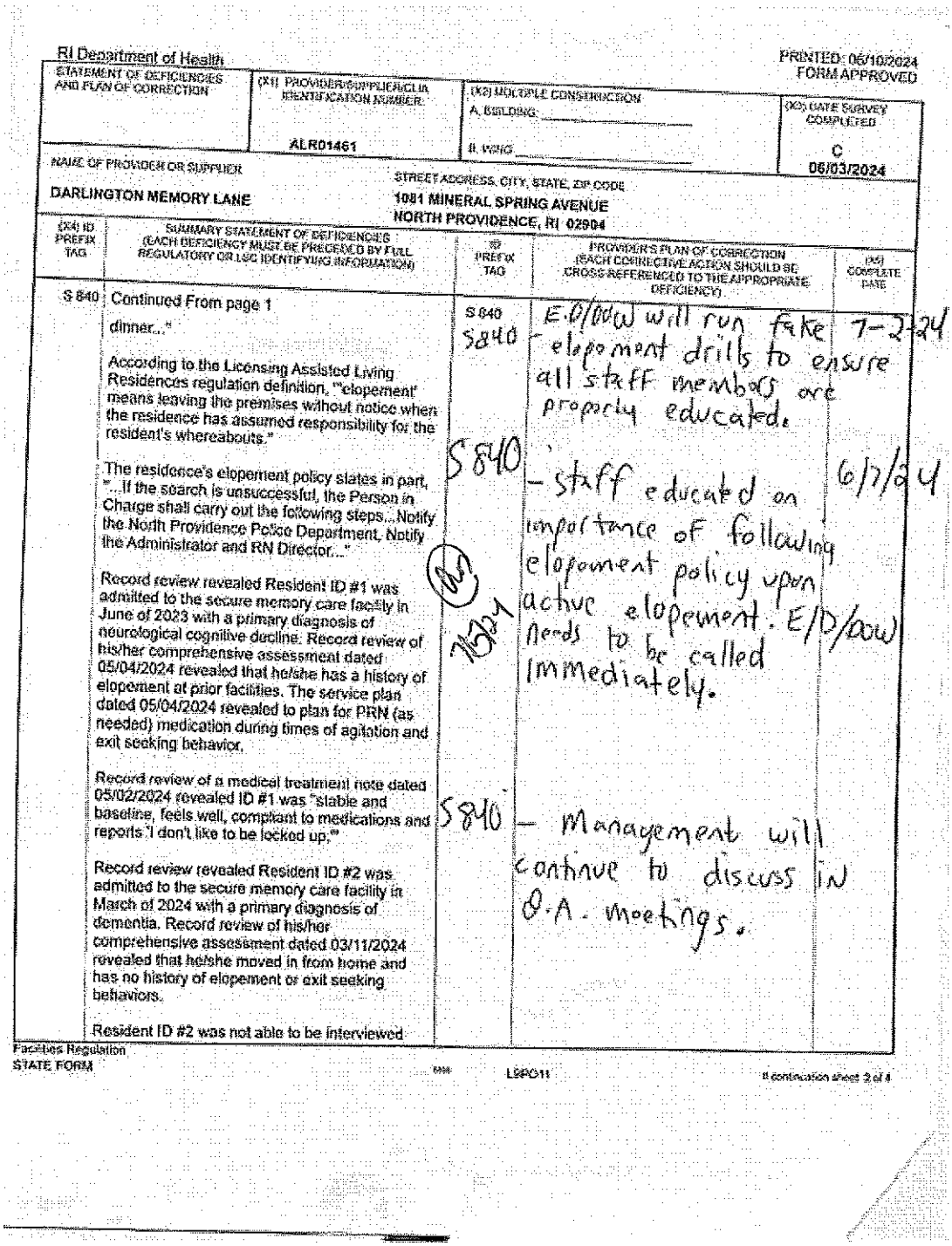
PRINTED: 06/10/2024
FORM APPROVED
RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01461	A. BUILDING _____ B. WING _____	C 06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DARLINGTON MEMORY LANE	1081 MINERAL SPRING AVENUE NORTH PROVIDENCE, RI 02904

