STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075200	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southport Center for Nursing & Rehabilitation LLC	930 Mill Hill Terrace Southport, CT 06890

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of facility documentation, facility policy, and interviews for 2 of 2 residents (Resident #12 and Resident 105) reviewed for choices, the facility failed to ensure that hand soap was not provided as a body/hair wash, per the residents' preferences. The findings include: 1. Resident #12 was admitted to the facility in February 2023 with diagnoses that included paraplegia, morbid obesity, and irritant contact dermatitis due to friction or contact with body fluids. The quarterly MDS dated [DATE] identified Resident #12 had intact cognition, was dependent for bathing, toileting and personal hygiene, and was always incontinent of bowel and bladder.Interview with Resident #12 on 7/27/25 at 8:40 AM identified that the nurse aides use hand soap pink soap and a paper towel (disposable cloth) for bathing, hair washing, and incontinent care. Resident #12 indicated that he/she could no longer use the pink soap provided by the facility because his/her skin became too dry and combing his/her hair hurt following a wash with the pink soap. Resident #12 further indicated that he/she had told multiple staff members about his/her concerns with the pink soap, but the concerns were not addressed. Subsequently a family member has been purchasing hair and body wash products for the nurse aides to use for his/her bathing and incontinent care. 2. Resident #105 was admitted to the facility in August 2024 with diagnoses that included rash and non-specific skin eruption, protein-calorie malnutrition, and enterocolitis due to clostridium difficile. The quarterly MDS dated [DATE] identified Resident #105 had intact cognition and was independent with toileting and personal hygiene. Interview with Resident #105 on 7/27/25 at 9:00 AM identified that the pink soap used in the bathroom for hand washing was the same pink soap that was provided for showers and hair washing. Resident #105 indicated that the pink soap dried out his/her skin, and that he/she would only use water to wash his/her hair because the pink soap tore up his/her hair. Resident #105 identified that for a short (unspecified) time, a body and hair combination wash was provided, but the facility had since returned to the pink soap with a stack of disposable towels for bathing and hair washing. Observation and interview with Housekeeper #1 on 7/29/25 at 7:11 AM identified that he had used the bottle labeled Hand Soap Pink Perfect Mild Lotion Hand Cleaner to stock the entire house: including bathrooms, resident rooms, and shower rooms.Interview with NA #7 and NA #8 on 7/29/25 at 9:15 AM identified that earlier this year the body and hair wash used to bath residents was taken away, and they were informed that the pink soap, stocked in the bathrooms for handwashing, would be used for body and hair washing. NA #7 and NA #8 indicated that residents had complained that it was drying their skin and clumping their hair. NA #7 and NA #8 identified that they had notified the Director of Housekeeping that the pink soap was not working out, and she had indicated that she was told by corporate that was what the facility uses. Interview with Housekeeper #2 on 7/29/25 at 12:10 PM identified that she had been filling all of the shower rooms and bathrooms from the bottle labeled Hand Soap Pink Perfect Mild Lotion Hand Cleaner, for the last few months. Interview with NA #4 on 7/29/25 at 12:13 PM identified that she had been using the pink soap to clean and bathe residents, since May or June of this year.Review of the Product History document dated 7/29/25 identified that 23 gallons of Hand Soap- Pink were purchased between the dates of 4/15/25 through 7/26/25, and 4 gallons of Shampoo and Body Wash had been purchased in the last 2 years, on 6/20/25 and 6/30/25. Interview with the Director of Housekeeping on 7/30/25 at 4:16 PM, hire date 12/10/24, identified that the facility was already using the pink soap when she was first hired, and that the staff had complained to her that they were experiencing dry skin from using the product; it was not communicated to her that the residents were complaining of dry skin due to the pink soap. The Director of Housekeeping indicated that, in response to the staff's feedback, she ordered shampoo and body wash in June of 2025, but the staff had not provided feedback if the shampoo and body wash was an improvement or not, so when it ran out, they resumed using the supply of pink soap. The Director of Housekeeping further indicated that the residents' concerns about the pink soap were not brought to her attention by staff or during any of the resident council meetings that she had attended, but she would circle back to residents and staff for feedback and order whatever they like.Interview with the Administrator on 7/31/25 at 10:35 AM identified that during the 6/6/25 resident council meeting it was brought up that some of the residents did not like the pink soap and liked the shampoo and body wash better. The feedback was discussed with corporate, and he was told that the pink soap was meant to be a full body wash. The Administrator indicated that he was not aware that the soap referred to as pink soap was a hand soap. The Resident Rights policy directs that residents have the right to receive quality care and services with reasonable accommodation of individual

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075200	A. Building B. Wing	07/31/2025

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observation, review of the clinical record, facility documentation, facility policy, and interviews for 3 residents (Resident #10, 76 and 122) the facility failed to notify the physician and/or resident representative when required.For 1 of 5 residents (Resident #10) reviewed for unnecessary medications, the facility failed to notify the physician and resident representative of elevated blood sugars and change in condition. For 1 of 4 residents (Resident #76) reviewed for dental services, the facility failed to notify the physician when a dental provider observed moderate inflammation with a possible abscess of the resident's tooth. For 1 of 3 residents (Resident #122) reviewed for closed record, the facility failed to notify the physician when the resident left the facility AMA. The findings include: 1.The hospital Discharge summary dated [DATE] identified Resident #122 was admitted to the hospital on [DATE] with symptoms of generalized weakness with acute on chronic bilateral knee pain, left greater than right, abdominal pain, and diarrhea. Resident #122’s last use of alcohol beverage was the day of admission early in the morning. Resident #122 was unfortunately unhoused. Resident #122 was evaluated and discharged on 6/19/25 to a nursing facility with diagnoses of diarrhea, and alcohol withdrawal. Resident #122 was admitted to the facility on [DATE] with diagnoses that included acute embolism and thrombosis of left popliteal vein, alcohol abuse, opioid use, and pain. The physician’s order dated 6/19/25 directed to transfer out of bed to any surface with limited assist for safety. Apply oxygen via nasal cannula at 2 liters to maintain oxygen saturation at or greater than 90% as needed. Special instructions: (If unable to maintain saturation equal to or greater than 90%, administer oxygen via non-rebreather mask at a minimum of 10 liters). Call the physician for status update and further recommendations. The care plan dated 6/20/25 identified Resident #122 was at risk for falls related to gait difficulty, left knee pain, and alcohol withdrawal. Interventions included for medication review by the pharmacist, assess for pain and rehabilitation screen. Review of a discharge AMA form dated 6/23/25 at 10:15 AM identified Resident #122 signed the form along with SW #1 to leave AMA. Review of the clinical record failed to reflect a physician’s order that directed to discharge the resident against medical advice (AMA). Additionally, the nurse’s note failed to reflect documentation on 6/23/25 regarding Resident #122 leaving the facility AMA and failed to reflect documentation that the physician was notified when Resident #122 left the facility AMA. The social service note dated 6/23/25 at 10:25 AM identified SW #1 spoke with Resident #122 after she was updated that Resident #122 wanted to leave AMA. SW #1 indicated she asked Resident #122 to reconsider staying at the facility for health reasons. SW #1 indicated she spoke in length with Resident #122 about not leaving but Resident #122 indicated he/she had things to do and would like to leave. SW #1 indicated she updated Resident #122 regarding the weather and heat advisory. SW #1 indicated Resident #122 updated SW #1 that his/her ride would be here soon. SW #1 indicated she provided Resident #122 with a bottle of water for his/her trip. (continued on next page)

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	075200	A. Building B. Wing	07/31/2025

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with SW #1 on 7/30/25 at 9:10 AM identified she met with Resident #122 and asked the resident to allow the facility couple of days to prepare for a safe discharge back to the community. SW #1 indicated she performed a cognition assessment and failed to document the result. Interview with the DNS on 7/30/25 at 8:00 AM identified she was aware Resident #122 was leaving the facility AMA. The DNS indicated she was not aware that RN #1, and LPN #3 did not notify the physician/APRN that Resident #122 left the facility AMA. The DNS indicated it was the responsibility of the RN Supervisor and the charge nurse to notify the physician/APRN that Resident #122 was leaving or left the facility AMA, and document that information in the clinical record. Although attempted, an interview with RN #1, and LPN #3 were not obtained. Review of the facility discharge against medical advice (AMA) policy identified it is the policy of the facility to respect a resident’s right to self-determination, including the right leave the facility against medical advice (AMA). The facility will take all reasonable measures to inform the resident (or their legal representative) of the risks, document informed refusal, and ensure compliance with federal and state regulations governing safe discharge and resident rights. The policy applies to all nursing, medical, administrative, and social services staff involved in resident discharge planning. Any resident who expresses intent to leave AMA will be assessed immediately by a Registered Nurse (RN) for decision-making capacity. Notification to the attending physician or on-call provider immediately. Evaluated safety risks (e.g. cognitive impairment, mobility limitations). The attending physician/APRN is contacted promptly to discuss the clinical risks of leaving AMA with the resident/legal representative. Provide written medical advice regarding the risks associated with discharge. Document recommendations in the electronic health record (EHR). The resident or legal representative must sign an “AMA Discharge Form”. 2. Resident #10 was admitted to the facility in August 2023 with diagnoses that included traumatic brain injury, dysphagia, and diabetes with hypoglycemia. A physician's order dated 12/11/24 directed to check blood sugars 4 times daily before meals (6:00 AM, 12:00 PM, 6:00 PM, 12:00 AM) and notify the physician when blood sugars are less than 70 or greater than 400. The quarterly MDS dated [DATE] identified Resident #10 had severely impaired cognition, was always continent of bowel and bladder and required supervision with toileting, dressing, and eating. The care plan dated 7/11/25 identified Resident #10 was at risk for abnormal blood sugar levels including hypoglycemia and hyperglycemia due to diabetes. Interventions included to obtain finger sticks as ordered and report abnormal findings to the physician. Interventions also included to monitor the resident for signs and symptoms of hyperglycemia. A nurse’s note dated 7/15/25 at 7:20 PM by RN #3 identified that at 4:30 PM she was informed by the charge nurse that Resident #10 had a blood sugar of 54, was nonverbal and sweating. The note further identified following treatments that included supplementation and Glucagon (a medication used to treat low blood glucose), Resident #10 had a blood sugar of 74 and became more responsive and alert. The note identified that by 7:00 PM, Resident #10’s blood glucose was 267 after dinner. The note also identified the APRN was notified, and the charge nurse was to notify Resident #10's resident representative. (continued on next page)

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	075200	A. Building B. Wing	07/31/2025

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A nurse's note dated 7/15/25 at 10:04 PM by LPN #9, the unit charge nurse, identified that Resident #10 had a hypoglycemic reaction during the shift. Further review of the documentation failed to identify that Resident #10's resident representative had been notified of the hypoglycemic episode with need for treatment. Review of the clinical record identified Resident #10’s blood sugar, obtained by LPN #4 on 7/24/25, was 436. Further, the clinical record failed to identify additional documentation including notification of the physician. Interview with APRN #1 on 7/30/25 at 12:07 PM identified that she was not notified of the residents elevated blood sugar of 436 by LPN #4 on 7/24/25. APRN #1 identified that LPN #4 was not the regular nurse assigned to care for Resident #10. APRN #1 also identified that if she had been notified of the elevated blood sugar on 7/24/25 it would have been documented in her notes. APRN #1 also identified that the order in place regarding directed staff to notify her or the physician of any blood glucose levels less than 70 and greater than 400. Interview with LPN #4 on 7/30/25 at 1:14 PM identified she was a float nurse at the facility and did not typically provide care for Resident #10. LPN #4 identified she could not recall if she notified the RN Supervisor on 7/24/25 of the elevated blood sugar but indicated she did notify APRN #1. LPN #4 was unable to identify if she notified APRN #1 in person or via phone and was unable to identify any orders from APRN #1. LPN #4 identified that sometime before the end of her shift at 3:00 PM she rechecked Resident #10’s blood sugar. LPN #4 identified that she took it upon herself to recheck the blood sugar without discussing it with APRN #1 and identified the blood sugar was somewhere around the lower 300’s but could not identify the actual number and was not sure if it was documented. Review of the clinical record failed to identify documentation by LPN #4 related to a recheck of Resident #10's blood sugar level on 7/24/25. Interview with RN #3 on 7/30/25 at 4:55 PM identified she directed LPN #9 to contact and notify Resident #10’s resident representative of the hypoglycemic episode and altered mental status that occurred 7/15/25. RN #3 identified that she did not follow up or speak with LPN #9 any further regarding if she made contact or attempted to notify Resident #10’s resident representative but if it was done LPN #9 would typically document any attempts to contact in her progress note. Interview with the DNS on 7/31/25 at 11:01 AM identified that licensed nurses were responsible to notify the resident representative and document the notification or attempts in the resident’s clinical record. The DNS also identified that the licensed nursing staff was expected to follow the physicians orders including when to notify the physician for abnormal findings. The DNS identified LPN #4 should have notified the RN Supervisor of the elevated blood sugar. The DNS further identified LPN #4 should have also notified the APRN and documented the notification in the clinical record, and it would not have been appropriate for LPN #4 to obtain a blood sugar level without direction from APRN #1. Although multiple attempts were made, an interview with LPN #9 was not obtained. (continued on next page)

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	075200	A. Building B. Wing	07/31/2025

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy on hyperglycemia management directed that the facility would promptly identify, monitor, and treat hyperglycemia in accordance with the physician's orders. The policy further directed that residents with diabetes would have blood sugar monitoring per the physicians orders and staff would recognize signs and symptoms of hyperglycemia. The policy further directed for blood sugar levels greater than 400 with altered mental status, vomiting, small respirations or fruity breath odor, staff would call 911, follow facility emergency response protocol, monitor vital signs and initiate oxygen if indicated, and document interventions and notify family/POA. The policy also directed to record all blood sugar readings, symptoms, interventions, and provider notifications in the clinical record. The facility policy on change of condition directed it was the policy of the facility to ensure that changes in the resident’s conditions were reported to providers and families. The policy further directed that the facility must immediately consult with the residents physician and notify the residents legal representative or interested family member if there was a significant change in the resident’s physical, mental, or psychosocial status or a need to alter treatment significantly. The policy further directed that any resident with the change of condition would receive timely and appropriate intervention. The policy further directed that the LPN was to collect data and administer provider ordered treatments or medications as indicated and that the RN Supervisor would also be notified accordingly, and the RN would assess and determine if a change of condition had occurred. The policy also directed that repeated attempts would be made to reach the attending physician and/or medical director and family until successful. The nurse would document attempts, noting the date and time. 3. Resident #76 had diagnoses that included stroke and hemiplegia (paralysis) of the left side. The care plan dated 12/6/22 identified Resident #76 was at risk for pain related to physical condition. Interventions included encouraging the resident to report pain and provide medical management of underlying causes. The admission MDS dated [DATE] identified Resident #76 had moderately impaired cognition, was independent with eating and had no dental related concerns. A dental consultation dated 7/14/25 identified Resident #76 was seen for an exam, prophylaxis and fluoride. Soft tissues were noted to have generalized moderate inflammation with a possible abscess of the #18 buccal (side of molar) #18 root tip, and the resident had not yet been to an oral surgeon. Recommendations for an oral surgeon to extract #18 tooth. Review of the clinical record dated 7/14/25 through 7/25/25 failed to identify the physician had been notified about the possible abscess of the #18 tooth root tip. Interview with Dental Hygienist #1 on 7/28/25 at 1:34 PM identified she last saw Resident #76 on 7/14/25 for prophylaxis. Dental Hygienist #1 identified she observed inflammation at the gumline and a fistula at the #18 tooth site consistent with signs of infection. The dentist was not onsite to further evaluate, however, previous recommendations for extraction of #18 were documented during earlier visits. (continued on next page)

