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	02/06/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation, facility policy, and interviews, for two (2) of five (5) sampled residents (Resident #1 and Resident #2) reviewed for a safe and sanitary environment, the facility failed to ensure Resident #1 received care in a safe environment when a bathroom grab bar detached from the wall during use, resulting in a fall and rib fractures, and failed to ensure Resident #2 was provided a sanitary sleeping environment when the resident's mattress had a urine odor. The findings include:a. Resident #1's diagnoses included history of falls, heart failure, and anxiety.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had moderately impaired cognition (Brief Interview for Mental Status (BIMS) score of 12), was independent with care, transfers, and wheelchair use. The Resident Care Plan (RCP) dated 12/12/25 identified Resident #1 had limited physical mobility and was at risk of falls. Interventions included staff assistance with daily care as needed, provide urinal for use at night, call bell within reach, and use of non-skid socks.A Nurse's note by RN #2 (the 3:00 PM to 11:00 PM supervisor) dated 1/5/26 at 9:01 PM identified at 8:45 PM Resident #1 was using the grab bar in his/her bathroom to pull him/herself up from the wheelchair to transfer to the toilet when the grab bar dislodged from the wall and Resident #1 came back down to the wheelchair with his/her knees on the floor. There were no injuries, marks, or bruises. The Reportable Event form by the Director of Nursing (DON) dated 1/9/26 at 2:00 PM identified Resident #1 fell on 1/5/26 at 8:30 PM when the grab bar Resident #1 was using in the bathroom to transfer from the wheelchair to the toilet became dislodged from the wall. Resident #1 had no signs of injury and no significant complaints of pain until 1/9/26 at which time the Advanced Practice Registered Nurse (APRN) ordered a chest x-ray. The chest x-ray identified rib fractures to the left 5th to 7th rib.A nurse's note dated 1/9/26 at 2:20 PM identified a chest x-ray was performed on 1/9/26 which identified fifth (5th) to seventh (7th) rib fractures.A nurse's note dated 1/9/26 at 9:24 PM identified physician's orders directed Tramadol fifty (50) milligrams (mg) three (3) times a day for pain and Incentive Spirometer ten (10) breaths three (3) times per day. Interview with Resident #1 on 2/6/26 at 12:30 PM identified he/she was permitted to use the bathroom independently and to self-transfer to the toilet. Resident #1 identified that on 1/5/26 he/she grasped the bathroom grab bar when attempting to transfer from the wheelchair to the toilet and the grab bar dislodged from the wall. Resident #1 further identified falling to the floor with his/her head against the door. Resident #1 used the call bell to call for assistance, and two staff assisted Resident #1 off the floor. Resident #1 identified that a few days later, he/she experienced chest pain and an x-ray was performed and identified rib fractures. Interview with NA #2 (the 3:00 PM to 11:00 PM nurse aide) on 2/6/26 at 1:57 PM identified on 1/5/26 Resident #1 called for help using his/her call bell in the bathroom. Resident #1 was found positioned on his/her knees on the floor between the wheelchair and the toilet and the grab bar was observed on the floor. NA (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#1 called for a nurse and helped assist Resident #1 off the floor.Interview with the Administrator on 2/6/26 at 2:30 PM identified Maintenance conducted monthly environmental rounds of the facility, and an assigned resident room is assessed during those rounds, however checking the stability of grab bars was not part of those rounds prior to the incident on 1/5/26. b. Resident #2's diagnoses included Congestive Heart Failure, history of urinary tract infections, and history of pressure ulcers.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had severely impaired cognition (Brief Interview for Status Mental (BIMS) was unable to be conducted), was dependent with all care and required the assistance of two (2) for transfers with a mechanical lift.The Resident Care Plan (RCP) dated 11/17/25 identified Resident #2 had a self-care deficit and was at risk for skin breakdown. Interventions directed staff to reposition the resident every two (2) hours, follow the orders to get the resident out of bed, check and change the resident during rounds and as needed for incontinence, and apply barrier cream after each change.Interview with Person #1 on 2/5/26 at 11:30 AM identified that at times when he/she visited Resident #2, Resident #2's mattress smelled of urine and he/she reported the mattress odor to the facility.Observation on 2/6/26 at 10:10 AM with RN #1 (7:00 AM-3:00 PM Supervisor) and NA #1 (7:00 AM-3:00 PM nurse aide) identified Resident #2 had been incontinent of urine. No odor was noted from Resident #2's brief upon assessment; however, when NA #1 lifted the mattress sheet, a strong urine odor was detected emanating from the mattress beneath the sheet.Interview with NA #1 on 2/6/26 at 10:10 AM identified housekeeping was responsible for washing residents' mattresses.Interview with the Administrator on 2/6/26 at 11:00 AM identified that any facility staff providing care were responsible for ensuring the resident's mattress was cleaned if it was soiled or had an odor.Although attempted, a call was not returned by RN #2Review of the facility Cleaning Checklist failed to identify a mattress cleaning schedule.Review of the facility Monthly Environmental Round Logs failed to identify checking grab bars for stability.