

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075078	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2025
NAME OF PROVIDER OR SUPPLIER Westview Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 150 Ware Rd Dayville, CT 06241	

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)
<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>(continued on next page)</p>

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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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #1) reviewed for abuse, the facility failed to ensure the resident was free from misappropriation of resident property. The findings include: Resident #1 was admitted to the facility for short term rehabilitation stay on 8/16/2023 with diagnoses that included diabetes, anxiety, and heart failure. The quarterly MDS assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of fifteen out of fifteen, indicative of no cognitive impairment, required assistance with personal care, and was independent with meals. The RCP dated 6/1/2025 identified an alteration in ADL function and a history of hallucinations which resident is able to verbalize as not real. Interventions directed assist with personal care, one to one with the social services as needed, and monitor for psych/social needs. Review of facility Reportable Event Form dated 6/27/2025 at 10:30 AM by the DNS identified the Administrator was contacted by the State Police regarding a suspected exploitation (misappropriation of Resident #1's funds) by Nurse Aide (NA) #1, and NA #1 was suspended pending the investigation. Employee file review for NA #1 identified she was hired on 2/13/2023. Additional information provided by the facility identified the allegation was credit card fraud beginning on 9/15/2023 when Resident #1's credit card was stolen and a large amount of charges ensued, and Resident #1 was made whole by the credit card company. Documentation identified NA #1 used the internet VPN addresses and used the credit card for various charges up to \$20,000. NA #1 indicated she used the credit card to purchase some snacks and inadvertently made additional charges by mistake. Further, NA stated when she realized the erroneous charges, she just kept using the card because of her financial and emotional problems, she just kept going. NA #1 admitted the allegation, stated she charged \$10,000 but returned most of it, and her employment was terminated on 6/27/2025. Nursing note written by LPN #1 dated 6/27/2025 at 4:41 PM indicated writer (LPN #1) spoke to Resident #1's emergency contact regarding a credit card, and the Administrator met with resident regarding charges on Resident #1's credit card. Resident #1 expressed he/she was grateful for the update. During an interview with NA #1 on 9/15/2025 at 11:46 AM, NA #1 stated in September 2023, Resident #1 asked her to purchase some snacks for him/her, and she reluctantly agreed to use resident's credit card. She purchased items online and did not realize resident's card was still attached on/in her phone until she saw that items she was purchasing for herself were not coming out of her account, were charged under Resident #1's card. NA #1 stated she continued to utilize Resident #1's credit card and only stopped using the card after about a year, either in December 2023 or December 2024 when the card was shut off. NA #1 was unable to explain why she kept using the card; she indicated she needed stuff for school, medical usage and for things she didn't have, and that she had a spending problem. Interview on 9/15/2025 at 12:38 PM with Officer #1 identified NA #1 was arrested, charged with Larceny with a \$10,000 bond, and was pending a court date. Interview, clinical record review and facility documentation review with the DNS and Administrator on 9/12/2025 at 12:18 PM identified the facility was notified by the State Police that about 9/2023 Resident #1 had a credit card stolen with a large amount of charges made over a long period of time by NA #1. NA #1 worked at the facility during 9/2023 when Resident #1 was a resident. Once the facility was notified of the allegation, NA #1 was placed on suspension (on 6/27/2025). The facility indicated Resident #1 had believed his/her credit card was hacked and he/she had never loaned the card to an employee, and did not authorize NA #1 to use the credit card. The facility was notified by the State Police that NA #1 acknowledged the use of the credit card, and NA #1's employment was terminated. Interview identified residents should be free from abuse and misappropriate of personal property, and the allegation of abuse was substantiated by the facility. Review of facility Assault/Abuse/Crime Policy directed in part, each resident has the right to be free from abuse, misappropriation of resident property. Residents must not be subjected to criminal acts by anyone, including facility staff. Misappropriation of resident property is defined as the patterned deliberate temporary or permanent use of a resident's/patient's belongings, or money without the resident's/patient's consent. Review of facility Employee Handbook directed in part, to provide the most comprehensive, holistic care possible to residents by: maintaining a safe environment. Critical Offenses which may justify immediate discharge without regard to the employee's length of service or prior record in part, any violation of Resident's/Patient's rights, and stealing any property.</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #1) reviewed for abuse, the facility failed to ensure a resident's care plan was updated after the facility was notified of an unauthorized use of the resident's credit card. The findings include: Resident #1 was admitted to the facility for short term rehabilitation stay on 8/16/2023 with diagnoses that included diabetes, anxiety, and heart failure. The quarterly MDS assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of fifteen out of fifteen, indicative of no cognitive impairment, required assistance with personal care, and was independent with meals. The RCP dated 6/1/2025 identified an alteration in ADL function and a history of hallucinations which resident is able to verbalize as not real. Interventions directed assist with personal care, one to one with the social services as needed, and monitor for psych/social needs. Review of facility Reportable Event Form dated 6/27/2025 at 10:30 AM by the DNS identified the Administrator was contacted by the State Police regarding a suspected exploitation (misappropriation of Resident #1's funds) by Nurse Aide (NA) #1, and NA #1 was suspended pending the investigation. Employee file review for NA #1 identified she was hired on 2/13/2023. Additional information provided by the facility identified the allegation was credit card fraud beginning on 9/15/2023 when Resident #1's credit card was stolen and a large amount of charges ensued, and Resident #1 was made whole by the credit card company. Documentation identified NA #1 used the internet VPN addresses and used the credit card for various charges up to \$20,000. NA #1 indicated she used the credit card to purchases some snacks and inadvertently made additional charges by mistake. Further, NA stated when she realized the erroneous charges, she just kept using the card because of her financial and emotional problems, she just kept going. NA #1 admitted the allegation, stated she charged \$10,000 but returned most of it, and her employment was terminated on 6/27/2025. Nursing note written by LPN #1 dated 6/27/2025 at 4:41 PM indicated writer (LPN #1) spoke to Resident #1's emergency contact regarding a credit card, and the Administrator met with resident regarding charges on Resident #1's credit card. Resident #1 expressed he/she was grateful for the update. Additional record review failed to identify the RCP was updated after the misuse of the credit card was reported on 6/27/2025. Interview, clinical record and facility documentation review with the DNS and Administrator on 9/12/2025 at 12:18 PM identified the care plan was not updated after the facility was notified on 6/27/2025 of the unauthorized use of Resident #1's credit card. The DNS stated Resident #1 was monitored, but not specifically to the incident, and the facility believed it was a non-issue as Resident #1 did not bring it up to staff as far as the DNS knew. The DNS stated, although the incident was substantial, the DNS was unable to provide documentation that Resident #1's care plan included interventions to support Resident #1 regarding the incident. Interview failed to identify why the RCP was not updated after the incident. Review of the facility Abuse/Assault/Criminal Acts Policy directed in part, documentation of investigation and follow up should be in in the clinical record of resident, if resident is involved Review of facility Care Plan - Comprehensive Policy directed in part; policy to develop a comprehensive care for each resident/patient that includes measurable objectives and goals to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p>		