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	075200	A. Building B. Wing	07/31/2025

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with Dentist #1 on 7/28/25 at 1:33 PM identified he provided dental services to Resident #76 in the past but had not evaluated the resident recently. Dentist #1 identified based on review of the clinical findings, Resident #76 had a chronic infection of the area that had exacerbated. Dentist #1 identified the #18 tooth required removal for some time and likely required antibiotics. Dentist #1 would have expected the facility provider to consider an antibiotic after reviewing the consultation. Interview with NP #1 on 7/29/25 at 11:50 AM identified she began providing services in March of 2024 and had not previously been notified of any dental related concerns related to Resident #76. NP #1 further identified she was not notified of the possible abscess noted on the dental consultation of 7/14/25. Based on the clinical findings, NP #1 would have instructed nursing to contact the dental provider to see if they would like treatment with antibiotics or wait to see the oral surgeon prior to extraction. Interview with the DNS on 7/28/25 at 2:30 PM identified she would expect the nurse who received the consultation form back from the dental provider to notify the physician of the changes which included moderate inflammation with a possible abscess. The change of condition policy directed any change in a resident’s baseline is considered a change in condition. All changes in condition will be reported to providers and families and the residents will receive a timely and appropriate intervention.

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	075200	A. Building B. Wing	07/31/2025

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for 4 of 6 residents (Resident #43, 65, 99 and 116) reviewed for abuse, the facility failed to protect Resident #43, 65, 99 and 115 from physical abuse by Resident #123, who had a history of resident-to-resident altercations, and injured Resident #99. The findings include:1a. Resident #65 was admitted to the facility in May 2019 with diagnoses that included dementia without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, schizophrenia, and obesity.The quarterly MDS dated [DATE] identified Resident #65 had intact cognition and required supervision with transfer, and locomotion on/off unit. Additionally, Resident #65 had no physical and verbal behaviors directed toward others. The care plan dated 3/9/23 identified Resident #65 had diagnoses of dementia and was at risk for impaired decision making. Interventions included to administer medications as ordered. Encourage to attend preferred recreational activities.The physician's order dated 5/1/23 directed Resident #65 was independent with bed mobility, transfer, and ambulation. No assistive device was needed. The nurse's note dated 5/9/23 at 4:57 PM identified RN #5 was called to the front desk. Receptionist #1 reported she observed Resident #65 chasing Resident #123 and grabbed Resident #123 by his/her shirt. Resident #65 said to Resident #123 do not put your hands on me again. Both residents were immediately separated by Receptionist #1. The investigation identified Resident #123 asked Resident #65 at the cafe area for a cigarette and Resident #65 reply no. Resident #123 then kicked Resident #65 on the right leg which led to the chase. RN assessment provided with no redness, no swelling to the right leg. The care plan dated 5/9/23 identified Resident #65 had a resident-to-resident altercation. Resident #65 was kicked by another resident on the right leg and Resident #65 chased the resident and grabbed him/her by the shirt. Interventions included to provide psychiatry and social worker support. Educate and encourage to approach staff and report any incidents for prompt interventionThe psychiatric evaluation and consultation form dated 5/9/23 identified the psychiatric APRN, APRN #2 was asked to evaluate Resident #65 who was alleged to have had an altercation with Resident #123. Resident #65 reported Resident #123 kicked him/her on the leg because he/she had refused to give him/her a cigarette. Resident #65 reported he/she did not hit or kick Resident #123. Resident #65 was placed on 1:1 monitor until evaluated by psychiatrist. Resident #65 was encouraged to talk to the nursing staff if there are issues with another resident. No adjustment of resident medications at this time. Considering Resident #65 was not a danger to himself or other at that time, Resident #65 was cleared. Discontinue 1:1 monitoring. Continue with current psychiatric medication as ordered.The social service note dated 5/9/23 at 4:18 PM identified SW #4 checked with Resident #65 regarding the incident that occurred. Resident #65 reported no issues or complaints.b. Resident #123 was admitted to the facility in July 2020 with diagnoses that included major depressive disorder, anxiety disorder, schizophrenia, paranoid personality disorder, and psychosis. The annual MDS dated [DATE] identified Resident #123 had moderately impaired cognition and required supervision with transfer and locomotion off on/off unit. Additionally, Resident #123 had no physical and verbal behaviors directed toward others. The care plan dated 4/20/23 identified Resident #123 was in a physical altercation with another resident. Interventions included psychiatric services as needed. Encourage the resident to seek out the staff when having difficulty with other residents.The physician's order dated 5/1/23 directed Resident #123 was independent with bed mobility, transfer, and ambulation. No assistive device was needed.A reportable event form dated 5/9/23 at 10:48 AM identified Resident #65 was kicked by Resident #123. Both residents were separated immediately. Resident #65 was placed on 1:1 monitoring. Resident #65 was evaluated by psychiatrist and cleared. The social service note dated 5/9/23 at 2:00 PM identified SW #4 checked with Resident #123 post resident to resident altercation. Resident #123 indicated he/she vehemently pursued Resident #65 because he/she refused to offer him/her a cigarette. Educated interventions of self-control and mood management are ineffective because of diminutive duration, as evidence of Resident #123 inability to preserve focus or maintain presence for an extended period. The nurse's note dated 5/9/23 at 4:37 PM identified RN #5 after the resident to resident altercation Resident #123 was placed on 1:1 monitoring immediately. Resident #123 refused assessment and was not cooperative with further questioning and stated to leave him/her alone he/she was ok. Resident #123 pending PEC (physician's emergency certificate) and to be sent to a facility in AM. The psychiatric evaluation and consultation form dated 5/9/23 identified Resident #123 was with increasing psychosis and assaultive behavior as well as non-adherence to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075200	A. Building B. Wing	07/31/2025

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for 4 of 5 residents (Resident #3, 8, 21 and 79) reviewed for pre-admission screening and resident review (PASARR), for Residents #3, 8 and 21 the facility failed to notify the State-designated authority when the residents were identified with a new mental health diagnosis and for Resident #79 who had a history of attempted self-harm and physically violent behavior directed as others, the facility failed to incorporate PASARR recommendations that included a crisis/safety plan in the resident's plan of care. The findings include: Resident #79 was admitted to the facility in September 2024 with diagnoses that included schizoaffective disorder and bipolar disorder. The PASARR dated 4/8/25 identified Resident #79 received short term approval without specialized services with an approval period of 120 days. The Connecticut Summary of Findings PASARR dated 4/8/25 identified important symptoms, diagnoses, behaviors, other needs, and history that a provider should know about Resident #79 included: having thoughts that people are out to get him/her, attempted self-harm in the past, physically violent behavior directed towards his/her sibling 5 years ago, and physically violent behavior directed toward his/her parent 20 years ago. It is important staff can recognize the presence of depressive symptoms, thoughts of self-harm, sensations that appear real but are not or changes in behaviors as the early signs of possible need for psychiatric or behavioral intervention. Services and supports the nursing facility staff are required to provide Resident #79 included: supportive counseling from nursing facility staff and a crisis intervention plan/safety plan due to his/her history of self-harm and a history of physically violent behaviors; this plan should include looking for an increase in symptoms or changes in behaviors as well as steps to take for the staff to take when this happens. The care plan dated 6/5/25 identified Resident #79 has been determined a positive Level 2 and has the potential for altered thought process and difficulty adjusting to situations. Interventions failed to identify that a crisis intervention plan/safety plan was in place. The quarterly MDS dated [DATE] identified Resident #79 had intact cognition, had no physical or verbal behavioral symptoms directed towards others over the last 2 weeks, and required supervision while wheeling 50 - 150 feet in a manual wheelchair. Interview with Resident #105 on 7/27/25 at 8:40 AM identified that Resident #79 sings, yells, and screams in the hallway all day long and it drives everyone crazy. Interview with Resident #12 on 7/27/25 at 10:20 AM identified that Resident #79 shouts all night and all day that people are stealing and she shouts indiscriminately that she will (explicative) people up. Resident #12 indicated listening to the behavior was tiring and that he/she has voiced concerns to the DNS and other staff members, but nothing had been done. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075200	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview and review of the clinical record with the Director of Social Services (SW #1) on 7/28/25 at 9:41 AM failed to identify a crisis/safety plan in Resident #79’s clinical record, and she was not aware that the PASARR recommendations included developing a crisis intervention plan/safety plan. SW #1 indicated that it was her responsibility to review PASARR recommendations, but this was an oversight on her part. SW #1 further indicated that she would collaborate with the interdisciplinary team, including nursing, the licensed clinical social worker, and the Psychiatric APRN, as well as Resident #79’s conservator to develop a crisis/safety plan, by tomorrow. The plan would include identifying Resident #79’s triggers and behavior and utilizing recreation, talk therapy, and non-pharmaceutical and pharmaceutical interventions. SW #1 identified that education would be provided to all department heads and the care team so direct care staff could identify early signs of behaviors, triggers, or escalation. Interview with the DNS on 7/30/25 at 5:10 PM identified that she was not aware that Resident 79 did not have a crisis/safety plan, but she would work with the interdisciplinary team in its development and ensure direct care nursing staff would be educated. Interview with the Psychiatric APRN (APRN #2) on 7/30/25 at 6:20 PM identified that prior to the survey process he was not aware of the PASARR recommendation to develop a crisis intervention plan/safety plan for Resident #79, but the plan had been developed, subsequent to surveyor inquiry. APRN #2 indicated that Resident #79 was alert and oriented and stable on his/her current medication regimen and continues to work with psychotherapy. APRN #2 identified that the team was aware of the importance of identifying early triggers and behaviors, and the need to place Resident #79 on a 1:1 or send him/her out for a higher level of psychiatric care, if needed, but currently he/she is stable and will remain on the current medication regimen. The facility’s PASARR policy directs that individuals with a serious mental illness, intellectual disability, or related condition will not be admitted without first undergoing the federally mandated PASARR screening process, consisting of Level 1 and, if applicable Level 2 screening. A Level 2 screening directs for the assessment of the need for specialized services and appropriateness of nursing facility placement. 2. Resident #3 was admitted to the facility in April 2012 with a diagnosis that included personality disorder and dementia. Notice of Level 1 screen dated 6/18/12 was negative and identified Resident #3 had a diagnosis of personality disorder. Additionally, Resident #3 had a diagnosis of dementia and required a comprehensive mental status exam. Resident #3 received long term care approval. The care plan dated 1/21/22 identified Resident #3 had increased risk for altered nutrition secondary to primary diagnosis of dementia, personality disorder, and mood disorder. Interventions included to encourage and monitor food intake. The quarterly MDS dated [DATE] identified Resident #3 had moderately impaired cognition and had a diagnosis of dementia, depression, and major depressive disorder, recurrent. The psychiatric evaluation and consultation dated 1/23/23 identified a diagnosis of mood disorder, severe to moderate, chronic illness and dementia. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The psychiatric evaluation and consultation dated 2/4/23 identified a new diagnosis of major depressive disorder. The census report for Resident #3 identified he/she was readmitted from the hospital on 1/9/24 and 4/8/24. Review of the active diagnosis list dated 4/1/24 identified Resident #3 received a diagnosis of major depression disorder, recurrent. The psychosocial evaluation dated 4/1/24 identified Resident #3 has the cognitive ability and verbal capacity to participate and benefit from psychotherapy. The treatment plan and objective identified to treat confusion, depression and irritability. Resident #3 has a diagnosis of major depressive disorder, recurrent. Interview with SW #1 on 7/29/25 at 6:38 AM indicated the social worker was responsible to update the State-designated authority when a resident gets a new mental health diagnosis. SW #1 indicated that upon notification, the State-designated authority will determine if an onsite visit for a level 2 evaluation is needed, or if there are any specialized services the facility needs to provide to the residents. SW #1 indicated Resident #3 had a negative Level 1 screen dated 6/18/12 with a diagnosis listed as dementia and personality disorder. The Level 1 did not list the diagnosis of major depression disorder, recurrent. SW #1 indicated that she was not aware nor could find the comprehensive mental status exam that was recommended at that time. SW #1 indicated that review of the psychiatric notes identified the new diagnosis was given on 2/4/23. SW #1 indicated the prior social worker should have submitted a new Level 1 PASARR to the State-designated authority for review due to the new diagnosis in February 2023. SW #1 indicated when Resident #3 was readmitted on [DATE] or 4/8/25 the social worker should have caught that the major depressive disorder, recurrent was not listed on the PASARR and resubmitted at that time. SW #1 indicated that she will submit and update the State-designated authority today with the new diagnosis and documentation. 3. Resident #8 was admitted to the facility in May 2021 with diagnoses that included anxiety and major depressive disorder. A Notice of Level 1 PASARR determination dated 5/10/21 identified Resident #8 had a diagnosis of dementia with behavioral disturbances. Resident #8 received long-term care approval based on the information provided. A physician’s order dated 11/25/21 directed to administer Seroquel (antipsychotic medication) 50 mg daily at 9:00 AM for depression, and Seroquel 25 mg at bedtime for anxiety, agitation, and paranoia. Additionally, a psychological evaluation and consultation to treat as needed. The quarterly MDS dated [DATE] identified Resident #8 had intact cognition and had a diagnosis of anxiety and major depressive disorder. The Resident #8’s diagnosis list identified a new diagnosis on 5/1/22 of schizoaffective disorder, bipolar type. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The annual MDS dated [DATE] identified Resident #8 had intact cognition and had a diagnosis of anxiety and major depressive disorder. Additionally, Resident #8 has a diagnosis of schizoaffective disorder, bipolar type. The psychiatric consultation dated 5/16/22 identified Resident #8 had a diagnosis of anxiety, dementia, and major depression disorder. The psychiatric consultation dated 7/7/22 identified Resident #8 had a new diagnosis schizoaffective disorder, bipolar type. The care plan dated 2/1/23 identified Resident #8 receives antidepressant and antipsychotic medications related to depression. Interventions included attempting gradual dose reduction to lowest dosage. A physician’s order dated 7/14/24 directed to administer Seroquel 50 mg daily and Seroquel 25 mg at bedtime for diagnosis of schizoaffective disorder, bipolar type. The census report identified Resident #8 had returned from the hospital on 7/14/24 and 12/21/24. Interview with SW #1 on 7/29/25 at 6:26 AM indicated Resident #8 only has a PASARR dated 5/10/21 which identified a diagnosis of dementia and anxiety but does not list the major depression or the diagnosis of schizoaffective disorder bipolar type. After clinical record review, SW #1 indicated Resident #8 received the diagnosis of schizoaffective disorder bipolar type on 7/7/22. SW #1 indicated that the social worker at that time should have submitted a notified the State-designated authority due to the new mental health diagnosis and update the care plan. SW #1 indicated that it was not picked up on 7/14/24 or 12/21/24 when the resident was readmitted . SW #1 identified she will be updating the State-designated authority with the new diagnosis of schizoaffective disorder and major depression. 4. Resident #21 was admitted to the facility in February 2021 with diagnoses that included violent behaviors and acute kidney injury. The care plan dated 1/3/22 identified Resident #21 was on antidepressant and antipsychotic medications. Interventions included attempting gradual dose reduction to the lowest therapeutic level. A physician’s order dated 1/4/22 directed to administer Risperidone (antipsychotic medication) 0.5 mg once a day. A physician’s order dated 3/24/22 directed to administer Risperidone 1 mg twice a day. Notice of Level 1 PASARR determination dated 4/4/22 identified Resident #8 had a diagnosis of dementia with behavioral disturbances and delusional disorder. Resident #8 received long-term care approval based on the information provided. There is no evidence of a PASARR condition or serious behavioral health condition. If changes occur or new information refutes these findings, a new screen must be submitted. The quarterly MDS dated [DATE] identified Resident #21 had moderately impaired cognition. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The quarterly MDS dated [DATE] identified Resident #21 had moderately impaired cognition and a diagnosis of schizophrenia. The annual MDS dated [DATE] identified Resident #21 had moderately impaired cognition with a active diagnosis of depression and schizophrenia. A physician’s order dated 8/4/22 directed to administer Risperidone 2 mg twice a day for a diagnosis of schizoaffective disorder. A physician’s order dated 2/5/24 directed to Risperidone 1.5 mg twice a day for a diagnosis of schizoaffective disorder. A physician’s order dated 4/8/25 directed to monitor behaviors every shift for use of psychotropic medication. Monitor for paranoia, agitation, and hallucinations for a diagnosis of schizoaffective disorder depressive type. Interview with SW #1 on 7/29/25 at 6:43 AM identified after clinical record review Resident #21 had received the diagnosis of schizoaffective disorder on 4/11/22. SW #1 indicated that the social worker at that time should have updated the State-designated authority with the new diagnosis of schizoaffective disorder to determine if there were any specialized services needed. SW #1 indicated that when she started at the facility about 4 months ago she was informed there were only 2 residents that had a Level 2 positive PASARR. SW #1 indicated that she did not do any audits to check if it was accurate. SW #1 indicates that she was only reviewing the new admissions to the facility. Interview with the Administrator on 7/29/25 at 6:51 AM identified she has looked at the book that was there for the Level 2's in the facility but has not done an audit yet. The Administrator indicated the social worker is responsible for PASSAR’s. After reviewing the policy, the Administrator indicated that when a resident receives a new mental health diagnosis the social worker is responsible to update the State-designated authority at that time. Review of the PASARR policy identified individuals with a serious mental illness, intellectual disability, or related condition will not be admitted to the facility without first undergoing the federally mandated PASARR screening process, consisting of Level 1 and if applicable Level 2 screening. This is to ensure compliance with federal and state regulations by identifying individuals with serious mental illness, intellectual disabilities, or related conditions prior to admission to the facility and providing appropriate care and services. Level 2 screening is required if a Level 1 screening is positive. Mandatory PASARR Level 2 resubmission for any resident receiving a new diagnosis of mental illness or related condition, regardless of admission date will be communicated within the interdisciplinary team. Notify the PASARR authority if a current resident shows signs of MI or ID not previously identified. Re-screening is also required upon a significant change in condition.

