

RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>ALR01425</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	NOV 20 2025 Facilities Regulation (X3) DATE SURVEY COMPLETED  <b>10/29/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>SAINT ELIZABETH COURT</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>109 MELROSE STREET PROVIDENCE, RI 02907</b>
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S 003	Initial Comments  A state licensure survey was conducted at this facility on 10/28/2025 through 10/29/2025. Deficiencies were identified.	S 003		
S 180	Organization And Management 2.4.13.C Administrative Management  2.4.13 (C)(1-5) Administrative Management  C. Pursuant to R.I. Gen. Laws §§ 23-17.4-15.1.1 and 23-17.4-15.2, each assisted living residence shall have an administrator who is licensed by the Department in accordance with Regulations established pursuant to R.I. Gen. Laws § 23-17.4-21.1, in charge of the maintenance and operation of the residence and the services to the residents. The name and contact information for the current administrator shall be displayed in a conspicuous public area of the residence. The administrator is responsible for the safe and proper operation of the residence at all times by competent and appropriate employee(s) and shall be responsible for no less than the following:  1. The management and operation of the residence and services to the residents;  2. Compliance with federal, state, and local laws and Rules and Regulations pertaining to, but not limited to: the management and operation of assisted living residences, fire, safety, zoning, building codes, sanitation, food service, communicable and reportable diseases, Americans with Disabilities Act, employee health and safety, other relevant health and safety requirements, and these Regulations.  3. Staffing the residence with adequate and qualified personnel to attend to the food	S 180		

11/28/25  
*[Signature]*

Facilities Regulation  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Maggie Connelley* TITLE: *Administrator* (X6) DATE: \_\_\_\_\_

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S 180	<p>Continued From page 1</p> <p>preparation, general housekeeping, assistance with personal care, medication administration, if applicable, and other such services;</p> <p>4. Establishment of written policies and procedures governing the operation of the residence which are aimed, to the extent possible, at maintaining the independence of residents. Such policies shall include provisions to implement no less than the following:</p> <p>a. The appropriate provisions of § 2.4.18 of this Part and other applicable provisions pertaining to admission, transfer, discharge, visitation privileges, availability and utilization of community resources, leisure time and such other;</p> <p>b. Accountability of the residence when acting as a fiduciary agent for the resident pursuant to § 2.4.18 of this Part;</p> <p>c. Notification of next of kin or other responsible person designated by the resident in the event of illness, accident or death; and</p> <p>d. Such other provisions as may be deemed appropriate.</p> <p>5. Compliance with all requirements appropriate to the service level for which the residence is licensed.</p> <p>This Requirement is not met as evidenced by: Based on surveyor observation and staff interview, it has been determined the residence failed to display a posting of the name and</p>	S 180		

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S 180	Continued From page 2 contact information for the current administrator in a conspicuous public area of the residence.  Findings are as follows:  A surveyor observation on 10/28/2025 at 10:26 AM, of the residence's lobby area, failed to reveal a posting of the name and contact information for the current administrator, as required.  During an interview on 10/28/2025 at approximately 10:30 AM, the Administrator acknowledged the required information was not prominently displayed in the residence, as required.	S 180  <i>OW</i> <i>11/28/25</i>	Plan of Correction S180  a. The name and contact information of the Administrator was posted in the lobby area. b. Although there were no residents identified in this tag, we recognize the importance of posting the name and contact information of the Administrator. c. The Administrator has reviewed the regulation requiring the posting of the name and contact information of the Administrator. d. For a 3 month period, the Administrator will periodically check to ensure that the name and contact information of the Administrator is posed in the lobby. The results of these checks will be presented at the QA meeting.	10/29/2025
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 update the comprehensive assessment each time a resident's condition changed significantly for 3 of 4 residents reviewed for outside services, 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	S 390		

