STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075113	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greentree Manor Nursing and Rehabilitation Center	4 Greentree Drive Waterford, CT 06385

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 documentation, facility policy, and interviews, for one (1) of three (3) sampled residents (Resident #1) reviewed for change in condition, the facility failed to ensure the provider was notified of changes in the resident's status following an unwitnessed fall with a head injury. This included failure to notify the provider timely of increasing confusion, continued pain, uncompleted diagnostic imaging, and worsening symptoms. These failures resulted in delayed evaluation and delayed care. The findings include:Resident #1's diagnoses included dementia without behavioral disturbances, repeated falls, muscle weakness, and unsteadiness on feet.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 was severely cognitively impaired and unable to make reasonable and consistent decisions regarding tasks of daily living (Brief Interview for Mental Status (BIMS) score of 2), was dependent on staff for bed mobility, required substantial assistance for transfers, and was independent with mobility using a manual wheelchair. It also identified Resident #1 had more than two (2) falls since admission, one (1) with injury.The Resident Care Plan (RCP) dated 1/26/26 identified Resident #1 was at risk for falls related to three (3) prior falls, deconditioning, generalized weakness, and dementia, and required assistance with Activities of Daily Living (ADLs). Interventions included providing an assist of one (1) with transfers, reminding the resident to call for assistance, maintaining a clutterˆfree environment, and providing frequent checks while in the room.A Post Fall Evaluation note by RN #1 dated 3/18/26 at 8:08 PM identified that at 7:20 PM Resident #1 had an unwitnessed fall after climbing out of bed independently and blood was noted coming from the nose. Vital signs were within normal limits, Resident #1 complained of 6/10 left lowerˆleg pain, and the APRN and responsible party were notified. A nurse's note at 9:00 PM identified that Resident #1 was assessed, assisted back to bed, and monitored per protocol.A nurse's note by the former DON dated 3/18/26 at 9:17 PM identified Resident #1 complained of left shoulder pain when the arm was raised. The onˆcall provider was notified, a left shoulder xˆray was ordered, and the diagnostic provider confirmed receipt. A physician's order dated 3/18/26 directed a two (2) view xˆray of the left shoulder.A nurse's note by LPN #5 dated 3/19/26 at 11:58 AM identified Resident #1 was alert and confused, received tramadol for left shoulder pain, and was selfˆpropelling into walls and objects. LPN #5 notified the nursing supervisor (RN #2) and documented that safety was maintained.A social services note dated 3/19/26 at 3:35 PM identified increased confusion, inability to determine spatial orientation, continued bumping into walls and objects, and leaning in the wheelchair, and noted the resident was being monitored by nursing.Review of the clinical record failed to identify documentation from RN #2 dated 3/19/26 or documentation that a provider was notified of the change in condition, despite changes identified beginning at 11:58 AM (nearly four hours earlier). The record also failed to identify that the left shoulder xˆray ordered on 3/18/26 was obtained or resulted.A nurse's note by RN #1 dated 3/19/26 at 6:18 PM identified Resident #1 was sent to the ED around 4:00 PM due to increased confusion and red spots under both eyes following the unwitnessed fall the previous day and identified the APRN requested transfer for evaluation.Ambulance documentation identified a call from the facility on 3/19/26 at 3:55 PM (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	reporting altered mental status following the fall the previous day. Upon arrival at 4:13 PM, Resident #1 was seated near the nurse's station with facial bruising around the eyes and guarding of the left arm and shoulder. Staff reported lowerˆthanˆusual responsiveness and that Emergency Services had not been called at the time of the fall. Resident #1 left the facility at 4:28 PM.Hospital documentation dated 3/19/26 identified imaging results showed a closed fracture of the proximal end of the left humerus and a closed fracture of the nasal bone. Resident #1 was discharged back to the facility with a left arm sling.Interview with APRN #1 on 5/8/26 at 11:43 AM identified she was notified on 3/18/26 at 7:13 PM of an unwitnessed fall, active bleeding, and uncertainty regarding the source. She ordered immediate ED transfer. At 9:00 PM, the facility reported the resident was not transferred because bleeding was believed to be nasal, and staff requested a left shoulder xˆray instead. On 3/19/26 at 3:00 PM, LPN #5 notified the APRN of increased