STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225709	A. Building B. Wing	11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Timothy Daniels House	84 Elm Street Holliston, MA 01746

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 and interviews, for one of three sampled residents (Resident #1), who had severe cognitive impairment, required constant supervision and a wander guard bracelet for safety, the Facility failed to ensure he/she was provided with an adequate level of staff supervision and that assistive devices such as wander guard safety alarm system /exit doors were functioning properly in order to prevent an incident of elopement, when on 10/18/25 during the evening shift, Resident #1 exited the facility undetected by staff, and was later found by Police in the surrounding neighborhood.Findings include: The Facility's Policy, titled Resident Elopement Guideline, undated, indicated the following:-any resident that is assessed and identified as having a wandering behavior will have a wander guard placed on the resident to audibly alert staff of attempts by the resident to exit the facility, and -placement and function will be checked by nursing as ordered.Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS) and the Facility's Investigation Narrative, both dated 10/23/25, indicated that on 10/18/25 at 5:00 P.M., staff brought Resident #1's dinner tray to his/her room, and he/she was not there. The Report indicated that staff searched the Facility, could not locate Resident #1 and then called 911. The Report indicated that Resident #1 was later found by the Police on the next street over sitting on a neighbor's front porch. The Report indicated that Resident #1 was not harmed. Resident #1 was readmitted to the Facility in September 2025, diagnoses included dementia, anxiety, diabetes, and heart failure. Review of Resident #1's Significant Change Minimum Data Set Assessment (MDS), dated [DATE], indicated Resident #1 had severe cognitive impairment and was dependent on staff for care. Review of Resident #1's Elopement Assessment, dated 05/01/25, indicated he/she was at risk of elopement, and use of a wander guard bracelet was indicated. Review of Resident #1's Behavior Care Plan, reviewed and renewed with his/her MDS assessment, dated 10/03/25, indicated Resident #1 was at risk for elopement and should be redirected by staff. Review of Resident #1's Fall Care Plan, reviewed and renewed with his/her MDS assessment, dated 10/03/25, indicated Resident #1 required continual supervision and staff assistance at times. During a telephone interview on 12/10/25 at 10:11 A.M, Certified Nurse Aide (CNA) #1 said that Resident #1 typically talked about going home but he (CNA #1) had never seen him/her attempt to leave the Facility. CNA #1 said he thinks he remembers seeing a wander guard bracelet on Resident #1's walker but could not remember. CNA #1 said that after Resident #1 had eloped, he (CNA #1) pushed on the exit door near Resident #1's room without entering the door code, and it opened and did not alarm. CNA #1 said if anyone pushes on the door it beeps and if a resident with a wander guard bracelet attempts to open the door, it locks and alarms. CNA #1 said the first time he tried to open the door after Resident #1 was noted to be missing, it (the door) malfunctioned, and failed to alarm or lock. CNA #1 said staff looked for Resident #1 and could not find him/her in or outside of the Facility, and that the Police later located him/her in the neighborhood and he/she returned to the Facility unharmed.During an interview on 11/25/25 at 3:50 P.M., the Maintenance Director said he does not check the functioning of wander guard system regularly and said he could not provide any documentation that indicated he had ever checked it. 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

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Maintenance Director said the exit door near Resident #1's should lock if a resident with a wander guard bracelet attempts to open it. The Director of Maintenance said that he checked all doors the night Resident #1 eloped but could not provide documentation on whether or not the system was functioning properly.During a telephone interview on 11/25/25 at 12:06 P.M., Nurse #1 said Resident #1 had a wander guard bracelet on his/her walker and said he checked it the night Resident #1 eloped. Nurse #1 said that nursing checks to see if Resident #1's wander guard bracelet is working by having him/her walk by the elevator and listening for the alarm. Nurse #1 said that around dinner time Resident #1 told him that he/she was going to his/her room, but then a little while later, Nurse #1 said he was unable to locate him/her. Nurse #1 said he and other staff were unable to locate Resident #1 so he called 911. Nurse #1 said the wander guard system had not alarmed, alerting them that a resident was near an exit door and said he does not know how Resident #1 was able to exit the Facility undetected by staff. Nurse #1 said Resident #1 returned to the Facility unharmed after Police located him/her in the Facility's neighborhood.During an interview on 11/25/25 at 2:52 P.M., the Director of Nurses (DON) said that Resident #1 requires continual supervision for ambulation and staff should therefore have eyes on him/her at all times when he/she is ambulating. The DON said Resident #1 was an elopement risk and had previously cut the wander guard bracelet off his/her wrist, so it had been attached to his/her walker. The DON said that she did an investigation and had no idea how Resident #1 was able to get out of the Facility. The DON said no one saw Resident #1 leave the Facility and no alarm sounded to alert staff, but it should have. During an interview on 11/25/25 at 3:42 P.M., the Administrator said staff had not seen Resident #1 leave the Facility, and no one heard the wander guard system alarm. The Administrator said she did not know how Resident #1 was able to get out of the Facility.