STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075411	A. Building B. Wing	01/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Matulaitis Rehabilitation & Skilled Care	10 Thurber Rd Putnam, CT 06260

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. Based on observation, review of the clinical record, and interviews, for one (1) of three (3) residents (Resident #1) reviewed for environmental conditions, the facility failed to maintain a safe environment by failing to ensure exterior fire doors in resident-accessible areas were functional and able to securely close. The findings include:Based on observation, review of the clinical record, and interviews, for one (1) of three (3) residents (Resident #1) reviewed for environmental conditions, the facility failed to maintain a safe environment by failing to ensure exterior fire doors in resident-accessible areas were functional and able to securely close. The findings include:Resident #1 was admitted to the facility in August of 2025 with diagnoses that included repeated falls, insomnia and dementia. Resident #1 had a medical responsible party. The elopement evaluation dated 8/13/25 identified Resident #1 was at risk for elopement and an elopement care plan was initiated.The reportable event dated 12/16/25 at 6:45 AM identified the fan in a resident's bathroom on the A wing caught fire. A resident was evacuated from the room, the NA pulled the fire alarm pull station, retrieved a fire extinguisher and extinguished the fire. Facility Maintenance, the fire department, Fire Marshall and Life Safety from the Department of Public Health responded.The accident and incident (A&I) form dated 12/17/25 at 1:00 AM identified the exterior fire doors on D wing alarmed, a safety check was performed, and Resident #1 was located outside the exterior fire doors on his/her hands and knees with no identified injuries. The A&I identified a wander guard was placed to Resident #1's right wrist for elopement risk, maintenance checked the locking mechanism alarm on the exterior fire door at the end of D wing and maintenance adjusted the door alarm to sound unless the magnetic locks were engaged.Observation on 1/13/26 at 10:00 AM of the D wing exterior fire doors identified the exterior fire doors were locked, there was a pin pad observed to open the exterior fire doors and a magnetic lock on top of each exterior fire door. Upon opening the exterior fire doors after entering the code, the doors alarmed. The left exterior fire door closed but the right exterior fire door did not latch shut. The right exterior fire door needed to be pulled shut to securely close and there was a piece of weather strip on the bottom of the right exterior fire door.Interview with the Maintenance Director on 1/13/26 at 10:00 AM identified when there is a fire alarm, the alarms on the exterior fire doors are disabled and the doors open automatically. He identified the fire alarm that was triggered the day before (12/16/25) could have caused the exterior fire doors to open, and then not close and latch properly once the fire alarm was completed. He identified no one from maintenance checked the exterior fire doors after the fire alarm to ensure they were secured and latched. He identified the exterior doors are checked monthly and was aware the exterior fire doors at the end of D wing had to be pulled to close and secure because they are old doors. He identified the weather strip on the inside of the right exterior fire door may contribute to the exterior fire doors not securely closing and that he would fix it.Interview with the DNS on 1/13/26 at 2:45 PM identified after the fire event on 12/16/25, the (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	exterior fire doors were not checked to ensure they were secured and latched.

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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 review of the clinical record, facility documentation, facility policy, and interviews, for one (1) of three (3) residents (Resident #1) reviewed for elopement, the facility failed to develop a person-centered care plan with individualized interventions to address the resident's assessed risk for elopement. The findings include: Resident #1 was admitted to the facility in August of 2025 with diagnoses that included repeated falls, insomnia and dementia. Resident #1 had a medical responsible party. The elopement evaluation dated 8/13/25 identified Resident #1 was at risk for elopement and an elopement care plan was initiated.The Resident Care Plan (RCP) dated 8/13/25 identified Resident #1 was at risk for elopement related to dementia as evidenced by a history of wandering while in the community and at the facility. The RCP Identified Resident #1 was previously an elevator repair person and had a history of thinking he had a service call and wanting to leave at night per his daughter. Interventions included to introduce yourself in a calm, reassuring manner, explain routines and procedures, orient to room and environment, frequent checks as necessary, picture in business office and encourage family to bring in familiar objects.The physician's order dated 8/14/25 directed assist of one with no device in room and assist of one in hall with walker.The psychiatric note dated 9/16/25 identified Resident #1 had late evening and early morning wakefulness, agitation and walking around confused. She suggested Trazodone 25 mg every six (6) hours as needed for thirty (30) days for breakthrough agitation.The physician's order dated 9/16/25 - 10/16/25 directed Trazodone 25 mg every six (6) hours as needed for agitation/anxiety for thirty (30) days.The psychiatric note dated 10/22/25 identified Resident #1 was recently up during early morning hours wandering and looking for his/her family member. Resident #1 had a history of insomnia and sundowning. She suggested Trazodone 25 mg every six (6) hours as needed for thirty (30) days for breakthrough agitation.The physician's order dated 10/22/25- 11/19/25 directed Trazodone 25 mg every six (6) hours as needed for agitation/insomnia for thirty (30) days.The fall assessment tool dated 11/12/25 identified Resident #1 was