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	075200	A. Building B. Wing	07/31/2025

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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 observation, review of the clinical record, facility documentation, facility policy and interviews for 2 of 8 residents (Resident #7 and 79) reviewed for range of motion and/or behaviors, the facility failed to develop and implement a comprehensive care plan for a resident with a contracture and a resident exhibiting disruptive behaviors. The findings include: Resident #7 was admitted to the facility in January 2025 with diagnoses that included dementia, cerebral infarction, and adult failure to thrive. The admission observation dated 1/3/25 identified Resident #7’s hand grasp strength was stronger on one side than the other side due to a right-hand contracture: Resident #7 presented with a contracture of the right hand and wrist joint. The care plan dated 7/15/25 failed to address Resident #7’s right-hand contracture and failed to identify therapeutic and nursing interventions and functional goals/outcomes. The quarterly MDS dated [DATE] identified Resident #7 had severely impaired cognition and had no upper extremity impairment. (The MDS failed to identify the right-hand contracture). Interview with the MDS Coordinator (LPN #14) on 7/30/25 at 5:38 PM identified that Resident #7 was not coded as having a contracture, and therefore she was unaware of the contracture. The ICD code for the diagnoses would have prompted her to document the contracture in the MDS and to create a care plan with appropriate interventions and therapy recommendations, as needed. Interview with the DNS on 7/30/25 at 6:00 PM identified that she would expect a comprehensive, interdisciplinary care plan for Resident #7’s contracture to have been developed. The DNS indicated that it would be the primary responsibility of the MDS Coordinator to develop the care plan, but any nurse could initiate a care plan. The facility’s Nursing Services policy directs that a consistent and interdisciplinary approach to the prevention, identification, treatment, and monitoring of contractures among residents is established. Thereby promoting functional independence, optimizing range of motion, and enhancing quality of life. The policy further directs that for residents at risk or with existing contractures, an individualized care plan shall be developed by the interdisciplinary team and collaboration with the resident and or responsible party. Care plans must address specific joints affected, therapy interventions (e.g., PT/OT), use of splints, positioning aids or orthotics, nursing interventions (e.g., ROM exercises, turning/repositioning schedule), functional goals, and expected outcomes. 2. Resident #79 had diagnoses that included schizoaffective disorder and post-traumatic stress disorder (PTSD). The quarterly MDS dated [DATE] identified Resident #79 required 1 person assist with transfers and toileting and had not exhibited any recent behavior symptoms. (continued on next page)

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	075200	A. Building B. Wing	07/31/2025

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The care plan dated 6/5/25 identified Resident #79 had a diagnosis of PTSD and was an active smoker. Interventions included to assess the resident for anxiety and mood swings, identify triggers while addressing resident needs, and ensure the resident abides by the smoking policy. Physician’s order dated 7/10/25 directed to administer Nicotine Lozenge 4mg every 2 hours as needed for nicotine dependence. The July 2025 MAR identified a Nicotine Lozenge was last administered on 7/27/25 at 6:51 PM. Observation on 7/28/25 at 7:40 AM identified Resident #79 self-propelling to the nurse’s station where LPN #12 was inside the medication room visible through a half glass door. Resident #79 requested a lozenge. LPN #12 opened the medication door and informed Resident #79 that he/she would need to take a shower first. In response, Resident #79 began yelling, stating, “I don’t want to shower first, I want my lozenge now.” The nurse continued to repeat the instruction for the resident to shower first while Resident #79 was observed becoming increasingly agitated, yelling and screaming profanities at the nurse and stated “I am not feeling well.” An interview with LPN #12 on 7/28/25 at 7:40 AM identified she was the assigned nurse for the 11:00 PM to 7:00 AM shift 7/27/25 overnight to 7/28/25 and was counting controlled medications with the oncoming nurse. LPN #12 identified she had previously notified the nursing supervisor regarding Resident #79’s behavior but was unable to provide information on interventions to be implemented to address Resident #79’s escalating behaviors. Further observation identified LPN #12 closed the medication room door without any further intervention or redirection in response to Resident #79’s escalating behavior. Resident #79 self-propelled back down the hall, continually yelling and screaming profanities. An interview with RN #1 on 7/28/25 at 7:48 AM identified she was the assigned nursing supervisor for the 11:00 PM to 7:00 AM shift 7/27/25 overnight to 7/28/25. RN #1 identified she had not previously been notified of any concerning behaviors related to Resident #79 during the shift. RN #1 identified Resident #79 could occasionally get loud, disruptive and accusatory, sometimes requiring hospital transfer. RN #1 identified sitting with and allowing Resident #79 to talk about events would help to redirect the residents behaviors. RN #1 further identified Resident #79 should have received the lozenge when requested to prevent the escalating behavior. An interview with LPN #12 on 7/28/25 at 7:55 AM identified she was in the process of counting controlled medications with the oncoming nurse when Resident #79 approached her at the nurse’s station. LPN #12 indicated she put up her finger to gesture she was busy; however, Resident #79 continued to yell and scream profanities. According to LPN #12, she continued to put up her finger towards Resident #79 who should have known to wait. LPN #12 was unable to articulate what interventions should have been implemented to prevent or to de-escalate behaviors during the incident. An interview with the DNS on 7/28/25 at 8:02 AM identified Resident #79 had been known to hallucinate, make accusatory statements, and could become agitated, at times requiring a hospital transfer for evaluation. The DNS identified Resident #79 responded well to redirection through changes in activity or engaging in active listening. The DNS further identified LPN #12 should have paused the task, determined whether the medication could be administered, and notified the nursing supervisor. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075200	A. Building B. Wing	07/31/2025

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A subsequent interview with the DNS on 7/30/25 at 2:30 PM identified she would expect staff to follow the care plan regarding Resident #79’s escalating behavior. Although requested a policy for implementing the plan of care was not provided.

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	075200	A. Building B. Wing	07/31/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, facility documentation, facility policy, and interviews for 4 residents (Resident #7, 10, 17 and 100) the facility failed to provide care according to professional standards.For 1 of 2 residents (Resident #7) reviewed for range of motion, the facility failed to provide treatment and care in accordance with professional standards, for a resident with a contracture.For 1 of 5 residents (Resident #10) reviewed for unnecessary medications, the facility failed to ensure that a resident with a history of hyperglycemia was assessed by a Registered Nurse following an elevated blood sugar.For 1 of 4 residents (Resident 17) reviewed for medication administration, the facility failed to ensure a self-administration assessment was completed for safety prior to leaving medication at the bedside.For 1 of 3 residents (Resident #100) reviewed for non-pressure ulcer, the facility failed to ensure the physician's orders were followed related to applying ace wraps and weekly skin checks. The findings include: 1. Resident #7 was admitted to the facility in January 2025 with diagnoses that included dementia, cerebral infarction, and adult failure to thrive. The admission observation dated 1/3/25 identified Resident #7’s hand grasp strength was stronger on one side than the other side due to a right-hand contracture: Resident #7 presented with a contracture of the right hand and wrist joint. The admission MDS dated [DATE] identified Resident #7 had severely impaired cognition and had no upper extremity impairment. (The MDS failed to identify a right-hand contracture). The physician’s order dated 3/11/25 directed for skin checks every shift, days, evening, and nights. The care plan dated 7/15/25 identified Resident #7 was at risk for pain. Interventions included observing for non-verbal signs of pain, positioning for comfort, providing medical management for underlying cause of pain, and PT/OT referral as indicated. The care plan failed to address Resident #7’s contracture and failed to identify therapeutic and nursing interventions and functional goals/outcomes. The quarterly MDS dated [DATE] identified Resident #7 had severely impaired cognition and had no upper extremity impairment. (The MDS failed to identify a right-hand contracture). Review of the physician’s orders failed to identify an interdisciplinary approach to monitor, manage, and treat Resident #7’s contracture. The nurse’s note dated 1/3/25 through 7/29/25 failed to identify documentation of on-going assessments specific to the contracture, monitoring skin integrity of the area of the contracture, or nursing interventions for the care Resident #7’s contracture. Interview with LPN #3 on 7/27/25 at 11:11 AM identified that she had worked for the facility for 6 months. LPN #3 indicated Resident #7’s right hand was contracted and that the resident goes to therapy, but she was not sure if an orthotic or splint had ever been ordered for the resident. (continued on next page)

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	075200	A. Building B. Wing	07/31/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Intermittent observations between 7/27/25 and 7/29/25 identified Resident #7’s right hand and wrist are contracted. Digits #2 and 3 are closed tightly with light yellow crust in between. Digit #1 is set under digits #2 and 3. The top portion of digit #1 was exposed in between digit #3 and 4. Digits #4 and #5 were closed tightly with digit #4 slightly laying on top of digit #5 and light-yellow crust in between the digits. Resident #7 exhibited facial grimacing when staff members attempted to gently move any of the digits. Interview and observation with NA #5 on 7/29/25 at 1:55 PM identified that she was not Resident #7’s regular nurse aide; she was a float and worked on this unit about once a week. NA #5 indicated that it was hard to get in between Resident #7’s fingers and palm of the contracted hand because it was so tight and painful. NA #5 identified that the yellow crust between the contracted fingers was not present when she last provided care for the resident approximately 2 weeks ago. NA #5 indicated she had cleaned the area earlier in the morning but could not remove all the crust because it was painful for the resident. NA #2 indicated that she did not notify the nurse of Resident #5’s pain during care because the pain was not new. Interview and observation with LPN #4 on 7/29/25 at 2:06 PM identified that she was not aware of the crust between Resident #7’s contracted fingers, and that usually there is a little piece of gauze in between the fingers and palm; she was unaware of any specific orders for the care of the contracture, but would notify OT that there was crust in the area of the contracture to find out how to best manage the area. Interview and observation with APRN #1 on 7/30/25 at 10:40 AM identified that Resident #7’s contracture was present on admission to the facility. APRN #1 further identified that she has observed some redness and dryness on the skin around the contracture, in the past, but was not aware of the yellow crust between his/her fingers. APRN #1 indicated that she would discuss recommendations with OT to protect the skin from experiencing any breakdown and refer Resident #7 to be seen by the Wound Specialist. APRN #1 further indicated that she was unaware that Resident #7 was having pain during care in the area of the contracture, and she would put in an order for Tylenol for pain management. Interview with the DNS on 7/30/25 at 5:10 PM identified that after OT assessed the contracture, an interdisciplinary plan should have been put in place, then orders would need to be put into the system to prevent further contracture and skin breakdown, based on the OT’s recommendations. The DNS indicated that on-going monitoring of Resident #7’s skin for breakdown in the area of the contracture should be completed every shift and as needed. The DNS indicated that she would sit with OT and the APRN to put appropriate orders in place to prevent skin breakdown and further contracture. Interview with the Medical Director (MD #1) on 7/31/25 at 11:40 AM identified that he would expect a plan between OT and nursing services to be put into motion to ensure Resident #7 had documented interventions in place to maintain skin integrity and to prevent further decline of the contracture. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075200	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southport Center for Nursing & Rehabilitation LLC	930 Mill Hill Terrace Southport, CT 06890

