

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225395	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2024
NAME OF PROVIDER OR SUPPLIER Lanessa Extended Care		STREET ADDRESS, CITY, STATE, ZIP CODE 751 School Street Webster, MA 01570	

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 0603</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from separation (from other residents, his/her room, or confinement to his/her room).</p> <p>37227</p> <p>Based on records reviewed and interviews, for two of four sampled residents (Resident #1 who had a history of exit seeking and routinely wandered the unit during the evening shift and Resident #4, his/her roommate who was also ambulatory) the Facility failed to ensure that they were free from involuntary seclusion by being confined to their room by staff, when on 01/12/24 from approximately 9:30 P.M. to 11:30 P.M., a plastic bag was tied from the door handle of Resident #1 and Resident #4's room to the handrail in the hallway outside their room, by Certified Nurse Aide (CNA) #1 who admitted to doing it in order to prevent Resident #1 from exiting his/her room to wander the unit and exit seek.</p> <p>Findings include:</p> <p>Review of the Facility Policy titled Abuse, Neglect and Exploitation, dated as implemented February 2023, indicated the Facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation.</p> <p>Further review of the policy indicated it included the following definition of involuntary seclusion: the separation of a resident from other residents or from his/her room or confinement to his/her room against the resident's will or the will of the resident's legal representative.</p> <p>Review of the Facility's Investigation Narrative, dated 01/22/24, indicated that during a review of clinical notes on 01/15/24, it was noted that staff found a plastic bag tied around the door handle to Resident #1's room. The Narrative indicated that Certified Nurse Aide (CNA) #1, said that she tied the plastic bag around the door handle to lock Resident #1's room and keep him/her safe while she (CNA#1) attended to another resident.</p> <p>Resident #1 was admitted to the Facility in November 2021, diagnoses included unspecified dementia, adult failure to thrive, weakness and other abnormalities of gait and mobility.</p> <p>Review of Resident #1's Annual Minimum Data Set (MDS) assessment, dated as completed 10/27/23, indicated he/she was severely cognitively impaired with a score of 6 out of 15 on the Brief Interview for Mental Status (BIMS, scores indicate: 0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, and 13-15 cognitively intact). Further review of the MDS indicated Resident #1 ambulated independently, required the use of a walker, and had wandering behaviors that occurred four to six days a week.</p> <p>(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 0603</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #1's Behavior Care Plan, dated 11/17/23, indicated he/she wandered and was at risk of eloping from the facility. Care Plan interventions included providing diversional activities and redirection when exit seeking.</p> <p>Review of Resident #1's Nurse Progress Note, dated 01/13/24 and time stamped 7:07 A.M., indicated at 11:30 P.M. (1/12/24), a CNA notified Nurse #1 that a plastic bag was around this resident's door. The Note indicated staff removed the bag, and both residents in the room were safe.</p> <p>Resident #4 was admitted to the Facility in August 2021, diagnoses included unspecified dementia, and delusional disorders.</p> <p>Review of Resident #4's Quarterly MDS assessment, dated as completed 10/27/23, indicated he/she was severely cognitively impaired with a score of 2 out of 15 on the BIMS. Further review of the MDS indicated Resident #4 transferred and ambulated with supervision and did not require an assistive device.</p> <p>During a telephone interview on 04/03/24 at 2:59 P.M., Certified Nurse Aide (CNA) #1 (which also included a review of her written witness statement dated 01/15/24) said she worked the 3:00 P.M. to 11:00 P.M. (evening) shift on 01/12/24 on the Elmwood Unit that housed several residents with dementia that wandered and had exit seeking behaviors. CNA #1 said the unit was short staffed that evening, with only two CNAs after 8:00 P.M. to care for over 40 residents. CNA #1 said that evening, Resident #1 had been wandering and setting off the exit door alarms.