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	04/06/2026

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

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for one (1) of three (3) sampled residents (Resident #1) reviewed for accidents, the facility failed to ensure a licensed nurse remained with Resident #1 following an unresponsive episode of unknown origin and failed to ensure Resident #1 was kept in place and not moved until directed by the Nursing Supervisor following an unresponsive episode in the outside smoking area. The findings include:Resident #1?s diagnoses included Chronic Obstructive Pulmonary Disease (COPD), myoclonus (sudden, brief, involuntary twitching or jerking of a muscle or a group of muscles), seizures, bradycardia (low heart rate less than 60 beats per minute), macular degeneration (an eye disease that affects central vision), weakness and cognitive communication deficit.The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had intact cognition (Brief Interview for Mental Status (BIMS) score of 13), and required setup assistance for bed mobility, substantial assistance for transfers, did not ambulate, utilized a wheelchair and was dependent on staff for mobility. The Resident Care Plan (RCP) dated 3/4/26 identified Resident #1 was a current smoker, had an Activities of Daily Living (ADL) self-care, mobility and performance deficit due to failure to initiate, weakness and impaired vision, a history of chest pain and altered respiratory status/difficulty breathing due to COPD. Interventions included supervision for smoking at all times, observing for smoking safety through observation and interview, assist of two (2) transfer to bed/chair/bathroom, wheelchair use for locomotion and monitoring, documenting and reporting abnormal breathing patterns to the physician. A nurse's note by RN #4 dated 3/8/26 at 12:14 PM identified Resident #1 went to the smoking activity by rolling walker with an assist at 8:45 AM, as Resident #1 wanted to walk rather than utilize the wheelchair. The note identified the nursing supervisor (RN #3) went to RN #4 and reported Resident #1 was slumped over on a bench in the smoking area, so she went to check on Resident #1, who was unresponsive, with abnormal skin color and a sternal rub was initiated. The note reported she went back into the building to obtain oxygen, and when she returned Resident #1 was responsive and was in the wheelchair being brought towards his/her room by another nurse. She applied oxygen to Resident #1 in the hallway prior to Resident #1 being brought into his/her room and reported Resident #1 had one episode of vomiting as Emergency Medical Services (EMS) came to transport Resident #1.A nurse's note by RN #3 dated 3/8/26 at 2:06 PM identified she was at the nurse's station when NA #1 reported Resident #1 was outside and may not be breathing. She immediately went outside and observed Resident #1 hunched over on a bench breathing but nonverbal, not communicating, not moving and his/her skin color appeared pale/abnormal. She immediately called EMS, initiated a code and reported she witnessed Resident #1 being assisted back to his/her room by nursing staff. Resident #1 remained on observation until EMS arrived and upon EMS arrival, Resident #1 was awake in his/her room and had one episode of vomiting. Review of the Patient Care Record (ambulance run sheet) dated 3/8/26 identified, in part, they were notified at 9:32 AM that Resident #1 sustained a fall and was subsequently unconscious, not breathing and with a possible cardiac arrest. When crews arrived on scene, Resident #1 was found lying in bed, conscious and alert but at an altered state and crews attempted to get an accurate history of the incident, but staff were unable to give an accurate (continued on next page)

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	description of the event, could not agree on what transpired, were unsure if a head strike occurred and reported they were not actually present for the majority of the incident. EMS treated Resident #1 according to his/her symptoms and transported Resident #1 to the hospital.The hospital discharge summary identified Resident #1 was admitted from 3/8/26 through 3/19/26 for acute hypoxemic respiratory failure (not enough oxygen in the blood) likely due to bacterial pneumonia and COVID-19 and Resident #1 was treated with intravenous (IV) fluids and antibiotics.Interview with RN #3 on 4/6/26 at 11:39 AM identified that just prior to 9:30 AM, NA #1 came running down the hallway, visibly distraught, and notified her that Resident #1 was unresponsive and possibly not breathing in the outside smoking area and that NA #1 and herself both ran out to the outside smoking area immediately. She identified she assessed Resident #1, checked vital signs and neurological signs, which were normal, but identified Resident #1 had his/her eyes closed and was not responding to verbal cues. RN #3 identified she requested NA #1 and NA #2 stay with Resident #1 and directed them not to move Resident #1 while she ran back inside to call a code blue, notify the charge nurse (RN #4) and call EMS with the computer in front of her. RN #3 reported she observed staff running in the direction of the outside smoking area to respond but when she got off the phone with EMS, LPN #1 was pushing Resident #1 down the hallway to his/her room. She identified she should have stayed with Resident #1 until another licensed nurse responded to assist and ensure Resident #1 was stable and kept in place until she identified what happened. She left Resident #1 with the two (2) NA's and Resident #1 was subsequently transferred to a wheelchair and transported inside before she could finish her assessment. RN #3 identified NA #1 and NA #2 reported afterwards that Resident #1 leaned forward and fell back into a seated position on the bench and became unconscious. RN #3 identified she did not document those reports in her nurse's note and did not obtain statements regarding the