

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075325	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/27/2025
NAME OF PROVIDER OR SUPPLIER  Mary Wade Home, the Incorporated		STREET ADDRESS, CITY, STATE, ZIP CODE  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 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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on review of the clinical record, facility documentation and facility policy, and interviews for one of three residents (Resident #1), reviewed for accidents, the facility failed to provide adequate supervision to ensure a resident identified at risk for wandering was not able to leave the facility without staff knowledge. The findings include:Based on review of the clinical record, facility documentation and facility policy, and interviews for one of three residents (Resident #1), reviewed for accidents, the facility failed to provide adequate supervision to ensure a resident identified at risk for wandering was not able to leave the facility without staff knowledge. The findings include: Resident #1 was admitted with diagnoses that included major depression and epilepsy. A quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of 14 (indicated was alert and oriented) and was independent for transfers and ambulation with a walker. The Resident Care Plan (RCP) dated 6/4/2025 identified required assistance with ADLs. Interventions directed independent ambulation with a rollator (walker). Record review identified Resident #1 had a voluntary court appointed Conservator of Person and Estate. A facility reportable event (RE) form dated 7/15/2025 at 1:30 PM identified a missing resident. Resident #1 left the building to take a walk. Staff followed Resident #1 out of the building, and due to a history of combativeness/resistive to care, staff followed Resident #1 until he/she returned to the facility. A facility RE summary dated 7/15/2025 identified Resident #1 had a BIMS of 14, was conserved, and was deemed to be an elopement risk. A wander guard was placed, a care plan was developed for elopement, and a picture was placed at nursing station and front desk as per facility policy. The Resident Care Plan (RCP) dated 7/16/2025 identified Resident #1 was an elopement risk, and had previously left the building and stated he/she was going for a walk. Interventions directed a wander guard placed on the left wrist and placed on the rollator (walker). A physician's order dated 7/15/2025 directed to check placement of wander guard to left wrist and rollator every shift. A facility RE form dated 8/2/2025 at 3 PM identified Resident #1 was alert, oriented, had mild cognitive impairment, and ambulated independently. Staff observed Resident #1 went to the library on campus and staff notified the front desk. Resident #1 stated he/she went to the library to get something good to read, and was escorted back to his unit without any incident. Observations during survey identified the campus library was located across the street from the facility. The street was a one (1) way street with sidewalks, parking on both sides of the street, and a traffic light at the corner with a pedestrian cross walk. The facility RE summary dated 8/5/2025 identified on 8/2/2025 at approximately 2:15 PM, Resident #1 exited through the front doors and went to the assisted living facility located across the street to use their library for a good book. At 3:00 PM, LPN #1 was parking her car and saw Resident #1 on the assisted living facility's property walking back towards the facility. She watched Resident #1 and called the security guard have someone get Resident #1. Resident #1 was escorted by security staff and a second staff member back into the building with no injuries identified. Resident #1 was last seen on the unit at 1:30 by Nurse Aide (NA) #1. Further, the investigation identified the security guard turned off the wander guard alarm when Resident #1 exited the facility about 2:15 PM. Interview and review of facility statement with the security guard (SG #1) identified if a resident with a wander guard comes close enough to the lobby wander guard system, it will activate the alarm, and the alarm noise sometimes causes a resident to turn around and move away from the door. On 8/2/2025 at approximately 2:15 PM he was at the front receptionist desk, and observed Resident #1 approach the front entrance of the building when the wander guard alarm sounded. SG #1 got up, entered the code to stop the alarm without speaking to Resident #1, and Resident #1 continued to walk out the front door of the facility. SG #1 stated that earlier in the shift the alarm had gone off and he did not observe any resident in the area, and he deactivated/reset the alarm. SG #1 stated although he had seen Resident #1's picture in the elopement book, he did not connect the observation to when the wander guard alarm was activated with Resident #1 nearby. When the alarm triggered with Resident #1 nearby, he did not realize it was triggered by Resident #1 because Resident #1 was previously in the residential care level and allowed to come and go freely. SG #1 was not aware Resident #1 was currently a resident in the nursing home section of the facility and although his/her photo was in the elopement book, he did not know Resident #1 had a wander guard. At approximately 3:00 PM, he was contacted by a nurse in the parking lot across the street and informed that she had observed Resident #1 coming out the assisted living building headed across the street back to the facility and was directed to go get Resident #1 as he/she</p>		