</p> <p>CNA #1 said she was the only staff member on the unit from around 9:00 P.M. to 9:30 P.M., while Nurse #1 and CNA #3 went on break at the same time. CNA #1 said that during that time, one of her assigned residents needed incontinence care, so she put Resident #1 in his/her room with his/her roommate (Resident #4) who was asleep, and tied the door shut with a plastic bag for safety reasons, to keep Resident #1 from coming out of his/her room, wandering, and potentially exiting the facility.</p> <p>CNA #1 further said that she did not untie the bag from Resident #1's door at any time after 9:30 P.M. and she said the door was still tied shut 90 minutes later at 11:00 P.M., when she exited the facility at the end of her shift.</p> <p>During a telephone interview on 04/05/24 at 12:24 P.M., Certified Nurse Aide (CNA) #2 (which also included a review of her written witness statement dated 01/13/24) said that Resident #1 often wandered in the hallway during both the evening and night shifts. CNA #2 said Resident #1 was independent using a rolling walker and he/she would often walk in the hall and go in and out of his/her room to rest or have a snack. CNA #2 said Resident #4 stayed in bed and did not come out of his/her room unless encouraged by staff.</p> <p>Although Resident #4 did not have a history of wandering, had Resident #4 decided that night to get out of bed and leave his/her room, he/she therefore also had the potential to be affected by being involuntarily confined to his/her room.</p> <p>(continued on next page)</p>		

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<p>F 0603</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>CNA #2 said she worked the 11:00 P.M. to 7:00 A.M. shift (starting on 01/12/24 into 1/13/24) and while she was checking on her assigned residents, at approximately 11:30 P.M., she observed that Resident #1's door was tied shut with a plastic bag. CNA #2 said one end of the plastic bag was tied to the door handle and the other end of the plastic bag was tied to the adjacent handrail, preventing the door from being opened. CNA #2 said she saw the door handle move as though a resident in the room was trying to open it.</p> <p>CNA #2 said she immediately alerted Nurse #1 and CNA #3 and they opened the door, finding Resident #1 in the room, standing just behind the door. CNA #2 said that Resident #1 did not appear upset or agitated, CNA #2 said that Resident #4 was asleep in bed.</p> <p>During a telephone interview on 04/03/24 at 2:15 P.M., Certified Nurse Aide (CNA) #3 (which also included a review of his written witness statement dated 01/13/24) said he worked a double shift on 1/12/24, from 3:00 P.M. to 7:00 A.M. on 01/13/24, on the Elmwood unit. CNA #3 said Resident #1 regularly wandered up and down the hall during the evening shift and opened all the doors, including the alarmed exit doors.</p> <p>CNA #3 said that around 11:30 P.M., CNA #2 asked him to help her untie a plastic bag that was fastened to Resident #1's door. CNA #3 said the door was tied shut with a plastic bag, from the door handle to the handrail, in a way that would prevent it from being opened. CNA #3 said the plastic bag was difficult to remove. CNA #3 said that when CNA #2 opened the door, Resident #4 was asleep but Resident #1 was awake and he/she did not appear distressed.</p> <p>CNA #3 said he did not notice the door was tied shut until CNA #2 pointed it out to him around 11:30 P.M., because he was working in another area.</p> <p>Review of Nurse #1's written statement, dated 01/12/24, indicated she was notified by a CNA that a plastic bag was tied on Resident #1's door handle and when the CNA removed the bag both residents in the room (Resident #1 and Resident #4) were safe inside.</p> <p>The Surveyor was unable to interview Nurse #1 as she did not respond to the Department of Public Health's telephone or letter requests for an interview.</p> <p>During a telephone interview on 04/03/24 at 2:15 P.M., Nurse #2 (which also included a review of her written witness statement dated 01/13/24) said that on 01/12/24, sometime around 11:30 P.M., Nurse #1 told her that staff had found Resident #1's door tied shut with a plastic bag. Nurse #2 said she asked both CNA #2 and CNA #3 if they knew who tied the door shut, and they both said they did not know who was responsible. Nurse #2 said she told Nurse #1 it was a reportable incident.</p> <p>During a telephone interview on 04/05/24 at 8:48 A.M., Director of Nurses (DON) #1 said that on the morning of 01/15/24, she discovered a nurse progress note in Resident #1's record, dated 01/13/24, that indicated a bag was found on his/her door. DON #1 said the note was confusing due to a lack of details, so she spoke with Nurse #1 and Nurse #2 for clarification, at approximately 7:30 A.M., that day before they left at the end of their overnight shift. DON #1 said that both Nurses told her that on 01/12/24 at approximately 11:30 P.M., the door to Resident #1's room was found tied shut for an undetermined amount of time.</p> <p>(continued on next page)</p>		

