| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 075379 | A. Building<br>B. Wing | 04/27/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Sharon Center for Health & Rehabilitation | 27 Hospital Hill Road<br>Sharon, CT 06069 |

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<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation review, facility policy review, and staff interviews for one of three residents (Resident #1) reviewed for accident hazards and supervision, the facility failed to ensure adequate supervision of a resident with moderate cognitive impairment and an unsteady gait requiring walker-assisted ambulation, failed to accurately assess elopement risk despite a BIMS score of 9 indicating moderate cognitive impairment, and failed to ensure staff responded appropriately to an activated exit door alarm by searching for a resident or notifying the supervisor prior to deactivation. On 3/30/2026, Resident #1 exited the facility undetected, walked 0.3 miles on a two-way street without sidewalks or a crosswalk to the hospital emergency department, and remained unaccounted for by staff for one hour and 45 minutes. Resident #1 was on Apixaban (a blood thinner increasing the risk of serious bleeding from falls or trauma), was confirmed by the hospital to be confused and disoriented upon arrival, and was discharged with diagnoses including disorientation and at risk for elopement from a healthcare setting. The facility's elopement risk evaluation inaccurately concluded Resident #1 lacked the physical ability to leave; no written policy existed governing staff response to exit door alarms; and the staff member who responded to and deactivated the alarm did not look outside, search for residents, or notify the supervisor, an individual staff failure compounded by a systemic organizational failure. These failures placed Resident #1 and six additional residents identified by the facility as elopement risks in Immediate Jeopardy of serious harm or death, beginning 3/30/2026. The findings include: Record review identified Resident #1 was responsible for him/herself. Physician order dated 3/26/2026 directed Apixaban (Eliquis, used to prevent blood clots) 2.5 milligrams (mg) by mouth daily. The nursing admission assessment dated [DATE] identified Resident #1 required assistance for transfers, had an unsteady gait with poor trunk control, and was alert and oriented to person, place, time and situation. Elopement risk evaluation dated 3/26/2026 identified Resident #1 was not at risk for wandering/elopement. The evaluation identified Resident #1 did not have the physical ability to leave the facility, was not cognitively impaired, and did have the capacity to make informed decisions about leaving. The resident care plan (RCP) dated 3/27/2026 identified Resident #1 was at risk for falls due to an unsteady gait and required assistance for activities of daily living (ADL). Interventions directed to anticipate needs, and supervision for transfers and ambulation with a walker. An admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of 9 (moderate cognitive impairment) and required partial assistance for bed mobility and transfers. APRN note dated 3/30/2026 at 5:54 AM identified a remote visit was conducted for nursing reports of moderate bright red blood noted while passing stool. No rectal bleeding, on Eliquis, likely constipation and plan monitor for bleeding. A nursing note written by RN #1, dated 3/30/2026 at 10:35 PM identified she received a call from the hospital ED at 7:50 PM that Resident #1 had walked into the ED at 6:20 PM. Resident #1 was alert and oriented to self and provided her/his current birth date. Resident #1 told the hospital that he/she lived in the elderly housing across the street but did not know the name. A facility reportable event (RE) dated 3/30/2026 at 8:28 PM identified the facility received a phone call from<br>(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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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | the ED stating Resident #1 was there and inquired if he/she was a resident at the facility. Hospital staff stated resident arrived at 6:20 PM and appeared confused, believing he/she was in Texas. Resident #1 was last seen by LPN #1 when he/she received medication at 6:08 PM (12 minutes prior to the reported hospital arrival). Surveyor observations identified the visitor parking lot was directly in front of the lobby door and led to a long driveway with a slight decline and to the street. The street was a two (2) way street, had residential homes on both sides, had no sidewalks or crosswalk, and the hospital was located directly across the street from the second house down from the facility driveway. Online directions identified the hospital was 0.3 miles away. A nursing note dated 3/31/2026 at 2:10 AM identified Resident #1 returned to the facility at 1:00 AM and was alert to self and cooperative, stated he/she was tired and going to bed. Resident #1 stated he/she just went out the front door and walked over (to the hospital) to get a checkup. Report from the hospital indicated was Resident #1 was cleared with no new orders. A wander guard was placed, and Resident #1 was reoriented and redirected several times during the shift and was placed on every 15-minute checks. Hospital discharge instructions dated 3/31/2026 at 12:33 AM identified