STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075158	A. Building B. Wing	06/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New London Sub-Acute and Nursing	90 Clark Lane Waterford, CT 06385

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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	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility policy and interviews for one (1) of eleven (11) residents (Resident #1) reviewed for medication administration, the facility failed to ensure the provider was notified of a change in condition when it was identified that the resident was having difficulty swallowing. The findings include:Resident #1 's diagnoses included dementia without behavioral disturbances, epilepsy (a brain disease where clusters of nerve cells signal abnormally causing a seizure), type 2 diabetes mellitus and adult failure to thrive.The 5-day Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had severely impaired cognition (Brief Interview for Mental Status (BIMS) score of 0), was dependent on staff for eating, bed mobility and transfers and identified Resident #1 exhibited no signs and symptoms of a swallowing disorder.The Resident Care Plan (RCP) dated 6/7/25 identified Resident #1 had impaired cognitive functioning/dementia. Interventions included administering medications as ordered by the provider and monitoring and documenting side effects and effectiveness, asking yes and no questions to determine the resident's needs, and cueing, reorienting and supervising the resident as needed.Review of the June 2025 Medication Administration Record (MAR) for Resident #1 identified that on 6/7/25, the following medications were not administered by LPN #1 and the option 'see progress note' was selected within the MAR: Aspirin (pain reducer/anti-platelet) 81 milligrams (mg) by mouth daily for Peripheral Vascular Disease (circulation disorder causing reduced circulation of blood to body parts) at 8:00 AM. Levetiracetam (anticonvulsant) 750 mg twice daily for epilepsy at 8:00 AM. Cardizem Extended Release 120 mg capsule daily for hypertensive heart disease (high blood pressure) with heart failure at 8:00 AM. Simvastatin 40 mg daily for hyperlipidemia (high cholesterol) at 8:00 AM. Gabapentin (2) 100 mg capsules three times daily for neuropathic pain (chronic pain resulting from nerve damage) at 8:00 AM. Acetaminophen 975 mg three times daily for pain at 8:00 AM, 2:00 PM and 8:00 PM. Lactobacillus (probiotic) capsule twice daily at 8:00 AM and 4:00 PM. Liquid protein 30 milliliters (mL) twice daily at 8:00 AM and 5:00 PM. Docusate Sodium (stool softener) 100mg twice daily for constipation at 8:00 AM and 8:00 PM. Restasis ophthalmic solution 0.05 percent (%) 1 dop to each eye twice daily for dry eyes at 8:00 AM and 8:00 PM. Effer-K (used to treat/prevent low potassium levels) 20 milliequivalent (mEq) daily for low potassium at 9:00 AM Lisinopril (used to treat high blood pressure) 5 mg daily at 9:00 AM. Ciprofloxacin (antibiotic) 500 mg twice daily for sepsis at 9:00 AM and 4:00 PM.Review of the June 2025 Medication Administration Record (MAR) for Resident #1 identified that on 6/7/25, the following medications were administered by LPN #1: Levetiracetam (anticonvulsant) 750 mg twice daily for epilepsy at 8:00 PM. Gabapentin (2) 100 mg capsules three times daily for neuropathic pain at 1:00 PM and 8:00 PM. Oxycodone (narcotic pain medication) 5 mg every six (6) hours as needed for pain was administered at 7:31 AM and 1:44 PM and was noted to be effective.A nurse's MAR progress note dated 6/7/25 at 9:13 AM by LPN #1 identified medications were not administered because Resident #1 was 'unable to swallow'. A nurse's MAR progress note dated 6/7/25 at 5:41 PM by LPN #1 identified medications were not administered because Resident #1 was 'unable to swallow'. A nurse's MAR progress note dated 6/7/25 at 8:15 PM by LPN #1 identified medications were not administered because Resident #1 refused.Review of nurse's notes dated 6/7/25 failed to identify a further detailed note or that the nursing supervisor or the provider had been notified that Resident #1 was unable to swallow his/her medication. Interview with LPN #1 on 6/24/25 at 12:10 PM identified that on 6/7/25, she worked both the 7:00 AM to 3:00 PM and 3:00 PM to 11:00 PM shifts. She identified Resident #1 had difficulty swallowing so she crushed the most important medications and omitted the rest. She identified she administered oxycodone twice on first shift and could not recall administering the 1:00 PM and 8:00 PM doses of gabapentin or the 8:00 PM dose of levetiracetam even though they were documented as administered. LPN #1 identified she reported Resident #1 was having difficulty swallowing to RN #1 (nursing supervisor) on the 7:00 AM to 3:00 PM shift, but was never notified of new orders. Review of physician's orders identified an order dated 6/1/24 directing that staff may crush medications and mix in food/beverage when appropriate unless contraindicated. Interview with RN #1 (7 AM to 7 PM nursing supervisor) on 6/24/25 at 12:23 PM identified LPN #1 notified her that Resident #1 was unable to swallow but did not report an urgency or that she administered oxycodone. RN #1 indicated that LPN #1 should not have administered any medications if Resident #1 was unable to swallow. RN #1 identified she knew Resident #1 had dysphagia so did not assess Resident #1 and did not notify the provider, but identified that she should have. Interview with APRN #1 on 6/24/25 at 2:36 PM