confusion, raccoon eyes, and difficulty moving the shoulder. The APRN identified the resident should have been transferred immediately following the 7:13 PM order and staff should not have waited nearly two hours to report they chose not to follow it. She indicated the facility should have notified the provider when the xˆray could not be obtained, should have followed up on diagnostic timing, and should not have waited until 3:00 PM to report continued confusion and pain.Interview with Person #2 (diagnostic representative) on 5/8/26 at 11:58 AM identified the xˆray was called in on 3/18/26 at 9:17 PM as ASAP (within 6-8 hours) but not STAT. Person #2 indicated they notified the facility at 9:30 PM that no technician was available until the next day. On 3/19/26 at 4:30 PM, a technician arrived but Resident #1 had already been sent to the ED and the xˆray was never obtained.Interview with RN #1 on 5/8/26 at 1:40 PM identified Resident #1 frequently got out of bed without calling for assistance and was found on the floor with blood on the face and floor. She called the onˆcall provider, received the order to send the resident to the ED, and assessed the resident. She indicated the DON and RN #3 reassessed Resident #1 later and determined the resident did not need ED evaluation, but she was unsure why the provider was not contacted immediately regarding that decision. RN #1 identified that when she returned the next day, the resident was already being transferred to the ED and she documented a summary note.Interview with LPN #5 on 5/8/26 at 12:54 PM identified she observed Resident #1 selfˆpropelling into walls around 11:00 AM on 3/19/26, which was not baseline. She medicated the resident and notified RN #2 regarding the change in cognition, pain, and the absence of the xˆray technician. LPN #5 eventually called the onˆcall provider at 3:00 PM but indicated she could not recall why notification was delayed.Interview with RN #2 on 5/8/26 at 2:26 PM identified she could not recall being notified of changes on 3/19/26 and indicated that if she did not document an assessment or provider notification, she could not confirm she was informed.Interview with the Regional Nurse/Interim DON and RN #3 on 5/8/26 at 3:05 PM identified the resident should have been transferred immediately after the initial ED order at 7:13 PM. They identified the provider should have been notified when staff chose not to send the resident, when the diagnostic provider reported the xˆray delay, and when changes in cognition continued. They indicated an RN assessment should have occurred and been documented with the change in condition and identified a delay in notifying the provider and a delay in care following the 3/18/26 fall.Although attempted, an interview with the former DON was not obtained.Review of the Change in Condition, Change in Treatment/Services policy (undated) directed that the provider must be immediately informed following an accident with injury, significant physical, mental, or psychosocial change, or when treatment needs to be altered. The policy required the Charge Nurse to notify the RN Supervisor, who completes an assessment and notifies the physician and responsible party; and required documentation of all notification attempts. Examples of change in condition included behavioral changes, neurological changes, and falls.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for one (1) of three (3) sampled residents (Resident #1) reviewed for falls, the facility failed to ensure adequate supervision and assistive measures to prevent accidents. Specifically, the facility failed to address the resident's repeated behaviors of getting out of bed independently despite requiring assistance, resulting in an unwitnessed fall with injuries, and failed to ensure the resident was transferred to and evaluated timely in the Emergency Department (ED) following an identified head injury, limited range of motion, and complaints of pain. The findings include:Resident #1's diagnoses included dementia without behavioral disturbances, repeated falls, muscle weakness, and unsteadiness on feet.A Fall Evaluation dated 1/12/26 identified Resident #1 was a medium risk for falls.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 was severely cognitively impaired and unable to make reasonable and consistent decisions regarding tasks of daily living (Brief Interview for Mental Status (BIMS) score of 2), was dependent on staff for bed mobility, required substantial assistance for transfers, and was independent with mobility in a manual wheelchair. The MDS identified Resident #1 had experienced more than two (2) falls since admission, including one (1) with injury.The Resident Care Plan (RCP) dated 1/26/26 identified Resident #1 was at risk for falls related to three (3) previous falls, deconditioning, generalized weakness, and dementia and required assistance with Activities of Daily Living (ADLs). Interventions included