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility’s Nursing Services policy directs that a consistent and interdisciplinary approach to the prevention, identification, treatment, and monitoring of contractures among residents is established. Thereby promoting functional independence, optimizing range of motion, and enhancing quality of life. The policy further directs that upon admission, nursing and therapy staff shall conduct a comprehensive functional mobility and muscular skeleton assessment. Risk factors for contracture development shall be identified and range of motion shall be evaluated and documented by therapy at admission, quarterly, and with significant change in condition. Therapy services interventions include evaluating for and implementing therapeutic exercises, manual stretching, positioning, and splinting, and training nursing staff and caregivers in techniques for safe range of motion exercises and positioning. Nursing interventions include performing passive/active range of motion exercises per the care plan, at least daily or as ordered, ensuring proper application and monitoring of splints/positioning devices, and maintaining correct body alignment during bed rest and wheelchair use. Monitoring and reassessment interventions should include monitoring skin integrity under devices at least once per shift and monitoring for any signs of pain, skin breakdown, or decline in function and reporting changes immediately to the charge nurse and therapy. All assessments, interventions, and resident responses must be documented and the clinical record. 2. Resident #100 was admitted to the facility in April 2023 with diagnoses that included lymphedema, acute kidney injury, and hypertension. The annual MDS dated [DATE] identified Resident #100 had intact cognition, required maximum assistance for dressing, putting on footwear, and personal hygiene and had 2 venous or atrial ulcers present. The care plan dated 5/20/25 identified Resident #100 has venous ulcers to the bilateral lower extremities. Interventions included providing wound treatments as ordered and wrapping both legs with compression socks. a. A vascular consultation dated 6/17/25 identified Resident #100 needs compression stockings or ace wraps to both legs from the ankle to the knee every morning and remove at bedtime. A wound note, written by MD #2 dated 6/18/25 identified Resident #100 has venous statis dermatitis to both lower extremities and venous statis ulcers to the left lateral leg, right superior leg, right inferior leg, and left inferior leg. Resident #100 was seen by vascular yesterday and recommendations included wrapping legs with compression stockings or ace wraps from the feet to the knees every morning and remove at bedtime. A physician’s order dated 6/19/25 directed to cleanse bilateral lower extremities with soap and water, rinse and dry well. Apply ammonium lactate 12% lotion to intact skin. Apply calcium alginate with silver to open areas, gauze to open wound, and xeroform to any blister and cover with a dry clean dressing twice daily and as needed. Apply ace wraps to bilateral lower extremities from the toes to the base of the knees. Ace wraps on in the morning and off at bedtime. Observation of Resident #100 on 7/27/25 at 10:21 AM identified the resident was seated in his/her wheelchair in the recreation room wearing shorts with feet dependent on the floor. Resident #100 has bilateral lower extremities wrapped with kerlix which is not dated. Resident #100 was without the benefit of ace wraps per the physician’s order. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 7/27/25 at 1:15 PM identified Resident #100 was sitting in his/her wheelchair in the dining room wearing shorts with feet on the floor. The bilateral lower extremities are wrapped with kerlix, and the resident is without the benefit of the ace wraps. Observation on 7/28/25 at 10:00 AM identified Resident #100 was sitting in the unit dining room in the wheelchair wearing shorts with his/her feet on the floor. The bilateral lower extremities are wrapped with kerlix dated 7/27/25 3:00 PM to 11:00 PM, and the resident is without the benefit of the ace wraps. Observation of Resident #100 on 7/28/25 at 12:00 PM, 1:00 PM, and 1:50 PM identified the resident was sitting in the unit dining room in the wheelchair in a pair of shorts with his/her legs dependent wrapped in kerlix, feet on the floor. Resident #100 was without the benefit of ace wraps. Interview with LPN #2 on 7/28/25 at 1:52 PM indicated that the nurse aides got Resident #100 up this morning before she got to do the treatments today because she was busy doing the medication pass this morning and did not have time to do the treatments. LPN #2 indicated that she did not inform the supervisor or ask for assistance. LPN #2 indicated that sometimes she does the treatments in the mornings and sometimes in the afternoons, depending on the day. LPN #2 indicated the physician’s order says to put the ace wraps on in the morning, but the nurse aides sometimes get Resident #100 up out of bed before she can get to do the treatments with the ace wraps. After surveyor inquiry, LPN #2 indicated that she plans on doing Resident #100’s treatments now including putting on the ace wraps. Interview with MD #2 (wound physician) on 7/30/25 at 7:54 AM identified he had spoken with the vascular physician regarding wanting to continue to apply ace wraps versus the compression stockings. MD #1 indicated they decided the ace wraps were better for Resident #100’s edema and vascular wounds. MD #2 indicated the ace wraps must be applied to both legs before Resident #100 gets out of bed to give some compression to reduce edema and help with the venous return and circulation. MD #2 identified without the ace wraps the edema will increase. Interview with the DNS on 7/30/25 at 10:09 AM indicated the charge nurse was responsible to do the treatments on the unit and sometimes the supervisor will help the charge nurse with their treatments if the nurse notifies the supervisor they need assistance. The DNS indicated the ace wraps per the physician’s order should have been applied before Resident #100 gets out of bed daily and removed at bedtime. Review of the Compliance with and Implementation of Physician Orders Policy identified to ensure that all physicians orders are implemented accurately, timely, and in accordance with federal and state regulations. The IDT team, under the direction of the DNS, is responsible for verifying that services ordered by a physician or authorized provider are provided as prescribed. b. A physician’s order dated 4/29/25 directed to perform weekly body audits on shower days scheduled Thursday 7:00 AM to 3:00 PM. Review of the weekly skin checks dated 5/1/25 - 7/30/25 identified 3 out of 13 were completed. (continued on next page)

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	075200	A. Building B. Wing	07/31/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DNS on 7/30/25 at 10:00 AM indicated that charge nurses were responsible to perform a weekly body audit on every resident based on the physician order. The DNS indicated the nurses must fill out the weekly skin check after inspecting the resident from head to toe. After clinical record review, the DNS indicated that the only completed weekly skin checks completed were done on 5/8, 6/12, and 6/19/25. The DNS indicated the skin checks are done and documented to identify if there are any new skin concerns or breakdown. Interview with APRN #1 on 7/30/25 at 11:01 AM identified the expectation is that nurses follow the physician’s orders. APRN #1 indicated the nurse is responsible to do a weekly head to toe assessment of the residents skin when the resident has a shower. APRN #1 indicated the nurses must document their assessment. Review of the Weekly Skin Check Policy identified this was to ensure residents’ skin is observed and the assessment is documented. Skin checks are completed by the nurse on the resident’s shower day and entered into matrix observation forms. Document all areas of concern on the skin sheet. Notify the wound nurse and physician of all areas of concern. Document in the medical record on the weekly skin check form. 3. Resident #17 was admitted to the facility in June 2024 with diagnoses that included aspiration pneumonia, poor vision, blindness in one eye, cataracts, visual hallucinations, and nicotine dependance. The self-administration assessment dated [DATE] at 11:28 AM identified Resident #17 did not want to self-administer medications. The self-administration assessment for a quarterly evaluation dated 12/16/24 at 10:16 PM identified Resident #17 did not want to self-administer medications. A physician’s order dated 6/14/25 directed to administer Budesonide-Formoterol HFA aerosol inhaler 160-4.5 mcg/actuation give 2 puffs twice a day. The care plan dated 6/24/25 identified at Resident #17 had decreased mobility and poor vision. Interventions included to orient Resident #17 to environment and placement of items. The July 2025 MAR identified Budesonide-Formoterol HFA aerosol inhaler 160-4.5 mcg/actuation was given late 32 out of 61 times and on 7/31/25 at 9:00 AM the medication was not available. The quarterly MDS dated [DATE] identified Resident #17 had intact cognition and required touching assistance with dressing and personal hygiene. The physician’s note dated 7/21/25 identified Resident #17 has acute chronic cough with increased phlegm, dark colored sputum, no blood in sputum. (continued on next page)

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	075200	A. Building B. Wing	07/31/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medication observation on 7/31/25 at 10:20 AM identified RN #1 prepared medication for Resident #17. After RN #1 gave Resident #17 his/her medications, RN #1 informed Resident #17 she did not have the Budesonide-Formoterol Inhaler. Resident #17 indicated he/she was aware because it has been at his/her bedside for about 2 months. Resident #17 reached for the Budesonide-Formoterol Inhaler, which was on the top of the nightstand at the bedside. RN #1 indicated the Budesonide-Formoterol Inhaler was not dated when opened and must be discarded. RN #1 identified she would order a new Budesonide-Formoterol Inhaler from the pharmacy. RN #1 asked Resident #1 which nurse had provided him/her with the Budesonide-Formoterol Inhaler and Resident #17 indicated that he/she did not recall because it has been a couple of months now. Resident #17 indicated he has not used the Budesonide-Formoterol Inhaler for at least a month. Interview with Resident #17 on 7/31/25 12:20 PM indicated that the nurses were not giving him/her the Budesonide-Formoterol Inhaler when he/she needed it so about 2 months ago the nurse left it with him/her to use as needed. Resident #17 indicated that he/she was using the Budesonide-Formoterol Inhaler multiple times a day because when he/she laid down, he/she would get short of breath so he/she would sit up and use the inhaler during the day and at night. Resident #17 indicated that recently his/her physician had made some medication changes, and he/she has not used the Budesonide-Formoterol Inhaler in at least the last month because he/she does not need it any longer. Resident #17 did not know the name of the Budesonide-Formoterol Inhaler or how many times a day it should be taken. Interview with the DNS on 7/31/25 at 10:54 AM identified residents cannot self-administer medications or inhalers with a nurse doing a self-administration assessment first. The DNS indicated if the resident was able to self-administer any inhalers or medications it would be specific on the assessment and the nurse would get a physician order for the medication or inhaler. After clinical record review, the DNS indicated that Resident #17 does not have a self-administration assessment for the Budesonide-Formoterol Inhaler. The DNS indicated if Resident #17 was able to self-administer the Budesonide-Formoterol Inhaler, the charge nurse would be responsible to hand the Budesonide-Formoterol Inhaler to the resident for use only and keep the Budesonide-Formoterol Inhaler in the medication cart when not in use. Review of the facility Self-Administration of Medications Policy identified residents of the facility may self-administer medications if the interdisciplinary team, including a licensed nurse and a prescribing practitioner, determines that it is safe for them to do so. The procedure includes a licensed nurse who will conduct a self-administration assessment to evaluate the resident’s cognitive status, physical ability to handle and take medication, understanding of medication regimen, and willingness to self-administer. A physician’s order or other prescriber must write an order approving self-administration and the order will be specific which medication the resident is allowed to self-administer. The medications must be stored in the nursing medication cart. Each time the resident has a scheduled medication or is requesting medication the nurse is responsible to deliver that medication to the resident for use and then the nurse will place it back into the cart. Residents will be reassessed at least quarterly, upon change in condition, or if concerns about self-administration arise. 4. Resident #10 was admitted to the facility in August 2023 with diagnoses that included traumatic brain injury, dysphagia, and diabetes with hypoglycemia. (continued on next page)

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	075200	A. Building B. Wing	07/31/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician’s order dated 12/11/24 directed to check blood sugars 4 times daily before meals (6:00 AM, 12:00 PM, 6:00 PM, 12:00 AM) and notify the physician for blood sugars less than 70 and/or greater than 400. A physician's order dated 1/25/25 directed may check blood sugars as needed. A physician’s order dated 2/6/25 directed for Glyxambi (an oral medication used to treat diabetes) 25-5 milligram tablet daily at 9:00 AM. A physician’s order dated 3/13/25 directed a no concentrated sweets/low carb diet to include 1/2 portion of starch with all meals. A physician’s order dated 3/17/25 directed to administer Lantus Insulin (a long-acting Insulin) 38 units nightly at 9:00 PM. The quarterly MDS dated [DATE] identified Resident #10 had severely impaired cognition and received daily Insulin. The care plan dated 7/11/25 identified Resident #10 was at risk for abnormal blood sugar levels including hypoglycemia and hyperglycemia due to diabetes. Interventions included to obtain finger sticks as ordered and report abnormal findings to the physician. Interventions also included to monitor the resident for signs and symptoms of hyperglycemia. Review of the clinical record dated 7/24/25 at 1:44 PM identified the residents blood sugar, obtained by LPN #4, was 436. Further, the clinical record failed to identify any additional documentation including a RN assessment of Resident #10’s condition at that time. Interview with APRN #1 on 7/30/25 at 12:07 PM Resident #10 was routinely non-compliant with diet orders and often purchased snacks and sodas from the facility vending machine. APRN #1 identified that Resident #10 had a recent history of large fluctuations between hypoglycemia and hyperglycemia and had been seen by an endocrinologist outside the facility but was discharged from his care 6/9/25 due to continued dietary noncompliance. APRN #1 also identified that no adjustments would be made to Resident #10’s current diabetic management due to the large fluctuations in blood sugar levels and the dietary noncompliance. APRN #1 identified that the order in place regarding Resident #10’s blood sugar levels was for nursing staff to notify her or the physician of any blood sugar levels less than 70 and greater than 400, especially given the large fluctuations in blood sugar levels. APRN #1 identified that LPN #4 was not the regular nurse assigned to care for Resident #10, and she had not been notified by LPN #4 regarding the high blood sugar on 7/24/25. APRN #1 also identified that if she had been notified of the elevated blood sugar on 7/24/25 it would have been documented in her notes in the clinical record. (continued on next page)