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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. (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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for two (2) of four (4) residents (Resident #4 and #7) reviewed for neglect, the facility failed to ensure allegations of neglect were reported to the State Agency timely. The findings include:1. Resident #4's diagnoses included heart failure, chronic pain and type II diabetes mellitus.The Resident Care Plan (RCP) dated 12/23/2024 identified Resident #4 had diabetes mellitus, chronic pain, altered cardiac status and an implanted cardiac defibrillator (an implanted device under the skin that corrects life threatening heart rhythms). Interventions included administering medications as ordered by the physician and monitoring and documenting side effects and effectiveness.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #4 had intact cognition (Brief Interview for Mental Status (BIMS) score of 15) and was independent with eating, bed mobility and transfers.Interview with Resident #4 on 6/24/25 at 3:05 PM identified that when LPN #1 worked, he/she did not receive ordered medications until hours after they were ordered, at times, his/her blood sugar was not obtained and, at times, he/she did not receive medications at all, which caused increased pain. Resident #4 identified he/she reported the medication issues to the ADNS about three (3) weeks prior but LPN #1 continued to work on the unit. Review of the State Agency Reportable Events website on 6/24/25 failed to identify that the State Agency was notified of Resident #4's allegation of neglect.Interview with the ADNS on 6/24/25 at 3:11 PM identified Resident #4 reported the medication issues to her when she accompanied Resident #4 on an outpatient appointment, but she did not report the allegation to the DNS, or to the State Agency and did not investigate the allegation. The ADNS identified she was new to her position and was unaware of the requirements for an allegation of neglect. 2. Resident #7 's diagnoses included muscle spasms of the back, neuropathy, chronic pain and congestive heart failure.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #7 had intact cognition (Brief Interview for Mental Status (BIMS) score of 15), required setup assistance for eating and was dependent on staff for bed mobility and transfers.The Resident Care Plan (RCP) dated 01/11/2025 identified Resident #7 had chronic pain and altered cardiac function. Interventions included administering medications as ordered, anticipating the need for pain relief and responding immediately to complaints of pain.Interview with Resident #7 on 06/25/2025 at 9:28 AM identified his/her medications were consistently administered late when LPN #1 and RN #2 worked, causing him/her increased pain and anxiety. Resident #7 indicated when he/she complained to the staff, he/she would eventually receive the medications but indicated he/she was worried about residents who could not self-advocate. Resident #7 identified that on 06/19/2025 at 10:00 PM he/she rang the call bell because he/she had not seen RN #2 since the start of the shift and both him/her and the roommate (Resident #5) had not yet received medications. Resident #7 identified a NA then administered a cup of pills to Resident #5 but he/she (Resident #7) received no medication that night. Resident #7 identified he/she wrote a complaint and gave it to staff to deliver to administration regarding the incident, but no one followed up with him/her regarding the complaint.Review of the letter dated 06/21/2025 from Resident #7 on 06/26/2025 identified, in part, that on the night of 06/19/2025, his/her nurse (RN #2) appeared to be absent and a NA brought Resident #5 (roommate) his/her medications at the end of the shift but he/she (Resident #7) did not receive any medications that night. Additionally, the letter identified that on 6/20/25, his/her second shift NA (NA #9) had a cold bedside manner, walked away from a water spill on Resident #7's floor and stated it was not her problem, and failed to provide personal care for Resident #7 that evening.Review of the State Agency Reportable Events website on 6/25/25 failed to identify that the State Agency was notified of Resident #7's allegations of neglect.Interview with the Administrator on 06/25/2025 at 10:48 AM identified there was a