at high risk for falling.The quarterly MDS dated [DATE] identified Resident #1 had moderately impaired cognition (Brief Interview for Mental Status (BIMS) score of 11), could walk at least 150 feet independently, and had wandering behaviors that occurred one (1) to three (3) days out of seven (7).The psychiatric note dated 11/12/25 identified Resident #1 had intermittent middle of the night confusion, insomnia, looking for his/her family member, was often re-directable, but if not re-directable had orders for Trazodone 25 mg as needed.The physician's order dated 11/20/25- 12/20/25 directed Trazodone 25 mg every twenty-four (24) hours as needed for agitation/insomnia for thirty (30) days.The accident and incident (A&I) form dated 12/17/25 at 1:00 AM identified the exterior fire doors on D wing alarmed, a safety check was performed, and Resident #1 was located outside the exterior fire doors on his/her hands and knees with no identified injuries. The A&I identified a wander guard was placed to Resident #1's right wrist for elopement risk, maintenance checked the locking mechanism alarm on the exterior fire door at the end of D wing and maintenance adjusted the door alarm to sound unless the magnetic locks were engaged.Interview with NA #1 on 1/13/26 at 3:02 PM identified Resident #1 had behaviors at night to include packing his/her belongings to go home.Interview with RN #1 on 1/13/26 at 3:11 PM identified Resident #1 had a history of staying up at night and would sometimes wander the hall.Interview with the DNS on 1/13/26 at 2:45 PM identified if a resident is exit seeking, ambulatory and/or making statements of wanting to leave, a wander guard should be placed on the resident. She identified there was no other room available for Resident #1 on admission (Resident #1's room was the furthest away from the nursing station and the closest room to the exterior (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	fire doors). She further identified the facility had not done any elopement drills and had no documentation of drills.Review of the RCP failed to identify individualized interventions to address the resident's specific elopement risk behaviors such as: wandering at night, confusion and looking for family members at night, packing belongings at night to leave the facility and room location near exterior exits.Review of the Risk for Wandering/Elopement Resident policy and procedure identified that if a resident is identified as an elopement risk, the following measures will be implemented: a wander guard bracelet will be initiated to maintain the resident safety, the wander guard will be checked every shift and as needed for function, the resident's photo ID will be placed at the front desk and center court, and an elopement drill will be performed periodically and as needed.

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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 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 observation, review of the clinical record, facility documentation, facility policy, and interviews for one (1) of three (3) residents (Resident #1) reviewed for elopement, the facility failed to provide adequate supervision and prevent accidents by failing to ensure exterior fire doors in resident-accessible areas remained secured and failing to implement adequate interventions for an ambulatory resident assessed as being at risk for elopement, resulting in the resident exiting the facility unsupervised. The findings include: Resident #1 was admitted to the facility in August of 2025 with diagnoses that included repeated falls, insomnia and dementia. Resident #1 had a medical responsible party. The Elopement evaluation dated 8/13/25 identified Resident #1 was at risk for elopement and an elopement care plan was initiated.The Resident Care Plan (RCP) dated 8/13/25 identified Resident #1 was at risk for elopement related to dementia as evidenced by a history of wandering while in the community and at the facility. The RCP Identified Resident #1 was previously an elevator repair person and had a history of thinking he had a service call and wanting to leave at night per his daughter. Interventions included to introduce yourself in a calm, reassuring manner, explain routines and procedures, orient to room and environment, frequent checks as necessary, picture in business office and encourage family to bring in familiar objects.The physician's order dated 8/14/25 directed assist of one with no device in room and assist of one in hall with walker.The psychiatric note dated 9/16/25 identified Resident #1 had late evening and early morning wakefulness, agitation and walking around confused. She suggested Trazodone 25 mg every six (6) hours as needed for thirty (30) days for breakthrough agitation.The physician's order dated 9/16/25 - 10/16/25 directed Trazodone 25 mg every six (6) hours as needed for agitation/anxiety for thirty (30) days.The psychiatric note dated 10/22/25 identified Resident #1 was recently up during early morning hours wandering and looking for his/her family member. Resident #1 had a history of insomnia and sundowning. She suggested Trazodone 25 mg every six (6) hours as needed for thirty (30) days for breakthrough agitation.The physician's order dated 10/22/25-11/19/25 directed Trazodone 25 mg every six (6) hours as needed for agitation/insomnia for thirty (30) days.The fall assessment tool dated 11/12/25 identified Resident #1 was at high risk for falling.The quarterly MDS dated [DATE] identified Resident #1 had moderately impaired cognition (Brief Interview for Mental Status (BIMS) score of 11), could walk at least 150 feet independently, and had wandering behaviors that occurred one (1) to three (3) days out of seven (7).The psychiatric note dated 11/12/25 identified Resident #1 had intermittent middle of the night confusion, insomnia, looking for his/her family member, was often re-directable, but if not re-directable had orders for Trazodone 25 mg as needed.The physician's order dated 11/20/25- 12/20/25 directed Trazodone 25 mg every twenty-four (24) hours as needed for agitation/insomnia for thirty (30) days.The reportable event dated 12/16/25 