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	04/22/2026

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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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility policy and interviews for two (2) of three (3) sampled residents (Residents #1 and #7) reviewed for accidents and incidents, the facility failed to ensure timely physician notification following significant changes in resident condition and behavioral incidents requiring medical and psychiatric evaluation. For Resident #1, the facility failed to notify the on-call provider or Medical Director following a choking incident requiring the Heimlich maneuver. For Resident #7, the facility failed to notify the provider regarding omitted medications, refusal of as needed medication, escalating behaviors and a behavioral incident involving Resident #7 entering and remaining in another resident's bed despite multiple unsuccessful staff redirection attempts. The findings include:1. Resident #1's diagnoses included dementia without behavioral disturbances, oropharyngeal dysphagia (weakening of the throat muscles making it difficult to move food from the mouth into the throat and esophagus during swallowing) cerebrovascular disease (conditions that affect blood flow in the brain) and type II diabetes mellitus.A physician's order dated 7/4/25 directed a regular diet IDDSI 6 soft and bite sized texture, IDDSI 0 thin Liquids consistency. The orders directed Resident #1 to utilize a lip plate, built-up utensils, and required supervision with meals.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had severely impaired cognition (Brief Interview for Mental Status (BIMS) score of 4), and required supervision assistance for eating and was dependent on staff for oral care, bed mobility and transfers. Resident #1 required a mechanically altered diet.The Resident Care Plan (RCP) dated 1/20/26 identified Resident #1 had impaired cognitive function or impaired thought processes related to dementia and had a potential swallowing problem related to a history of dysphagia and cerebral infarction (an ischemic stroke where the blood supply to part of the brain is blocked or reduced preventing brain tissue from getting oxygen and nutrients). Interventions included providing supervision with meals, diet to be followed as prescribed, instructing Resident #1 to eat in an upright position, to eat slowly, and to chew each bite thoroughly, monitoring/documenting/reporting as needed any signs and symptoms of dysphagia such as pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing, refusing to eat and appearing concerned during meals and monitoring for shortness of breath, choking, labored respirations and lung congestion.A late entry nurse's note by RN #1 (the 7:00 AM to 3:00 PM nursing supervisor) dated 3/19/26 at 1:59 PM identified she was called to the dining room where Resident #1 was in the wheelchair eating lunch when he/she experienced a choking episode and the Heimlich maneuver was performed. Resident #1's lung sounds were clear but diminished bilaterally and vital signs were obtained to include a heart rate of 96, blood pressure of 151/95 and oxygen level of 95 percent (%) on room air. Resident #1 remained at the nurse's desk for further evaluation by APRN #1 and no new orders were obtained.A nurse's note by the DON on 3/19/26 at 2:06 PM identified she was called to assess Resident #1 following an incident of choking while in the dining room. The Speech Language Pathologist (SLP) was in the dining area and yelled out to LPN #1 who responded and performed the Heimlich maneuver. A speech evaluation was placed, the physician and Conservator were notified and vital signs were to be initiated and obtained every (continued on next page)

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	four (4) hours.A provider note by APRN #1 dated 3/20/26 identified Resident #1 had a choking episode on 3/19/26 requiring the Heimlich maneuver. APRN #1 directed a 2-view chest x-ray to evaluate for aspiration or consolidation and that staff would obtain vital signs every shift for 3 days and lab work would be obtained 3/23/26 to monitor for developing leukocytosis (elevated white blood cell count signifying an infection) or dehydration. Additionally, Resident #1's diet was downgraded to minced and moist and Resident #1 would be a one (1) to one (1) feed for meals.Interview with RN #1 on 4/13/26 at 1:24 PM identified when she arrived on the unit on 3/19/26, Resident #1 was sitting upright in the wheelchair at the nurse's station. She reported Resident #1's eyes were red and watery, she assessed Resident #1 immediately and vital signs were normal, had no abnormal lung sounds and no further coughing was noted. She texted APRN #1 to report the incident, but APRN #1 did not respond. She did not contact the on-call provider or the Medical Director when she did not receive a response from APRN #1. RN #1 entered an order for vital signs every four (4) hours for three (3) days, downgraded Resident #1's diet to puree, entered a speech screen, and notified APRN #1 the following morning.Interview with APRN #1 on 4/13/26 at 2:25 PM identified she was off on 3/19/26 and evaluated Resident #1 on 3/20/26 when she was back in the building. She reported RN #1 should have contacted the on-call provider or the Medical Director following the choking incident, as Resident #1 should have had a chest x-ray ordered and obtained the same day to ensure Resident #1 had not aspirated.Interview with APRN #1 on 4/13/26 at 2:25 PM identified she was not scheduled to work on 3/19/26 and evaluated Resident #1 on 3/20/26. She identified following any resident concern or change in condition, if a call is not returned by a provider within ten (10) minutes, the facility should contact different provider, and staff should document provider notification accurately. She reported RN #1 should have contacted the on-call provider or the Medical Director following the choking incident so a chest x-ray could have been ordered and obtained the same day to rule out aspiration.2. Resident #7?s diagnoses included metabolic encephalopathy (a change in brain function due to an underlying condition), dementia without behavioral disturbances, mild cognitive impairment, delusional disorder, anxiety disorder and major depressive disorder.The Nursing Evaluation dated 4/1/26 identified Resident #7 was admitted for a change in mental status, chronic decline and wandering. Resident #7 was alert and oriented to person, place and time and required extensive assistance for bed mobility, transfer and ambulation status was not determined at that time.A physician's order dated 4/3/26 directed trazodone oral tablet 50 milligrams (mg), administer 25 mg by mouth every six (6) hours as needed for anxiety, restlessness or agitation.A nurse's note by RN #1 dated 4/3/26 at 7:01 PM identified Resident #7 had increased agitation and yelling, unable to administer evening or as needed medications or redirect Resident #7. Resident #7 was found lying in a male resident's bed and multiple attempts by staff to remove Resident #7 were unsuccessful. The family was notified and recommendations on how to handle Resident #7 were requested. With help from a NA, RN #1 was able to remove Resident #7 from the bed. Attempts were made to reorient Resident #7 to his/her personal space and belongings but Resident #7 continued to be irate and difficult. The note failed to identify a provider was notified of the missed medications or the escalation of behaviors.Review of the April 2026 Medication Administration Record (MAR) and Treatment Administration Record (TAR) identified Resident #7 was not administered the 8:00 PM dose of pramipexole dihydrochloride tablet 0.5 milligrams (mg) for restless legs syndrome, the 8:00 PM dose of montelukast sodium tablet 10 mg for seasonal allergies, the 9:00 PM dose of memantine tablet 10 mg for dementia, topical triamcinolone acetonide cream 0.1 percent (%) to affected areas on the evening shift for allergic contact dermatitis (inflammation of the skin) or topical ketoconazole cream 2 % to affected areas for tinea corporis (superficial fungal infection of the skin).Review of the clinical record for 4/3/26 failed to identify a provider was notified of the missed medications, refusal of the as needed trazodone or the escalation of behaviors.Interview with RN #1 on 4/22/26 at 10:49 AM identified although she documented on 4/3/26 that Resident #7 was not administered medications, had an escalation in behaviors and was found in a male resident's bed and Resident #7 continued to be irate and difficult, she did not contact (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	an on-call provider to report the behaviors.Interview with APRN #2 (psychiatric APRN), on 4/20/26 at 2:15 PM identified she was not made aware of the 4/3/26 incident with Resident #7 and nursing should have notified the on-call provider of the escalating behaviors and refusal of trazodone. She identified she was not aware Resident #3 was found in a male resident's bed on 4/3/26 despite evaluating Resident #7 several times after that date.Interview with the DON on 4/20/26 at 3:40 PM identified that an on-call provider should have been notified for any missed medications/refusal of medications, escalation in behaviors and behavioral incidents. She was unaware an on-call provider and psychiatric APRN were not notified of the 4/3/26 incident with Resident #7 wandering into a male resident's bed.Review of the Change of Condition in a resident status policy dated 6/2023 directed, in part, the nurse will notify the resident's attending physician or on-call physician when there has been an accident or incident involving the resident, a significant change in the resident's physical/emotional/mental condition or a need to alter the resident's medical treatment significantly. A significant change of condition is a decline or improvement in the resident's status that requires interdisciplinary review and/or revision to the care plan. The RN will assess the resident's change of condition and document their findings in the medical record. The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status.Review of the Charting and Documentation policy dated 6/2023 directed, in part, documentation of procedures and treatments will include care specific details, including: the assessment data and/or unusual findings obtained during the procedure/treatment and notification of family, physician or other staff, if indicated.Review of the Medication Refusal Policy dated 7/2023 directed, in part, that for medication refusals, the nurse will explain to the resident the possible consequences of medication refusal, and for non-competent confused residents, the nurse will go back and offer the medication again within an hour. The nursing supervisor will notify the MD once 3 consecutive doses of any medication is refused, will document the conversation with the MD in the clinical record and the nurse will properly document the medication refusal on the resident's electronic medical record.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policies, and staff interviews, for one (1) of three (3) sampled residents reviewed for abuse (Resident #8), the facility failed to protect a resident from abuse when staff failed to implement interventions for a roommate (Resident #7) with known, escalating aggressive and delusional behaviors, resulting in Immediate Jeopardy to resident health and safety. Specifically, despite documented behavioral episodes beginning on 4/3/26 - including agitation, yelling, paranoia, combativeness, and medication refusals - the facility failed to develop a behavior care plan or a care plan addressing medication refusals for Resident #7. On 4/15/26 and 4/16/26, staff failed to administer a prescribed PRN medication (trazodone 25 mg) for documented agitation and behavioral symptoms, failed to reattempt medication administration following refusal, and failed to implement alternative non-pharmacological interventions. On 4/16/26 at approximately 3:00 AM, following an episode in which Resident #7 refused food, threw food at staff, refused trazodone, and remained agitated and talking to him/herself, staff left Resident #7 unsupervised in a shared room with Resident #8 - a cognitively and physically impaired roommate with a Brief Interview for Mental Status (BIMS) score of 3 who was dependent on staff for transfers and had limited ability to protect him/herself. At approximately 3:30 AM, staff heard a loud noise, entered the room, and observed Resident #7 standing over Resident #8, holding a round hairbrush, yelling. Resident #8 was found with bruising to the left eye, face, and right hand, and his/her face was saturated with lotion. Resident #8 was subsequently transported to the emergency department, where imaging confirmed an acute subarachnoid hemorrhage (bleeding between the brain and the tissue covering it), new since a prior exam on 11/27/25. Resident #8's blood thinner (Eliquis) was held for two weeks due to the intracranial bleed. The facility's own Director of Nursing (DON) stated that if Resident #7 had been supervised, the incident could have been prevented. These failures resulted in the finding of Immediate Jeopardy. The findings include:1. Resident #8?s diagnoses included dementia without behavioral disturbances, chronic pain, major depressive disorder and anxiety disorder.A physician's order dated 10/8/25 directed Resident #8 required an assist of two (2) stand pivot transfer and utilized a wheelchair for mobility.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #8 had severely impaired cognition (Brief Interview for Mental Status (BIMS) score of 3), required substantial assistance with bed mobility and was dependent on staff for transfers.The Resident Care Plan (RCP) dated 4/9/26 identified Resident #8 had impaired cognitive function or impaired thought processes related to dementia, a communication problem related to a cognitive deficit, was hard of hearing and had limited physical mobility related to a Cerebrovascular Accident (CVA). Interventions included anticipating and meeting needs, cueing, reorienting and supervising as needed and ensuring and providing a safe environment.2. Resident #7?s diagnoses included metabolic encephalopathy (a change in brain function due to an underlying condition), dementia without behavioral disturbances, mild cognitive impairment, delusional disorder, anxiety disorder and major depressive disorder.The Nursing Evaluation dated 4/1/26 identified Resident #7 was admitted for a change in mental status, chronic decline and wandering. Resident #7 was alert and oriented to person, place and time and required extensive assistance for bed mobility, transfer and ambulation status was not determined at that time.A physician's order dated 4/2/26 directed Resident #7 was independent for mobility with no device on the secured memory unit.A physician's order dated 4/3/26 directed trazodone oral tablet 50 milligrams (mg), administer 25 mg by mouth every six (6) hours as needed for anxiety, restlessness or agitation.The Resident Care Plan (RCP) dated 4/12/26 identified Resident #7 had impaired cognitive function related to dementia, utilized psychotropic medications related to anxiety, depression and dementia, resided on the secured memory unit and ambulated independently with no assistive device on the secured memory unit. