STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225548	A. Building B. Wing	01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Blaire House of Tewksbury	10 Erlin Terrace Tewksbury, MA 01876

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **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 a permanent Guardianship in place, the Facility to ensure staff consistently implemented interventions identified in his/her plan of care, which clearly indicated prior to going out on a social leave, that nurses must obtain identification information of the person taking him/her out, when on 12/08/24, although Resident #1 had told his/her nurse he/she was going out with friends no identifying or contact information was obtained. Findings Include: The Facility's Policy, titled, Care Plans, Comprehensive Person-Centered, has no date, indicated a comprehensive, person-centered care plan that includes measurable, objective and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Review of the Facility's Internal Investigation, dated 12/09/24, indicated that at approximately 3:00 P.M. (on 12/08/24), Resident #1 told Nurse #1 that he/she was going out with a friend and signed out without friends providing their contact information. Resident #1 left the Facility without following proper protocol. Resident #1 was admitted to the Facility in June 2021; diagnoses included morbid obesity, cognitive heart failure, alcoholic cirrhosis of the liver with ascites, osteoarthritis of the knee, major depressive disorder, anxiety, and bipolar disorder. Review of Resident #1's Quarterly Minimum Data Set Assessment (MDS), dated [DATE], indicated that his/her Brief Interview for Mental Status (BIMS) score was 14/15, (0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired cognition, and 12-15 suggests a resident is cognitively intact). However, further review of the medical record indicated Resident #1 had a Court Order for Legal Guardianship in place, which went into effect on 11/23/20, and the Court Order remains current. Review of Resident #1's Care Plan titled: Disposition Resident will remain in LTC at the Facility, reviewed and renewed with his/her December 2024 MDS, indicated interventions included that Resident #1 will provide a phone number and a copy of the license of each individual [for Social leaves of Absence] before designated individual taking him/her out, per the Guardian's request. (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
	225548	A. Building B. Wing	01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Blaire House of Tewksbury	10 Erlin Terrace Tewksbury, MA 01876

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/29/25 at 11:44 A.M., the Director of Social Services (DSS) said that staff were educated and aware of the plan of care put in place for Resident #1's when going out for Social Leaves of Absence (SLOA). The DSS said Resident #1 was also educated about not leaving without being accompanied by a friend(s), completing information in the sign-out book, and providing contact information of person he/she leaves with. During a telephone interview on 02/03/25 at 2:15 P.M., Nurse #1 said that at approximately 2:00 P.M. on 12/08/24, Resident #1 told her that he/she would be going shopping with his/her friend later in the day. Nurse #1 said that at approximately 6:00 P.M., she went to Resident #1's room to administer him/her medications, and Resident #1 was not in his/her room. Nurse #1 said that Resident #1 had signed out in the sign out book. Nurse #1 said she was not aware of the interventions in Resident #1 plan of care for the need to obtain specific information about the person(s) taking Resident #1 out for SLOA's. During an interview on 01/29/25 at 11:00 A.M., the Director of Nursing (DON) said that Resident #1 had a plan of care and protocol in place for social leaves, that staff were aware of the protocol that Resident #1's friend(s) needed to sign him/her out and provide contact information.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Blaire House of Tewksbury	10 Erlin Terrace Tewksbury, MA 01876