letter under his office door when he arrived to the facility on [DATE]. He identified he was unaware of who delivered the letter and that the facility was looking into it and indicated the DNS was given the letter for follow up.Interview with the DNS on 06/25/2025 at 10:53 AM identified she placed a call to RN #2 on 06/25/2025 in regards to Resident #7's complaint. She identified that RN #2 worked as an NA at the facility prior to becoming an RN and some residents still thought RN #2 was an NA. The DNS further identified she had not interviewed any other staff who worked during the evening/night shift on 06/19/2025 or on 6/20/25. The DNS identified she reviewed the Medication Administration Record (MAR) for Residents #5 and #7 which identified medications were signed off as administered late on 06/19/2025 and that the provider should have been notified but was not. The DNS identified that the allegation from Resident #7 should have

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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. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for two (2) of four (4) residents (Resident #4 and #7) reviewed for neglect, the facility failed to ensure an investigation was completed timely and thoroughly following an allegation of neglect. The findings include: 1. Resident #4's diagnoses included heart failure, chronic pain and type II diabetes mellitus. The Resident Care Plan (RCP) dated 12/23/2024 identified Resident #4 had diabetes mellitus, chronic pain, altered cardiac status and an implanted cardiac defibrillator (an implanted device under the skin that corrects life threatening heart rhythms). Interventions included administering medications as ordered by the physician and monitoring and documenting side effects and effectiveness. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #4 had intact cognition (Brief Interview for Mental Status (BIMS) score of 15) and was independent with eating, bed mobility and transfers. Interview with Resident #4 on 6/24/25 at 3:05 PM identified that when LPN #1 worked, he/she did not receive ordered medications until hours after they were ordered, at times, his/her blood sugar was not obtained and, at times, he/she did not receive medications at all, which caused increased pain. Resident #4 identified he/she reported the medication issues to the ADNS about three (3) weeks prior but LPN #1 continued to work on the unit. Interview with the ADNS on 6/24/25 at 3:11 PM identified Resident #4 reported the medication issues to her when she accompanied Resident #4 on an outpatient appointment, but she did not report the allegation to the DNS, or to the State Agency and did not investigate the allegation. The ADNS identified she was new to her position and was unaware of the requirements for an allegation of neglect. 2. Resident #7 's diagnoses included muscle spasms of the back, neuropathy, chronic pain and congestive heart failure. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #7 had intact cognition (Brief Interview for Mental Status (BIMS) score of 15), required setup assistance for eating and was dependent on staff for bed mobility and transfers. The Resident Care Plan (RCP) dated 01/11/2025 identified Resident #7 had chronic pain and altered cardiac function. Interventions included administering medications as ordered, anticipating the need for pain relief and responding immediately to complaints of pain. Interview with Resident #7 on 06/25/2025 at 9:28 AM identified his/her medications were consistently administered late when LPN #1 and RN #2 worked, causing him/her increased pain and anxiety. Resident #7 indicated when he/she complained to the staff, he/she would eventually receive the medications but indicated he/she was worried about residents who could not self-advocate. Resident #7 identified that on 06/19/2025 at 10:00 PM he/she rang the call bell because he/she had not seen RN #2 since the start of the shift and both him/her and the roommate (Resident #5) had not yet received medications. Resident #7 identified a NA then administered a cup of pills to Resident #5 but he/she (Resident #7) received no medication that night. Resident #7 identified he/she wrote a complaint and gave it to staff to deliver to administration regarding the incident, but no one followed up with him/her regarding the complaint. Review of the letter dated 06/21/2025 from Resident #7 on 06/26/2025 identified, in part, that on the night of 06/19/2025, his/her nurse (RN #2) appeared to be absent and a NA brought Resident #5 (roommate) his/her medications at the end of the shift but he/she (Resident #7) did not receive any medications that night. Additionally, the letter identified that on 6/20/25, his/her second shift NA (NA #9) had a cold bedside manner, walked away from a water spill on Resident #7's floor and stated it was not her problem, and failed to provide personal care for Resident #7 that evening. Interview with the Administrator on 