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<p>F 0603</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>DON #1 said CNA #1 told her that she became overwhelmed when the other staff on the unit took a break at the same time, so she tied the door closed to Resident #1's room to keep her safe while she attended to another resident on her assignment.</p> <p>During an interview on 04/03/24 at 3:47 P.M., the Administrator said the Facility's investigation substantiated an allegation of involuntary seclusion based on statements from staff and an interview with CNA #1 where she admitted to tying Resident #1's door closed to keep him/her from exiting the room.</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>37227</p> <p>Based on records reviewed and interviews, for two of four sampled residents (Resident #1 and Resident #4), the Facility failed to ensure staff implemented and followed their Abuse Policy related to the need to immediately report an allegation of involuntary seclusion to the Administrator or designee, when on 01/13/24, Nurse #1 and Nurse #2 became aware during the overnight shift, that the door to a bedroom occupied by two ambulatory residents was tied shut, preventing them from exiting the room at will. However, although both Nurse #1 and Nurse #2 were both aware of the incident, the Facility Administration was not made aware of the incident until 01/15/23 (two days later), when Director of Nurses (DON) #1 spoke with Nurse #1 and Nurse #2 after discovering a progress note about the incident.</p> <p>Findings include:</p> <p>Review of the Facility Policy titled Abuse, Neglect and Exploitation, dated as implemented February 2023, indicated the Facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation.</p> <p>The Policy indicated the following definition of Involuntary Seclusion: the separation of a resident from other residents or from his/her room or confinement to his/her room against the resident's will or the will of the resident's legal representative.</p> <p>Further review of the Policy indicated the facility will have written procedures that include reporting of all alleged violations to the administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes:</p> <p>a) Immediately, but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse or serious bodily injury,</p> <p>Or</p> <p>b) Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.</p> <p>Review of the Facility's Investigation Narrative, dated 01/22/24, indicated that during a review of clinical notes on 01/15/24, it was noted that staff found a plastic bag tied around the door handle to Resident #1's room (which he/she shared with Resident #4). The Narrative indicated that Certified Nurse Aide (CNA) #1, said that she tied the plastic bag around the door handle to lock Resident #1's room and keep him/her safe while she (CNA#1) attended to another resident.</p> <p>During a telephone interview on 04/05/24 at 12:24 P.M., Certified Nurse Aide (CNA) #2 said that while she was checking on her assigned residents at approximately 11:30 P.M., during the start of the overnight shift on 01/12/24, she observed that Resident #1's door was tied shut with a plastic bag, while he/she was in the room along with Resident #4, his/her roommate.</p> <p>(continued on next page)</p>

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>CNA #2 said she immediately reported the incident to Nurse #1, who came to observe the situation, along with CNA #3.</p> <p>Although Resident #4 did not have a history of wandering, had Resident #4 decided that night to get out of bed and leave his/her room, he/she would have also been affected by being involuntarily confined to his/her room.</p> <p>CNA #2 said that when she and CNA #3 untied the bag and opened the door, Resident #1 was in the room, standing just behind the door and Resident #4 was in bed asleep. CNA #2 said that Resident #1 typically wandered the unit during the evening and overnight shifts. CNA #2 said Resident #4 usually stayed in bed during the night and said he/she did not leave the room unless encouraged by staff.</p> <p>Review of Nurse #1's Written Witness Statement, dated 01/12/24, indicated a CNA reported that a bag was tied to the door handle of Resident #1's room. The Statement indicated both residents were safe inside.</p> <p>The Surveyor was unable to interview Nurse #1 as she did not respond to the Department of Public Health's telephone and letter requests for an interview.