AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _____	COMPLETED
	ALR01324	B. WING _____	C 12/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DARLINGTON ASSISTED LIVING CENTER NO	123 ARMISTICE BOULEVARD PAWTUCKET, RI 02860

(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 at this residence. Deficiencies were identified as a result of this survey.	S 003	S230 Admin re-educated DOW on Elopement policy & post Fall protocol	12/7/23
S 230	Organization And Management 2.4.13.A Management Of Services 2.4.13 (A/B) Management of Services A. Each residence shall provide services with adequate professional and ancillary employees and in accordance with applicable state law. Further, the residence shall assure that all services are rendered in a safe and effective manner and consistent with the requirements herein. The residence shall provide all care and services to all residents in accordance with the prevailing community standard of care. This Requirement is not met as evidenced by: Based on record review and staff interview it has been determined that the residence failed to follow the community standard of care for two of three sample residents reviewed relative to incidents and accidents, Resident ID #s 1 and 2. Findings are as follows: 1. Review of a policy titled "Elopement Response Procedure" states in part, "...If the search is unsuccessful, the Person in Charge shall...Notify the Resident's physician..." Record review failed to reveal evidence that Resident ID #1's physician was notified following an elopement from the residence on 12/3/2023.	S 230	S230 DOW will ensure to call & document any phone call made to physician, regarding any resident update/ change of condition. S230 — DOW will set reminders to make sure she updates physician on next business day. S230 — DOW will make a check list, & after hours set a reminder for following business day (NB) 1/4/24	12/8/23 12/8/23 12/8/23

Facilities Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Melissa Sanford, ED — TITLE: Executive Director — (X6) DATE: 12-26-23

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	ALR01324	B. WING	C 12/07/2023

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DARLINGTON ASSISTED LIVING CENTER NO	123 ARMISTICE BOULEVARD PAWTUCKET, RI 02860

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S 230	Continued From page 1 During a surveyor interview with the Wellness Director on 12/6/2023 at approximately 3:00 PM, she was unable to provide evidence that Resident ID #1's physician was notified. During a surveyor interview with the Administrator on 12/7/2023 at 10:28 AM, she indicated that she would expect the physician to be notified of a resident's elopement. 2. Review of a protocol titled, "Post fall protocol" revealed in part, "...If a resident did not go to the ER (emergency room) please follow the Q [every] 2 hour check sheet..." Record review revealed Resident ID #2 was admitted to the residence in May of 2022 with diagnoses including, but not limited to, epilepsy (seizure disorder) and a history of falls. Record review revealed the resident sustained falls at the residence on 8/16/2023 and 8/27/2023. Further review revealed the resident was not transferred to the ER following those falls. Record review failed to reveal evidence that the 2-hour check sheets had been completed following the resident's falls on 8/16/2023 or on 8/27/2023. During a surveyor interview with Nursing Assistant, Staff A, she indicated that staff are expected to complete 2-hour checks following a resident's fall. She further revealed that the checks should be completed for 24 hours. Additionally, she acknowledged that the 2-hour checks had not been documented as completed following the above mentioned falls for Resident	S 230	S230 - DOW/Admin re-educated all medication Aides Importance of providing & documenting 2-HR checks. IF resident refused Admin needs to be aware S230 - Any resident rerriving 2-HR check DOW/Admin will monitor checks being done in appropriate time frame, along w proper documentation. S230 - Management will continue quarterly staff meetings to enforce Policies.	12/19/23 12/8/23 1/16/23

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S 230	Continued From page 2 ID #2. During a surveyor interview with the Wellness Director on 12/7/2023 at 10:35 AM, she indicated that she would have expected the 2-hour checks to be completed and documented following the above-mentioned falls.	S 230		
S 375	Residency Requirements 2.4.16.F Resident Assessment/Service Plans 2.4.16 (F) Nurse Review 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	S 375	S375 Resident #1 discharged on 12/11/2023. Resident no longer wanted to reside e facility. 12/11/23 S375 – Admin re-educated DOW on importance of documenting quarterly assessment & any changes of condition resident might have. 12-7-23 S375 – DOW will set reminder/ Alarm to ensure she updates quarterly assessment when needed. 12/8/23	

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S 375	Continued From page 3 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 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 or more licensed registered nurses (i.e., at least one 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 the nurse review form failed to	S 375	S 375 Management will discuss in quarterly Q.A. meetings. 12/20/23 AM 1/4/24	