providing an assist of one (1) with transfers, identifying the resident was nonˆambulatory, reminding the resident to call for assistance, maintaining a clutterˆfree environment, and providing frequent checks while in the room.A Post Fall Evaluation note by RN #1 dated 3/18/26 at 8:08 PM identified that at 7:20 PM Resident #1 had an unwitnessed fall after climbing out of bed. Blood was noted coming from the nose, vital signs were within normal limits, and the resident complained of six (6) out of ten (10) left lowerˆleg pain. The APRN and responsible party were notified.A nurse's note by RN #1 dated 3/18/26 at 9:00 PM identified Resident #1 was assessed, assisted back into bed, and monitored per facility protocol.Review of the March 2026 Medication Administration Record (MAR) identified an order dated 6/19/25 for tramadol 25 milligrams (mg) by mouth every six (6) hours as needed for moderate to severe pain. The MAR identified Resident #1 was administered tramadol 25 mg on 3/18/26 at 9:03 PM, one hour and fortyˆthree minutes after the documented pain of 6/10, and the medication was noted as effective.A nurse's note by the former DON dated 3/18/26 at 9:17 PM identified Resident #1 complained of left shoulder pain when the arm was flexed above the head. The onˆcall provider was notified, a left shoulder xˆray ordered, and a confirmation number obtained from the diagnostic provider.A physician's order dated 3/18/26 directed a two (2) view xˆray of the left shoulder.A nurse's note by LPN #5 dated 3/19/26 at 11:58 AM identified Resident #1 was alert and confused, was administered tramadol for left shoulder pain, and was selfˆpropelling in a wheelchair and bumping into walls and objects. LPN #5 identified she notified the nursing supervisor (RN #2).A social services note dated 3/19/26 at 3:35 PM identified Resident #1 had increased confusion, was unable to determine positioning relative to objects and walls, continued bumping into objects, and was leaning in the wheelchair.Review of the clinical record failed to identify documentation from RN #2 dated 3/19/26 or documentation that a provider was notified of the change in condition, despite the change being identified around 11:58 AM. Review also failed to identify that the left shoulder xˆray had been obtained.A nurse's note by RN #1 dated 3/19/26 at 6:18 PM identified Resident #1 was sent to the ED around 4:00 PM due to increased confusion and red spots under both eyes following the unwitnessed fall the prior day. The APRN was notified and directed the transfer.The ambulance run sheet identified a call received on 3/19/26 at 3:55 PM, reporting Resident #1 had an unwitnessed fall the previous day and was now displaying altered mental status. Upon arrival at 4:13 PM, Resident #1 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was seated near the nurse's station with facial bruising and guarding of the left arm/shoulder. Staff reported lower responsiveness than usual and confirmed Emergency Services had not been contacted after the fall.Hospital documentation dated 3/19/26 identified a closed fracture of the proximal end of the left humerus and a closed fracture of the nasal bone. Resident #1 was discharged back to the facility with a left arm sling.Interview with APRN #1 on 5/8/26 at 11:43 AM identified she was notified on 3/18/26 at 7:13 PM of an unwitnessed fall with active bleeding on the right side of the head and ordered immediate ED transfer. At 9:00 PM, staff reported the resident was not transferred because bleeding was believed to be nasal and requested a left shoulder xˆray instead. On 3/19/26 at 3:00 PM, LPN #5 notified the APRN of increased confusion, raccoon eyes, and difficulty moving the shoulder, and an ED transfer order was given.Interview with Person #2 (diagnostic representative) on 5/8/26 at 11:58 AM identified the xˆray was called in as ASAP, requiring completion within six (6) to eight (8) hours. Person #2 reported they notified the facility at 9:30 PM that no technician was available until the next day and no timeframe was provided.Interview with RN #1 on 5/8/26 at 1:40 PM identified Resident #1 frequently got out of bed without calling for assistance and was found lying on the left side with blood noted on the face and floor. She called the onˆcall provider and received the order to send the resident to the ED. She identified the DON and RN #3 reassessed Resident #1 later and determined transfer was unnecessary, but the APRN was not notified of this decision.Interview with LPN #3 on 5/8/26 at 2:16 PM identified Resident #1 often got out of bed without calling and had never been on documented frequent checks. She reported she administered tramadol at approximately 9:00 PM after RN #1 reported pain.Interview with NA #1 on 5/8/26 at 2:55 PM identified she assisted Resident #1 to bed forty (40) minutes before the fall but had not checked again due to caring for other residents.Interview with LPN #5 on 5/8/26 at 