diagnoses from visit included at risk for elopement from a healthcare setting, disorientation and history of a nephrectomy. The facility RE summary dated 4/3/2026 identified Resident #1 was last seen on 3/30/2026 at 6:05 PM (1 hour and 45 minutes prior to the call from the hospital at 7:50 PM) and had no indication of an elopement risk prior to the incident. Resident #1 left the facility without notifying staff, exited through the front lobby and activated the 15-second egress mechanism and door alarm. Resident #1 walked to the hospital located across the street, arriving at the hospital at 6:20 PM. Interview with Therapeutic Recreational Assistant ([NAME] #1) on 4/27/2026 at 11:54 AM identified she was in the unit common area near the end of the hallway by the lobby when she heard the facility front door alarm activate. [NAME] #1 stated she went to the door and immediately deactivated the alarm (only staff had the code to deactivate/silence the alarm). [NAME] #1 stated residents had a scheduled, supervised smoke break at 7:00 PM. She thought the alarm had been activated when the residents went outside for the smoke break and she did not realize the time was around 6 PM. [NAME] #1 stated she deactivated the alarm to stop the noise without looking for any residents and returned to her recreation activity. [NAME] #1 stated she did not search for any residents, and she did not notify the nurse or supervisor that the alarm had sounded. Interview with the LPN #1 on 4/27/2026 at 1:45 PM identified she was the nurse assigned to Resident #1 on 3/30/2026 and stated she administered medications to Resident #1 about 6:05 PM, and she did not hear any alarm activation. LPN #1 stated about 8 PM, RN #1 notified her that Resident #1 was missing and had walked to the hospital emergency room (across the street). Interview with RN #1 on 4/27/2026 at 12:30 PM identified she was the nursing supervisor on 3/30/2026 and received a phone call from the hospital at 7:50 PM notifying her that Resident #1 arrived at the hospital (emergency room) at 6:20 PM and was confused. Resident #1 reported he/she resided in the elderly housing across the street. RN #1 stated she notified the DON who instructed her to conduct a head count of all residents and indicated there were no other residents missing. RN #1 stated she had not heard any alarms activated, and stated that Resident #1 should not have been able to leave the facility without staff knowledge. Interview with the Director of Nursing (DON) on 4/27/2026 at 2:25 PM identified when an exit door alarms, staff are expected to respond to the door alarm, observe outside the door and inside in the vicinity of the door prior to deactivation of the alarm for any residents. The DON stated she observed the facility security video recording of the front door lobby area and identified that on 3/30/2026, Resident #1 exited the building at 6:07 PM and the alarm activated. The video then showed within seconds of the alarm sounding, [NAME] #1 responded to the alarm and deactivated the alarm. The DON stated if [NAME] #1 looked outside, she would have been able to observe Resident #1 in front of the building. The DON stated that dinner had already been served when Resident #1 left the building and was last seen by staff about 6:05 PM. The facility was notified Resident #1 was at the hospital at 7:50 PM, one (1) hour and 45 minutes later (staff were not aware Resident #1 was not in the facility for one (1) hour and 45<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | minutes). The DON stated the facility had six (6) additional residents identified at risk for elopement. Interview with the Administrator on 4/27/2026 at 2:15 PM identified that the front desk receptionist leaves at 6:00 PM daily and locks the front entrance door which activates the door alarm. The front door was an egress door and will open (unlock) if pushed by anyone after 15 seconds for fire safety reasons. The alarm activates if the door is opened and only staff have the code to deactivate the alarm. Resident #1 should not have been able to leave without staff knowledge, and the recreation staff should have searched for a resident outside the alarmed door after it was activated. Interview failed to identify that recreation staff should notify the supervisor of the alarm activation. The facility policy Elopement dated 2/2025 directed in part that residents will be accounted for at all times. Although requested, a policy for staff response to exit door alarms was not provided. During the on-site visit, a review of facility documentation subsequent to the incident, identified education was initiated on 3/31/2026 and directed staff to answer all door alarms by responding immediately to the alarmed door, scan the vicinity near the alarmed door for any residents, walk outside to check for any residents prior to deactivation of the alarm, and for staff to complete a bed check (resident head count) to account for residents or identify any missing resident. Elopement drills were conducted starting on 3/31/2026 on each shift to ensure appropriate response to door alarm and activation of code yellow or facility elopement procedures if resident not located. Audits were initiated on 4/2/2026 to ensure appropriate response to alarms on each shift, and a QAPI meeting was held. Review of the facility documentation identified a finding of past non-compliance effective 3/31/2026. |