STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225516	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/21/2026
NAME OF PROVIDER OR SUPPLIER Eliot Center for Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 168 West Central Street Natick, MA 01760	

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 observations, interviews, and records reviewed, for one of three sampled residents (Resident #1), who resided on a secured unit, had a guardianship in place, and whose care plan indicated he/she was to remain within the Facility unless supervised, the Facility failed to ensure they provided an adequate level of staff supervision to maintain his/her safety and prevent an incident of elopement.Findings include:The Facility Policy, titled Elopement of a Resident, last revised July 2025, indicated that if a resident was identified as at risk for wandering, elopement, or other safety concerns, the resident's care plan would include strategies and interventions to maintain his/her safety.Resident #1 was admitted to the Facility in November 2023, diagnoses included dementia with behavioral disturbances, anxiety, major depressive disorder, and frontotemporal neurocognitive disorder.Review of Resident #1's Quarterly Minimum Data Set (MDS) Assessment, dated 01/14/26, indicated he/she had a Guardian, ambulated independently, and required physical assistance with Activities of Daily Living (ADL) care.Review of the Facility's Internal Investigation, dated 03/17/26, indicated that on 03/17/26 at around 3:00 P.M., Resident #1 was identified as missing and an elopement code was immediately called overhead. The Investigation indicated staff searched the Facility, including the interior and exterior grounds, with negative results. The Investigation indicated that about 45 minutes later, staff and local police located Resident #1 at his/her former home address, about 2 miles from the Facility.The Investigation indicated Resident #1 was sent to the local Emergency Department for evaluation, and returned to the Facility the same day at around 6:00 P.M., with no injuries. The Investigation indicated Resident #1's care plan was updated following the incident.During an interview on 04/21/26 at 3:00 P.M., Certified Nurse Aide (CNA) #2 said he saw Resident #1 around 2:30 P.M. at the nurse station asking how to leave from the Facility. CNA #2 said Resident #1 routinely wandered throughout the unit; however, he/she was not known to exhibit exit-seeking behavior, and at that time, CNA #2 said he did not think he/she would leave the Facility.During a telephone interview on 04/28/26 at 1:00 P.M., Nurse #1 said he saw Resident #1 around 2:40 P.M. at the nursing station interacting with staff. Nurse #1 said that around 3:00 P.M., during his final clinical rounds, he noticed Resident #1 was missing and immediately activated the elopement code overhead.During an interview on 04/21/26 at 12:15 P.M., the Administrator said staff on Resident #1's unit had not observed exit-seeking behavior prior to the incident. The Administrator said the unit exit doors were equipped with alarms and required a code to open, and the rear exit doors also had audible alarms.The Administrator said the Facility presumed Resident #1 may have entered the elevator with a visitor who had access to the code and then exited the building. The Administrator said staff were re-educated not to share elevator or door alarm codes with visitors or outside consultants.During an interview on 04/21/26 at 1:30 P.M., the Director of Nurses (DON) said that the Facility had not initiated an elopement assessment or care plan interventions for Resident #1, even though staff observed Resident #1 asking how to leave the Facility prior to the incident. The DON said Resident #1 had no prior history of exit-seeking, and staff assumed he/she would not remember how to leave the unit.On 04/21/26, the Facility was found to be in Past Non-Compliance and presented the Surveyor with a Plan of Correction, effective 04/02/26, which addressed the (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 - Minimal harm or potential for actual harm Residents Affected - Few	identified area(s) of concern, as evidenced by:A. On 03/17/26, following evaluation in the local Emergency Department, Resident #1 returned to the Facility later the same day, and had no injuries.B. On 03/17/26 the Facility completed assessments for Resident #1 for elopement risk, functional abilities, goals, and a nursing evaluation.C. The Facility initiated one-to-one staff monitoring to ensure Resident #1's safety and applied a Wander Guard to his/her left ankle.D. On 03/18/26, the Facility updated Resident #1's care plan interventions to include the use of a Wander Guard, with placement and function checks every shift.E. On 03/18/26, Resident #1 was evaluated by the Facility Nurse Practitioner and Facility Social Worker for ongoing assessment and support.F. On 03/18/26, the Facility's alarm company assessed the door alarms and determined they were functioning appropriately.G. On 03/18/26 and ongoing, the Facility initiated random Leadership audits of staff response times to door and elevator alarm sounds.H. From 03/18/26 through 03/31/26, all Facility staff were educated by the Director of Nurses (DON) and the Staff Development Coordinator on the following: Identifying exit-seeking behaviors and management, including reporting behaviors to clinical management. Reassessing elopement risk and implementing preventative measures. Safety checks, door alarm response procedures, elevator alarm/code response, and not sharing alarm codes. I. From 03/18/26 through 04/01/26, the Maintenance Director completed audits of all exit doors and elevator alarms and secured all windows on the unit.J. During the March 2026 monthly Quality Assurance and Performance Improvement (QAPI) meeting, the committee reviewed and discussed the incident, identified an area of concern, and developed a corrective action plan.K. The QAPI committee will continue to monitor this concern area for several months to ensure continued substantial compliance.L. The Administrator and/or designee are responsible for overall compliance.