</p> <p>During a telephone interview on 04/03/24 at 2:15 P.M., Nurse #2 said that on 01/12/24, sometime after 11:30 P.M., Nurse #1 told her that staff had found Resident #1's door tied shut with a plastic bag.</p> <p>Nurse #2 said she asked both CNA #2 and CNA #3 to complete witness statements about the incident. Nurse #2 said she told Nurse #1 that the incident was suspected abuse and it needed to be reported to administration.</p> <p>Although Nurse #2 was also aware of the incident, told Nurse #1 that it needed to be reported, and instructed the CNA's to write statements, Nurse #2 also did not make sure Administration was made aware of the incident.</p> <p>During a telephone interview on 04/05/24 at 8:48 A.M., Director of Nurses (DON) #1 said that on the morning of 01/15/24 she discovered a nurse progress note in Resident #1's record, dated 01/13/24, that indicated a bag was found on his/her door. DON #1 said the note was confusing due to a lack of detail, so she spoke with Nurse #1 and Nurse #2, at approximately 7:30 A.M. for clarification, before they left at the end of their overnight shift. DON #1 said that both Nurses told her that on 01/12/24, at approximately 11:30 P.M., the door to Resident #1's room was found tied shut (by a plastic bag) for an undetermined amount of time.</p> <p>DON #1 said that neither Nurse #1 or Nurse #2 reported the incident to Facility Administration as required, therefore, the investigation was not initiated until 01/15/24, placing other residents at risk for abuse.</p> <p>During an interview on 04/03/24 at 3:47 P.M., the Administrator said the expectation when abuse is suspected by a staff member, is for the staff to report it to their supervisor immediately. The Administrator said the Supervisor's responsibility is to immediately notify the administrator or the DON. The Administrator said Nurse #1 should have notified administration of the incident immediately on 01/12/24</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>37227</p> <p>Based on records reviewed and interviews, for two of four sampled residents (Resident #1 and Resident #4), the Facility failed to ensure that an allegation of involuntarily seclusion, was reported to the Department of Public Health (DPH) within two hours, as required, per Federal Regulations and Facility policy. When on 01/15/24 at approximately 7:30 A.M., Director of Nurses (DON) #1 became aware of an incident that occurred on 01/12/24, where the door to the bedroom occupied by Resident #1 and Resident #4 was found to be tied shut, however the incident was not reported that day to DPH until 6:07 P.M., more than ten hours later.</p> <p>Findings include:</p> <p>Review of the Facility Policy titled Abuse, Neglect and Exploitation, dated as implemented February 2023, indicated the Facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation.</p> <p>The Policy indicated the following definition of Involuntary Seclusion: the separation of a resident from other residents or from his/her room or confinement to his/her room against the resident's will or the will of the resident's legal representative.</p> <p>Further review of the Policy indicated the facility will have written procedures that include reporting of all alleged violations to the administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes:</p> <p>a) Immediately, but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse or serious bodily injury,</p> <p>Or</p> <p>b) Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.</p> <p>Review of Resident #1's Nurse Progress Note, dated 01/13/24 at 7:07 A.M., indicated at 11:30 P.M., a CNA notified Nurse #1 that a plastic bag was around this resident's door. The Note indicated staff removed the bag and both residents in the room were safe.</p> <p>During an interview on 04/03/24 at 3:47 P.M., the Administrator said she first heard about the 1/12/24 incident on 01/15/24, during the morning meeting. The Administrator said the former Director of Nurses (DON #1) was responsible for reporting the incident to DPH. The Administrator said any incident involving abuse must be reported to DPH within two hours.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated as submitted on 01/15/24 at 6:07 P.M., indicated that DON #1 reported an incident to DPH, that occurred on 01/12/24 at 11:30 P.M., when CNA #2 found that the door to a room occupied by Resident #1 and Resident #4, was tied shut. The Report indicated that CNA #1 said she tied the door shut to keep Resident #1 safe in his/her room while she attended to another resident.</p> <p>Further review of the Report indicated DON #1 submitted the HCFRS report of the incident greater than 10 hours after she learned of the incident on 01/15/24, when she interviewed Nurse #1 and Nurse #2 at 7:30 A.M., that morning.