STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01454	A. BUILDING: _____ B. WING _____	C 07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PACIFICA SENIOR LIVING VICTORIA COURT	55 OAKLAWN AVENUE CRANSTON, RI 02920

(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 was conducted on 7/31/2024 at this residence. Continued non-compliance was identified as a result of this survey.	S 003		
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 #4. 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." A community reported complaint to the Rhode Island Department of Health on 7/29/2024 alleges that a resident eloped from the residence on 7/27/2024 and was found on a different street by	S 840	S 840 Special Care License Requirements 2.5.2.L Specific Requirements 2.5.2 (L) Specific Requirements Resident ID#4 has been reassessed by the Resident Care Director/ RN and the resident's comprehensive assessment and service plan has been updated to reflect the resident's elopement risk. Resident's medications have been adjusted Per physician's orders. Medtechs have been Instructed by Resident Care Director/ RN to administer physician ordered PRN medication before the resident's behaviors escalate. Resident ID #4 is also being counseled regularly, and as needed, by Supportive Care, a provider of comprehensive Behavioral Health services. Staff have been instructed to contact the resident's POA for assistance, as needed, to redirect resident away from negative thoughts and unsafe behaviors. Pacifica Victoria Court residents are checked on regularly throughout the day and night per company policy. 7/31/2024 All residents have potential to be affected by this deficient practice. To ensure that this deficient practice does not recur: Elopement assessments will be conducted per policy and interventions implemented as indicated with the resident service plans being updated respectively. Residents at risk of elopement and the wander management system policies and procedures will be reviewed and discussed monthly during the safe resident handling meetings. 7/31/2024 ...continue to page 2...	

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

Executive Director — 8/20/2024

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S 840	Continued From page 1 a couple who called the police. Additionally, the report indicates that this is the second time the resident has eloped from this residence. This was cited in a previous survey (RVMZ11). An initial reportable incident form submitted to the Rhode Island Department of Health on 7/30/2024 alleges that a staff member received a call from the police indicating that the resident was picked up by a couple down the street from the residence, they drove the resident to a different location, and then called the police. Record review reveals the resident moved into the residence in August of 2022 with a diagnosis of dementia. Record review of a progress note dated 7/29/2024 reveals that the resident is suspected to have eloped through the side kitchen door after having dinner at approximately 5:40 PM. Surveyor observation of the residence's dining area on 7/31/2024 at approximately 12:00 PM revealed the "servery door" (the entrance into the kitchenette space beside the dining room) was locked at this time. The "servery door" reveals a sign that states, "This Door MUST be Closed and Locked when staff is not in the Kitchen Servery!..." Another sign on the door states, "This door must be locked at all times!!!..." The resident eloped by exiting the dining room through the "servery door", then exiting the kitchenette through the exterior door. During a surveyor interview on 07/31/2024 at 12:28 PM with Dishwasher, Staff A, while Nursing Assistant, Staff B, was interpreting, he acknowledged he left the "servery door" open and unlocked. The night the resident eloped, he forgot	S 840	Continued from page 1... Wander guard bracelets will be placed on those residents who have been assessed with at risk of wandering and/or elopement. A Wander Management/ Wander Guard bracelet tracking form has been created and will be updated by the Resident Care Director/ RN each time a wander guard bracelet is placed on a resident who is at risk of wandering and/or elopement. The tracking form documents the name of the resident, the room number, the date of activation, the date to check that the wander guard is still properly working, and the date to replace the wander guard bracelet. (Please see attached). The Resident Care Director/ RN will continue to meet weekly with the Executive Director to review the Wander Management tracking form and discuss any potential residents who are at risk for elopement; these meetings will be documented. 7/31/2024 Alarm systems are randomly checked multiple times per day. In addition, Maintenance staff or designee checks the alarmed doors weekly to ensure they are working properly. Weekly checks are documented in the maintenance log book. 7/31/2024 Staff in all departments have been and will be regularly re-educated and in-serviced on the company's Elopement and Wander Management System policies and procedures 7/31/24. Staff continues to be reminded to continue to monitor and report to RCD and/or ED of any accidents/incidences and any change in resident's condition and/or behavior, including any recommendation for a resident to wear a wander guard bracelet. Staff #A has been terminated from employment within the company due to safety violations and after a thorough investigation. 8/8/24 Continue to page 3...	

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S 840	Continued From page 2 to lock the door when he left. He further acknowledged that he knew the "servery door" is to be locked at all times, as the signs state. During a surveyor interview on 07/31/2024 with the Administrator at 12:48 PM, she acknowledged that the resident eloped through the "servery door." Additionally, she could not provide evidence that the residence provided a secure living environment for this resident.	S 840	Continued from page 2... Signs continue to be placed outside the kitchen servery door stating that the Door MUST be Closed and Locked when staff are not in the kitchen servery. (Please see attached signs) There are also a translated versions written in Haitian Creole and Spanish of this directive posted on the door. Prior to the resident elopement on 7/27/2024, as well as currently, new electrical delayed egress doors and alarms are in the process of being installed on the doors leading to the exterior of the building.	7/31/24