STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075196	A. Building B. Wing	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harbor Village North Health and Rehabilitation Cen	78 Viets St Extension New London, CT 06320

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 interviews, record, and policy reviews for 2 of 3 sampled residents (Resident #15 and Resident #40) reviewed for abuse, the facility failed to ensure a resident was free from physical abuse. The findings include:1. Resident #15's diagnoses included vascular dementia with behaviors, schizophrenia and paranoid personality disorder.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #15 had a Brief Interview of Mental Status of 9 indicating moderate cognitive impairment and was independent for eating, transferring, and changing position. Additionally, the MDS identified Resident #15 had no potential indicators of psychosis.The Resident Care Plan dated 1/28/26 identified Resident #15 had a potential for behaviors related to a diagnosis of dementia, paranoia, delusions, a history of physical aggression and a resident to resident altercation (6/1/25). Interventions included approaching the resident in a calm manner, documenting behaviors and following up with psychiatry.Review of the psychiatry APRN progress note dated 2/10/26 identified Resident #15 was seen as a regular follow up due to a diagnosis of schizophrenia and dementia, presenting with a stable mood and no reports by nursing staff of behavioral disturbances, aggression, or unsafe behaviors.2. Resident #40's diagnoses included unspecified dementia, bipolar II disorder, and anxiety.The comprehensive Minimum Data Set (MDS) assessment dated [DATE] identified Resident #40 had a Brief Interview of Mental Status score of 9 indicating moderate cognitive impairment and was independent for eating, changing position, and required partial/moderate assistance for transfers. Additionally, the MDS identified Resident #40 had no potential indicators of psychosis.The Resident Care Plan dated 11/19/25 identified Resident #40 was at risk for mood/behaviors due to a diagnosis of anxiety and depression, rummaging, anger, yelling at staff, increased delusions and confusion. Interventions included evaluations by psychiatry services, observation for changes in mood /depression and encouragement to talk about problems.Review of the Psychiatry APRN progress note dated 2/13/26 at 4:00 PM identified Resident #40 was seen due to increased agitation, demonstrating stability in mood and behavior with no delusions, hallucinations or safety concerns identified at the time.a. Review of a nurse's note dated 6/1/25 at 10:29 PM identified Resident #15 allegedly grabbed her roommate's arm after an exchange of words.Review of the Reportable Event investigation dated 6/1/25 identified that Resident #15 had a BIMS score of 1. Upon interview of both residents, they denied physical contact but indicated that words were exchanged. There were no other witnesses to the altercation, only statements that residents were agitated were immediately separated from each other. The social worker and psychiatric services followed up with both residents, and they expressed no harm/emotional distress. There were no injuries on initial or subsequent assessments.Review of the psychiatry Advanced Practice Registered Nurse (APRN) note dated 6/1/25 at 10:10 PM identified Resident #15 was seen due to an alleged interpersonal issue and presented in a calm pleasant and cooperative manner during the interview and was not a danger to self or others.Review of the nurse's note dated 6/2/25 at 9:00 AM identified Resident #15 was spoken to regarding a heated discussion he/she had with a roommate. At the time Resident #15 felt the roommate did not belong in the room but was agreeable to having another (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	roommate.Review of nurse's notes dated 6/2/25 to 2/23/26 failed to identify any resident to resident altercations.b. Verbal notification by the Administrator to surveyors on 2/24/26 at 12:54 PM identified there was a report of a resident to resident altercation between Resident #15 and Resident #40.Review of the nurse's note dated 2/24/26 at 1:04 PM identified Resident #15 admitted to grabbing his/her roommate, Resident #40, around the neck.Review of the facility Reportable Event form dated 2/24/26 identified that on 2/24/26 Resident #40 reported to a Nurse Aide (NA) that Resident #15 grabbed him/her around the neck. The investigation identified Resident #40 rolled to the thermostat in his/her wheelchair and adjusted the temperature, which appeared to trigger an altercation. Resident #40 stated that Resident #15 grabbed his/her neck. The NA reported that Resident #15 admitted to putting her hands on Resident #40 and justified it by stating the resident had a foul mouth and deserved it. The roommate, Resident #46 witnessed Resident #15 place his/her hands on Resident #40's shoulders and confirmed an altercation occurred. During the investigation, both roommates felt the room placement was not appropriate for Resident #40, and Resident #40 was moved out of the room. The residents involved received 72 hour follow-up, and each reported feeling safe in their new rooms, including the roommate, Resident #46. No further incidents or concerns were identified.Review of the Psychiatry APRN progress note dated 2/24/26 at 2:36 PM identified Resident #15 was seen for follow up of a negative interaction with another resident, presented as pleasant, calm and engaged and the previous dose of Seroquel (an antipsychotic medication) would be resumed, noting the attempted gradual dose reduction had