</p> <p>During a telephone interview on 04/05/24 at 8:48 A.M., Director of Nurses (DON) #1 said that on the morning of 01/15/24 she discovered a nurse progress note in Resident #1's record, dated 01/13/24, that indicated a bag was found on his/her door. DON #1 said the note was confusing due to a lack of detail, so she spoke with Nurse #1 and Nurse #2 for clarification, at approximately 7:30 A.M., before they left at the end of their overnight shift.</p> <p>DON #1 said both the Nurses told her that on 01/12/24 at approximately 11:30 P.M., CNA #2 reported that the door to a room occupied by Resident #1 and Resident #4 was tied shut, preventing the residents from exiting the room at will. DON #1 said that Nurse #2 told her that both CNA #2 and CNA #3 had denied knowing who tied the door shut.</p> <p>DON #1 said that on 01/15/24 at 3:00 P.M., when CNA #1 arrived for work, she interviewed her about the incident. DON #1 said that CNA#1 told her that she had tied the door closed to prevent Resident #1 from exiting his/her room and to keep him/her safe. The DON said she reported the incident to DPH later that evening.</p>		

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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>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>37086</p> <p>Based on records reviewed and interviews, for one of three sampled residents (Resident #2), who had dementia and was known by staff to wander the hallways and exhibited exit seeking behaviors, the Facility failed to ensure that Resident #2 was provided with an adequate level of staff supervision, in an effort to maintain his/her safety to prevent an elopement. On 03/11/2024, at some point during the day shift, unbeknownst to staff, Resident #2 exited the Facility, unit staff only became aware of the elopement after Resident #2's lunch tray was left untouched, and staff could not locate him/her. Resident #2 was found later that same day by the police, seated on the side of a road, four miles from the Facility.</p> <p>Findings include:</p> <p>Review of the Facility's policy titled Elopement, dated July 2015, indicated the Facility would maintain a process to screen all residents for risk of elopement, implement preventative strategies for those identified at risk, institute measures for resident identification at the time of admission, and conduct missing resident procedures, as warranted.</p> <p>Resident #2 was admitted to the secured unit (alarms at all exit doors) of the Facility in December 2023, diagnoses included dementia, anxiety disorder, and history of traumatic brain injury (TBI).</p> <p>Review of Resident #2's Elopement and Wandering Risk assessments, dated 12/22/23 and 01/25/24, indicated Resident #2 was at risk for wandering and elopement.</p> <p>Review of Resident #2's Admission Minimum Data Set (MDS) assessment, dated 12/28/23, indicated he/she was moderately cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 9, (0-7 indicates severe cognitive impairment, 8-12 indicates moderate cognitive impairment, 13-15 indicates cognitively intact). The MDS also indicated that Resident #2 had wandering behavior for one to three days during the seven day look back period.</p> <p>Review of Resident #2's wandering care plan, with a revision date of 01/18/24, indicated Resident #2 expressed desires to go home, moved without regard to his/her safety, paced and roamed in an out of resident rooms and tried to leave the Facility.</p> <p>Review of Resident #2's Nurse Progress Note, dated 01/13/24, indicated that around 9:00 P.M., Resident #2 became increasingly agitated and banged on the doors (to exit the unit) and was asking to return to the hospital where he/she had previously been treated in. The Note indicated that Resident #2 pushed the door (leading to the lobby) until it opened and walked across the lobby to the other nursing unit.</p> <p>Review of Resident #2's Nurse Progress Note, dated 02/12/24 at 3:33 P.M., indicated Resident #2 had been exit seeking all shift and managed to get outside. The Note indicated Resident #2 was escorted back to the unit, and that Resident #2 said he/she wanted to return to the hospital he/she had previously been treated in.</p> <p>(continued on next page)</p>		

