STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075404	A. Building B. Wing	10/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maefair Center for Health & Rehabilitation	21 Maefair Court Trumbull, CT 06611

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41682 Based on observation, clinical record reviews, facility documentation, facility policies, and interviews for one (1) of three (3) sampled residents (Resident #1) reviewed for elopement, the facility failed to provide adequate supervision to prevent the resident from exiting through a door that was ajar during a recreation activity. Resident #1 was observed outside in the parking lot by another resident. The failures resulted in a finding of Immediate Jeopardy. The finding includes: Resident #1's diagnoses included Alzheimer's disease, dementia, major depressive disorder, and anxiety disorder. The Elopement Evaluation performed on 7/6/24 identified a score of three (3) indicating Resident #1 was at risk for wandering and elopement. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 had severely impaired cognition and was independent with ambulation. The Resident Care Plan dated 7/31/24 identified Resident #1 was at risk to try and leave the nursing facility due to verbalized expressions of wanting to leave. Interventions included a wanderguard bracelet was applied to the left ankle, ensure placement of the wanderguard bracelet every shift and function every night, and to provide the resident's picture ID and description to the offices and staff located near exits. (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 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Facility Reported Incident form and investigation dated 9/13/24 at 3:40 PM identified Receptionist #1 was alerted by Resident #2 that Resident #1 was walking outside the building unsupervised. Staff responded immediately and observed Resident #1 standing at the end of the facility's driveway. Resident #1 was calm and cooperative and walked back to the facility accompanied by facility staff. Resident #1 was assessed, and no injuries were noted. The facility investigation concluded that Resident #1 was in attendance during a group event, the program ended around 3:10 PM and Resident #1 was assisted back to his/her unit around 3:20 PM by recreation staff. The report identified at approximately 3:30-3:35 PM, Resident #1 got on the elevator (equipped with a wander guard alarm) with visitors and went back down to the first floor. The wander guard alarm did activate. Social Worker #1 deactivated the alarm and directed Resident #1 to the recreation room. At approximately 3:40 PM, facility staff became aware that Resident #1 was walking outside the building in the parking lot. The investigation identified the recreation door was observed ajar, family members were noted to have used the recreation door before the incident occurred, and no staff witnessed Resident #1 exiting the recreation room. Interview and tour of the facility with review of Resident #1's elopement on 10/3/24 with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) at 10:30 AM identified the recreation department had a party, Resident #1 was in attendance and after the party ended Resident #1 was escorted by the recreation staff back to his/her room located on the third floor. The DON explained Registered Nurse (RN) #1 saw Resident #1 at approximately 3:00-3:15 PM on the unit, at the change of shift, Resident #1 then managed to get on the elevators with visitors. The DON identified to utilize the elevator a code was required, and the code was given to visitors upon entrance to the facility by the receptionist. The elevator only needs the code from the third floor to go down to the main floor but does not need a code to go up from main floor. The DON identified when Resident #1 got off the elevator on the main floor, the wanderguard system was activated within the elevator area and SW #1 came out of her office, deactivated the alarm, and brought Resident #1 to the recreation area. Observations of the recreation area identified two (2) main double doors on the same side of the room, one (1) door was equipped with a wanderguard system, and the other door was only equipped with a keycode pad. The DON identified only staff members have the code for both doors. The DON indicated during the investigation, it was noted that the double door with only the keycode pad, was noted to be ajar and not fully latched, there was no alarm sounding, and it was believed Resident #1 managed to elope through this door into the parking lot, where he/she was found approximately 400-500 feet away from the building. Interview with Recreation Director (RD) #1 on 10/3/24 at 11:20 AM identified on 9/13/24, the recreation department had a party, with attendance of approximately thirty-two (32) residents, including Resident #1. RD #1 explained once the event was over, Resident #1 was escorted back to his/her room by the recreational staff. RD #1 identified she knew that Resident #1 was an elopement risk and would ensure supervision whenever Resident #1 or any other elopement risk resident was in the recreation area. RD #1 identified on 9/13/24 she was unaware that Resident #1 had returned to the recreation area and did not witness Resident #1 exiting the facility. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with Resident #2 on 10/3/24 at 11:50 AM identified he/she was sitting in the parking lot, as his/her friend had just left, when he/she noticed a person resembling Resident #1 in the distance within the parking lot. Resident #2 indicated he/she was unsure it was Resident #1, due to him/her wearing a facemask and hat and as Resident #1 got closer, Resident #2 was able to identify Resident #1. Resident #2 identified he/she asked Resident #1 what he/she was doing, and Resident #1 responded just walking, as Resident #1 continued to check car doors. Resident #2 indicated he/she ran to the front desk and reported the occurrence. Interview with SW #1 on 10/3/24 at 12:15 PM identified on 9/13/24, she was in her office, located directly across from the elevators, when she heard the wanderguard alarm sounding. SW #1 indicated Resident #1 was in the elevator area and had activated the alarm. SW #1 identified she deactivated the alarm and brought Resident #1 into the recreation area. SW #1 indicated although there were staff members in the recreation area, she did not let the staff members know she brought Resident #1 into the recreation area. Review of the Elopement Policy dated 07/2015 identified the facility strives to promote resident safety by maintaining a process to screen all residents for risk of elopement, implement preventative strategies for those identified at risk, institute measures for resident identification at the time of admission, and conduct missing resident procedures, as warranted. Elopement is defined as the ability of a resident who is not capable of protecting themselves from harm to successfully leave the facility unsupervised and unnoticed and who may enter harm's way.