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	075200	A. Building B. Wing	07/31/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LPN #4 on 7/30/25 at 1:14 PM identified she was a float nurse at the facility and did not typically provide care for Resident #10. LPN #4 identified she could not recall if she notified the RN Supervisor of the resident’s high blood sugar but indicated she did notify APRN #1 on 7/24/25. LPN #4 was unable to identify if she notified APRN #1 in person or via phone, and identified she recalled APRN #1 discussing the possibility of additional Insulin for the resident. LPN #4 identified that before the end of her shift at 3:00 PM, she rechecked Resident #10’s blood sugar level without discussion with APRN #1 and identified the blood sugar was somewhere around the lower 300’s but could not identify the number. Review of the clinical record failed to identify documentation by LPN #4 related to a recheck of Resident #10's blood sugar level on 7/24/25 or that the resident had been assessed by a Registered Nurse. Interview with the DNS on 7/31/25 at 11:01 AM identified that the licensed nursing staff was expected to follow the physician’s orders including when to notify for abnormal findings. The DNS identified LPN #4 should have notified the APRN and the RN Supervisor regarding the elevated blood sugar. The facility policy on hyperglycemia management directed that the facility would promptly identify, monitor, and treat hyperglycemia in accordance with the physician's orders and identified hyperglycemia was a blood sugar greater than 180 (persistent or acute); and severe hyperglycemia, a blood sugar greater than 300 or symptomatic (i.e. polyuria, polydipsia, confusion) The policy further directed that residents with diabetes would have blood sugar monitoring per the physicians orders and staff would recognize signs and symptoms of hyperglycemia, which included: increased thirst (polydipsia), frequent urination (polyuria), fatigue, weakness, blurred vision, nausea and vomiting, confusion, or altered mental state. The policy further directed for blood sugar levels greater than 400 with altered mental status, vomiting Kussmaul respirations, or fruity breath odor, staff would call 911, follow facility emergency response protocol, monitor vital signs and initiate oxygen if indicated, and document interventions and notify family/POA. The policy also directed to record all blood sugar readings, symptoms, interventions, and provider notifications in the clinical record.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, facility documentation, facility policy, and interviews for 2 of 4 residents (Resident #77 and 82) reviewed for pressure ulcers, the facility failed to ensure weekly skin audits were completed and documented per the facility policy, and a specialty air mattress was set to the resident's weight per the physician's order. The findings include: Resident #77 was admitted to the facility in September 2021 with diagnoses that included peripheral vascular disease (PVD), obesity, and type 2 diabetes mellitus (DM). The quarterly MDS dated [DATE] identified Resident #77 had intact cognition, was dependent for toileting hygiene and bathing, required supervision for rolling left to right and sitting to lying, refused toilet transfers. Resident #77 had an indwelling catheter, was frequently incontinent of bowel, was at risk for developing pressure ulcers/injuries, and had one unstageable pressure ulcer. The care plan dated 7/20/25 identified Resident #77 was at risk for injury, impaired skin integrity and impaired tissue perfusion related to PVD. Interventions included reporting issues to the physician as needed and providing treatment, care, and lotion as needed for prevention. The care plan further identified Resident #77 had an unstageable pressure ulcer to the left buttock. Interventions included assessing the pressure ulcer first stage, size, and condition of the surrounding skin weekly. Review of the physician’s orders dated 2/1/25 through 7/27/25 failed to identify an order directing weekly skin checks. Subsequent to surveyor inquiry, a physician’s order dated 7/28/25 directed to complete weekly skin checks on shower days; once a day on Tuesdays 3:00-11:00 PM. Review of the clinical record dated 2/1/25 through 7/30/25 failed to identify documentation that weekly skin checks were being completed. Interview with APRN #1 on 7/30/25 at 11:02 AM identified that she would expect nurses to complete and document skin checks weekly and as needed, if a skin concern was identified by a nurse aide. APRN #1 indicated that weekly skin checks were important to monitor for changes occurring week to week. Interview and review of the clinical record with the DNS on 7/30/25 at 6:00 PM failed to identify a physician’s order for weekly skin checks, per the facility policy, and failed to identify documentation that weekly skin checks were being completed. The DNS indicated that she would expect weekly skin check documentation to be completed by nursing on the weekly skin check form; if Resident #77 refused the skin check she would expect to see a progress note documenting the refusal, education provided to the resident on the importance of a skin check, and notification of the refusal made to the nursing supervisor, APRN, and the resident representative, if applicable. Interview with the Medical Director (MD #1) on 7/31/25 identified that a resident with a history of PVD and DM would create a set up for skin issues, further Resident #77 refuses to move. MD #1 indicated Resident #77 should have weekly skin checks ordered (continued on next page)

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	075200	A. Building B. Wing	07/31/2025

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility’s Weekly Skin Checks policy directs that a resident’s skin is observed by the nurse on shower days and observations documented in the electronic health record: document all areas of concern on the skin sheets, notify the Wound Care Nurse/MD of all areas of concern, document on the 24-hour report to alert the team to areas of concern, and document in the medical record on the weekly skin check form. 2. Resident #82 was admitted to the facility in December 2023 with diagnoses that included spina bifida, hearing loss, and kidney disease. The clinical record identified Resident #82 had a stage 4 facility acquired pressure ulcer on the right ischium first identified on 5/12/24. The quarterly MDS dated [DATE] identified Resident # 82 had intact cognition, was always incontinent of bowel and bladder, required substantial assistance with toileting, partial assistance with bathing and set up for transfers. A physician's order dated 1/6/25 directed staff to complete body audits weekly on Saturdays (shower day). Review of the clinical record for January 2025 identified only 2 weekly body audits had been completed; 1/11/25 and 1/25/25. A physician’s order dated 2/1/25 directed to provide a low air loss mattress with a setting of 150. The order further directed to check placement and function every shift and coordinate with the maintenance department if there was a noticeable malfunction. Review of the clinical record identified weekly body audits were not completed twice in February 2025 and once in March 2025. A care plan dated 4/15/25 directed that Resident #82 had actual skin impairment related to a stage 4 right ischium pressure ulcer. Interventions included weekly skin checks, use of a pressure-relieving mattress if appropriate, and reporting any skin changes to the physician or APRN as necessary. Review of the clinical record identified weekly body audits were not completed once in May 2025, 3 times in June 2025 and twice in July 2025. Review of the clinical record identified Resident #82 had a weight of 111.4 lbs. on 7/9/25. Observation and interview with Resident #82 on 7/27/25 at 10:00 AM identified he/she had a pressure ulcer located on the right buttock that was almost healed, and the facility had provided him/her with an air mattress that would only function intermittently at times. Resident #82 identified he/she had a communication barrier and that staff in the facility could not communicate effectively with him/her. Resident #82 reported during the observation that the air mattress was currently working, and he/she had not reported the issue to facility staff. Observation of the low air loss mattress weight settings identified the mattress was set at 220 lbs. Observation of Resident #82 on 7/29/25 at 11:58 AM identified that the low air loss mattress was set to 60 lbs. During this observation Resident #82 was observed to be sleeping. (continued on next page)

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	075200	A. Building B. Wing	07/31/2025

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation with MD #2 (wound MD) and the ADNS on 7/30/25 at 7:20 AM identified Resident #82’s pressure ulcer had resolved. Observation with the ADNS immediately following the visit with MD #2 identified the low air loss mattress was set to 60 lbs. The ADNS identified the setting was not correct for Resident #82's weight but identified Resident #82 routinely changed the mattress setting. Observation and interview with Resident #82 on 7/30/25 at 7:30 AM identified the low air loss mattress did not appear to be operating. Resident #82 identified that the mattress had completely stopped working but the resident was unable to indicate the exact time frame. Resident #82 identified he/she was unsure if the facility staff ever checked the mattress. Resident #82 also identified he/she was unsure how to adjust the mattress setting. Observation and interview with RN #1 on 7/30/25 7:40 AM identified Resident #82’s low air loss mattress was not functioning and she would contact maintenance to replace the mattress. Observation on 7/30/25 at 8:45 AM identified Resident #82’s low air loss mattress had been replaced by maintenance. Observation of the replacement mattress settings identified the low air loss mattress was set to 660 lbs. Observation on 7/30/25 at 2:15 PM identify resident #82 low air loss mattress remained set at 660 lbs. Observation and interview on 7/30/25 at 2:25 PM with LPN #8 identified that she had not been notified Resident #82’s low air loss mattress had been changed. LPN #2 initially identified that she checked Resident #82’s mattress at least once during her shift and also identified Resident #82 changed the settings on the mattress regularly. LPN #8 was unable to identify when she had last checked on Resident #82 or observed his/her air mattress during her shift and further identified that while she signed off that she checked the settings daily, sometimes she did not always verify what the actual settings were compared to the physician's order. Subsequent to surveyor inquiry, LPN #8 changed the mattress setting for Resident #82 from 660 lbs. to 150 lbs. Review of the clinical record and care plans failed to identify documentation or a care plan related to Resident #82 changing the mattress settings and/or measures to address such. Review of the clinical record and interview with the ADNS on 7/31/25 at 9:07 AM identified that she was the wound nurse for the facility and identified that Resident #82 should have had weekly skin checks done and documented. The ADNS identified that the documentation related to skin checks required 2 steps. The steps included a sign off on the TAR for the weekly body audits and documentation under the weekly skin check assessments in the clinical record that would include the actual observations made by the nurse. The DNS identified that simply signing the TAR that the body audit was done did not mean that the skin check had been completed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075200	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southport Center for Nursing & Rehabilitation LLC	930 Mill Hill Terrace Southport, CT 06890

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DNS on 7/31/25 at 11:01 AM identified that skin checks should be done weekly on the resident’s scheduled shower day and as needed if the nurse aide or licensed nurse identified an issue with the resident’s skin. The DNS identified that the licensed nurse assigned to the resident was expected to complete and document the skin check under the weekly skin assessment check area in the observations section of the clinical record which included the ability to document any changes related to the resident’s skin. The DNS identified the purpose was to ensure that any changes in the resident’s skin were documented week to week. The DNS identified she had been made aware there was an issue related to the nurses completing assessment documentation for the weekly skin checks during the survey and she had planned on providing education to the nursing staff to ensure complete skin assessments were documented in all residents’ clinical records. The DNS also identified that Resident #82’s low air loss mattress should have been set per the physician's order. The DNS identified she and other nursing staff in the facility had completed spot checks of the low air loss mattresses for residents but identified that Resident #82 had been reported by staff to change the settings of his/her air mattress. The DNS was unable to identify any specific incidents related to this or any documentation in the clinical record. The DNS identified that staff should be checking the mattress settings and function of the mattress at least once a shift and report any issues to maintenance per the physician's order. The facility policy on weekly skin checks directed that the policy was to ensure the resident skin was observed and documented on. The policy also directed that skin checks were completed by the nurse on shower days and entered under observations in the clinical record. The facility policy on air mattress overlays directed that an air mattress was used to prevent skin breakdown in accordance with the physician's order. The policy further directed that clinical staff were to verify the physician’s order and after placing the mattress, staff were to evaluate the inflation of the mattress within 20 minutes by performing a hand check and evaluate the mattress's function and proper inflation every shift. The facility policy on skin and wound management directed that the purpose of the policy was to provide guidelines for the structured assessment and identification of residents at risk for developing pressure ulcers/injuries. The policy directed at risk factors that could increase a residents susceptibility to develop or to not heal of pressure ulcers included the resident’s refusal related to some aspects of care and treatment. The policy also directed information that should be recorded in the resident’s medical record should include the type of assessment conducted; the condition of the resident’s skin; if the resident refused treatment including the reason for refusal; observations of anything unusual exhibited by the resident; and documentation in the medical record addressing physician notification if any new skin alterations were noted with a change in the plan of care.

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	075200	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075200	A. Building B. Wing	07/31/2025

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 2 residents (Resident #7) reviewed for range of motion, the facility failed to provide appropriate treatment and services to increase range of motion and/or prevent further decrease in range of motion for a resident with a hand contracture. The findings include:Resident #7 was admitted to the facility in January 2025 with diagnoses that included dementia, cerebral infarction, and adult failure to thrive. The admission observation dated 1/3/25 identified Resident #7's hand grasp strength was stronger on one side than the other side due to a right-hand contracture: Resident #7 presented with a contracture of the right hand and wrist joint. The Occupational Therapy Discharge Summary dates of service 1/6/25 through 1/29/25 identified a short-term goal was for Resident #7 to tolerate gentle passive range of motion (PROM) to the right hand to open hand slightly for placing of a hand towel/splint to prevent skin breakdown and prevent further contracture. Discharge reason: discharged to the hospital.The Occupational Therapy Discharge Summary dates of service 2/11/25 through 2/26/25 identified a short-term goal was for Resident #7 to tolerate gentle passive range of motion (PROM) to right hand to open hand slightly for placing of a hand towel/splint to prevent skin breakdown and prevent further contracture. Discharge reason: discharged to the hospital.The Occupational Therapy Discharge Summary dates of service 3/11/25 through 4/24/25 failed to identify short-term or long-term goals related to Resident #7's right-hand contracture. Discharge reason: highest practical level achieved.The Occupational Therapy Discharge Summary dates of service 7/10/25 through 7/23/25 failed to identify short-term or long-term goals related to Resident #7's right-hand contracture. Discharge reason: highest practical level achieved.The quarterly MDS dated [DATE] identified Resident #7 had severely impaired cognition and had no upper extremity impairment. (The MDS failed to identify a right-hand contracture). The care plan dated 7/15/25 failed to identify Resident #7's contracture and failed to identify therapeutic and nursing interventions and functional goals/outcomes.Intermittent observations between 7/27/25 and 7/29/25 identified Resident #7's right hand and wrist are contracted. Digits #2 and 3 are closed tightly with light yellow crust in between. Digit #1 is set under digits #2 and 3. The top portion of digit #1 was exposed in between digit #3 and 4. Digits #4 and #5 were closed tightly with digit #4 slightly laying on top of digit #5 and light-yellow crust in between the digits. Resident #7 exhibited facial grimacing when staff members attempted to gently move any of the digits. Interview and review of the clinical record with the Rehabilitation (Rehab) Services Director on 7/29/25 at 9:40 AM identified that Resident #7's right-hand contracture was chronic, and it was present on admission. The Rehab Director further identified it was the expectation that passive range of motion (PROM) would be completed daily by the nurse aides on the unit, in order for the resident to maintain functional ability, and Resident #7 was previously evaluated for a splint but there was no splint that could accommodate his/her deformity. The Rehab Director identified that she did not see interventions in the physician's orders or in the care plan, but she would expect nursing staff to be performing hand hygiene, ensuring proper positioning of the arm and hand, monitoring to ensure no new contractures develop on the upper arm, and reporting any changes in the condition or decline of the contracture. The Rehab Director indicated that there were limited interventions for OT to implement because Resident #7 would not regain function of the contracted hand; the goal would be to avoid skin breakdown and worsening of the contracture. Interview with OT #1 on 7/29/25 at 9:55 AM identified that she recently added Resident #7's name on a list to be seen by Physiatry for an evaluation due to pain when opening his/her hand or when completing range of motion (ROM) with the elbow and upper arm. OT #1 further indicated that she had encouraged the nurse aides to notify the rehab staff if they had trouble completing daily ADL care so that they could provide assistance, and she also encouraged the nurse aides to soak Resident #7's hand in warm water, as heat can help loosen it up.Interview with the Rehab Director on 7/31/25 at 8:25 AM identified that, subsequent to surveyor inquiry, she notified APRN #1 that Resident #7 had pain in the contracted hand, and he/she will need something for pain management. The Rehab Director indicated that Resident #7 would be seen by the Physiatrist on 8/6/25 to see if there are other interventions that can be attempted. Interview with the Medical Director (MD #1) on 7/31/25 at 11:40 AM identified that he would expect PT/OT to have followed up on Resident #7's right-hand contracture, weekly to start then every other week, and if the contracture remained stable, he would expect it to be seen monthly and as needed. MD #1 indicated that he would expect a plan between OT and nursing services to be put into motion to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075200	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southport Center for Nursing & Rehabilitation LLC	930 Mill Hill Terrace Southport, CT 06890

