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

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, review of facility policy and interview for 1 sampled resident (Resident #368) reviewed for Advanced Directives, the facility failed to ensure the resident signed Advance Directives were reflected correctly on the Electronic Medical Record (EMR. The findings include: Resident #368 's diagnoses included atherosclerotic heart disease of native coronary artery without angina pectoris, Congestive Heart Failure (CHF) and anxiety. Review of Resident #368 paper chart indicated a code status signed on [DATE] directing Do Not Resuscitate (DNR). The care plan with a revision dated [DATE] identified the resident has an established Advanced Directive. Residents wish to receive Cardiopulmonary Resuscitation (CPR). Interventions included reviewing Advanced Directives with resident and/ or healthcare decision maker quarterly and to support residents' decision for CPR. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #368 was moderately cognitively impaired and required moderate assistance with bed mobility, transfers and personal hygiene. Observation on [DATE] at 12:00 PM of Resident's # 368 Electronic Medical Records indicated a code status of full code. Interview with the Director of Nursing Services (DNS) on [DATE] at 2:00 PM identified the nursing staff will use the code status indicated on the EMR. The DNS identified she was unsure why Resident's 368 code status from her/his chart and the EMR did not match. She also identified it is her/his expectation that the EMR is updated as soon as an Advance Directives is signed. The DNS further indicated it is the responsibility of the nursing team, including herself and physicians, to ensure this practice is done. She indicated I do audits, but I must have missed this one. After surveyors' inquiry, a physician's order dating [DATE] identified Resident # 368's Advanced Directive order and care plan were updated to reflect the signed Advanced Directives (DNR). (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:	(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

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	After the surveyor inquiry, the care plan reviewed on [DATE] indicated Advanced Directive Guidelines code status: DNR/DNI/no artificial nutrition. Intervention included: to honor Advanced Directives as directed by resident/responsible party for guidance, and to provide information to resident/responsible party to complete advanced directives and assist as necessary. After surveyor to inquiry, the facility reported they conducted a mock survey on [DATE], which identified this as an issue. The facility reported believing they would have caught the missed Advanced Directive. Facility provided in service; random audits of residents related to Advanced Directives. Resident #368 was identified as resident with advanced directive concerns on [DATE], After surveyors' inquiry. Facilities Advanced Care Planning Code Status policy indicated in part; A physicians order must be written accordingly, documentation of the resident's choice to opt for Do Not Resuscitate shall be maintained in the medical records. A DNR physician's order will be placed in the EMR.

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

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical reviews, observations and review of facility documentation and interviews for 1 of 2 residents reviewed for the environment (Resident #82), the facility did not provide a homelike environment by not ensuring personal care equipment was stored appropriately and for 1 of 2 residents (Resident # 68)) reviewed for Environment, the facility failed to ensure residents room was free from odors in order to ensure a home like environment. The findings included: 1. Resident #82's diagnoses included pelvic fracture and dementia. A significant change MDS assessment dated [DATE] identified Resident #82 as severely cognitive impairment and dependent on staff for toileting. The MDS assessment also identified Resident #82 had a urinary catheter and noted continent of bowel. A care plan dated 3/10/2025 identified Resident #82 had a deficit in functional mobility and that the resident was non-ambulatory. Interventions On 4/23/2025 at 1:51 PM an interview with (Person ----) identified a concern about the smell in the resident's bathroom. People were told the facility had cleaned the room, including some rust in the bathroom, and had placed an air freshener under the sink. However, Person # indicated the dirty smell had not been resolved. Although a foul smell was not identified on 4/23/2025 at 1:51 PM, an observation of Resident #82's shared bathroom identified a grey bedpan wedged in between the right wall and the [NAME] next to the toilet. Two clear, graduated, triangular containers upside down on top of the toilet tank. Resident #82's denture cup, toothpaste, and toothbrush were also noted to be on a shelf over the sink. On 4/23/2025 at 2:02 PM, an interview with the nursing supervisor Registered Nurse (RN#1) indicated the graduated containers and bedpan were in their usual storage locations. RN#1 also indicated the resident's toiletries should have been stored in the resident's bedside dresser. On 4/23/2025 at 2:11 PM, an interview with the Nurse Aide (NA # 10) assigned to Resident #82 for the day identified she did not know who the grey bedpan belonged to or how long it had been there. NA #10 indicated the bedpan, and graduated containers should be stored in a bag and placed in the residents' nightstand. NA # 10 also indicated the graduated containers were used to empty the resident's urinary catheter bag. On 4/28/2025 at 8:42 AM, an interview with the Director of Nursing Services (DNS) indicated the facility had found out about the smell in the resident's bathroom last week and the facility had promptly gotten the room cleaned. Additionally, the DNS indicated the smell was related to an incident with the flowers that were brought in by the family and not related to the bedpan or graduated containers. (continued on next page)

