STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225511	A. Building B. Wing	03/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Lowell	30 Princeton Boulevard Lowell, MA 01851

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 0655 Level of Harm - Actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 37342 Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who had dementia, with a history of wandering and exit seeking, but whose nursing admission assessment related to his/her risk for elopement was left incomplete and unfinished, the Facility failed to ensure they developed and implemented a baseline care plan that at a minimum contained the necessary information for staff to properly care for him/her. On 02/22/23, Resident #1 left the Facility, unbeknownst to staff, and was found 0.4 miles away at his/her Family's residence by a Family Member. Resident #1 was noted to be bleeding from his/her head and left elbow, 911 was called, and he/she was transferred to the Hospital Emergency Department for evaluation. Resident #1 was diagnosed with a head injury, an injury to his/her left eyebrow, and having had a fall. Findings include: The Facility was unable to provide any policies regarding the development of baseline care plans and/or policy that addressed the care needs of a wandering or exit seeking resident. Resident #1 was admitted to the Facility in February 2023, diagnoses dementia and a history of falls. The Hospital History and Physical Report, dated 02/10/23, indicated Resident #1 was admitted to the Emergency Department following a fall at home, was assessed to be confused and was wandering. The Report indicated hospital nursing staff placed him/her in a Soma bed (a bed with a mesh enclosure) for safety, and that his/her family was unable to safely keep Resident #1 at home. The Facility Nursing Evaluation, dated 02/17/23, indicated Resident #1 was disoriented and had short term memory issues. Review of Resident #1's facility Elopement Risk Scale Assessment, dated 02/17/23, indicated he/she was ambulatory but was not dependent with ambulation, could not follow instructions, could communicate with staff, and was medically diagnosed with dementia. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Actual harm Residents Affected - Few	However further review of the Elopement Risk Assessment indicated it was incomplete, that the section of the assessment form designated for history of wandering, observations, and current behaviors, were left blank. During interview on 03/06/23 at 2:32 P.M., Nurse #3 said she assessed Resident #1 upon his/her initial admission to the facility. Nurse #3 said Resident #1 was confused, and she deferred most of the admissions questions to his/her Family Member. Nurse #3 said Resident #1's Family was mostly concerned about his/her fall risk and said she did not ask questions regarding his/her elopement risk factors. Nurse #3 said she reviewed Resident #1's Hospital discharge paperwork, but did not recall reading that he/she had been wandering while at the Hospital. During interview on 03/08/23 at 1:18 P.M., Nurse #2 said that he was Resident #1's nurse a few times during his/her admission to the Facility and said Resident #1 would become increasingly confused in the evenings, would gather his/her clothes, ambulate around the unit, and ask staff about how to get home. Nurse #2 said he did not report Resident #1's behaviors to anyone and did not complete an Elopement Risk Assessment that included Resident #1's behaviors. The Nurse Progress Note, dated 02/17/23, indicated Resident #1 was confused, ambulated independently, was asking to go home, and staff had to redirect him/her. The Nurse Progress Note, dated 02/19/23, indicated Resident #1 was confused, refused care from staff, and was up several times looking to go home. The Nurse Progress Note, dated 02/21/23, indicated Resident #1 had periods of confusion and forgetfulness, had gathered his/her clothing, and was looking for a way to go home. Review of Resident #1's Medical Record indicated, that despite his/her exit seeking behaviors, that there was no documentation to support they had developed and implemented a baseline care plan for his/her wandering and exit seeking behaviors in an effort to keep him/her safe. During interview on 03/06/23 at 2:13 P.M., the Regional Director of Clinical Operations said Resident #1's Elopement Risk Scale, dated 02/17/23, was incomplete. The Nurse Progress Note, dated 02/22/23, indicated Resident #1's Family Member called the Facility to report that Resident #1 was found at their house at 5:10 P.M., bleeding