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observation, review of the clinical record, facility documentation, facility policy, and interviews for 2 of 6 residents (Resident #6 and 125) reviewed for accidents, for Resident #6 the facility failed to provide adequate supervision to a resident who required aspiration precautions and supervision with intake and for Resident #125 the facility failed to provide adequate supervision and care planned interventions for a resident with a known history of substance abuse and a recent drug overdose to prevent a reoccurrence, and for 1 resident (Resident #10) reviewed for tube feeding and aspiration precautions, the facility failed to provide 1:1 feeding assistance and failed to ensure that mechanically altered diet orders were followed. The findings include:1a. Resident #125 was admitted to the facility in March 2024 with diagnoses that included osteomyelitis of vertebra, opioid abuse, anxiety disorder, and dorsalgia. The care plan dated 3/28/24 identified Resident #125 had a history or active diagnoses of substance abuse. Intervention included to offer resident the option of attending substance abuse group. Nursing and social services support as needed. The admission MDS dated [DATE] identified Resident #125 had intact cognition, required setup or clean up assistance with personal hygiene, and independent with eating. Additionally, Resident #125 had no physical and verbal behaviors directed toward others. The physician’s order dated 6/1/24 directed to monitor pain every shift and administer Oxycodone 10mg every 6 hours as needed for pain. The June 2024 identified Resident #125 received the medication Oxycodone 10mg on 6/3/24 at 4:55 PM for pain with good effect. The nurse’s note dated 6/3/24 at 7:00 PM by RN #3 identified around 6:25 PM there was a STAT call to the unit and Resident #125 was noted to be unresponsive to verbal/tactile command. Narcan was administered at 6:30 PM in left nostril times one with good effect. Resident #125 opened their eyes, vital signs were obtained, oxygen saturation was 97% on room air and EMS was called. Resident #125 was verbally responsive, and emergency responders arrived at 6:40 PM. Resident #125 left the facility at 6:50 PM. The APRN was notified, W-10, and the bed hold policy initiated. Message left for the resident representative. Consultation for pain management and mouth check with every medication pass every shift initiated. The reportable event form dated 6/3/24 at 6:25 PM identified Resident #125 became unresponsive and required the use of Narcan. Resident #125 was sent to the hospital for evaluation and monitoring. Resident #125 reported taking 2 doses of his/her pain medication. The Administrator was notified, and an investigation was initiated. The care plan dated 6/3/24 identified Resident #125 had a history or active diagnoses of substance abuse. On 6/3/24 Resident #125 had an unresponsive episode. Intervention included to check mouth with every medication pass on every shift. Pain management consultation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075200	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A written statement by LPN #10 dated 6/3/24 identified she was called to Resident #125’s room at around 6:30 PM by NA #17, stating it’s an emergency. Resident #125 was being assisted up in a sitting position by NA #17 who was calling the resident’s name over and over. Resident #125 did not respond. LPN #10 called RN #3 over immediately and Narcan was administered and 911 was called. The hospital discharge document dated 6/3/24 at 11:11 PM identified Resident #125 presented for an accidental overdose. Narcan revival from a nursing facility. Upon examination Resident #125 reported he/she possibly took two of his/her Oxycodone too close together. Resident #125 reported that he/she crushed up two of the Oxycodone today and snorted them. Resident #125 denies this was an intentional overdose. Resident #125 does not require admission or further hospitalization at this time, appropriate for discharge back to nursing home. The summary report dated 6/5/24 identified Resident #125 last received his dose Oxycodone 10mg as needed at 9:56 AM on 6/3/24. Resident #125 indicated he/she saved the earlier dose of medication, then requested a second dose of the day at 4:55 PM. Resident #125 indicated then he/she took both medication pills together. A room search was yielded with no results. This incident has not occurred with Resident #125 before. Resident #125 denies taking any other medications or recreational drug. Resident #125 returned from the hospital with no new orders, and no urinary toxicology screen had been done in the hospital. Resident #125 was seen by the Physiatrist who recommended a consultation with an addiction specialist. Mouth check with all medications administered. Although attempted, an interview with previous Administrator (Administrator #1), previous DNS (DNS #1), LPN #10, and NA #17 were not obtained. b. A physician’s order dated 6/1/24 directed to monitor pain every shift. A physician’s order dated 6/3/24 directed to check the resident’s mouth with every medication pass and obtain a pain medication consultation. The care plan dated 6/3/24 identified Resident #125 had a history or active diagnoses of substance abuse. On 6/3/24 Resident #125 had an unresponsive episode. Intervention included to check the resident’s mouth with every medication pass on every shift. Pain management consultation. A physician’s order dated 6/18/24 directed to administer Oxycodone 10mg every 12 hours for pain. The nurse’s note dated 6/19/24 at 9:50 PM by RN #3 identified at 8:30 PM she was notified by LPN #10 that Resident #125 was unresponsive to verbal and tactile stimulation with eyes closed. RN #3 indicated per Resident #250; Resident #125 was noted on his/her knees and Resident #250 called staff due to Resident #125 was not answering. Narcan was administered in left nostril at 8:37 PM, EMS was activated, and W-10 and bed hold policy initiated. Resident #125 slowly became responsive and alert. The ambulance arrived at 8:50 PM, and Resident #125 left at 9:00 PM for the hospital for evaluation. The physician and resident representative were notified. Room checked with no inappropriate contraband noted. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075200	A. Building B. Wing	07/31/2025

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Southport Center for Nursing & Rehabilitation LLC	930 Mill Hill Terrace Southport, CT 06890

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The reportable event form dated 6/19/24 at 8:30 PM identified Resident #125 was observed unresponsive in Resident #250’s room. Narcan was administered time one and 911 was activated. Resident #125 became verbally responsive and alert. Resident #125 transferred to the hospital. The physician, Administrator, DNS, and resident representative were notified. The care plan dated 6/19/24 identified Resident #125 had a history or active diagnoses of substance abuse. On 6/19/24 Resident #125 had an unresponsive episode. Intervention included to check mouth with every medication pass on every shift. Supervised visits with Resident #250. Move resident to another unit. The summary report dated 6/24/24 at 11:22 AM identified at approximately 8:00 PM on 6/19/24, LPN #10 observed Resident #125 going down the hallway with Resident #250. At approximately 8:30 PM Resident #250 yelled down the hallway for help. LPN #10 observed Resident #125 unresponsive and Narcan was administered with positive effect. Investigation initiated. Resident #125 returned from the hospital with no new order, psychiatric and social service support to be provided. Upon the investigation, Resident #250 had gone out on leave of absence. Resident #125 last received his/her Oxycodone 10mg at 8:00 AM on 6/19/24 and did not receive the second dose due to incident. Mouth checks were maintained and care plan included recommendations for addictions services. Resident #125 indicated he/she “took two of the oxycodone’s together.” The previous Maintenance Director privately asked Resident #125 what happened. Resident #125 admitted to taking a Methadone pill but would not admit who gave him/her the pill. Resident #250 declined involvement and did not want to participate in the investigation process. Resident #250 was discharged home per his/her request on 6/20/24. Resident #125 had a planned discharge to home date of 6/21/24 with addiction and home care services. Interventions: Addiction services set up for Resident #125, mouth checks maintained, and last medication administration of Oxycodone schedule was assessed. Both residents were discharged home. Although attempted, an interview with the previous Administrator, (Administrator #1), previous DNS (DNS #1), LPN #10, and the Maintenance Director were not obtained. Review of the facility Narcan administration policy identified the facility will provide emergency treatment for residents who may demonstrate signs and symptoms of opiate overdose. 2. Resident #6 was admitted to the facility on [DATE] with diagnoses that included hemiplegia affecting the right side following a stroke, dysphagia, and dementia. The clinical record identified Resident #6 was hospitalized from [DATE] - 4/20/25 for Covid 19 infection. Review of the 4/20/25 hospital discharge documentation identified Resident #6 required speech therapy evaluation during hospitalization due to issues with swallowing. The documentation also identified Resident #6 had expressive aphasia and was unable to provide any information. The hospital documentation identified Resident #6 had a modified barium swallow and speech therapy evaluation which identified reduced airway closure and silent aspiration with swallowing. Recommendations included 1:1 supervision with intake, slow rate of feeding, single bites/sips, and pureed diet with nectar thickened liquids due to deficits with swallow safety and efficacy. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075200	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southport Center for Nursing & Rehabilitation LLC	930 Mill Hill Terrace Southport, CT 06890

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The care plan dated 4/20/25 identified Resident #6 was at risk for aspiration due to noncompliance with diet. Interventions included to counsel and encouraged Resident #6 to be compliant with the plan of care. A physician’s order dated 4/21/25 directed a nectar thick pureed diet. Review of the physician’s orders and nurse aide care card failed to direct aspiration precautions or supervision with meals. The 5-day MDS dated [DATE] identified Resident #6 had moderately impaired cognition, was frequently incontinent of bowel and bladder, required set up for meals and substantial assistance with toileting and bathing. The MDS also identified Resident #6 had issues with swallowing that included coughing or choking during meals. A Speech Therapy discharge note dated 5/25/25 identified Resident #6 received skilled speech therapy services from 4/21/25 - 5/25/25 for dysphagia. The note identified Resident #6 had made gains with speech therapy and was consuming a pureed and nectar thickened liquid diet with no overt signs/symptoms of aspiration with cured strategy use. The note further identified discharge recommendations that included Resident #6 to continue with pureed consistency diet and nectar thick liquids, and close supervision with oral intake. The note also identified that Resident #6 had a good prognosis with consistent staff follow-up. Review of the care plan failed to identify the Speech therapy recommendations of 5/25/25. Observation on 7/27/25 at 8:27 AM identified Resident #6 was in bed, the bedside table located directly next to the left side of the bed with a meal tray on the table. Observation of the meal tray identified eggs and oatmeal were untouched while a small carton of milk and orange juice were empty. During this observation, Resident #6 was observed sleeping, lying flat, and no staff were observed within the vicinity of the room. Interview with LPN #13, an agency nurse, on 7/27/25 at 8:30 AM identified she was unsure of Resident #6’s diet order or supervision level with meals as it was her first shift working on Resident #6’s unit. Interview with NA #13 on 7/27/25 at 8:31 AM identified she was the regular nurse aide on the unit for Resident #6. NA #13 identified Resident #6 ate independently and did not require supervision with meals. Interview with APRN #1 on 7/29/25 at 12:07 PM identified that all residents on aspiration precautions or that required mechanically altered diets were addressed by the facility speech therapy department. APRN #1 identified she would receive emails and updates on these residents but did not write the orders or place the residents on aspiration precautions and this was the responsibility of the speech therapist. Interview with LPN #8 on 7/30/25 at 9:00 AM identified she was the nurse regularly assigned to care for Resident #6 and that the resident was to have supervision with meals and was usually brought to the dining room for all meals. (continued on next page)

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	075200	A. Building B. Wing	07/31/2025

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Southport Center for Nursing & Rehabilitation LLC	930 Mill Hill Terrace Southport, CT 06890

