

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225445	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/22/2024
NAME OF PROVIDER OR SUPPLIER Affinity Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 1102 Washington Street Braintree, MA 02184	
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 - Immediate jeopardy to resident health or safety</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** 43963</p> <p>Based on records reviewed and interviews for three of three sampled residents (Resident #1, #2, and #3), who all resided on a locked, secured unit (B1), were on scheduled safety checks by unit staff, and required staff supervision, both on and off the unit, the Facility failed to ensure they provided an adequate level of staff supervision, which included unit staff responding adequately to exit door alarms, to prevent an incident of elopement.</p> <p>On [DATE] at approximately 11:17 P.M., Residents #1, #2, and #3, exited through the locked and alarmed door of their unit undetected by staff, made their way onto the elevator, proceeded to the main entrance/exit door leading to the parking lot, exited through the front alarmed door and proceeded to walk away from the facility. Although a staff member saw the residents get off of the elevator, she did not question them or alert other staff. An off duty staff member noticed Resident #1 and #3 down the street from the facility with police, and alerted staff at the facility.</p> <p>Resident #2 was found several minutes later laying on the ground with his/her wheelchair on top of him/her, he/she was transferred to the Hospital Emergency Department (ED) for evaluation of chest pain, and for treatment of facial and head lacerations, both of which required sutures to close.</p> <p>Findings include:</p> <p>Review of the Facility Policy titled Safety Awareness and Building Safety, undated, indicated the following:</p> <p>-that all staff should ensure residents have the appropriate level of supervision if they are seen off of their unit without a staff member present.</p> <p>-that staff should not reset a sounding alarm without notifying a nurse supervisor and the nurse supervisor will assess the situation and determine if a Code Silver (missing person) should be activated.</p> <p>Review of the Facility Policy titled Elopement of a Resident, dated [DATE], indicated the following:</p> <p>-all residents at the facility will be provided with a secure environment, and</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 225445
		If continuation sheet Page 1 of 8

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-all residents will be assessed for the potential for elopement on admission, quarterly, and with a significant change in status.</p> <p>-Residents identified as an elopement risk will have their photos maintained in a confidential manner at the main entrance to the Facility and on each unit;</p> <p>-A care plan will be developed and implemented for every resident that is at risk for elopement; and</p> <p>-A licensed nurse will have visual contact with each resident at the beginning and end of each shift.</p> <p>Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated [DATE], indicated that on [DATE] at 11:45 P.M., two staff members who had left at the end of the second shift (3:00 P.M. to 11:00 P.M.), reported seeing Resident #1 and #3 outside of the Facility, three structures down, at a donut shop.</p> <p>The Report indicated that staff remained with the Residents and the Facility and Police were notified. Resident #1 refused to return to the Facility with staff, became aggressive and he/she was taken to the Hospital ED on a Section 12 (emergency restraint and hospitalization of persons posing a risk of serious harm by reason of mental illness).</p> <p>The Report further indicated that Resident #2 was not located until staff were escorting Resident #3 back to the Facility. Resident #2 was found on the ground with his/her wheelchair on top of him/her, he/she was transported to the Hospital ED for evaluation and treatment.</p> <p>1) Resident #1 was admitted to the Facility in [DATE], diagnoses included Traumatic Brain Injury (TBI), schizoaffective (combination of schizophrenia and mood issues) disorder, late effects hemiparesis (muscle weakness or partial paralysis on one side of the body) due to a Cerebral Vascular Accident (CVA), late effects cognitive deficits from CVA, and substance abuse disorders.</p> <p>Review of Resident #1's Petition for Appointment of Guardianship, dated [DATE], indicated that his/her original Guardianship had expired, and the Facility is petitioning for a new legal guardian for Resident #1.