| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 415076 | A. Building<br>B. Wing | 09/25/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| John Clarke Senior Living | 600 Valley Road<br>Middletown, RI 02842 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>(continued on next page) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to provide adequate supervision for one of one resident reviewed, Resident ID #1. This resident successfully eloped from the facility on two separate occasions and later entered an unsecured area within the facility, where they sustained a fall that required a hospital transfer for evaluation.Findings are as follows:Review of a community reported complaint submitted to the Rhode Island Department of Health on 9/21/2025 alleges that Resident ID #1 has eloped out of the facility multiple times, and indicated the resident is not appropriate for the facility.Review of an undated facility policy titled, Elopement of Resident, states in part, .All residents will be assessed for potential elopement risk at admission and with a significant change in status.For residents identified as at risk, an interdisciplinary elopement prevention care plan will be developed.Staff witnessing a confused resident or an identified elopement risk resident attempting to leave the Center will intervene as appropriate to redirect the resident to a safe area and prevent elopement.Record review revealed the resident was admitted to the facility in March of 2025, with a diagnosis including, but not limited to, dementia.Review of a Significant Change Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status score of 3 out of 15, indicating the resident has severely impaired cognition. Further review revealed the resident displayed wandering behaviors, one to three days, during the seven-day look back period and utilized a wander guard (a device designed to prevent individuals from wandering away by alerting caregivers when a resident breaches a designated perimeter) daily. Review of a Wandering Assessment dated 7/20/2025 revealed a score of 11, indicating s/he is at high risk for wandering. Record review failed to reveal evidence that an Elopement Assessment was completed, after the resident's significant change in status on 7/18/2025, per the facility policy.Review of a care plan focus area initiated on 6/16/2025 revealed the resident has exit seeking behaviors due to his/her diagnosis of dementia. Interventions include, distract resident from wandering by offering pleasant diversions, food, or conversation and to utilize a wander guard, as ordered. Record review revealed the following physician's orders dated 6/14/2025:- Check functional status of wander guard to right wrist, each shift- Check placement of wander guard on right wrist, each shiftReview of a progress note dated 8/26/2025 revealed the resident successfully eloped from the facility and was found by nursing staff outside of the front door. Further review states, additional safety measures implemented.Record review failed to reveal evidence that additional safety measures were identified and implemented, following the resident's successful elopement on 8/26/2025. Record review revealed a progress note dated 9/20/2025, authored by Registered Nurse (RN), Staff A, which states, at 17:25 [5:25 PM] resident was found by RN outside of building in facility parking lot. Wander guards functioning properly on wheelchair and wrist, wander guard system did not activate. On call supervisor notified and made aware.Record review failed to reveal evidence that additional safety measures were identified and implemented, following the resident's successful elopement on 9/20/2025. Record review revealed a progress note dated 9/21/2025, one day after the resident's successful elopement, which states in part, Resident unable to be located, CNA [Certified Nursing Assistant] found resident lying on the floor in dark therapy room on [his/her] back with difficulty to arouse. Resident responded yes when RN called out [his/her] name multiple times in a delayed response. Resident unable to verbalize any pain and gave a blank stare when asked questions. Resident lethargic on assessment, then became alert with 0 orientation. able to move all 4 [extremities] unable to grasp hands to determine hand strength, pupils unequal at baseline with sluggish response to light accommodation .On call provider.notified with new orders to send resident to [NAME] ED [Emergency Department] for treatment and evaluation via EMS [Emergency Medical Services] . Resident transferred off therapy room floor onto stretcher via EMS personnel.Record review revealed the resident retuned to the facility on 9/22/2025 with a diagnosis of a urinary tract infection. During a surveyor observation on 9/24/2025 at 9:29 AM, Resident ID #1 was noted to have a wander guard on his/her right wrist and 2 additional wander guards located on the back of his/her wheelchair. Record review failed to reveal evidence of a physician's orders to check for functionality or placement of the two wander guards located on the resident's wheelchair. During surveyor interviews on 9/24/2025 at 10:39 AM and 12:35 PM, with RN, Staff A, she indicated that she was one of the nurses on duty on 9/20/2025. She acknowledged that Resident ID #1 successfully eloped from the facility on 9/20/2025, through the main entrance door, and was found in the parking lot, in his/her wheelchair. She revealed that when she was unable to locate the resident |