3's App C Assessment has been updated to include a physical assessment and a medication verification to physician orders. Resident ID #4's App Assessment has been updated to include a physical assessment and a medication verification to physician orders. Resident ID #5's App Assessment has been updated to include a physical assessment and a medication verification to physician orders.	8/31/26

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S 400	Continued From page 7 container is current with physician orders (M-1 level only); (EE) Physical assessment identifying symptoms of illness and/or changes in mental or physical health status and appropriateness of placement; (FF) Such reports shall be on file at the residence. (7) Complete the quarterly evaluation of the residence ' s registered medication aide(s) administration of medication. (Approved Department form is available for downloading online). b. In those residences that have one (1) or more licensed registered nurses (i.e., at least one (1) full-time equivalent equal to thirty-five (35) hours) on-site, the nurse review shall be completed at least once every ninety (90) days. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined that the residence failed to ensure that nurse reviews held the required components for 5 of 5 sample residents reviewed, Resident ID #s 1, 2, 3, 4, and 5. Findings are as follows: 1. Record review revealed Resident ID #1 moved into the residence in May of 2024. A "Nurse Review" was completed on 6/11/2025, 9/16/2025, 12/28/2025, and 3/8/2026.	S 400	ID Residents A review of all residents' service plans will be completed to confirm that they identify the parties responsible for providing services and interventions needed for falls when indicated. Systematic changes Quarterly service plans will be updated to include the parties that are responsible for implementation as well as fall risk interventions when indicated. Monitor The RCD or designee will do random monthly reviews of resident service plans to confirm a fall risk interventions are in place if indicted and that the individuals responsible for implementation are identified.	8/31/26

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S 400	Continued From page 8 2. Record review revealed Resident ID #2 moved into the residence in February of 2026. A "Nurse Review" was completed on 3/9/2026. 3. Record review revealed Resident ID #3 moved into the residence in July of 2025. A "Nurse Review" was completed on 9/10/2025, 12/7/2025, 2/22/2026, and 6/3/2026. 4. Record review revealed Resident ID #4 moved into the residence in March of 2024. A "Nurse Review" was completed on 6/11/2025, 10/23/2025, 1/18/2026, and 6/3/2026. 5. Record review revealed Resident ID #5 moved into the residence in December of 2023. A "Nurse Review" was completed on 8/21/2025, 9/10/2025, 12/28/2025, and 3/8/2026. Record review of the above-mentioned residents' "Nurse Review(s)" failed to reveal evidence of a physical assessment of each resident and verification that the medication listed by the pharmacist on the mediset, blister pack, or medication container is current with physician orders, as required. During a surveyor interview with the Resident Care Director on 6/22/2026 at approximately 12:20 PM, she was unable to provide evidence that the "Nurse Reviews" were completed with all required components for the above-mentioned residents.	S 400		
S 405	Residency Requirements 2.4.17.G.1. Resident Assessment/Service Plans 2.4.17 (G) (1) Service Plans	S 405		

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S 405	Continued From page 9 1. Within a reasonable time after move-in, not to exceed seven (7) days, the Administrator shall be responsible for the development of a written service plan based on the initial assessment. The service plan shall include at least: a. The services and interventions needed, including all services provided by outside healthcare agencies (e.g., home nursing care, hospice); b. Description, frequency, duration relating to the service or intervention, including personal assistance, medication, special diets, recreational activities, and other similar services rendered; c. Party responsible for arranging and/or providing the service; and d. The resident ' s requested and/or therapeutically needed recreational and social activities. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined the residence failed to document in the service plan interventions needed for 2 of 3 residents reviewed for falls, Resident ID #s 1 and 2, and parties responsible for arranging and/or providing services for 5 of 5 sample residents reviewed, Resident ID #s 1, 2, 3, 4, and 5. Findings are as follows:	S 405	S 405 Corrective Action Resident ID #1 is out of the facility on leave of absence. The fall interventions will be added to service plan and the parties responsible for implementation will be added upon return. Resident ID #2 is out of the facility on leave of absence. The fall interventions will be added to service plan and the parties responsible for implementation will be added upon return. Resident ID #3's service plan will be updated to identify parties responsible for providing services. Resident ID #4's service plan will be updated to identify parties responsible for providing services. Resident ID #5's service plan will be updated to identify parties responsible for providing services.	8/31/26

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S 405	Continued From page 10 1. Record review revealed Resident ID #1 moved into the residence in May of 2024 with a diagnosis including, but not limited to, a history of a myocardial infarction (heart attack). Review of the resident's comprehensive assessment, dated 6/12/2026, revealed the resident had falls on 11/6/2025, 4/19/2026, and 6/10/2026. Review of the fall risk assessments revealed that on 4/21/2026 and 6/10/2026 the resident scored a 10, indicating the resident is at risk for falls. Review of the resident's service plan, dated 3/8/2026, failed to be updated to document the resident is at risk for falls with interventions in place to reduce the fall risk. Additionally, the service plan failed to reveal the party responsible for arranging services for bathing, dressing, eating, hygiene, toileting, transferring, and medication management. 2. Record review revealed Resident ID #2 moved into the residence in February of 2026 with a diagnosis including, but not limited to, dementia. Review of the resident's comprehensive assessment, updated on 6/6/2026, revealed the resident had falls on 3/3/2026, 5/2/2026, and 5/8/2026. Review of the fall risk assessments revealed that on 3/9/2026 and 5/3/2026 the resident scored a 17, and on 5/25/2026 the resident scored a 19, indicating the resident is a fall risk. Review of the resident's service plan, dated 6/18/2026, failed to document that the resident is at risk for falls with interventions in place to	S 405	ID Residents A review of all residents' service plans will be completed to confirm that they identify the parties responsible for providing services and interventions needed for falls when indicated. Systematic changes Quarterly service plans will be updated to include the parties that are responsible for implementation as well as fall risk interventions when indicated. Monitor The RCD or designee will do random monthly reviews of resident service plans to confirm a fall risk interventions are in place if indicted and that the individuals responsible for implementation are identified.	8/31/26