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interventions included anticipating and meeting needs, keeping the routine consistent and try to provide consistent care givers to decrease confusion, cueing, reorienting and supervising as needed, administering medications as ordered and monitoring and documenting side effects and effectiveness.An Order Administration note by RN #3 dated 4/15/26 at 1:45 AM identified Resident #7 was paranoid, talking to him/herself loudly, ambulated the hallway and complained of being unable to sleep. Trazodone 25 mg was administered.An Order Administration note by RN #3 dated 4/15/26 at 4:06 AM identified the trazodone was effective in managing behavioral symptoms.A nurse's note by RN #4 dated 4/15/26 at 3:04 PM identified Resident #7 was paranoid, yelling and not easily redirected. Medications were taken after multiple attempts.A nurse's note by RN #3 on 4/16/26 at 3:49 AM identified at around 3:30 AM, Resident #7 became belligerent due to not being able to have breakfast, food and fluids were offered but Resident #7 refused to take any meal items that were offered. Resident #7 went back to bed, staff heard Resident #7 talking to him/herself and a few minutes later, a loud noise was heard, staff ran to the room and observed Resident #7 standing next to the roommates (Resident #8's) bed holding a round brush and yelling at him/her. The left side of Resident #8's hair was covered in lotion and Resident #8 had a red mark to the left side of the nose, bruising to the left eye and bruising to the right hand. The residents were immediately separated, one-to-one observation was initiated for Resident #7, Emergency Medical Services (EMS) was called, the provider was notified and the responsible parties were notified.Review of the April 2026 Medication Administration Record (MAR) failed to identify Resident #7 had been administered trazodone 25 mg for anxiety, restlessness or agitation per physician's order on 4/15/26 by RN #4 or on 4/16/26 by RN #3 prior to or following the documented behaviors.Review of the clinical record from 4/1/26 through 4/14/26 identified on 4/3/26 Resident #7 had increased agitation and yelling, refused medications and was unable to be directed. Resident #7 was found laying in a male resident's bed and multiple attempts were made to remove Resident #7 without success. There were multiple notations of Resident #7 refusing medications, weights, skin checks, vital signs, blood work and treatments as well as becoming agitated, confused, yelling, accusatory, paranoid, and combative with care.Review of the RCP for Resident #7 failed to identify a behavior care plan or a care plan related to refusals for Resident #7.Review of the Prehospital Care Report (ambulance run sheet) dated 4/16/26 identified EMS were dispatched to the facility on 4/16/26 at 3:50 AM, arrived on site at 4:00 AM and departed the facility at 4:19 AM. It was reported to them that staff found Resident #8's roommate (Resident #7) on top of him/her beating him/her in the face and head with a heavy hairbrush and Resident #8 did not know what happened but did know that he/she was injured. Resident #8 presented with severe bruising, swelling, discoloration, pain, and tenderness to his/her face, around the eyes, and on the forehead and staff reported Resident #8's roommate covered Resident #8 in lotion, which was found dripping out of Resident #8's ears.A psychiatric APRN note by APRN #2 on 4/16/26 identified she was asked to see Resident #7 following the alleged altercation with Resident #8. Resident #7 was calm but increasingly confused and Resident #7 explained someone broke into his/her room last night and he/she was fearful, reporting the person was his/her family member who molested him/her at a young age. The note identified Resident #7 was noted by staff to be calling Resident #8 a name with Resident #7's last name. Resident #7 was currently on one-to-one observation and showing signs of increased confusion and delusions and due to unpredictability of Resident #7's behaviors, recommended an inpatient psychiatric and medical evaluation and that the facility would facilitate the transfer. Resident #7 was calm and pleasant, was not a danger to him/herself or others but could become increasingly confused later in the afternoon/evenings and recommended continued one-to-one supervision until Resident #7 was transferred later in the day. A nurse's note by the DON on 4/16/26 at 1:03 PM identified Resident #7 was a planned pick-up at 7:30 PM for transfer to the inpatient psychiatric hospital and report was called in.Review of the hospital Emergency Department (ED) documentation dated 4/16/26 identified Resident #8 was seen following an assault and reported a contusion (soft tissue injury caused by blunt force trauma) to the right side (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	of the head, contusion to the face and contusion to the right hand. Imaging dated 4/16/26 at 6:37 AM identified a small five (5) by six (6) millimeter peripheral hyper density in the right frontal region, new since prior exam on 11/27/25, consistent with an acute subarachnoid hemorrhage (bleeding in the area between the brain and the thin tissue that covers and protects it). The documentation directed for Resident #8 not to take Eliquis (blood thinner) for two (2) weeks and to follow-up with the primary care provider.Review of the facility census on 4/20/26 identified Resident #7 remained hospitalized .Interview and observation of Resident #8 on 4/20/26 at 12:09 PM, identified purple and yellow bruising to the left side of the face and under the left eye, reddened discoloration under the right nostril, large bruising to both forearms and bruising to the right hand.Interview with NA # 12 on 4/21/26 at 9:07 AM identified on 4/16/26 she was providing care to Resident #8 around 6:00 PM, who had no visible bruising or injuries. Resident #7 was in the room talking to him/herself, yelling out and shrieking. She identified she could not redirect Resident #7 and RN #3 later came in, spoke with Resident #7 and pulled the curtain all the way around his/her bed and Resident #7 calmed down. NA #12 worked the 11:00 PM to 7:00 AM shift preceding and Resident #7 was out of bed, walking around and yelling out the door prior to the incident that occurred with Resident #8. She reported that at around 3:30 AM, she heard a loud noise and entered the room and Resident #7 was standing over Resident #8 with an object and Resident #8 was saturated with lotion and had multiple injuries, including a left black eye and reported it appeared Resident #8 had put his/her right arm up in defense, as it was starting to discolor. NA #12 identified Resident #8, was always seen smiling prior to the incident, appeared scared and fearful following the incident. She was directed by RN #3 to sit with and observe Resident #7 following the incident and Resident #7 reported thinking Resident #8 was a family member that hurt him/her as a child.Interview with NA # 11 on 4/21/26 at 9:41 AM identified she normally worked on the locked memory unit where both Residents #7 and #8 resided and she was assigned to Resident #7 the night of the incident. She identified since Resident #7 was admitted to the facility on [DATE], would intermittently talk to him/herself, scream, slam doors and wander the halls while awake. Prior to the incident, Resident #7 started yelling around 2:30 AM and was in and out of bed, She identified she last saw Resident #7 around 3:00 AM and at that time he/she had gone back to bed but was still talking to him/herself. NA #11 identified she went to care for other residents and around 3:30 AM heard yelling. When she went into the room, she observed Resident #7 standing next to Resident #8 and Resident #8 had bruising to his/her left eye and face, bruising to the right arm and his/her face was covered in lotion and reported Resident #8 appeared fearful of Resident #7. NA #11 identified looking back, Resident #7 probably should have been brought out of the room and into the common area so he/she could have been supervised. She identified staff would not have performed frequent checks on Resident #7 while in the room because Resident #7 continuously closed the room door.Interview with RN #3 on 4/21/26 at 8:26 AM identified on 4/15/26 she worked part of the 3:00 PM to 11:00 PM shift. Resident #7 was yelling and getting in and out of bed but Resident #7 seemed to calm down after she spoke with him/her and closed the curtain. She identified at around 2:00 AM, she heard Resident #7 talking to him/herself and yelling again so she went to speak with Resident #7 who was ordering breakfast into the call bell and started demanding a full hot breakfast and hot tea and then got out of bed and started walking around. She reported she left to try and gather some food for Resident #7 and when she returned Resident #7 refused the food and drinks she offered, threw the food back at her and became increasingly agitated. RN #3 reported she then attempted to give Resident #7 trazodone but he/she refused, and Resident #7 went back into the room and herself and NA #11 stood outside the door for a few minutes. Resident #7 seemed to calm down so they left the door ajar and went to care for other residents around 3:00 AM. RN #3 reported that at around 3:30 AM she heard yelling and went into Resident #7's room and saw him/her standing over Resident #8 with a round hairbrush in his/her hand and Resident #8 was noted with bruising to the left eye, face and right hand but Resident #7 would not explain what he/she had done. After calling EMS and the families, EMS refused to take Resident #7 because he/she appeared alert (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	and oriented and refused to go, so Resident #7 remained in the building on a one-to-one until seen by a provider. At around 4:30 AM, Resident #7 was again yelling, slamming things in the room and trying to get out of the window. RN #3 identified she did not normally work on the locked memory unit. She identified she administered trazodone to Resident #7 the previous night when he/she started yelling which was effective. She could not explain why she did not immediately administer trazodone when Resident #7 began having behaviors around 6:00 PM on 4/15/26 or at 2:00 AM on 4/16/26. She reported she should have reapproached Resident #7 and reattempted to medicate him/her with the trazodone after the first refusal and identified she should not have left Resident #7 alone in the room with Resident #8 after Resident #7 was identified to be agitated. She thought Resident #7 calmed down but was still talking to him/herself and should have brought Resident #7 to the common area to be supervised by staff.Interview with APRN #2 (psychiatric APRN), on 4/20/26 at 2:15 PM identified she saw Resident #7 numerous times and made several medication adjustments. She did not receive clear staff reports regarding Resident #7's behaviors or incidents. The trazodone was ordered for anxiety, restlessness or agitation and if Resident #7 displayed those behaviors, staff should have offered the medication, documented on the behaviors and documented the effectiveness of the medication. She identified Resident #7 should have been supervised while the behaviors were occurring and ensured Resident #7 was completely calm and back to baseline after the aggressive behavior prior to allowing Resident #7 to go back to his/her room with Resident #8. Additionally, she identified Resident #7 was increasingly confused and not at baseline when she evaluated him/her on 4/16/26 and reported Resident #8 still appeared nervous when she saw him/her on 4/16/26.Interview with the Director of Rehab on 4/22/26 at 3:01 PM identified Resident #8 was an assist of two (2) stand pivot for transfers and utilized the wheelchair for mobility and Resident #8's ambulation level fluctuated but he/she required a rolling walker for ambulation with therapy. She identified she never saw Resident #8 get off the floor, had never evaluated Resident #8 for getting off the floor and was unsure of Resident #8's arm and leg strength to be able to push and pull him/herself up independently into a standing position but the resident was an assist of 2 for transfers. She reported she could not answer with certainty if it was possible for Resident #8 to have fallen out of bed and gotten him/herself up off the floor independently and back into bed independently within a half hour to have sustained a subarachnoid hemorrhage.Interview with the DON on 4/20/26 at 3:40 PM identified if a resident is ordered a medication by a psychiatric provider for anxiety, agitation or restlessness, staff should be attempting to administer the medication to the resident if behaviors occur so the resident's behaviors do not escalate out of control. She identified if a resident refuses a medication, other interventions should be implemented for safety, and the resident should be reapproached several times. She reported if a resident has behaviors, including aggression, staff should monitor the resident to ensure the resident is completely calmed down and have the resident sit in the common area so they can be supervised by several staff. She identified Resident #7 should not have been left in his/her room without frequent checks or supervision for a half hour following identified behaviors. She identified if Resident #7 was supervised the incident could have been prevented.Review of the Preventing Resident Abuse policy dated 6/2023 directed, in part, the abuse prevention/intervention program included: Assessing, care planning and monitoring residents with needs and behaviors that may lead to conflict or neglect and assessing residents with signs and symptoms of behavioral problems and developing and implementing care plans that can assist in resolving behavioral issues.Review of the Abuse Reporting policy dated 6/2023 directed, in part, abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm of pain or mental anguish or deprivation by an individual. Physical abuse is defined as hitting, slapping, pinching, kicking, etc.Review of the Q15 minute and 1 to 1 policy dated 7/2023 directed, in part, that the policy establishes procedures for the observation of residents at risk of self harm, aggression, elopement, or severe confusion/agitation ensuring safety. 1:1 constant observation is when a staff member is assigned to a single resident, maintaining direct line-of-sight at all times (continued on next page)

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	075158	A. Building B. Wing	04/22/2026