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S 375	Continued From page 4 report appropriate information related to the resident's needs relative to elopement risk for 1 of 3 residents reviewed, Resident ID #1. Findings are as follows: Record review revealed the resident originally moved into the residence in May of 2023 with diagnoses including, but not limited to, hypertension and tachycardia. Record review revealed the resident eloped from the residence on 10/30/2023 and was found by a staff member on a nearby street on 11/6/2023. Further review revealed the resident was hospitalized following the elopement and returned to the residence on 11/9/2023. Record review of the quarterly assessment dated 11/8/2023 failed to reveal evidence that the resident was identified for "wandering" including, "...moving about aimlessly/without purpose or regard for safety ...has HX [history] of leaving..." Further record review revealed the resident eloped from the facility for a second time on the morning of 12/3/2023 and was unable to be located by the facility. Further review revealed the police were notified of the elopement after 10:00 PM on 12/3/2023. Record review of the progress notes revealed the police found the resident on 12/4/2023 and s/he was transported to the hospital. Further review revealed the resident was found to be hypothermic (low body temperature). During a surveyor interview with the Wellness Director on 12/6/2023 at 2:35 PM she acknowledged that the resident's history of	S 375		

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S 375	Continued From page 5 elopement from the facility was not included on the resident's most recent quarterly assessment.	S 375		
S 380	Residency Requirements 2.4.16.G.1 Resident Assessment/Service Plan 2.4.16 (G) (1) Service Plans 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 that the residence failed to document a description of the services and interventions needed on the service plan for 1 of 3 residents reviewed, Resident ID #2.	S 380	S380 Resident #1 D/C, resident did not want to return. 12/11/23 S380 - Admin re-educated DOW on importance of documenting Service Plan when resident has ANY change of condition, & developing a prevention plan. 12/7/23 S380 - DOW will set reminder Alarm to ensure she updates S.P, & Prevention Plan when needed. 12/7/23	

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S 380	Continued From page 6 Findings are as follows: Review of a policy titled "Elopement Response Procedure" states in part, "...Upon return of the Resident to the facility:...The Resident's Service Plan will be revised to reflect elopement and a prevention plan developed." Record review revealed the resident eloped from the residence on 10/30/2023 and was found by a staff member on a nearby street on 11/6/2023. Further review revealed the resident was hospitalized following the elopement and returned to the residence on 11/9/2023. Additional record review failed to reveal evidence that the service plan dated 5/16/2023 was updated following the elopement on 10/30/2023 and a prevention plan was developed, per the residence's policy. Record review revealed the resident eloped a second time from the facility on the morning of 12/3/2023 and was unable to be located by the residence. During a surveyor interview with the Wellness Director on 12/6/2023 at 2:35 PM, she acknowledged that the resident's service plan had not been updated with any interventions following the initial elopement in 10/30/2023, as required.	S 380	S380- DOW will also utilize a checklist to ensure proper documentation is being done. 12/8/23 11/1/24 S380- Management will discuss in quarterly Q.A. meetings - "Proper Documentation" in the event resident has a change in condition. 12/20/23	
S 405	Residency Requirements 2.4.17.B Reporting Requirements 2.4.17 (B) Reporting Requirements B. Accidents, incidents, and medication errors	S 405		

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S 405	Continued From page 7 resulting in out-of-residence emergency medical services resulting in a hospital admission of any resident shall be reported to the Center for Health Facilities Regulation in writing, via facsimile or electronic transmission to doh.ofr@health.ri.gov by the end of the next working day. A copy of each report shall be retained by the residence for review during subsequent inspections by the Department. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined that the residence failed to report accidents and incidents resulting in a hospital admission of any resident to the Center for Health Facilities Regulation in writing, by the end of the next working day for 1 of 2 residents reviewed for falls, Resident ID #2. Findings are as follows: Record review revealed the resident sustained an unwitnessed fall on 9/13/2023 at 11:10 AM, which resulted in a hospital admission on 9/14/2023. Further record review revealed the resident sustained another unwitnessed fall on 9/26/2023 at 11:00 PM, which resulted in a hospital admission on 9/27/2023. Record review failed to reveal evidence that the falls on 9/13/2023 and on 9/26/2023, resulting in hospital admissions, were reported to the Center for Health Facilities Regulations in writing. During a surveyor interview on 12/7/2023 at 10:28 AM with the Administrator, she acknowledged the incidents were not reported on the next working	S 405 S405 S405 S405 S405	S405 Admin/DOW will set reminder for following business day. 12/8/23 S405 – Supervisor will remind Admin & DOW to ensure residents get reported to DOH in a timely manner 12/8/23 S405 Management conducts weekly meetings to ensure building runs efficiently. S405 Management will also continue to discuss in quarterly Q.A. Meetings 12/20/23	

S 405	Continued From page 8 day, as required.	S 405	