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

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/29/2025 at 10:39 AM, an interview and facility record review with the Director of Maintenance identified due to a resident family concern about a urine smell in the bathroom, on 3/17/2025, maintenance performed some repairs, and housekeeping cleaned the room. A review of the facility records for Room of the Day identified a picture taken on 3/17/2025 at 10:51 AM (5 weeks before the surveyor's observation on 4/23/2025) that showed a grey bed pan wedged between a wall and the grab-bar to the right of the toilet. The picture also showed a clear graduated container on top of the toilet water tank. Although requested, the facility was unable to provide a policy for the storage and dating of bedpans and containers used to empty urinary catheter bags. 2. 2. Resident #68's diagnoses included hypertension, diabetes and Post Traumatic Stress Disorder (PTSD). The quarterly Minimum Data Set assessment dated [DATE] identified Resident #68 as moderately cognitively impaired and required moderate assistance with toileting hygiene and toilet transfers. The MDS further noted the resident is occasionally incontinent of urine. The care plan dated 3/25/25 identified resident continence of bladder status fluctuated and at times resident is incontinent of bladder and require assistance with: Bathing, Dressing, Hygiene. Interventions included: To gather, provide and assist with all materials, supplies, and equipment needed. To ensure materials and equipment are clean and function appropriately, to let residents know where the placement of items is located and to be consistent. On 4/23/25 at 10:47 AM Resident # 68 reported she/he sometimes urinates in her/his pull ups due to not having urinary device in the correct spot. Observation of the room identified a urine like odor. Observation on 4/24/25 at 11:04 AM of Resident #68's room identified a urine like odor. On 4/25/25 10:25 AM observation of the resident's room identified urine smell. Interview with NA #9 on 4/25/25 10:25 AM identified the odor as urine. NA#9 indicated she believes the odor might be from soiled sheets. She further indicated that if soiled sheets are the reason, then it is the responsibility of the assigned NA to remove the sheet informing the appropriate personnel to clean the room. Observation further identified beds in the room made without soil. Observation on 4/25/25 at 10:32 AM of NA#9 informing Licensed Practical Nurse (LPN#6) of the odor of room and LPN#6 informing Housekeeper#1. Interview with Housekeeper #1 on 4/25/25 at 10:34 AM identifies the smell was urine. He reported this may be due to urine seeping in the tiles over time. Housekeeper #1 also indicated the odor could be addressed by using air freshener. He further indicated if a room needed special attention, the nursing team would inform him. Housekeeper #1 indicated he was informed of this room's odor prior today. (continued on next page)

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

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LPN#6 on 4/25/25 at 10:39 AM indicated she noticed the smell today and have informed housekeeping. LPN #6 indicated that the room might have the urine odor due to Resident #68 transitioning to independent toileting and having moments of missing the toilet. She also indicated once she notices the room has an ongoing odor, she would inform housekeeping and monitor daily.

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

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, observation, facility policy and interviews for 1 of 5 residents reviewed for Unnecessary Medication, the facility failed to ensure medication was administered according to physician's orders. The findings include: Resident #14's diagnoses included Gastroesophageal Reflux Disease (GERD) without esophagitis, Type 2 diabetes mellitus and bipolar disorder. The care plan dated 1/14/25 identified resident is at risk for constipation. Interventions included administering medication as ordered, monitoring bowel movement. The resident care plan also identified Resident #14 utilization of psychotropic medications related to bipolar disorder. Interventions include orthostatic blood pressure as ordered. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #14 was cognitively intact and required supervision or touching assistance for eating. The assessment noted dependence on staff for toilet hygiene. Observation of 4/19/25 of the Medication Administration Record (MAR) identified missed medications of Pantoprazole Sodium Oral, Linaclotide and a blood sugar check. The nurse's notes dated 4/19/25 failed to indicated Resident # 14 refused the medications, or rational for why the MAR was not signed off/ and medication not given. A physician's order dated 4/22/25 directed for blood sugar check two times a day. The physician's orders dated 5/22/24 directed to give 1 tablet of Pantoprazole Sodium (for GERD) by mouth one time a day and to give 1 capsule of Linaclotide (constipation) by mouth one time a day. Interview with the Director of Nursing Services (DNS) on 4/30/25 at 10:15 AM identified all Medication Administration Records and Treatment Administration Record should be signed. The nursing team is responsible for ensuring medications are signed off when administered. Facilities Medication Pass Policy indicates in part it is the facility policy that medications are administered safely and timely per physician's order. Staff will notify the Medical Doctor (MD) if a resident refuses medication. Document the refusal in the Electronic Medical Record (EMR) the resident refused. Document the refusal also in the progress notes indication why resident refused.

