STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225395	A. Building B. Wing	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lanessa Extended Care	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)
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. Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who had dementia, resided on a secured unit, was known by staff to exhibit exit seeking behaviors and was assessed at being at risk for elopement, the Facility failed to ensure that Resident #1 was provided with an adequate level of staff supervision to prevent an incident of elopement when on 01/05/26, Resident #1 exited the secured unit, through an alarmed door unbeknownst to staff and was found outside at the end of the block by the police.Findings include: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, and institute measures for resident identification at the time of admission. Elopement is defined as the ability of a resident who is not capable of protecting him/herself from harm to successfully leave the facility unsupervised and unnoticed and who may enter harm's way.Review of the report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 01/05/26, indicated Resident #1 exited the secured unit around 2:10 A.M., [through an alarmed door] the staff heard the alarm but assumed the Nurse set it off when she left the unit to obtain supplies. The Report indicated the alarm had sounded for five minutes when staff discovered footsteps outside one of the exit doors. The Report indicated staff implemented Dr. Hunt protocol (a Facility wide code to alert staff of a missing resident and to implement their search policy) and Resident #1 was found by the police at the end of the block.Further review of the Report indicated Resident #1 was transferred to the Hospital Emergency Department (ED) where he/she was evaluated and it was determined he/she did not have hypothermia. Resident #1 returned to the facility later that morning, around 7:00 A.M.Resident #1 was admitted to the secured unit (alarms on all exit doors) of the facility in April 2025, diagnoses included vascular dementia and generalized anxiety disorder.Review of Resident #1's Elopement and Wandering Risk Assessments, dated 11/03/25, indicated Resident #1 was at risk for elopement and wandering.Review of Resident #1's Minimum Data Set (MDS) assessment, dated 11/04/25, 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, and 13-15 indicates cognitively intact). The MDS also indicated that Resident #1 had a behavior of wandering four to six days during the seven day look back period.Review of Resident #1's Behavior Care Plan, dated 05/05/25, indicated Resident #1 had behaviors of wandering, exit seeking and was sometimes resistive to care.Review of Resident #1's Nursing Progress Note, dated 01/05/26 and written by Nurse #1, indicated that at 2:10 A.M. an alarm was sounding on the secured unit, staff began a unit wide search and at 2:18 A.M. a Dr. Hunt was called. The Note indicated Nurse #1 called 911 as other staff drove around the premises and Resident #1 was located by the police and a facility staff member. The Police transferred Resident #1 to the Hospital Emergency Department (ED) for an evaluation and the Hospital ED reported to Nurse #1 that Resident #1 had no signs of hypothermia or low body temperature (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

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 01/21/2026
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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and was discharged back to the facility.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. During a telephone interview (which included review of his written statement) on 01/22/26 at 8:15 A.M., Certified Nurse Aide (CNA) #1 said he was on duty the night shift (11:00 P.M. to 7:00 A.M.) on 01/05/26, when Resident #1 eloped from the facility. CNA #1 said Resident #1 often wandered the halls throughout the night, sometimes pushed on the exit doors, and required redirection by staff.CNA #1 said he was completing his documentation at the opposite end of the hallway to the door Resident #1 exited out of, when Nurse #1 approached him and asked if he could hear the alarm sounding on the exit door. CNA #1 said he could not hear it because there was a loud TV on in a resident room close to him, and said once he walked closer to the Nurses Station, he could hear the alarm sounding on the exit door.CNA #1 said the staff began searching the entire unit and discovered Resident #1 was missing. CNA #1 said he looked outside and in the parking lot for Resident #1 and was later told that he/she had been located by the police, not far from the facility.During a telephone interview (which included review of her written statement) on 01/22/26 at 7:37 A.M., Certified Nurse Aide (CNA) #2 said she was on duty the night shift of 01/05/26. CNA #2 said Resident #1 was well known to her and often wandered the unit during the night. CNA #2 said she was providing care in a resident's room when she heard an alarm sounding sometime around 2:10 A.M., and said she thought it was the alarm to the door that was between the unit and the lobby. CNA #2 said Nurse #1 had just told her that she was going to the other unit [through the doors to the lobby] to get supplies, and when she heard the alarm, she assumed it was because Nurse #1 had not entered the code when she left the unit. CNA #2 said she then came out of the resident's room and looked around to see which door was sounding and that's when she saw it was the exit door to the outside.CNA #2 said Nurse #1 came back to the unit, they all began searching the unit and identified that Resident #1 was missing. CNA #2 said when they could not find him/her inside the facility, she drove down the street and located Resident #1 who was a block away with the police. CNA #1 said she called Nurse #1 at 2:33 A.M. to tell her that she was with Resident #1 and the police.During an interview on 01/21/26 at 2:56 P.M., the Director of Nurses (DON) said the secured unit is for residents who have exit seeking behaviors. The DON said the staff mistakenly thought the alarm they heard on the morning of 01/05/26 was due to Nurse #1 leaving the unit.The DON said their investigation concluded that the exit door to the lobby and the exit door to the outside have the same sounding alarms, and the alarm on the exit door to the outside is not loud enough to be heard throughout the unit. The DON said she expected all staff to respond to all alarms in a timely manner.On 01/21/26, the Facility presented the Surveyor with a plan of correction with an effective date of 01/12/26, that addressed areas of concern identified in this survey, the Plan of Correction is as follows:A) Resident #1 returned to the facility, he/she sustained no injuries during the elopement, and is monitored/supervised by unit staff.B) On 01/05/26 the Director of Nurses and Administrator educated all facility staff of door alarm response time and Dr. Hunt Protocol.C) On 01/05/26 the Facility initiated random of audits of staff response times to alarms set off (by management staff) on the unit with response times recorded. They will continue to monitor and conduct random tests to ensure appropriate staff response times to alarms.D) Door Alarm Audits for staff response time will continue to be conducted weekly for three months.E) The Facility determined the door alarms should have different sounding alarms, and this change was tasked to the Maintenance Department. F) Ad-hoc QAPI was conducted, and new QAPI project for Elopement was implemented, with targeted completion date 03/20/26.G) The Administrator and/or Designee are responsible for overall compliance.