STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075325	A. Building B. Wing	11/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mary Wade Home, the Incorporated	118 Clinton Ave New Haven, CT 06513

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 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. (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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, facility documentation, facility policies and interviews for one (1) of three (3) sampled residents (Resident #1) who were dependent on staff for personal care, the facility failed to ensure the resident was not verbally abused by a nurse aide. The findings include:Resident #1's diagnoses included Alzheimer's Disease, depression, and anxiety. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 rarely or never made decisions regarding tasks of daily life, resisted care from staff at times, and was dependent on staff for dressing, toileting, personal hygiene and transfers in and out of bed. The Resident Care Plan dated 8/7/25 identified Resident #1 had a self-care deficit and altered cognition. Interventions directed staff to assist with activities of daily living, give simple explanations, use orientation guides, and reapproach if the resident refused care. The Facility Reported Incident form dated 8/27/25 identified on 8/27/25 at 7:45 PM the 3-11PM nursing supervisor, Registered Nurse (RN) #1, was called to Resident #1's room by the 3-11PM charge nurse, Licensed Practical Nurse (LPN) #1, because LPN #1 had witnessed a nurse aide, Nurse Aide (NA) #1, screaming at Resident #1 while NA #1 was attempting to get the resident ready for bed. In a written statement dated 8/27/25, LPN #1 identified she observed NA #1 approach Resident #1 in the hallway, started to push Resident #1's wheelchair into the room, and she advised NA #1 to tell Resident #1 what she was doing because Resident #1 could get upset at times during care. LPN #1 explained approximately thirty (30) seconds later as she was in the hallway outside Resident #1's room, she visualized NA #1 aggressively gesturing and hovering over Resident #1 as NA #1 yelled what's up with you? Don't be putting your hands on me, and you're not going to put your hands on me. LPN #1 wrote she went into the room and told NA #1 that she could not yell at a resident even though NA #1 said Resident #1 was scratching her. LPN #1 informed NA #1 she should have ensured Resident #1 was safe and stepped away from the situation but never should have yelled at a resident. LPN #1 stated NA #1 was asked to leave Resident #1's room and the nursing supervisor was contacted. The Social Worker's note dated 8/29/25 at 12:25 PM identified the Social Worker met with Resident #1 on 8/29/25 in follow-up to an interaction with a staff member that occurred on 8/27/25, there were no signs of distress, and Resident #1 could not recall any negative interaction with a staff member. Interview with NA #1 on 9/15/25 at 12:45 PM identified she recalled working with Resident #1 from 3-11PM on 8/27/25. NA #1 identified after she pushed Resident #1 into his/her room she bent over to put the brakes on the wheelchair and Resident #1 began swinging and yelling at her NA #1 identified as she was backing away from Resident #1 she said to Resident #1, No, don't swing at me. The nurse told me to put you to bed. Interview with another 3-11PM charge nurse, Licensed Practical Nurse (LPN) #2, on 9/15/25 at 1:00 PM identified on 8/27/25 she was in the hallway at her medication cart approximately three (3) doors away from Resident #1's room when she began to hear very loud yelling. LPN #2 stated heard NA #1 say, Stop doing that to me, I'm trying to help you. LPN #2 identified NA #1 was extremely loud and everyone could hear the altercation. LPN #2 identified she responded to Resident #1's room and when she arrived, she saw LPN #1 in the room. LPN #2explained Resident #1 would often resist care and could become combative while staff were trying to help him/her but if staff left Resident #1 and reapproached, Resident #1 would eventually allow staff to provide care. Interview with the Assistant Director of Nursing (ADON) on 9/15/25 at 1:40 PM identified she conducted the investigation for the alleged verbal abuse on 8/27/25 and LPN #1 and LPN #2 both identified they heard NA #1 screaming at Resident #1. The ADON indicated the nurses did not witness any physical altercation and were able to stop the altercation quickly. The ADON explained the nurse aide was removed from the building pending the facility's investigation. The ADON identified based on the investigation that the facility was able to substantiate the allegation of verbal abuse and the facility informed the staffing agency they would no longer employ NA #1 in the future. Review of the facility policy for Abuse, Neglect, and Exploitation, directed in part, the facility would implement policies and procedures that prohibit and prevent abuse and neglect. Review of the facility policy for Resident Rights, directed in part, the resident has a right to be treated with respect and dignity and be free from neglect.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, facility documentation, facility policies and interviews for one (1) of three (3) sampled residents (Resident #1) who was dependent on staff for personal care, the facility failed to report an allegation of verbal abuse to law enforcement timely. The findings include:Resident #1's diagnoses included Alzheimer's Disease, depression, and anxiety. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 rarely or never made decisions regarding tasks of daily life, resisted care from staff at times, and was dependent on staff for dressing, toileting, personal hygiene and transfers in and out of bed. The Facility Reported Incident form dated 8/27/25 identified on 8/27/25 at 7:45 PM the 3-11PM nursing supervisor, Registered Nurse (RN) #1, was called to Resident #1's room by the 3PM to 11PM charge nurse, Licensed Practical Nurse (LPN) #1, because LPN #1 had witnessed a nurse aide, Nurse Aide (NA) #1, screaming at Resident #1 while NA #1 was attempting to get the resident ready for bed. In a written statement dated 8/27/25, the nursing supervisor, RN #1, identified she was called to Resident #1's room by LPN #1 due to alleged verbal abuse by a nurse aide against Resident #1. NA #1 denied yelling at Resident #1 and was told to leave the facility pending an investigation. Interview with the Assistant Director of Nursing (ADON) on 9/15/25 at 1:40 PM identified she conducted the investigation for the alleged verbal abuse on 8/27/25 and LPN #1 and LPN #2 both identified they heard NA #1 screaming at Resident #1. The ADON indicated the nurses did not witness any physical altercation and were able to stop the altercation quickly. The ADON explained the nurse aide was removed from the building pending the facility's investigation. The ADON identified based on the investigation that the facility was able to substantiate the allegation of verbal abuse and the facility informed the staffing agency they would no longer employ NA #1 in the future. The ADON identified the facility did not notify law enforcement of the allegation of verbal abuse because there was no evidence of the abuse being physical abuse. Review of the facility policy for Abuse, Neglect, and Exploitation, directed in part, the facility would notify law enforcement not later than two (2) hours after the allegation, if the events that cause the allegation involve abuse.