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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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	including bathroom. Staff must not leave patient unless an in-person report is given. Q15 minute observation is physically checking and verifying the safety of a resident within every 15 minutes and documenting. Although requested, a facility policy for behavioral management was not provided.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for one (1) of three (3) sampled residents (Resident #8) reviewed for abuse, the facility failed to ensure the state agency was notified within two (2) hours of an abuse allegation. The findings include:1. Resident #8?s diagnoses included dementia without behavioral disturbances, chronic pain, major depressive disorder and anxiety disorder.A physician's order dated 10/8/25 directed Resident #8 required an assist of two (2) stand pivot transfer and utilized a wheelchair for mobility.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #8 had severely impaired cognition (Brief Interview for Mental Status (BIMS) score of 3), required substantial assistance with bed mobility and was dependent on staff for transfers.The Resident Care Plan (RCP) dated 4/9/26 identified Resident #8 had impaired cognitive function or impaired thought processes related to dementia, a communication problem related to a cognitive deficit, was hard of hearing and had limited physical mobility related to a Cerebrovascular Accident (CVA). Interventions included anticipating and meeting needs, cueing, reorienting and supervising as needed and ensuring and providing a safe environment. 2. Resident #7?s diagnoses included metabolic encephalopathy (a change in brain function due to an underlying condition), dementia without behavioral disturbances, mild cognitive impairment, delusional disorder, anxiety disorder and major depressive disorder.The Nursing Evaluation dated 4/1/26 identified Resident #7 was admitted for a change in mental status, chronic decline and wandering. Resident #7 was alert and oriented to person, place and time and required extensive assistance for bed mobility, transfer and ambulation status was not determined at that time.A physician's order dated 4/2/26 directed Resident #7 was independent for mobility with no device on the secured memory unit.A physician's order dated 4/3/26 directed trazodone oral tablet 50 milligrams (mg), administer 25 mg by mouth every six (6) hours as needed for anxiety, restlessness or agitation.The Resident Care Plan (RCP) dated 4/12/26 identified Resident #7 had impaired cognitive function related to dementia, utilized psychotropic medications related to anxiety, depression and dementia, resided on the secured memory unit and ambulated independently with no assistive device on the secured memory unit. Interventions included anticipating and meeting needs, keeping the routine consistent and try to provide consistent care givers to decrease confusion, cueing, reorienting and supervising as needed, administering medications as ordered and monitoring and documenting side effects and effectiveness.An Order Administration note by RN #3 dated 4/15/26 at 1:45 AM identified Resident #7 was paranoid, talking to him/herself loudly, ambulated the hallway and complained of being unable to sleep. Trazodone 25 mg was administered.An Order Administration note by RN #3 dated 4/15/26 at 4:06 AM identified the trazodone was effective in managing behavioral symptoms.A nurse's note by RN #4 dated 4/15/26 at 3:04 PM identified Resident #7 was paranoid, yelling and not easily redirected. Medications were taken after multiple attempts. A nurse's note by RN #3 on 4/16/26 at 3:49 AM identified at around 3:30 AM, Resident #7 became belligerent due to not being able to have breakfast, food and fluids were offered but Resident #7 refused to take any meal items that were offered. Resident #7 went back to bed, staff heard Resident #7 talking to him/herself and a few minutes later, a loud noise was heard, staff ran to the room and observed Resident #7 standing next to the roommates (Resident #8's) bed holding a round brush and yelling at him/her. The left side of Resident #8's hair was covered in lotion and Resident #8 had a red mark to the left side of the nose, bruising to the left eye and bruising to the right hand. The residents were immediately separated, one-to-one observation was initiated for Resident #7, Emergency Medical Services (EMS) was called, the provider was notified and the responsible parties were notified. A psychiatric APRN note by APRN #2 on 4/16/26 identified she was asked to see Resident #7 following the alleged altercation with Resident #8. Resident #7 was calm but increasingly confused and Resident #7 explained someone (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	broke into his/her room last night and he/she was fearful, reporting the person was his/her family member who molested him/her at a young age. The note identified Resident #7 was noted by staff to be calling Resident #8 a name with Resident #7's last name. Resident #7 was currently on one-to-one observation and showing signs of increased confusion and delusions and due to unpredictability of Resident #7's behaviors, recommended an inpatient psychiatric and medical evaluation and that the facility would facilitate the transfer. Resident #7 was calm and pleasant, was not a danger to him/herself or others but could become increasingly confused later in the afternoon/evenings and recommended continued one-to-one supervision until Resident #7 was transferred later in the day. A nurse's note by the DON on 4/16/26 at 1:03 PM identified Resident #7 was a planned pick-up at 7:30 PM for transfer to the inpatient psychiatric hospital and report was called in.Review of the hospital Emergency Department (ED) documentation dated 4/16/26 identified Resident #8 was seen following an assault and reported a contusion (soft tissue injury caused by blunt force trauma) to the right side of the head, contusion to the face and contusion to the right hand. Imaging dated 4/16/26 at 6:37 AM identified a small five (5) by six (6) millimeter peripheral hyper density in the right frontal region, new since prior exam on 11/27/25, consistent with an acute subarachnoid hemorrhage (bleeding in the area between the brain and the thin tissue that covers and protects it). The documentation directed for Resident #8 not to take Eliquis (blood thinner) for two (2) weeks and to follow-up with the primary care provider. Review of the Connecticut Department of Public Health Facility Licensing and Investigations Section Reportable Event website on 4/20/26 identified the incident between Residents #7 and #8 occurred at 3:30 AM, the DON first knew about the incident at 5:00 AM but the incident was not reported until 6:41 AM (over 3 hours after the incident occurred).Interview with RN #3 on 4/21/26 at 8:26 AM identified she was aware the incident that occurred on 4/16/26 at 3:30 AM was required to be reported to the state agency and that she contacted the DON around 4:15 AM to notify her of the events that took place.Interview with the DON on 4/20/26 at 3:40 PM identified although RN #3 contacted her before 5:00 AM, she did not report the incident to the state agency until 6:41 and she should have ensured the incident was reported by 5:30 AM, within the two (2) hour timeframe.Review of the Abuse Reporting policy dated 6/2023 directed, in part, abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm of pain or mental anguish or deprivation by an individual. Physical abuse is defined as hitting, slapping, pinching, kicking, etc. It identified report allegations involving abuse (physical, verbal, sexual, mental) no later than two (2) hours after the allegation is made.

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F 0636 Level of Harm - Potential for minimal harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility policy and interviews for six (6) of six (6) sampled residents (Residents #8, 13, 14, 15, 16 and 17) reviewed for comprehensive assessments, the facility failed to ensure the resident comprehensive assessments were completed within fourteen (14) days of the Assessment Reference Date (ARD) as required. The findings include:1. The admission Minimum Data Set (MDS) assessment for Resident #13 was noted to have an ARD of 3/18/26 and was due to be completed by 4/1/26. Review of the admission MDS dated [DATE] for Resident #13 identified it was completed on 4/6/26 (5-days late). 2. The quarterly MDS assessment for Resident #15 was noted to have an ARD date of 4/1/26 and was due to be completed by 4/15/26. Review of the quarterly MDS dated [DATE] for Resident #15 on 4/20/26 identified it had yet to be completed (5-days late). 3. The quarterly MDS assessment for Resident #8 was noted to have an ARD (final day of the resident's observation period) of 4/2/26 and was due to be completed by 4/16/26. Review of the quarterly MDS dated [DATE] for Resident #8 on 4/20/26 identified it had yet to be completed (4-days late). 4. The annual MDS assessment for Resident #14 was noted to have an ARD date of 4/4/26 and was due to be completed by 4/18/26. Review of the annual MDS dated [DATE] for Resident #14 on 4/20/26 identified it had yet to be completed (2-days late). 5. The quarterly MDS assessment for Resident #16 was noted to have an ARD date of 4/4/26 and was due to be completed on 4/18/26. Review of the quarterly MDS dated [DATE] for Resident #16 on 4/20/26 identified it had yet to be completed (2-days late). 6. The quarterly MDS assessment for Resident #17 was noted to have an ARD date of 4/4/26 and was due to be completed by 4/18/26. Review of the quarterly MDS dated [DATE] for Resident #17 on 4/20/26 identified it had yet to be completed (2-days late). Interview with the MDS nurse, LPN #3 on 4/20/26 at 2:44 PM identified admission, quarterly and annual MDS's are due within 14 days of the ARD date. She reported she failed to complete the MDS assessments for Residents #8, 13, 14, 15, 16 and 17 prior to going on vacation and when she returned they were past the 14-day ARD date. She identified she should have completed the MDS's prior to going on vacation or delegated them to the MDS Coordinator (RN #6). Interview with the DON on 4/20/26 at 3:40 PM identified each MDS should be completed within 14 days of the resident's ARD. She identified she was unaware that MDS's were not being completed timely and reported LPN #3 should have delegated the MDS's she was unable to complete on time/before her vacation to the MDS Coordinator. Review of the MDS policy dated 7/2023 directed, in part, that the policy of the facility is to complete the MDS on a new admission within 14 days and review it quarterly thereafter. A new MDS is done annually or with significant change in a residents condition. The MDS Coordinator is responsible for the timely completion of the MDS and for completing the physical/medical sections of the MDS. Other disciplines are responsible for conducting their assessments and completing the section specific to their department on the MDS. The MDS Coordinator will sign the MDS upon completion and review it for items triggered.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **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 three (3) sampled residents (Resident #1) reviewed for modified texture diets, the facility failed to revise the Resident Care Plan (RCP) to identify physician-ordered one-to-one feeding assistance following a choking incident resulting in Resident #1 not being provided one-to-one feeding assistance for meals per physician's order and for one (1) of three (3) residents (Resident #7) reviewed for behaviors, the facility failed to develop an RCP for ongoing behaviors, agitation, and repeated care refusals. The findings include:1. Resident #1's diagnoses included dementia without behavioral disturbances, oropharyngeal dysphagia (weakening of the throat muscles making it difficult to move food from the mouth into the throat and esophagus during swallowing) cerebrovascular disease (conditions that affect blood flow in the brain) and type II diabetes mellitus.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had severely impaired cognition (Brief Interview for Mental Status (BIMS) score of 4), and required supervision assistance for eating and was dependent on staff for oral care, bed mobility and transfers. Resident #1 required a mechanically altered diet.The Resident Care Plan (RCP) dated 1/20/26 identified Resident #1 had impaired cognitive function or impaired thought processes related to dementia and had a potential swallowing problem related to a history of dysphagia and cerebral infarction (an ischemic stroke where the blood supply to part of the brain is blocked or reduced preventing brain tissue from getting oxygen and nutrients). Interventions included providing supervision with meals, diet to be followed as prescribed, instructing Resident #1 to eat in an upright position, to eat slowly, and to chew each bite thoroughly, monitoring/documenting/reporting as needed any signs and symptoms of dysphagia such as pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing, refusing to eat and appearing concerned during meals and monitoring for shortness of breath, choking, labored respirations and lung congestion.A late entry nurse's note by RN #1 (the 7:00 AM to 3:00 PM nursing supervisor) dated 3/19/26 at 1:59 PM identified she was called to the dining room where Resident #1 was in the wheelchair eating lunch when he/she experienced a choking episode and the Heimlich maneuver was performed. Resident #1's lung sounds were clear but diminished bilaterally and vital signs were obtained to include a heart rate of 96, blood pressure of 151/95 and oxygen level of 95 percent (%) on room air. Resident #1 remained at the nurse's desk for further evaluation by APRN #1 and no new orders were obtained.A nurse's note by the DON on 3/19/26 at 2:06 PM identified she was called to assess Resident #1 following an incident of choking while in the dining room. The Speech Language Pathologist (SLP) was in the dining area and yelled out to LPN #1 who responded and performed the Heimlich maneuver. A speech evaluation was placed, the physician and Conservator were notified and vital signs were to be initiated and obtained every four (4) hours.A provider note by APRN #1 dated 3/20/26 identified Resident #1 had a choking episode on 3/19/26 requiring the Heimlich maneuver. APRN #1 directed a 2-view chest x-ray to evaluate for aspiration or consolidation and that staff would obtain vital signs every shift for 3 days and lab work would be obtained 3/23/26 to monitor for developing leukocytosis (elevated white blood cell count signifying an infection) or dehydration. Additionally, Resident #1's diet was downgraded to minced and moist and Resident #1 would be a one (1) to one (1) feed for meals.A physician's order dated 3/20/26 directed Occupational Therapy Activities of Daily Living recommendation: 1:1 feed for meals. Interview with the SLP on 4/13/26 at 11:45 AM identified Resident #1 had not been on her caseload at the time of the 3/19/26 choking incident, but following the incident, nursing downgraded the diet to puree, requested a speech evaluation, and she evaluated Resident #1 on 3/20/26. The evaluation identified Resident #1 was unable to self-feed due to cognition, required rate modification (slowing eating rate) had decreased safety awareness and the SLP recommended a downgrade to a level 5 minced and moist texture diet, which did not include (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	peanut butter and jelly sandwiches. Resident #1 required one-to-one feeding assistance.Observations of the dining room on 4/13/26 at 12:57 PM identified NA #2 and NA #3 present in the dining room for the lunch meal. Resident #1 was observed feeding him/herself, although a physician's order was in place directing Resident #1 receive one-to-one feeding assistance. Further, Resident #1's meal ticket did not indicate Resident #1 required one-to-one feeding assistance.Interview and observation with the Rehab Director on 4/13/26 at 1:00 PM identified NA #2 to be sitting in a chair beside Resident #1 in the dining room assisting Resident #1 with ice cream. Resident #1 was noted to have regular utensils and not built-up foam utensils in front of him/her. The Rehab Director identified following the 3/19/26 choking incident, Resident #1 required one-to-one feeding assistance so staff should have been feeding Resident #1 at all times. At 1:01 PM, NA #2 reported to the Rehab Director that Resident #1 was feeding him/herself. Review of Resident #1's Kardex on 4/13/26 identified Resident #1 was on a mechanically altered diet and required supervision for eating. (Not consistent with physician's order)Interview with the DON on 4/20/26 at 9:26 AM identified the charge nurse or nursing supervisor should have updated the RCP immediately upon notification by SLP #1 that Resident #1 would require one-to-one feeding assistance effective 3/20/26. The DON reported she was unaware that the RCP and Kardex did not accurately identify the supervision status for feeding, but identified the physician's order, RCP and Kardex should have all matched so Resident #1 was supervised appropriately for meals.Interview with the MDS nurse, LPN #3 on 4/20/26 at 2:24 PM identified nursing or the interdisciplinary team (IDT) that is initially aware of a resident change is responsible for updating the RCP for an intervention that needs to be updated immediately, such as a resident requiring increased supervision for meals, behaviors or refusals of care. She reported nursing or the IDT would been responsible for updating the RCP and Kardex to identify the change or would have