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide medically-related social services to help each resident achieve the highest possible quality of life.</p> <p>(continued on next page)</p>

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The quarterly MDS assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of fifteen out of fifteen, indicative of no cognitive impairment, required assistance with personal care, and was independent with meals. The RCP dated 6/1/2025 identified an alteration in ADL function and a history of hallucinations which resident is able to verbalize as not real. Interventions directed assist with personal care, one to one with the social services as needed, and monitor for psych/social needs. Review of facility Reportable Event Form dated 6/27/2025 at 10:30 AM by the DNS identified the Administrator was contacted by the State Police regarding a suspected exploitation (misappropriation of Resident #1's funds) by Nurse Aide (NA) #1, and NA #1 was suspended pending the investigation. Employee file review for NA #1 identified she was hired on 2/13/2023. Review of June 2025 signed physician orders dated 7/10/2025 directed psych services as needed. Additional information provided by the facility identified the allegation was credit card fraud beginning on 9/15/2023 when Resident #1's credit card was stolen and a large amount of charges ensued, and Resident #1 was made whole by the credit card company. Documentation identified NA #1 used the internet VPN addresses and used the credit card for various charges up to \$20,000. NA #1 indicated she used the credit card to purchase some snacks and inadvertently made additional charges by mistake. Further, NA stated when she realized the erroneous charges, she just kept using the card because of her financial and emotional problems, she just kept going. NA #1 admitted the allegation, stated she charged \$10,000 but returned most of it, and her employment was terminated on 6/27/2025. Nursing note written by LPN #1 dated 6/27/2025 at 4:41 PM indicated writer (LPN #1) spoke to Resident #1's emergency contact regarding a credit card, and the Administrator met with resident regarding charges on Resident #1's credit card. Resident #1 expressed he/she was grateful for the update and was informed he/she can reach out to this writer, social services director or Administrator at any time. Record review failed to identify follow-up visits related to the unauthorized use of Resident #1's credit card, failed to identify support visits were provided by nursing, social services or psychiatry visits. Interview and clinical record review with APRN #1 on 9/9/2025 at 9:50 AM identified she was not aware that Resident #1 had an incident of misappropriation of property by any staff prior to the interview. APRN #1 stated she would have wanted to be notified and if she had known she would have followed up with Resident #1 and involved social and psychiatry services to support Resident #1. On 9/12/2025 at 10:35 AM interview, clinical record and facility documentation review with SW #1 identified that she was aware of the incident regarding unauthorized use of Resident #1's credit card by NA #1. SW #1 stated she did not speak to Resident #1 about the issue as she thought Resident #1 really did not want to talk about. She further indicated she would have to review the record to identify if she documented any attempts to speak to Resident #1, and if she referred Resident #1 to psychiatry services. Interview, clinical record review and facility documentation review with the DNS and Administrator on 9/12/2025 at 12:18 PM identified the social worker should have provided and documented follow-up conversations/check-ins with Resident #1 after the incident on 6/27/2025. Further, at the time of the incident, Resident #1 did not have any psychiatric services ordered and support was not provided by psychiatry. Subsequent to surveyor inquiry, SW #1 and DNS were unable to provide nursing notes, social services notes or psychiatry notes regarding support provided to Resident #1 regarding the incident. Although the DNS stated Resident #1 was monitored, he/she was not monitored or support provided related to the allegation of unauthorized use of the credit card. Interview failed to identify why support services were not provided. Review of facility Assault/Abuse/Crime Policy directed in part, documentation of any follow-up care shall be in the facility files and the clinical record of the resident, if the resident is involved.</p>		