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

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 - Minimal harm or potential for actual harm 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** Based on clinical record review, observation, facility documentation, facility policy and interviews for 4 residents (Resident #38) reviewed for accidents, the facility failed to ensure a safe transfer with a mechanical lift per manufacture specifications to prevent a potential accident. The findings include: Resident #38's diagnoses include morbid obesity, Intellectual Disabilities, and osteoarthritis. The Resident Care Plan with a revision date of 3/1/25 identified the resident had a deficit in functional mobility. Interventions included a mechanical lift for transfers. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #38 as cognitively intact and depended on staff with transferring, personal hygiene and bathing. An observation on 4/23/25 of the mechanical lift transfer at 11:05 AM identified the nurse aides (NA# 5 and NA# 6) did not open the base of the mechanical lift before getting Resident #38 out of bed. In an interview with NA #5 on 4/23/25 at 11:10 AM identified she did not open the base and never opens the base until the mechanical lift is positioned to lower the resident into the chair. Further when asked if she knew why it was important to open the base of the lift she stated no, she did not and she was not taught to do that. In an interview with NA#6 at 11:15 AM identified she was unaware the base of the lift needed to be open prior to engaging the mechanical lift. In an interview with the Director of Staff Development on 4/25/2025 at 12:15 PM she instructs the nurse aides to ensure the base is open on the mechanical lift as it provides stability. Additionally, the Director of Staff Development indicated all staff are in service on the use of the mechanical lift upon hire. NA #5 was oriented to use of the mechanical lift on 11/21/24 and NA #6 was oriented to use of the mechanical lift on 1/23/25. On 4/30/25 Mechanical lifts were assessed for maintenance and weight capacity. The Hoyer # 13 was serviced 1/25, weight capacity 500 pounds, Hoyer, (no number, but is on the resident's floor) was serviced 7/3/24, weight capacity 500 pounds and a spare Hoyer #10 had a weight capacity of 660 pounds and no date of service on it. Facility Policy, Mechanical lift, with a revision date of 1/2023 still in effect, directed in part, The base legs of the lift will be locked in the maximum open position. The base legs must be always locked for stability and resident safety when lifting and transferring a resident. (continued on next page)

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

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 - Minimal harm or potential for actual harm Residents Affected - Few	As per DNS, the brand of lift is Lumex bariatric lift. Review of the Lumex manufacturers guidelines identify: Maximum weight capacity is 600 pounds evenly distributed. Patient lift may tip over if used incorrectly. Recommend that 2 care givers assist with the lift transfers. During lifting or lowering, whenever possible, always keep the patient lift legs in the maximum open position. When transferring to a patient, always keep the patient centered over the base. Do not lock the brakes or block the wheels when lifting. The casters must be free to roll to allow the patient lift to stabilize itself when the patient is initially lifted from a chair, bed, or any stationary object. During lifting or lowering, whenever possible, always keep the patient lift legs in the maximum open position.

