STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075084	A. Building B. Wing	06/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa Maria Nursing and Rehabilitation Community	20 Babcock Avenue Plainfield, CT 06374

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility policy, and interviews for the only sampled resident (Resident #212) reviewed for hospitalization, the facility failed to notify the physician for a change in condition and for 1 of 5 sampled residents (Resident #213) reviewed for medication administration, the facility failed to notify the physician when the medication was not available for administration. The findings include: 1. Resident #212 was admitted to the facility in November 2024 with diagnoses that included end stage renal disease, diabetes, hypertension, and cerebral infarction (death of brain tissue) without residual deficits. The annual Minimum Data Set assessment dated [DATE] identified Resident #212 had a Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive impairment, required substantial/maximum assistance for personal hygiene, was dependent on bed to chair transfers, and was receiving hemolytic treatment. The Resident Care Plan (RCP) in effect for the month of May of 2025 identified Resident #212 was on hemolytic treatment due to end stage renal failure. Interventions included administer/hold/monitor effectiveness of medications per the physician order, check/complete hemolytic treatment communication log on return for any reports, communicate and collaborate with the hemolytic center regarding medications and treatments. A physician's order in effect for the month of May 2025 directed to send Resident #212 to hemolytic treatments 3 times per week on Tuesdays, Thursdays, and Saturdays, and to administer Nitroglycerin (for chest pain) sublingual (under the tongue) 0.4 MG every 5 minutes as needed for chest pain up to 3 doses, if not relieved call the physician. Review of Resident #212's nurse's note written by LPN #3 dated 5/16/2025 at 11:12 PM identified Resident #212 complained of chest pain and Nitroglycerin 0.4 mg was administered. A reassessment was performed at 12:00 AM and the resident's Blood Pressure (BP) was 131/61 (normal BP 120/80). Resident #212 denied any further chest pain, his/her color was pale, and the head of bead was elevated. A nurse's note dated 5/17/2025 at 12:47 AM written by LPN #3 identified Resident #212's BP had decreased and was 80/40. The resident's BP was taken again 7 hours later at 7:48 AM and noted to still be low at 85/40. No further BP rechecks were documented and there was no documentation the provider was notified of Resident #212's abnormally low BP. (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
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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nurse's note dated 5/17/2025 at 7:41 AM written by LPN #3 identified that Resident #212 presented with increased lethargy, mild shortness of breath, diminished lung sounds. The note failed to document the provider was contacted for notification of a change in condition. Interview and record review with LPN #5 on 6/6/2025 at 3:40 PM identified that she was the nurse taking care of Resident #212 on 5/17/2025 on the 7:00 AM to 3:00 PM shift. LPN #5 indicated that Resident #212 did not look good when she assumed his/her care at 7:00 AM and was unable to recall if she had rechecked the resident's vital signs as no vital signs were apparent in the clinical record. LPN #5 identified that although Resident #212 had received nitroglycerin, had a low BP on the night shift, and did not appear well, she had not informed the facility physician or notified the hemolytic center of the change in condition prior to sending him/her for treatment. When Resident #212 returned from treatment in the evening, he/she was still unstable and was subsequently sent to the emergency room (ER). Interview with LPN #3 on 6/10/2025 at 9:12 AM identified that she notified RN #3 (RN Supervisor) about Resident #212's change in condition on 5/17/2025 but that RN #3 did not notify the physician of the resident's change in condition on her shift. LPN #3 indicated that she did not recheck Resident #212's vital signs again until 7:48 AM (7 hours) after Resident #212's initial presentation of his/her low BP that occurred at 12:47 AM and did not explain why she waited 7 hours to recheck the residents BP. Additionally, LPN #3 stated that she failed to notify the provider of Resident #212 change when he/she presented with increased lethargy, mild shortness of breath, and diminished lung sounds and did not explain why she did not call the provider. Review of the clinical record failed to identify RN #3 had assessed or documented Resident #212's change in condition or that the physician had been notified. A nursing note dated 5/17/2025 at 4:47 PM identified that when Resident #212 returned from the hemolytic center at 4:00 PM his/her vital signs were unstable. Resident# 212's oxygen saturation was around 80% (normal 95% to 100%). The facility was unable to stabilize Resident #212, and he/she was sent out to the ER for further evaluation. Review of hospital documentation identified that Resident #212 was admitted to the hospital on [DATE] with hypoxic respiratory failure. During hospitalization Resident #212 exhibited stroke like symptoms, was treated and was discharged back to the facility. Interview with APRN#1 on 6/10/2025 at 10:00AM identified that the physician should have been notified for hypotension (low BP) and for the changes in condition. Interview with the DNS on 6/10/2025 at 11:10 AM identified that the physician should have been notified for Resident #212's change in condition and was unable to explain why none of the facility staff had done so. Attempts to contact RN #3 were unsuccessful. (continued on next page)

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy, Resident Change in Condition, identified in part, that a resident's change in condition will be reported immediately to the unit manager or shift nursing supervisor. The licensed nurse will assess the resident for signs and symptoms of physical or mental change of condition. If a change in condition is non emergent the licensed nurse will complete a progress note and all attempts of physician notification will be documented in the progress notes. 2. Resident #213 was admitted with diagnoses that included anxiety, arthritis and hypertension. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #213 had a Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive impairment, required set up assistance for eating, and was independent for bed mobility and transfers. The Resident Care Plan dated 5/27/2025 identified Resident #213 used psychotropic medications related to antianxiety to manage restlessness. Interventions included administering medications as ordered and to observe/document for side effects and effectiveness. A physician's orders dated 6/4/25 at 1:00 PM directed to administer Prozac 20 milligrams (mg), 1 capsule in the morning for depression. Interview and review of the Medication Administration Record (MAR) for Resident #213 on 6/6/2025 at 8:30 AM, with LPN #4 identified Prozac was not available in the medication cart and she would contact the pharmacy to inquire about the medication. LPN #4 reported to RN #2 that Prozac had not been delivered by the pharmacy and requested him follow up. Subsequently RN #2 updated LPN #4 that he had reached out to APRN #1 regarding the medication, was instructed to place Prozac on hold for 6/6/2025, and was to restarted the Resident #213's medication the following day, 6/7/2025, so that the facility would not be out of compliance. Although a review of the nurse's notes and MAR identified that Prozac had been ordered on 6/4/2025 at 1:00 PM and was scheduled to be started on 6/5/2025 at 9:00 AM, the MAR failed to identify Resident #213 received his/her scheduled Prozac on 6/5/2025 or 6/6/2025. A notation, indicating the number 9, directed to refer to the nurse's note for an explanation. Review of LPN #4's nursing notes failed to identify why the medication was not administered as directed on 6/5 or 6/6/2025. A nursing note dated 6/6/2025 identified that the start date for Prozac had been moved to 6/7/2025 and the pharmacy had been contacted regarding the order. Re-interview with LPN #4 on 6/6/2025 at 10:00 AM identified that Prozac was not available to be administered on 6/5/2025 and 6/6/2025 despite having been ordered on 6/4/2025. LPN #4 identified that she had failed to report the unavailability of Resident #213's Prozac to the nursing supervisor, had not contacted the pharmacy, and had not notified the physician on 6/5/2025 when she realized that the medication was not available. Further, LPN #4 identified that it was her responsibility to ensure medications were administered as directed and she should have notified the physician on 6/5/2025 to inform then that Resident #213 would not receive his/her medication per the physician's order. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with RN #2 on 6/6/2025 at 10:10 AM identified he was never notified that Resident #213's Prozac not available to be administered on 6/5/2025 but should have been. RN #2 further indicated that had he been notified, he would have contacted the pharmacy to inquire about the missing medication and would have notified the physician for further directions. RN #2 was unable to explain why LPN #4 had not followed the facility policy to notify the physician when a medication was not available or administered. Interview with the APRN #2 on 6/6/2025 at 11:30 AM indicated that she was not aware that Prozac was not available to be administered to Resident #213 until today when RN #2 notified her. APRN#2 indicated that she should have been notified when Resident #213's Prozac was unavailable and had not been administered. Interview with the DNS on 6/10/2025 at 10:30 AM identified that the RN supervisor should have been notified the Prozac was not available, a phone call to the pharmacy should have been placed to determine why the medication had not been delivered, and that the unavailability and lack of administration of Resident #213's Prozac should have been reported to the physician. The DNs was unable to explain why LPN #4 failed to follow up when Resident #213's medication was not available. Review of facility policy titled, Ordering and Receiving Non-Controlled Medications, identified in part, medications and related products will be received from pharmacy on a timely basis . Licensed nurse promptly reports discrepancies and omissions to the issuing pharmacy and the charge nurse/supervisor.

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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 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 interviews, review of clinical records, facility documentation, and facility policy for 1 of 3 residents, (Resident #25) reviewed for dignity, and for 2 of 5 sampled residents (Resident #32 and #39) reviewed for abuse, the facility failed to report allegations of abuse to the State Agency. The findings include: 1. Resident #25's diagnoses included malignant neoplasm of the head, face, and neck, chronic heart failure, and post-traumatic stress disorder. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #25 had a Brief Interview of Mental Status (BIMS) score of 15 indicating no cognitive impairment, was dependent with personal hygiene and chair/bed-to-chair transfers and required maximal assistance in rolling left and right. The Resident Care Plan (RCP) dated 12/12/2024 identified Resident #25 had a problem with anxiety and agitation. Interventions included an assist of 2 at all times due to accusatory behavior, allow time to communicate effectively, and re-offer behavioral health services as needed. Interview on 6/4/2025 at 11:05 AM with Resident #25 identified that a few months ago, Nurse Aide (NA) #3 came into his/her room shaking her bootie and flashed the resident her breasts. Resident #25 stated that he/she notified NA #2 about the incident shortly after it had occurred, which resulted in NA #3 being taken off of his/her care assignment. Interview with NA #2 on 6/6/2025 at 11:52 AM identified that Resident #25 told him in February or March of 2025 that NA #3 had flashed her breasts at him/her. NA #2 stated he reported the incident to RN #5. NA #2 stated he had also reported the incident to the Administrator and was told by the Administrator that the incident was just a hallucination. NA #2 further indicated that NA #3 continued to report for work after he reported the incident, that she would still go into the resident's room, and that she would talk to the resident like a sex operator. NA #2 stated he was concerned that Resident #25 had NA #3's personal cell phone number. Interview with the Administrator on 6/6/2025 at 12:25 PM identified that a report had not been sent to the State Agency (SA) because he was unaware of the incident that had occurred between Resident #25 and NA #3. Subsequent to surveyor inquiry, the Administrator reported the allegation of sexual abuse to the SA on 6/6/2025 at 1:00 PM. A written statement by NA #3 dated 6/6/2025 at 2:19 PM identified that 2 co-workers had informed her in February of 2025 that Resident #25 had made an allegation against her that she had flashed her breasts in front of him/her during care. NA #3 stated that the allegations were reported by NA #2 to RN #5, who then reported the incident to the nurse supervisor RN #6. NA #3 further indicated that during a conversation with RN #6, she was directed not to return to Resident #25's room or provide care to him/her. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with NA #4 on 6/6/2025 at 4:01 PM identified that Resident #25 had informed her at 2:30 PM that NA #3 had flashed her breasts, but he/she didn't want to tell anyone about it now for fear of getting NA #2 in trouble. She further identified Resident #25 reported to her that while receiving care from NA #3 and NA #8, his/her genitalia were blown on by NA #8. NA #4 stated she had told the Administrator about the allegation of sexual abuse following which he had her write a statement. Interview with RN #6 on 6/9/2025 at 10:56 AM identified he had not been informed that NA #3 had flashed her breasts at Resident #25 but had taken NA #3 off the resident's care assignment due to a question of the resident using the call light too frequently when NA #3 was assigned to him/her. Further, RN #6 stated he failed to report his concerns to the Director of Nursing Services or the SA because the problem was already resolved and the resident had a care plan in place for accusatory behavior. Interview with NA #3 on 6/9/2025 at 3:28 PM identified that Resident #25 did have her personal cell phone number. She indicated she did not give her number to the resident, but another staff member did. NA #3 stated she had never flashed her breasts at Resident #25 and had been removed from his/her care assignment because of the allegation that she flashed him/her but had never been taken off the schedule following the allegation, only taken off Resident #25's assignment. Review of the facility's Abuse Policy identified that suspicion of any form of abuse should be reported to the Department of Public Health (State Agency) immediately but no later than 2 hours after the allegation after forming the suspicion. 2. Interview with the Administrator on 6/5/2025 at 3:11 PM identified that following Resident #4's report of a missing cell phone he went to interview Resident #4. Resident #4 indicated that both Resident #32's and Resident #39's cell phones had been missing. A. Resident #32's diagnosis included Chronic Obstructive Pulmonary Disease, anxiety, and depression. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #32 had a Brief Interview of Mental Status (BIMS) score of 12 indicating moderate cognitive impairment. Resident #32 required a wheelchair for mobility, and assistance with personal hygiene, bed mobility and all transfers. The Resident Care Plan in effect in May 2025 identified Resident #32 was on psychotropic medications related to a major depressive disorder and anxiety. Interventions directed staff to encourage participation in activities, observe for medication side effects, and administer medication as ordered. Review of the Facility Reported Incident (FRI) event dated 6/5/2025 at 3:30 PM identified Resident #32's cell phone had been missing for more than 3 weeks. The facility initiated an investigation and searched Resident #32's room and the Laundry Department but did not locate the phone. The facility notified the police, the MD and Resident #32's family. Education was provided to Resident #32 to utilize the lock box in the resident's room to store all personal items. According to the facility's investigation report, the facility failed to identify the allegation of a missing cell phone was previously reported by Resident #32 to a staff member. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Therapeutic Recreation Director (TRD) #1 on 6/10/2025 at 10:58 AM identified approximately 2 months prior, Resident #32 reported to her that he/she was missing a cell phone. TRD #1 reported that Resident #32 informed her of the missing cell phone while she was passing beverages from room to room. She stated she searched through Resident #32's belongings but could not locate the cell phone. In addition, she stated that she did not report the incident to the Administrator, nor did she complete a grievance. She did, however, reach out to the Director of Environmental Services (EVS) #1 and told him the cell phone was missing and to notify her if he found a phone in the laundry. TRD #1 acknowledged she should have reported the incident and completed a grievance, but stated, I really don't have a good answer for you as to why I did not report the missing cell phone. Observation and interview with Resident #32 on 6/10/2025 at 11:24 AM identified Resident #32's cell phone had been missing for approximately two weeks. Resident #32 believed it may have fallen off the tray table but stated he/she had told the facility Administrator the cell phone was missing. Interview with the Director of EVS #1 on 6/10/2025 at 12:18 PM identified he had been informed that Resident #32 was missing a cell phone and was asked to check the room and the laundry area. He searched both locations but did not find the cell phone. EVS #1 indicated he did not file a report because he assumed TRD #1 had already done so. He stated he would have expected the person who discovered Resident #32's phone was missing would report the issue to the Social Services Department and the Administrator. Interview with the Director of Nursing (DNS) on 6/10/2025 at 11:47 AM identified the DNS would have expected staff to report Resident #32's missing cell phone to either herself or the Administrator. She stated a grievance and incident report should have been completed and could not explain why this was not done. B. Resident #39's diagnosis included hemiplegia following a cerebral infarction, attention and concentration deficit, and major depressive disorder. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #39 had a Brief Interview of Mental Status (BIMS) score of 13 indicating no cognitive impairment. Resident #39 used a walker and wheelchair for mobility, and required extensive assistance with personal hygiene, bed mobility, and moderate assistance with all transfers. The Resident Care Plan dated 4/24/2025 identified Resident #39 was at risk for alterations in psychosocial well-being related to little or no interest in activities. Interventions directed staff to encourage Resident #39 to participate in activities of interest. Review of the Facility Reported Incident (FRI) event dated 6/5/2025 at 3:30 PM identified Resident #39's cell phone went missing approximately 3 weeks ago. The facility initiated an investigation and searched Resident #39's room and the laundry Department but did not find the phone. The police, the MD, and the family were notified of the incident. Education was provided to Resident #39 to utilize the lock box located in his/her room for storage of all personal items. According to the facility's investigation report, the facility failed to identify the allegation of the missing cell phone was previously reported to a staff member. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview with resident #39 on 6/10/2025 at 11:18 AM identified that Resident #39's cell phone had been missing for approximately 4 weeks. Resident #39 stated he/she normally kept the phone in the drawer and had informed NA #8 that the phone was missing. Resident #39 indicated that NA #8 thoroughly searched for the phone, but the phone was never found. Attempts to interview NA # 8 were unsuccessful. Interview with NA #4 on 6/10/2025 at 12:08 PM identified she was aware that Resident #39's cell phone was missing. She stated she did not report the issue as she had assumed it had already been addressed since several other nursing assistants were aware and had searched for the cell phone. NA #4 acknowledged that she should have reported the missing cell phone when she learned of the incident to the DNS or the Administrator. Interview with the DNS on 6/10/2025 at 12:35 PM identified per the facility policy, missing resident property should be reported immediately to either the DNS or the Administrator. The DNS could not explain why staff had failed to report Resident #39's missing cell phone. Interview with the facility Administrator on 6/10/2024 at 12:48 PM identified subsequent to surveyor inquiry, a Reportable Event form was completed and reported to the State Agency on 6/5/2025 at 3:30 PM and an investigation was initiated, along with police notification. During the facility's initial investigations of multiple reports of missing personal property (cell phones), he stated he had learned that some staff members may have been aware of the missing cell phones but had not reported the incident or filed a grievance. The Administrator stated he was unsure why staff failed to report the allegations and noted that the facility had recently been provided with an updated abuse policy and education was administered in April. The facility determined the allegations of the missing cell phones were unsubstantiated. Review of the Abuse Prohibition Policy directed, in part, all staff who have knowledge of apparent abuse or neglect of a resident or misappropriation of a resident's property shall be obligated to report such incidents to his or her immediate supervisor. Any allegation or suspicion of abuse must be reported to the DNS and Administrator. Reporting crimes must be reported to the State Regulatory Agency immediately, but not later than 2 hours.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, review of clinical records, facility documentation, and facility policy for 1 of 3 residents, (Resident #25) reviewed for dignity, the facility failed to investigate an allegation of sexual abuse and failed to remove the staff member from the schedule following the allegation. The findings include: Resident #25's diagnoses included malignant neoplasm of the head, face, and neck, congestive heart failure, and post-traumatic stress disorder. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #25 had a Brief Interview of Mental Status (BIMS) score of 15 indicating no cognitive impairment, was dependent with personal hygiene and chair/bed-to-chair transfers and required maximal assistance in rolling left and right. The Resident Care Plan (RCP) dated 12/12/2024 identified Resident #25 had a problem with anxiety and agitation. Interventions included an assist of 2 at all times due to accusatory behavior, allow time to communicate effectively, and re-offer behavioral health services as needed. Interview on 6/4/2025 at 11:05 AM with Resident #25 identified that a few months ago, Nurse Aide (NA) #3 came into his room shaking her bootie and flashed the resident her breasts. Resident #25 stated that he/she notified NA #2 about the incident shortly after it had occurred, which resulted in NA #3 being taken off of his/her care assignment. Interview with NA #2 on 6/6/2025 at 11:52 AM identified that Resident #25 told him in February or March of 2025 that NA #3 had flashed her breasts at him/her. NA #2 stated he reported the incident to RN #5. NA #2 stated he had also reported the incident to the Administrator and was told by the Administrator that the incident was just a hallucination. NA #2 further indicated that NA #3 continued to report for work after he reported the incident, that she would still go into the resident's room, sit on the bed, and would talk to the resident like a sex operator. NA #2 stated he was concerned that Resident #25 had NA #3's personal cell phone number. Interview with the Administrator on 6/6/2025 at 12:25 PM identified that the incident was not investigated because he was unaware of the incident that had occurred between Resident #25 and NA #3. Subsequent to surveyor inquiry, the Administrator reported the allegation of sexual abuse to the State Agency (SA) on 6/6/2025 at 1:00 PM and an investigation into the allegations commenced. A written statement by NA #3 dated 6/6/2025 at 2:19 PM identified that 2 co-workers had informed her in February of 2025 that Resident #25 had made an allegation against her that she had flashed her breasts in front of him/her during care. NA #3 stated that the allegations were reported by NA #2 to RN #5, who then reported the incident to the nurse supervisor RN #6. NA #3 further indicated that during a conversation with RN #6, she was directed not to return to Resident #25's room or provide care to him/her. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with NA #4 on 6/6/2025 at 4:01 PM identified that Resident #25 had informed her at 2:30 PM that NA #3 had flashed her breasts, but he/she didn't want to tell anyone about it now for fear of getting NA #2 in trouble. She further identified Resident #25 reported to her that while receiving care from NA #3 and NA #8, his/her genitalia were blown on by NA #8. NA #4 stated she had told the Administrator about the allegation of sexual abuse following which he had her write a statement. Interview with the Director of Nursing Service (DNS) on 6/9/25 at 8:50 AM identified that she was not notified by NA #2, RN #5, or RN #6 of the allegation of suspected abuse by NA #3 toward Resident #25. She was unable to explain why she was not notified of the allegation which would have allowed her to investigate at that time. Interview with RN #6 on 6/9/2025 at 10:56 AM identified he had not been informed that NA #3 had flashed her breasts at Resident #25 but had taken NA #3 off the resident's care assignment due to a question of the resident using the call light too frequently when NA #3 was assigned to the resident. Further RN #6 stated he failed to report his concerns to the Director of Nursing Services or the SA because the problem was already resolved and the resident had a previous care plan for accusatory behavior. Interview with NA #3 on 6/9/2025 at 3:28 PM identified that Resident #25 did have her personal cell phone number. She indicated she did not give her number to the resident, but another staff member did. NA #3 stated she had never flashed her breasts at Resident #25 and had been removed from his/her care assignment because of the allegation that she flashed him/her but had never been taken off the schedule following the allegation, only taken off Resident #25's assignment. Review of the facility's Abuse Reporting Policy identified, in part, the Administrator will be informed immediately of an allegation or suspicion of abuse, a thorough investigation of the alleged abuse will be investigated by the Administrator or Director of Nursing, and the resident involved in a case of suspected abuse will be protected from potential additional harm during the investigation. Upon notification of the allegation of abuse, the supervisor will take steps to protect the resident in question as well as other residents that may be affected. If someone is identified in the allegation, the person will be escorted to a non-resident area to be interviewed and document the events that allegedly occurred, and the identified alleged staff member will be suspended pending the outcome of the investigation.

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Villa Maria Nursing and Rehabilitation Community	20 Babcock Avenue Plainfield, CT 06374

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for 3 of 3 sampled residents (Resident #25, Resident #31, Resident #39) reviewed for care plans, the facility failed to review and revise the Resident Care Plan (RCP) and for Resident #31 failed to conduct Resident Care Plan Conferences per the requirement. The findings include: 1. Resident #25's diagnoses included malignant neoplasm of the head, face, and neck, chronic heart failure, and post-traumatic stress disorder. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #25 had a Brief Interview of Mental Status (BIMS) score of 15 indicating no cognitive impairment, was dependent with personal hygiene and chair/bed-to-chair transfers and required maximal assistance in rolling left and right. The Resident Care Plan (RCP) dated 12/12/2024 identified Resident #25 had a problem with anxiety and agitation. Interventions included an assist of 2 at all times due to accusatory behavior, allow time to communicate effectively, and re-offer behavioral health services as needed. Interview and review of clinical record review on 6/9/2025 at 11:37 AM with Social Worker (SW) #1 identified that a resident's care plan would be completed within 5 days of a Resident Care Conference (RCC). SW #1 was unable to determine when Resident #25's RCCs had occurred, as the MDS Coordinator, Licensed Practical Nurse (LPN) #1, was responsible for those records. Interview and review of clinical record on 6/9/2025 at 12:51 PM with SW #1 and LPN #1 identified that Resident #25 had RCCs on 4/4/2024, 9/12/2024, 10/10/2024, and 3/6/2025. SW #1 and LPN #1 identified the facility failed to update the care plan within 5-7 days, pre the requirement, of the 4/4/2024, 10/10/2024, and 3/6/2025 RCCs. Although LPN #1 stated she was responsible for updating the care plans, she was unable to identify why the care plans were not updated in a timely manner after the 3 RCCs held on 4/4/2024, 10/10/2024, and 3/6/2025. 2. Resident #31's diagnoses included dementia, type 2 diabetes, and anxiety. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #31 had a Brief Interview of Mental Status (BIMS) score of 1 indicating severe cognitive impairment, required moderate assistance with personal hygiene, upper and lower body dressing, and chair/bed-to-chair transfers. The Resident Care Plan (RCP) dated 6/4/2025 identified Resident #31 required staff assistance with his/her involvement in activities related to behavioral symptoms that may affect his/her participation. Interventions included to explain/ encourage the importance of social interaction, leisure activity time and participation, encourage to participate with activities of choice, and inform the resident that he/she may leave activities at any time, and was not required to stay for the entire activity. (continued on next page)

