STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225282	A. Building B. Wing	04/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of the South Shore	309 Driftway Box 830 Scituate, MA 02066

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 43963 Based on records reviewed and interviews for one of three sampled residents (Resident #1), the Facility failed to ensure his/her Minimum Data Set (MDS) Assessment accurately reflected his/her behaviors of wandering and repeated requests to go home, which contributed to a delay in developing a plan of care and implementing interventions to address these behaviors. Findings include: Review of the Facility Policy titled, Resident Assessment Instrument (RAI) and Care Plan Development, dated as last revised 08/22/2023, indicated the following; -The MDS Assessment uses patient observation, staff, family, and patient interviews to form the foundation of the comprehensive assessment; -The Care Area Triggers are derived from the information coded on the MDS that identify patient who have or at risk for developing specific functional problems that require further assessment; and -The information identified using the MDS and Care Area Assessment process is used to develop an individualized person-centered care plan that includes the patient's voice, the patients' goals while residing in the Facility and for discharge that assists the patient to attain and/or maintain their highest practicable level of well-being. Resident #1 was admitted to the Facility in March 2024, diagnoses include neurocognitive disorder with Lewy Body Dementia (problems with thinking, unpredictable changes in attention and alertness), atrial fibrillation, depression and Parkinson's Disease (disorder of the central nervous system that affects movement, often includes tremors). Review of Resident #1's Admission Nursing Progress Notes (located within the Admission Collection Tool), dated 03/12/24, indicated he/she had been looking for his/her coat to go out and had been continuously asking to go home. Review of Resident #1's Nurse Progress Note, dated from 03/13/24 through 03/30/24, indicated the following; -On 03/13/24, he/she had been looking for his/her coat to go out and was continuously asking to go home; (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 03/17/24, he/she had been wandering, was intrusive at times going into other resident rooms, and rummaging through trash; -On 03/18/24, he/she had been wandering frequently, intrusive at times, rummaging through other resident belongings and trash; -On 03/21/24, he/she had been wandering, intrusive at times, packing his/her bags and stated that he/she was leaving; -On 03/23/24, he/she had been wandering on unit; -On 03/24/24, he/she had been agitated, anxious, restless, pacing, screaming at others and refusing care; and -On 03/25/24, he/she had been wandering and intrusive at times, attended activities, however, wanders away and attempts to distract him/her works short term only. Review of Resident #1's Admission MDS Assessment, section E (Behaviors), dated 03/18/24, indicated he/she had not exhibited any types of behaviors, including wandering, intrusiveness, rummaging, and pacing during the Assessment Reference Period (ARD) 03/12/24 through 03/18/24. However, this was not consistent with Nurse Progress Notes, dated 03/13/24, 03/17/24, and 03/18/24, which documented Resident #1 had exhibited those types of behaviors. Per the Facility's Investigation, on 4/01/24 at approximately 3:30 P.M., Resident #1 walked to the door at the main entrance, a staff member disengaged the lock that opened the front door and Resident #1 proceed to walk out of the entrance and away from the Facility. During an interview on 04/16/24 at 12:16 P.M., the Social Worker (SW) said she had missed Resident #1's nursing notes describing his/her behaviors and realized that she had not captured that information in Section E on Resident #1's MDS. The SW said if she had captured those behaviors within the admission MDS, a Behavior Care Area Assessment (CAA) would have triggered and a wandering and/or behavior care plan with interventions and goals, would have been developed. During an interview on 04/16/24 at 12:48 P.M., the Director of Social Services said he had not realized that Section E, on Resident #1's MDS, had not been completed correctly and said if Section E had been completed correctly, a care plan would have been developed for wandering and/or exit seeking behaviors for Resident #1. During an interview on 04/16/24 at 3:47 P.M., the Director of Nurses said that the coding error on Resident #1's MDS led him/her to not being triggered for wandering and exit seeking behaviors, so no care plan was initiated. The DON said it is the Facility's expectation to complete all sections of the MDS accurately in order to properly care for each resident and develop care plans that are appropriate for each individual resident.