been responsible for notifying her immediately to do so, which they did not. She identified had the Care Plan for Resident #1 been updated immediately following the physician's order for Resident #1 to be a one-to-one feed and ensured it displayed on the Kardex, NA staff would have been able to see the changes on the Kardex and provided the necessary one-to one assistance for meals.2. Resident #7?s diagnoses included metabolic encephalopathy (a change in brain function due to an underlying condition), dementia without behavioral disturbances, mild cognitive impairment, delusional disorder, anxiety disorder and major depressive disorder.The Nursing Evaluation dated 4/1/26 identified Resident #7 was admitted for a change in mental status, chronic decline and wandering. Resident #7 was alert and oriented to person, place and time and required extensive assistance for bed mobility, transfer and ambulation status was not determined at that time. An Order Administration note dated 4/3/26 at 9:29 AM identified Resident #7 refused the fluticasone nasal suspension 50 micrograms (mcg) per actuation (spray), 2 sprays in both nostrils once daily for seasonal allergies.Order Administration notes dated 4/3/26 at 3:02 PM and 3:05 PM identified Resident #7 refused the weekly body evaluation and the weekly weight as well as triamcinolone cream 1 percent (%) that was to be applied to affected areas every evening shift for contact dermatitis (inflammation of the skin).A nurse's note by RN #1 dated 4/3/26 at 7:01 PM identified Resident #7 had increased agitation and yelling, unable to administer evening or as needed medications or redirect Resident #7. Resident #7 was found lying in a male resident's bed and multiple attempts by staff to remove Resident #7 were unsuccessful. The family was notified and recommendations on how to handle Resident #7 were requested. With help from a NA, RN #1 was able to remove Resident #7 from the bed. Attempts were made to reorient Resident #7 to his/her personal space and belongings but Resident #7 continued to be irate and difficult. A nurse's note by LPN #4 dated 4/3/26 at 8:00 PM identified Resident #7 continued to refuse 8:00 PM medications. Resident #7 was educated on the risk and benefit and Resident #7 continued to refuse so the nursing supervisor was notified.A nurse's note by LPN #5 dated 4/4/26 at 2:53 PM identified Resident #7 became agitated with staff and refused to go to his/her room.An Order administration note dated 4/4/26 at 7:39 PM identified Resident #7 refused to have vital signs obtained.An Order Administration note dated 4/4/26 at 11:05 PM identified Resident (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#7 refused triamcinolone cream 1 percent (%) that was to be applied to affected areas every evening shift for contact dermatitis.A nurse's note by LPN #5 dated 4/5/26 at 12:37 PM identified Resident #7 became agitated with staff and refused to go to his/her room.A nurse's note by LPN #5 dated 4/6/26 at 3:00 PM identified Resident #7 refused lab work and that it was rescheduled.An Order Administration note dated 4/6/26 at 9:21 PM identified Resident #7 refused vital signs three (3) times.An Order Administration note dated 4/8/26 at 7:35 PM identified Resident #7 refused ketoconazole cream 2% that was to be applied to affected areas topically every evening shift for tinea corporis (superficial fungal infection of the skin).An Order Administration note dated 4/8/26 at 7:56 PM identified Resident #7 refused triamcinolone cream 1 percent (%) that was to be applied to affected areas every evening shift for contact dermatitis.A Skilled Nursing note by LPN #4 on 4/8/26 at 10:52 PM identified Resident #7 was alert but confused and agitated, yelling and refused evening care.An Order Administration note dated 4/9/26 at 8:08 PM identified Resident #7 refused triamcinolone cream 1 percent (%) that was to be applied to affected areas every evening shift for contact dermatitis.An Order Administration note dated 4/9/26 at 8:39 PM identified Resident #7 refused ketoconazole cream 2% that was to be applied to affected areas topically every evening shift for tinea corporis (superficial fungal infection of the skin).An Order Administration note dated 4/11/26 at 12:37 PM identified Resident #7 refused constulose 10 grams (gm) per 15 milliliter (mL) solution, give 30 mL for bowel management.A Skilled Nursing note by LPN #4 on 4/11/26 at 10:53 PM identified Resident #7 was alert but confused with increased agitation, was hard to redirect and took medications with a lot of encouragement.A nurse's note by RN #5 on 4/12/26 at 6:41 AM identified Resident #7 slept on and off throughout the night, crying and talking outload with increased paranoia, agitation and aggression towards staff. Resident #7 refused all medications and vital signs.A nurse's note by LPN #4 on 4/12/26 at 9:47 PM identified Resident #7 was alert but confused, paranoid, agitated, talking loudly to him/herself, however took all medications as ordered. An Order Administration note dated 4/13/26 at 4:50 AM identified Resident #7 refused to have vital signs taken and was paranoid and agitated.An Order Administration note dated 4/13/26 at 5:03 AM identified Resident #7 refused to take Synthroid 112 micrograms (mcg) tablet for hypothyroidism (underactive thyroid). A nurse's note by LPN #4 on 4/13/26 at 10:56 PM identified Resident #7 was alert but agitated and yelling loudly in the hallway. Resident #7 was redirected with a lot of encouragement.A Skilled Nursing note by LPN #4 on 4/14/26 at 10:07 PM identified Resident #7 was alert but confused, yelling, talking loudly to him/herself, tearful and anxious but took medications as ordered.A nurse's note by RN #3 dated 4/15/26 at 8:12 AM identified at the beginning of the shift Resident #7 was paranoid, talking to him/herself loudly, ambulated in the hallway and reported he/she was unable to sleep. It reported Resident #7 was medicated with as needed trazodone with good effect and he/she rested for the remainder of the night.A nurse's note by RN #4 dated 4/15/26 at 3:04 PM identified Resident #7 was paranoid, yelling and was not easily redirected. Medications were taken after multiple attempts.A nurse's note by RN #3 on 4/16/26 at 3:49 AM identified at around 3:30 AM, Resident #7 became belligerent due to not being able to have breakfast, food and fluids were offered but Resident #7 refused to take any meal items that were offered. Resident #7 went back to bed, staff heard Resident #7 talking to him/herself and a few minutes later, a loud noise was heard, staff ran to the room and observed Resident #7 standing next to the roommates (Resident #8's) bed holding a round brush and yelling at him/her. The left side of Resident #8's hair was covered in lotion and Resident #8 had a red mark to the left side of the nose, bruising to the left eye and bruising to the right hand.Review of the clinical record failed to identify a Resident Care Plan (RCP) for behaviors or refusal of care prior to the 4/16/26 incident. Interview with the DON on 4/20/26 at 9:26 AM identified nursing or the IDT should have identified the pattern of behaviors and refusals for Resident #7 from admission and initiated RCPs and interventions as soon as the behaviors were identified.Review of the Care Plans policy dated 6/2023 directed, in part, Resident Care Plans (RCP's) can be revised, as needed, at any time, on an interim basis. RCP's will include physical, cognitive and psycho-social (continued on next page)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	problems and will address the residents' needs on an individualized basis.Review of the Resident Profiles policy dated 7/2023 directed, in part, that nursing staff must be aware of all of the residents' current needs for care to provide safe care. It is the responsibility of the nursing staff to check the resident profile on the computer system at the start of their shift and as needed throughout the shift for each resident they provide care for. This will ensure that nursing staff has the most up to date information regarding the residents' needs and abilities. The profile is accessible to all nursing staff through the POC or PCC accessible on the wall or desk units.Although requested, a facility policy for staff supervision for meals in the dining room was not available prior to 4/13/26.Although requested, a facility policy on therapy recommendations was not available.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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 two (2) of five (5) sampled residents (Resident #1 and #2) reviewed for accident hazards, the facility failed to ensure residents received altered texture diets consistent with physician's orders and International Dysphagia Diet Standardization Initiative (IDDSI) guidelines and were provided supervision during meals as required for residents with dysphagia, creating a choking hazard. Specifically, on 3/19/26 at approximately 1:00 PM, Resident #1, who had diagnoses of dementia and dysphagia who required supervision during meals and was ordered an IDDSI Level 6 diet, was served and consumed a peanut butter and jelly sandwich that was not ordered and not consistent with the prescribed diet. Resident #1 began choking, was observed to be red in the face and unable to breathe and required the Heimlich maneuver to be performed to expel the obstructing food. Upon further observation, Resident #1 was feeding him/herself in the dining room although following the choking incident, Resident #1 required one-to-one feeding assistance. The failures resulted in the finding of Immediate Jeopardy. The findings include:1. Resident #1's diagnoses included dementia without behavioral disturbances, oropharyngeal dysphagia (weakening of the throat muscles making it difficult to move food from the mouth into the throat and esophagus during swallowing) cerebrovascular disease (conditions that affect blood flow in the brain) and type II diabetes mellitus.A physician's order dated 7/4/25 directed a regular diet IDDSI 6 soft and bite sized texture, IDDSI 0 thin Liquids consistency. The orders directed Resident #1 to utilize a lip plate, built-up utensils, and required supervision with meals.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had severely impaired cognition (Brief Interview for Mental Status (BIMS) score of 4), and required supervision assistance for eating and was dependent on staff for oral care, bed mobility and transfers. Resident #1 required a mechanically altered diet.The Resident Care Plan (RCP) dated 1/20/26 identified Resident #1 had impaired cognitive function or impaired thought processes related to dementia and had a potential swallowing problem related to a history of dysphagia and cerebral infarction (an ischemic stroke where the blood supply to part of the brain is blocked or reduced preventing brain tissue from getting oxygen and nutrients). Interventions included providing supervision with meals, diet to be followed as prescribed, instructing Resident #1 to eat in an upright position, to eat slowly, and to chew each bite thoroughly, monitoring/documenting/reporting as needed any signs and symptoms of dysphagia such as pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing, refusing to eat and appearing concerned during meals and monitoring for shortness of breath, choking, labored respirations and lung congestion.A late entry nurse's note by RN #1 (the 7:00 AM to 3:00 PM nursing supervisor) dated 3/19/26 at 1:59 PM identified she was called to the dining room where Resident #1 was in the wheelchair eating lunch when he/she experienced a choking episode and the Heimlich maneuver was performed. Resident #1's lung sounds were clear but diminished bilaterally and vital signs were obtained to include a heart rate of 96, blood pressure of 151/95 and oxygen level of 95 percent (%) on room air. Resident #1 remained at the nurse's desk for further evaluation by APRN #1 and no new orders were obtained.A nurse's note by the DON on 3/19/26 at 2:06 PM identified she was called to assess Resident #1 following an incident of choking while in the dining room. The Speech Language Pathologist (SLP) was in the dining area and yelled out to LPN #1 who responded and performed the Heimlich maneuver. A speech evaluation was placed, the physician and Conservator were notified and vital signs were to be initiated and obtained every four (4) hours.Review of nurse's notes dated 3/19/26 for the 3:00 PM to 11:00 PM and 11:00 PM to 7:00 AM shifts failed to identify monitoring or assessments following the choking incident.A provider note by APRN #1 dated 3/20/26 identified Resident #1 had a choking episode on 3/19/26 requiring the Heimlich maneuver. APRN #1 directed a 2-view chest x-ray to evaluate for aspiration or consolidation (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	and that staff would obtain vital signs every shift for 3 days and lab work would be obtained 3/23/26 to monitor for developing leukocytosis (elevated white blood cell count signifying an infection) or dehydration. Additionally, Resident #1's diet was downgraded to minced and moist and Resident #1 would be a one (1) to one (1) feed for meals.A physician's order dated 3/20/26 directed a regular diet, IDDSI 5 minced and moist texture, IDDSI 0 thin liquids consistency.A physician's order dated 3/20/26 directed Occupational Therapy Activities of Daily Living recommendation: 1:1 feed for meals.Review of the IDDSI guidance identified level 6 soft and bite sized texture included bite sized pieces no bigger than 1.5 centimeters (cm) by 1.5 cm pieces to reduce choking risks and should be able to be mashed or broken down with the pressure from a fork. No regular dry bread due to choking risks and to avoid sticky or gummy food including nut butters. Interview with the SLP on 4/13/26 at 11:45 AM identified Resident #1 had not been on her caseload at the time of the 3/19/26 incident, but reported residents who are on an altered texture diet for dysphagia and wish to have peanut butter and jelly sandwiches require an evaluation by a SLP to ensure safety. If approved, a physician's order should be entered to allow peanut butter and jelly sandwiches per exception, and the sandwich should be cut into 1.5 cm by 1.5 cm pieces. She identified that on 3/19/26, she was evaluating another resident in the dining room and had her back to Resident #1 when she heard loud banging on a table. She turned around, observed Resident #1 to be red in the face and it appeared Resident #1 was not breathing. She ran to the doorway of the dining room and alerted LPN #1, who was sitting at the nurse's station near the dining room entrance. The SLP reported LPN #1 immediately ran into the dining room, assessed Resident #1 and performed the Heimlich maneuver which dislodged a piece of food. The food and Resident #1's dentures launched out of his/her mouth. Following the incident, nursing downgraded the diet to puree, requested a speech evaluation, and she evaluated Resident #1 on 3/20/26. The evaluation identified Resident #1 was unable to self-feed due to cognition, required rate modification (slowing eating rate) had decreased safety awareness and the SLP recommended a downgrade to a level 5 minced and moist texture diet, which did not include peanut butter and jelly sandwiches. Resident #1 required one-to-one feeding assistance. The SLP identified the 3/19/26 choking incident could have been prevented if Resident #1's diet orders were followed. She reported she was not asked to supervise the dining room for the lunch meal on 3/19/26, she was only focused on the resident she was in the dining room to evaluate.Interview with LPN #1 on 4/13/26 at 11:14 AM identified on 3/19/26 she was at the nurse's station when the SLP ran to the dining room entrance and alerted her Resident #1 was choking. She reported she assessed Resident #1, who was clenching his/her teeth shut and she was unable to see food in