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

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility policy and staff interviews for 1 of 4 residents (Resident #75) reviewed for nutrition, the facility failed to ensure staff obtained weekly weights and a re-weight as ordered by the physician. The findings include: Resident #75's diagnosis included sepsis, chronic osteomyelitis, a stage 4 pressure ulcer and a urinary tract infection. A physician's order dated 12/9/2024 directed to obtain weight on admission then weekly x 4 weeks. The care plan dated 12/12/2024 indicated Resident #75 was at risk for malnutrition due to variable intake, grade 3 obesity, and a pressure wound. Interventions included: allowing sufficient time to eat, encouraging intake of fluids throughout the day, monitoring and evaluating weight and weight changes and obtaining weights as indicated. The admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #75 was cognitively intact, weighed 180 pounds and did not have a 5% weight loss or gain in the last 30 days or 10 % in the last 6 months. The MDS assessment further indicated Resident #75 had an unstageable pressure ulcer present on admission to the facility. A review of the facility documented weights in the Weights and Vitals Summary include 4 entries on admission date of 12/9/2025 of 179.6 pounds recorded at 12:55 PM, 1:05 PM, 1:07 PM and 2:03 PM. The next weight recorded was obtained on 1/03/2025 at 3:00PM recorded at 169.5 pounds (a 10.1 lb. weight loss). The Medication Administration Record (MAR) dated 12/9/2025 through 12/31/2025 directed to obtain an admission weight and weekly weight for four weeks every Saturday on 3-11 PM shift. Saturday 12/14/2024 and 12/21/2024 are signed off as completed but no weight recorded. On 12/28/2024 the MAR indicated Resident #75 was at the hospital. The facility documented weights in the Weights and Vitals Summary indicated Resident #75 weighed 169.7 pounds on 1/17/2025 and on 1/18/2025 weighed 167.2 pounds, a 5% weight loss compared to admission. The quarterly MDS assessment dated [DATE] indicated Resident #75 had mild cognitive impairment and no weight loss or gain of 5% in the last 30 days or 10% in the past 6 months. The care plan dated 3/20/2025 indicated Resident #75 was at risk for malnutrition due to variable oral intake, grade 3 obesity and a pressure wound. Interventions included: to monitor and document intake of food and beverages, monitor and evaluate weight and weight changes, notify the Registered Dietician, family and physician, and to provide a medical food supplement as ordered, obtain and record weights as indicated. (continued on next page)

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

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A dietician note dated 3/27/2025 at 9:12 PM indicated the evaluation was a wound follow up as the healing process was slow. The note further indicated a slight weight loss x 3 months which was beneficial in terms of the coccyx wound healing. Given the stage 4 pressure ulcer and a BMI of 31.1 dietician recommendations indicated Juven, a protein supplement to restart, and the Ensure supplement to decrease from three times a day to once a day. A physician's order dated 3/27/2025 directed to discontinue Ensure 8 ounces 3 times daily and to encourage oral intake. In addition, the physician's orders also directed to restart Juven (one packet twice daily for a month and to provide a liquid protein supplement (LPS) twice daily. A health status note dated 4/1/2025 at 3:02 PM indicated the primary physician was in and was notified of Resident #75's 10 pound. weight loss in the last 3 months. A physician's order dated 4/01/2025 directed to provide Mirtazapine 7.5 Mg at bedtime for appetite stimulation. The facility documented weights in the Weights and Vitals Summary indicated Resident #75 weighed 168.4 pounds on 4/05/2025 and a weight on 4/11/2025 indicated Resident #75 weighed 153.2 pounds (a 10. 2-pound weight loss in 6 days, no reweight was obtained to confirm the accuracy of the weight). A nursing note dated 4/11/2025 at 9:21 PM indicated Resident #75 took 30% of her/his meal. A weekly weight of 153.2 lbs. was documented as obtained on 4/19/2025 (8 days after the first noted 10.2 lb. weight loss on 4/11/2025). A nursing note dated 4/20/2025 at 7:47 AM indicated Resident # 75 had been taking Bactrim DS (an antibiotic) for urine infection since 4/17/2025 with drug sensitivity results received today indicated resistance to Bactrim DS. The APRN was notified and Macrobid was ordered. A physician's order dated 4/20/2025 directed to provide Macrobid (antibiotic) 100mg by mouth, twice daily for 7 days for positive urine test. Mulit-Resistant Drug Organism in the urine and to weight weekly for Wednesday for weight loss monitoring. A physician's progress note dated 4/21/2025 identified Resident #75 was evaluated due to low grade fever, weight loss, fatigue and not feeling well, having completed a 6-week course of intravenous antibiotics on 4/07/2025 to treat osteomyelitis of a pressure wound with bone involvement. A health status note dated 4/23/2025 at 11:21 AM indicated Resident #75 had a significant weight loss, the dietician, the physician and the family were notified. A physician's order dated 4/24/2025 at 2:00PM, (13 days after the initial weight loss on 4/11/2025), directed the 7-3 PM shift to reweigh Resident #75 by 4/25/2025. The resulting weight on 4/25/2025 was 153.4 pounds. (continued on next page)

