STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225227	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER: Fitchburg Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 94 Summer Street Fitchburg, MA 01420	

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 37086 Based on records reviewed and interviews for two of three sampled residents (Resident #1 and Resident #2) who were assessed by nursing to be at risk for elopement, the Facility failed to ensure 1) nursing updated Resident #1's comprehensive plan of care with new interventions following an elopement on 07/07/24, and 2) nursing developed and implemented an individualized comprehensive care plan with interventions, treatment goals and outcomes that addressed Resident #2's risk for elopement. Findings include: Review of the Facility's policy titled Care Plans Comprehensive Person-Centered, dated 03/2022, included the following: -A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. -The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. -Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. Review of the Facility's policy titled Wandering and Elopements, dated 03/2019, indicated if a resident is identified to be at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety. 1) Resident #1 was admitted to the Facility in July 2023, diagnoses include hereditary ataxia (impaired balance or coordination), mild cognitive impairment, and repeated falls. Review of Resident #1's Elopement and Wander Risk Evaluation, dated 04/15/24, indicated he/she was assessed as being at high risk for elopement. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's Quarterly Minimum Data Set (MDS) assessment, dated 04/17/24, indicated he/she scored a 10 out of 15 on the Brief Interview for Mental Status (BIMS) assessment (0-7 suggests severe cognitive impairment, 8-12 suggests moderate cognitive impairment, and 13-15 suggests no cognitive impairment). Review of Resident #1's Elopement Care Plan, renewed and reviewed with his/her April 2024 MDS, indicated he/she was at risk for elopement with an intervention to make the receptionist and other staff aware of his/her risk for elopement. Review of Resident #1's Nurse Progress Note, dated 07/07/24 and signed by Nurse #3, indicated Resident #1 had an argument with his/her roommate and Resident #1 attempted to leave the Facility. The Note indicated staff were able to redirect Resident #1 back into the Facility, but he/she refused to go back to his/her room and Resident #1 was moved to a different room for the night. During an interview on 11/26/24 at 3:16 P.M., Nurse #3 said she was the nurse on duty for the evening shift (3:00 P.M. through 11:00 P.M.) on 07/07/24. Nurse #3 said staff found Resident #1 outside in the parking lot adjacent to the facility, that Resident #1 was crying and said that he/she wanted to go home. Nurse #3 said staff were able to redirect Resident #1 back into the Facility. Nurse #3 said she notified the Director of Nurses (DON), Assistant Director of Nurses (ADON) and the Administrator that Resident #1 spent that night in a different room. Nurse #3 said no changes were made to Resident #1's care plan. Review of Resident #1's Elopement Care Plan, initiated 04/12/24, indicated there was no documentation to support that new interventions were implemented after his/her elopement on 07/07/24. Review of an Employee Statement, undated and signed by Certified Nurse Aide (CNA) #1, indicated CNA #1 entered Resident #1's room at 7:40 P.M. on 09/21/24, to provide him/her care, and Resident #1's roommate said Resident #1 left the building to meet his/her spouse. During a telephone interview on 11/26/24 at 4:43 P.M., Nurse #1 said he worked through a staffing agency and was on duty the evening shift of 09/21/24 and he did not know how Resident #1 was able to leave the Facility that evening, unattended by staff. Nurse #1 said it was a busy time of night when Resident #1 left the Facility. Nurse #1 said when Resident #1 returned to the Facility, he/she had bruises on his/her face and abrasions to his/her knees and palms. Nurse #1 said the abrasions were all superficial. During an interview on 11/26/24 at 3:59 P.M., the Director of Nurses (DON) said had she realized that Resident #1 was found outside of the building in the facility's parking lot on 07/07/24, she would have revised the care plan at that time to add new interventions which would have included for Resident #1 to always wear a wander guard bracelet (triggers an alarm at the exit doors) and to increase safety checks performed by staff, in an effort to prevent his/her second elopement. 2) Resident #2 was admitted to the Facility in May 2024, diagnoses include Alzheimer's Disease, repeated falls, and unsteadiness on feet. Review of Resident #2's Nursing Elopement and Wander Risk Evaluation, dated 08/26/24, indicated he/she was assessed to be at high risk for elopement. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #2's medical record indicated there was no documentation to support that an individualized comprehensive care plan with interventions, treatment goals and outcomes that addressed his/her risk of elopement, had been developed. During an interview on 11/26/24 at 3:59 P.M., the Director of Nurses (DON) said Resident #2 should have had a care plan related to his/her risk of elopement once the risk of elopement was identified.