12:54 PM identified she observed Resident #1 bumping into walls around 11:00 AM on 3/19/26 and complaining of left shoulder pain. She medicated the resident and notified RN #2, who she believed was responsible for provider notification. She eventually contacted the APRN at 3:00 PM.Interview with RN #2 on 5/8/26 at 2:26 PM identified she did not recall being notified of changes and stated that without documentation she could not verify being informed.Interview with the Director of Rehab on 5/8/26 at 12:45 PM identified Resident #1 was an assist of one (1) for transfers, nonˆambulatory, and independent with wheelchair mobility. She identified therapy was not reˆconsulted despite reports of unsafe selfˆtransferring.Interview with the Regional Nurse/Interim DON and RN #3 on 5/8/26 at 3:05 PM identified Resident #1 should have been transferred immediately following the ED order at 7:13 PM, and the APRN should have been notified when staff chose not to transfer the resident and when imaging could not be obtained. They stated an RN assessment should have been completed and documented when cognition changed and identified a delay in care following the fall.Although attempted, an interview with the former DON was not obtained.Review of the Fall Risk Assessment policy (undated) directed staff to identify and document fall risk factors and develop a residentˆcentered fall prevention plan based on assessment information, including evaluation of functional, psychosocial, and environmental contributors.Review of the Change in Condition, Change in Treatment/Services policy (undated) directed that the provider must be immediately informed when an accident results in injury, there is a significant change in status, or treatment must be altered. The policy required RN assessment, documentation, and timely physician notification.A facility policy for xˆrays and diagnostic imaging orders was requested but not provided.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management 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 one (1) of three (3) sampled residents (Resident #1) reviewed for falls, the facility failed to ensure the resident's pain was treated timely following a fall with head trauma and identified pain. The findings include:Resident #1's diagnoses included dementia without behavioral disturbances, repeated falls, muscle weakness, and unsteadiness on feet.Physician's orders dated 6/19/25 directed tramadol 25 milligrams (mg), one (1) tablet by mouth every six (6) hours as needed for moderate to severe pain. A physician's order dated 7/8/25 directed acetaminophen 325 mg, two (2) tablets by mouth every six (6) hours as needed for pain or fever.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 was severely cognitively impaired (Brief Interview for Mental Status (BIMS) score of 2), dependent on staff for bed mobility, required substantial assistance for transfers, and was independent with mobility in a manual wheelchair.The Resident Care Plan (RCP) dated 1/26/26 identified Resident #1 was at risk for pain related to deconditioning and immobility and at risk for falls due to three (3) previous falls, deconditioning, generalized weakness, and dementia. Interventions included assessing characteristics of pain, administering pain medications as ordered, providing an assist of one (1) with transfers, reminding the resident to call for assistance, maintaining a clutterˆfree environment, and providing frequent checks while in the room.A Post Fall Evaluation by RN #1 dated 3/18/26 at 8:08 PM identified that at 7:20 PM Resident #1 had an unwitnessed fall after climbing out of bed. Blood was noted coming from the nose, vital signs were within normal limits, and Resident #1 complained of 6/10 pain to the left lower leg. The APRN and responsible party were notified. A nurse's note dated 3/18/26 at 9:00 PM identified that an assessment was completed, Resident #1 was helped back into bed, and monitoring continued per protocol.Review of the March 2026 Medication Administration Record (MAR) identified Resident #1 was administered tramadol 25 mg on 3/18/26 at 9:03 PM-one hour and fortyˆthree minutes after the fall-for 6/10 pain, which was effective.A nurse's note by the former DON dated 3/18/26 at 9:17 PM identified Resident #1 complained of left shoulder pain when the arm was flexed above the head. The onˆcall provider was notified, a left shoulder xˆray was ordered and called into the diagnostic provider, and a confirmation number obtained. The responsible party was notified.A nurse's note by LPN #5 dated 3/19/26 at 11:58 AM identified Resident #1 was alert and confused, tramadol was administered for left shoulder pain, and Resident #1 was selfˆpropelling into walls and objects. RN #2, the nursing supervisor, was notified. The note identified no new injuries, that Resident #1 was reoriented as needed, and was seated at the nurse's station.Review of the clinical record failed to identify documentation