06/25/2025 at 10:48 AM identified there was a letter under his office door when he arrived to the facility on [DATE]. He identified he was unaware of who delivered the letter and that the facility was looking into it and indicated the DNS was given the letter for follow up. Interview with the DNS on 06/25/2025 at 10:53 AM identified she placed a call to RN #2 on 06/25/2025 in regards to Resident #7's complaint. She identified that RN #2 worked as an NA at the facility prior to becoming an RN and some residents still thought RN #2 was an NA. The DNS further identified she had not interviewed any other staff who worked during the evening/night shift on 06/19/2025 or on 6/20/25. The DNS identified she reviewed the Medication Administration Record (MAR) for Residents #5 and #7 which identified medications were signed off as administered late on 06/19/2025 and that the provider should have been notified but was not. The DNS identified that the allegation from Resident #7 should have been reported to the Administrator or herself immediately rather than staff sliding a letter under the Administrator's office door and the allegation should have been reported to the State Agency, fully investigated and followed up on timely. Further, the DNS

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, facility documentation and interviews for eleven (11) of eleven (11) residents (Resident #14, #15, #16, #17, #18, #19, #20, #21, #22, #23, and #24) reviewed for physician's orders, the facility failed to ensure residents' orders were reviewed and signed by the physician monthly. The findings include:1. Resident #14 was admitted to the facility on [DATE].Review of physician orders identified medical orders were not reviewed and signed on 5/1/25 or 6/1/25 in accordance with facility practices.2. Resident #15 was admitted to the facility on [DATE].Review of physician orders identified medical orders were not reviewed and signed on 6/1/25 in accordance with facility practices.3. Resident #16 was admitted to the facility on [DATE].Review of physician orders identified medical orders were not reviewed and signed on 5/1/25 or 6/1/25 in accordance with facility practices.4. Resident #17 was admitted to the facility on [DATE]. Review of physician orders identified medical orders were not reviewed and signed on 6/1/25 in accordance with facility practices.5. Resident #18 was admitted to the facility on [DATE].Review of physician orders identified medical orders were not reviewed and signed on 6/1/25 in accordance with facility practices.6. Resident #19 was admitted to the facility on [DATE].Review of physician orders identified medical orders were not reviewed and signed on 5/1/25 or 6/1/25 in accordance with facility practices.7. Resident #20 was admitted to the facility on [DATE].Review of physician orders identified medical orders were not reviewed and signed on 5/1/25 or 6/1/25 in accordance with facility practices.8. Resident #21 was admitted to the facility on [DATE].Review of physician orders identified medical orders were not reviewed and signed on 5/1/25 or 6/1/25 in accordance with facility practices.9. Resident #22 was admitted to the facility on [DATE]. Review of physician orders identified medical orders were not reviewed and signed on 5/1/25 or 6/1/25 in accordance with facility practices.10. Resident #23 was admitted to the facility on [DATE].Review of physician orders identified medical orders were not reviewed and signed on 5/1/25 or 6/1/25 in accordance with facility practices.11. Resident #24 was admitted to the facility on [DATE].Review of physician orders identified medical orders were not reviewed and signed on 6/1/25 in accordance with facility practices. Interview with the Administrator and RN #8 (Regional) on 6/20/25 at 1:30 PM identified that the medical director (MD #1) was responsible for reviewing medical orders monthly and the facility's standard of practice was to have the physician's review and sign the resident's medical orders monthly. They identified they were unaware that the monthly orders had not been signed for May 2025 and June 2025. They indicated MD #1 (Medical Director) was new to the facility and they would contact her to have the orders signed.Interview with MD #1 on 7/8/25 at 2:30 PM identified the Administrator contacted her to sign monthly orders on 6/20/25 and she notified him that she did not have access within the electronic medical record to sign orders (the 'sign' button was grayed out). She reported she was new to long-term care, and no one reviewed the regulations for signing physician's orders or how often they needed to be signed. MD #1 identified that as of 7/8/25, the facility had still not given her access to sign physician's orders electronically or came up with an alternative means to have the orders signed and further identified the orders were still unsigned.The facility was unable to provide a policy detailing the frequency the physician's orders were to be reviewed.

