STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225523	A. Building B. Wing	06/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Glen Ridge	120 Murray Street Medford, MA 02155

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 #2), the Facility failed to ensure they provided an environment free from safety hazards and adequate supervision to prevent an elopement. On 04/14/26 Resident #2 eloped from the Facility unbeknownst to staff. Facility staff were notified by local Hospital Emergency Department (ED) staff that he/she was there being evaluated. Staff were unaware he/she was missing from the Facility for over four hours.Findings include:The Facility Policy, titled Wandering Resident, dated as revised 04/2022, indicated a missing resident was considered a facility-wide emergency, and if a resident was missing the elopement emergency procedure would be initiated.The Facility Policy, titled Missing Resident/Elopement, dated as revised 03/2022, indicated staff would investigate and report all cases of missing residents. The Policy indicated staff were to attempt to locate any resident that was identified as missing.Review of the Report submitted by the facility via the Health Care Facilities Reporting System (HCFRS), dated 04/22/26, indicated that on 04/14/25 around 05:45 P.M., the Facility was notified by the Hospital Emergency Department (ED) that Resident #2 was being evaluated in the ED. The Incident Report indicated staff were unaware that Resident #2 had left the Facility earlier that day.The Facility's Investigation Report include a statement, dated 4/15/26, provided by the facility where Resident #2 was located, which indicated that on 04/14/26 at 1:30 P.M., the Director of Facility Operations for the Specialized Psychiatric Hospital located next door to the Facility was alerted that a resident (later identified as Resident #2) who was unknown to the Psychiatric Hospital, was found seated in a wheelchair near the loading dock area.Resident #2 was admitted to the Facility in September 2025, diagnoses included dementia, depression, anxiety, and diabetes.During an interview on 06/03/26 at 09:23 A.M., the Activities Director said that on 04/14/26 around 1:30 P.M., he was asked by Resident #2's family member to check on him/her because he/she was in the bathroom located on the ground floor across from the Cafe where he/she had been seen during the diabetic foot clinic. The Activities Director said he knocked on the bathroom door and Resident #2 said he/she was almost done, so he thought whoever helped Resident #2 get to the bathroom would come back and help him/her, so he left the area and returned to his office.The Activities Director was the last known Facility staff member to interact with Resident #2 that day.Review Certified Nurse Aide (CNA) #6's written witness statement, dated 04/14/26, indicated CNA #6 was assigned to care for Resident #2 on the 3:00 P.M., to 11:00 P.M., shift on 04/14/26. The Statement indicated CNA #6 could not locate Resident #2 on the unit at dinner time and thought he/she was in the Hospital.During an interview on 06/02/26 at 04:15 P.M., Nurse #5 said that on 04/14/26 she worked the 3:00 P.M., to 11:00 P.M., shift. Nurse #5 said at the beginning of her shift she noticed that Resident #2 was not on the unit but said he/she was often at activities so that's where she thought he/she was. Nurse #5 said she was not aware that Resident #2 was not in the Facility until 06:00 P.M., when she was notified via telephone by the Hospital that Resident #2 was in the Emergency Department.Nurse #5 said CNA #6 did not tell her that Resident #2 was not on the unit for dinner. Nurse #5 said she would have initiated the Facility's Elopement Procedure if she knew Resident #2 was missing.During an interview on 06/03/26 at 10:05 A.M., the Director of Nursing (DON) (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	said at the time Resident #2 eloped, there was no system in place to sign residents on and off the unit. The DON said staff should have been aware of where Resident #2 was after the diabetic foot clinic or should have looked for him/her when he/she was not on the unit for dinner but had not.During an interview on 06/02/26 at 3:00 P.M., the Administrator said through an investigation, the Facility had determined that on 04/14/26 around 2:00 P.M., Resident #2 left the Facility through a side door located down a hallway from the bathroom where he/she had last been known to be. The Administrator said the side door did not have an alarm and was unlocked from the inside, however the door locked from the outside once closed. The Administrator and the Surveyor observed that there was a walkway located outside the side door that led down a slope and over to the loading dock area of the Facility next door, where Resident #2 was located by staff at that Facility.