STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225356	A. Building B. Wing	03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Care One at Randolph	49 Thomas Patten Drive Randolph, MA 02368

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 43963 Based on records reviewed and interviews, for one of three sampled residents (Resident #2), who had experienced a change in condition related to an incident of elopement, the Facility failed to ensure that nursing notified Resident #2's Health Care Agent (HCA, Family Member #3 aka, his/her Resident Representative), when on 02/21/25 at approximately 5:45 A.M., an individual that had dropped off a staff member for work, found a person (later identified as Resident #2) outside the Facility sitting on the pavement in the middle of the facility's driveway, and Family Member #3 was not made until much later that day (around 2:00 P.M.) when she came into visit Resident #2 and questioned staff about the areas of bruising to Resident #2's knees. Findings include: Review of the Facility Policy titled Change in a Resident's Condition or Status, dated as last revised February 2021, indicated that the Facility promptly notifies the resident, his/her attending physician, and the resident's representative of changes in the resident's medical/mental condition and/or status. The Policy further indicated that unless otherwise instructed by the resident, a nurse will notify the resident's representative when: -The resident is involved in any accident or incident that results in an injury including injuries of unknown origin; -There is a significant change in the resident's physical, mental, or psychosocial status; -There is a need to change the resident's room assignment; -A decision has been made to discharge the resident from the facility; and/or -It is necessary to transfer the resident to the hospital/treatment center. Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 02/28/25, indicated that on 02/21/25 at approximately 5:45 A.M., Resident #2 was found outside sitting in the driveway of the facility. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #2 was admitted to the Facility in February 2025, diagnoses include respiratory failure with Chronic Obstructive Pulmonary Disease (COPD), malignant lung cancer and dementia. Review of Resident #2's Hospital Discharge Summary, dated 02/18/25, indicated that his/her Health Care Proxy was invoked while at the Hospital and his/her HCA was responsible for health care related decisions. Review of Resident #2's Admission Face Sheet, indicated that his/her Health Care Agent was his/her first Emergency Contact (Family Member #3). Review of Resident #2's Brief Interview for Mental Status (BIMS, evaluates cognitive impairment and can help with dementia diagnoses), dated 02/19/25, indicated his/her BIMS score was a 12, (8-12 indicates moderately impaired cognition). During a telephone interview on 03/17/25 at 11:11 A.M., Family Member #3 said that on the day of his/her admission to the facility, she reported to the nurse that she was Resident #3's HCA and that his/her Health Care Proxy (HCP) had been invoked at the Hospital. Family Member #3 said that she wanted to ensure that Resident #3's medications were accurate, that he/she could not comprehend medical issues and asked the nursing staff to reach out to her as his/her Resident Representative. Family Member #3 said she requested that nursing ask his/her physician to evaluate the need to invoke his/her HCP as well, while in the Facility, as soon as possible. During a telephone interview on 03/19/25 at 9:10 A.M., Nurse #2 said that on 2/21/25, he was not aware that Resident #2 had eloped from the Facility and at approximately 5:30 A.M., Nurse #7 brought Resident #2 to his/her unit after being found outside on the ground in the driveway, just minutes earlier. Nurse #2 said that he reported the incident to the Director of Nurses, but said he did not call to inform Resident #2's responsible party (Resident Representative/HCA/Family Member #3) of the incident. Review of Resident #2's medical record, indicated that there was no documentation to support that nursing staff notified his/her HCA/Resident Representative after the accident/incident had occurred on 02/21/25. During an interview on 03/20/25 at 6:22 A.M., the Staff Development Coordinator (SD) said that all accidents and incidents should be reported to a resident's representative/HCA after an incident occurs unless otherwise requested and/or documented by the resident. During an interview on 03/19/25 at 12:48 P.M., the Assistant Director of Nurses (ADON) said that she was not aware Resident #2's responsible party (HCA/Resident Representative) had not been notified of the incident that occurred that morning. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The ADON said that at 2:00 P.M., on 2/21/25, Family Member #3 pointed out to her that Resident #2 had bruising to both of his/her knees. The ADON said that Family Member #3 had still not been told of the incident of Resident #2 being found on the ground in the driveway earlier that morning. The ADON said that she then informed Family Member #3 (HCA) that the injuries may have been from the fall that he/she had sustained earlier that morning. During an interview on 03/20/25 at 9:58 A.M., the Director of Nurses said that she was not aware that Nurse #3 had not informed Resident #2's responsible party (HCA/Resident Representative) of his/her incident earlier that morning. The DON said that it is the facility's expectation that when a serious accident/incident occurs while a resident is residing at the facility, it is the responsibility of the nurse to inform the appropriate parties, including the resident's responsible party (HCA/Resident Representative) unless otherwise indicated by the resident.