Resident #1's mouth so she performed the Heimlich maneuver which required six (6) to seven (7) thrusts to dislodge the food. LPN #1 identified Resident #1 always received crustless, halved peanut butter and jelly sandwiches with meals and she was unaware there was no order for the sandwich or that it was not permitted on a level 6 texture diet. LPN #1 could not identify which NA was assigned to supervise lunch in the dining room or if there was an NA in the dining room to supervise lunch.Interview with RN #1 on 4/13/26 at 1:24 PM identified when she arrived on the unit on 3/19/26, Resident #1 was sitting upright in the wheelchair at the nurse's station. She reported Resident #1's eyes were red and watery, she assessed Resident #1 immediately and vital signs were normal, had no abnormal lung sounds and no further coughing was noted. She texted APRN #1 to report the incident, but APRN #1 did not respond. She did not contact the on-call provider or the Medical Director when she did not receive a response from APRN #1. RN #1 entered an order for vital signs every four (4) hours for three (3) days, downgraded Resident #1's diet to puree, entered a speech screen, and notified APRN #1 the following morning. She identified the subsequent licensed nurses should have monitored and documented assessments until Resident #1 was evaluated by APRN #1. She reported all staff interacting with residents on altered texture diets should be aware of what the diets include. She identified NA's are responsible for ensuring care is provided according to the residents plan of care and staff should have ensured Resident #1 was supervised for the lunch meal. RN #1 was unable to identify if there was an NA (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	present in the dining room at the time of the choking incident.Interview with APRN #1 on 4/13/26 at 2:25 PM identified she was not scheduled to work on 3/19/26 and evaluated Resident #1 on 3/20/26. She reported Resident #1 should have been evaluated to eat peanut butter and jelly sandwiches prior to being served the sandwiches and identified a physician's order should have been in place allowing Resident #1 to have the peanut butter and jelly sandwiches only if it was deemed safe by the SLP. APRN #1 reported staff should follow diet orders and supervision orders prior to providing any resident with food or drinks. She identified that providing residents with food that is not authorized for a specific altered diet causes a choking risk. She reported RN #1 should have contacted the on-call provider or the Medical Director following the choking incident so a chest x-ray could have been ordered and obtained the same day to rule out aspiration.Review of the facility schedule dated 3/19/26 identified NA #1, NA #3, NA #4, NA #5, NA #10 and LPN #2 were also working on the south-east unit on the 7:00 AM to 3:00 PM shift on 3/19/26.Interviews with NA #1, NA #3, NA #4, NA #5, NA #10 and LPN #2 on 4/13/26 identified they were not assigned to the dining room for the lunch meal on 3/19/26 and did not witness Resident #1 choking around 1:00 PM. They identified at least one (1) NA is required to be present in the dining room at all times once meals are served to supervise residents and reported Resident #1 always received peanut butter and jelly sandwiches with meals for as long as they could remember and they were unaware a level 6 texture diet did not include peanut butter and jelly sandwiches or where guidance on IDDSI diets was posted. Additionally, NA #1 identified she often gave Resident #1 crustless peanut butter and jelly sandwiches for snacks because she thought Resident #1 could have them.Interview with the Rehab Director on 4/13/26 at 12:30 PM identified that per her records, Resident #1 was never evaluated by an SLP for an exception for peanut butter and jelly sandwiches. Residents on a modified diet that prohibits peanut butter should not be provided with a peanut butter and jelly sandwich unless first cleared by a SLP for an exception and then approved by the provider and an order entered. The Rehab Director identified the choking incident could have been prevented if staff followed the diet order.Observations of the dining room on 4/13/26 at 12:57 PM identified NA #2 and NA #3 present in the dining room for the lunch meal. Resident #1 was observed feeding him/herself, although a physician's order was in place directing Resident #1 receive one-to-one feeding assistance. Further, Resident #1's meal ticket did not indicate Resident #1 required one-to-one feeding assistance.Interview and observation with the Rehab Director on 4/13/26 at 1:00 PM identified NA #2 to be sitting in a chair beside Resident #1 in the dining room assisting Resident #1 with ice cream. Resident #1 was noted to have regular utensils and not built-up foam utensils in front of him/her. The Rehab Director identified following the 3/19/26 choking incident, Resident #1 required one-to-one feeding assistance so staff should have been feeding Resident #1 at all times. At 1:01 PM, NA #2 reported to the Rehab Director that Resident #1 was feeding him/herself.Interview with the Food Service Director (FSD) on 4/13/26 at 1:07 PM identified a level 6 soft and bite sized diet includes soft foods that are cut into 1.5 cm cubes and would not include peanut butter and jelly sandwiches. She reported Resident #1 was on a level 6 texture diet and his/her meal tickets included a peanut butter and jelly sandwich to be provided for each meal. She was unsure who approved the sandwich and was unable to locate a diet order slip directing dietary that Resident #1 had been approved to receive peanut butter and jelly sandwiches. Additionally, she identified all residents on modified diets would receive a crustless sandwich cut in half, reporting that they were never cut into 1.5 cm cubes or smaller.Interview with the Staffing Coordinator on 4/13/26 at 1:55 PM identified the 3/19/26 NA assignment sheet did not have any 7:00 AM to 3:00 PM staff assigned to supervise the dining room for the lunch meal. She identified that the nursing supervisors were responsible for assigning staff for their shift which was not consistently done. Review of Resident #1's Kardex on 4/13/26 identified Resident #1 was on a mechanically altered diet and required supervision for eating. (Not consistent with physician's order)Interview with the DON on 4/13/26 at 5:39 PM identified Resident #1 should have been provided with his/her diet per physician's orders, and staff should be aware of a residents diets, restrictions and ensuring meal (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	tickets match the meal provided prior to serving a meal. She identified that following the incident, staff reported to her that Resident #1 always received peanut butter and jelly sandwiches with meals. She reported peanut butter and jelly sandwiches are outside of the level 6 texture and Resident #1 should have been evaluated by the SLP and an order should have been obtained prior to Resident #1 receiving a peanut butter and jelly sandwich. She reported residents who require supervision or one-to-one assistance should receive that level of care with all meals and the plan of care should be accurate. She identified two (2) NA's should be present in the dining room at all times once food is served. She was unable to identify if a NA was present when the choking incident occurred. The DON reported Resident #1 should not have been served peanut butter and jelly sandwiches and if Resident #1 had been provided with the correct diet and received supervision per physician's orders, the choking incident could have been avoided. Additionally, RN #1 should not have called APRN #1 on 3/19/26 following the incident, since she was not working and should have contacted the on-call provider or the Medical Director. She identified following any resident concern or change in condition, if a provider is contacted and they do not call back within ten (10) minutes, staff are to call back or contact a different provider and document accurately regarding provider notification.Interview with NA #8 on 4/14/26 at 9:55 AM identified she was assigned to the Pavilion unit on 3/19/26, did not see or have any contact with Resident #1 and was not assigned and did not go into the dining room on 3/19/26. 2. Resident #2?s diagnoses included oropharyngeal dysphagia and cerebral infarction (an ischemic stroke where blood supply to part of the brain is blocked or reduced).A physician's order dated 7/4/25 directed a regular diet, IDDSI 6 soft and bite sized texture, IDDSI 3 moderately thick/ honey consistency and Resident #2 may have soft crustless sandwiches (tuna salad, egg salad, peanut butter and jelly) and required supervision with meals.A Stern Speech Therapy Screen by SLP #1 dated 7/31/25 identified Resident #2 was currently on a IDDSI 6 and honey thickened liquids diet, but she observed Resident #2 demonstrating overt signs and symptoms of aspiration with coughing after swallowing food. The screen identified a SLP evaluation for oropharyngeal swallow function was warranted.A physician's order dated 7/31/25 directed to provide Resident #2 a regular diet, IDDSI 5 minced and moist texture, IDDSI 3 moderately thick/honey consistency liquids.The SLP Discharge Summary for dates of service 7/31/25 through 10/24/25 and signed by SLP #1 on 10/27/25 identified Resident #2 met the highest practical level of function and refused to engage in speech therapy treatment or adhere to safe swallowing strategies that may have improved function. Diet recommendations were made for IDDSI 5 minced and moist texture, IDDSI 3 moderately thick/honey consistency liquids. The Discharge Summary did not identify Resident #2 was evaluated for peanut butter and jelly sandwiches or that Resident #2 was safe to consume peanut butter and jelly sandwiches.Physician's orders dated 9/11/25 and 1/6/26 directed Resident #2 may have crustless peanut butter and jelly sandwiches with every meal.Review of the clinical record from 10/25/25 through 4/13/26 failed to identify Resident #2 was evaluated by an SLP approving the crustless peanut butter and jelly sandwiches for Resident #2 after the 10/24/25 discharge.The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had severely impaired cognition (Brief Interview for Mental Status (BIMS) score of 0), and required setup assistance for eating, partial assistance for bed mobility and was dependent on staff for oral hygiene and transfers. The MDS identified Resident #2 required a mechanically altered diet. The Resident Care Plan (RCP) dated 2/3/26 identified Resident #2 had impaired cognitive function and dysphagia. Interventions included cueing, reorienting and supervising as needed, providing setup assistance for feeding and an assist of one (1) as needed, providing a regular diet, IDDSI level 5 minced and moist texture; IDDSI 3 moderately thick/honey consistency liquids, providing a crustless peanut butter and jelly sandwich with each meal, taking aspiration precautions such as elevating the head of the bed, remaining in an upright position when eating.Observations of the dining room on 4/13/26 at 12:57 PM identified NA #2 and NA #3 present in the dining room for the lunch meal. Resident #2 was observed to have been served a halved, crustless peanut butter and jelly sandwich. NA #2 and NA #3 identified Resident #2 always (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	received a crustless peanut butter and jelly sandwich with meals.Review of the IDDSI guidance identified level 5 minced and moist texture included foods that are soft and moist with no liquid leaking or dripping from the food, biting was not required, minimal chewing was required, lumps are to be 4 millimeter (mm) in size, lumps can be mashed with the tongue, no regular dry bread due to choking risks and to avoid textures that pose a choking risk for adults including sticky foods or nut butters.Interview with SLP #1 on 4/13/26 at 11:45 AM identified residents who are on altered texture diets who have been evaluated by an SLP and approved to be safe to consume peanut butter and jelly sandwiches should have a physician's order to allow the peanut butter and jelly sandwiches per exception and the sandwich should be cut up into pieces as specified by the IDDSI guidance.Observations on 4/14/26 at 12:38 PM, identified Resident #2 was served a quartered, crustless peanut butter and jelly sandwich.Review of physician's orders identified the 1/6/26 physician's order for the crustless peanut butter and jelly sandwich with every meal was discontinued on 4/14/26 following the lunch meal.Re-interview with SLP #1 on 4/20/26 at 12:56 PM identified after picking up Resident #2 for SLP services on 7/31/25, she trialed crustless peanut butter and jelly sandwiches but Resident #2 was not safe to consume the peanut butter and jelly sandwiches without one-to-one SLP observation. When she discharged Resident #2 on 10/24/25, she wrote a diet slip recommendation, which was submitted to nursing and identified Resident #2 should be placed on a IDDSI level 5 minced and moist texture; IDDSI 3 moderately thick/honey consistency liquids but did not mention that Resident #2 was permitted to consume crustless peanut butter and jelly sandwiches. She reported nursing should have ensured any physician's orders for crustless peanut butter and jelly sandwiches were discontinued and she did not know why physician's orders dated 9/11/25 and 1/6/26 directed crustless peanut butter and jelly sandwiches with every meal when she identified Resident #2 was not safe to consume the peanut butter and jelly sandwiches and had not indicated on the diet slip or to any staff that there was an approved exception for the peanut butter and jelly sandwiches.Interview with APRN #1 on 4/20/26 at 1:45 PM identified Resident #2 should have been served meals per SLP recommendations and if SLP #1 had not recommended Resident #2 was safe to receive crustless peanut butter and jelly sandwiches, an order should not have been entered by nursing. She identified she signed the 9/11/25 and 1/6/26 physician's orders directing Resident #2 to receive crustless peanut butter and jelly sandwiches with meals, but nursing had not discussed the order with her. APRN #1 identified she signed orders in bulk and assumed the order was approved by SLP #1.Interview with the DON on 4/20/26 at 9:26 AM identified she was unsure why orders were entered by nursing on 9/11/25 and 1/6/26 directing that Resident #2 may have crustless peanut butter and jelly sandwiches with every meal when it was not recommended by SLP #1 on the 10/24/25 discharge. She reported the 9/11/25 and 1/6/26 physician's orders should not have been entered, and Resident #2 should not have been receiving crustless peanut butter and jelly sandwiches with every meal.Review of the Modified Textures policy dated 1/25/26 directed, in part, residents will be provided foods which are the consistency that will be safe, tolerable and ordered by the physician and/or speech therapy. The diet texture is part of the diet ordered by the physician. Any texture ordered is provided according to the Diet Manual and transcribed onto the resident's diet card. Texture needs are regularly screened by the Speech Therapist. Revisions to the planned and menued modified texture diets can be made upon the request of the Speech Therapist or Dietician to accommodate individual needs. Modified textures may not be omitted on special occasions.Review of the Feeding Residents policy dated 6/2023 directed, in part, to ensure that the food listed on the dietary card are the foods on the tray.Although requested, a facility policy for staff supervision for meals in the dining room was not available prior to 4/13/26.Although requested, facility policies on diet consistency/texture exceptions for residents on modified texture diets, speech therapy recommendations and Nurse Aide Care Cards/Kardex were not available.

