STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225555	A. Building B. Wing	05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mary Ann Morse Nursing & Rehabilitation	45 Union 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records reviewed, interviews and observations for one of three sampled residents (Resident #1), who had been assessed as having moderately impaired cognition, the Facility failed to ensure he/she was provided with an adequate level of staff supervision to prevent an incident of elopement, when on 04/30/26 at 3:00 A.M., Resident #1 was able to exit his/her unit and the Facility, undetected by staff and was found on a loading dock of a neighboring Facility about 150 yards away. Resident #1 was transferred to the Hospital Emergency Department (ED) for evaluation.Findings include:Review of the Facility Policy titled Missing Persons Policy (Absent Without Leave), dated as last revised 08/23/24, indicated the following;-Unit Clinical Staff are required to know the location of each resident at all times of day; and-Unit Charge Nurse is responsible for assuring that each unit resident's location is known and accounted for in a manner that relies upon formal communications and data systems.Review of the report submitted by the Facility via Health Care Facility Reporting System (HCFRS), dated 05/05/26, indicated Resident #1 had been last seen by the Nurse Supervisor at 3:00 A.M. in his/her bed. The Report indicated that at around 3:30 A.M., staff received a call from the local Police Department (PD) informing them a resident (later identified as Resident #1) had been located on the loading dock of a nearby Facility and was being transported to the Hospital Emergency Department (ED) for evaluation.Resident #1 was admitted to the Facility in April 2026, diagnoses include diabetes mellitus, new onset of atrial fibrillation, pancreatic head lesion, and dementia.Review of Resident #1's admission Minimum Data Set (MDS) assessment dated [DATE], indicated he/she scored an 11 out of 15 on his/her Brief Interview for Mental Status (BIMS, 0-7 suggests severe cognitive impairment, 8-12 suggest moderately impaired cognition, and 12-15 suggests a resident in cognitively intact).Review of Resident #1's Physician's Orders, dated 04/27/26, indicated his/her Health Care Proxy had been invoked.During an interview on 05/20/26 at 8:51 A.M., the Nursing Supervisor said she was Resident #1's nurse on 4/29/26 into 04/30/26, for the night shift (11:00 P.M.-7:00 A.M).The Supervisor said around 12:30 A.M. she observed Resident #1 walking in the hallway, and he/she asked her what time it was. The Supervisor said she told him/her the time, asked if he/she knew where he/she was (in a facility), escorted Resident #1 to the bathroom and then assisted him/her back to bed.The Supervisor said she checked on Resident #1 each time she passed his/her room, said he/she was last seen (by her) in bed between 2:50 A.M. and 3:00 A.M. and he/she appeared to be asleep (observed with eyes closed).The Supervisor said she was in another resident's room when Nurse #1 said a Police Officer called asking if one of their resident's was missing and said that he/she may be at the Facility next door.The Supervisor said the Police Officer had located Resident #1 on the loading dock on the adjacent property, outside knocking on their back door. The Supervisor said that the Police Officer told her Resident #1 had abrasions on his/her knees and they were calling for Emergency Medical Services (EMS) to transport his/her to the ED.The Supervisor said that she had no idea how Resident #1 could have eloped [exited the facility] and said she never heard any alarms to indicate someone had left the building.During an interview on 05/20/26 at 11:33 A.M., with the Environmental Service Director (ESD, which included a Facility tour and (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	Surveyor observations) the ESD said the Facility has a security surveillance camera system that covers the exit doors to the Facility. The ESD said that they reviewed the security footage from 04/30/26 and identified which door Resident #1 was seen exiting the building through.The ESD said that no one saved the security surveillance footage and said they were unable to retrieve the footage from their Corporate Information Technology (IT) Department. The ESD said although there was no surveillance camera footage to show how Resident #1 exited the Facility and no witnesses that had determined where and how Resident #1 got out of the building. The ESD said that Resident #1's room was adjacent to a hallway which led to an employee service door (about 100 feet from Resident #1's room), that employee service door led to a stairwell and egress door that led outside, which is how he/she got out that night.The ESD said and the Surveyor observed a door in the service corridor that had a keypad for staff to enter a numerical code that would disengage a locking mechanism and the alarm making it clear to exit.The ESD said some doors have a keypad for the staff to enter a code to open the door and disengage the alarm so staff can pass through the door without issue while maintaining resident safety.During the observation the Surveyor opened the service door via lever (handle), without putting the code into the keypad, the door opened as an alarm sounded. The alarm was loud, however, the ESD said and the Surveyor observed the door was not hard-wired to a system that would allow the alarm to be heard in other parts of the building, such as on the nursing units.The Surveyor observed that once the door closed behind them, the alarm automatically shut off.During the observation the Surveyor noted that crossing the threshold of the door entering the stairwell, led to a flight of stairs down to a second door that exited to the outside.At the second door there was a keypad requiring a code to exit, when the Surveyor pushed down on the door lever to exit, the door opened and the alarm sounded, and again the alarm shut off (no longer sounding) once the door was the closed.The ESD said that doors with the keypad should continue to sound through to a central point where other staff are able to hear the sounding alarm. The ESD said the alarm should sound until a responding staff member arrives at the door, looks into why it sounded and enters the security code which disengages the alarm.The ESD said Resident #1 was seen via security surveillance camera footage (unsaved, not recorder) at that exit door, that Resident #1 was seen walking up the back lot/driveway and likely went through the woods to the neighboring Facility onto their loading dock.The ESD said the alarmed doors should have had a maglock (secures doors using a low-voltage electromagnet and a metal armature plate (crossbar) and because of a fail-safe, cutting the power or pressing the crossbar for 15 seconds releases the door and one is able to exit while alarm is still sounding).During an interview on 05/20/26 at 3:40 P.M., the Administrator said the doors that Resident #1 exited through were not properly secured and the alarms could only be heard if someone had been nearby at the time the doors were opened.On 05/20/26, the Facility staff presented the Surveyor with a plan of correction with an effective date of 05/16/26 that addressed the area of concern identified in this survey, as follows:A) Resident #1 was transported to the ED for evaluation, upon assessment was not found to have any serious physical injuries and was not readmitted to the Facility.B) On 04/30/26, the Administrator and Unit Managers completed new Elopement Risk Assessments for all Residents and updated care plans as needed.C) On 04/30/26 through 05/03/26, the Director of Nurses (DON) and Administrator began Facility wide Staff education regarding elopement, alarmed and locked doors, night shift responsibilities, and missing resident protocols.D) On 04/30/26 the ESD and Regional Support inspected all doors requiring a keypad and code to exit, identifying three (3) doors requiring changes and/or updates.E) On 05/01/26, the Administrator contacted a Security Door company to evaluate and fix all doors identified as not being properly secured.F) On 05/01/26, a third Certified Nurse Aide (CNA) was added to the 11:00 P.M.-7:00 A.M. shift for additional monitoring. One CNA (of the three scheduled) on the overnight shift will not have a resident assignment, that CNA will be responsible for monitoring the hallway(s) on unit, making observations of residents, redirecting as needed, until the new doors and alarms are installed.G) On 5/01/26 all door alarm codes were changed by the ESD and Administrator and will continue to be (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	changed quarterly and on an as needed basis.H) On 5/15/26, the Door Company provided the Facility with quotes and contracts to fix/upgrade identified doors, parts have been ordered and will be fixed as soon as the company is able.I) Audits will be conducted on all alarmed doors nightly on the 11:00 P.M.-7:00 A.M. shift by Nursing and weekly by the ESD.J) Results of all audits will be reviewed at QAPI meeting by the management team.K) The Administrator is responsible for overall compliance.