STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075412	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lord Chamberlain Manor	7003 Main Street Stratford, CT 06614

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. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record and facility documentation, and interviews for one resident (Resident #1) reviewed for accidents, the facility failed to provide adequate supervision to ensure a resident identified at risk for elopement did not leave the facility without staff knowledge. The findings include: Based on observation, review of the clinical record, facility documentation, and interviews for one resident (Resident #1) reviewed for accidents, the facility failed to provide adequate supervision to ensure a resident identified at risk for elopement did not leave the facility without staff knowledge. The findings include: Resident #1 was admitted to the facility with a diagnoses of a left femur fracture. Record review identified Resident #1 was self-responsible, and Person #1 was the emergency contact. The Hospital Discharge summary dated [DATE] (Friday) identified Resident #1 was alert and oriented, was discharged with planned short term rehab admission, and Resident #1 understood discharge instructions. A nursing note dated 7/25/2025 at 6:31 PM by RN #3 identified Resident #1 was admitted from the hospital, and was alert and confused, and expressed that he/she did not want to be in the facility; stated I want to go home. APRN #1 spoke with Person #1 regarding discharge Against Medical Advice (AMA) and Person #1 refused to send Resident #1 home. MD #1 was notified, and new orders were obtained to transfer Resident #1 to the hospital. A nursing note dated 7/30/2025 (Wednesday) at 3:53 PM written by RN #3 identified Resident #1 was readmitted to the facility, was alert and oriented and was accompanied by Person #1. The Resident Care Plan (RCP) dated 7/31/2025 identified Resident #1 had a risk for falls. Interventions directed call bell in reach, physical therapy as indicated and ensure appropriate footwear. An Elopement Evaluation dated 7/31/2025 at 3:29 AM identified Resident #1 had a score of five (5) which indicated a risk for elopement (a score value of one (1) or higher indicates a risk for elopement). A wander guard bracelet was placed to Resident #1's right wrist. A nursing note dated 8/2/2025 at 7:40 AM by LPN #1 identified Resident #1 was alert but confused and was up most of the night in a recliner chair watching TV. Resident #1 repeatedly stated how do I get out of here? and became agitated and was exit seeking with staff redirection given. Nursing supervisor was notified. Facility reportable event dated 8/2/2025 at 12:30 PM identified Resident #1 was alert, confused, and required standby assist for mobility, and eloped from the facility. Additional information identified Resident #1 was self-responsible with no history of elopement or wandering and had a wanderguard in place. Resident #1 was in the cafe and asked a Dietary Aide to sit outside, and exited through the cafe door. Within a few minutes the RN supervisor called for a search and discovered Resident #1 was missing. The supervisor was notified that Resident #1 was found at a gas station across the street (approximately 25 to 50 feet away). Staff attempted to redirect Resident #1 to return to the facility, but Resident #1 became agitated and emergency services (EMS) were called. EMS transferred Resident #1 to the hospital. A nursing note dated 8/2/2025 at 3:03 PM by RN #1 identified that she was notified by Receptionist #1 that a visitor reported seeing a resident walking down the street unattended. The facility code Dr.Hunt (missing resident) was called, and a search of the surrounding area was immediately conducted, but Resident #1 was not located. Shortly after, Person #1 called the facility and reported Resident #1 called him/her from a local gas station and stated the facility had discharged him/her. RN #1 proceeded to the gas station and observed sitting on the stoop outside the gas station with a black bag and a grabber (reacher). Resident #1 stated he/she walked, and I'm not going back. I'm going home. Further, the note indicated during the beginning of the shift RN #1 observed Resident #1 was wearing a wanderguard bracelet on the right wrist, but at the gas station there was no wanderguard. Resident #1 refused to state what happened to the device, became upset and refused to answer further questions or allow any assessments. Resident #1 refused multiple attempts to encourage him/her to return to the facility. EMS was called, and transferred Resident #1 to the facility. Resident #1 refused to return to his/her room, declined to sign Against Medical Advice discharge paperwork, declined to speak with Person #1, and EMS transferred Resident #1 to the hospital. Review of mapquest identified Resident #1 was located 0.3 miles from the facility, across a four (4) lane road with no sidewalks. Facility incident summary dated 8/8/2025 identified Resident #1 was transferred to the hospital after he/she was located at the gas station. Further, the door leading outside from the cafe will be equipped with coded keypad. Although attempted, an interview with RN #1 was unable to be obtained during the survey. Interview with Dietary Aide #1 (DA #1) on 8/27/2025 at 12:35 PM identified the facility had a cafe and she was the cashier on 8/2/2025. DA #1 stated she saw Resident #1 come into the cafe, he/she requested to go outside