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 43963 Based on records reviewed and interviews for one of three sampled residents (Resident #1), who upon admission wandered, verbalized to staff that he/she wanted to go home and had physician's orders for psychotropic medication for anxiety and depression, the Facility failed to ensure that upon admission, nursing developed and implemented a baseline care plan with interventions, treatments, goals, and outcomes that addressed the residents overall immediate care needs. Findings include: Review of the Facility Policy titled, Baseline Care Plan, dated as last revised 08/11/23, indicated that a baseline care plan will be developed for every resident within 48 hours of admission to provide an initial set of instructions needed to provided effective and person-centered care of the resident that meet professional standards of care. Resident #1 was admitted to the Facility in March 2024, diagnoses include neurocognitive disorder with Lewy Body Dementia (problems with thinking, unpredictable changes in attention and alertness), atrial fibrillation (irregular, often rapid heart rate that commonly causes poor blood flow), depression and Parkinson's Disease (disorder of the central nervous system that affects movement, often includes tremors). Review of Resident #1's Admission Nursing Assessment, dated 03/12/24, indicated he/she was noted with the following; -verbalizing wanting to go home with wandering; -exhibited agitation, restlessness, anger and sadness; -taking multiple psychotropic medications; and -risk for falls; Review of Resident #1's Medical Record indicated there was no documentation to support Baseline Care Plans were developed or implemented for Resident #1 within 48 hours of admission addressing his/her immediate needs, with the exception of Advanced Directives. The Baseline Care Plan Form for potential problems and/or areas of concern, including behaviors was left blank. Per the Facility's Investigation, on 4/01/24 at approximately 3:30 P.M., Resident #1 walked to the door at the main entrance, a staff member disengaged the lock that opened the door and Resident #1 proceed to walk out of the Facility. During an interview on 04/16/24 at 12:48 P.M., the Director of Social Services said he was not able to provide any documentation to support that baseline care plans were completed for Resident #1. (continued on next page)

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/25/24 at 4:18 P.M., the Case Manager said she had no documentation to support that the baseline care plans were ever completed for Resident #1, and said she did not know how Resident #1's Baseline Care Plans slipped through the cracks. During an interview on 04/16/24, the Director of Nurses said she was unaware that Resident #1 had no baseline care plans in place within 48 hours of admission. The DON said that it is the Facility's expectation that all residents have a baseline care plans developed and implemented within 48 hours of admission, that addresses the immediate needs for each resident until the comprehensive assessment is completed.

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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	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 43963 Based on records reviewed and interviews for one of three sampled residents (Resident #1), who upon admission exhibited wandering behavior and verbalized to staff that he/she wanted to go home, the Facility failed to ensure that the Interdisciplinary Team developed and implemented a person-centered comprehensive care plan with interventions, treatments, goals, and outcomes that addressed the resident's risk for wandering and/or elopement. Findings include: Based on the Facility Policy titled Comprehensive Care Plans and Conferences, dated as last revised 08/22/2023, indicated that the facility is required to develop and implement a comprehensive person-centered care plan for each resident that includes measurable objectives and time frames to meet a residents medical nursing, and mental psychosocial needs that are identified in the comprehensive assessment. The Policy also indicated the following; -The Comprehensive Care Plan cannot be completed until the MDS, the Care Area Triggers are addressed through the CAA Assessment Process; and -Identify and collect information that is needed to identify an individual's condition that enables proper definitions of their conditions, strengths, needs, risks, problems, and prognosis. Resident #1 was admitted to the Facility in March 2024, diagnoses include neurocognitive disorder with Lewy Body Dementia (problems with thinking, unpredictable changes in attention and alertness), atrial fibrillation, depression and Parkinson's Disease (disorder of the central nervous system that affects movement, often includes tremors). Review of Resident #1's Admission Nursing Progress Note (located within the Admission Collection Tool), dated 03/12/24, indicated he/she had been looking for his/her coat to go out and was continuously asking to go home. Review of Resident #1's Nurse Progress Note, dated from 03/13/24 through 03/30/24, indicated the following; -On 03/13/24, he/she had been looking for his/her coat to go out and continuously asking to go home; -On 03/17/24, he/she had been wandering and intrusive at times going into other resident rooms and rummaging through trash; -On 03/18/24, he/she had been wandering frequently and intrusive at times, rummaging through other resident belongings and trash; (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 