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S 405	Continued From page 11 reduce the fall risk. Additionally, the service plan failed to reveal the party responsible for arranging services for bathing, dressing, hygiene, toileting, transferring, and medication management. 3. Record review revealed Resident ID #3 moved into the residence in July of 2025 with a diagnosis including, but not limited to, dementia. Review of the resident's service plan, dated 6/3/2026, failed to reveal the party responsible for arranging services for feeding, bathing, dressing, hygiene, toileting, transferring, and medication management. 4. Record review revealed Resident ID #4 moved into the residence in March of 2024 with a diagnosis including, but not limited to, Alzheimer's disease. Review of the resident's service plan, dated 6/3/2026, failed to reveal the party responsible for arranging services for feeding, bathing, dressing, hygiene, toileting, transferring, and medication management. 5. Record review revealed Resident ID #5 moved into the residence in December of 2023 with a diagnosis including, but not limited to, Alzheimer's disease. Review of the resident's service plan, dated 3/8/2026, failed to reveal the party responsible for arranging services for bathing, dressing, hygiene, toileting, and medication management. During a surveyor interview with the Resident Care Director (RCD) on 6/22/2026 at approximately 12:20 PM, she was unable to provide evidence the service plans for Resident	S 405		

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S 405	Continued From page 12 ID #s 1 and 2 had fall risk interventions in place. Additionally, she acknowledged the service plans failed to reveal the party responsible for arranging the above-mentioned services.	S 405		
S 805	Practices and Procedures, Violations, Sa 2.4.34.A Variance Procedure 2.4.34 (A) Variance Procedure A. The Department may grant a variance either upon its own motion or upon request of the applicant from the provisions of any Rule or Regulation in a specific case if it finds that a literal enforcement of such provision will result in unnecessary hardship to the applicant and that such a variance will not be contrary to the public interest, public health and/or health and safety of residents. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined the residence failed to submit a variance for approval from the Department for 3 of 3 sample residents reviewed for receiving hospice services, Resident ID #s 3, 4, and 5. Findings are as follows: Per the Rules and Regulations for Licensing Assisted Living Residences the definition of a resident states in part "... an established resident may receive daily skilled nursing care or therapy from a licensed health care provider for a condition that results from a temporary illness or injury for up to forty-five (45) days subject to an extension of additional days as approved by the Department, or if the resident is under the care of	S 805		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01426	A. BUILDING: _____ B. WING _____	C 06/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PHYLLIS SIPERSTEIN TAMARISK ALR	3 SHALOM DRIVE WARWICK, RI 02886

(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 805	Continued From page 13 a Rhode Island licensed hospice agency provided the assisted living residence assumes responsibility for ensuring that the required care is received..." 1. Record review revealed Resident ID #3 moved into the residence in July of 2025 with a diagnosis including, but not limited to, dementia. Record review revealed the resident was admitted to hospice services on 12/15/2025. Review of the resident's record failed to reveal evidence an approved variance was obtained from the Department, as required. 2. Record review revealed Resident ID #4 moved into the residence in March of 2024 with a diagnosis including, but not limited to, Alzheimer's disease. Record review revealed the resident was admitted to hospice services on 10/17/2025. Review of the resident's record failed to reveal evidence an approved variance was obtained from the Department, as required. 3. Record review revealed Resident ID #5 moved into the residence in December of 2023 with a diagnosis including, but not limited to, Alzheimer's disease. Record review revealed the resident was admitted to hospice services on 9/9/2025. Review of the resident's record failed to reveal evidence an approved variance was obtained from the Department, as required.	S 805	S 805 Corrective Action A variance request for Resident ID #3 has been submitted for approval. A variance request for Resident ID #4 has been submitted for approval. A variance request for Resident ID #5 has been submitted for approval. ID Residents A review of all residents' requiring daily skilled nursing from a licensed provider including hospice services will be conducted to be sure the required variance is submitted for approval. Systemtic changes Upon the implementation of hospice services and/or any services provided for skilled nursing services, a request for variance approval will be submitted. Each service provider will report to the nursing office and log their visit into a logbook. Monitor The RCD or designee will do random monthly reviews of outside services including hospice and verify that the required variance has been submitted for approval.	8/31/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01426	A. BUILDING: _____ B. WING _____	C 06/22/2026

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THE PHYLLIS SIPERSTEIN TAMARISK ALR	3 SHALOM DRIVE WARWICK, RI 02886

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S 805	Continued From page 14 During a surveyor interview with the Executive Director on 6/22/2026 at 10:20 AM, he could not provide evidence a variance was submitted to the Department for the above-mentioned residents, as required.	S 805		