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview and review of clinical record on 6/9/2025 at 11:37 AM with Social Worker (SW) #1 identified that a RCP would be completed within 5 days of a Resident Care Conference (RCC). SW #1 was unable to determine when Resident #31's RCCs had occurred, as the MDS Coordinator, LPN #1, was responsible for those records. Interview and review of clinical record on 6/9/2025 at 12:59 PM with SW #1 and LPN #1 identified that RCCs should be held on a quarterly basis, once every 3 months. a. Resident #31 had RCCs on 4/4/2024, 6/27/2024, 10/31/2024, 4/24/2025 and 5/1/2025. SW #1 and LPN #1 identified the facility failed to update the care plan within 5-7 days of the 4/4/2024, 6/27/2024, 4/24/2025, and 5/1/2025 RCCs. Although LPN #1 stated she was responsible for updating the care plans, she was unable to identify why the care plan was not updated in a timely manner after the 4 RCCs held on 5/1/2025, 4/24/2025, 6/27/2024, and 4/4/2024. b. Resident #31 had a RCC on 10/31/2024 with the next RCC occurring on 4/24/2025 (a gap of 5 months and 24 days). SW #1 was unable to explain why the facility did not hold an RCC quarterly as required (every 3 months) from the date of the 10/31/2024 RCC, but did note there was a change in staffing during that time. 3. Resident #39's diagnoses included hemiplegia and hemiparesis, diabetes, and dementia. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #39 had a Brief Interview of Mental Status (BIMS) score of 12 indicating moderate cognitive impairment, required maximal assistance with lower body dressing and chair/bed-to-chair transfers. The Resident Care Plan (RCP) dated 10/24/2024 identified Resident #39 had an alteration in psychosocial well-being. Interventions included facilitation of Resident #39's opportunities to self-direct his/her care plan, allowing him/her to verbalize feelings, and encouraging him/her to verbalize pleasures and requirements to achieve peace and happiness. Interview and review of clinical record on 6/9/2025 at 11:37 AM with Social Worker (SW) #1 identified that a resident's care plan will be completed within 5 days of a Resident's Care Conference (RCC). She was unable to determine when Resident #39's RCCs had occurred, as the MDS Coordinator, Licensed Practical Nurse LPN #1, was responsible for those records. Interview and review of clinical record review on 6/9/25 at 12:51 PM with SW #1 and LPN #1 identified that Resident #39 had RCCs on 10/10/2024, 12/12/2024, 2/20/2025, and 4/24/2025. Further, SW #1 and LPN #1 identified the facility failed to update the care plan within 5-7 days of the 10/10/2024, 2/20/2025, and 4/24/2025 RCCs. Although LPN #1 stated she was responsible for updating the care plans, she was unable to identify why the care plan was not updated in a timely manner after the 3 RCCs held on 10/10/2024, 2/20/2025, and 4/24/2025. Review of the facility's Comprehensive Person-Centered Care Plan Policy identified, in part, that care plans will be developed no later than 7 days after the comprehensive MDS is completed, and that the care plan will be updated at least quarterly.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of clinical records, facility documentation, facility policy, and interviews for 1 of 5 residents, (Resident #13) reviewed for accidents, the facility failed to ensure that a resident with obvious deformities of the wrist and hip was not moved according to standards of practice and for the only sampled resident (Resident #212) reviewed for hospitalization, the facility failed to complete a Registered Nurse (RN) assessment for change in condition according to standards of practice. The findings include: 1. Resident #13 was admitted to the facility in November of 2024 with diagnoses that included dementia, depression, heart failure and hypertension. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #13 had a Brief Interview for Mental Status (BIMS) score of 12 indicating moderate cognitive impairment and required moderate assistance for personal hygiene and was independent for bed mobility and transfers. The Resident Care Plan (RCP) dated 2/27/2025, identified Resident #13 was at risk for falls. Interventions included use of appropriate footwear, remind the resident to request assistance prior to ambulation, keep the call light within reach, provide adequate lighting, and keep resident area free of clutter. A Reportable Event form dated 2/16/2025 at 3:20 AM written by Registered Nurse (RN) #3, identified that Resident #13 was in the dining room trying to throw something away and had tripped. Resident #13 was found on the floor with a head injury, left wrist deformity, and hip pain. RN #3 reported the fall as unwitnessed. An RN assessment was completed, neurological and vital signs were initiated, the physician was notified, and Resident #13 was transferred to the Emergency Department (ED) for further evaluation. Review of a nursing note dated 2/16/2025 at 3:49 AM written by RN #3 identified Resident #13 was sitting in dining room watching television throughout night. At approximately 3:20 AM, a loud thud was heard, and Resident #13 was found on the floor, against a wall, in the dining room. Resident #13 reported that he/she tripped while trying to throw something in the trash. Resident #13 was assessed while on the floor and had a visible deformity of left wrist, abrasion/black-and-blue to left temple, and complained of excruciating left hip pain. Resident #13's vital signs were all stable and there was no loss of consciousness reported. Resident #13 was assisted/lifted physically by 3 staff members from the floor to a chair. RN #3 applied ice and a splint to the left wrist, ice to the head injury, and off-loaded Resident #13's left hip to relieve pressure from the injury site. RN #3 further identified that based on the RN assessment and visible injuries, as well as fact that the resident had sustained a head injury while on a blood thinner, she made decision to send Resident #13 out to the Emergency Department (ED). The physician, resident's conservator, and family member were notified. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with RN #3 on 6/9/2025 at 7:40 AM identified that Resident #13 was a retired night shift worker, stayed awake most of the night, independently walked with a walker and had sustained multiple falls in the past without major injuries. RN #3 indicated that Resident #13 fell face down and by the time staff arrived she was sitting on the floor, leaning towards the wall. RN #3 indicated that she assessed Resident #13 while on the floor and noted a visible deformity on the left arm and the right leg was shorter (shortened, indicative of a hip fracture) more than the left leg. Resident #13 was then physically lifted from the floor to a chair by 3 staff members and the physician was notified of the fall once Resident #13 was in the chair. RN #3 further identified that she splinted Resident #13's left arm using a pillowcase across the chest, placed ice on his/her head and arm, and offloaded pressure against the right hip. During an interview with Physician #1 on 6/9/2025 at 1:50 PM he was unable to recall if he had been notified of Resident #13's fall on 2/16/2025. Physician #1 indicated that he no longer was a physician with the facility, so he was unable to retrieve his previous telephone logs from February 2025. Physician #1 identified that he did not recall the RN #3 discussing the extent of Resident #13's injuries with him. Although Physician #1 was unable to recall if he had been notified, he indicated that based on the extent of Resident #13's injuries, he would have expected RN #3 to follow the facility's standard practice not to move the resident until Emergency Medical Technician's (EMT) arrived. Interview with LPN #6 on 6/9/2025 at 3:00 PM identified that she responded with other staff to the fall. LPN #6 identified that Resident#13 was in pain and had an abrasion to his/her head but could not recall what she did to help Resident #13. Interview with NA #7 on 6/9/2025 at 4:30 PM identified that she assisted to transfer Resident #13 from the floor to the chair. Interview with NA #6 on 6/9/2025 at 4:40 PM identified that she assisted to transfer Resident #13 from the floor to the chair. NA #6 stated that 1 staff member was on each side of Resident #13 and that they, in a hook like fashion, took the resident under the arms, while a third staff member had the residents legs. They transferred Resident 13 from the floor to the