RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01519	A. BUILDING: _____ B. WING _____	C 06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITHFIELD WOODS	171 PLEASANT VIEW AVENUE SMITHFIELD, RI 02917

(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 101331, 101255, and 101394, was conducted at this residence on 06/25/2025 to determine compliance with state regulations. A deficiency was identified.	S 003	The filing of this plan of correction does not constitute an admission of the allegations set forth in this statement of deficiencies. This plan of correction is prepared and executed as evidence of this facility's compliance with applicable law.	8/14/25
S 840	Special Care License Requirements 2.5.2.L Specific Requirements 2.5.2 (L) Specific Requirements L. The Alzheimer Dementia Special Care Unit/Program shall provide a secure distinct living environment appropriate for the resident population. This requirement may include, but not be limited to, a locked unit, secured perimeter, or other mechanism to ensure resident safety and quality of life. The residence shall have elopement policies in place, specific to the Unit/Program. This Requirement is not met as evidenced by: Based on surveyor observation, record review, and staff interview, the residence's Special Care Unit failed to provide a secure distinct living environment, relative to a singular resident reviewed for elopement, Resident ID #1. Findings are as follows: According to the regulation's definition, "'elopement' means leaving the premises without notice when the residence has assumed responsibility for the resident's whereabouts." Review of the residence's policy on "Alarmed Exit	S 840	1. Education on elopement/door alarm policy completed with associate by 7/10/25. 2. All staff education to be completed on elopement/ door alarm policy by 8/14/25. 3. Alarm audit to be completed weekly x4 weeks, monthly x5 months and reviewed in quarterly x6 months to review/monitor response time and compliance. Received AUG 07 2025 Facilities Regulation	

Facilities Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE 8/7/25

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S 840	Continued From page 1 Doors" states in part, "...Staff will respond immediately to Community exit door alarm signals. Staff will determine which door alarm is sounding and the reason: A thorough search outside the building to check for any resident who may have exited will be done. Following an outside search, staff will account for all Residents. If all Residents are accounted for, reset door alarm. If a Resident is found to be missing, staff will follow the Elopement/Missing Resident procedure." The report sent to the Rhode Island Department of Health on 6/24/2025 alleges Resident ID #1 eloped through an exterior door at 6:25 PM and was found outside at 8:24 PM. Record review revealed the resident moved into the residence in December of 2024 with a diagnosis including, but not limited to, Alzheimer's disease. The resident was unable to be interviewed due to his/her cognitive status. During a surveyor observation of the resident at 11:00 AM, he/she was utilizing his/her walker with a physical therapist. Review of a fall risk assessment dated 6/6/2025 reveals a score of 21 (a score of 10 or greater indicates, at risk for falls). During a surveyor interview with Nursing Assistant (NA), Staff A, on 6/25/2025 at 10:00 AM, she revealed the resident eloped after dinner when she was bringing the dirty dishes to the kitchen. She revealed she heard the door alarm sound and went to the door to reset it, without looking to see if anyone had exited the building	S 840		

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S 840	Continued From page 2 through the door. Additionally, she revealed she was the only staff member on the unit at that time. Surveyor observation of the recorded memory care footage on 6/25/2025 at 10:30 AM in the presence of the Executive Director (ED), revealed the resident came out of the dining room and went straight down the hallway to the outside door. He/she was pushing on the door at 6:23 PM for approximately 2 minutes when it released, he/she then left the building. Approximately 2 minutes later, Staff A went to reset the alarm then went into a resident's room that was nearby. At this time, she did not open the door to look outside or do a head count. At approximately 7:15 PM, Staff A checked Resident ID #1's room, she then began looking for the resident. Review of an emergency department Continuity of Care form dated 6/24/2025 reveals, the resident presented with heat exhaustion after being outside for approximately 2 hours, fully clothed wearing a sweatshirt and sweatpants. His/her temperature was 101.9 degrees Fahrenheit. During a surveyor interview with the ED on 6/25/2025 at approximately 10:45 AM, she acknowledged the resident eloped through one of the memory care doors due to the lack of supervision on the unit and staff not following the facility's alarmed exit door policy. Additionally, she revealed the resident was found outside the building at 8:24 PM, he/she had fallen in the woods.	S 840		