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

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview and record review on 4/29/2025 at 10:45 AM with Dietician #1 indicated no weights were found for 12/16, 12/23 or 12/30/2024 as ordered weekly x 4 and no weight was found for 1/10/2025. On 1/25/2025 Resident #75 went to the hospital and returned on 2/4/2025 with a weight of 166.3 pounds obtained on readmission. The resident was seen by the dietician after readmission further indicating weight loss could be expected after being in the hospital. An interview and record review on 4/29/2025 at 11:50 AM through 12:05 PM with RN #6 indicated the Director of Nursing Services (DNS) or her assistant the (ADNS) provided a list and indicated the nurse aides obtained the weights. RN#6 further indicated the DNS would also let the staff know if re-weights were needed. RN #6 indicated in addition to the list the charge nurses on the units would obtain a re- weight if they noticed a weight discrepancy. However, RN # 6 did not know why a re-weight was not obtained. An interview with the DNS at 12:00PM with RN #6 present identified she/he could not find any weights other than what was in the electronic medical record chart mentioning in January 2025 during the facility's own mock survey, not obtaining weekly weights and re-weights were identified and the facility has been working on the issue. On 4/29/2025 at 12:15 PM an interview with Dietician #2 indicated s/he had been requested by Dietician #3 to evaluate Resident #75 for a significant weight loss. Dietician #2 further indicated the DNS sent an email on 4/23/2025 at 7:36 AM requesting to look at Resident #75 weights. Dietician #2 indicated having reviewed Resident #75's weights and physician's orders she/he then responded to the DNS on 4/24/2025 (no time given) requesting a re-weight and to refer to the 3/27/2025 dietician note as the Ensure orders had been discontinued. Dietician #2 further indicated on 4/11/2025 it would have been up to nursing to have obtained a recheck of Resident #75's weight. An interview and record review on 4/29/2025 at 1:27 PM with Regional Nurse (RN #8) indicated the electronic orders on 3/27/2025 identified Dietician #3 wrote the order; the charge nurse took a telephone order from the physician and the physician signed the order to discontinue the Ensure supplement and a note indicated to encourage oral intake. An interview with Dietician #3 who evaluated Resident #75 on 3/27/2025 indicated s/he enters the recommendations in the electronic orders for the resident and the physician would review and sign the orders. Dietician #3 further indicated s/he may have changed her/his mind regarding the once daily ensure as weight loss would be beneficial due to the resident's slow to heal pressure ulcer and high body mass index (BMI). The weight loss would reduce the body weight being placed on the pressure ulcer. On 4/30/2025 at 10:00 AM the DNS provided the quality improvement plan regarding the issue of weekly weights and re-weights not obtained, was initiated on 1/17/2025 with estimated completion date of 5/31/2025. In-servicing of staff was completed by 2/18/2025 and audits of 3-5 resident's weekly were initiated on 2/24/2025 continuing for 8 weeks, then monthly for 3 months or until substantial compliance met. (continued on next page)

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

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy labeled Weight Policy and Procedure indicated in part an initial weight will be obtained and recorded within 24 hours of a resident's admission then weighed weekly for the first 4 weeks, then monthly unless the physician orders indicate otherwise. The policy further indicated significant weight changes will have a weight measurement for accuracy and documentation purposes and once the significant weight loss is verified, the resident/responsible party, the physician and the dietician will be notified, the resident will be added to weekly weights for 4 weeks until the resident weight is stabilized as determined by the interdisciplinary team and the care plan updated.

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

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, the facility failed and staff interviews, the facility failed to discard expired medications in a timely manner and for 1 or 4 residents (Resident #7) reviewed for accidents, the facility failed to adequately secure medications. The findings included: 1. On 4/28/2025 at 11:41 AM, an observation of the Intravenous Therapy (IV) cart located in the third-floor medication room with the Infection Preventionist (RN #7) identified two bags of expired IV fluids. The fluids were 1-liter bags of 10% dextrose, both bags with an expiration date of March 2025. An interview with RN #7 indicated that the fluids were usually used for residents who were waiting for their total parental nutrition (TN) to arrive. RN#7 also indicated the night supervisor was responsible for checking the IV cart for expired medications. On 4/28/2025 at 11:53 AM, an observation with RN#7 and the nursing supervisor (RN#1) identified two expired tablets in the emergency stock box located in the third-floor medication room. The tablets were white circular penicillin (an antibiotic) tablets of 250 milligrams. The expiration date was 4/26/2025. An interview with RN#1 indicated the emergency stock box was usually reviewed for expired medications by the unit nurses or the supervisors and indicated she could not provide a record of the checks. On 4/28/2025 at 12:30 PM, an interview with the DNS indicated the facility has a process where the pharmacy consultant checks the emergency stock box and fluids for expired medications every month, However, the DNS was unable to indicate why the expired medications were not discarded. A review of the facility policy for medication storage indicated all medications expire on the date specified by the manufacturer on the product label and if the manufacturer only specified a month and year of expiration, the product expires on the last day of the calendar month indicated by the manufacturer. 2. Resident 7's diagnoses included dementia, heart failure, and Peripheral Vascular Disease (PVD). The Resident Care plan dated 1/15/25 identified the resident required had a self-care deficit. Interventions included allowing time to participate in tasks and using an unhurried approach. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #7 as cognitively intact and required maximum assistance with bathing, toileting and personal hygiene. A physician's order dated 4/22/25 directed to administer Guaifenesin Oral tablets 800 Milligrams (MG) by mouth for cough for 7 days. Observation on 4/23/25 at 10:30 AM identified a medication cup with 2 white pills in it. (continued on next page)

