STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225445	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Affinity Healthcare	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)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and records reviewed, for one of three sampled Residents (Resident #1), who resided on a secured unit, made verbal statements to staff a desire to leave the Facility, had a Guardianship in place, and a care plan that indicated that he/she would remain within the Facility unless supervised, the Facility failed to ensure he/she was provided with an adequate level of staff supervision to maintain his/her safety in an effort to prevent an elopement. On 6/23/25, Resident #1 exited the secure second-floor unit (B2), unsupervised and unbeknownst to staff, through a locked and alarmed door which lead to a fire escape. At the time of the elopement, three staff members working on the B2 Unit, failed to recognize that the sounding alarm had been triggered by the opening of the door leading to the fire escape and instead mistook the alarm for a malfunction. Resident #1 descended the fire escape into a secure courtyard, climbed over a fence and left the Facility grounds. Resident #1's whereabouts were unknown for approximately twelve hours, at which time he/she was located in a bar about 58 miles away. As a result, this placed the resident at risk for the likeliness of an adverse outcome that could have led to serious harm, injury, impairment or death. Findings include: The Facility Policy, titled, Elopement of a Resident, dated as last revised 2/10/25, indicated that all residents are assessed for potential elopement risk on admission and a care plan will be implemented for any resident who is at risk. Review of the Medical Record indicated that the court had appointed a permanent Guardian for Resident #1 on 12/12/23 and on 4/02/25 the court ordered a temporary Guardianship with a different individual serving as Guardian. The Medical Record indicated Resident #1's diagnoses included traumatic subarachnoid hemorrhage, history of traumatic brain injury, cognitive communication deficit, adjustment disorder and difficulty in walking. Review of Resident #1's Quarterly Minimum Data Set Assessment, dated 4/12/25, indicated he/she had a Guardian. (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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the most recent Elopement Risk Assessment, dated 4/10/25, indicated that Resident #1 was at risk for elopement and a care plan would be developed. Review of Resident #1's Care Plan related to Elopement, dated as initiated 10/12/23, indicated he/she was at risk for elopement based on the elopement risk assessment and verbal statements indicating a desire to discharge. The Care Plan indicated a goal that Resident #1 would remain within the Facility unless supervised and remain free from harm. The Care Plan interventions included residing on a secure unit, completing an elopement risk assessment quarterly and with a significant change in status, engaging in a structured activity program based on his/her preference, evaluating need for additional supervision and safety supervision checks as indicated. Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 6/23/25, indicated that at 7:30 A.M., Facility staff noted that Resident #1 was not in his/her bed and could not be located on his/her Unit. During an interview on 6/26/25 at 12:45 P.M., Resident #1 said that he/she left the faciity on [DATE], through the fire escape door and jumped the fence. Resident #1 said that he/she heard the alarm on the door sounding, however, he/she did not notice staff looking for him/her. During a telephone interview on 6/30/25 at 11:55 A.M., Nurse #1 said that she was the nurse on the B2 Unit during the 11:00 P.M. to 7:00 A.M. shift starting on 6/22/25 and ending on 6/23/25. Nurse #1 said that when she arrived to the B2 Unit shortly after 11:00 P.M., the two 11:00 P.M. to 7:00 A.M. shift Certified Nurse Aides (CNAs #1 and #2) told her they had already done a head count. Nurse #1 said that she completed paperwork in the nursing station for much of the 11:00 P.M. to 7:00 A.M. shift. Nurse #1 said around 5:00 A.M. an alarm sounded on the B2 Unit. Nurse #1 said that CNAs #1 and #2 told her that the doors on the B2 Unit were alarmed. Review of the Facility Floor Plan indicated the B2 Unit was shaped like a letter T with the resident rooms located along one long main corridor. The Floor Plan showed that off of the main corridor was a single shorter corridor which passed the nurses station and ended in a day room for residents. The Floor Plan showed doors located at each end of the long main corridor and a door in the day room which lead to an exterior fire escape. Nurse #1 said that in response to the sounding alarm, CNAs #1 and #2 showed her the doors located at each end of the B2 Unit main corridor and showed her how to use the fob to lock and unlock the door in order to pass through them. Nurse #1 said that although CNAs #1 and #2 said that the fob should reset the sounding alarm, it did not. Nurse #1 said that CNAs #1 and #2 told her that the sounding door alarm was a malfunction. Nurse #1 said that the alarm continued to sound until sometime between 6:00 A.M. and 7:00 A.M. when it stopped without explanation. Nurse #1 said she did not become aware that there was a third door on the B2 Unit which lead to a fire escape until after the 7:00 A.M. to 3:00 P.M. shift arrived to the B2 Unit and realized that Resident #1 was missing. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Nurse #1 said that although she worked at the Facility through an Agency for a year, she only worked on the B2 Unit once before and she did not understand the door alarm system. Nurse #1 said although she knew that the B2 Unit was locked, she did not know Resident #1 was an elopement risk and said she was not aware of his/her care plan. During a tour on 6/26/25 at 6:15 A.M., the Surveyor with the Nurse Consultant observed that the three doors on the B2 Unit were locked. The locking mechanism on the doors were deactivated by contact with a hand held fob to allow egress. The doors can only be opened by using the fob to deactivate the door lock. In addition, if the alarm sounds at the door for any reason, the fob silences it. The Nurse Consultant said that on 6/23/25 the Security Company checked the day room door and reviewed surveillance camera footage depicting the door. The Nurse Consultant said the Security Company told the Facility that the magnetic lock on the day room door operated correctly, however, Resident #1 hip checked the door with sufficient force to overcome the magnetic lock and force the door open. The Nurse Consultant said that opening the door without a fob using with sufficient force to overcome the magnetic lock, will sound the door alarm. The Surveyor attempted to reach CNAs #1 and #2 by telephone on 6/26/25 and 6/30/25 without success. The Surveyor asked the Administrator to arrange for telephone interviews with CNAs #1 and #2, however, CNAs #1 and #2 were unresponsive to the Administrator as well. Written statements, dated 6/23/25, taken by the Director of Nurses and the Assistant Director of Nurses, to document telephone interviews of CNA #1 and CNA #2 indicated the following: - CNA #1 said that he worked the 11:00 P.M. to 7:00 A.M. shift starting on 6/22/25 and ending 6/23/25, that he did not see Resident #1 in bed and saw him/her in the bathroom, that he could not recall whether he saw Resident #1 at 5:00 A.M., that he heard the door alarm and was given the fob to deactivate the alarm by Nurse #1, that the door continued to alarm despite his attempt to deactivate it, that he did not see any resident at the alarming door and that he reported to Nurse #1 that the alarm must be malfunctioning. -CNA #2 said that she worked the 11:00 P.M. to 7:00 A.M. shift starting on 6/22/25 and ending 6/23/25, that it was her first time on the B2 Unit, that CNA #1 completed checks of the B2 residents, that she responded to a sounding door alarm with other staff, that she and other staff checked the area including the area outside of the door by the elevator, that the alarm did not stop and that Nurse #1 was aware. During a telephone interview on 6/26/25 at 1:00 P.M., the Housekeeper said that he arrived to the B2 Unit around 6:20 A.M. on 6/23/25. The Housekeeper said that as he arrived to the B2 Unit, heard a sounding alarm and said although he recognized the alarm as a door alarm, he did not know which door was alarming. The Housekeeper said that he proceeded to wash the floor on the B2 Unit, which he estimated took ten to fifteen minutes, and then entered the day room in order to wash the floor there. The Housekeeper said that once in the day room, he realized that the sounding alarm was the door in the day room which lead to a fire escape. The Housekeeper said he used his fob to deactivate the door alarm, however, he did not discuss the door alarm with any of the staff on the B2 Unit or report that he had deactivated the sounding alarm. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on 6/26/25 at 1:47 P.M., Nurse #2 said that on 6/23/25, she arrived to work on the B2 Unit at 7:00 A.M. and made rounds. Nurse #2 said that she could not locate Resident #1. Nurse #2 said she enlisted other staff members to assist her in looking for Resident #1 and when he/she was not located, she notified Facility leadership that Resident #1 was missing. During an interview on 6/26/25 at 6:35 A.M., the Nurse Supervisor said that she worked at the Facility during the 11:00 P.M. to 7:00 A.M. shift starting on 6/22/25 and ending on 6/23/25. The Nurse Supervisor said that shortly after 7:00 A.M. she became aware that Resident #1 was missing from the B2 Unit. The Nurse Supervisor said that she assisted with searching for Resident #1. The Nurse Supervisor said that during the overnight shift, she was not made aware that a door alarm on the B2 Unit was sounding and that staff could not deactivate the sounding alarm and thought that there was a malfunction. During an interview with the Administrator, the Director of Nurses and the Nurse Consultant on 6/26/25 at 6:53 A.M., they said that shortly after 7:00 A.M. on 6/23/25 staff reported that Resident #1 was missing from the B2 Unit. They said that the Facility was searched and the Police and Guardian were notified. The Administrator, the Director of Nurses and the Nurse Consultant said that review of video surveillance camera footage indicated that Resident #1 eloped from the B2 Unit on 06/23/25, during the 11:00 P.M. to 7:00 A.M. shift, through the door in the day room which lead to a fire escape. They said that further review of the video surveillance camera footage indicated that after descending the fire escape into the secure courtyard, Resident #1 climbed a fence and eloped from the Facility property. Review of the video surveillance camera footage obtained from two cameras, recorded on 6/23/25, viewed with the Nurse Consultant indicated the following: -at 4:49 A.M. Resident #1 walked passed the nursing station and into the day room, he/she checked the fire escape door and looked out a nearby window into the courtyard and returned to his/her room (time stamp on footage is 5:59, however per the Nurse Consultant, the time stamp is one hour ahead of the actual time of the recording at 4:49 A.M.) -at 5:08 A.M., Resident #1 walked passed the nurses station dressed in street clothes and carrying a bag, pushed open the day room door leading to the fire escape and exited through the door (time stamp on footage is 6:08, however per the Nurse Consultant, the time stamp is one hour ahead of the actual time of the recording at 5:08 A.M.) -at 5:21 A.M. Resident #1 threw his/her bag over the fence which separated the secure courtyard from the street and climbed the fence to exit the Facility property (time stamp on footage is 4:41, however per the Nurse Consultant, the time stamp on this second camera is forty minutes behind the actual time of the recording at 5:21 A.M.) (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Police Report, dated 6/23/25, indicated that at 7:45 A.M. the Facility notified the Police that Resident #1 was missing. The Report indicated the Police arrived at the Facility to search for Resident #1 and initiated search efforts in the community, which included pinging his/her cell phone. The Report indicated that at 6:30 P.M., Resident #1 was located in a pub, in the town in which he/she formerly resided, which was about 58 miles from the Facility. On 6/26/25, the Facility was found to be in past non-compliance. The Facility provided the Surveyor with a plan of correction which addressed the concern as evidenced by: A. On 6/23/25, the Facility suspended CNA #1 and CNA #2 pending the outcome of the Facility Internal Investigation and the Agency was notified that the Facility would no longer use Nurse #1. B. Resident #1 was evaluated in the hospital emergency department on 6/23/25 and returned to the facility on 6/24/25. On his/her return, the Facility assessed him/her for Elopement, Functional Abilities and Goals and conducted a Nursing Evaluation. The Facility initiated one on one monitoring of Resident #1 by staff to ensure his/her safety and applied a Wanderguard to his/her left ankle. C. Resident #1 was seen by the Facility Nurse Practitioner and the Facility Social Worker on 6/24/25 for on-going assessment and support. D. On 6/24/25, the Facility updated interventions on Resident #1's plan of care to include use of a Wanderguard (checked for placement and function every shift), one to one monitoring by staff and on-going efforts toward discharge planning at his/her request. E. On 6/23/25, the Facility alarm company assessed the door alarms and determined they were functioning appropriately. A recommendation was made to increase the resistance of the magnetic lock on the B2 Unit day room door and implementation is planned pending equipment availability. F. On 6/23/25, all Facility staff were educated by the Staff Development Coordinator/designee on Safety Checks and Door Alarm Response Procedures. G. On 6/24/25, the Director of Nursing enhanced existing orientation materials for Agency staff to include information on the Facility physical plant and security systems. H. On 6/24/25 and on-going, the Facility initiated random audits by Leadership of staff member response times to sounding door alarms. I. On 6/24/25, the Facility conducted an ad hoc Quality Assurance Meeting to review the corrective action plan. J. The Administrator/designee is responsible for overall compliance.