failed.Interview with Registered Nurse (RN) #4 on 2/24/26 at 1:43 PM identified he was the charge nurse on the unit where the resident-to-resident incident occurred, stating that although Resident #40 gets mad, loud and unpleasant with other residents and staff, even to him at times, in this scenario he/she was not the aggressor. Additionally, RN #4 stated Resident #15 who is usually very quiet was the aggressor and grabbed Resident #40's neck when he/she came to change the temperature setting on the heater, adding maybe Resident #15 just had enough of listening to Resident #40. The residents were immediately separated, and both were put under 1:1 observation at the time.Interview with Social Worker (SW) #1 on 2/25/26 at 11:01 PM identified Resident #15 and Resident #40 had a verbal disagreement over the temperature of the room that led to Resident #15 grabbing Resident #40 by the neck. Additionally, SW #1 identified Resident #40 had a feisty personality and although no issues were reported in the past with Resident #15 and Resident #40, the personalities were not a good match with resident #40 verbally initiating the disagreement that led to Resident #15 becoming physically aggressive. Subsequently both Residents were on 1:1 for 24 hours, cleared by psych and Resident #40 was being monitored for adjustment to a room change while Resident #15 stayed in the original room.Interview with NA #2 on 2/25/26 at 11:30 AM identified that Resident #40 was usually mild mannered, and there were no prior altercations between the 2 residents, and no indicators that the altercation would have occurred.Review of the Psychiatry APRN progress note dated 2/26/26 at 6:06 PM identified Resident #40 was seen due to an alleged incident with a peer, presented as calm, cooperative and engaged appropriately in conversation. Additionally Resident #40 reported feeling safe and denying any concerns?Resident #15 and Resident #40 both had Resident Care Plans indicating behavioral issues. Resident #15 had a history, per a past Reportable Event, of becoming agitated with others. According to RN #4 Resident #40, was known to get mad, loud and unpleasant with other residents and staff, even to him at times and according to SW #1, Resident #40 was known to have a feisty personality, and not a good match with Resident #15. Despite this, Resident #15 and #40 were deemed appropriate roommates leading to the physical altercation of Resident #15 grabbing Resident #40 around the neck.Review of the Abuse and Prohibition Policy revised 10/7/24 directed in part to maintain a zero-tolerance policy for any form of abuse or neglect of a resident by maintaining an environment free from abuse (verbal, physical, mental, psychological, or sexual), neglect, corporal punishment, involuntary seclusion, or misappropriation of property.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, review of the clinical record, facility documentation, and policy for 1 of 3 sampled residents, (Resident #47) reviewed for abuse, the facility failed to report an injury of unknown origin to the State Agency. The findings include: Resident #47's diagnoses included dementia with agitation, cognitive communication deficit, Parkinson's Disease with dyskinesia with fluctuations.The 5-day Minimum Data Set (MDS) assessment dated [DATE] identified Resident #47 had a Brief Interview for Mental Status score of 9, indicating moderate cognitive impairment, required partial/moderate for transfers from sitting to lying and lying to sitting on the side of the bed. The MDS also identified the resident required substantial/maximal assistance for transferring to/from the toilet and was fully dependent on staff for upper and lower body dressing, rolling left and right in bed, and transferring from sitting to standing as well as chair/bed to chair transfers. The Resident Care Plan (RCP) in effect from 1/7/26 through 3/3/26 identified Resident #47 had an Activity of Daily Living (ADL)/Mobility deficit. Interventions included assistance of 2 for toileting, dressing, bathing, and assistance of 2 with a mechanical lift for all transfers. An interview with Person #1 on 2/26/26 at 12:43 PM identified Resident #47 had an unwitnessed injury to the left side of his/her forehead on the morning of 2/18/26 resulting in a hematoma (large, raised, painful, firm collection of clotted blood lasting longer than a bruise). When staff notified Person #1 they indicated it was believed Resident #47 had hit his/her head on the headboard of the bed, due to intermittent episodes of dyskinesia (increased involuntary movements).A Reportable Event dated 2/18/26 identified at 7:00 AM, while Resident #47 was seated in his/her wheelchair at the nurse's station, an LPN had noticed a hematoma to the left side of the resident's forehead. The cause of the hematoma was unknown as no one had witnessed what happened to cause the hematoma. Staff concluded the resident had hit his/her head on the headboard of his/her bed inside the room earlier in the morning. An interview with the Assistant Director of Nursing (ADNS) on 2/26/26 at 1:20 PM identified after conferring with the Regional Clinical Director, Registered Nurse (RN) #3, and indicating to her the cause of the injury was able to be explained by dyskinesia, RN #3 stated the facility was still within the 24 hour State Agency time reporting window, therefore the injury did not need to be reported as an injury of unknown origin. The ADNS indicated that although the policy directed her to go back 72 hours to interview staff with access to Resident #47 to determine the cause of the injury, she had not done so and interviewed only the 2 Nurse Aid (NA) staff who had cared