from RN #2 dated 3/19/26 or documentation that a provider was notified of the change in cognition or pain, despite the change being identified at 11:58 AM (nearly four hours earlier). The record also failed to identify that an RN assessed Resident #1's pain. Review additionally failed to identify the resident was offered or administered pain medication prior to transfer to the ED.A nurse's note by RN #1 dated 3/19/26 at 6:18 PM identified Resident #1 was sent to the ED around 4:00 PM due to increased confusion and red spots under both eyes following the unwitnessed fall the previous day and that the APRN requested evaluation.Hospital documentation dated 3/19/26 identified imaging showed a closed fracture of the proximal end of the left humerus and a closed fracture of the nasal bone. Resident #1 was discharged back to the facility with a left arm sling.Interview with RN #1 on 5/8/26 at 1:40 PM identified that on 3/18/26 Resident #1 was found on the floor lying on the left side with a moderate amount of blood on the face and floor. She contacted the onˆcall provider, received instructions to send Resident #1 to the ED, and then assessed the resident. She reported Resident #1 complained of moderate leg pain but did not recall if she notified the charge nurse. She identified the DON and RN #3 reassessed the resident and, despite complaints of left shoulder pain, determined Resident #1 did not need to be transferred and the onˆcall provider was notified for a shoulder xˆray instead. RN #1 (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reported that when she arrived the next day, Resident #1 was already being transferred to the ED, and she completed a summary note. She identified she could not recall whether Resident #1 complained of or displayed signs of pain prior to transfer but stated staff should have assessed, documented, and administered pain relief as needed before transfer.Interview with LPN #5 on 5/8/26 at 12:54 PM identified she observed Resident #1 self˜propelling into walls around 11:00 AM on 3/19/26 and complaining of left shoulder pain. She medicated the resident and notified RN #2. She stated she did not recall the last time she saw Resident #1 prior to the end of her shift and indicated that had the resident been sent to the ED during her shift, she would have offered pain medication.Interview with RN #2 on 5/8/26 at 2:26 PM identified she could not recall sending Resident #1 to the ED on 3/19/26, but if the resident was transferred due to cognition changes and left shoulder pain, pain medication should have been offered prior to transfer.Interview with the Regional Nurse/Interim DON and RN #3 on 5/8/26 at 3:05 PM identified staff should document all care provided prior to the end of their shift. RN #3 reported she was present on 3/18/26 after the fall and Resident #1 complained of left shoulder pain and should have been medicated for pain relief and should not have waited until after 9:00 PM. They further identified Resident #1 was transferred to the ED for a change in cognition and left shoulder pain and should have been offered pain relief medication prior to transfer.Although attempted, an interview with the former DON was not obtained.Review of the Pain Assessment and Management policy (undated) directed that pain management is based on the resident's condition and treatment goals and requires a comprehensive pain assessment upon admission, quarterly, with significant changes, and with new or worsening pain. Staff are to observe for signs of pain, ask the resident about pain, review medication administration patterns, and ensure interventions reflect the type and severity of pain and underlying causes.Review of the Change in Condition, Change in Treatment/Services policy (undated) directed that the physician must be immediately informed when there is an accident with injury, significant physical, mental, or psychosocial change, or when treatment must be altered. The policy required the Charge Nurse to notify the RN Supervisor, who completes an assessment, documents findings, and notifies the physician and responsible party.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 review of the clinical record, facility documentation, facility policy and interviews for one (1) of three (3) sampled residents (Resident #1) reviewed for falls, the facility failed to ensure a full RN assessment was documented following a fall with injury, including documentation of the time the provider was notified, and failed to ensure pain medication was signed out under the correct licensed nurse's name in the Medication Administration Record (MAR). The findings include:Resident #1's diagnoses included dementia without behavioral disturbances, repeated falls, muscle weakness, and unsteadiness on feet.A physician's order dated 6/19/25 directed tramadol 25 milligrams (mg), one (1) tablet by mouth every six (6) hours as needed for moderate to severe pain.