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

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #7 stated that the medication was his/her Mucinex (administered whole), and the staff usually leave it for him/her to take. He/she has taken the last 3 doses on his/her own as he/she takes a while to eat, so they leave pills for him/her. Resident # 7 also stated he/she has not taken the medication this AM as the nurse did not break them in half for him/her and he/she could not take them whole. Observation and interview on 4/23/25 with RN #4 at 10:45 AM identified she did not administer Resident #7's medication because the resident was taking too long this AM to take the medication. RN # 4 also identified she never leaves her medication for the resident to take later. In an interview on 4/23/25 with the Nursing Supervisor (RN #5) at 11:55 AM identified she was not sure why the medication was left for the resident to take independently this morning. Further indicated she was calling the nurses to see who left the medication for him/her to take and had not determined who left the medication. RN identified the process for self-administration of the medication is to assess the resident to determine if it is safe for self-administration, the facility will obtain a physician's order. On 4/24/25 the medication in the cup at the resident's bed side was compared to the resident's medication cards and it was identified as Guaifenesin. In an interview on 4/30/25 with Licensed Practical Nurse (LPN#5) at 1045 AM identified she administered medications to the resident on 4/23/25 in the morning. LPN # 5 also indicated she administered all her medications and did not leave any for the resident to take later. Although she saw the 2 pills in the cup, she was unaware how they got there. She also stated that she would never leave residents without seeing them swallow all their medications. A review of facility policy, Medication Pass dated 9/23/24 and still in effect, directed in part, to always observe residents until they have swallowed all medications that have been administered. Do not leave medication in the medication cup at the bedside or on the tableside.

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

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 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical reviews, observations, facility policy and interviews for 1 of 1 sampled resident, (Resident #61) reviewed for dental services, the facility failed to follow up on a recommendation made by a physician regarding dental. The findings include: Resident #61 was admitted to the facility on [DATE]. The resident's diagnoses included pulmonary embolism (blood clot in lungs), unspecified dementia with behavioral disturbance, schizophrenia, anxiety disorder, and depression. The physician's orders dated 11/30/22 directed for consult: dental care as needed. A review of the facility dental vendor visit dated 1/29/24 with Resident #61 identified a lump/lesion on lower right side of lip. A recommendation was made that the lesion on the lower lip be evaluated by an oral surgeon. A quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #61 was cognitively intact and required setup/clean up assistance with eating, maximal assistance (helper does more than half the effort) with personal hygiene, oral hygiene, putting on footwear, and dependent (helper does all the effort) with showering, toilet hygiene, and chair to bed transfers. Observation on 4/23/25 at 11:20 AM of Resident #61 who verbalized while sitting in his/her wheelchair by the nurses' station in hallway his/her tooth was hurting. A staff member went to communicate the resident concern to the nurse. The interview with Register Nurse (RN #1) on 4/28/25 at 12:01 PM identified he was very familiar with Resident #61, and noted no complaints of any pain. The resident was able to eat his/her breakfast with no issues. RN #1 further identified Resident # 61's last dental visit in the chart was from 2023. RN #1 also indicated she/he would provide documents for all of Resident #61's dental visits. An interview with the Director of Nursing Services (DNS) on 4/30/25 at 8:30 AM identified she and the Assistant Director of Nursing (ADNS) receive recommendations from the dentist by email and they print them out to review the recommendations with the Advanced Practice Registered Nurse (APRN) to ensure follow up. She identified that there was no consultation for Resident #61 to see an oral surgeon for his/her mouth legion, and she would have the APRN follow up . Review of the dental services policy dated September 2017 and revised June 2023 identified the facility is responsible for providing an outside resource, routine, and emergency dental services to meet the needs of each resident. After surveyor inquiry, an oral surgeon consultation dated for May 2025 was set up for Resident # 61.