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S 390	<p>Continued From page 3</p> <p>diagnoses including, but not limited to, osteoarthritis and history of urinary tract infections.</p> <p>Record review of the resident's comprehensive assessment dated 3/5/2025 failed to reveal evidence the assessment was updated indicating that the resident is receiving hospice services with a start of care date of 4/22/2025.</p> <p>2. Record review revealed Resident ID #2 moved into the residence in December of 2022 with diagnoses including, but not limited to, anxiety and fractured right hip</p> <p>Record review of the resident's comprehensive assessment dated 11/6/2024 failed to reveal evidence the assessment was updated after the resident had a change in condition resulting in a hospital admission and a skilled nursing facility admission from 6/28/2025 through 7/30/2025.</p> <p>3. Record review revealed Resident ID #3 moved into the residence in March of 2024 with diagnoses including, but not limited to, lung cancer and major depressive disorder.</p> <p>Record review of the resident's comprehensive assessment dated 3/5/2025 failed to reveal evidence the assessment was updated indicating the resident is receiving hospice services with a start of care date of 8/20/2025.</p> <p>During a surveyor interview with the Director of Wellness on 10/28/2025 at 2:30 PM, she acknowledged Resident ID #s 1 and 3's comprehensive assessments were not updated to reflect that the residents are receiving hospice services. Additionally, she acknowledged Resident ID #2's comprehensive assessment</p>	S 390  	<p>Plan of Correction for S390</p> <p>a. The comprehensive assessment for Resident ID#1 was updated to indicate that the resident began receiving hospice services as of 04/22/25. The comprehensive assessment for Resident ID#2 was updated indicating there had been a hospital admission and SNF admission from 06/28/25-07/30/25. In addition, the assessment for ID#2 was updated to reflect outside services received. The comprehensive assessment for Resident ID#3 was updated indicating the resident began receiving hospice services as of 08/20/25</p> <p>b. An audit of all resident records was completed to ensure that the comprehensive assessments were updated each time a resident's condition changed significantly. Comprehensive assessments were updated as needed.</p> <p>c. Nursing staff were educated about the need to review the assessments at intervals not to exceed 12 months and each time a resident's condition changes significantly.</p> <p>d. For a 3- month period, the nursing staff will audit all medical records to ensure that the comprehensive assessments are being updated when there is a significant change in the residents condition. The results of the audits will be</p>	11/01/25

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S 390	Continued From page 4 was not updated after s/he had a significant change and had received outside services.	S 390	S390 continued: presented at the QA meeting.	
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 the service plan each time a resident's condition changes significantly and failed to accurately reflect that the resident had received outside services for 1 of 3 sample residents reviewed, Resident ID #2.  Findings are as follows:  Record review revealed Resident ID #2 initially moved into the residence in December of 2022 and was readmitted in July of 2025. S/he has diagnoses including, but not limited to, right hip fracture and anxiety.  Record review of a progress note dated 6/28/2025 revealed the resident had an unwitnessed fall, s/he was sent to the emergency room, and was admitted with a hip fracture. Additional record review revealed the resident returned to the residence after a hospital admission and skilled nursing facility admission on 7/30/2025, with an order for physical therapy.	S 415  <i>AWB</i> <i>11/28/25</i>	Plan of correction S415  a. The service plan for Resident ID#2 was updated to reflect that the resident received physical therapy, following a hospital admission. b. An audit of all resident records was completed to ensure that the service plans were updated each time a residents condition changed significantly. Service plans were updated as needed. c. Nursing staff were educated about the need to review the service plans at intervals not to exceed 12 months and each time a residents condition changes significantly. d. For a 3-month period, the nursing staff will audit all medical records to ensure that service plans are being updated when there is a significant change in the residents condition. The results of the audits will be presented at the QA meeting.	11/01/2025