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Constant observation on 7/30/25 beginning at 12:20 PM identified Resident #6 seated in the wheelchair in the unit dining room. NA #4 was observed providing meal trays to other residents in the dining room and NA #13 was observed setting up Resident #6’s lunch meal tray and left the tray and table at 12:21 PM. Resident #6 was observed feeding him/herself without supervision beginning at 12:21 PM. NA #4 and NA #13 were observed exiting the dining room to the meal truck located in the hallway of the unit. Resident #6 was observed taking large spoonful’s of food, one after the other, and at 12:23 PM began coughing. At 12:24 PM, NA #4 reentered the dining room, came to Resident #6’s side as he/she was coughing, and directed Resident #6 to take smaller bites. At 12:25 PM, Resident #6 stopped coughing as NA #13 also reentered the dining room, and NA #4 continued to provide prompts to Resident #6 to take smaller bites and requested NA #13 find a smaller spoon because the spoon the resident was using was “too large. ” Resident #6 began coughing again with NA #4 standing at his/her side. At 12:26 PM, NA #4 brought a chair next to Resident #6 as Resident #6 stopped coughing. At 12:29 PM NA #4 got up from the chair and began checking on other residents in the dining room. No other nurse aides were in the dining room from this point. At 12:30 PM, NA #4 provided verbal prompts to Resident #4 while circulating the dining room, and at 12:32 PM sat back down at Resident #6’s side and provided prompts to take small sips while drinking his/her milk. NA #4 was observed at Resident #6’s side until 12:36 PM, when the observation ended after Resident #6 declined the remainder of his/her meal. Constant observation on 7/30/25 beginning at 4:56 PM identified Resident #6 seated in the wheelchair in the unit dining room. At 5:00 PM, NA #11 was observed setting up Resident #6’s dinner meal tray and leaving the dining room. Resident #6 was then observed eating his/her meal unsupervised beginning at 5:01 PM. At 5:02 PM, LPN #11 was observed standing in one of 2 entryways of the dining room next to a medication cart also positioned at and blocking the entryway. LPN #11 was positioned opposite Resident 6’s table and seat position. Between LPN #11 and Resident #6 was a residential refrigerator. Observation directly behind Resident #6 failed to visualize LPN #11 due to obstruction by the refrigerator, and LPN #11 was only visible after moving approximately 3 feet to the left of Resident #6’s table to be able to see LPN #11 around the refrigerator and at the entryway. Resident #6 was observed continuing eating unsupervised taking large spoonful’s of food and had multiple coughing episodes at 5:04 PM, 5:07 PM, 5:11 PM, 5:14 PM, and 5:15 PM. During these episodes, LPN #11 continued to remain at the entryway on the opposite side of the refrigerator and did not attempt to observe or check on Resident #6 and was instead observed speaking with other residents regarding medications. At 5:18 PM, Resident #6 had another episode at which time LPN #11 stepped back from the side of refrigerator and into the dining room. LPN #11 asked Resident #6 if he/she was okay. Resident #6 had stopped coughing but did not provide a response. At 5:19 PM LPN #11 stepped back the medication cart at the dining room entryway, again obstructed by the refrigerator. At 5:20 PM, Resident #6 began coughing again after taking in half (2 oz) of thickened apple juice with one attempt. At 5:21 PM, while Resident #6 continued coughing, LPN #11 again stepped from the side of the refrigerator and again asked Resident #6 if he/she was okay. Resident #6 nodded yes and stopped coughing, and at 5:22 PM LPN #11 again stepped back to the medication cart at the dining room entryway. Resident #6 stopped eating and drinking and slightly pushed his/her meal tray away. Observation of the tray identified Resident #6 ate approximately 75% of the meal, which included pureed teriyaki chicken breast, rice, and stir-fried vegetables and 100 % of the thickened liquids, which included 4 oz of apple juice, 4 oz of skim milk, and 4 oz of coffee. No other staff were observed in the vicinity of Resident #6 or in the dining room area during Resident #6’s meal. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075200	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southport Center for Nursing & Rehabilitation LLC	930 Mill Hill Terrace Southport, CT 06890

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with LPN #11 on 7/30/25 at 5:22 PM identified she was aware Resident #6 was on aspiration precautions and required supervision with meals, and felt she was providing supervision of Resident #6 due to being in the dining room entryway. LPN #11 did not identify how she provided supervision while passing medications to other residents and being positioned on the opposite side of large appliance. Interview with the DNS on 7/30/25 at 5:24 PM identified Resident #6 should have direct supervision with all meals due to aspiration precautions, and that would include having a facility nurse or nurse aide in the dining room with eyes on Resident #6 for the entirety of his/her meals. The DNS identified Resident #6 was impulsive with eating and drinking and often took large bites and sips but did well if supervised and prompted by staff to take smaller bites and sips. The DNS identified that she would immediately in-service the nursing staff regarding the need to provide supervision to any residents who required aspiration precautions. Interview with SLP #1 on 7/31/25 at 8:03 AM identified that Resident #6 is to have close supervision with all meals due to dysphagia and aspiration risks. SLP #1 identified if Resident #6 opted to eat in his/her room, then the resident would need 1:1 supervision, but if in the dining room, close supervision was sufficient. SLP #1 identified that Resident #6 was impulsive with meals and when he/she ate or drank too fast, he/she would often cough which was a sign of aspiration. SLP #1 also identified that Resident #6 had a history of noncompliance with liquids and would often hang out by the facility vending machine. SLP #1 identified that while Resident #6 was unable to verbalize due to aphasia, other residents would often help and purchase sodas and other liquids from the facility vending machine. SLP #1 identified that she had observed intermittent issues regarding supervision of Resident #6 related to meals and had also observed meal trays in Resident #6’s room without any staff present. SLP #1 identified that she had not placed a specific order for Resident #6 related to aspiration precautions along with Resident #6’s diet order and identified that there may have been some confusion regarding this with some of the staff. Review of the clinical record failed to identify documentation related to Resident #6’s noncompliance related to vending machine items. The facility policy on aspiration precautions directed that the purpose of the policy was to establish standardized procedures for preventing aspiration and residents at risk due to dysphasia, altered mental status, or other conditions ensuring safe feeding practices and maintaining airway integrity. The policy directed that upon admission, quarterly, and with a significant change of condition, residents would be assessed for swallowing ability and aspiration risk including a referral to the speech language pathologist and findings and recommendations would be documented in the resident care plan. The policy also directed that residents identified as high risk for aspiration precautions would receive supervision during meals and snacks along with documentation of the supervision level including 1:1 feeding assistance or close observation, residents would be maintained at a 90° angle during meals and remain upright for at least 30 minutes after a meal, and would be observed for signs of aspiration which included coughing, choking, or respiratory distress. The policy also directed the speech and language pathologist would provide evaluations care plan input and staff training related to aspiration precautions; and nursing and dietary would implement interventions and monitor compliance. (continued on next page)

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	075200	A. Building B. Wing	07/31/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy on therapeutic diets directed that modified diet texture were altered inconsistency including pureed diets for residents with chewing or swallowing difficulties the policy also directed special considerations for dysphagia and aspiration risk included texture modified diets would follow speech language pathology recommendations and thickened liquids would only be used when ordered and proper consistency of the liquid would be verified prior to service the policy also directed that residents may decline therapeutic diet after being informed of potential risks per resident rights and refusals would be documented. The facility policy on a hazard free environment directed that the facility would identify, correct, and prevent environmental hazards to ensure resident safety and regulatory compliance. The policy further directed that all employees shared the responsibility of recognizing, reporting, and removing hazards promptly. The policy further directed that nursing staff would visually inspect resident rooms, hallways, and areas for hazards during routine care. 3. Resident #10 was admitted to the facility in August 2023 with diagnoses that included traumatic brain injury, dysphagia, and diabetes with hypoglycemia. Review of the clinical record identified Resident #10 had a g-tube in place upon admission but had fully transitioned to nutritional intake by mouth in March 2025. A physician’s order dated 3/13/25 directed diet orders that included ground solids and nectar thick liquids with single sips only, 1:1 feeding assistance, aspiration precautions, and encourage use of double swallow. The quarterly MDS dated [DATE] identified Resident #10 had severely impaired cognition, was always continent of bowel and bladder and required supervision with toileting, dressing, and eating. Review of a speech therapy evaluation by SLP #1 dated 7/12/25 identified Resident #10 had a history of dysphasia and aspiration pneumonia. Resident #10 was noted to have coughing with thin liquids, (a clinical sign and symptom of dysphasia), had behaviors impacting safety with meals including uncontrolled talking while eating, impulsive rate, unsafe intake amounts with decreased self-correction, decreased safety awareness, and poor self-monitoring skills. The report recommended to continue baseline diet of ground consistency with nectar thickened liquids, 1:1 supervision with all oral intake, small bites and sips, double swallow, throat clearance, and re-swallow. The note also identified due to documented physical impairments and associated functional deficits, Resident #10 was at risk for aspiration, behavioral outburst, weight loss, pneumonia, and further decline in function. An APRN note dated 7/21/25 at 4:46 PM identified Resident #10 was receiving 100% of caloric intake and medications by mouth and was only receiving g-tube flushes. The note identified a three-day caloric count scheduled from 7/22/25 - 7/24/25 to determine if Resident #10’s oral intake was adequate to establish the removal of the g-tube. Observation on 7/30/25 at 8:05 AM identified Resident #10 was seated in the dining room with several other residents. Resident #10 was observed to consume 100% of the meal by 8:10 AM. During the observation Resident #10 was observed taking large spoonful’s by mouth. Clinical staff were not present and did not provide 1:1 supervision at any time during the meal. (continued on next page)

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	075200	A. Building B. Wing	07/31/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 7/30/25 at 12:21 PM identified Resident #10 was seated in the unit dining room with several other residents. At 12:29 PM, NA #13 was observed setting up Resident #10’s meal tray and exiting the dining room. NA #4, who was assisting other residents in the dining room was present but was not observed providing any supervision to Resident #10. Resident #10 was observed eating his/her meal unsupervised, taking large spoonful’s of food by mouth and began coughing at 12:37 PM for approximately one minute. Resident #10 consumed 75 % of the meal and stopped eating at 12:39 PM and was observed coughing multiple times until 12:40 PM, when NA #4 came to Resident #10’s table. NA #4 left the table and Resident #10 exited the dining room at 12:41 PM while continuing to cough intermittently. Observation on 7/30/25 beginning at 4:56 PM identified Resident #10 seated in his/her wheelchair in the unit dining room with NA #11 who was observed setting up Resident #10’s dinner meal tray and leaving the dining room. Resident #10 was observed eating his/her meal unsupervised beginning 4:57 PM and taking in large spoonful’s of his/her meal. At 5:02 PM, LPN #11 was observed standing in one of the 2 entryways of the dining room next to a medication cart also positioned at and blocking the entryway, directly across from Resident #10. At this time, Resident #10 was observed to have consumed approximately 75 % of his/her meal. At the same time, NA #11 was also observed retrieving 2 clear plastic cups of a red colored liquid from an insulated beverage dispenser located in the dining room. Observation of the liquid identified it was regular thin liquid consistency. NA #11 handed one plastic cup of liquid to another resident and the second cup of liquid to Resident #10 while speaking to LPN #11 requesting medication to treat a headache. Resident #10 drank the entirety of the cup directly in front of LPN #11 in one attempt. At 5:05 PM, Resident #10 was observed to have completed 100% of his/her meal. Interview with LPN #11 on 7/30/25 at 5:22 PM identified she was aware Resident #10 required supervision with meals. LPN #11 was unable to identify if she visualized Resident #10 consuming the thin liquid or if he/she required 1:1 supervision during meals. Interview with the DNS on 7/30/25 at 5:24 PM identified Resident #10 is required to have 1:1 supervision with all meals due to aspiration precautions, was impulsive with eating and drinking, and often took large bites and sips. The DNS identified that Resident #10 also had a history of aspiration pneumonia and non-compliance with his/her diet orders due to often going to the facility vending machines. The DNS also identified even with prompts and 1:1 supervision, Resident #10 was often impulsive and took in large amounts of food and liquids too quickly. The DNS identified that she would immediately in-service the nursing staff regarding the need to provide supervision to any residents with aspiration precautions. Interview with SLP #1 on 7/31/25 at 8:03 AM identified that Resident #10 had multiple issues related to oral intake including behaviors with meals that included impulsivity, inability to self-regulate intake of large amounts of food at one time, poor safety awareness, along with functional and cognitive issues. SLP #1 identified that she had provided therapy to Resident #10 multiple times since his/her admission to the facility in 2023 and Resident #10 had reached his/her baseline in terms of swallowing function. SLP #1 identified that Resident #1 would always need 1:1 supervision with any oral intake due to his/her high risk for aspiration. SLP #1 identified Resident #10 was only to have nectar thickened liquids and should not have any thin liquids due to aspiration risk. (continued on next page)

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	075200	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy on aspiration precautions directed that the purpose of the policy was to establish standardized procedures for preventing aspiration and residents at risk due to dysphasia, altered mental status, or other conditions ensuring safe feeding practices and maintaining airway integrity. The policy directed that upon admission, quarterly, and with a significant change of condition, residents would be assessed for swallowing ability and aspiration risk including a referral to the speech language pathologist and findings and recommendations would be documented in the resident care plan. The policy also directed that residents identified as high risk for aspiration precautions would receive supervision during meals and snacks along with documentation of the supervision level including 1:1 feeding assistance or close observation, residents would be maintained at a 90° angle during meals and remain upright for at least 30 minutes after a meal, and would be observed for signs of aspiration which included coughing, choking, or respiratory distress. The policy also directed the speech and language pathologist would provide evaluations care plan input and staff training related to aspiration precautions; and nursing and dietary would implement interventions and monitor compliance. The facility policy on therapeutic diets directed that modified diet texture were altered inconsistency including pureed diets for residents with chewing or swallowing difficulties the policy also directed special considerations for dysphagia and aspiration risk included texture modified diets would follow speech language pathology recommendations and thickened liquids would only be used when ordered and proper consistency of the liquid would be verified prior to service the policy also directed that residents may decline therapeutic diet after being informed of potential risks per resident rights and refusals would be documented.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075200	A. Building B. Wing	07/31/2025

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. (continued on next page)

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	075200	A. Building B. Wing	07/31/2025