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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 clinical record reviews, facility documentation, facility policy and interviews for one (1) of four (4) sampled residents (Resident #3) who had an order for a leave of absence with a responsible party only and had left the facility without informing the staff, the facility failed to ensure the front entrance door was secured or monitored to prevent the resident from leaving the facility unattended. The findings include: Resident #3's diagnoses included dementia, depression, and convulsions. A physician's orders dated 4/1/25 directed the resident may go on a leave of absence with a responsible party only and supervision for transfers and ambulation in the room and hallways. The Elopement Risk Assessment conducted on 5/15/25 identified Resident #3 was not at risk of elopement. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #3 had poor short- and long-term memory recall, had not exhibited behaviors of wandering or elopement and ambulated without a device. The Resident Care Plan dated 5/16/25 identified Resident #3 had a self-care deficit, impaired cognition, and was at risk for falls. Interventions directed staff assistance of one (1) with ambulation, cue and reorient the resident when needed and to keep the routine consistent. The nurse's note dated 6/8/25 written at 4:03 PM identified the 7AM-3PM Nursing Supervisor was called to the unit at 10:15 AM on 6/8/25 because Resident #3 could not be located, Resident #3 was last seen in the dining room at 9:30 AM. The facility emergency search protocol was initiated and after a thorough search of the building the police were called. Resident #3 was found down the street at 10:40 AM in the Stop and Shop parking lot by facility staff and brought back to the facility, and when the Nursing Supervisor assessed Resident #3, there were no injuries noted. The social service note dated 6/9/25 at 8:15 AM identified Resident #3's Conservator of Person had been contacted on 6/8/25 and authorized to move Resident #3 to a secure memory unit. Interview with Resident #3 on 6/24/25 at 11:10 AM identified he/she was socializing in the dining room during coffee hour. Resident #3 identified he/she recalled walking to Stop and Shop alone but could not recall the reason or which door he/she had exited the building from, and stated that he/she would never do that again. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Assistant Director of Nursing (ADON) on 6/24/25 at 11:25 AM identified the front door was kept locked when no one was sitting at the receptionist's desk. The ADON identified the receptionist comes in at 7:00 AM on weekdays, 9:00 AM on weekends and would unlock the door upon entering the building. The ADON explained that when the receptionist was not at the front desk someone would be there in her place and the receptionist had a list at the front desk that identified residents with a wander guard and those that had a physician's order to leave the building independently. Interview with the 7AM-3PM nurse aide, Nurse Aide (NA) #2, on 6/24/25 at 11:50 AM identified he last saw Resident #3 around breakfast time. NA #2 indicated a resident could leave the building without anyone's knowledge if they didn't have a wander guard and there was no one sitting at the front desk. Interview with the Director of Nursing (DON) on 6/24/25 at 12:20 PM identified the receptionist would unlock the door in the morning and lock it at night before leaving the building, and the Nursing Supervisor was responsible for locking and unlocking the door when there was no receptionist on duty. The DON identified based on Resident #3's orders, Resident #3 should have been supervised when he/she left the dining room on 6/8/25. Interview with the Occupational Therapist (OT) #1 and the Certified Occupational Therapist (COTA) #1 on 6/24/25 at 12:32 PM identified Resident #3 was able to ambulate independently without a device but required assistance of one (1) due to being at risk for falls, and Resident #3 required line of sight while ambulating. Interview with the Administrator on 6/24/25 at 1:15 PM identified the facility determined through their investigation that Resident #3 was able to exit the front door either because a staff member unlocked the front door and did not lock it back up or a family member pushed open the front door and the door did not shut all the way. The Administrator indicated the front door was supposed to be kept locked when the receptionist was not working and on 6/8/25 the receptionist arrived at work at 9:30 AM. Interview with the 7AM-3PM charge nurse, Licensed Practical Nurse (LPN) #3, on 6/24/25 at 1:50 PM identified on 