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S 415	<p>Continued From page 5</p> <p>Record review of a list of residents that have received outside services provided by the residence revealed the resident received physical therapy from 8/1/2025 through 10/10/2025.</p> <p>Record review of the resident's service plan dated 12/30/2024 failed to reveal evidence the service plan was updated to reflect that the resident had received physical therapy, had a hospital admission, and skilled nursing facility admission, as mentioned above.</p> <p>During a surveyor interview on 10/28/2025 at 2:31 PM with the Director of Wellness, she acknowledged the resident's service plan was not updated after s/he was hospitalized and was not updated to reflect the outside services the resident received, as required.</p>	S 415	<p>Plan of Correction for S495</p> <ol style="list-style-type: none"> <li>The most recent state survey results were placed in the survey book in the lobby where it is prominently displayed.</li> <li>Although there were no residents identified in this tag, we recognize the importance of prominently posting the most recent survey results.</li> <li>The Administrator has reviewed the regulation requiring the posting of the most recent state survey results.</li> <li>For a 3-month period, the Administrator will periodically check to ensure that the most recent state survey results are posted prominently in the lobby.</li> </ol>	10/29/25
S 495	<p>Licensure Requirements 2.4.19.D Rights of Residents</p> <p>2.4.19 (D) Rights of Residents</p> <p>D. The residence must:</p> <ol style="list-style-type: none"> <li>Implement written policies and procedures to ensure that all residence employees are aware of and protect the resident's rights contained in these Regulations;</li> <li>Have prominently displayed a posting of the most recent State licensing survey of the assisted living residence; and</li> <li>Provide each resident or his/her representative upon admission, a copy of the provisions of § 2.4.18 of this Part and shall display in a</li> </ol>	S 495	<p>Plan of Correction for S495</p> <ol style="list-style-type: none"> <li>The most recent state survey results were placed in the survey book in the lobby where it is prominently displayed.</li> <li>Although there were no residents identified in this tag, we recognize the importance of prominently posting the most recent survey results.</li> <li>The Administrator has reviewed the regulation requiring the posting of the most recent state survey results.</li> <li>For a 3-month period, the Administrator will periodically check to ensure that the most recent state survey results are posted prominently in the lobby.</li> </ol>	10/29/25

*[Handwritten Signature]*  
11/28/25

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S 495	<p>Continued From page 6</p> <p>conspicuous place on the premises a copy of the "Rights of Residents."</p> <p>This Requirement is not met as evidenced by: Based on surveyor observations and staff interview, it has been determined that the residence failed to ensure that the most recent State licensing survey results of the assisted living residence was prominently displayed, as required.</p> <p>Findings are as follows:</p> <p>A surveyor observation of the main entrance/lobby area of the residence, on 10/28/2025 at 10:22 AM, failed to reveal evidence of the most recent State licensing survey results being prominently displayed, as required.</p> <p>During a surveyor interview with the Administrator on 10/28/2025 at 10:25 AM, she acknowledged that the residence's recent survey results were not accessible and prominently displayed, as required.</p>	S 495		
S 560	<p>Residential Care Services 2.4.23.C Dietetic Services</p> <p>2.4.23 (C) Dietetic Services</p> <p>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.</p> <p>This Requirement is not met as evidenced by:</p>	S 560		