</p> <p>Review of Resident #1's Care Plan titled Activities Of Daily Living (ADL), dated as last revised [DATE], indicated he/she required continual supervision with wheelchair locomotion on the unit and extensive assistance of one staff member off the unit.</p> <p>Review of Resident #1's Elopement Assessment, dated [DATE], indicated he/she was at moderate risk for elopement.</p> <p>Review of Resident #1's Nurse Progress Note, dated [DATE], indicated that around 1:00 P.M., Resident #1 was attempting to leave the building.</p> <p>Review of Resident #1's Nurse Practitioner (NP) Note, dated [DATE], indicated that he/she became very aggressive, combative, attempted to assault staff, made his/her way out to the main entrance [on the ground level of the facility] seeking to exit and was sent to the Hospital ED for evaluation.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident #1's Nurse Progress Note, dated [DATE], indicated he/she returned to the Facility around 8:00 P.M. and was placed on 5-minute safety checks.</p> <p>Review of Resident #1's Nurse Progress Note, dated [DATE], indicated that he/she remained under close supervision due to being at risk for elopement.</p> <p>During an interview on [DATE] at 11:48 A.M., Resident #1 said that on [DATE], he/she left the building and went to the donut shop down the street. Resident #1 said that he/she just kicked the door (locked and alarmed) on the unit open and went out with his/her friends (Resident #2 and #3).</p> <p>Resident #1 said he/she could not recall if an alarm sounded when he/she kicked the door open, and said they then made their way onto the elevator and then right out the front door.</p> <p>Resident #1 said that Resident #2 was far behind them (him/her and Resident #3) as they walked away from the facility and said he/she later found out that he/she ended up getting hurt.</p> <p>On [DATE], when approached by Police/Staff at the donut shop, Resident #1 became aggressive and violent, he/she refused to return to the facility, an order for a Section 12 was obtained and he/she was transported to the Hospital ED for evaluation.</p> <p>2) Resident #2 was admitted to the Facility in [DATE], diagnoses include unspecified psychosis, alcohol abuse, late effects hemiparesis related to a cerebral vascular accident, hemochromatosis (iron overload, leading to poisoning organs), and major depression.</p> <p>Review of Resident #2's Medical Record indicated that he/she had a court appointed legal guardian in place since 2021.</p> <p>Review of Resident #2's Elopement Risk Assessment, dated [DATE], indicated he/she was not at risk for elopement.</p> <p>However, Resident #2's picture was in the Facility elopement book kept at the reception desk (main entrance lobby area), and he/she had a care plan in place for a risk for elopement.</p> <p>Review of Resident #2's Care Plan titled ADL's, indicated he/she required supervision with wheelchair mobility.</p> <p>During an interview on [DATE] at 11:41 A.M., Resident #2 said that he/she, Resident #1 and Resident #3 escaped from the Facility and tried to get to the donut shop down the street.</p> <p>Resident #2 said that Resident #1 and Resident #3 were ahead of him/her, and that he/she wiped out (fell while self propelling his/her wheelchair) before he/she could get there.</p> <p>Resident #2 said he/she fell out of his/her wheelchair onto the cement and started bleeding. Resident #2 said that his/her wheelchair ended up on top of him/her that it took some time before anyone found him/her. Resident #2 said he/she needed to go to the Hospital ED for stitches.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident #2's Hospital ED Discharge Summary, dated [DATE], indicated he/she had been ejected from his/her wheelchair and onto his/her face suffering road rash to his/her right upper extremity, abrasions and laceration to the right side of his/her face, and complained of chest pain.</p> <p>The Summary indicated Resident #2 had a one centimeter (cm) laceration to his/her right cheek requiring two sutures and a 2.5 cm laceration to his/her right forehead requiring four sutures to close.</p> <p>3) Resident #3 was admitted to the Facility in [DATE], diagnoses include traumatic brain injury, psychosis, anxiety disorder, and major depression.</p> <p>Review of Resident #1's Physician's Orders, indicated his/her Health Care Proxy had been activated since [DATE].</p> <p>Review of Resident #3's Elopement Risk Assessment, dated [DATE], indicated he/she was at high risk for elopement.</p> <p>Review of Resident #3's Care Plan titled ADL's, dated as last revised [DATE], indicated he/she required supervision for locomotion on and off the unit.