STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075404	A. BUILDING _____ B. WING _____	**07/15/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MAEFAIR HEALTH CARE CENTER	**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 0842 **Level of harm -** Potential for minimal harm **Residents Affected -** Some	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, review of facility documentation, review of facility policy, and interviews for one of three residents (Resident #1), the facility failed to record/document the amount of intravenous fluids on the facility ' s input/output record in accordance with policy and procedures. The findings include: Resident # 1 ' s [DIAGNOSES REDACTED]. Review of the quarterly MDS assessment dated [DATE] identified Resident #1 was moderately cognitively impaired and required set up only with one person for eating. The Resident Care Plan (RCP) dated 5/11/20 identified a potential nutritional problem related to [DIAGNOSES REDACTED]. The nurse ' s note dated 6/3/20 at 4:12 PM identified that Resident #1 was alert and verbal. There was no respiratory of cardiac distress noted, was afebrile and denied pain. Resident #1 had no signs and symptoms of [MEDICAL CONDITION] infection. The note identified Resident #1 had increased confusion and the APRN was notified. an order for [REDACTED]. Review of the clinical lab collected on 6/6/20 at 1:32 PM identified that the resident ' s Blood Urine and Nitrogen level (BUN) was elevated at 45, indicative of hydration status. Review of the Medication Administration Record [REDACTED]. Review of the Resident #1 ' s Input and Output documentation record failed to reflect that the shift to shift intravenous fluid input documentation from 6/5/20 to 6/13/20 was completed for every shift. Interview with The Director of Nursing (DNS) on 7/14/20 at 2:10PM indicated that the nurses should have documented the amount of input intravenously on the input and output record in the parental section of the input and output record for any resident who is on intravenous fluids. Review of The Facility ' s Hydration Policy identified residents identified for a potential at risk for dehydration will be placed on intake and output monitoring until adequate hydration status is achieved.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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.