STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225516	A. Building B. Wing	06/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eliot Center for Health and Rehabilitation	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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. Based on records reviewed and interviews for one of three sampled residents (Resident #1) who had a history of opioid dependency and alcohol use disorder, the facility failed to ensure supportive services to maintain his/her sobriety were offered and available.Findings include:Review of the facility's policy, titled Substance Use Disorder (SUD-a medical condition that is defined by the inability to control the use of a particular substance(s) despite harmful consequences), with a revision date of 11/2025, included the following:-The purpose of this policy is to identify residents prior to admission and discharge processes as they relate to substance use disorder. To identify all appropriate diagnoses or specific services needed as they relate to the substance abuse/use on addiction and to determine risk for relapse and the level of supervision needed.-Social Services will work on setting up support groups in collaboration with the Activities department to provide adequate support to the residents, as allowed by the resident.-Social Services staff will work on setting up other more specific and relevant support services, as allowed by the resident.-Social Services staff will create a plan of care based on specific resident needs to ensure adequate supports are in place.Review of the facility's policy for Comprehensive Care Plans, with a revision date of 07/2023, indicated the following:-Policy: An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, emotional and psychological needs is developed for each resident.-Each resident's comprehensive care plan is designed to:*Aid in preventing or reducing declines in the resident's functional status and/or functional levels.*Enhance the optimal functioning of the resident by focusing on a rehabilitative program (when appropriate)*Reflect currently recognized standards of practice for problem areas and conditions.Resident #1 was admitted to the facility in April 2026 diagnoses included opioid dependence, alcohol abuse, hepatic encephalopathy (occurs when the liver cannot adequately filter toxins, particularly ammonia, from the blood, allowing them to reach the brain and disrupt its function), and alcoholic cirrhosis (scarring) of liver with ascites (fluid in the abdomen).Review of Resident #1's Substance Use Assessment, dated 04/28/26, indicated the following:-Opioid use: in remission-Alcohol: recent use-Methadone is prescribed to assist with current Substance Use Disorder-Substance Use History: Active user (used within 0-3 months)Review of Resident #1's Substance Use Disorder Care Plan, initiated on 04/28/26, indicated it included the following intervention(s):-Offer/encourage Alcoholics Annonymous (AA)/Narcotics Annonymous (NA) meeting participation.Review of Resident #1's Minimum Data Set (MDS) Assessment, dated 05/04/26, indicated he/she was cognitively intact and scored a 15 out of 15 on the Brief Interview for Mental Status (BIMS) assessment (0-7 suggests severe cognitive impairment, 8-12 suggests moderate cognitive impairment, 13-15 suggests cognitively intact).Review of Resident #1's Psychiatric Nurse Practitioner (PNP) Evaluation, dated 05/18/26, indicated that Resident #1 openly discussed his/her history of substance abuse and long history of alcohol abuse. The Evaluation indicated Resident #1 stated that participation in Alcoholics Anonymous had been beneficial in his/her recovery.Further review of the Evaluation indicated the Plan included to encourage Resident #1's ongoing participation in recovery-based supports and utilization of healthy coping skills.Review of Resident #1's medical (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	record indicated there was no documentation to support that he/she was offered or provided an opportunity to attend Alcoholics Annonymous meetings, in person or virtually, during his/her stay at the facility.During a telephone interview on 06/10/26 at 8:25 A.M., Psychiatric Nurse Practitioner (PNP) said she had visited Resident #1 at the facility on 05/18/26 and 05/28/26. The PNP said it was not her responsibility to have facilitated Resident #1's participation in AA meetings. The PNP said it was the facility's responsibility to offer AA meetings.During a telephone interview on 06/11/26 at 1:54 P.M., Mental Health Clinician (MHC) #1 said she had visited Resident #1 at the facility on 05/19/26 and 05/27/26. MHC #1 said it was the facility's responsibility to facilitate Resident #1's participation in AA meetings.During an interview on 06/09/26 at 1:10 P.M., Social Worker (SW) #1 said she had visited Resident #1 at the facility on multiple occasions and his/her goal was to be discharged to a transitional SUD house. SW #1 said that it was the Psychiatric Services responsibility to offer SUD services and support. SW #1 said she did not collaborate with Psychiatric Services regarding the care and services for Resident #1. SW #1 said if she had collaborated with Psychiatric Services related to Resident #1's care, she would have documented it in her progress notes.During a telephone interview on 06/10/26 at 3:55 P.M., the Administrator said she thought it was the Psychiatric Services responsibility to offer and facilitate AA meetings for Resident #1.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on records reviewed and interviews, for one of three sampled residents (Resident #1), the facility failed to ensure they maintained complete, accurate, and accessible medical records, when his/her psychiatric service progress notes were not readily accessible and not included in his/her medical record.Findings include:Review of the facility's policy, titled Charting and Documentation, with a revision date of 07/2023, included the following:-All services provided to the resident, progress towards the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record.-The following information is to be documented in the resident medical record:*Treatments or services performed.Resident #1 was admitted to the facility in April 2026 diagnoses included opioid dependence, alcohol abuse, hepatic encephalopathy (occurs when the liver cannot adequately filter toxins, particularly ammonia, from the blood, allowing them to reach the brain and disrupt its function), and alcoholic cirrhosis (scarring) of liver with ascites (fluid in the abdomen).During the survey on 06/09/26, the surveyor requested copies of all Resident #1's Psychiatric Progress Notes.During a telephone interview on 06/10/26 at 3:55 P.M., the Administrator asked the surveyor if she had read the Mental Health Clinician's (MHC) progress notes for Resident #1. The surveyor then informed the Administrator that the MHC's progress notes were not in Resident #1's Electronic Medical Record (EMR) nor were they provided during the survey.Resident #1's Mental Health Clinician visit notes were faxed to the surveyor on 06/11/26 (two days after the onsite survey) for review.Review of Resident #1's Nursing Progress Note, dated 05/29/26, indicated he/she eloped out of a third-floor window.Review of Resident #1's Comprehensive [Psychotherapy] Assessment (progress note), with date of service documented as 05/27/26, indicated he/she had jumped out of a second story window and was transferred to the hospital. Further review of the Assessment indicated it was signed and dated by Mental Health Clinician (MHC) #1 on 06/10/26 at 9:31 P.M.During a telephone interview on 06/11/26 at 1:54 P.M., Mental Health Clinician (MHC) #1 said that she visited Resident #1 at the facility on 05/19/26 and 05/27/26. MHC #1 said she had written Resident #1's progress notes for the visit on 05/27/26 the night before [6/10/26] this interview because the Administrator had requested, she write a note.MHC #1 said she had not written Resident #1's progress notes immediately following the visit and mistakenly wrote in his/her Comprehensive Assessment/progress note for 5/27/26, that he/she had jumped out of a window when that had not yet happened. MHC #1 said she was supposed to have a progress note relate to her visits completed and signed within 48 to 72 hours following a clinical visit.During a telephone interview on 06/11/26 at 2:23 P.M. the Administrator said it was her expectation that all medical records were accurate and accessible.