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	03/19/2025

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** 47826 Based on clinical record reviews, facility documentation, facility policies and interviews for one (1) of three (3) sampled residents (Resident #1) who had a history of wandering throughout the facility and self-propelled in a wheelchair, the facility failed to ensure the resident was accounted for after an alarmed door was triggered. The findings include: Resident #1's diagnoses included dementia, anxiety, and depression. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of three (3) indicating short and long-term memory recall deficits, was dependent on staff for transfers and utilized a wheelchair for mobilization. The Resident Care Plan dated 12/10/24 identified Resident #1 was at risk for falls due to dementia, had a history of wandering throughout the unit while self-mobilizing in a wheelchair and at times attempted to open exit doors. Interventions directed assistance of one (1) with transfers, use of a wander guard, assist the resident to find his/her room when needed, and to keep the resident in common areas when up in the wheelchair. The nurse's note dated 2/10/25 at 6:00 PM identified the 3-11PM Nursing Supervisor, Registered Nurse (RN) #1, was alerted around 4:30 PM that Resident #1 was not on the unit. The note indicated during the search of the facility, Resident #1 was found on the floor of the 3-2 (third floor, hallway 2) stairwell with his/her wheelchair to the side, lying on the right side with his/her head near the bottom of the first flight of stairs. Resident #1 was awake and alert but unable to explain what happened, 911 was activated and Resident #1 was transferred to the hospital at 5:30 PM. The Facility Reported Incident form dated 2/10/25 at 4:30 PM identified Resident #1 was observed on the floor in the 3-2 stairwell at the bottom of the first landing. Resident #1 was lying on his/her right side with the adaptive wheelchair upside down next to him/her. Resident #1 complained of neck, left shoulder and left leg pain. The hospital discharge summary dated 2/14/25 identified Resident #1 had been admitted to the hospital on 2/10/25 for a mildly nondisplaced fracture of the sternal end of the left clavicle, a minimally displaced fracture of the left pubic ramus, and acute cystitis without hematuria. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075404	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2025
NAME OF PROVIDER OR SUPPLIER: Maefair Center for Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 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	Resident #1 was admitted to the hospital and seen by orthopedics and started on an antibiotic. The resident was discharged back to the facility on [DATE]. Review of the facility's summary report dated 2/13/25 indicated at approximately 4:30 PM the staff were alerted by Resident #1's family member that Resident #1 was not in his/her room and a code yellow was called and during the search Resident #1 was found on the 3-2 stairwell. The facility's investigation indicated at approximately 3:30 PM a door alarm sounded, the 7AM-3PM Nursing Supervisor checked the three (3) doors, 3-1, 3-2, and 3-3 and no residents were found behind the fire doors, however the second door on the 3-2 leading to the stairwell was not checked. According to staff interviews, Resident #1 was last seen at approximately 3:15-3:30 PM in the hallway. The summary identified when the door alarmed at 3:30 PM, the third floor staff checked to ensure all residents were accounted but since there was a recreational activity on the first floor, the nurse aide thought Resident #1 was at the recreation activity. Interview with the Administrator on 2/28/25 at 12:35 PM identified on 2/10/25 at 3:30 PM while she was rounding on the second floor, she heard the 3-2 door alarm sound. The Administrator indicated she called the 7AM-3PM Nursing Supervisor, RN #2, and told him to check the 3-2 door, she proceeded to go to the third floor, and RN #2 reported to the Administrator that he did not see any resident on the other side of the 3-2 door. Interview and observations with the Director of Maintenance on 2/28/25 at 1:00 PM identified the only doors in the building that were activated by wander guards were on the first floor, the second and third floor hallway doors were alarmed and there were keypads at each door with codes to unlock the doors. The Director of Maintenance indicated the fire code dictates that an alarm would sound if the door was pressed for a continuous thirty (30) seconds, and the door would automatically open without entering a code into the keypad. The Director of Maintenance identified the alarm must be deactivated by staff. The Director of Maintenance explained the 3-1 and 3-3 hallways only have one door to exit through whereas the 3-2 hallway has a second door that leads to the stairwell down to the second floor and per the fire code the second door could not be locked or alarmed. The Director of Maintenance identified there were nine (9) stairs on the flight of stairs to the landing where Resident #1 was found. Interview with RN #2 on 2/28/25 at 1:25 PM identified on 2/10/25 he was in the nurse's office when the door alarm for 3-2 was activated and the Administrator called him to direct him to check all exits. RN #2 stated he checked the 3-2 exit first, did not see anyone beyond the first door but did not open the second door that led to the stairwell. RN #2 verified the two (2) other doors were checked as well, no residents were seen, and he directed the staff to check the location of all residents and report to him if any residents were not accounted for. RN #2 identified the staff did not report to him that residents were not accounted for. Interview with the Assistant Director of Nursing (ADON) on 2/28/25 at 1:40 PM identified on 2/10/25 at 4:30 PM a code yellow was called, and she went to the third floor to assist in looking for the resident. The ADON indicated while she was checking rooms on the 3-1 hallway, a nurse from the second floor called her to the 3-2 exit where the second floor staff had found Resident #1.