incident.Interview with LPN #1 on 4/6/26 at 2:22 PM identified when she responded to the code blue in the outside smoking area on 3/8/26, Resident #1 was on a bench leaning forward, breathing and answering questions appropriately and she sat him/her up. She identified no RN's were present at the time and could not recall anyone directing her to move Resident #1 or to transfer him/her to a wheelchair. She located a wheelchair and transferred Resident #1 with the help of NA #1 and NA #2 to the wheelchair and transported Resident #1 into the building to his/her room.Interview with the DON on 4/6/26 at 3:18 PM identified RN #3 should not have left Resident #1, who was identified to be unresponsive, without first requesting assistance from another licensed nurse. Additionally, she reported staff should have never moved Resident #1 following the 3/8/26 incident without first being directed by RN #3 to ensure a full assessment had been completed and to prevent any injuries.Although attempted, an interview with NA #2 was not obtained.Review of the Resident Change in Condition and Notification of Change policy dated 6/13/25 directed, in part, the licensed nurse will assess the resident for signs and symptoms of physical or mental change in condition and will complete the assessment for change in condition. Documentation of the change in condition will be completed by the licensed nurse who completed the assessment in a progress note.Review of the Accident and Incidents policy dated 6/16/2017 directed, in part, the center provides an environment that is free from accident hazards over which the center has control and provides supervision and assistive devices to each resident to prevent avoidable accidents. Staff are involved in observing and identifying potential hazards in the environment, while taking into consideration the unique characteristics and abilities of each resident and they help to identify solutions to ensure a safe resident environment.Although requested, a facility policy for unresponsive episodes was not provided.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation/policy and interviews for one (1) of three (3) sampled residents (Resident #1) reviewed for accidents, the facility failed to ensure adequate supervision and the use of appropriate assistive devices to prevent accidents when staff did not follow the resident's mobility plan, did not have a wheelchair readily available, and did not follow established procedures during an emergency at a supervised smoking activity. The findings include: Resident #1?s diagnoses included Chronic Obstructive Pulmonary Disease (COPD), myoclonus (sudden, brief, involuntary twitching or jerking of a muscle or a group of muscles), seizures, bradycardia (low heart rate less than 60 beats per minute), macular degeneration (an eye disease that affects central vision), weakness and cognitive communication deficit.A physician's order dated 1/7/26 directed an assist of one (1) for all transfers with a rollator and Resident #1 was to ambulate with therapy only.The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had intact cognition (Brief Interview for Mental Status (BIMS) score of 13), and required setup assistance for bed mobility, substantial assistance for transfers, did not ambulate, utilized a wheelchair and was dependent on staff for mobility.A Smoking Evaluation dated 2/28/26 identified Resident #1 could safely smoke with supervision and a cigarette holder, and a smoking apron would be utilized for safety interventions.The Resident Care Plan (RCP) dated 3/4/26 identified Resident #1 was a current smoker, had an Activities of Daily Living (ADL) self-care, mobility and performance deficit due to failure to initiate, weakness and impaired vision, a history of chest pain and altered respiratory status/difficulty breathing due to COPD. Interventions included supervision for smoking at all times, observing for smoking safety through observation and interview, assist of two (2) transfer to bed/chair/bathroom, wheelchair use for locomotion and monitoring, documenting and reporting abnormal breathing patterns to the physician.A nurse's note by RN #4 dated 3/8/26 at 12:14 PM identified Resident #1 went to the smoking activity by rolling walker with an assist at 8:45 AM, as Resident #1 wanted to walk rather than utilize the wheelchair. The note identified the nursing supervisor (RN #3) went to RN #4 and reported Resident #1 was slumped over on a bench in the smoking area, so she went to check on Resident #1, who was unresponsive, with abnormal skin color and a sternal rub was initiated. The note reported she went back into the building to obtain oxygen, and when she returned Resident #1 was responsive and was in the wheelchair being brought towards his/her room by another nurse. She applied oxygen to Resident #1 in the hallway prior to Resident #1 being brought into his/her room and reported Resident #1 had one episode of vomiting as Emergency Medical Services (EMS) came to transport Resident #1.A nurse's note by RN #3 dated 3/8/26 at 2:06 PM identified she was at the nurse's station when NA #1 reported Resident #1 was outside and may not be breathing. She immediately went outside and observed Resident #1 hunched over on a bench breathing but nonverbal, not communicating, not moving and his/her skin color appeared pale/abnormal. She immediately called EMS, initiated a code and reported she witnessed Resident #1 being assisted back to his/her room by nursing staff. Resident #1 remained on observation until EMS arrived and upon EMS arrival, Resident #1 was awake in his/her room and had one episode of vomiting.The hospital discharge summary identified Resident #1 was admitted from 3/8/26 through 3/19/26 for acute hypoxemic respiratory failure (not enough oxygen in the blood) likely due to bacterial pneumonia and COVID-19.Interview with RN #3 on 4/6/26 at 11:39 AM identified neither NA #1 nor NA #2 contacted her by phone to notify her of the incident at the outside smoking area on 3/8/26 and that NA #1 ran inside the building and notified her in person.Interview with the Director of Rehab (DOR) on 4/6/26 at 12:11 PM identified Resident #1 was receiving Occupational Therapy (OT) and Physical Therapy (PT) services at the time of the 3/8/26 incident and Resident #1 was unsafe to ambulate with nursing staff. Resident #1 was legally blind and had inconsistent weakness, balance (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and activity tolerance. The DOR identified NA #6 should have checked the resident care card (RCC) and transported Resident #1 to the smoking activity via wheelchair, as Resident #1 required the wheelchair to be within reach at all times due to being unpredictable.Interview with NA #1 on 4/6/26 at 1:42 PM identified on 3/8/26 during the morning smoking activity, Resident #1 walked outside independently with a rolling walker and sat on a bench. She identified NA #2 and herself were responsible for supervising around twelve (12) residents at the time, including Resident #1 and about fifteen (15) minutes into the smoking activity, she observed Resident #1 slumped forward and to the right side while sitting on the bench. Resident #1 appeared faint and unresponsive to verbal cues. She identified she panicked and ran inside to locate RN #3, leaving NA #2 outside with Resident #1 and the other residents at the smoking activity. NA #1 reported she knew it was required that two (2) staff were to remain outside during the smoking activity at all times but she needed to contact RN #3. She identified the facility did not utilize walkie-talkies and she did not think to call the facility main line. She reported that another staff member had to go back inside once a code was called to locate a wheelchair since there were none nearby.Interview with NA #6 on 4/6/26 at 2:30 PM identified on 3/8/26 she dressed and assisted Resident #1 into the wheelchair for the morning smoking activity and Resident #1 requested to walk with a rolling walker. She identified she did not know Resident #1 to walk, and instead of referencing the RCC, she asked RN #4 if she could walk Resident #1 to the smoking activity and RN #4 indicated that was fine and Resident #1 could use the exercise. NA #6 reported she walked alongside Resident #1, without a wheelchair following behind the resident, as Resident #1 pushed the rolling walker the length of the hallway to the Center dining room and assisted him/her into a chair in the dining room, which was a holding room until the outside doors were opened for the smoking activity. She left Resident #1 and went back to the unit to care for other residents. NA #6 identified she was unaware Resident #1 was not supposed to walk and should have instead been pushed in the wheelchair to the smoking activity.Interview with RN #4 on 4/6/26 at 2:47 PM identified on 3/8/26, NA #6 reported Resident #1 wanted to walk to the morning smoking activity, and she told NA #6 that was fine. She identified that she did not check physician's orders or the RCP to ensure Resident #1 was cleared and safe to walk. RN #4 identified she was unaware there was a physician's order directing Resident #1 walk with therapy only, and she should have verified orders prior to communicating that Resident #1 could walk to the activity which could have prevented the search for a wheelchair when Resident #1 became unresponsive outside at the smoking activity.Interview with the DON on 4/6/26 at 3:18 PM identified NA #6 should have verified Resident #1's activity orders on the RCC prior to walking Resident #1 to the activity and returning back to the unit. The DON reported RN #4 should have verified Resident #1's ambulation orders prior to communicating with NA #6 that she could walk Resident #1 to the smoking activity, as she put Resident #1's safety at risk by not ensuring Resident #1 was transported by wheelchair. She identified staff do not utilize walkie-talkies during the smoking activity because they are unreliable but the staff supervising the residents during the smoking activity are responsible for having a cell phone and contacting the phone that the nursing supervisor kept on hand during weekends and the afternoon smoking activity. The DON reported NA #1 should have ensured NA #2 or herself contacted RN #3 from the outside activity immediately and should not have left Resident #1 and the other residents with only one (1) staff member, which was against facility policy.Although attempted, an interview with NA #2 was not obtained.Review of the Smoking policy dated 10/11/23 directed, in part, the supervision will include a maximum of twelve (12) residents to two (2) observers. Any unusual occurrences regarding smoking or smoking materials should be reported to the charge nurse/supervisor immediately. Walkie-talkies/electronic devices must be brought out with the smoking cart. One of the walkie-talkies are to be kept with the cart and the other is to be given to the Supervisor or North wing nurse in case of need/emergency while supervising smoking session.Review of the Accident and Incidents policy dated 6/16/2017 directed, in part, the center provides an environment that is free from accident hazards over which the center has control and provides supervision and assistive devices to each resident to prevent avoidable (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	accidents. Staff are involved in observing and identifying potential hazards in the environment, while taking into consideration the unique characteristics and abilities of each resident and they help to identify solutions to ensure a safe resident environment. The center assesses residents to determine the resident's degree of mobility and physical impairment and the proper transfer method. The center provides appropriate assistive devices to reduce the risk and/or prevent accidents. Ways to reduce risk and/or prevent risk are: education of the staff in using assistive devices properly. Although requested, a facility policy for following physician's orders was not provided.