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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>Review of the Facility's Investigation Report, dated 03/18/24, indicated that on 03/11/24, at approximately 2:15 P.M., staff could not locate Resident #2. The Report indicated that Resident #2 was last seen at approximately 11:45 A.M. when he/she was observed by a staff member Physical Therapy Assistant (PTA) #1, pushing a handle on the door used to exit the unit. The Report indicated that PTA #1 did not notify nursing (that Resident #2 was exit seeking) or redirect Resident #2 away from the exit door.</p> <p>The Report indicated that at approximately 2:00 P.M., Certified Nurse Aide (CNA) #7 alerted the nurse on the unit (Nurse #4) that Resident #2 was not in his/her room. The Report indicated that at approximately 2:15 P.M., a Dr. Hunt code (a Facility wide code to alert staff of a missing resident and to implement their search policy) was called, the staff searched the grounds of the Facility and 911 was notified.</p> <p>The Report indicated that the local police department notified the Facility at approximately 2:45 P.M. on 03/11/24, that Resident #2 had been located.</p> <p>Review of the Police Report, indicated Resident #2 was located on 03/11/24 (time not specified), seated on the side of the road, more than four miles away from the Facility. The Report indicated that due to Resident #2 being outside for several hours, and the wind chill, Resident #2 was transported to the Hospital Emergency Department (ED) for an evaluation.</p> <p>Review of Resident #2's Hospital ED Report, dated 03/11/24, indicated he/she presented with cold exposure but was stable and returned to the Facility.</p> <p>During a telephone interview on 04/03/24 at 1:09 P.M., Physical Therapy Assistant (PTA) #1 said that on 03/11/24, at approximately 11:00 A.M., she observed Resident #2 push the handle on a door used to exit the unit. PTA #1 said the alarm on the door sounded, which appeared to startle Resident #2, who then sat down on a chair in the hallway, near the exit door.</p> <p>PTA #1 said that in hindsight, she should have alerted the nursing staff on the unit that Resident #2 was exit seeking before she (PTA #1) left the unit.</p> <p>During an interview on 04/03/24 at 1:31 P.M., Nurse #4 said she was on duty on 03/11/24 for the 7:00 A.M. to 3:00 P.M shift and Resident #2 was on her assignment. Nurse #4 said that on 03/11/24 around lunchtime (exact time unknown), Resident #2's daughter called to speak with Resident #2. Nurse #4 said she went to Resident #2's room but he/she was not in the room and Nurse #4 said she assumed that Resident #2 was in his/her bathroom, but she (Nurse #4) did not check the bathroom.</p> <p>Nurse #4 said that later in the shift (exact time unknown), she was alerted by CNA #7 that Resident #2 had not touched his/her lunch tray. Nurse #4 said she went to Resident #2's room and he/she was not in his/her room or bathroom. Nurse #2 said a code Dr. Hunt was called.</p> <p>During a telephone interview on 04/11/24 at 1:40 P.M., CNA #7 said that Resident #2 was on her assignment for the 7:00 A.M. to 3:00 P.M. shift on 03/11/24. CNA #7 said that she provided care to Resident #2 that morning (exact time unknown). CNA #7 said she did not know who delivered Resident #2's lunch tray to him/her. CNA #7 said she noticed around 1:50 P.M. that Resident #2 was not in his/her room and that his/her lunch tray was untouched. CNA #2 said she alerted Nurse #4 and a code Dr. Hunt was called.</p> <p>(continued on next page)</p>

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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>CNA #7 said that Resident #2 was exit seeking almost all of the time and would hang around the exit doors of the unit.</p> <p>During an interview on 04/03/24 at 2:56 P.M., CNA #5 said she had observed Resident #2 attempt to exit the unit fairly regularly through the main doors on the unit (leading to the lobby) and that Resident #2 would attempt to leave with other people who were exiting the unit.</p> <p>During an interview on 04/03/24 at 3:03 P.M., CNA #6 said that she had observed Resident #2 attempt to exit the unit, bang on the doors that lead outside, and would try to follow people outside. CNA #6 said Resident #2 was observed in the lobby about one month ago and they were able to redirect him/her back onto his/her unit.</p> <p>During an interview on 04/03/24 at 11:05 A.M., Nurse #5 said Resident #2 was known to exit seek. Nurse #5 said they had to be careful because the exit doors on the unit (leading to the lobby) did not shut quickly enough and that Resident #2 would try to sneak out with the other residents when they went outside for their supervised smoke breaks.</p> <p>During an interview on 04/03/24 at 4:18 P.M., the Administrator said that Resident #2 probably exited through the unit's main door (leading to the lobby) because their investigation revealed that visitors knew the code to enter and exit the unit, and Resident #2 could have been mistaken for a visitor, making it possible for him/her to exit the unit with other visitors. The Administrator said no one except for staff members should have the code to enter or exit the secured unit.