</p> <p>Review of Resident #3's Care Plan titled, Risk for Elopement, dated as last revised [DATE], indicated to distract him/her from wandering, monitor location as indicated, and document wandering behaviors.</p> <p>During an interview on [DATE] at 4:22 P.M., Resident #3 said on [DATE], Resident #1 planned an escape, that Resident #2 was also going to escape, and at the last minute they asked him/her to go with them. Resident #3 said that he/she was pushing Resident #1 in his/her wheelchair.</p> <p>Resident #3 said that when they got off of their unit, he/she does not remember hearing any alarms sound and when they got to the lobby, they just walked out the front door.</p> <p>Review of Resident #1, #2, and #3' Facility Supervision Check Sheets, dated [DATE], indicated the following;</p> <ul style="list-style-type: none"> -Resident #1 had been on 15 minute safety checks (last signed off by staff as being seen at 11:00 P.M.); -Resident #2 had been on hourly safety checks (last signed off by staff as being seen at 10:00 P.M.); and -Resident #3 had been on 15 minute safety checks (last signed off by staff as being seen at 11:00 P.M.). <p>Review or the Facility's Logbook Documentation titled Door Safety, dated [DATE] and [DATE], indicated that the Unit B1 door had been functioning properly and verified by the Lead Maintenance Worker.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] at 1:56 P.M., the Senior/Lead Maintenance Worker, said the all alarmed doors are checked weekly, that the exit door on Unit B1 had just been checked the day of the incident ([DATE]) on his weekly rounds. The Senior/Lead Maintenance Worker, said and once the exit doors are closed, that the alarm automatically stops sounding.</p> <p>During multiple observations from 8:00 A.M. to 4:00 P.M. on [DATE], the Surveyor observed multiple locked and alarmed doors functioning and sounding properly. On Unit B1, the locked and alarmed door that Resident #1, #2, and #3 exited off the Unit through, was working properly, however, once the exit door is closed, the surveyor noted that the alarm stops sounding (there is no code needed to deactivate the alarm).</p> <p>Observations also included how visitors and/or residents get onto and off of Unit B1 (same process is also required for Units B2 and M2). In order for a visitor (non-employee) to enter the secured units, a staff member must walk to the locked door, use a fob like key device to deactivate the lock and it will then disengage the locking mechanism (including the alarm) and the door to the unit will open. The same applies when exiting the secured units, an employee must walk the visitor and/or resident to the exit door and disengage the lock (which will cancel an alarm) by using the fob like key device and the door will open.</p> <p>Review of the Facility's surveillance camera video (no audio available) footage from Unit B1, dated [DATE], showed the following: (it is important to note that the Facility's video footage and real times are not synched)</p> <p>-11:15:17 P.M., Resident #1 independently wheels him/herself out of his/her room into the hallway to meet with Resident #2 and #3, who are standing very close to the locked and alarmed door of their secured unit.</p> <p>-11:16:37 P.M., Resident #1 wheels up to the exit door on the unit and kicks it, until the door opens, Resident #1 is then pushed by Resident #3, and Resident #2 independently mobilizes his/her wheelchair behind Resident #1 and #3, as they exit the unit at 11:17:13 P.M.</p> <p>-11:17:51 P.M., CNA # 1 walks into view of the camera and proceeds to enter a residents room where a call light is illuminated (CNA #1 does not look in the direction of the Unit exit door).</p> <p>-11:19:00 P.M., CNA #1 walks across and down the hall passing Resident #1's room (observed briefly glancing in), walks past it, and then enters the room closest to the exit door.</p> <p>-11:19:28 P.M., CNA #1 walks back toward the nursing station and out of the cameras view.</p> <p>-11:17:51 P.M. to 11:19:28 P.M., during this time there are no other staff members seen on the surveillance camera on B1 responding to the exit door alarm, (which based on Senior/Lead Maintenance Worker's interview and equipment report, the alarm on B1 was functioning properly and therefore should have sounded).</p> <p>-11:20:36 P.M., Residents #1, #2, and #3 exit the elevator on the ground floor and encounter a CNA who was coming into the facility to work the 11:00 P.M. to 7:00 A.M. shift and there does not appear to be any type of verbal exchange between the CNA and the Residents (video has no audio).