RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01477	A. BUILDING: _____ B. WING _____	C 08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE CENTRE OF NEW ENGLAND	600 CENTRE OF NEW ENGLAND COVENTRY, RI 02816

(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 101775 and 101770, was conducted at this residence on 08/12/2025 to determine compliance with state regulations. A deficienciency was identified.	S 003	**CONE POC 8/12/2025** The following is the Plan of Correction for Brookdale Centre of New England regarding the Statement of Deficiencies from the community biannual survey investigation on August 12, 2025. This Plan of Correction is not to be construed as an admission of, or agreement with the findings and conclusions in the Statement of Deficiencies. Rather, it submitted as confirmation of our ongoing efforts to comply with statutory regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We remain committed to delivery of quality health care services and will continue to make changes and improvement to satisfy that objective.	
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, it has been determined the residence continued to fail to ensure the Alzheimer Dementia Special Care Unit/Program provided a secure distinct living environment appropriate for the resident population. Findings are as follows: Per the Facility Missing Resident Policy, "Definitions for Elopement ...any incident where a resident leaves the secured memory care area of the community or the secured courtyard, unescorted, with or without injury."	S 840		

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

Executive Director 8/25/25

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S 840	Continued From page 1 It was identified during a survey on 05/03/2022 that the doorway from the dining room to an exit and the kitchen was not properly secured to prevent elopement. Per an initial report sent to the Department of Health on 08/06/2025 Resident ID #1 had a successful elopement on 08/05/2025. The route of egress was unknown at the time and the resident was sent to the hospital after the elopement. The resident had a reported prior successful elopement on 08/04/2025. Record review revealed the resident was admitted to the residence on 8/1/2025 from an acute care hospital with a diagnosis that includes, but is not limited to, major neurocognitive disorder with behavioral disturbances. Record review of the hospital discharge record dated 8/1/2025 revealed the resident was admitted to the hospital 6/13/2025-8/1/2025. During that hospital admission Resident ID #1 had numeous exit seeking behaviors, including trying to follow staff and/or visitrs off the unit and waiting near the unit entry/exits for an opportunity to leave. During a surveyor observation of the secure Clare Bridge unit on 8/12/2025 at approximately 11:00 AM, four modes of entrance/exits were revealed. All doors are locked by a monitoring system. The monitoring system consists of a door alarm that sounds for 5 seconds before the main alarm sounds, the door needs to be pushed for a total of 15 seconds for it to open. Alarms were in working order at the time of this observation. Additionally, there are two alarm panels on the secure unit, one at the Wellness Director's desk and the other in the dining room.	S 840	**2.5.2 (L) Specific Requirements** The Resident was readmitted to Geri-psych for further evaluation and will not be returning to community. All residents admitted to the memory care unit are potentially at risk. Memory care admissions identified as elopement risks, will be on frequent checks for the first 48hrs and then reevaluated by the clinical team. Additional interventions will be updated to the PSP where indicated.	8/5/25 8/5/25 Ongoing 8/5/25 Ongoing

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S 840	Continued From page 2 During a surveyor interview on 8/12/2025 at 10:30 AM with the Director of Wellness, she revealed that the resident had a very fast gait, would walk behind individuals, and sat near exit doorways. She further revealed that the resident was found in the office of the complex next door to the facility on 8/4/2025; staff were not aware he/she had eloped from the unit prior to receiving the notification. She further revealed that the resident walked out of the residence without any of the alarms sounding. She indicated that the residence's internal investigation suggested that the resident followed a visitor and/or staff member out of the unit on 8/4/2025 and that the resident may have seen what the code to exit the unit was. Record review revealed that 15 minute safety checks were implemented as a result of the 8/4/2025 elopement. Record review revealed that the resident eloped again on 8/5/2025, the incident report to the Department stated in part, "...was participating in an activity at 4pm, seen by Nurse entering [his/her] room shortly after. At 4:20 pm staff gathering residents for dinner, CNA ' s alerted Nurse that [he/she] could not be located. Rooms were checked and perimeter of building was searched...It was noted that resident exited the facility without alarms sounding..." During an additional surveyor interview on 8/12/2025 with the Director of Wellness regarding the elopement on 8/5/2025 she revealed that 15 minute checks were in place and that the resident was last seen at 4:15 PM walking to his/her room. At 4:20 PM the resident was not seen in his/her room or on the unit. The police were contacted	S 840	The Executive Director/HWD's re trained associates who work the Memory Care Unit on the community's elopement policy and protocol. Memory care admissions identified as elopement risks, will be on frequent checks for the first 48hrs and then reevaluated by the clinical team. Additional interventions will be updated to the PSP where indicated. Monthly elopement drills and weekly door alarm checks to be completed and put into the community's TELS monitoring system. Shift report checks doors daily. Residents exhibiting elopement seeking activity will be assigned 1-1 oversight until physician and family review occurs.	8/5/25 Ongoing 8/5/25 Ongoing 8/5/25 Ongoing 8/5/25 Ongoing

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S 840	Continued From page 3 and the resident was brought back to the facility safely. The resident was placed on 1:1 supervision until transport arrived to bring him/her to an acute care hospital for an evaluation. She indicated that the resident has not returned to the residence since the two successful elopements occured. During an exit interview on 8/12/2025 at approximately 3:00 PM the Director of Wellness acknowledged that the resident successfully eloped out of the locked unit on two seperate occassions and that based on directionality of where he/she headed, it is likely the resident exited out of the door that leads to the kitchen area, but neither time alarms sounded. Surveyor: BISHOP, AUTUMN Surveyor: Catalfano, Annette	S 840	The community's Safety committee will meet monthly to review Memory Care admissions. In addition, The Collaborative Care Review committee will meet monthly to review new Memory Care admissions. Quarterly Quality Assurance review will be conducted by the Health and Wellness Director and Executive Director to verify compliance.	9/16/25 Ongoing 10/8/25 Ongoing