</p> <p>The Administrator said it was her expectation that any staff who observed a resident exit seeking, would notify the nursing staff on the unit, in an effort to prevent a resident elopement.</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>37227</p> <p>Based on records reviewed and interviews, for two of four sampled residents (Resident #1 and Resident #2) the Facility failed to ensure they provided sufficient nursing staff so that the care and safety needs of the residents were adequately met, when on 01/12/24 during the evening shift, Resident #2 was able to wander off the locked unit he/she resided on, and that same night, Certified Nurse Aide (CNA) #1 admitted to securing the door to Resident #1's room to prevent him/her from exiting his/her room to wander and exit seek while she attended to another resident, because the unit was short staffed.</p> <p>Findings include:</p> <p>Review of the Facility Policy titled Abuse, Neglect and Exploitation, dated as implemented February 2023, indicated the following:</p> <ul style="list-style-type: none"> - Identifying, correcting, and intervening in situations in which abuse, neglect, exploitation and/or misappropriation of resident property is more likely to occur with deployment of trained and qualified, registered, licensed, and certified staff on each shift in sufficient numbers to meet the needs of residents, and assure that the staff assigned have the knowledge of the individual residents' care needs and behavioral symptoms. - Assuring an assessment of the resources needed to provide care and services to all residents is included in the facility assessment. - Assigning responsibility for the supervision of staff on all shifts for identifying inappropriate staff behaviors. - Involuntary seclusion: the separation of a resident from other residents or from his/her room or confinement to his/her room against the resident's will or the will of the resident's legal representative. <p>Review of the Facility's Assessment, dated 10/27/23, indicated the Facility was licensed for 96 beds and the average daily census was 88. The Facility Assessment indicated their staffing needs were at 3.58 nurses per patient day (PPD) and 3.58 CNAs PPD, using the Mass Health guidelines.</p> <p>The Facility Assessment indicated the Elmwood long term care unit housed residents with mid to late-stage Dementia, and many required frequent staff interactions and/or interventions to maintain safety.</p> <p>Review of the Daily Census, dated 01/12/24, indicated there were two Resident Units in the Facility.</p> <ul style="list-style-type: none"> - Elmwood, which had 47 available beds, and the census was 40. - Windsor, which had 49 available beds, and the census was 42. <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Nursing Schedule for 01/12/24, indicated the following facility staffing totals:</p> <ul style="list-style-type: none"> - 4 CNAs and 2 nurses worked on the 7:00 A.M. to 3:00 P.M. shift. - 4.6 CNAs and 3 nurses worked on the 3:00 P.M. to 11:00 P.M. shift. - 4 CNAs and 2 nurses worked on the 11:00 P.M. to 7:00 A.M. shift. <p>Further review of the Schedule for 01/12/24, indicated for the 3:00 P.M. to 11:00 P.M. shift on the Elmwood unit, it was staffed as follows to care for the 40 residents:</p> <ul style="list-style-type: none"> - 2 CNAs from 3:00 P.M. to 11:00 P.M. - 1 CNA from 3:00 P.M. to 8:00 P.M. - 1 Nurse from 3:00 P.M. to 11:00 P.M. - 1 Community Nurse shared between two units between 3:00 P.M. and 11:00 P.M. <p>Review of an email from the Administrator to the Surveyor, dated 04/10/24, indicated the facility staffing on 01/12/24 was 1.836 PPD for both nurses and CNAs (below the facility's assessed need of 3.58 PPD).</p> <p>1.) Resident #1 was admitted to the Facility in November 2021, diagnoses included unspecified dementia, adult failure to thrive, weakness and other abnormalities of gait and mobility.</p> <p>Review of Resident #1's Annual Minimum Data Set (MDS) assessment, dated as completed 10/27/23, indicated he/she was severely cognitively impaired with a score of 6 out of 15 on the Brief Interview for Mental Status (BIMS, scores indicate: 0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, and 13-15 cognitively intact). Further review of the MDS indicated Resident #1 ambulated independently, required the use of a walker, and had wandering behaviors that occurred four to six days a week.