STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075113	A. Building B. Wing	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greentree Manor Nursing and Rehabilitation Center	4 Greentree Drive Waterford, CT 06385

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. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, review of facility documentation, facility policies, and interviews for one (1) of three (3) sampled residents (Resident #1) who was at risk for elopement and wore a wanderguard, the facility failed to ensure staff responded appropriately to a door alarm when the resident exited the facility unattended and was found by an off-duty staff member on the sidewalk located near the front driveway. The findings include:Resident #1's diagnoses included dementia, depression, and anxiety disorder. The quarterly Minimum Data Seta assessment dated [DATE] identified Resident #1 had poor memory recall difficulty focusing, required substantial/maximal assistance with most Activities of Daily Living, was non-ambulatory, used a wheelchair for mobility, was able to self-propel independently once in the wheelchair, and used a wander/elopement alarm daily. The Resident Care Plan dated 10/31/25 indicated Resident #1 was at risk for wandering and elopement as evidenced by pacing, roaming or wandering in and out of peers' rooms. The care plan indicated Resident #1 had not attempted to leave the facility without an escort. Interventions directed to check function of the wanderguard every evening shift, ensure resident's picture was in the elopement risk binder at receptionist's desk, check placement of the wanderguard every shift, introduce resident to all staff as a wanderer, apply a code alert bracelet if indicated and make sure the bracelet was functioning appropriately, check using code alert transmitters as per facility policy, and assist to find own room or unit as needed. The Facility Reported Incident form dated 11/26/25 identified on 11/26/25 at 1:15 PM Resident #1 was observed outside of the building, sitting in his/her wheelchair, unsupervised. The report indicated Resident #1 was observed five (5) to eight (8) feet outside the building and was brought back through the main entrance by a witness. The investigation identified Resident #1 pushed on the emergency exit door until the door opened and although staff heard and responded to the alarm, the staff did not witness Resident #1 leave the building or proceed to go outside to check the surrounding area. Interview and review of the 11/26/25 incident with the Director of Nursing (DON) on 12/22/25 at 12:57 PM identified she was the person responsible for the investigation. The DON indicated it was determined Resident #1 exited the building through the South pod exit door located at the end of the unit on the South wing. The DON explained although Resident #1 was wearing a wanderguard at the time of the incident, the South pod exit door was not equipped with a wanderguard alarm because it was an emergency exit door. The DON identified Resident #1 was last seen by a nurse aide, Nurse Aide (NA) #2, ten (10) minutes prior to being found outside. The DON indicated Resident #1 had pushed the South pod exit door long enough for the door to open, then self-propelled in the wheelchair to the sidewalk located near the main entrance, where Resident #1 was observed minutes later, about five (5) feet from the main entrance by an off-duty nurse aide (NA #1) who had returned to the facility to pick up a personal item NA #1 left behind. The DON identified statements were obtained from staff during the investigation, which determined no staff on duty observed Resident #1 leave through the South pod exit door, although the staff had heard the emergency door alarm going off. The DON identified a statement provided by the Food Service Director identified on 11/26/25 at 1:15 PM, he observed a nurse aide (NA #1) bring Resident #1 through the front door, heard the front door alarm go off because of Resident #1's wanderguard and turned off the front door alarm and then the Food Service Director checked all the doors. The DON stated the Food Service Director saw the South pod exit door had a green light, which indicated Resident #1 had exited out that door, and the Food Service Director then pushed on the door, opened it, and reset the door because the alarm was going off. The DON identified staff did not exit out the South pod door immediately following the alarm being set off, which staff were expected to do, and indicated staff did not know the code to reset the exit door alarm. Interview with RN #1 on 12/22/25 at 1:17 PM identified she was notified on 11/26/25 that an off-duty nurse aide (NA #1) brought Resident #1 into the building through the front doors after Resident #1 was found unattended in his/her wheelchair outside the building. RN #1 indicated the temperature was in the mid-sixties and Resident #1 was wearing long pants, a sweater, and sneakers. RN #1 indicated following the incident Resident #1 was assessed, no injuries were noted, Resident #1's doctor and responsible party were notified, and education was initiated the same day for all staff. RN #1 identified facility policy indicated staff were responsible for checking the alarm, checking the area, and making sure no one was outside the area. Although requested, facility policies for Missing Resident/Elopement and for Wanderguard/Secured Exit were not provided.