(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. A deficiency was identified.	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, it has been determined the residence failed to provide a secure environment for two memory care residents reviewed, Resident ID #s 1 and 2, relative to an exterior gate and staff following the residence's elopement policy. Findings are as follows: Per an initial report sent to the Rhode Island Department of Health (RIDOH) on 06/03/2024, an incident of successful elopement of two residents occurred on 06/01/2024 at 4:11 PM. The report states in part, "@ (at) approximately 5:20 PM, [Staff A] alerted the DOW (Director of Wellness)/ ED (Executive Director) that [Resident ID #1] and [Resident ID #2] where [sic] not in the building for	S 840	RECEIVED JUN 26 2024 FACILITIES REGULATION S 840 E.D/Maintenance installed a secondary fence with a gate, so you would have to get through two gates to get out, leaving only management & the keys. 6/5/24 7/15/24	

Facilities Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Melissa Sanford, Director — TITLE: 6-23-2024 — (X6) DATE



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S 840	Continued From page 1 dinner..." According to the Licensing Assisted Living Residences regulation definition, "'elopement' means leaving the premises without notice when the residence has assumed responsibility for the resident's whereabouts." The residence's elopement policy states in part, "...If the search is unsuccessful, the Person in Charge shall carry out the following steps...Notify the North Providence Police Department, Notify the Administrator and RN Director..." Record review revealed Resident ID #1 was admitted to the secure memory care facility in June of 2023 with a primary diagnosis of neurological cognitive decline. Record review of his/her comprehensive assessment dated 05/04/2024 revealed that he/she has a history of elopement at prior facilities. The service plan dated 05/04/2024 revealed to plan for PRN (as needed) medication during times of agitation and exit seeking behavior. Record review of a medical treatment note dated 05/02/2024 revealed ID #1 was "stable and baseline, feels well, compliant to medications and reports 'I don't like to be locked up.'" Record review revealed Resident ID #2 was admitted to the secure memory care facility in March of 2024 with a primary diagnosis of dementia. Record review of his/her comprehensive assessment dated 03/11/2024 revealed that he/she moved in from home and has no history of elopement or exit seeking behaviors. Resident ID #2 was not able to be interviewed	S 840 S840 S840 7-2-24 S840	E.D/DOW will run fake elopement drills to ensure all staff members are properly educated. 7-2-24 - staff educated on importance of following elopement policy upon active elopement. E/D/DOW needs to be called immediately. 6/7/24 - Management will continue to discuss in D.A. meetings.	

Facilities Regulation
STATE FORM 6899 L9PO11 If continuation sheet 2 of 4

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S 840	Continued From page 2 due to his/her level of cognitive impairment. During surveyor observation and concurrent interview on 06/03/2024 at approximately 4:30 PM in the courtyard, the ED revealed that Resident ID #s 1 and 2 were able to elope through the terrace gate. She further revealed that Resident ID #1 yelled through the gate to a resident of the independent living facility who was outside and requested to be let out through the gate. Review of camera footage confirms that an independent living resident opened the unlocked gate for Resident ID #s 1 and 2, allowing them to leave the premises for several hours and take the public bus. During a surveyor interview on 06/03/2024 at approximately 5:00 PM, with the DOW and the ED, it was revealed that hourly checks were done at 4:00 PM and Resident ID #s 1 and 2 were accounted for. Before dinner, sometime around 4:45, Staff A, Certified Medication Technician, realized that the two residents were not in the common areas for dinner. Staff A then instructed staff to search the building for Resident ID #s 1 and 2. When the staff were unsuccessful in locating the two residents, Staff A then called the DOW, who was in the adjacent building, and informed her the residents were missing. The DOW sent staff down both sides of the street to look for the residents and instructed additional staff to continue looking inside the building. When the search was unsuccessful the ED was called; she informed the staff to call the local police department. The DOW and the ED acknowledged that the time lapse between identifying the residents as missing and calling the police was too long, due to lack of immediate communication from Staff A to the DOW regarding the residents' absences. Both residents	S 840		

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S 840	Continued From page 3 were successfully located between 10:00-11:00 PM at the bus station in downtown Providence. During a surveyor interview on 06/03/2024 at approximately 6:00 PM, Resident ID #1 revealed that he/she asked someone on the other side of the gate to open it and let them out. The resident further revealed, "I do not like being locked in here all the time. And I planned on going to do some shopping and get some food and take the bus back." He/she further revealed that Resident ID #2 wanted to come and that he/she wanted to take the bus back home to his/her parents.	S 840		