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S 560	<p>Continued From page 7</p> <p>Based on surveyor observation and staff interviews, it has been determined that the residence failed to comply with the appropriate requirements of the Rhode Island Food Code related to the main kitchen and the serving kitchen on the first floor.</p> <p>Findings are as follows:</p> <p>1a. 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..."</p> <p>1b. Record review of the 2022 Food Code published by the U.S. Food and Drug Administration Section 5-202.13 states in part, "...An air gap between the water supply inlet and the flood level rim of the PLUMBING FIXTURE, EQUIPMENT, or nonfood EQUIPMENT shall be at least twice the diameter of the water supply inlet and may not be less than 25 mm (1 inch)..."</p> <p>A surveyor observation on 10/28/2025 at 9:17 AM of the serving kitchen on the first floor, in the presence of the Food Service Director (FSD), revealed an ice machine which was observed with a brown wipeable matter on the top surface of the interior part where the ice is dispensed. Additional observation revealed the ice machine drain tube was lying directly in the drainage tube without an air gap between the drain tube and the flood level rim of the plumbing fixture, as required.</p> <p>During a surveyor interview immediately following this observation, the FSD acknowledged the brown wipeable matter in the ice machine and was unable to provide evidence when the ice</p>	S 560  	<p>Plan of Correction S560</p> <p>a. The brown wipeable matter in the ice machine was cleaned off. The ice machine was completely drained and thoroughly cleaned to sight and touch. Maintenance staff repaired the plumbing fixture so that there is an air gap between the water supply inlet and the flood level rim of the plumbing fixture. The thermometer was sanitized. The staff member washed her hands before touching the clean dishes.</p> <p>b. Although there were no residents identified in this tag, we recognize the importance of complying with the requirements of the Rhode Island Food Code as related to the main kitchen and the serving kitchen on the first floor.</p> <p>c. All Dining staff were educated on how to properly clean the ice machine. A schedule has also been developed so that the ice machine is cleaned and emptied on a monthly basis. Staff have also been educated on the requirement to clean and wipe down the ice machine daily. The ice machine is also on a service plan with an outside vendor. Cleaning instructions are posted.</p>	<p>10/30/25</p> <p>11/04/2025</p>
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S 560	<p>Continued From page 8</p> <p>machine was last cleaned. Additionally, the FSD acknowledge the ice machine did not have an air gap and the drain tubing from the ice machine was lying directly in the drainage tube.</p> <p>2. Record review of the 2022 Food Code published by the U.S. Food and Drug Administration Section 4-702.11 states in part, "...Utensils and Food-Contact Surfaces of Equipment shall be SANITIZED before use after cleaning..."</p> <p>During a surveyor observation on 10/29/2025 at 11:57 AM of the lunch meal service in the serving kitchen on the first floor, in the presence of a cook, Staff A, he was observed placing a thermometer into a prepared ready to serve tray of baked chicken to check the temperature without sanitizing it.</p> <p>During a surveyor interview on 10/29/2025 at 12:53 PM with Staff A, he acknowledged that he did not sanitize the thermometer prior to placing it into the ready to serve tray of baked chicken.</p> <p>3. Record review of the 2022 Food Code published by the U.S. Food and Drug Administration Section, 2-301.14 states in part, "...when to wash...food employees shall clean their hands...after handling soiled equipment or utensils..."</p> <p>During a surveyor observation on 10/29/2025 at 12:48 PM of the main kitchen, a dietary aide, Staff B, was observed handling the soiled dishes while putting them in the dishwasher, she failed to wash her hands after, and instead Staff B proceeded to touch the clean dishes before she was stopped by the surveyor.</p>	S 560  <i>(Signature)</i> <i>11/20/25</i>	<p>S560 cont: The cooks were educated on the need to sanitize the thermometer and other utensils and food- Contact surfaces of equipment before use after cleaning. All Dietary staff were educated about the need to wash hands after handling soiled dishes before handling the clean dishes.</p> <p>d. For a 3- month period, the Food Service Director will periodically check to ensure equipment food contact surfaces are clean to sight and touch and there is an air gap between the water supply inlet and the flood level rim of the plumbing fixture equipment.</p> <p>For a 3- month period, the Food service Director will periodically observe meal service to ensure that the cooks are properly sanitizing utensils and Food Contact Surfaces of equipment before use after cleaning.</p> <p>For a 3-month period, The Fodd Service Director will periodically observe meal service to ensure that staff are washing their hands after handling soiled dishes before handling the clean dishes. The results of these observations/audits will be presented at the QI meeting.</p>	11/04/25

