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	04/30/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, facility documentation, and staff interviews for one of three residents (Resident #96) reviewed for abuse, the facility failed to ensure the resident was free from neglect and failed to ensure care was provided timely. The findings include: Resident #96 had a diagnosis of hemiparesis (weakness on one side) and vascular dementia. The Annual MDS dated [DATE] identified Resident #96 had a Brief Interview for Mental Status (BIMS) score of 12 indicating moderately impaired cognition and required maximal assistance with Activities of Daily Living (ADLs) and was frequently incontinent of bowel and bladder. The Resident Care Plan (RCP) dated 4/3/2025 identified incontinence. Interventions directed two (2) staff members to provide care for left sided weakness and accusatory behaviors, and provide incontinent care. Facility incident report dated 4/11/2025 identified Resident #96 alleged on 4/11/2025 at approximately 2:45 PM he/she had the call light on for 45 minutes, and alleged that he/she did not receive ADL care from morning. Facility incident summary dated 4/15/2025 identified on 4/11/2025 at approximately 2:45 PM Resident #96 alleged no one touched him all day. The Nurse Aide (NA) and the RN unit manager went to the room immediately, NA #2 gave care immediately, and NA #2 was suspended pending an investigation. The summary indicated the facility investigation identified NA #2 checked on Resident #96 at the start of her shift, then gave incontinent care before lunch but did not provide any morning care/ADL care. NA #2 stated she told Resident #96 that she would provide a full bed bath (later). The summary indicated it was NA #2's first day on the assignment, was not familiar with the residents and she found the assignment heavy. The summary identified the facility did not substantiate the allegation of neglect. NA documentation review identified the last time Resident #96 received incontinent care was at 6:59 AM on 4/11/2025 (7 hours and 46 minutes before the complaint was made). Further record review failed to identify any documentation that Resident #96 received care from 7 AM to 3 PM on 4/11/2025. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with NA #2 on 4/22/2025 at 12:38 PM identified she worked from 7 AM to 3 PM on 4/11/2025 and she checked Resident #96 around 7:30 AM and 8:15 AM for incontinence, and he/she was not soiled/wet. NA #2 stated she did not check Resident #96 again until around 11:45 AM to 12 PM (approximately 3 ½ hours after she last provided care), and Resident #96 was incontinent at that time and she provided incontinent care. NA #2 stated she did not provide care again for Resident #96 until about 2:35 PM (approximately 2 hours and 35 minutes later). NA #2 stated Resident #96 required two (2) staff for care, but she provided the care for Resident #96 without a second staff member to assist her because she was experienced enough to do it herself and all other Nurse Aides (NAs) were busy. NA #2 stated she did not provide morning care/personal care for Resident #96 during the morning, and stated she gave morning care at 2:35 PM because she did not have time earlier. Interview with LPN #2 on 4/22/2025 at 1:16 PM identified she went into Resident #96's room at around 8 AM and again at around 10:30 AM for medication administration, but she did not check Resident #96 for incontinence or ADL/personal care. LPN #2 stated NA #2 did not ask her for assistance. Interview and record review with the Administrator, DNS, and ADNS on 4/22/2025 at 2:35 PM identified staff should check on residents every two (2) hours for incontinent care/repositioning, and provide ADL/personal care in the morning. Interview identified Resident #96 did not receive morning care until 2:35 after he/she requested the care. Further, rounds were not conducted every two (2) hours in accordance with facility policy. Resident #96 was checked for incontinence before breakfast and at 8:15 AM, and then again about noon (3 hours and 45 minutes after the last check). Further, morning care was not provided until directed by the supervisor about 2:35 PM. NA #2's employment was terminated due to not providing care in a timely manner. Review of NA #2 job description signed on 4/1/2025 identified their primary function includes making rounds on assigned residents at the beginning of each shift and every two (2) hours thereafter. Review of facility Resident Rights policy dated 2/2024 identified residents have the right to receive quality care and services with reasonable accommodation of their individual needs and preferences. Review of facility documentation identified staff education was initiated on 4/11/2025 and included directing staff that AM care must be provided in a timely manner, notify the nurse if unable to provide the care, and provide incontinent care. A QAPI meeting was held on 4/11/2025 and audits were initiated on 4/11/2025. Based on review of facility documentation, past non-compliance was identified.