for the resident the shift prior. She indicated that she had not spoken to the unit nurse who had interacted with the resident minutes prior the initial report of the hematoma stating she forgot and also did not feel it was necessary based on the 2 interviews obtained by the NAs.An interview with the Regional Director of Clinical Services Registered Nurse (RN) #3 on 2/26/26 at 1:31 PM identified that Resident #47's injury to his/her forehead was not reported to the State Agency as she was under the impression that a complete and thorough investigation had been performed with the cause being known and due to dyskinesia and bumping his/her head. RN #3 indicated had she known the investigation was incomplete, she would have had the ADNS report Resident #47's injury to the State Agency within the 24 hour time frame and classified it as an injury of unknown origin.A review of the facility policy for abuse directs, in part that an injury of unknown source is when both of the following conditions are met: 1) the source of the injury was not observed by any persons or the source of the injury could not be explained by the resident, and 2) the injury is suspicious because of the extent of the injury or the location of the injury. It also directs that the time periods for reporting reasonable suspicion of a crime depends on the seriousness of the event that leads to the reasonable suspicion, and that if there is a result of serious bodily injury or not, the individual shall report the suspicion immediately, but not later than 2 hours after forming the suspicion; and in CT to the Department of Social Services within 24 hours after forming the suspicion.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, review of the clinical record, facility documentation, and facility policy for 1 of 3 residents, (Resident #47) reviewed for abuse, the facility failed to thoroughly investigate an injury of unknown origin. The findings include:Resident #47's diagnoses included dementia with agitation, cognitive communication deficit, and Parkinson's disease with dyskinesia with fluctuations.The 5-day Minimum Data Set (MDS) assessment dated [DATE] identified Resident #47 had a Brief Interview for Mental Status score of 9, indicating moderate cognitive impairment, required partial/moderate for transfers from sitting to lying and lying to sitting on the side of the bed. The MDS also identified the resident required substantial/maximal assistance for transferring to/from the toilet and was fully dependent on staff for upper and lower body dressing, rolling left and right in bed, and transferring from sitting to standing as well as chair/bed to chair transfers. The Resident Care Plan (RCP) in effect from 1/7/26 through 3/3/26 identified Resident #47 had an Activity of Daily Living (ADL)/Mobility deficit. Interventions included assistance of 2 for toileting, dressing, bathing, and assistance of 2 with a mechanical lift for all transfers. An interview with Person #1 on 2/26/26 at 12:43 PM identified Resident #47 had an unwitnessed injury to the left side of his/her forehead on the morning of 2/18/26 resulting in a hematoma (large, raised, painful, firm collection of clotted blood lasting longer than a bruise). When staff notified Person #1 they indicated it was believed Resident #47 had hit his/her head on the headboard of the bed, due to intermittent episodes of dyskinesia (increased involuntary movements).A Reportable Event and investigation dated 2/18/26 identified at 7:00 AM, while Resident #47 was seated in his/her wheelchair at the nurse's station, an LPN noticed a hematoma to the left side of the resident's forehead. The cause of the hematoma was unknown as no one had witnessed what happened to cause the hematoma. The 2 NA statements were inconclusive, indicating an assumption Resident #47 had hit his/her head on the headboard of the bed inside the room earlier in the morning.An interview with the Assistant Director of Nursing (ADNS) on 2/26/26 at 1:20 PM identified after conferring with the Regional Clinical Director, Registered Nurse (RN) #3, and indicating to her the cause of the injury was able to be explained by dyskinesia, RN #3 stated the facility was still within the 24 hour State Agency time reporting window, therefore the injury did not need to be reported as an injury of unknown origin. The ADNS indicated that although the policy directed her to go back 72 hours to interview staff with access to Resident #47 to determine the cause of the injury, she had not done so and interviewed only the 2 Nurse Aid (NA) staff who had cared for the resident the shift prior. She indicated that she had not spoken to the unit nurse who had interacted with the resident minutes prior the initial report of the hematoma stating she forgot and also did not feel it was necessary based on the 2 interviews obtained by the NAs.An interview with the Regional Director of Clinical Services RN #3 on 2/26/26 at 1:31 PM identified that Resident #47's injury to his/her forehead was not reported to the State Agency as she was under the impression that a complete and thorough investigation had been performed with the cause being known and due to dyskinesia and bumping his/her head. RN #3 indicated had she known the investigation was incomplete, she would have had the ADNS report Resident #47's injury to the State Agency within the 24 hour time frame and classified it as an injury of unknown origin.Review of the abuse policy identified that a thorough investigation of alleged abuse or neglect would be conducted by the Administrator and/or Director of Nursing to determine if the conduct of the individual is in violation of any standard of care.