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on clinical record review, facility documentation/policy and interviews, for one (1) of five (5) sampled residents (Resident #2) reviewed for grievances, the facility failed to ensure complaints/concerns reported by a resident representative were documented in the grievance log, investigated, and resolved in writing in accordance with the facility's grievance policy. The findings include: Interview with Person #1 on 2/5/26 at 11:30 AM identified he/she reported multiple care complaints/concerns to Social Workers (SW) and the Administrator over a prolonged period of time and had not been aware of a grievance process. Once made aware that the facility had a grievance process, he/she sent multiple emails regarding complaints/concerns because he/she did not know how to file a grievance using the grievance form. Person #1 did not receive written resolution for any complaints/concerns reported to the facility and was not made aware of resolutions to the complaints/concerns. Person #1 was not satisfied with the lack of follow-through on the complaints/concerns reported.Interview with the Administrator on 2/6/26 at 11:00 AM identified Person #1 reported care complaints/concerns to her regarding Resident #2 and she addressed the complaints/concerns immediately. The Administrator identified that after addressing the complaints/concerns, she thought the complaints/concerns were resolved. The Administrator further identified it was the responsibility of the SW to log reported complaints/concerns in the grievance log and communicate the complaints/concerns to the appropriate staff members for resolution. The Administrator identified she did not treat the complaints/concerns reported as grievances, did not ensure they were entered in the grievance log, and did not investigate as directed in the facility grievance policy. The administrator did not follow up in writing with Person #1 on findings or applicable resolutions if indicated.Interview with the SW on 2/6/26 at 11:57 AM and review of email correspondence dated 11/24/25 between Person #1 and the SW identified Person #1 reported several complaints/concerns to the SW. The SW identified that she addressed the complaints/concerns immediately but she did not log the complaints/concerns as grievances, did not document the outcome of the conversation with Person #1, and did not follow the facility policy on Grievances.Interview with the Director of Social Services (DSS) on 2/6/26 at 12:10 PM and review of email correspondences dated 5/15/25, 5/16/25, 5/18/25, 5/19/25, 5/20/25, 5/21/25, 5/22/25, 6/14/25, and 6/19/25 between Person #1 and the DSS identified Person #1 reported several complaints/concerns to the DSS. The DSS identified she either addressed the complaints/concerns immediately or forwarded them to the facility's former Administrator. The DSS identified she did not log the complaints/concerns as grievances, did not document the outcome of the conversation with Person #1, and did not follow the facility policy on Grievances. The facility Resident Rights Policy identified the resident had the right to have the facility respond to their grievance.The facility Grievance Policy identified persons residing at the facility, their families, and other interested parties are given fair and proper procedure to voice complaints, grievances, or suggestions. The policy further identified the Social Worker will document the complaint, actions taken, and resolution of the problem in the facility grievance log.

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F 0689 Level of Harm - 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/policies, and interviews, for one (1) of three (3) residents (Resident #1) reviewed for accidents, the facility failed to ensure the environment was free from accident hazards when a bathroom grab bar used for transfers dislodged from the wall, resulting in a fall and subsequent rib fractures. The findings include:Resident #1's diagnoses included history of falls, heart failure, and anxiety.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had moderately impaired cognition (Brief Interview for Mental Status (BIMS) score of 12), was independent with care, transfers, and wheelchair use. The Resident Care Plan (RCP) dated 12/12/25 identified Resident #1 had limited physical mobility and was at risk of falls. Interventions included staff assistance with daily care as needed, provide urinal for use at night, call bell within reach, and use of non-skid socks.A Nurse's note by RN #2 (the 3:00 PM to 11:00 PM supervisor) dated 1/5/26 at 9:01 PM identified at 8:45 PM Resident #1 was using the grab bar in his/her bathroom to pull him/herself up from the wheelchair to transfer to the toilet when the grab bar dislodged from the wall and Resident #1 came back down to the wheelchair with his/her knees on the floor. There were no injuries, marks, or bruises. The Reportable Event form by the Director of Nursing (DON) dated 1/9/26 at 2:00 PM identified Resident #1 fell on 1/5/26 at 8:30 PM when the grab bar Resident #1 was using in the bathroom to transfer from the wheelchair to the toilet became dislodged from the wall. Resident #1 had no signs of injury and no significant complaints of pain until 1/9/26 at which time the Advanced Practice Registered Nurse (APRN) ordered a chest x-ray. The chest x-ray identified rib fractures to the left 5th to 7th rib.A nurse's note dated 1/9/26 at 2:20 PM identified a chest x-ray was performed on 1/9/26 which identified fifth (5th) to seventh (7th) rib fractures.A nurse's note dated 1/9/26 at 9:24 PM identified physician's orders directed Tramadol fifty (50) milligrams (mg) three (3) times a day for pain and Incentive