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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 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 #8) reviewed for abuse, the facility failed to ensure a pain assessment was completed following injuries sustained from a resident to resident incident and failed to ensure Resident #8 was offered or administered as needed pain relief medication when the injuries were identified prior to hospital transfer. The findings include:Resident #8?s diagnoses included dementia without behavioral disturbances, chronic pain, major depressive disorder and anxiety disorder. A physician's order dated 10/8/25 directed Resident #8 required an assist of two (2) stand pivot transfer and utilized a wheelchair for mobility. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #8 had severely impaired cognition (Brief Interview for Mental Status (BIMS) score of 3), required substantial assistance with bed mobility and was dependent on staff for transfers. The Resident Care Plan (RCP) dated 4/9/26 identified Resident #8 had the potential for pain due to osteoporosis (when bones become weak, thin and brittle) and chronic pain, had impaired cognitive function or impaired thought processes related to dementia, had a communication problem related to a cognitive deficit and hard of hearing and had limited physical mobility related to a Cerebrovascular Accident (CVA). Interventions included anticipating the resident's need for pain relief and responding immediately to any complaint of pain, administering analgesic medications as per orders, anticipating and meeting needs, cueing, reorienting and supervising as needed and ensuring and providing a safe environment. A nurse's note by RN #3 dated 4/16/26 at 4:04 AM identified at 3:30 AM Resident #8 was assaulted by his/her roommate (Resident #7). Resident #8 was awake, alert and nonverbal at baseline and had been covered in body lotion to the left side of his/her hair, had a red mark to the left side of the nose, bruising to the left eye and a bruise to the right hand. The note failed to identify Resident #8 was assessed for pain or offered pain relief medications. Review of the Pain Assessment Interview and Pain Evaluations failed to identify Resident #8 had been evaluated for pain following the 4/16/26 assault. Review of the April 2026 Medication Administration Record (MAR) for Resident #8 identified a physician's order dated 7/4/25 for acetaminophen 325 milligrams (mg), give two (2) tablets every four (4) hours as needed for pain but failed to identify that it had been administered on 4/16/26. Review of the Prehospital Care Report (ambulance run sheet) dated 4/16/26 identified Emergency Medical Services (EMS) were dispatched to the facility on 4/16/26 at 3:50 AM, arrived on site at the facility and to Resident #8 at 4:03 AM and departed the facility at 4:19 AM (leaving 49 minutes for the facility to medicate Resident #8 for pain relief). The report identified it was reported to them that staff found Resident #8's roommate (Resident #7) on top of him/her beating him/her in the face and head with a heavy hairbrush and Resident #8 did not know what happened, but knew he/she was injured in some way. Resident #8 presented with severe bruising, swelling, discoloration, pain, and tenderness to his/her face, around the eyes, and on the forehead and indicated staff reported that Resident #8's roommate also covered Resident #8 in lotion, which was found dripping out of Resident #8's ears. Review of the hospital Emergency Department (ED) document dated 4/16/26 identified Resident #8 was seen following an assault and reported a contusion (soft tissue injury caused by blunt force trauma) to the right side of the head, contusion to the face and contusion to the right hand. Imaging dated 4/16/26 at 6:37 AM identified a small five (5) by six (6) millimeter peripheral hyper density in the right frontal region, new since prior exam on 11/27/25, consistent with an acute subarachnoid hemorrhage (bleeding in the area between the brain and the thin tissue that covers and protects it). The document directed for Resident #8 not to take Eliquis (blood thinner) for two (2) weeks and to follow-up with the primary care provider. Additionally, the documentation identified Resident #8 was administered acetaminophen 650 mg at 9:54 AM (over 6 hours after the injuries occurred). Interview with RN #3 on 4/21/26 at 8:26 AM identified she did not think to administer Resident #8 pain relief medication following the injuries. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RN #3 reported she should have documented a full assessment including pain, as well as complete a pain evaluation following the change in condition but identified she was preoccupied with Resident #7.Interview with the DON on 4/22/26 at 11:55 AM identified RN #3 should have ensured Resident #8 was assessed for pain and that a full pain assessment was completed following the injuries on 4/16/26. She reported although the early morning was chaotic due to the incident, RN #3 should have ensured Resident #8 was cared for and that acetaminophen was offered or administered following the injuries prior to transport to the hospital.Review of the Pain Control and Management policy dated 7/2023 directed, in part, complete a pain assessment on admission quarterly and as needed to assess pain and interventions as needed, monitor effectiveness of pain treatment and with non-verbal residents and monitor for pain via behavioral changes, such as weepiness/crying, grimacing, decrease in appetite, agitation and/or restlessness. For the non-verbal/dementia pain rating scale, assess for facial grimacing/frowning, intermittent moaning, sighing, decrease in appetite, restlessness, crying and loss of appetite.

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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 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **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 #7) reviewed for behaviors, the facility failed to ensure behavioral symptoms were identified and managed to prevent escalation. Specifically, this failure included the failure to document ineffective interventions, reapproach and administer medication for anxiety, restlessness or agitation, and implement effective interventions for ongoing yelling, paranoia, agitation and wandering behaviors prior to an altercation with another resident. The findings include:Resident #7?s diagnoses included metabolic encephalopathy (a change in brain function due to an underlying condition), dementia without behavioral disturbances, mild cognitive impairment, delusional disorder, anxiety disorder and major depressive disorder.The Nursing Evaluation dated 4/1/26 identified Resident #7 was admitted for a change in mental status, chronic decline and wandering. Resident #7 was alert and oriented to person, place and time and required extensive assistance for bed mobility, transfer and ambulation status was not determined at that time.A physician's order dated 4/3/26 directed trazodone oral tablet 50 milligrams (mg), administer 25 mg by mouth every six (6) hours as needed for anxiety, restlessness or agitation.The Resident Care Plan (RCP) dated 4/12/26 identified Resident #7 had impaired cognitive function related to dementia, utilized psychotropic medications related to anxiety, depression and dementia, resided on the secured memory unit and ambulated independently with no assistive device on the secured memory unit. Interventions included anticipating and meeting needs, keeping the routine consistent and try to provide consistent care givers to decrease confusion, cueing, reorienting and supervising as needed, administering medications as ordered and monitoring and documenting side effects and effectiveness. A nurse's note by RN #4 dated 4/15/26 at 3:04 PM identified Resident #7 was paranoid, yelling and was not easily redirected. Medications were taken after multiple attempts but failed to identify what interventions were initiated to deescalate Resident #7 or that the PRN trazodone was offered.A nurse's note by RN #3 on 4/16/26 at 3:49 AM identified at around 3:30 AM, Resident #7 became belligerent due to not being able to have breakfast, food and fluids were offered but Resident #7 refused to take any meal items that were offered. Resident #7 went back to bed, staff heard Resident #7 talking to him/herself and a few minutes later, a loud noise was heard, staff ran to the room and observed Resident #7 standing next to the roommates (Resident #8's) bed holding a round brush and yelling at him/her. The left side of Resident #8's hair was covered in lotion and Resident #8 had a red mark to the left side of the nose, bruising to the left eye and bruising to the right hand. The residents were immediately separated, one-to-one observation was initiated for Resident #7, Emergency Medical Services (EMS) was called, the provider was notified and the responsible parties were notified.Review of the April 2026 Medication Administration Record (MAR) failed to identify Resident #7 had been administered trazodone 25 mg for anxiety, restlessness or agitation per physician's order on 4/15/26 by RN #4 or on 4/16/26 by RN #3 prior to or following the documented behaviors.Review of the clinical record from 4/1/26 through 4/14/26 identified on 4/3/26 Resident #7 had increased agitation and yelling, refused medications and was unable to be directed. Resident #7 was found lying in a male resident's bed and multiple attempts were made to remove Resident #7 without success. There were multiple notations of Resident #7 refusing medications, weights, skin checks, vital signs, blood work and treatments as well as becoming agitated, confused, yelling, accusatory, paranoid, and combative with care.Review of the clinical record failed to identify a Resident Care Plan (RCP) for behaviors or refusal of care. Interview with APRN #2 (psychiatric APRN), on 4/20/26 at 2:15 PM identified she saw Resident #7 numerous times and made several medication adjustments. She did not receive clear staff reports regarding Resident #7's behaviors or incidents. The trazodone was (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ordered for anxiety, restlessness or agitation and if Resident #7 displayed those behaviors, staff should have offered the medication, documented on the behaviors and documented the effectiveness of the medication. Interview with the DON on 4/20/26 at 3:40 PM identified if a resident is ordered a medication by a psychiatric provider for anxiety, agitation or restlessness, staff should be attempting to administer the medication to the resident if behaviors occur, so the resident's behaviors do not escalate out of control. She identified if a resident refuses medication, other interventions should be implemented for safety, and the resident should be reapproached several times. Interview with RN #4 on 4/20/26 at 5:50 PM identified during her shift on 4/15/26 Resident #7 was in and out of bed, demanding and yelling about food. She reported it was her first time working on the unit and was unsure how to calm Resident #7 down, so she kept reapproaching him/her which took multiple attempts over hours to get Resident #7 to take ordered medications. RN #4 identified she did not think to check for medication available to calm him/her down but indicated she should have checked, and if she knew trazodone was available, she would have administered it to Resident #7.Interview with RN #3 on 4/21/26 at 8:26 AM identified on 4/15/26 she worked part of the 3:00 PM to 11:00 PM shift. Resident #7 was yelling and getting in and out of bed, but Resident #7 seemed to calm down after she spoke with him/her and closed the curtain. She identified at around 2:00 AM, she heard Resident #7 talking to him/herself and yelling again so she went to speak with Resident #7 who was ordering breakfast into the call bell and started demanding a full hot breakfast and hot tea and then got out of bed and started walking around. She reported she left to try and gather some food for Resident #7 and when she returned Resident #7 refused the food and drinks she offered, threw the food back at her and became increasingly agitated. RN #3 reported she then attempted to give Resident #7 trazodone, but he/she refused, and Resident #7 went back into the room and herself and NA #11 stood outside the door for a few minutes. Resident #7 seemed to calm down so they left the door ajar and went to care for other residents around 3:00 AM. RN #3 reported that at around 3:30 AM she heard yelling and went into Resident #7's room and saw him/her standing over Resident #8 with a round hairbrush in his/her hand and Resident #8 was noted with bruising to the left eye, face and right hand but Resident #7 would not explain what he/she had done. After calling EMS and the families, EMS refused to take Resident #7 because he/she appeared alert and oriented and refused to go, so Resident #7 remained in the building on a one-to-one until seen by a provider. At around 4:30 AM, Resident #7 was again yelling, slamming things in the room and trying to get out of the window. RN #3 identified she did not normally work on the locked memory unit. She identified she administered trazodone to Resident #7 the previous night when he/she started yelling which was effective. She could not explain why she did not immediately administer trazodone when Resident #7 began having behaviors around 6:00 PM on 4/15/26 or at 2:00 AM on 4/16/26. She reported she should have reapproached Resident #7 and reattempted to medicate him/her with the trazodone after the first refusal Interview with NA # 12 on 4/21/26 at 9:07 AM identified on 4/16/26 she was providing care to Resident #8 around 6:00 PM, who had no visible bruising or injuries. Resident #7 was in the room talking to him/herself, yelling out and shrieking. She identified she could not redirect Resident #7 and RN #3 later came in, spoke with Resident #7 and pulled the curtain all the way around his/her bed and Resident #7 calmed down. NA #12 worked the 11:00 PM to 7:00 AM shift preceding and Resident #7 was out of bed, walking around and yelling out the door prior to the incident that occurred with Resident #8. Interview with NA # 11 on 4/21/26 at 9:41 AM identified she normally worked on the locked memory unit where both Residents #7 and #8 resided and she was assigned to Resident #7 the night of the incident. She identified since Resident #7 was admitted to the facility on [DATE], and would intermittently talk to him/herself, scream, slam doors and wander the halls while awake. Prior to the incident, Resident #7 started yelling around 2:30 AM and was in and out of bed, she identified she last saw Resident #7 around 3:00 AM and at that time he/she had gone back to bed but was still talking to him/herself. NA #11 identified she went to care for other residents and around 3:30 AM heard yelling. When she went into the room, she observed Resident #7 standing next to Resident #8 and Resident #8 had bruising to (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	his/her left eye and face, bruising to the right arm and his/her face was covered in lotion and reported Resident #8 appeared fearful of Resident #7.Review of the Medication Refusal Policy dated 7/2023 directed, in part, that for medication refusals, the nurse will explain to the resident the possible consequences of medication refusal, and for non-competent confused residents, the nurse will go back and offer the medication again within an hour. The nursing supervisor will notify the MD once 3 consecutive doses of any medication is refused, will document the conversation with the MD in the clinical record and the nurse will properly document the medication refusal on the resident's electronic medical record.Although requested, a facility policy for behavioral management was not provided.