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 37086 Based on records reviewed and interviews for one of three sampled residents (Resident #1), who was assessed by nursing to be at high risk for elopement, and was moderately cognitively impaired, the Facility failed to ensure he/she was provided an adequate level of staff supervision to prevent two incidents of elopement, when on 07/07/24, Resident #1 was found out in the parking lot adjacent to the facility (unescorted by a staff member) and, on 09/21/24, Resident #1 was able to exit the facility unbeknownst to staff, was found by staff a couple of blocks away from the facility with bruises on his/her face and abrasions on his/her bilateral knees and palms. Findings include: Review of the Facility Policy titled Wandering and Elopements, dated March 2019, indicated the following: -The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. Review of the Report submitted by the facility via the Health Care Facility Reporting System (HCFRS), dated 09/21/24, indicated that at approximately 7:40 P.M., during evening rounds, the staff were unable to locate Resident #1. Further review of the Report indicated Resident #1 was found at 7:50 P.M., by a staff member, two blocks away from the facility. The Report indicated that Resident #1 said that while he/she was walking outside, he/she fell down but was able to get back up and continue walking. Resident #1 was admitted to the Facility in July 2023, diagnoses include hereditary ataxia (impaired balance or coordination), mild cognitive impairment, difficulty in walking, and repeated falls. Review of Resident #1's Nursing Elopement and Wander Risk Evaluation, dated 04/15/24, indicated he/she was assessed as being at high risk for elopement. Review of Resident #1's Quarterly Minimum Data Set (MDS) assessment, dated 04/17/24, indicated he/she scored a 10 out of 15 on the Brief Interview for Mental Status (BIMS) assessment (0-7 suggests severe cognitive impairment, 8-12 suggests moderate cognitive impairment, and 13-15 suggests no cognitive impairment). Review of Resident #1's Elopement Care Plan, reviewed and renewed with his/her April 2024 MDS, indicated he/she was at risk for elopement and included an intervention to make the receptionist (located at the building's entrance) and other staff aware of elopement risk. Review of Resident #1's Nurse Progress Note, dated 07/07/24 and signed by Nurse #3, indicated Resident #1 had an argument with his/her roommate and Resident #1 attempted to leave the facility. The Note indicated staff were able to redirect Resident #1 back into the facility, but he/she refused to go back to his/her room; Resident #1 was moved to a different room for the night. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further Review of the Note indicated the Director of Nurses (DON), Assistant Director of Nurses (ADON) and the Administrator were all notified. During an interview on 11/26/24 at 3:16 P.M., Nurse #3 said she was the nurse on duty for the evening shift (3:00 P.M. through 11:00 P.M.) on 07/07/24. Nurse #3 said staff found Resident #1 outside in the parking lot adjacent to the facility, that Resident #1 was crying and said that he/she wanted to go home. Nurse #3 said Resident #1 probably walked out of the facility's back door which was not alarmed until 8:00 P.M. Nurse #3 said staff were outside, possibly coming in at change of shift, when they saw Resident #1 in the parking lot. Nurse #3 said staff were able to redirect Resident #1 back into the facility. Nurse #3 said Resident #1 should not have been outside alone. During an interview on 11/26/24 at 3:59 P.M., the Director of Nurses (DON) said that she was notified by Nurse #3 of an incident related to Resident #1 on 07/07/24, but did not realize that Resident #1 was found in the facility's parking lot. The DON said no new interventions to prevent another elopement were added to Resident #1's care plan at that time but should have been. Review of an Employee Statement, undated and signed by Certified Nurse Aide (CNA) #1, indicated CNA #1 entered Resident #1's room at 7:40 P.M. [on 09/21/24] to assist with his/her care and Resident #1's roommate said Resident #1 left the building to meet his/her spouse. Review of an Employee Statement, dated 09/21/24 and signed by Nurse #2, indicated that around 7:40 P.M. a CNA reported to her that Resident #1 was not in his/her room and Resident #1's roommate had reported that Resident #1 left the facility to go home. The Statement indicated Nurse #2 drove down the road from the facility and found Resident #1 crossing a bridge and he/she had bruises to his/her forehead, lips, chin, and bilateral palms. During a telephone interview, which included review of his witness statement, on 11/26/24 at 4:43 P.M., Nurse #1 said he worked at the facility through a staffing agency and was on duty the evening shift of 09/21/24 and Resident #1 was on his assignment. Nurse #1 said a CNA told him that Resident #1 had left the facility alone. Nurse #1 said he began to search the inside of the building. Nurse #1 said he did not know how Resident #1 was able to leave the facility that evening, unattended by staff. Nurse #1 said it was a busy time of night when Resident #1 left. Nurse #1 said when Resident #1 returned to the facility, he/she had bruises on his/her face and abrasions to his/her knees and palms. Nurse #1 said the abrasions were all superficial. During an interview on 11/26/24 at 3:59 P.M., the Director of Nurses (DON) said if she had realized that Resident #1 was found outside of the building in the facility's parking lot on 07/07/24, she would have added new interventions which would have included for Resident #1 to always wear a wander guard bracelet (triggers alarms at the exit doors) and to increase safety checks performed by staff, in an effort to prevent future elopements.