at 6:45 AM identified the fan in a resident's bathroom on the A wing caught fire. A resident was evacuated from the room, the NA pulled the fire alarm pull station, retrieved a fire extinguisher and extinguished the fire. Facility Maintenance, the fire department, Fire Marshall and Life Safety from the Department of Public Health responded.A Nursing note by RN #1 dated 12/17/25 at 6:45 AM identified at approximately 1:00 AM the exterior fire doors on D-Wing alarmed. She identified herself and NA #1 responded immediately. The supervisor (RN #2) was notified. NA #1 noted the exterior fire door to be slightly ajar and secured the door so it was fully closed. RN #1 directed NA #1 to perform a resident head count. Resident #1 was not in his/her room. Resident #1 was last observed at 12:00 AM resting in bed with no signs of distress. RN #1, RN #2 and NA #1 opened the exterior fire doors and observed Resident #1, who was wearing a jacket, pants and white (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sneakers, outside the facility door, kneeling on his/her hands and knees on the ground. RN #2 and NA #1 assisted Resident #1 to a standing position while RN #1 obtained a wheelchair and Resident #1 was safely wheeled into the facility.The accident and incident (A&I) form dated 12/17/25 at 1:00 AM identified the exterior fire doors on D wing alarmed, a safety check was performed, and Resident #1 was located outside the exterior fire doors on his/her hands and knees with no identified injuries. The A&I identified a wander guard was placed to Resident #1's right wrist for elopement risk, maintenance checked the locking mechanism alarm on the exterior fire door at the end of D wing and maintenance adjusted the door alarm to sound unless the magnetic locks were engaged.Observation on 1/13/26 at 10:00 AM of the D wing exterior fire doors identified the exterior fire doors were locked, there was a pin pad observed to open the exterior fire doors and a magnetic lock on top of each exterior fire door. Upon opening the exterior fire doors after entering the code, the doors alarmed. The left exterior fire door closed but the right exterior fire door did not latch shut. The right exterior fire door needed to be pulled shut to securely close and there was a piece of weather strip on the bottom of the right exterior fire door.Interview with the Maintenance Director on 1/13/26 at 10:00 AM identified when there is a fire alarm, the alarms on the exterior fire doors are disabled and the doors open automatically. He identified the fire alarm that was triggered the day before (12/16/25) could have caused the exterior fire doors to open, and then not close and latch properly once the fire alarm was completed. He identified no one from maintenance checked the exterior fire doors after the fire alarm to ensure they were secured and latched. He identified the exterior doors are checked monthly and was aware the exterior fire doors at the end of D wing had to be pulled to close and secure because they are old doors. He identified the weather strip on the inside of the right exterior fire door may contribute to the exterior fire doors not securely closing and that he would fix it.Interview with NA #1 on 1/13/26 at 3:02 PM identified Resident #1 had behaviors at night to include packing his/her belongings to go home. She identified on 12/17/25 she last saw Resident #1 at 12:00 AM asleep in bed wearing pajama pants, a white shirt, sweater and socks. She identified she was in the middle of the hall when she heard the alarm sound and did not know what it was. She identified she was directed to check the halls and identified the exterior fire door at the end of D wing was slightly open so she closed the door. She then began to check resident rooms beginning with Resident #1's room because his/her room was nearest to the exterior fire doors on the left. She identified Resident #1 was not in his/her room. She opened the exterior fire doors and found Resident #1 outside. She identified she had not done elopement drills since employed by the facility.Interview with RN #1 on 1/13/26 at 3:11 PM identified Resident #1 had a history of staying up at night and would sometimes wander the hall. She identified on 12/17/25 she last saw Resident #1 at 12:00 AM in bed. She identified she was at the nursing station when she heard an alarm sound. She identified herself and NA #1 were trying to figure out what alarm it was. She identified she called the nurse on the A wing to inquire, and that nurse also did not know. She then called the supervisor who notified her to start looking at the exterior fire doors. They started a resident head count when Resident #1 was identified outside of the D wing exterior fire doors. He/she was brought back inside and an assessment was completed with no injuries. She identified she had not done any elopement drills while being employed by the facility.Interview with the DNS on 1/13/26 at 2:45 PM identified if a resident is exit seeking, ambulatory and/or making statements of wanting to leave, a wander guard should be placed on the resident. She identified Resident #1 did not have a wander guard because he/she was not exit seeking or making statements of wanting to leave. She identified there was no other room available for Resident #1 on admission (Resident #1's room was the furthest away from the nursing station and the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	closest room to the exterior fire doors). She identified after the fire event on 12/16/25, the exterior fire doors were not checked to ensure they were secured and latched. She further identified the facility had not done any elopement drills and had no documentation of drills.Review of the Risk for Wandering/Elopement Resident policy and procedure identified that if a resident is identified as an elopement risk, the following measures will be implemented: a wander guard bracelet will be initiated to maintain the resident safety, the wander guard will be checked every shift and as needed for function, the resident's photo ID will be placed at the front desk and center court, and an elopement drill will be performed periodically and as needed.