STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075325	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mary Wade Home, the Incorporated	118 Clinton Ave New Haven, CT 06513

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47826 Based on clinical record reviews, facility documentation, facility policies and interviews for two (2) of three (3) sampled residents (Residents #1 and #2) who were dependent on staff for toileting and personal hygiene, the facility failed to ensure the residents were not neglected by a nurse aide and had been provided with the appropriate care. The findings include: 1. Resident #1's diagnoses included peripheral neuropathy, morbid obesity, and had a history of urinary tract infections. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 had no memory recall deficits, was oriented to person, place, and time, was dependent on staff for toileting and personal hygiene, required partial assistance with bed mobility, and was occasionally incontinent of urine. The Resident Care Plan dated 1/17/25 identified Resident #1 was incontinent of bowel and bladder. Interventions directed to provide incontinent care every two (2) hours and as needed, keep resident clean and dry, monitor for signs and symptoms of urinary tract infections, offer and assist with the bedpan every two (2) hours when awake while in bed, toilet resident every two (2) hours and as needed, encourage resident to state need to void, and to keep the call bell in reach. The nurse's note dated 3/21/25 at 6:19 PM identified Resident #1 was noted to have concerns about the nurse aide, Nurse Aide (NA) #1, that cared for him/her last evening on 3/20/25. The note indicated Resident #1 stated NA #1 did not provide incontinent care after she put him/her to bed. The note identified Resident #1 was comfortable at that time and in no distress. Review of the point of care history report failed to reflect documentation that toileting hygiene had been provided on 3/21/25 from 11PM-7AM. The Facility Reported Incident form dated 3/21/25 identified Resident #1 had complained that the nurse aide assigned to him/her did not provide incontinent care from 6:00 PM on 3/20/25 to 7:00 AM on 3/21/25. The report indicated Resident #1 was provided incontinent care by the 7AM-3PM shift between 7-7:30AM. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Resident #1 on 4/11/25 at 12:15 PM identified he/she recalled a recent incident with a nurse aide that he/she had not worked with in the past. Resident #1 reported the nurse aide had entered his/her room at approximately 6:30 PM, changed him/her and put him/her to bed, which was all part of his/her normal routine. Resident #1 identified a nurse aide usually came in before the end of the shift at about 10:30 PM, changed him/her if needed, and a nurse aide normally came to the room at 4:30 AM to change him/her but no one came in the room after 6:30 PM on 3/20/25. Resident #1 recalled waking up off and on during the night but was unable to reach the call bell to call for assistance. Resident #1 reported he/she was soaked in the morning when the 7AM-3PM nurse aide changed him/her. 2. Resident #2's diagnoses included osteoarthritis, rheumatoid arthritis, and had a history of recurrent urinary tract infections. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #2 had no memory recall deficits, was oriented to person, place, and time, was dependent on staff for toileting and personal hygiene, was always incontinent of bladder and frequently incontinent of bowel. The Resident Care Plan dated 1/9/25 identified Resident #2 was incontinent of bowel and bladder. Interventions directed to provide incontinent care every two (2) hours and as needed, keep resident clean and dry, monitor for signs and symptoms of urinary tract infections, offer and assist with the bedpan every two (2) hours when awake in bed, toilet resident every two (2) hours and as needed, encourage resident to state need to void, and to keep the call bell in reach. The nurse's note dated 3/21/25 at 6:13 PM identified Resident #2 had complaints about a nurse aide, NA #1, that took care of him/her last evening on 3/20/25. The note indicated Resident #2 reported NA #1 had a poor attitude and did not provide any care after 9:00 PM. The note indicated Resident #1 was comfortable at that time and in no distress. Review of the point of care history report failed to reflect documentation that toileting hygiene had been provided on 3/21/25 from 11PM-7AM. The Facility Reported Incident form dated 3/21/25 identified Resident #2 had complained that the nurse aide assigned to him/her refused to provide incontinent care and assistance. Resident #2 stated that he/she did not receive care from approximately 3/20/25 at 9:00 PM through 7:00 AM on 3/21/25. The report indicated Resident #2 was provided with incontinent care by the 7AM-3PM shift. In a written statement dated 3/21/25 the 7AM-3PM charge nurse identified Resident #2 made a complaint to her that the last time he/she received any care was on 3/20/25 at 9:00 PM and no one came into his/her room during the night to offer care and Resident #2 reported when he/she asked NA #1 to help boost him/her up in bed, NA #1 told Resident #2 you can do it yourself, use your feet. The Summary Report dated 3/27/25 identified at the conclusion of the investigation it was determined that NA #1 was neglectful in providing care to the residents and NA #1 had a pattern of refusing to provide care to residents. In an interview on 4/11/25 at 12:50 PM NA #1 denied all allegations. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Assistant Director of Nursing (ADON) on 4/11/25 at 1:30 PM identified on 3/21/25 the 7AM-3PM charge nurse informed her that Resident #1 and Resident #2 both reported NA #1 neglected to provide incontinent care to them overnight. The ADON interviewed both residents and their statements were the same as the initial statements they had made. The ADON identified NA #1 was suspended pending the facility's investigation and the facility terminated NA #1 as a result of the investigation. Resident #2 was out of the facility and not available for an interview. Review of the facility policy for Abuse, Neglect, and Exploitation, directed in part, the facility would implement policies and procedures that prohibit and prevent abuse and neglect. Review of the facility policy for Resident Rights, directed in part, the resident has a right to be treated with respect and dignity and be free from neglect.