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, facility documentation, and staff interviews for one of three residents (Resident #96) reviewed for abuse, the facility failed to ensure care was provided in accordance with the plan of care. The findings include: Resident #96 had a diagnosis of hemiparesis (weakness on one side) and vascular dementia. The Annual MDS dated [DATE] identified Resident #96 had a Brief Interview for Mental Status (BIMS) score of 12 indicating moderately impaired cognition and required maximal assistance with Activities of Daily Living (ADLs) and was frequently incontinent of bowel and bladder. The Resident Care Plan (RCP) dated 4/3/2025 identified incontinence. Interventions directed two (2) staff members to provide care for left sided weakness and accusatory behaviors, and provide incontinent care. Facility incident report dated 4/11/2025 identified Resident #96 alleged on 4/11/2025 at approximately 2:45 PM he/she had the call light on for 45 minutes, and alleged that he/she did not receive ADL care from morning. Record review failed to identify documentation that another staff member was present when NA #2 provided care for Resident #96. Interview with LPN #2 on 4/22/2025 at 1:16 PM identified Resident #96 required two (2) staff members for care and NA #2 did not ask her to assist with any care for Resident #96 during the shift. Interview with NA #2 on 4/22/2025 at 12:38 PM identified she worked from 7 AM to 3 PM on 4/11/2025 and she checked Resident #96 around 7:30 AM and 8:15 AM for incontinence, and he/she was not soiled/wet. NA #2 stated she did not check Resident #96 again until around 11:45 AM to 12 PM (approximately 3 ½ hours after she last provided care), and Resident #96 was incontinent at that time and she provided incontinent care. NA #2 stated she did not provide care again for Resident #96 until about 2:35 PM (approximately 2 hours and 35 minutes later). NA #2 stated Resident #96 required two (2) staff for care, but she provided the care for Resident #96 without a second staff member to assist her because she was experienced enough to do it herself and all other Nurse Aides (NAs) were busy. NA #2 stated she should have had another staff member with her when she provided care for Resident #96. Interview and record review with the Administrator, DNS, and ADNS on 4/22/2025 at 2:35 PM identified Resident #96 required two (2) staff for care, in accordance with the resident plan of care. Interview identified NA #2 should have had another staff member to assist when providing care for Resident #96 on 4/11/2025. Interview failed to identify why NA did not have a second staff member with her to provide the care. Review of facility Comprehensive Person Centered Care Plan Policy dated 3/2023 directed in part, the care plan included information necessary to properly care for the resident. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility documentation identified staff education was initiated on 4/11/2025 and included directing staff on the different types of abuse, to check on residents every two (2) to four (4) hours and provide care as needed, and to follow the plan of care, and if two (2) staff are required for care then two (2) staff must be in the room when care is provided. A QAPI meeting was held on 4/11/2025 and audits were initiated on 4/11/2025. Based on review of facility documentation, past non-compliance was identified.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, facility documentation, and staff interviews for one of three residents (Resident #96) reviewed for abuse, the facility failed to ensure the record was complete and accurate to include incontinent care provided. The findings include: Resident #96 had a diagnosis of hemiparesis (weakness on one side) and vascular dementia. The Annual MDS dated [DATE] identified Resident #96 had a Brief Interview for Mental Status (BIMS) score of 12 indicating moderately impaired cognition and required maximal assistance with Activities of Daily Living (ADLs) and was frequently incontinent of bowel and bladder. The Resident Care Plan (RCP) dated 4/3/2025 identified incontinence. Interventions directed two (2) staff members to provide care for left sided weakness and accusatory behaviors, and provide incontinent care. Facility incident report dated 4/11/2025 identified Resident #96 alleged on 4/11/2025 at approximately 2:45 PM he/she had the call light on for 45 minutes, and alleged that he/she did not receive ADL care from morning. Facility incident summary dated 4/15/2025 identified on 4/11/2025 at approximately 2:45 PM Resident #96 alleged no one touched him all day. The Nurse Aide (NA) and the RN unit manager went to the room immediately, NA #2 gave care immediately, and NA #2 was suspended pending an investigation. The summary indicated the facility investigation identified NA #2 checked on Resident #96 at the start of her shift, then gave incontinent care before lunch but did not provide any morning care/ADL care. NA #2 stated she told Resident #96 that she would provide a full bed bath (later). The summary indicated it was NA #2's first day on the assignment, was not familiar with the residents and she found the assignment heavy. The summary identified the facility did not substantiate the allegation of neglect. NA documentation review identified the last time Resident #96 received incontinent care was at 6:59 AM on 4/11/2025 (7 hours and 46 minutes before the complaint was made). Further record review failed to identify any documentation that Resident #96 received care from 7 AM to 3 PM on 4/11/2025. Interview with NA #2 on 4/22/2025 at 12:38 PM identified she worked from 7 AM to 3 PM on 4/11/2025. Although NA #2 stated she provided incontinent care at about 11:45 AM to 12 noon, she did not document the care in the clinical record. NA #2 stated she did not have time to document the care before her shift ended. Interview and record review with the Administrator, DNS, and ADNS on 4/22/2025 at 2:35 PM identified they were unable to provide documentation of the incontinent care provided for Resident #96 by NA #2. Interview identified NA #2 should have documented the care provided prior to the end of her shift (her shift ended at 3:15 PM). Record review of NA #2's punch detail form dated 4/11/2025 identified she punched in at 7:16 AM and punched out at 3:26 PM. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility Charting and Documentation policy dated 1/2025 directed documentation shall be completed at the time of service, but no later than the shift in which the assessment, observation, or care service occurred.