chair. Review of the hospital records, radiological investigations (CT scan of the left hip) dated 2/16/2025 at 4:04 AM, identified an acute mildly displaced comminuted left femoral neck trans-trochanteric fracture with surrounding soft tissue swelling and x-ray of the left wrist identified a non-displaced distal radial fracture. Additionally, Resident #13 was being admitted to the hospital with a diagnosis of closed left hip fracture and closed fracture of the left radial bone due to a fall. Review of APRN #1's progress note dated 2/20/2025 at 10:30 AM, identified that Resident #13 had been readmitted back to the facility following a fall resulting in a femoral neck fracture and a non-displaced left distal radial fracture. Resident #13 was seen in consultation by orthopedics and underwent surgery on 2/27/2025, receiving a left femur intramedullary nail and closed reduction with splinting of her left distal radius fracture. Interview with the DNS on 6/10/2025 at 10:30 AM identified that based on injuries sustained by Resident #13, and described by RN #3, he/she should not have been physically lifted from the floor to the chair by staff. The DNS could not explain why Resident #13 was moved from the floor but indicated that he/she should not have been moved until EMS arrived. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy titled, Falls Response and Management, identified, in part, that residents who have fallen are assessed to determine if there is injury while maintaining the safety of the resident. If a resident falls, avoid moving the resident until status is fully evaluated to prevent further injury if an injury has occurred as a result of a fall. Determine the extent of the resident's injuries, note any deviations from the resident's baseline condition and notify the physician. If an injury is suspected, don't move the resident until a doctor examines them. 2. Resident #212 was admitted to the facility in November of 2024 with diagnoses that included end stage renal disease, diabetes, hypertension and personal history of transient ischemic attack (brief stroke like attack), and cerebral infarction (death of brain tissue) without residual deficits. The annual Minimum Data Set assessment dated [DATE] identified Resident #212 had a Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive impairment, required substantial/maximum assistance for personal hygiene, was dependent on bed to chair transfers and was receiving hemolytic treatment. The Resident Care Plan (RCP) in effect for the month of May of 2025 identified Resident #212 was on hemolytic treatment due to end stage renal failure. Interventions included administer/hold medications per the physician order, administer/monitor effectiveness of medications as ordered, check complete hemolytic treatment communication log record on return from hemolytic appointments for any reports, communicate with hemolytic center regarding medications, coordinate resident's care in collaboration with the hemolytic center, coordinate meals, activities, medications and treatments with the hemolytic center. A physician's order in effect for the month of May 2025 directed to send Resident #212 to hemolytic treatments 3 times per week on Tuesdays, Thursdays, and Saturdays and to administer Nitroglycerin (for chest pain) sublingual (under the tongue) 0.4 MG every 5 minutes as needed for chest pain up to 3 doses, if not relieved call the physician. Review of Resident #212's nurse's note by LPN #3 dated 5/16/2025 at 11:12 PM identified Resident #212 complained of chest pain and Nitroglycerin 0.4 mg was administered. A reassessment was performed at 12:00 AM and the resident's Blood Pressure (BP) was 131/61 (normal BP 120/80), and pulse oximetry 95% on oxygen at 2.5 liters per minute (lpm). Resident #212 denied any further chest pain, his/her color was pale, and the head of bead was elevated. The note failed to indicate the Resident #212 was seen by an RN. A nurse's note dated 5/17/2025 at 12:47 AM by LPN #3 identified Resident #212's BP was 80/40. The resident's BP was next taken, 7 hours later, at 7:48 AM, and noted to be 85/40. No further BP rechecks were documented prior to sending the resident for hemolytic treatment on the next shift. The note failed to document Resident #212 was seen by an RN or that the provider was notified of Resident #212's abnormally low BP. A nurse's note dated 5/17/2025 at 7:41 AM by LPN #3 identified that Resident #212 presented with increased lethargy, mild shortness of breath, diminished lung sounds, and was on oxygen at 2.5 lpm via nasal cannula. The note failed to document Resident #212 was seen by an RN or that the provider was notified of Resident #212's abnormally low BP. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and record review with LPN #5 on 6/6/2025 at 3:40 PM identified that she was the nurse taking care of Resident #212 on 5/17/2025 on the 7:00 AM to 3:00 PM shift. LPN #5 indicated that Resident #212 did not look good when she assumed his/her care at 7:00 AM and was unable to recall if she had rechecked the resident's vital signs as no vital signs were apparent in the clinical record. LPN #5 identified that although Resident #212 had received nitroglycerin, had a low BP on the night shift, and did not appear well once she assumed care, she had not informed the hemolytic center of the resident's change in condition prior to sending him/her for hemolytic treatment. Additionally, the note failed to document Resident #212 was seen by an RN or that the provider was notified of Resident #212's abnormally low BP. When Resident #212 returned from treatment in the evening, he/she was still unstable and was subsequently sent to the emergency room (ER). Interview with LPN #3 on 6/10/2025 at 9:12 AM identified that she notified RN #3 about Resident #212's change in condition on 5/17/2025 but that RN #3 did not notify the physician of the resident's change in condition on her shift. LPN #3 indicated that she did not recheck Resident #212's vital signs again until 7:48 AM (7 hours later) after Resident #212's initial presentation of his/her low BP that occurred at 12:47 AM. Additionally, LPN #3 stated that she had not notified the provider of the change in condition including increased lethargy, mild shortness of breath, and diminished lung sounds. Review of clinical record failed to identify RN #3 or any RN had assessed or documented Resident #212's change in condition or notified the physician. Interview with APRN #1 on 6/10/2025 at 10:00 AM identified that the physician should have been notified for hypotension (low BP) and for the change in condition. Interview with the DNS on 6/10/2025 at 11:10 AM identified that the physician should have been notified for Resident #212's change in condition and was unable to explain why none of the facility staff had done so. Attempts to contact RN #3 were unsuccessful. Review of facility's policy, Resident Change in Condition, identified in part, that a resident's change in condition will be reported immediately to the unit manager or shift nursing supervisor. The licensed nurse will assess the resident for signs and symptoms of physical or mental change of condition. If a change in condition is non emergent the licensed nurse will complete a progress note and all attempts of physician notification will be documented in the progress notes.