</p> <p>Review of Resident #1's Behavior Care Plan, dated 11/17/23, indicated he/she wandered and was at risk of eloping from the facility. Care Plan interventions included providing diversional activities and redirection when exit seeking.</p> <p>Review of Resident #1's Nurse Progress Note, dated 01/13/24 and time stamped 7:07 A.M., indicated at 11:30 P.M. a CNA notified Nurse #1 that a plastic bag was around this resident's door. The Note indicated staff removed the bag, and both residents in the room were safe.</p> <p>Review of the Facility's Investigation Narrative, dated 01/22/24, indicated that during a review of clinical notes on 01/15/24, it was noted that staff found a plastic bag tied around the door handle to Resident #1's room. The Narrative indicated that CNA #1, said that she tied the plastic bag around the door handle to lock Resident #1's room to keep him/her safe while she (CNA#1) attended to another resident.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 04/03/24 at 2:59 P.M., Certified Nurse Aide (CNA) #1 said that on 01/12/24, during the evening shift, the Facility was severely understaffed. CNA #1 said three CNAs worked on the Elmwood Unit (secure unit), but one of the CNAs was only scheduled to work until 8:00 P.M., leaving only two CNAs to care for 40 residents, on the unit until 11:00 P.M.</p> <p>CNA #1 said she was alone on the unit with 40 residents and became overwhelmed when several residents were exhibiting wandering and exit seeking behaviors, from around 9:00 P.M. to 9:30 P.M., while Nurse #1 and CNA #3 went on break at the same time. CNA #1 said one resident had packed his/her clothes in a trash bag and he/she wanted to go home. CNA #1 said that Resident #1 had been wandering, exit seeking, and setting off the alarms to the exit doors. CNA #1 said she locked Resident #1 in his/her room by tying the door shut with a plastic bag so that he/she could not exit the room, to prevent him/her from wandering and to keep him/her safe while she provided incontinence care to another resident.</p> <p>CNA #1 further said that while she was working alone on the unit, Resident #2 wandered off the unit through the locked doors, and he/she was found on the Windsor Unit. CNA #1 said that Resident #2 was returned to the Unit by CNA #3, who was on break.</p> <p>2.) Resident #2 was admitted to the secured unit (alarms at all exit doors) of the Facility in December 2023, diagnoses included dementia, anxiety disorder, and history of traumatic brain injury (TBI).</p> <p>Review of Resident #2's Admission MDS assessment, dated 12/28/23, indicated he/she was moderately cognitively impaired with a BIMS score of 9 out of 15. The Assessment also indicated that Resident #2 had wandering behavior for one to three days during the seven day look back period.</p> <p>Review of Resident #2's Elopement and Wandering Risk assessments, dated 12/22/23 and 01/25/24, indicated Resident #2 was at risk for wandering and elopement.</p> <p>Review of Resident #2's wandering care plan, with a revision date of 01/18/24, indicated Resident #2 expressed desires to go home, moved without regard to safety, paced and roamed in and out of resident rooms and tried to leave the Facility.</p> <p>Review of Resident #2's progress note, dated 01/13/24, indicated at around 9:00 P.M. he/she became increasingly agitated after talking to his/her daughter on the phone, and he/she was banging on the door, demanding to go to [specific hospital]. The Note indicated Resident #2 pushed the locked door until it released and walked over to the Windsor Unit. The Note indicated a male CNA walked with Resident #2 and sat with him/her until he/she calmed down.</p> <p>During an interview on 04/03/24 at 03:47 P.M., The Administrator said their assessed staffing need for the Facility is 3.58 PPD for nurses and for CNAs, but staffing the Facility has been a challenge and they have not been successful in achieving that level of PPD.</p> <p>The Administrator said that during the 3:00 P.M. to 11:00 P.M. shift there should be two nurses and four CNAs scheduled per unit. The Administrator said that on 0/12/24 there was one nurse and two CNAs on the Windsor unit, one nurse and 2.6 CNAs on the Elmwood unit, and one nurse split between both units. The Administrator further said that staff should alternate break times, especially when the facility is short staffed.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Administrator said the Facility's investigation, of the incident that occurred on 01/12/24, involving CNA #1 tying Resident #1's door closed, was substantiated as involuntary seclusion, and insufficient staffing was determined to be a contributing factor.</p>