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S 560	Continued From page 9  During a surveyor interview immediately following the above-mentioned observation, Staff B acknowledged that she did not wash her hands after handling the soiled dishes before handling the clean dishes.  During a surveyor interview on 10/29/2025 at 2:00 PM with the Administrator, she was unable to provide evidence the staff was in compliance with the Rhode Island Food Code.	S 560  		
S 640	Residential Care Services 2.4.26.B.1 Medication Services  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.	S 640	Plan of correction S640  a. A physicians order was obtained for Resident ID#3 to self-administer Oxycodone. b. An audit of all residents was completed to ensure that there was a physicians order obtained for any resident who self-administers medication. c. The nurses have been educated on the need to obtain a physicians order for any resident who self-administers medication. d. For a 3- month period, the Administrator will audit the records to ensure that there is a physicians order for any resident who self-administers medication. The results of these audits will be presented at the QI meeting.	11/03/25

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S 640	<p>Continued From page 10</p> <p>d. The resident must be identified prior to administration of any medication.</p> <p>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.</p> <p>f. Injectable medications, including but not limited to insulin, which cannot be self-administered by the resident, must be administered by a licensed nurse.</p> <p>g. There shall be written a policy/procedure 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.</p> <p>(1) The legal destruction of hypodermic needles, syringes or other such instruments is the responsibility of the last entitled or authorized possessor.</p> <p>(AA) All personnel or residents legally authorized to use disposal syringes and needles, shall destroy them after one (1) use.</p> <p>(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.</p> <p>(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</p>	S 640		

RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>ALR01425</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/29/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>SAINT ELIZABETH COURT</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>109 MELROSE STREET PROVIDENCE, RI 02907</b>
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S 640	<p>Continued From page 11</p> <p>regulated medical waste for off-site transport by a DEM-permitted medical waste transporter.</p> <p>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.</p> <p>i. Any medication administered by the residence and refused by a resident shall be documented and reported, as appropriate.</p> <p>j. Medications shall be stored securely and in 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.</p> <p>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.</p> <p>l. All centrally stored medications shall be maintained in accordance with manufacturer's labeling and administered by authorized personnel.</p> <p>This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined that the residence failed to provide care and services in accordance with prevailing community standards of practice and in accordance with a written physician's order to self-administer medication for the singular</p>	S 640	<p>Plan of correction S640</p> <p>a. A physicians order was obtained for Resident ID#3 to self-administer Oxycodone.</p> <p>b. An audit of all residents was completed to ensure that there was a physicians order obtained for any resident who self-administers medication.</p> <p>c. The nurses have been educated on the need to obtain a physicians order for any resident who self-administers medication.</p> <p>d. For a 3- month period, the Administrator will audit the records to ensure that there is a physicians order for any resident who self-administers medication. The results of these audits will be presented at the QI meeting.</p>	

*(Handwritten signature)*  
11/28/25

RI Department of Health

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S 640	<p>Continued From page 12</p> <p>resident reviewed for self-administration, Resident ID #3.</p> <p>Findings are as follows:</p> <p>According to Mosby's 4th Edition, Fundamentals of Nursing, page 314 states in part, "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe that the orders are in error or would harm the clients."</p> <p>Record review revealed Resident ID #3 moved into the residence in March of 2024 with a diagnosis including, but not limited to, lung cancer.</p> <p>Record review of a physician's order dated October 23, 2025, revealed an order for Oxycodone 5 milligram tablet to be administered every four hours, as needed, for pain.</p> <p>During a surveyor interview on 10/28/2025 at 1:48 PM with the resident, she acknowledged that s/he had the above-mentioned medication in his/her possession and self-administers this medication. The resident was observed with the Oxycodone in his/her apartment.</p> <p>Record review of a service plan dated 3/27/2025 revealed the resident is dependent with medication administration, and all medications will be administered by the licensed staff.</p> <p>Record review failed to reveal evidence a physician's order was obtained for the resident to self-administer the Oxycodone.</p> <p>During a surveyor interview on 10/28/2025 at 2:15 PM, with the Director of Wellness, she</p>	S 640		
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S 640	Continued From page 13  acknowledged the resident self-administers his/her Oxycodone and acknowledged a physician's order was not obtained for the resident to self-administer this medication, as required.	S 640		