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for the only sampled resident (Resident #212) reviewed for hospitalization, the facility failed to ensure appropriate communication with the hemolytic treatment center. The findings include: Resident #212's diagnosis included end stage renal disease, diabetes, hypertension, and cerebral infarction (death of brain tissue) without residual deficits. The annual Minimum Data Set assessment dated [DATE] identified Resident #212 had a Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive impairment, required substantial/maximum assistance for personal hygiene, was dependent on bed to chair transfers, and was receiving hemolytic treatment. The Resident Care Plan (RCP) in effect for the month of May of 2025 identified Resident #212 was on hemolytic treatment due to end stage renal failure. Interventions included administer/hold, monitor effectiveness of medications as ordered, check complete hemolytic treatment communication log record on return from hemolytic appointments for any reports, communicate with hemolytic center regarding medications, treatments, and coordination of care. A physician's order in effect for the month of May 2025, directed to send Resident #212 to hemolytic treatments 3 times per week on Tuesdays, Thursdays and Saturdays at 11:30AM. Review of the hemolytic treatment center's communication book and clinical record documentation of visits that occurred from 11/1/2024 through 6/5/2025 failed to identify documentation from the hemolytic treatment center. Additionally, a review of the nurse's notes from 11/1/2024 through 6/5/2025 failed to indicate facility staff had contacted the hemolytic treatment center to give information in regard to Resident #212's care, such as a list of diagnosis, current medications, contact information, dietary needs, the amount of assistance required for activities of daily living, fluid needs, or any changes in condition. Further review of nurse's notes identified a change in condition that occurred on 5/16/2025 at 11:12 PM and into 5/17/22025 when Resident #212 complained of chest pain and Nitroglycerin sublingual tablet 0.4 mg was administered. Subsequently the resident Blood Pressure (BP) was noted to drop to 80/40 on 5/17/2025 at 12:47AM and remained low 85/40 when the next BP was taken on 5/17/2025 at 7:48 AM. A nursing note dated 5/17/2025 at 7:41 AM by LPN #3 identified that Resident #212 presented with increased lethargy, presented with mild shortness of breath, and diminished lung sounds. Interview and record review with LPN #5 on 6/6/2025 at 3:40 PM identified that she was the nurse taking care of Resident #212 on 5/17/2025 on the 7:00 AM to 3:00 PM shift. LPN #5 indicated that Resident #212 did not look good when she assumed his/her care at 7:00 AM and was unable to recall if she had rechecked the resident's vital signs as no vital signs were apparent in the clinical record. LPN #5 identified that although Resident #212 had received nitroglycerin, had a low BP on the night shift, and did not appear well once she assumed care, she had not informed the hemolytic center of the resident's change in condition prior to sending him/her for hemolytic treatment. Additionally, when Resident #212 returned from treatment in the evening, he/she was still unstable and was subsequently sent to the emergency room (ER). (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and record review with RN #2 on 6/9/2025 at 10:30AM failed to identify facility documentation that had accompanied Resident #212 to the hemolytic treatment center since Resident #212's admission in November of 2024. RN #2 indicated that even though the facility had not completed any hemolytic documentation the issue had been identified, and documentation had been started on 6/7/2025. RN #2 indicated that night shift was responsible for completing the paperwork and could not identify why there was no documentation completed since Resident#212 was admitted to the facility. Interview with RN #5 (hemolytic treatment center nurse) on 6/10/2025 at 11:00AM identified that communication with the facility is done in the communication book/binder which contains both facilities and hemolytic center's communication paperwork. RN #5 indicated that there was no communication from the facility to the hemolytic center regarding Resident #212's change in condition on 5/17/2025. RN #5 indicated that Resident #212 presented with increased lethargy, increased shortness of breath and decreased blood pressure than his/her baseline upon arrival. RN#5 identified that hemolytic treatment physician was notified and hemolytic treatment was administered but at minimum level and resident was monitored closely every 15 minutes. A nursing note dated 5/17/2025 at 4:47 PM identified that Resident #212 returned from the homolytic center at 4:00 PM and was subsequently sent to the ED. Interview with the DNS on 6/10/2025 identified that she had identified that staff were not completing facility hemolytic documentation as required and she had recently re-educated staff. The DNS indicated that documentation/communication with the hemolytic center had been started on 6/7/2025. The DNS was unable to explain why staff had failed to complete the required documentation since Resident #212 was admitted to the facility in November of 2024. Review of Facility's Hemolytic Communication Tool identified that the facility nurse should complete the following: Medication given in the six (6) hours prior to sending resident out for dialysis treatment .signs of infection . any changes in condition or information. Review of facility's End Stage Renal Disease (ESRD), identified in part, that agreements between the facility and the contracted ESRD facility will include all aspects of how the resident's care will be managed including . how information will be exchanged between facilities.

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	075084	A. Building B. Wing	06/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa Maria Nursing and Rehabilitation Community	20 Babcock Avenue Plainfield, CT 06374

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interviews, and a temperature test, the facility failed to ensure that food was palatable and served at a safe and appetizing temperature. The findings included: Interview with Resident #4 on 6/05/2025 at 10:25 AM identified the food was cold and sometimes the meat was raw. Interview with Resident #59 on 6/4/2025 at 10:30 AM identified there was often cold toast, coffee, and eggs. Interview with Resident #47 on 6/4/2025 at 12:24 PM identified he is hungry even after eating and doesn't get enough food served at meals. Interview with Resident #8 on 6/6/2025 at 12:55 PM identified that the facility serves food that is cold. On 6/10/2025 at 11:26 AM a temperature check of the tray line was performed with the Dietary Director using the kitchen's calibrated thermometer as the first meal cart was being plated. The temperature of the potatoes was 168.1 degrees Fahrenheit (*F), chicken nuggets were 166.0 *F, cauliflower was 169.3 *F, and the coleslaw was 57.1 *F. Interview and observation with the Dietary Director on 6/10/2025 at 11:26 AM identified the temperature of the coleslaw should be served at no greater than 45 *F for safety and palatability. Subsequent to surveyor inquiry the container of coleslaw was placed back into the kitchen fridge by the Dietary Director who stated he would serve residents coleslaw in souffle cups when it was colder. Observation identified that plates with coleslaw already on them did not have the coleslaw removed from the plate. On 06/10/2025 a test/temperature tray conducted with the Dietary Director identified the lunch tray consisting of chicken nuggets and French fries, with no coleslaw, left the kitchen at 12:00 PM. The test tray arrived on the second floor at 12:02 PM and was delivered to residents starting at 12:02 PM. The last tray was delivered at 12:07 PM. The temperature of the test tray was conducted with the Dietary Manager at that time and identified the following: The chicken nuggets were 116.0 *F per the surveyor calibrated thermometer and the Dietary Manager's thermometer. The French fries internal temperature was 96.2 *F per the surveyor calibrated thermometer and 96.3 *F per the Dietary Manager's thermometer. Interview and observation with the Dietary Director on 6/10/2025 at 12:09 PM identified a palatable temperature for both the chicken nuggets and French fries should be 140 *F or above. He indicated the reason for the heat loss to the plate was due to the lid not holding the food's temperature properly. Interview on 6/10/2025 at 12:14 PM with the Administrator identified he was aware of resident complaints of cold food, and that the facility was looking into purchasing steam tables to provide a point of service option for residents. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation on 6/10/2025 at 12:18 PM identified that coleslaw was being delivered to the residents, 16 minutes after the trays were delivered to the dining room. Review of the facility's food preparation on serving policy identified, in part, that proper hot and cold temperatures are to be maintained during food service.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of clinical records, facility policy, and interviews for 1 of 3 residents (Resident #9) reviewed for infection control practices, the facility failed to ensure proper hand hygiene during wound care. The findings include: Resident #9's diagnoses included cellulitis of lower left limb, non-pressure chronic ulcer of left lower leg, and congenital deformities of feet. The Minimum Data Set assessment dated [DATE] identified Resident #9 had a Brief Interview for Mental Status score of 15 indicating no cognitive impairment and was dependent for chair/bed to chair transfer and required partial/moderate assistance for turning/repositioning in bed. The Resident Care Plan dated 5/14/2025 identified Resident #9 had DTIs (deep tissue injuries) to bilateral heels. Interventions included providing wound care treatment as ordered, soft boots to be worn at all times while in bed, and off load heels in bed at all times with pillows or bunny boots. A physician's order dated 5/20/2025 directed nursing staff to clean the left heel with wound cleanser, pat dry and apply xeroform, followed by the application of a bordered gauze every day shift and as needed. A physician's order dated 5/22/25 directed nursing staff to clean the right heel with wound cleanser, pat dry and apply xeroform, followed by the application of a bordered gauze every day shift. An observation of wound care and interview with LPN #4 on 6/5/2025 at 2:12 PM identified LPN #4 had removed the old dressing from the Resident #9's right heel, removed her gloves, and reapplied gloves without performing hand hygiene. LPN#4 cleansed the right heel and applied the xeroform. LPN #4 then removed her gloves and applied a new pair of gloves, again without the benefit of hand hygiene. LPN #4 was interrupted by the surveyor and identified that hand hygiene should have been performed before and after each glove change. Continued observation of LPN #4, who was now performing the left heel dressing, identified she did not perform hand hygiene or change gloves between removal of soiled dressing and cleansing of left heel wound. LPN #4 then she removed gloves, performed hand hygiene, donned new gloves and applied bordered gauze dressing to left heel. LPN#4 removed her gloves at the completion of dressing change and performed hand hygiene. Interview with DNS on 6/6/2025 8:31 AM identified that hand hygiene should be done before care, with each glove change, and when care is complete. Interview with Infection Preventionist/ Staff Development, Registered Nurse (RN) #1 on 6/9/2025 at 9:48 AM, identified that hand hygiene and glove changes would be expected upon entry into a resident room, after initial wound cleansing, when applying a clean dressing and after dressing completion. Review of the Pressure Ulcers Definitions, Management & Treatment Policy instructed, in part, that nursing staff were to remove their gloves and wash or sanitize their hands immediately after removal of a soiled dressing. The policy also instructs staff to sanitize or wash hands and put on clean gloves prior to cleansing the wound and applying the ordered dressing. Per this policy, gloves should be removed after wound treatment is complete followed by hand hygiene.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for 3 of 5 residents (Resident #28, Resident #48, Resident #58) reviewed for immunizations, the facility failed to identify Covid 19 vaccination status, offer the Covid 19 vaccination (or provide information where to obtain), and failed to educate the resident on the risks and benefits of Covid 19 vaccinations. The findings include: 1. Resident #28's diagnoses included cellulitis, lymphedema, and diabetes. The admission Minimum Data Set assessment dated [DATE] identified Resident #28 had a Brief Interview for Mental Status (BIMS) of 15 identifying cognitively intact and required set-up assistance with personal hygiene, substantial maximum assistance with dressing, and bed mobility. The Covid 19 immunization status was noted to not be up to date. The Resident Care Plan dated 5/6/2025 failed to reflect the Covid 19 vaccination status or that education provided for vaccination. Review of the electronic health record for immunizations failed to identify the Covid 19 vaccination was offered, or that vaccine education was provided. Review of the physician's order dated May 2025 did not direct any orders related to the Covid 19 vaccination. 2. Resident #42's diagnosis included end stage renal disease, diabetes and protein calorie malnutrition. The admission baseline Resident Care Plan dated 4/15/2025 failed to reflect the Covid 19 vaccination status or that education provided for vaccination. The Minimum Data Set, dated [DATE] identified the Brief Interview for Mental Status (BIMS) score of 13 which indicated cognitively intact, required partial moderate to substantial maximum assistance with dressing, substantial maximum assistance with bed mobility, and total assistance with transfers. The Covid 19 vaccination status was not up to date. Review of the electronic health record for immunizations failed to identify the Covid 19 vaccination was offered, or that vaccine education was provided. A physician's order dated 6/8/2025 did not direct any orders related to the Covid 19 vaccination. 3. Resident #58's diagnosis included Alzheimer's disease, rheumatic tricuspid insufficiency, and chronic kidney disease. The admission baseline Resident Care Plan dated 5/20/2025 failed to reflect the Covid 19 vaccination status or that education provided for vaccination. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Minimum Data Set assessment dated [DATE] identified the Brief Interview for Mental Status (BIMS) score of 0 indicating severely cognitively impaired and required, partial moderate assistance with bed mobility and transfer, and substantial maximum to total assistance with dressing. The Covid Vaccination status was not up to date. Review of the electronic health record for immunizations failed to identify the Covid 19 vaccination was offered, or that vaccine education was provided. A physician's order dated 6/9/2025 did not direct any orders related to the Covid 19 vaccination. Interview review of the clinical record review, and review of the vaccination report on 6/9/2025 at 12:50 PM with Registered Nurse (RN) #1, the Infection Preventionist (IP), failed to identify that Resident #28, Resident #42 and Resident #58 had their Covid 19 vaccination status obtained or that education regarding receiving the Covid 19 vaccination had been provided. Additionally, none of the residents appeared on the vaccination log. RN #1 indicated that staff were no longer required to offer the Covid 19 vaccination to residents or track a residents Covid 19 vaccination history. Review of the Covid 19 vaccination requirements for residents and staff policy dated 4/14/2025 directed, in part, to ensure education of resident or resident representatives with regard to the benefits and potential side effects associated with the COVID-19 vaccine. The vaccine is offered unless it is medically contraindicated, or the resident has already been immunized. Additionally, the facility will maintain appropriate documentation to reflect that the facility provided the required COVID-19 vaccine education and whether the residents received the vaccine.