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **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 eleven (11) sampled residents (Residents #11 and #12) reviewed for laboratory testing, the facility failed to ensure abnormal laboratory results were documented as reviewed with the provider and that a follow up assessment of the resident was completed by the nursing supervisor per policy. The findings include:1. Resident #11?s diagnoses included end stage renal disease, dependence on renal dialysis and type II diabetes mellitus.The Nursing Evaluation assessment dated [DATE] identified Resident #11 was alert, oriented and appropriate and required limited assistance for bed mobility and extensive assistance for personal hygiene and transfers.The Resident Care Plan (RCP) dated 4/1/26 identified Resident #11 had type II diabetes mellitus and required hemodialysis (a treatment to filter waste and water from the blood as the kidneys did when they were healthy) for end stage renal disease. Interventions included monitoring lab work as ordered and reporting to the provider as needed.Review of lab work dated 4/6/26 identified Resident #11 had a critically high creatinine level (when kidneys are not properly clearing waste) of 4.24 (normal range of .70 to 1.5) that was reported to the facility on 4/6/26 at 5:40 PM and the lab work was reviewed by RN #1 on 4/7/26 at 9:00 AM.Review of nurse's notes from 4/6/26 through 4/7/26 failed to identify the critical creatinine level was reported to the provider on 4/6/26 when it was reported to the facility or on 4/7/26 when it was reviewed by RN #1 and failed to identify an RN supervisor assessed Resident #11.Review of a provider note dated 4/6/26 by APRN #1 which was signed at 6:13 PM failed to identify the critical creatinine level of 4.24 or that it was reported to her.The provider note dated 4/8/26 by APRN #1 identified the 4/6/26 lab work was reviewed, including the critical creatinine level (2-days later).2. Resident #12?s diagnoses included heart failure, acute kidney failure and type II diabetes mellitus.The Nursing Evaluation assessment dated [DATE] identified Resident #12 was alert, oriented and appropriate and was dependent on staff for bed mobility, transfers and personal hygiene.The Resident Care Plan (RCP) dated 4/3/26 identified Resident #12 had the potential for fluid imbalance related to fluid restriction, diuretic therapy, congestive heart failure and bilateral lower extremity edema. Interventions included obtaining lab work, including Blood Urea Nitrogen (BUN) and creatinine per physicians order and notifying the physician or abnormal lab work.A. Review of lab work dated 4/6/26 identified Resident #12 had a critically high BUN level (indicating severe kidney dysfunction, profound dehydration or other acute conditions) of 73 (normal range of 10 to 24) that was reported to RN #8 on 4/6/26 at 3:08 PM and the lab work was reviewed by RN #1 on 4/8/26 at 10:41 AM.Review of nurse's notes failed to identify any notes on 4/6/26 and failed to identify the critical BUN level was reported to the provider on 4/6/26 when it was reported to the facility or on 4/8/26 when the lab work was reviewed by RN #1 and failed to identify an RN supervisor assessed Resident #12.Review of a provider note dated 4/6/26 by APRN #1 which was signed at 3:20 PM failed to identifiy the critical BUN level of 73 or that it was reported to her.The provider note dated 4/8/26 by APRN #1 identified the 4/6/26 lab work was reviewed, including the critical BUN level (2-days later).B. Review of lab work dated 4/9/26 identified Resident #12 had a critically high BUN level of 70 that was reported to the facility on 4/9/26 at 2:10 PM and the lab work was reviewed by RN #1 on 4/10/26 at 7:33 AM.Review of nurse's notes from 4/9/26 through 4/10/26 failed to identify the critical BUN level was reported to the provider on 4/9/26 when it was reported to the facility or on 4/10/26 when the lab work was reviewed by RN #1 and failed to identify an RN supervisor assessed Resident #12.Review of the provider note dated 4/10/26 by APRN #1 identified the critical BUN level of 70 (1-day later).C. Review of lab work dated 4/13/26 identified Resident #12 had a critically high BUN level of 80 that was reported to RN #7 on 4/13/26 at 1:55 PM and the lab work was reviewed by RN #1 on 4/14/26 at 4:52 AM.Review of nurse's notes from 4/13/26 through 4/14/26 failed to identify the critical BUN (continued on next page)

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	level was reported to the provider on 4/13/26 when it was reported to RN #7 or on 4/14/26 when the lab work was reviewed by RN #1 and failed to identify an RN supervisor assessed Resident #12.Review of provider note dated 4/13/26 by APRN #1 which was signed at 6:13 PM failed to identify the critical BUN level of 80 or that it was reported to her.Review of a provider note dated 4/14/26 by MD #1 mentioned the critical BUN level of 80 (1-day later).D. Review of lab work dated 4/16/26 identified Resident #12 had a critically high BUN level of 75 that was reported to RN #7 on 4/16/26 at 1:07 PM and the lab work was reviewed by RN #1 on 4/17/26 at 6:27 AM.Review of nurse's notes from 4/16/26 through 4/17/26 failed to identify the critical BUN level was reported to the provider on 4/16/26 when it was reported to RN #7 or on 4/17/26 when the lab work was reviewed by RN #1 and failed to identify an RN supervisor assessed Resident #12.Review of a provider note dated 4/17/26 by APRN #1 identified the critical BUN level of 75 (1-day later).Interview with RN #1 on 4/22/26 at 10:49 AM identified although she reviewed Resident #11 and #12's critical lab work results and was aware of the critical results and thought she reported them, she could not recall who she notified, at what time and if any new orders were obtained. She reported she was unaware that the policy directed that an RN assessment was to be performed by the RN Supervisor and reported along with the abnormal lab work results. RN #1 identified she should have ensured a provider was notified immediately of the critical values and should have written a note in both Resident #11 and #12's clinical record reporting who was notified, at what time and if there were any new orders. Additionally, RN #1 identified she could not recall RN #7 notifying her that she (RN #7) received calls regarding either Resident #11 or Resident #12's critical lab work results or that the lab work results were critical. She reported that she had been signing off lab work results as reviewed for all residents to clear them off her homepage and was not aware that the providers are the ones to review the lab work results under the results tab and that she should not have signed them off as reviewed. Further, she identified APRN #1 is off on Thursdays, and all critical and abnormal lab work results should have been reported to the Medical Director or the on-call provider (4/9/26 and 4/16/26).Interview with the Medical Director on 4/21/26 at 1:12 PM identified that a provider should be notified of abnormal lab work results by the RN receiving the critical lab work value results immediately after they are notified by the lab. He reported if a provider is notified and does not respond, or the abnormal results are received off hours, the on-call or himself should be notified and the RN should document the name of the provider notified, what time they were notified and if any new orders were obtained. He identified that although he was aware of critical lab work results for both Residents #11 and #12, he was unsure when exactly he was notified. Additionally, he identified no one should sign off the lab work of any resident as reviewed under the results tab except for a provider because the alert disappears and does not trigger for the provider to review.Interview with the DON on 4/21/26 at 11:35 AM identified RN #7 should have contacted a provider immediately upon receiving critical results from the lab for Resident #12 and RN #1 should have ensured a provider was notified if she was reviewing the critical lab work results for Residents #11 and #12. The DON identified both RN #7 and RN #1 should have ensured the provider notification for the critical lab work for Residents #11 and #12 was complete to include the provider notified, what time the provider was notified and if new orders were obtained. She reported she was unaware RN #1 had been signing off the lab work results as reviewed under the results tab and she was unsure who should be signing the lab work off as reviewed and was unsure what the abnormal lab work and physician's notification policies directed, stating she would have to review it.An interview with RN #7 was not obtained.Review of the Physician Notification of Abnormal Lab Values policy dated 7/2023 directed, in part, that it's the policy of the facility that the RN Supervisor will call all providers with any abnormal lab values. If a resident's lab values are abnormal it is the responsibility of the charge nurse to notify the RN supervisor on duty. It is then the RN Supervisor's responsibility to do a follow-up assessment and then report all changes to the provider.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **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 five (5) residents (Residents #1 and #2) reviewed for modified texture diets, the facility failed to ensure residents received prescribed diets per physician's orders and the diet manual per International Dysphagia Diet Standardization Initiative (IDDSI) guidelines and failed to ensure staff were competent in the IDDSI modified texture diets. The findings include:1. Resident #1's diagnoses included dementia without behavioral disturbances, oropharyngeal dysphagia (weakening of the throat muscles making it difficult to move food from the mouth into the throat and esophagus during swallowing) cerebrovascular disease (conditions that affect blood flow in the brain) and type II diabetes mellitus.A physician's order dated 7/4/25 directed a regular diet IDDSI 6 soft and bite sized texture, IDDSI 0 thin Liquids consistency. The orders directed Resident #1 to utilize a lip plate, built-up utensils, and required supervision with meals.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had severely impaired cognition (Brief Interview for Mental Status (BIMS) score of 4), and required supervision assistance for eating and was dependent on staff for oral care, bed mobility and transfers. Resident #1 required a mechanically altered diet.The Resident Care Plan (RCP) dated 1/20/26 identified Resident #1 had impaired cognitive function or impaired thought processes related to dementia and had a potential swallowing problem related to a history of dysphagia and cerebral infarction (an ischemic stroke where the blood supply to part of the brain is blocked or reduced preventing brain tissue from getting oxygen and nutrients). Interventions included providing supervision with meals, diet to be followed as prescribed, instructing Resident #1 to eat in an upright position, to eat slowly, and to chew each bite thoroughly, monitoring/documenting/reporting as needed any signs and symptoms of dysphagia such as pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing, refusing to eat and appearing concerned during meals and monitoring for shortness of breath, choking, labored respirations and lung congestion.A late entry nurse's note by RN #1 (the 7:00 AM to 3:00 PM nursing supervisor) dated 3/19/26 at 1:59 PM identified she was called to the dining room where Resident #1 was in the wheelchair eating lunch when he/she experienced a choking episode and the Heimlich maneuver was performed. Resident #1's lung sounds were clear but diminished bilaterally and vital signs were obtained to include a heart rate of 96, blood pressure of 151/95 and oxygen level of 95 percent (%) on room air. Resident #1 remained at the nurse's desk for further evaluation by APRN #1 and no new orders were obtained.A nurse's note by the DON on 3/19/26 at 2:06 PM identified she was called to assess Resident #1 following an incident of choking while in the dining room. The Speech Language Pathologist (SLP) was in the dining area and yelled out to LPN #1 who responded and performed the Heimlich maneuver. A speech evaluation was placed, the physician and Conservator were notified and vital signs were to be initiated and obtained every four (4) hours.A provider note by APRN #1 dated 3/20/26 identified Resident #1 had a choking episode on 3/19/26 requiring the Heimlich maneuver. APRN #1 directed a 2-view chest x-ray to evaluate for aspiration or consolidation and that staff would obtain vital signs every shift for 3 days and lab work would be obtained 3/23/26 to monitor for developing leukocytosis (elevated white blood cell count signifying an infection) or dehydration. Additionally, Resident #1's diet was downgraded to minced and moist and Resident #1 would be a one (1) to one (1) feed for meals. A physician's order dated 3/20/26 directed a regular diet, IDDSI 5 minced and moist texture, IDDSI 0 thin liquids consistency.A physician's order dated 3/20/26 directed Occupational Therapy Activities of Daily Living recommendation: 1:1 feed for meals.Review of the IDDSI guidance identified level 6 soft and bite sized texture included bite sized pieces no bigger than 1.5 centimeters (cm) by 1.5 cm pieces to reduce choking risks and should be able to be mashed or broken down with the pressure from a fork. No regular dry bread due to choking risks and to avoid sticky or gummy food (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	04/22/2026