from his/her head and arm. The Progress Note indicated Resident #1 was transferred from his/her Family's home to the Hospital Emergency Department via 911. Review of the Facility's Security Camera Footage from 02/22/23 and time stamped 4:27 P.M., indicated Resident #1 left the Facility through a back door fire exit. The Facility's Investigation Summary, dated 02/22/23 indicated that on 02/22/23 Resident #1's Family Member called to notify staff that Resident #1 was at his house, 0.4 miles away from the Facility, and was bleeding from a cut on his/her head. The Summary indicated Resident #1 was taken to the Hospital Emergency Department via 911 and returned to the Facility later that day. (continued on next page)

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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 0655 Level of Harm - Actual harm Residents Affected - Few	The Hospital Emergency Department History and Physical, dated 02/22/23, indicated Resident #1 had an injury to his/her left eyebrow, was diagnosed with a fall and head injury, and was discharged back to the Facility that same day. Review of Resident #1's facility Skin Observation Tool, dated 02/23/23, indicated he/she had the following new areas of skin alterations: -Left elbow wound, measuring 18 centimeters (cm) by 7 cm, -Left knee wound, scabbed, no measurements indicated, -Face wound at the corner of his/her right eye, no measurements indicated, -Left lower leg (rear), scabbed, no measurements indicated. During interview on 03/09/23 at 1:27 P.M., Nurse #4 said that on 02/22/23 she worked a double shift on the other hall on the unit from Resident #1. Nurse #4 said Resident #1 was wandering about the unit for most of the day, and said she last saw him/her in the dayroom/dining on the unit at 4:30 P.M. Nurse #4 said Resident #1's Family called the Facility at 5:00 P.M. to report he/she was at their home. During interview on 03/06/23 at 3:03 P.M., Nurse #1 said she was Resident #1's Nurse on 02/22/23 on the 3:00 P.M., to 11:00 P.M., shift, and said she administered Resident #1 medications at 4:33 P.M. in the dayroom on the unit. Nurse #1 said that Nurse #4 told her at 5:00 P.M., that Resident #1's Family had called and said Resident #1 had left the Facility, was at their home, and that they sent him/her to the Hospital Emergency Department via 911. Nurse #1 said she did not know Resident #1 had a history of wandering and asking to go home. During interview on 03/10/23 at 12:51 P.M., the Administrator said the Facility did not have a policy specific to development of baseline care plans. During interview on 03/10/23 at 12:54 P.M., the Director of Nurses (DON) said she could not recall if she was aware of Resident #1's behaviors as noted in his/her Nurse Progress Notes of asking about going home and gathering his/her belongings. The DON said these behaviors should have triggered the Facility to develop a plan of care to prevent elopement.

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 37342 Based on records reviewed, interviews, and observations, for one of three sampled residents, (Resident #1), had dementia, with a history of wandering and exit seeking behaviors, the Facility failed to ensure he/she was appropriately assessed by nursing for his/her risk of elopement to determine his/her needs related to preventative measures for safety, including the necessary level of staff supervision to maintain his/her safety in an effort to prevent an incident/accident (elopement) resulting in an injury, and failed to ensure alarmed doors were kept secured, with alarms systems sounding and functioning adequately. On 02/22/23, Resident #1, unbeknownst to staff, eloped from the facility by exiting the through a fire exit door, and was found 0.4 miles away at his/her Family's residence by a Family Member. Resident #1 was noted to be bleeding from his/her head and left elbow, 911 was called, and he/she was transferred to the Hospital Emergency Department for evaluation. Resident #1 was diagnosed with a head injury, an injury to his/her left eyebrow, and having had a fall. It was later determined that Resident #1 eloped through an alarmed door that had been left unlocked and then made his/her way through a second alarmed door that should have, but did not, alarm at the nurses station to alert staff. Findings include: The Facility Policy, titled, Missing Resident/Elopement, dated 03/2022, indicated staff would promptly report any resident who tries to leave the premises to the Charge Nurse or Director of Nursing. The Facility was unable to provide any policies regarding alarmed