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 04/10/2026

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation review, and staff interviews for one resident (Resident #1) reviewed for accidents, the facility failed to ensure a complete and thorough post-fall investigation was conducted and documented in accordance with accepted standards of nursing practice. The findings include:Resident #1's diagnoses included vascular dementia, hypertension, nonthrombocytopenic purpura, psychotic disorder, anxiety, restlessness, and agitation. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 was unable to complete a Brief Interview for Mental Status (BIMS) and identified Resident #1 was severely cognitively impaired, and was dependent for ADL's (activities of daily living) and transfers. The Resident Care Plan dated 11/12/25 identified Resident #1 at risk for falls and had altered mobility. Interventions directed to reassess fall risk per policy and after each fall as needed, provide a busy blanket when at a table, encourage out of bed as tolerated and transfer per physician orders. Nursing note dated 12/24/2025 at 1:46 PM identified LPN #1 repositioned Resident #1 in the wheelchair as Resident #1 was leaning forward and refused to lean back. Resident #1 fell straight forward onto the floor, and the fall was also witnessed by NA #1. Resident #1 had a small laceration to the forehead and was transferred to the hospital for evaluation. Review of the facility reportable event form and investigation dated 12/24/25 at 12:38 PM identified that LPN #1 was repositioning Resident #1 in a wheelchair when Resident #1 leaned forward and fell to the floor, sustaining a small forehead laceration. Further review failed to identify staff interviews were conducted or additional investigative measures were completed to identify the root cause of the incident. Nursing note dated 12/24/2025 at 10:07 PM identified Resident #1 returned from the hospital with five (5) sutures on the middle of the forehead. Documentation review identified the facility failed to conduct a thorough investigation, including staff statements and an investigation to identify the root cause of the incident. Interview with the Director of Nursing (DON) on 4/10/26 at 12:00 PM identified the DON was unable to provide staff statements were obtained regarding the fall, and an investigation included an analysis of the cause of the fall. Further, the DON stated that RN #2 was the acting DON when the fall occurred, and stated her expectation was to complete a thorough investigation, including obtaining staff statements and a root cause analyses. Although attempted, an interview with RN #2 was unable to be conducted during the survey. Review of the facility Incidents and Accidents Policy dated 12/23/24 directed in part, if an incident/accident was witnessed by other people, the supervisor or designee will obtain written documentation of the event by those that witnessed it and submit that documentation to the Director of Nursing and/or Administrator. The Policy further directed to conduct a root cause analysis to ascertain causative/contributing factors to avoid further occurrences.

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