6/8/25 she saw Resident #3 walk from his/her room to the dining room around 9:00 AM and a little before 10:00 AM she went to administer Resident #3's medication and could not locate Resident #3 in his/her room or the dining room. LPN #3 explained someone in the dining room reported Resident #3 said he/she was going to the hairdressers, and she knew there was no hairdresser working in the building that day (Sunday). LPN #3 asked one of the nurse aides if she had seen Resident #3 and the nurse aide said no but had noticed someone sitting on a stone wall up the road and did not know that person was Resident #3. LPN #3 identified she immediately contacted the Nursing Supervisor, and the emergency search protocol was initiated. Interview with the Receptionist on 6/24/25 at 2:00 PM identified on 6/8/25 she arrived at work at 9:30 AM. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075158	A. Building B. Wing	06/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New London Sub-Acute and Nursing	90 Clark Lane 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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a subsequent interview with the Receptionist on 6/25/25 at 9:10 AM she identified when she arrived at work on 6/8/25 the front door was already unlocked. The Receptionist reported when she worked on weekends the front door was usually locked until she came in and unlocked it. The Receptionist indicated although she did not see Resident #3 exit the building, at around 10:00 AM when asked, she reported she had seen someone fitting Resident #3's description walking up the street when she was driving into work. Interview and observations with the Administrator on 6/25/25 at 9:20 AM identified the front slider doors are locked and unlocked by a switch at the top of the door. The Administrator explained although many staff enter the building through a back entrance where there is a keypad coded door, other staff enter through the front door. Interview with the 11PM-7AM charge nurse, Licensed Practical Nurse (LPN) #7, on 6/25/25 at 10:00 AM identified the front door was always locked at night when he arrived at work and the only time it was unlocked was for a pharmacy delivery or for Emergency Medical Services. LPN #7 indicated either the charge nurse or supervisor would unlock and re-lock the door and explained in the past he had unlocked the door in the morning for convenience so staff could get into the building. Interviews with five (5) of nine (9) staff on 6/24/25 and 6/25/25 that worked the 11PM-7AM shift on 6/7/25 into 6/8/25 identified the door was locked at the beginning of their shift. Interviews with six (6) housekeepers on 6/25/25 that worked from 6:30AM-3:00 PM on 6/8/25 identified when they came into work, if they used the front door, it was typically unlocked. They indicated if the door was locked, they would either walk around the building to enter through a key-coded door or ring the doorbell at the front door until a nurse came to open it. They all reported when they entered the building through the front door a staff member was not sitting at the desk in the lobby. In a subsequent interview and observations with the Administrator on 6/25/25 at 2:00 PM there was a sign noted on the front door that identified the front door being locked from 8:00 PM until 6:00 AM and to gain access persons should call or ring the bell. The Administrator was not aware of the signage and was not aware that staff were unlocking the front door so that the housekeeping staff could enter the building at 6:30AM. The facility Elopement Policy identified, in part, that at no time would a resident be unsupervised while outside of the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075158	A. Building B. Wing	06/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New London Sub-Acute and Nursing	90 Clark Lane Waterford, CT 06385

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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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that residents are free from significant medication errors. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075158	A. Building B. Wing	06/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New London Sub-Acute and Nursing	90 Clark Lane 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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for eleven (11) of thirteen (13) residents (Resident #1, 2, 4, 5, 6, 7, 8, 9, 12, 13 and 14) reviewed for medication administration, the facility failed to ensure that diabetic, cardiac, anti-seizure, pain and behavioral medications were administered timely per physician's orders. These failures resulted in a finding of Immediate Jeopardy. The findings include:1. Resident #1 's diagnoses included epilepsy, type 2 diabetes mellitus with foot ulcers, osteomyelitis (an infection in the bone) and atrial fibrillation (irregular heartbeat).The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had severely impaired cognition (Brief Interview for Mental Status (BIMS) score of 5), required moderate assistance for eating, substantial assistance for bed mobility and was dependent on staff for transfers.The Resident Care Plan (RCP) dated 12/19/2024 identified Resident #1 had diabetes mellitus, pain related to left first and fifth toe amputations and had the potential for seizure activity related to the diagnosis of epilepsy. Interventions included administering medications as ordered by the provider and monitoring and documenting side effects and effectiveness.Review of the facility census identified Resident #1 resided on the East unit.Review of the Medication Administration Audit Report from January 2025 through June 2025 identified Resident #1 was ordered to receive the following medications: 01/01/2025 at 9:00 PM: Keppra (anti-seizure medication) 750 milligrams (mg) (twice daily medication) which was not signed off as administered until 10:23 PM by LPN #1. 03/02/2025 gabapentin (used to treat nerve pain) (2) 100 mg capsules (three times daily medication) related to polyneuropathy (damage to peripheral nerves causing symptoms such as numbness, burning pain and weakness) and the 8:00 AM and 12:00 PM doses were signed off as administered together at 11:23 AM by LPN #1. 03/02/2025 at 9:00 AM: Keppra 750 mg (twice daily medication), metformin (medication used to treat diabetes mellitus) 1000 mg (twice daily medication) and lisinopril (medication used to treat high blood pressure) 5 mg which were not signed off as administered until 11:23 AM by LPN #1. 03/10/2025: gabapentin (2) 100 mg capsules (three times daily medication) and the 8:00 AM and 12:00 PM doses were signed off as administered together at 11:00 AM by LPN #1. 03/10/2025 at 9:00 AM: Keppra 750 mg (twice daily medication), metformin 1000 mg (twice daily medication) and lisinopril 5 mg, which were not signed off as administered until 11:00 AM by LPN #1. 04/22/2025 at 4:00 PM: gabapentin (2) 100 mg capsules (three times daily medication), Keppra 750 mg (twice daily medication) and metformin 1000 mg (twice daily medication) which were not signed off as administered until 10:48 PM by RN #2. 04/22/2025 at 4:30 PM: Insulin Lispro (short-acting insulin) 2 units subcutaneously (under the skin) was ordered before meals and was not signed off as administered until 6:17 PM by RN #2. 05/21/2025 at 5:00 PM: metformin 1000mg (twice daily medication) which was not signed off as administered until 10:34 PM by RN #2. 05/21/2025 at 8:00 PM: gabapentin (2) 100 mg capsules (three times daily medication), Keppra 750 mg (twice daily medication) and Tylenol (pain reliever) 975 mg (three times daily medication) which were not signed off as administered until 10:35 PM by RN #2. Review of nurse's notes from 01/01/2025 through 05/22/2025 failed to identify that the nursing supervisor or the provider were notified of the late medication administrations for Resident #1.2. Resident #2's diagnoses included dementia without behavioral disturbances, seizures, hypertension (high blood pressure) and neoplasm (cancer) to the bone, soft tissue and skin.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had severely impaired cognition (Brief Interview for Mental Status (BIMS) score of 5), required setup assistance for eating and substantial assistance for bed mobility and transfers.The Resident Care Plan (RCP) dated 12/12/2024 identified Resident #2 was at risk for alteration in comfort related to intracranial (inside the skull) injuries. Interventions included administering pain medication per physician's orders.Review of the facility census identified Resident #2 resided on the East unit.Review of the Medication Administration Audit Report for January 2025 identified Resident #2 was ordered to receive the following medications: 01/17/2025 at 8:00 AM: gabapentin 300 mg (twice daily medication) for pain which was not signed off as administered until 9:10 AM by LPN #1. 01/19/2025 at 8:00 AM: gabapentin 300 mg (twice daily medication) which was not signed off as administered until 9:22 AM by LPN #1. 01/20/2025 at 8:00 AM: gabapentin 300 mg (twice daily medication) which was not signed off as administered until 9:51 AM by LPN #1. 1/23/2025 at 4:00 PM: gabapentin 300 mg (twice daily medication) which was not signed off as administered until 5:18 PM by LPN #1.Review of nurse's notes from 01/17/2025 through 01/24/2025 failed to identify the nursing supervisor or the provider were notified of the late