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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 - 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 a Court Ordered Legal Guardianship in place and could go out on social leaves only if accompanied by a friend, the Facility failed to ensure he/she was provided with an adequate level of staff supervision to prevent an elopement, when on 12/08/24 during the day shift, Resident #1 told his/her nurse that he/she would be going out shopping with friends, and around 3:00 P.M., he/she left the unit, hung around the facility by going in/out of the lobby and activity room until approximately 5:00 P.M., when the Receptionist left, he/she then exited the facility undetected by staff and unaccompanied by anyone. Approximately seven hours later when staff realized he/she was not on the unit or anywhere in the facility, staff checked the Unit Sign Out Book which showed that Resident #1 had signed him/herself out at 3:00 P.M., and there was no name or contact information indicating who he/she left with, as required (per his/her plan of care) The facility notified the Guardian and police to report him/her missing. The facility was notified around 11:00 P.M., by local Police that Resident #1 was located and being evaluated in a local Emergency Department due to intoxication. Findings Include: The Facility's Policy, titled Procedural and Investigational Guide: Elopement, dated 12/2024, indicated elopement to a situation where a patient or resident who is cognitively, physically, mentally, emotionally, and/or chemically impaired wanders/walks/runs away, escapes, or otherwise leaves a caregiving institution or setting unsupervised, unnoticed, and/or prior to their scheduled discharge. Review of the Facility's Internal Investigation, dated 12/09/24, indicated that at approximately 3:00 P.M. (on 12/08/24), Resident #1 told Nurse #1 that he/she was going out with a friend and signed out without providing friend's contact information. The Investigation indicated Resident #1 left the Facility without following proper protocol. The Investigation indicated that around 10:40 P.M., staff noticed that Resident #1 was not in his/her room, so they began a search of the unit, the facility, and the grounds. The Investigation indicated staff called the Guardian and the Police to assist in locating Resident #1. The Police arrived at the Facility within 15 minutes and reported to staff that Resident #1 was in the local Hospital Emergency Department, unharmed but intoxicated. Resident #1 was admitted to the Facility in June 2021; diagnoses included morbid obesity, cognitive heart failure, alcoholic cirrhosis of the liver with ascites, osteoarthritis of the knee, major depressive disorder, anxiety, and bipolar disorder. Review of Resident #1's Quarterly Minimum Data Set Assessment (MDS), dated [DATE], indicated that his/her Brief Interview for Mental Status (BIMS) score was 14/15, (0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired cognition, and 12-15 suggests a resident is cognitively intact). However, further review of the medical record indicated Resident #1 had a Court Order for Legal Guardianship in place, which went into effect on 11/23/20, and the Court Order remains current. During an interview on 01/29/25 at 11:44 A.M., the Director of Social Services (DSS) said that (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Blaire House of Tewksbury		STREET ADDRESS, CITY, STATE, ZIP CODE 10 Erlin Terrace Tewksbury, MA 01876	

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	Resident #1 had permission from his/her Guardian to go out with his/her friends, if the friends signed him/her out and provided their contact information. The DSS said staff were educated and aware of the interventions in Resident #1's plan of care related to Social Leave of Absence (SLOA). The DSS said Resident #1 was also educated about not leaving without friends, completing the sign-out book, and providing contact information. During a telephone interview on 02/03/25 at 2:15 P.M., Nurse #1 said that, at approximately 2:00 P.M. on 12/08/24, Resident #1 told her that he/she would be going shopping with his/her friend later in the day. Nurse #1 said that at approximately 6:00 P.M., she went to Resident #1's room to administer his/her medications, and Resident #1 was not in his/her room. During a telephone interview on 02/03/25 at 11:46 A.M., Nurse #2 said she received the report at the beginning of her shift at 7:00 P.M. from Nurse #1 that Resident #1 was out with his/her friends. Nurse #2 said she assumed his/her friends had signed Resident #1 out with their contact information. Nurse #2 said that, at approximately 10:45 P.M. on 12/08/24, she could not find Resident #1 to administer his/her medications. Nurse #2 said she had immediately checked the sign-out book and noticed there was no contact information for the person who took Resident #1 out. Nurse #2 said she alerted all the staff that Resident #1's missing, staff began a search of the unit, the facility, and the grounds. Nurse #2 said the Guardian was notified, and the Police were called to assist in locating Resident #1. Nurse #2 said the Police arrived at the Facility within 15 minutes and reported that Resident #1 was in the local Hospital Emergency Department (ED), unharmed and intoxicated. Nurse #2 said the Police indicated that while Resident #1 was at his/her friend's house, he/she became intoxicated, fell, needed EMS to assist him/her off the floor and had taken him/her to the ED. During an interview on 01/29/25 at 11:00 A.M., the Director of Nursing (DON) said that during their investigation they determined that on 12/08/24 around 3:00 P.M., Resident #1 signed out in the Sign Out Book on the unit, stayed around in the lobby or activity room until the Receptionist left at 5:00 P.M. and then Resident #1 left the facility. DON said during the investigation they also determined that Resident #1 knew all the security codes to the doors and to the elevator. The DON said that staff were aware of the Resident #1 plan of care for SLOA's and that once Resident #1 informed nursing that he/she was going out with friend, staff failed to ask for or obtain the identity and contact information of the friend(s) he/she was going to be with.