STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075408	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Leeway, Inc	40 Albert Street New Haven, CT 06511

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 clinical record review, facility documentation, and staff interview for three of three residents (Resident #1, Resident #2, Resident #3) reviewed for accidents, the facility failed to ensure the approved LOA list was checked prior to allowing a resident to sign out on a Leave of Absence. The findings include: Resident #1 was admitted during June 2024 with diagnoses of schizophrenia, antisocial personality disorder, and psychoactive substance abuse. An admission Minimum Data Set (MDS) dated [DATE] identified Resident #1 was alert and oriented, independent with care and transfers, and had no wandering behavior exhibited. The Resident Care Plan (RCP) dated 7/22/2024 identified Resident #1 was at risk for falls and uses psychoactive medication. Interventions include call bell within reach and monitor side effects and adverse reactions to medications. Record review identified Resident #1 had a court appointed Conservator of Person (COP). Additional review identified Resident #1 had no orders for Leave of Absence (LOA) from the facility. Facility incident report dated 8/21/2024 at 11 PM identified Resident #1 was independent with mobility with rolling walking and with a wheelchair, signed him/herself out of the facility at 9:30 PM and did not return. The facility contacted Resident #1 who reported that he/she was on the city Green, the local police, COP, and APRN were notified. Review of the Release of Responsibility for Leave of Absence identified Resident #1 left the faciity on 8/21/2024 at 9:28 PM. The nursing note dated 8/22/2024 at 12:54 AM identified the evening nurse attempted to locate Resident #1, was unable to find him/her and identified Resident #1 had left the building. Resident #1 was contacted on his/her cell phone and he/she reported to be safe on the city Green. The nursing note dated 8/22/2024 at 11 AM identified Resident #1 returned to the facility at 8:20 AM. Interview with Security Guard #1 on 9/11/2024 at 12:05 PM identified when he signed Resident #1 out on the LOA on 8/21/2024, he did not check the LOA book to see if the resident was allowed LOA privileges. Interview failed to identify why Security Guard #1 did not verify LOA privileges prior to allowing Resident #1 leave the facility, or why he did not contact the nurse. (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
	075408	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Leeway, Inc	40 Albert Street New Haven, CT 06511

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DNS on 9/11/24 at 12:40 PM identified although Resident #1 should have had LOA privileges, there was no order for LOAs. The DNS stated the security guard should have verified the resident's LOA status prior to allowing Resident #1 to leave the facility.