doors or care of a wandering or exit seeking resident. Resident #1 was admitted to the Facility in February 2023, diagnoses included dementia and a history of falls. The Hospital History and Physical Report, dated 02/10/23, indicated Resident #1 was admitted to the Emergency Department following a fall at home, was assessed to be confused and was wandering, The Report indicate hospital nursing staff placed him/her in a Soma bed (a bed with a mesh enclosure) for safety and that his/her family were unable to safely keep Resident #1 at home. The Facility's Nursing Evaluation, dated 02/17/23, indicated Resident #1 was disoriented, and had short term memory issues. Review of Resident #1's facility Elopement Risk Scale Assessment, dated 02/17/23, indicated he/she was ambulatory but was not dependent with ambulation, could not follow instructions, could communicate with staff, and was medically diagnosed with dementia. (continued on next page)

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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 0689 Level of Harm - Actual harm Residents Affected - Few	However further review of the Elopement Risk Assessment indicated it was incomplete, that the section of the assessment form designated for history of wandering, observations, and current behaviors, were left blank. During interview on 03/06/23 at 2:32 P.M., Nurse #3 said she assessed Resident #1 upon his/her initial admission to the facility. Nurse #3 said Resident #1 was confused, and she deferred most of the admissions questions to his/her Family Member. Nurse #3 said Resident #1's Family was mostly concerned about his/her fall risk and said she did not ask questions regarding his/her elopement risk factors. Nurse #3 said she reviewed Resident #1's Hospital discharge paperwork, but did not recall reading that he/she had been wandering while at the Hospital. The Nurse Progress Note, dated 02/17/23, indicated Resident #1 was confused, ambulated independently, was asking to go home, and staff redirected him/her. The Nurse Progress Note, dated 02/19/23, indicated Resident #1 was confused, refused care from staff, and was up several times looking to go home. The Nurse Progress Note, dated 02/21/23, indicated Resident #1 had periods of confusion and forgetfulness, and had gathered his/her clothing and was looking for a way to go home. During interview on 03/08/23 at 1:18 P.M., Nurse #2 said that he was Resident #1's nurse a few times during his/her admission to the Facility and said Resident #1 would become increasingly confused in the evenings, would gather his/her clothes, ambulate around the unit, and ask staff about how to get home. Nurse #2 said he did not report Resident #1's behavior to anyone and did not complete an Elopement Risk Assessment that included Resident #1's behaviors. The Nurse Progress Note, dated 02/22/23, indicated Resident #1's Family Member called the Facility to report that Resident #1 was found at their house at 5:10 P.M., bleeding from his/her head and arm. The Progress Note indicated Resident #1 was transferred from his/her family's home to the Hospital Emergency Department via 911. Review of the Facility's Security Camera Footage from 02/22/23, and time stamped 4:27 P.M., indicated Resident #1 left the Facility through the back door fire exit. During a tour of the Facility with the Director of Nurses (DON) on 03/06/23 at 7:40 A.M., the Surveyor observed there was a set of self-closing swinging doors outside the unit dining room, and on the far right corner of the dining room, there was a fire exit door with a red magnet-style alarm in the shape of a stop sign affixed to the upper right corner of the door, with a key in it, that was turned to the off position. During the Observation, when the door was opened, no alarm sounded. On the other side of this door was a small hallway and another door with a keypad style alarm, which did alarm when opened. Beyond that door, there were seven stairs leading down to an outside door, which opened to a parking lot and was not alarmed. The DON said doors alarmed with a keypad should sound an alarm at a panel located near the Nurses' Station, which would alert staff that someone had opened the door. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	At 7:56 A.M., at the request of the Surveyor, the DON sounded the keypad alarmed door located at the top of the stairs of the fire exit, while the Surveyor stayed to observe the alarm panel at the first floor Nurses' Station. During the observation the Surveyor noted that when the alarmed door (with the keypad) was opened by the DON and the door alarm sounded, the alarm panel at the Nurses' Station did not sound. The Surveyor also noted that the alarm could not be heard from the outside of the dining room with the doors closed. During interview on 03/06/23 at 7:56 A.M., the Assistant Director of Nurses (ADON) , who was at the Nurse's station with the Surveyor, said she too could not hear the fire exit door alarm sounding, and acknowledged that the door alarm panel at the nurses station was not sounding. The Facility's Investigation Summary, dated 02/22/23, indicated that on 02/22/23 Resident #1's Family Member called to notify staff that Resident #1 was at his house, 0.4 miles away from the Facility, and was bleeding from a cut on his/her head. The Investigation Summary indicated Resident #1 was taken to the Hospital Emergency Department via 911 and returned to the Facility later that day. During interview on 03/06/23, Certified Nurse Aide (CNA) #1 said that on 02/22/23 at 4:30 P.M., she last saw Resident #1 seated in the dayroom on the unit. CNA #1 said she did not see Resident #1 leave the unit and did not hear any door alarms sounding. During interview on 03/09/23 at 1:27 P.M., Nurse #4 said that on 02/22/23 she worked a double shift on the other hall on the unit from Resident #1. Nurse #4 said Resident #1 was wandering about the unit for most of the day, and said she last saw him/her in the dayroom on the unit at 4:30 P.M. Nurse #4 said Resident #1's Family called the Facility at 5:00 P.M. to report he/she was at their home. Nurse #4 said that later that night, someone reviewed the Facility's Security Camera Footage and it revealed that Resident #1 had left the facility through a fire exit door, that he/she had to walk through the unit dayroom/dining room to get to. Nurse #4 said she did not hear a door alarm sound when Resident #1 left, and said when staff tested the alarm that night, staff were unable to hear the alarm on the unit, when outside of the dayroom/dining room doors. During interview on 03/06/23 at 3:03 P.M., Nurse #1 said she was Resident #1's nurse on 02/22/23 on the 3:00 P.M., to 11:00 P.M., shift, and said she administered Resident #1 medications at 4:33 P.M. in the dayroom on the unit. Nurse #1 said that Nurse #4 told her at 5:00 P.M., that Resident #1's Family had called and said Resident #1 had left the Facility and was at their home, and they sent him/her to the Hospital Emergency Department via 911. Nurse #1 said she did not know Resident #1 had a history of wandering and asking to go home. Nurse #1 said she did not hear any door alarms sound when Resident #1 eloped. The Hospital Emergency Department History and Physical, dated 02/22/23, indicated Resident #1 had an injury to his/her left eyebrow, was diagnosed with a fall and head injury, and was discharged back to the Facility that same day. Review of Resident #1's facility Skin Observation Tool, dated 02/23/23, indicated he/she had the following new areas of skin alterations: -Left elbow wound, measuring 18 centimeters (cm) by 7 cm. -Left knee wound, scabbed, no measurements indicated. (continued on next page)

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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 0689 Level of Harm - Actual harm Residents Affected - Few	-Face wound at the corner of his/her right eye, no measurements indicated. -Left lower leg (rear), scabbed, no measurements indicated. During interview on 03/10/23 at 12:54 P.M., the Director of Nurses (DON) said she could not recall if she was aware of Resident #1's behaviors as noted in his/her Nurse Progress Notes of asking about going home and gathering his/her belongings. The DON said these behaviors should have triggered the Facility to develop a plan of care to prevent an elopement. During interview on 03/06/23 at 2:13 P.M., the Regional Director of Clinical Operations said Resident #1's Elopement Risk Scale, dated 02/17/23, was incomplete. During interview on 03/06/23 at 8:45 A.M., the Administrator said the Facility currently did not have a Maintenance Director, and said their other Facilities' Maintenance Departments would come to help out. The Administrator said she did not know if routine door alarm checks were done, and was unable to provide any documentation to support that door alarm checks or maintenance related to the functional status of door alarms, were completed at the Facility prior to 03/06/23. On the day of the survey, there was a contracted Door/Alarm Company on-site at the facility to inspect doors, door alarms, and alarm panels, the Contractor completed any issues found that required repairs.