</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-11:23:46 P.M., the Residents are at the main entrance (rear of the building), Resident #3 pushes the Handicapped automatic release button with no effect, Resident #1 also pushes the same button, and then kicks the first inner locked alarmed door open, the outer door opens automatically, and they all exit into the parking lot.</p> <p>-11:24:29 P.M., Resident #3 can be seen pushing Resident #1, in his/her wheelchair across the back parking lot, they go to the far upper left portion of the parking lot and then take a right onto what is presumed to be a sidewalk. Resident #2 can be seen propelling his/her wheelchair well behind Resident #1 and #3, but he/she is unable to keep up with their pace (no staff are seen exiting the building on the surveillance footage in the time that it takes for the Residents to be out of sight from the facility grounds).</p> <p>During a telephone on [DATE] at 12:37 P.M., Life Enhancement Specialist (LES) #1 said that at the end of his shift, about 10:50 P.M., on [DATE], he saw Resident #1 and Resident #3 talking in Resident #1's room, so he went into the room and stayed with them until his shift ended at 11:00 P.M. LES #1 said he left Resident #1 and #3 in Resident #1's room and said after the LES workers leave at 11:00 P.M., the nursing staff take over the safety checks for the residents.</p> <p>During a telephone interview on [DATE] at 9:30 A.M., CNA #1 said on [DATE], she had arrived on the B1 unit around 11:00 P.M., and said she saw Resident #1 enter Resident #2's room and they were talking.</p> <p>CNA #1 said a few minutes later she saw Resident #1 and Resident #2 talking in the hallway, and then a few minutes after that, Resident #3 went into Resident #1's room and they (Resident #1 and #3) were talking, and Resident #2 was just standing in the hallway.</p> <p>CNA #1 said she went to assist another resident and had last seen all three residents in the hallway close to the exit door talking. CNA #1 said when she finished assisting her other resident, two CNA's had come up to the unit and said they found some residents outside of the Facility down the street at the donut shop.</p> <p>During a telephone interview on [DATE] at 1:12 P.M., CNA #2 said that on [DATE], she punched in at 11:17 P.M. for her 11:00 P.M.-7:00 A.M. shift and headed to the elevator. CNA #2 said when the elevator opened, three people (later identified as Resident #1, #2, and #3) exited the elevator.</p> <p>CNA #2 said she did not know the three people that exited the elevator and said she was not certain if they were residents or visitors. CNA #2 said there are some independent residents in the building that are able to use the vending machines on the ground floor.</p> <p>CNA #2 said that she did not speak to them and had not asked who they were. CNA #2 said sometime later, a staff member from B1 came down to her unit (M1) to report that they found a few residents down the street, CNA #2 said that was when she reported that she saw them exit the elevator, as she was getting on to the elevator.</p> <p>CNA #2 said that she only works on the M1 Unit, that it is not secured unit, and said she had not realized the other three units were locked/secured units.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on [DATE] at 1:29 P.M., CNA #3 said that she had worked the 3:00 P.M. to 11:00 P.M. shift on [DATE], left the Facility at 11:37 P.M., and as she was driving home and passed the donut shop, down the street from the facility, she observed Resident #1 and Resident #3 outside of the donut shop speaking to the Police.</p> <p>CNA #3 said she called CNA #4 and was advised to return to the donut shop and stay with the Residents and she (CNA #4) would inform the Facility. CNA #3 and said before she knew it, CNA #4 and two nurses arrived at the donut shop.</p> <p>During a telephone interview on [DATE] at 3:12 P.M., CNA #4 said that she received a call, at approximately 11:40 P.M., from CNA #3 saying there were two residents outside of the donut shop down the street from the facility. CNA #4 said she notified Nurse #1 and Nurse #2 and the three of them went to get the residents.</p> <p>CNA #4 said that on the way back to the Facility with Resident #3, she heard someone yelling out for help, that she looked down a side street and observed Resident #2 on the ground with his/her wheelchair on top of him/her and blood all over the ground. CNA #4 said the police called 911 and Resident #2 was sent to the Hospital ED for evaluation.</p> <p>During an interview on [DATE] at 3:53 P.M., Nurse #1 said that on [DATE], she was working on Unit B1, on the evening shift and had seen Resident #1 and #3 talking together in Resident #1's room.