Spirometer ten (10) breaths three (3) times per day. Interview with Resident #1 on 2/6/26 at 12:30 PM identified he/she was permitted to use the bathroom independently and to self-transfer to the toilet. Resident #1 identified that on 1/5/26 he/she grasped the bathroom grab bar when attempting to transfer from the wheelchair to the toilet and the grab bar dislodged from the wall. Resident #1 further identified falling to the floor with his/her head against the door. Resident #1 used the call bell to call for assistance, and two staff assisted Resident #1 off the floor. Resident #1 identified that a few days later, he/she experienced chest pain and an x-ray was performed and identified rib fractures. Interview with NA #2 (the 3:00 PM to 11:00 PM nurse aide) on 2/6/26 at 1:57 PM identified on 1/5/26 Resident #1 called for help using his/her call bell in the bathroom. Resident #1 was found positioned on his/her knees on the floor between the wheelchair and the toilet and the grab bar was observed on the floor. NA #1 called for a nurse and helped assist Resident #1 off the floor.Interview with the Administrator on 2/6/26 at 2:30 PM identified Maintenance conducted monthly environmental rounds of the facility, and an assigned resident room is assessed during those rounds, however checking the stability of grab bars was not part of those rounds prior to the incident on 1/5/26.Although attempted, a call was not returned by RN #2.Review of facility documentation identified that a Plan of Correction was initiated immediately:Grab bars in the entire facility were checked immediately and there were no additional findings. Staff training was completed and included random checks of grab bars during monthly environmental rounds of at least two (2) bathrooms per unit per month.Random audits of grab bars would be completed weekly for four (4) weeks, then monthly for three (3) months.Audits would be reviewed at the monthly QAPI meetings.The Administrator was responsible for the plan with a compliance date of (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	1/14/25.The plan of correction was reviewed on 2/6/26 during an on-site visit and the facility met all components for past non-compliance.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, facility documentation, facility policies and interviews for one (1) of five (5) sampled residents (Resident #2) reviewed for respiratory care, the facility failed to ensure Resident #2 who had a physician's order for oxygen was receiving oxygen as ordered. The findings include: Resident #2's diagnoses included Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure (CHF), and history of pressure ulcers.The Physician's order dated 7/4/25 directed oxygen zero (0) to four (4) liters to maintain oxygen saturation above 92% due to hypoxia and to check oxygen saturations every shift.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had severely impaired cognition (Brief Interview for Mental Status (BIMS) was unable to be conducted), was oxygen dependent, and was dependent with all care.The Resident Care Plan (RCP) dated 11/17/25 identified Resident #2 had an altered respiratory status due to COPD and a self-care deficit. Interventions directed staff administer medication as ordered, change oxygen and nebulizer tubing as ordered, monitor oxygen saturation as ordered, and when on portable oxygen check oxygen level of the portable tank every three (3) hours to ensure there was oxygen in the tank.Review of the Medication Administration Record (MAR) for January 2026 and February 2026 identified oxygen was administered to Resident #2 continuously and oxygen saturation rates were documented on each shift.Interview with Person #1 on 2/5/26 at 11:30 AM identified on several different occasions when visiting, Resident #2 was using oxygen supplied by a portable oxygen tank and there was no oxygen in the tank. Person #1 further identified the portable tanks that were not in use were often empty.Observation on 2/6/26 at 10:10 AM identified Resident #2 was lying in bed with the head of the bed elevated to approximately forty-five (45) and Resident #2's oxygen nasal canula was not in place and the oxygen concentrator was powered off. The oxygen tubing was observed on top of the dresser which was next to Resident #2's bed and out of Resident #2's reach, and the oxygen concentrator was next to the dresser and out of Resident #2's reach. Interview with NA #1 on 2/6/26 at 10:10 AM identified she fed Resident #2 breakfast at 8:45 AM and Resident #2's oxygen was on. NA #2 did not know how Resident #2's oxygen concentrator was powered off and identified it should have been on. Interview with LPN #1 on 2/6/26 at 10:15 AM identified she did not know why Resident #2's oxygen was off. LPN #1 checked Resident #2's oxygen saturation before re-applying the oxygen and the saturation was 90% (normal range: 95%-100%). LPN #1 identified she administered Resident #2's nebulizer treatment around 8:00 AM and Resident #2's oxygen was on at that time. She identified Resident #2's oxygen saturation was 95% prior to the nebulizer treatment and increased to 98% after the nebulizer treatment. LPN #1 further identified Resident #2 would not have been able to take his/her own oxygen nasal canula off or power off the oxygen concentrator and that the oxygen should not have been off.Interview with the Director of Nursing (DON) on 2/6/26 at 11:00 AM identified she saw Resident #2 when she did rounds around 6:30 AM and at that time, Resident 2's oxygen was on. The DON further identified that no one should have turned the oxygen off. Review of the facility policy on Oxygen use identified oxygen is administered per physician's orders.