03/21/24, he/she had been wandering, intrusive at times, and packing his/her bags and stated that he/she was leaving; -On 03/23/24, he/she had been wandering on unit; -On 03/24/24, he/she had been agitated, anxious, restless, pacing, screaming at others and refusing care; and -On 03/25/24, he/she had been wandering and intrusive at times, attends activities, however, wanders away and attempts to distract works short term only. Review of Resident #1's Admission MDS Assessment, section E (Behaviors), dated 03/18/24, indicated he/she had not exhibited any types of behaviors, including wandering, intrusiveness, rummaging, and pacing during the Assessment Reference Period (ARD) 03/12/24 through 03/18/24. However this was not consistent with Nurse Progress Notes during the same reference period of time, in which staff documented Resident #1 had wandering and exit seeking behaviors. Review of Resident #1's Comprehensive Care Plan, dated 03/20/24, indicated that there was no documentation to support that a person-centered care plan was developed or implemented for his/her risk for wandering and/or exit seeking (elopement risk) until 04/02/24, the day after Resident #1 actually eloped from the Facility. Review of the Facility Report submitted via the Health Care Facility Reporting System (HCFRS), dated 04/01/24, indicated that Resident #1 got out of the Facility. The Report indicated that on 4/01/24 at approximately 3:30 P.M., Resident #1 walked to the door at the main entrance, a staff member disengaged the lock that opened the door and Resident #1 proceed to walk out of the Facility. During an interview on 04/16/24 at 12:16 P.M., the Social Worker (SW) said she must have missed Resident #1's nursing notes describing his/her behaviors and realized that she had not captured the information in Section E of Resident #1's MDS. The SW said if she had captured those behaviors on the admission MDS a Behavior Care Area Assessment would have triggered and a wandering/elopement and/or behavior care plan would have been triggered to proceed to develop an at-risk care plan. During an interview on 04/16/24 at 12:48 P.M., the Director of Social Services said he had not known that section E was not completed correctly and said if section E had been completed correctly, a care plan would have been developed for a risk for wandering and/or behaviors for Resident #1. During an interview on 04/16/24 at 3:47 P.M., the Director of Nurses said that the coding error on Resident #1's MDS led to him/her not triggering for wandering and therefore no care plan was developed for his/her risk status. The DON said it is the Facility's expectation to complete all sections of the MDS accurately so a complete and accurate care plan is developed for each resident.

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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. 43963 Based on records reviewed and interviews for one of three sampled residents (Resident #1), who upon admission exhibited wandering behaviors and had verbalized to staff that he/she wanted to go home, the Facility failed to ensure he/she was provided an adequate level of staff supervision to prevent an incident of elopement, when on 04/01/24 at approximately 3:30 P.M., despite his/her photograph being placed at the reception desk alerting staff to the fact he/she was identified as an elopement risk, he/she successfully eloped from the facility when the receptionist on duty let him/her out of the facility. Resident #1 was found at the home of a family member in another town. Findings include: Review of the Facility Policy, titled Unsafe Wandering and Elopement Prevention, dated as last revised 08/10/21, indicated the Facility would promote safety and reduce unsafe wandering and elopements by proactively identifying, care planning and monitoring of Resident wandering and elopement indicators. The Policy further indicated the following; -Residents will be assessed for unsafe wandering and elopement indicators upon admission, readmission, change in condition, quarterly, and with any unsafe wandering or elopement event; and -During the admission and readmission process, a care plan will be initiated by the admitting nurse on any resident assessed with unsafe wandering or elopement behaviors. Review of the Facility Report submitted via the Health Care Facility Reporting System (HCFRS), dated 04/01/24, indicated that Resident #1 got out of the Facility. The Report indicated the facility received a call from a family member who notified them that Resident #1 was at his/her home (previous address prior to admission to the facility). The Report indicated, after walking away from the facility, Resident #1 had been picked up by a good Samaritan and driven to an address provided by Resident #1, but after dropping him/her off, the Samaritan became concerned and notified police in that community (a neighboring town). The Report indicated Resident #1 was unharmed and was brought back to the facility by his/her spouse. Resident #1 was admitted to the Facility in March 2024, diagnoses include neurocognitive disorder with Lewy Body Dementia (problems with thinking, unpredictable changes in attention and alertness), atrial fibrillation, depression and Parkinson's Disease (disorder of the central nervous system that affects movement, often includes tremors). Review of resident #1's Physician's Orders, dated 03/12/24, indicated his/her Health Care Proxy had been activated. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's Admission Minimum Data Set (MDS) Assessment, dated 03/18/24, indicated he/she scored an 8 out of 15 on his/her Brief Interview for Mental Status (BIMS) Assessment (0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired cognition, and 12-15 suggests a resident is cognitively intact). The MDS, Section GG (baseline mobility) indicated Resident #1 required supervision or touch assist with ambulating 10 feet and with ambulation of 50 feet, including making two turns. Review of Resident #1's Physician Progress Note, dated 03/12/24, indicated he/she scored a 3 out of 30 points (indicating severe cognitive impairment) on the Mini-Mental State Exam (MMSE, mild severity is greater than or equal to 20, mild to moderate cognitive impairment is 10-26, moderate to severe cognitive impairment is less than 14, and severe cognitive impairment is less than 10). Review of Resident #1's Admission Nursing Progress Note, (located within the Admission Collection Tool), dated 03/12/24, indicated he/she had been looking for his/her coat to go out and continuously asking to go home. Review of Resident #1's Nurse Progress Note, dated from 03/13/24 through 03/30/24, indicated the following; -On 03/13/24, he/she had been looking for his/her coat to go out and continuously asking to go home; -On 03/17/24, he/she had been wandering, was intrusive at times going into other resident rooms and rummaging through trash; -On 03/18/24, he/she had been wandering frequently, was intrusive at times, rummaging through other resident belongings and trash. -On 03/21/24, he/she had been wandering, was intrusive at times, had been packing his/her bags and stated that he/she was leaving; -On 03/23/24, he/she had been wandering on unit; -On 03/24/24, he/she had been agitated, anxious, restless, pacing, screaming at others and refusing care; and -On 03/25/24, he/she had been wandering, was intrusive at times, attended activities, however wanders away, attempts by staff to distract him/her worked short term only. Review of the Facility Surveillance Video Footage, dated 04/01/24 at 3:30 P.M., clearly showed Resident #1 exiting the Facility through the main entrance once a staff member (receptionist seat at desk) unlocked the door via a release/locking device behind the reception desk. The Video also showed that Resident #1 had approached the main entrance door alone and that there were no visitors, staff members, or other residents seen with him/her. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 04/16/24 at approximately 8:00 A.M., the Surveyor observed the Facility Reception Desk, directly upon entrance to the Facility. The Surveyor had to be let in by the receptionist sitting behind the front desk, who must hit a button to allow visitors in and out. The reception desk was surrounded by a wall of Plexiglas and no staff, visitors, or residents would be able to access the release / unlock feature for the main entrance door unless they were behind the desk. During an interview on 04/16/24 at 2:03 P.M., Receptionist #2 said that Resident #1's photograph had been hanging at the front desk for some time and said he/she would often go to the front desk on the evening shift (4:00 P.M.-8:00 P.M.) and she would have to call the Nurse to help get him/her back to the unit. During an interview on 04/16/24 at 2:24 P.M., Certified Nurse Aide (CNA) #2 said that Resident #1 was always wandering and that he/she would go to the front desk a lot and the receptionist would have to send him/her back to the unit. During a telephone interview on 04/23/24 at 12:05 P.M., Nurse #1 said she thought Resident #1 was at risk for elopement and said she had assumed his/her elopement assessment was completed correctly and that he/she had a wandering/elopement risk care plan in place. During a telephone interview on 04/24/24 at 2:03 P.M., the Unit Manager said that she had not read Resident #1's Admission Nurse Progress Note and had not realized he/she had been looking to go home upon admission. The Unit Manager said she was not aware of his/her elopement assessment results or that Baseline and Comprehensive Care Plans were never developed for Resident #1 as being at risk for wandering/elopement. During an interview on 04/16/24 at 3:15 P.M., the Assistant Director of Nurses (ADON) said at first they had not identified Resident #1 at risk for elopement, but said as time went on they had identified his/her to be at risk for elopement. The ADON said she had not read Resident #1's Admission Nurse Progress Note indicating he/she was asking to go home and wandering. The ADON said that a photograph of Resident #1 was placed at the front desk (exact date unknown) but acknowledged that it was done so prior his/her elopement. The ADON said that as soon as they identified Resident #1 was at risk for elopement a new elopement assessment and care plan should have been developed. During an interview on 04/16/24 at 3:47 P.M., the Director of Nurses (DON) said that the Unit Manager had placed a picture of Resident #1 at the reception/front desk because he/she was very ambulatory, wandered frequently and looked like a visitor. During an interview on 04/16/24 at 3:35 P.M., the Administrator said that the only way to exit the front door was to be buzzed out by a staff member who is behind the front desk. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Administrator said that Receptionist #1 had been working at the time of the elopement and said Receptionist #1 continued to repeat that Resident #1 had looked like a visitor. The Administrator said Resident #1's picture had been hanging at the reception desk and that Receptionist #1 had not noticed that she had let Resident #1 out the front entrance.