</p> <p>Nurse #1 said that she does not recall hearing the locked secured door on the unit alarm and said she was unaware that three residents were missing from the unit.</p> <p>During an interview on [DATE] at 4:10 P.M., Nurse #2 said that on [DATE] she was working, on Unit B1, for a double shift from 3:00 P.M.-7:00 A.M. and said she had not noticed anything unusual. Nurse #2 said she had observed Resident #1, #2, and #3, hanging out by Resident #1's room (which is the second room away from the exit door).</p> <p>Nurse #2 said she did not hear any alarms sound that night and had no idea that Residents #1, #2, and #3 had left the unit until a CNA called the Facility to inform them that she saw Resident #1 and #3 down the street outside of the local donut shop.</p> <p>During an interview on [DATE] at 3:16 P.M., the Director of Nurses (DON) said that it is the Facility's expectation, that if an alarm is going off in the building, the staff member responding must determine the cause of the alarm, if the reason for the alarm is unknown, staff must open the alarming door, look around, and determine the reason for the alarm sounding.</p> <p>The DON said that if the reason for the sounding alarm is not confirmed, staff must inform a supervisor and perform a census check on that unit.</p> <p>The DON said that it is the Facility's expectation that if any employee observes any resident unattended off of their unit, they must report the observation immediately to a supervisor.</p> <p>On [DATE], the Facility was found to be in Past Noncompliance and presented the Surveyor with a plan of correction (with an effective date of [DATE]) that addressed the area(s) of concern as evidenced by:</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>A) On [DATE], the Neurological Program Director and Director of Nurses (DON) placed Resident #1, #2, and #3 on five-minute safety checks for 72 hours. Currently, Resident #1, #2, and #3 remain on 15-minute safety checks and physician's orders were obtained for Resident #1 and #2's wheelchairs to be equipped with a wander guard device (Resident #3 continues to refuse the use of a device).</p> <p>B) On [DATE], the Administrator and Director of Maintenance changed the facility entrance and secured unit codes, inspected all doors and all were in functioning order. The Facility also contracted for an inspection by an outside vendor who also confirmed there were no issues with door alarm function. The Administrator and Director of Maintenance continue to search for a potential additional alarm device that may enhance the system already in place.</p> <p>C) On [DATE], the Administrator and DON added an additional staff member stationed at the main entrance during the off-shift hours (11:00 P.M. to 7:00 A.M.), to ensure that no one is allowed to exit the Facility without staff knowledge. The staff member was placed on the daily schedule as of [DATE].</p> <p>D) On [DATE], the Director of Nurse and/or designee completed new Elopement Risk Assessments for Resident #1, #2, and #3, assured their photographs were placed in the Elopement Book at the main entrance, the B1 unit and each of the Resident's care plans were updated to reflect the recent elopement.</p> <p>E) On [DATE], the Facility held an ad hoc Quality Assurance and Performance Improvement (QAPI) meeting to review the event, develop interventions and audit tools to minimize the risk of an event of this nature from happening again. and will continue to review for compliance.</p> <p>F) On [DATE] and ongoing, the DON and Staff Development Coordinator (SDC) educated all staff, including the Life Enhancement Specialist (LES) regarding the revised policy for Levels of Observations, Safety Check Procedures, and the Facility's Alarm Procedures. Education included steps to take if an alarm is sounding, ensuring residents are supervised when seen off the unit, and notifying a supervisor when a resident is observed unsupervised at any time. Administrative staff will conduct random audits for five weeks or until found to be in compliance, with all staff on all units to ensure their understanding of each of the identified issues.</p> <p>G) On [DATE] and ongoing, the DON and SDC completed new Elopement Assessment for all residents in the facility and care plans were updated by nursing staff according to the results.</p> <p>H) Results of all audits and observations will be brought to and reviewed at QAPI meetings for the next three months or until compliance is achieved.</p> <p>I) The Administrator and/or Designee are responsible for overall compliance.</p>		