

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225324	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/23/2026
NAME OF PROVIDER OR SUPPLIER West Newton Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 25 Armory Street West Newton, MA 02465	

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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records reviewed and interviews for one of three sampled residents (Resident #1), who was assessed as being at increased risk for elopement, had cognitive impairment, and required supervision for ambulation, the Facility failed to ensure that they provided adequate staff supervision to maintain Resident #1's safety, when on 04/09/26, Resident was transported to the hospital for an out-patient medical appointment without an escort, he/she eloped from the hospital, and was later found at the police station approximately four miles away from the hospital. Findings include: Resident #1 was admitted to the Facility in November 2024, diagnoses included muscle weakness, depression, anxiety disorder, and mild cognitive impairment. Review of a Guardianship document (Decree and Order of Appointment of Guardian for an Incapacitated Person), dated 08/28/24, indicated that Resident #1 had a legal guardianship in place. Review of Resident #1's Minimum Data Set Assessment (MDS), dated [DATE], indicated Resident #1 required supervision for ambulation, and had moderate cognitive impairment, evidenced by a Brief Interview for Mental Status (BIMS) score of 12/15 (13-15 indicates intact cognition, 8-12 indicates moderately impaired, and 0-7 indicates severely impaired). Review of Resident #1's Activities of Daily Living Care Plan reviewed and renewed with the MDS Assessment, dated 02/26/26, indicated he/she required supervision for ambulation. Review of Resident #1's Elopement Care Plan, dated as initiated 03/02/26, indicated he/she was at risk for elopement, and a Wandergard bracelet was initiated on 03/02/26. Review of a report submitted by the Facility via Healthcare Facility Reporting System (HCFRS), dated 04/09/26, indicated that Resident #1 left for an appointment at the Hospital with a transportation service, was found elsewhere, and was returned to the Hospital's Emergency Department. Review of the Facility's Internal Investigation Report, undated, indicated that the Facility received a call from the Hospital at around 1:30 P.M. stating that Resident #1 was in the Emergency Department (ED). The Report indicated that Resident #1 had an appointment at the Hospital, had been transported to the appointment by a transportation company and handed over to Hospital staff. The Report indicated that the clinic that Resident #1 was supposed to be at indicated he/she had not been present for the appointment. The Report indicated that Police said Resident #1 arrived at the Police Station and said he/she was supposed to be at an appointment at the Hospital, so the Police requested Emergency Medical Services to transport Resident #1 to the Hospital's ED. Further review of the Facility's Internal Investigation Report indicated that a Facility escort was scheduled to attend the Hospital appointment with Resident #1, but the transportation company had left the Facility with Resident #1 without his/her escort. Review of the Facility's appointment calendar indicated that on 04/09/26, Resident #1 was scheduled for an appointment, was being picked up by the transportation company at 9:30 A.M., and Certified Nurse Aide (CNA) #1 was assigned to be his/her escort. Review of a Police Report, dated 04/09/26, indicated that on 04/09/26 at about 12:10 P.M., Resident #1 walked into the Police Station, reported that he/she was lost and wanted to go to the Hospital, so the officer requested Emergency Medical Services (EMS) to transport Resident #1 to the Hospital. During a telephone interview on 04/30/26 at 1:33 P.M., Certified Nurse Aide (CNA) #1 said she was not sure which resident she was supposed to escort that day, but (continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Nurse #2 gave her paperwork and told her to go with Resident #1. CNA #1 said when she got downstairs, the transportation company had already left the Facility with Resident #1. During a telephone interview on 04/29/26 at 4:50 P.M., Nurse #1 said he was an agency nurse, and was not aware of the Facility's procedures for escorting residents to appointments. Nurse #1 said he was told that Resident #1 had an appointment, and so he thought nothing of it when the transport company came to pick him/her up. During a telephone interview on 04/30/26 at 12:22 P.M., Nurse #2 said Nurse #1 was assigned to Resident #1 that day, but when she saw Resident #1 leaving with a transport driver, she stopped them and asked where they were going. Nurse #2 said she checked the schedule and saw that Resident #1 had an appointment, so she found CNA #1, gave her the paperwork, and told her to go with Resident #1. Nurse #1 said that by the time CNA #1 got downstairs, the transport driver had left with Resident #1 without her. Nurse #2 said she told the Unit Manager and the Assistant Director of Nurses (ADON) that Resident #1 had left for an appointment with the transportation company without an escort. Nurse #2 said she could not remember the exact time but said Resident #1 left with the transport company sometime around 9:00 A.M. Nurse #2 said that the Hospital called one to two hours later and told staff that Resident #1 had been found wandering the streets. During a telephone interview on 04/30/26 at 1:48 P.M., the Unit Manager said that on 04/09/26, she showed up at the Facility at around 9:40 A.M., and Nurse #1 told her that Resident #1 had gone to a hospital appointment without an escort. The Unit Manager said she notified the ADON, but she was already aware. The Unit Manager said she could not remember the exact time, but said the Hospital called and reported to them that Resident #1 was found wandering, so she notified the Director of Nurses (DON). During a telephone interview on 05/01/26 at 10:06 A.M., (which included a review of her written witness statement), the Assistant Director of Nurses (ADON) said there had been several residents going out for appointments that morning and said Nurse #2 told her around 10:00 A.M. that Resident #1 had gone out for an appointment without an escort. The ADON said that Resident #1 always goes to medical appointments with an escort and should not have gone out that day without one. The ADON said even though she was notified immediately that Resident #1 went out without an escort, she didn't really process the information because she was trying to figure out other escorts for all of the appointments. During an interview on 04/23/26 at 2:25 P.M., the Director of Nurses (DON) said that she was notified by the Administrator on 04/09/26 in the afternoon that Resident #1 had gone out for an appointment with the transportation company without an escort. The DON said Resident #1 required an escort for appointments based on his/her cognitive status and that he/she was not safe to leave the Facility without one, but had, and was found wandering the streets. During an interview on 04/23/26 at 2:49 P.M., the Administrator said that on 04/09/26, he had been notified by Resident #1's Guardian sometime between 1:00 P.M. t and 1:30 P.M., that Resident #1 was wandering the streets. The Administrator said that Resident #1 should not have gone out for an appointment without an escort. The Administrator said nursing should have notified him immediately when they noticed that Resident #1 went out for an appointment with the transport company around 9:30 A.M. without an escort, but they had not. The Administrator said Resident requires an escort for safety. The Administrator said Resident #1 somehow made it from the hospital to a police station (approximately four miles away) and EMS then transported him/her to the Hospital's ED. The Administrator said Resident #1 was unharmed but had not returned to the Facility per his/her guardian's request. On 04/23/26, the Facility was found to be in Past Non-Compliance and presented the Surveyor with a plan of correction, with an effective date of 04/18/26 which addressed the area(s) of concern as evidenced by: A. On 04/09/26 Resident #1 was transported to the Hospital' ED, was evaluated, and no injuries were noted. Resident #1 was not readmitted to the Facility per Guardian's request. B. On 04/09/26, the Administrator instituted immediate changes to their procedures for resident appointments, including how appointments are tracked on their electronic calendar, and how they communicate with the transport company to ensure no resident leaves the Facility without an escort if, one is required. C. On 04/09/26, Nursing Staff were educated by the ADON to notify Administration (continued on next page)</p>		

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