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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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	including nut butters. Interview with the SLP on 4/13/26 at 11:45 AM identified Resident #1 had not been on her caseload at the time of the 3/19/26 incident, but reported residents who are on an altered texture diet for dysphagia and wish to have peanut butter and jelly sandwiches require an evaluation by a SLP to ensure safety. If approved, a physician's order should be entered to allow peanut butter and jelly sandwiches per exception, and the sandwich should be cut into 1.5 cm by 1.5 cm pieces. She identified that on 3/19/26, she was evaluating another resident in the dining room and had her back to Resident #1 when she heard loud banging on a table. She turned around, observed Resident #1 to be red in the face and it appeared Resident #1 was not breathing. She ran to the doorway of the dining room and alerted LPN #1, who was sitting at the nurse's station near the dining room entrance. The SLP reported LPN #1 immediately ran into the dining room, assessed Resident #1 and performed the Heimlich maneuver which dislodged a piece of food. The food and Resident #1's dentures launched out of his/her mouth. Following the incident, nursing downgraded the diet to puree, requested a speech evaluation, and she evaluated Resident #1 on 3/20/26. The evaluation identified Resident #1 was unable to self-feed due to cognition, required rate modification (slowing eating rate) had decreased safety awareness and the SLP recommended a downgrade to a level 5 minced and moist texture diet, which did not include peanut butter and jelly sandwiches. Resident #1 required one-to-one feeding assistance. The SLP identified the 3/19/26 choking incident could have been prevented if Resident #1's diet orders were followed. She reported she was not asked to supervise the dining room for the lunch meal on 3/19/26, she was only focused on the resident she was in the dining room to evaluate. Interview with LPN #1 on 4/13/26 at 11:14 AM identified on 3/19/26 she was at the nurse's station when the SLP ran to the dining room entrance and alerted her Resident #1 was choking. She reported she assessed Resident #1, who was clenching his/her teeth shut and she was unable to see food in Resident #1's mouth so she performed the Heimlich maneuver which required six (6) to seven (7) thrusts to dislodge the food. LPN #1 identified Resident #1 always received crustless, halved peanut butter and jelly sandwiches with meals and she was unaware there was no order for the sandwich or that it was not permitted on a level 6 texture diet. Interview with RN #1 on 4/13/26 at 1:24 PM identified when she arrived on the unit on 3/19/26, Resident #1 was sitting upright in the wheelchair at the nurse's station. She reported Resident #1's eyes were red and watery, she assessed Resident #1 immediately and vital signs were normal, had no abnormal lung sounds and no further coughing was noted. RN #1 entered an order for vital signs every four (4) hours for three (3) days, downgraded Resident #1's diet to puree, entered a speech screen. She reported all staff interacting with residents on altered texture diets should be aware of what each diet includes.Interview with APRN #1 on 4/13/26 at 2:25 PM identified she was not scheduled to work on 3/19/26 and evaluated Resident #1 on 3/20/26. She reported Resident #1 should have been evaluated to eat peanut butter and jelly sandwiches prior to being served the sandwiches and identified a physician's order should have been in place allowing Resident #1 to have the peanut butter and jelly sandwiches only if it was deemed safe by the SLP. APRN #1 reported staff should follow diet orders and supervision orders prior to providing any resident with food or drinks. She identified that providing residents with food that is not authorized for a specific altered diet causes a choking risk. Review of the facility schedule dated 3/19/26 identified NA #1, NA #3, NA #4, NA #5, NA #10 and LPN #2 were also working on the south-east unit on the 7:00 AM to 3:00 PM shift on 3/19/26.Interviews with NA #1, NA #3, NA #4, NA #5, NA #10 and LPN #2 on 4/13/26 identified they were not assigned to the dining room for the lunch meal on 3/19/26 and did not witness Resident #1 choking around 1:00 PM. They identified at least one (1) NA is required to be present in the dining room at all times once meals are served to supervise residents and reported Resident #1 always received peanut butter and jelly sandwiches with meals for as long as they could remember and they were unaware a level 6 texture diet did not include peanut butter and jelly sandwiches or where guidance on IDDSI diets was posted. Additionally, NA #1 identified she often gave Resident #1 crustless peanut butter and jelly sandwiches for snacks because she thought Resident #1 could have them.Interview with the Rehab Director on 4/13/26 at (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12:30 PM identified that per her records, Resident #1 was never evaluated by an SLP for an exception for peanut butter and jelly sandwiches. Residents on a modified diet that prohibits peanut butter should not be provided with a peanut butter and jelly sandwich unless first cleared by a SLP for an exception and then approved by the provider and an order entered. The Rehab Director identified the choking incident could have been prevented if staff followed the diet order.Interview with the Food Service Director (FSD) on 4/13/26 at 1:07 PM identified a level 6 soft and bite sized diet includes soft foods that are cut into 1.5 cm cubes and would not include peanut butter and jelly sandwiches. She reported Resident #1 was on a level 6 texture diet and his/her meal tickets included a peanut butter and jelly sandwich to be provided for each meal. She was unsure who approved the sandwich and was unable to locate a diet order slip directing dietary that Resident #1 had been approved to receive peanut butter and jelly sandwiches. Additionally, she identified all residents on modified diets would receive a crustless sandwich cut in half, reporting that they were never cut into 1.5 cm cubes or smaller. Interview with the DON on 4/13/26 at 5:39 PM identified Resident #1 should have been provided with his/her diet per physician's orders, and staff should be aware of a residents diets, restrictions and ensuring meal tickets match the meal provided prior to serving a meal. She identified that following the incident, staff reported to her that Resident #1 always received peanut butter and jelly sandwiches with meals. She reported peanut butter and jelly sandwiches are outside of the level 6 texture and Resident #1 should have been evaluated by the SLP and an order should have been obtained prior to Resident #1 receiving a peanut butter and jelly sandwich. The DON reported Resident #1 should not have been served peanut butter and jelly sandwiches and if Resident #1 had been provided with the correct diet and received supervision per physician's orders, the choking incident could have been avoided. 2. Resident #2?s diagnoses included oropharyngeal dysphagia and cerebral infarction (an ischemic stroke where blood supply to part of the brain is blocked or reduced).A physician's order dated 7/4/25 directed a regular diet, IDDSI 6 soft and bite sized texture, IDDSI 3 moderately thick/ honey consistency and Resident #2 may have soft crustless sandwiches (tuna salad, egg salad, peanut butter and jelly) and required supervision with meals.A Stern Speech Therapy Screen by SLP #1 dated 7/31/25 identified Resident #2 was currently on a IDDSI 6 and honey thickened liquids diet, but she observed Resident #2 demonstrating overt signs and symptoms of aspiration with coughing after swallowing food. The screen identified a SLP evaluation for oropharyngeal swallow function was warranted.A physician's order dated 7/31/25 directed to provide Resident #2 a regular diet, IDDSI 5 minced and moist texture, IDDSI 3 moderately thick/honey consistency liquids. The SLP Discharge Summary for dates of service 7/31/25 through 10/24/25 and signed by SLP #1 on 10/27/25 identified Resident #2 met the highest practical level of function and refused to engage in speech therapy treatment or adhere to safe swallowing strategies that may have improved function. Diet recommendations were made for IDDSI 5 minced and moist texture, IDDSI 3 moderately thick/honey consistency liquids. The Discharge Summary did not identify Resident #2 was evaluated for peanut butter and jelly sandwiches or that Resident #2 was safe to consume peanut butter and jelly sandwiches.Physician's orders dated 9/11/25 and 1/6/26 directed Resident #2 may have crustless peanut butter and jelly sandwiches with every meal.Review of the clinical record from 10/25/26 through 4/13/26 failed to identify Resident #2 was evaluated by an SLP approving the crustless peanut butter and jelly sandwiches for Resident #2 after the 10/24/25 discharge. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had severely impaired cognition (Brief Interview for Mental Status (BIMS) score of 0), and required setup assistance for eating, partial assistance for bed mobility and was dependent on staff for oral hygiene and transfers. The MDS identified Resident #2 required a mechanically altered diet. The Resident Care Plan (RCP) dated 2/3/26 identified Resident #2 had impaired cognitive function and dysphagia. Interventions included cueing, reorienting and supervising as needed, providing setup assistance for feeding and an assist of one (1) as needed, providing a regular diet, IDDSI level 5 minced and moist texture; IDDSI 3 moderately thick/honey consistency liquids, providing a crustless peanut butter and (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	jelly sandwich with each meal, taking aspiration precautions such as elevating the head of the bed, remaining in an upright position when eating. Observations of the dining room on 4/13/26 at 12:57 PM identified NA #2 and NA #3 present in the dining room for the lunch meal. Resident #2 was observed to have been served a halved, crustless peanut butter and jelly sandwich. NA #2 and NA #3 identified Resident #2 always received a crustless peanut butter and jelly sandwich with meals.Review of the IDDSI guidance identified level 5 minced and moist texture included foods that are soft and moist with no liquid leaking or dripping from the food, biting was not required, minimal chewing was required, lumps are to be 4 millimeter (mm) in size, lumps can be mashed with the tongue, no regular dry bread due to choking risks and to avoid textures that pose a choking risk for adults including sticky foods or nut butters.Interview with SLP #1 on 4/13/26 at 11:45 AM identified residents who are on altered texture diets who have been evaluated by an SLP and approved to be safe to consume peanut butter and jelly sandwiches should have a physician's order to allow the peanut butter and jelly sandwiches per exception and the sandwich should be cut up into pieces as specified by the IDDSI guidance.Observations on 4/14/26 at 12:38 PM, identified Resident #2 was served a quartered, crustless peanut butter and jelly sandwich.Review of physician's orders identified the 1/6/26 physician's order for the crustless peanut butter and jelly sandwich with every meal was discontinued on 4/14/26 following the lunch meal. Re-interview with SLP #1 on 4/20/26 at 12:56 PM identified after picking up Resident #2 for SLP services on 7/31/25, she trialed crustless peanut butter and jelly sandwiches but Resident #2 was not safe to consume the peanut butter and jelly sandwiches without one-to-one SLP observation. When she discharged Resident #2 on 10/24/25, she wrote a diet slip recommendation, which was submitted to nursing and identified Resident #2 should be placed on a IDDSI level 5 minced and moist texture; IDDSI 3 moderately thick/honey consistency liquids but did not mention that Resident #2 was permitted to consume crustless peanut butter and jelly sandwiches. She reported nursing should have ensured any physician's orders for crustless peanut butter and jelly sandwiches were discontinued and she did not know why physician's orders dated 9/11/25 and 1/6/26 directed crustless peanut butter and jelly sandwiches with every meal when she identified Resident #2 was not safe to consume the peanut butter and jelly sandwiches and had not indicated on the diet slip or to any staff that there was an approved exception for the peanut butter and jelly sandwiches. Interview with APRN #1 on 4/20/26 at 1:45 PM identified Resident #2 should have been served meals per SLP recommendations and if SLP #1 had not recommended Resident #2 was safe to receive crustless peanut butter and jelly sandwiches, an order should not have been entered by nursing. She identified she signed the 9/11/25 and 1/6/26 physician's orders directing Resident #2 to receive crustless peanut butter and jelly sandwiches with meals, but nursing had not discussed the order with her. APRN #1 identified she signed orders in bulk and assumed the order was approved by SLP #1.Interview with the DON on 4/20/26 at 9:26 AM identified she was unsure why orders were entered by nursing on 9/11/25 and 1/6/26 directing that Resident #2 may have crustless peanut butter and jelly sandwiches with every meal when it was not recommended by SLP #1 on the 10/24/25 discharge. She reported the 9/11/25 and 1/6/26 physician's orders should not have been entered, and Resident #2 should not have been receiving crustless peanut butter and jelly sandwiches with every meal. Review of the Modified Textures policy dated 1/25/26 directed, in part, residents will be provided foods which are the consistency that will be safe, tolerable and ordered by the physician and/or speech therapy. The diet texture is part of the diet ordered by the physician. Any texture ordered is provided according to the Diet Manual and transcribed onto the resident's diet card. Texture needs are regularly screened by the Speech Therapist. Revisions to the planned and menued modified texture diets can be made upon the request of the Speech Therapist or Dietician to accommodate individual needs. Modified textures may not be omitted on special occasions.Review of the Feeding Residents policy dated 6/2023 directed, in part, to ensure that the food listed on the dietary card are the foods on the tray.Although requested, facility policies on diet texture/consistency exceptions for residents on modified texture diets, speech therapy recommendations and Nurse Aide Care Cars/Kardex were not available.