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 was severely cognitively impaired (Brief Interview for Mental Status (BIMS) score of 2), dependent on staff for bed mobility, required substantial assistance for transfers, and was independent with mobility in a manual wheelchair.The Resident Care Plan (RCP) dated 1/26/26 identified Resident #1 was at risk for pain related to deconditioning and immobility and at risk for falls due to three (3) prior falls, deconditioning, generalized weakness, and dementia, and required assistance with Activities of Daily Living (ADLs). Interventions included assessing pain characteristics, administering pain medications as ordered, providing an assist of one (1) with transfers, reminding the resident to call for assistance, maintaining a clutterˆfree environment, and providing frequent checks while in the room.A Post Fall Evaluation note by RN #1 dated 3/18/26 at 8:08 PM identified that at 7:20 PM Resident #1 had an unwitnessed fall after climbing out of bed independently. Blood was noted coming from the nose, vital signs were within normal limits, and Resident #1 complained of 6/10 left lowerˆleg pain. The APRN and responsible party were notified. The note failed to identify a full assessment, including range of motion to all extremities, neurological signs, or the time the provider was notified.A nurse's note by RN #1 dated 3/18/26 at 9:00 PM identified that an assessment was completed and Resident #1 was assisted back into bed and monitored per protocol. The note failed to identify a full assessment, including range of motion and neurological signs following a fall with a head injury.Interview with RN #1 on 5/8/26 at 1:40 PM identified she completed a full assessment, including range of motion and neurological checks, but failed to document it. She identified she could not recall the time she called the onˆcall provider because she did not document the notification time and reported that she should have.Review of the March 2026 MAR identified Resident #1 was administered tramadol 25 mg on 3/18/26 at 9:03 PM for 6/10 pain. The MAR listed LPN #5 as administering the medication.Review of the facility's staffing schedule for 3/18/26 identified LPN #5 did not work the 3:00 PM to 11:00 PM shift that day; LPN #3 was scheduled.Review of the Controlled Substance Disposition Record for tramadol, dated as received on 6/19/25, identified LPN #3 administered the tramadol 25 mg tablet to Resident #1 on 3/18/26 at 9:03 PM.Interview with LPN #5 on 5/8/26 at 1:27 PM identified she did not work the 3:00 PM to 11:00 PM shift on 3/18/26 and left at 3:00 PM. She was unsure why the MAR identified she administered tramadol at 9:03 PM and indicated she should always log out of the computer before leaving her shift to ensure accurate documentation.Interview with LPN #3 on 5/8/26 at 2:16 PM identified she administered the tramadol 25 mg tablet at 9:03 PM per the Controlled Substance Disposition Record and was unaware the administration was documented under LPN #5's name. She identified she should ensure she is logged into the computer under her own credentials before documenting.Interview with the Regional Nurse/Interim DON and RN #3 (Staff Development nurse) on 5/8/26 at 3:05 PM identified licensed nurses should document a full assessment, including range of motion and neurological signs, following a fall with injury and should document the time of provider notification. They identified they were unaware that the tramadol administered on 3/18/26 was documented under the wrong nurse's name and stated licensed nurses should ensure they log out (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075113	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greentree Manor Nursing and Rehabilitation Center	4 Greentree Drive Waterford, CT 06385

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of the computer before leaving the shift and that oncoming nurses log in with their own credentials to ensure complete and accurate documentation.Review of the Change in Condition, Change in Treatment/Services policy (undated) directed that the physician must be immediately informed when an accident results in injury, when there is a significant change in physical, mental, or psychosocial status, or when treatment must be altered. The policy required the Charge Nurse to notify the RN Supervisor, who completes an SBAR assessment, documents findings in the clinical record, and documents the resident's response to symptoms such as pain, anxiety, or discomfort.Review of the Charting and Documentation policy dated 3/2023 directed that all services provided to the resident, progress toward care plan goals, and any changes in medical, physical, functional, or psychosocial condition must be documented. Documentation must include date and time, name and title of the staff member, assessment data, unusual findings, how the resident tolerated treatment, and notification of family, physician, or other staff.