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility policy, and interviews for the only sampled resident (Resident #77) reviewed for indwelling catheter, the facility failed to ensure care according to professional standards for a resident who refused removal of an indwelling catheter over 5 months, that was ordered to be removed after 7 days. The findings include: Resident #77 was admitted to the facility in September 2021 with diagnoses that included urinary tract infection, chronic kidney disease, and acute candidiasis of the vulva and vagina. The quarterly MDS dated [DATE] identified Resident #77 had intact cognition, required maximal assistance for toileting hygiene, was dependent for bathing, required supervision for toilet transfers. Resident #77 was occasionally incontinent of urine, was frequently incontinent of bowel, was at risk for developing pressure ulcers/injuries, and had no pressure ulcer.The care plan dated 1/5/25 identified Resident #77 refused showers and bedding changes, contributing to persistent itchiness; he/she declined hygiene assistance and personal care interventions. The APRN Note dated 2/6/25 at 11:45 AM identified Resident #77 reported a history of nighttime incontinence and requested a foley catheter. However, the resident was able to stand and knowingly urinate on him/herself while in bed. Educate patient on proper toileting habits and the importance of using the restroom when able. Will defer foley at this time.The APRN note dated 2/7/25 at 8:45 AM identified Resident #77 reported a moisture related rash on buttocks and an open wound on left buttocks due to incontinence. The patient requested a foley catheter to help the rash improve, discussed with interdisciplinary team and the decision was made to insert a foley to help the rash and wounds quicker.A physician's order dated 2/7/25 with an end date of 2/14/25 directed foley catheter related to diagnosis of: chronic wound, provide foley catheter care every shift, days, evenings, nights. Review of the nurse's notes dated 2/14/25 failed to identify removal of the foley catheter was attempted, per the APRN's order with an end date of 2/14/25.The nurse's note dated 2/21/25 at 4:47 AM identified that Resident #77's foley catheter was patent and draining yellow urine to gravity.The nurse's note dated 3/19/25 at 1:26 PM identified that Resident #77's foley catheter was in place and patent.The APRN note date 4/9/25 at 9:15 AM identified Resident #77 had an indwelling foley catheter in place to prevent worsening of skin condition. Patient reluctant to have foley catheter removed today, will reevaluate the need for foley catheter in one to two weeks.The nurse's note dated 4/30/25 at 12:48 PM identified that Resident #77's complained to the writer of burning and discomfort around the foley catheter, stated there was a leak when I urinate. Foley catheter removed, clear amber colored urine noted, peri care provided. APRN made aware, waiting for further instructions.The nurse's note dated 4/30/25 at 2:37 PM identified that an order was obtained from the APRN for urinalysis/culture and sensitivity (UA/C&S), reinsert foley, keep it in until final results of urine. Foley catheter in place draining well, resident educated on the importance of perineal care/catheter. Writer informed resident was at risk at keeping foley catheter in place long-term, The foley put the resident at more risk for urinary infection. Resident voiced understanding.The APRN note dated 4/30/25 at 10:45 AM identified Resident #77 was seen today for evaluation of urethral burning and discomfort, as well as for wound care management. Patient reports experiencing increasing discomfort and burning sensation around the urethra where the foley catheter was inserted. The foley catheter was removed and clear amber colored urine was noted. Foley was reinserted and will be kept in place until urine culture results are available. Patient educated on the importance of perineal care, catheter maintenance and risks of long-term catheter use including increased UTI risk.The nurse's note dated 5/22/25 at 6:53 AM identified that Resident #77's foley catheter was draining yellow urine, 1 liter.Review of the Wound Care Specialist progress notes dated 6/11/25 through 7/30/25 identified under the History of Present Illness that Resident #77 had been refusing to get out of bed, the foley spout drain was opened to drain freely into a basin on the floor. Patient was not medically incontinent, however cannot or will not get out of bed to toilet (observation date unknown).The APRN note dated 7/24/25 at 8:58 PM identified Resident #77 reported new onset of right-sided kidney pain and has noticed his/her urine has become foul smelling. The urine in the foley bag was noted to be yellow and cloudy, he/she was also experiencing discomfort in the upper left quadrant of his/her abdomen.A physician's order dated 7/24/25 directed for a UA/C&S-one time. Special instructions: remove foley and replace foley and collect urine for UAC&S.The APRN note dated 7/28/25 at 8:12 PM identified Resident #77 was evaluated 4 days ago, for right kidney pain, foul smelling urine, and left upper quadrant discomfort at that time, his/her urine in the foley bag was noted to be yellow and cloudy. A urinalysis and urine culture

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	075200	A. Building B. Wing	07/31/2025

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F 0791 Level of Harm - Actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for 2 of 4 residents (Resident #68 and 76) reviewed for dental services, for Resident #76, the facility failed to act on recommendations, over a period of 17 months, to have a broken tooth extracted, which resulted in a fistula, and for Resident #68, the facility failed to schedule a consultation with an oral surgeon in a timely manner. The findings include: Resident #76 had diagnoses that included a stroke with hemiplegia (paralysis) of the left side. Nurse’s note dated 12/2/22 identified Resident #76 had his/her own teeth. Mouth and oral mucous membranes were moist with no discomfort noted. The care plan dated 12/6/22 identified Resident #76 was at risk for pain related to physical condition. Interventions included encouraging to report pain and provide medical management of underlying causes. The admission MDS dated [DATE] identified Resident #76 had moderately impaired cognition, was independent with eating and had no dental related concerns. Dental consultation dated 12/15/22 identified Resident #76 was seen for exam only and noted to have a broken #18 tooth which could likely be restored with a filling. No other clinical findings noted. Recommendations were made for a hygiene visit and to formulate a treatment plan. APRN progress note dated 1/16/23 identified Resident #76 had complaints of a toothache with constant pain measured at 8 out of 10 pain level (pain scale used to assess pain with level 0 indicating no pain, 10 indicating severe pain) for the preceding two weeks with no effect on chewing and swallowing. Orders were prescribed for Medicated [NAME] and a dental consultation. APRN progress note dated 8/4/23 identified Resident #76 was complaining of a toothache for two weeks. Orders included a dental consultation and to continue Acetaminophen as needed. APRN progress note dated 11/3/23 at 9:01 AM identified Resident #76 was being seen for medical clearance for dental procedure (extraction of molar #18) scheduled for 11/9/23. Resident #76 was to continue Aspirin 81mg and would not need antibiotics prior to procedure. Physician’s progress note dated 11/8/23 at 1:40 PM identified Resident #76 complained of pain in the left lower tooth. Pain is not in area of said anticipated extraction with no jaw pain, fever, chills, or drainage. The plan included having the dentist check the area of pain on 11/9/23 prior to extraction and continue Acetaminophen as needed. Dental consultation dated 1/18/24 identified Resident #76 was examined. Recommendations were made for referral to an oral surgeon for extraction of #18 tooth. A nurses note dated 6/19/24 at 12:57 PM identified Resident #76 was added to the dental consultation list due to complaint of toothache. Pain relief to continue as needed. (continued on next page)

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	075200	A. Building B. Wing	07/31/2025

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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 0791 Level of Harm - Actual harm Residents Affected - Few	Dental consultation dated 3/4/25 identified Resident #76 received a limited oral exam and needed extraction of #18 tooth. Recommendations were made to refer the resident to the oral surgeon to extract #18 tooth. Dental consultation dated 7/14/25 identified Resident #76 was seen for an exam, prophylaxis and fluoride. Soft tissues were noted to have generalized moderate inflammation with a possible abscess of the #18 buccal (side of molar), 18 root tip. Resident #76 has not yet been to an oral surgeon. Recommendations were made to arrange for an oral surgeon to extract #18 tooth. An interview with ADNS on 7/28/25 at 11:41 AM identified nursing staff were responsible to report any resident care concerns to the nursing supervisor. Based on those concerns, a list of residents would be generated for the in-house consultations, including dental, and be provided to nursing staff. The charge nurse was responsible to follow up on consultation recommendations including scheduling appointments with any necessary specialty provider. The nursing supervisor was responsible for overseeing the process to ensure its completion. The ADNS identified Resident #76 needed to be evaluated by an outside oral surgeon. Nursing staff failed to schedule a visit with the oral surgeon for Resident #76 citing an ongoing breakdown in communication among nursing staff. The issue had previously been identified and discussed with the DNS, however, despite ongoing efforts to improve organization, Resident #76 still had not been scheduled with the oral surgeon as an oversight. Interview with the Medical Director on 7/28/25 at 12:32 PM identified he was not aware Resident #76 had not yet been seen by an oral surgeon despite repeated recommendations. As a result, the condition progressed over time likely leading to the development of the abscess. The Medical Director identified he would expect any recommendations made by a specialty provider to be appropriately followed up in a timely manner. An interview with Dental Hygienist #1 on 7/28/25 at 1:34 PM identified she last saw Resident #76 on 7/14/25 for prophylaxis. Dental Hygienist #1 identified she observed inflammation at the gumline and a fistula at the #18 site consistent with signs of infection. The dentist was not onsite to further evaluate; however, previous recommendations for extraction of #18 were documented during earlier visits. Dental Hygienist #1 further identified Resident #76 was first seen on 2/15/22 for a broken #18 tooth that was restorable at the time. The resident was seen again in July 2023 for complaints of pain, at which point it was noted the tooth could no longer be restored and required extraction. Resident #76 was subsequently seen on 8/29/23 for x-rays and again on 11/9/23 where an extraction was attempted but unsuccessful. Recommendations were made for a referral to an oral surgeon for extraction of #18 tooth. Based on the current clinical findings and prior documented recommendations, Dental Hygienist #1 again recommended extraction of the #18 tooth during the 7/14/25 visit. Interview with Dentist #1 on 7/28/25 at 1:33 PM identified he provided dental services to Resident #76 in the past but had not evaluated him/her recently. Dentist #1 identified based on review of the documented clinical findings, he determined that removal of #18 tooth was indicated some time ago, with Resident #76 now presenting with an acute exacerbation of a chronic infection. Dentist #1 further identified the facility had experienced ongoing issues with scheduling appointments. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075200	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southport Center for Nursing & Rehabilitation LLC	930 Mill Hill Terrace Southport, CT 06890

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F 0791 Level of Harm - Actual harm Residents Affected - Few	An interview with the DNS on 7/28/25 at 3:28 PM identified in-house consultation, including dental services providers visited the facility at scheduled times. LPN’s and nursing supervisors were responsible for scheduling appointments with outside providers and ensuring all relevant information following that consultation was communicated to the nurse practitioner. The DNS denied prior knowledge of any recommendations for oral surgery that had not been addressed but would be conducting audits and educating staff. A dental consultation dated 8/5/25 identified #18 tooth was noted to have a fistula, was visibly broken and severely decayed with pain at the site. The tooth was successfully extracted. Recommendations included treatment with Amoxicillin and Motrin for pain management with a follow up recall in 6 months. A review of the facility policy for ancillary services directed that services included but not limited to podiatry, dentistry, optometry, audiology and other specialized care. Ancillary services will be provided by the facility or through coordination with qualified external providers. All services will be documented including type of services and outcomes. 2. Resident #68 was admitted to the facility in March 2025 with diagnoses that included hypertension and peripheral vascular disease. The Clinical Note dated 6/4/25 identified Resident #68 complained of soreness on the upper and lower anterior when wearing dentures, bony defect in area of 8/9 from a BB gun accident when he/she was young. Now he/she has large overgrowth of upper lip in vestibule from trauma from denture. The patient has a large soft growth on floor of the mouth, and he/she stated it has been there, no pain. Upper and lower denture adjusted for now; refer to oral surgeon for evaluation/removal of upper excess tissue and biopsy on floor of mouth growth. The quarterly MDS dated [DATE] identified Resident #68 had moderately impaired cognition, and had no mouth or facial pain, discomfort, or difficulty with chewing. The care plan dated 7/18/25 identified Resident #68 should attend appointments with an escort. Interventions included providing resident education about appointment status. Review of the clinical record dated 6/4/25 through 7/29/25 failed to identify documentation that the evaluation with the oral surgeon was scheduled or refused by the resident or resident representative. Interview with Resident #68 on 7/28/25 at 11:00 AM identified that he/she needed a dental appointment, an appointment was put in with the dentist, but the appointment never happened. (continued on next page)

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	075200	A. Building B. Wing	07/31/2025

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F 0791 Level of Harm - Actual harm Residents Affected - Few	Interview and clinical record review with the DNS and ADNS on 7/28/25 at 2:50 PM failed to identify documentation that Resident #68’s appointment with the oral surgeon was scheduled. The ADNS indicated that she was unaware that Resident #68 required an oral surgeon consultation. The ADNS further identified that when the Scheduler receives a consult via email, she uploads it into the electronic health record and notifies the unit nurse that a follow up appointment is required. The nurse is responsible to notify the nursing supervisor who would schedule the appointment, once the appointment was scheduled the Scheduler will arrange transportation. The DNS indicated that she would expect to see documentation in the clinical record that the appointment was scheduled or that the resident/resident representative refused the consultation. Interview with the Scheduler on 7/29/25 at 11:18 AM identified that subsequent to surveyor inquiry a dental appointment with the oral surgeon was scheduled on 7/30/25, for Resident #68. The Scheduler indicated that it was an oversight on her part, that Resident #68’s oral surgeon consultation had not been scheduled sooner; she forgot to give the consult to the nurse. Interview with the DNS on 7/30/25 at 5:10 PM identified that consultation appointments should be scheduled or attempted to be scheduled within 24 hours. The DNS further identified that moving forward she will add the ADNS onto the emails containing the consultation appointment information, in addition to the Scheduler; the ADNS will now be responsible to schedule any medical or dental consults. The facility MD Consults/Appointments policy directs that all residents receive timely and coordinated care for outside medical appointments. All outside medical appointments must be arranged, documented, and communicated effectively.

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	075200	A. Building B. Wing	07/31/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, review of facility documentation, facility policy, manufacturer guidelines and interviews, the facility failed to ensure the level of sanitizing solution in the dishwasher was tested and maintained at an adequate level according to manufacturer guidelines to ensure tableware was sanitized. The findings include: A kitchen service report dated 7/22/25 identified ware washing results for glassware, plates, pots and pans were satisfactory with the sanitizer concentration measured 75 ppm (parts per million) falling within the acceptable range of 50 - 100 ppm.An observation during a test run of the low temperature dishwasher on 7/27/27 at 7:02 AM identified the sanitation strip had a recorded measurement of 0 - 10 ppm. A review of the dishwasher temperature log date 7/1/25 through 7/26/25 identified the wash cycle was recorded at 120. The rinse cycle was recorded at 50.An interview and facility documentation review with the Regional Food Service Director on 7/27/25 at 7:15 AM identified the number recorded under the wash cycle represented the temperature in degrees, while the number under rinse cycle reflected the sanitation concentration in ppm. Although not specifically labeled, staff were expected to understand that rinse reading represented ppm, obtained by submerging a sanitizer test strip in a reservoir of water flowing through the dishwasher to the clean side.An interview with Dietary Staff #1 on 7/27/25 at 7:22 AM identified she routinely operated the dishwasher and documented required readings onto the dishwasher temperature log as part of her assigned duties. Dietary Staff #1 identified she recorded both wash and rinse information based only on the dishwasher gauge (temperature readings) and never used test strips to measure sanitation.An interview with Dietary Staff #3 on 7/27/25 at 7:40 AM identified he routinely operated the dishwasher and documented required readings onto the dishwasher temperature log as part of his assigned duties. Dietary Staff #3 identified he recorded both wash and rinse information based only on the dishwasher gauge (temperature readings) and never used test strips to measure sanitation.An interview with the FSD on 7/27/25 at 7:42 AM identified the dishwasher was last serviced on 7/22/25 and was functioning properly with the appropriate sanitation levels. The FSD further identified she last checked the sanitation the previous morning, with a recorded reading of 50 ppm. The FSD further identified she was responsible to educate dietary staff on dishwasher sanitation procedure; however, was unable to provide any documentation of any prior training.An interview and sanitation strip manufacturer guideline review with Dietary Staff #4 on 7/27/25 at 8:24 AM identified he last checked the dishwasher sanitation at 1:00 PM following lunch the previous day. Dietary Staff #4 identified the reading at the time was within normal range. However, when asked to identify the corresponding range on the test strip. Dietary Staff #4 indicated the range fell between 0 - 10 ppm, despite the manufacturer's guidelines indicating the normal sanitizer range of 50 - 100 ppm.An interview with Dishwasher Technician #2 on 7/27/25 at 1:50 PM identified that a mechanism in the machine was not aligned properly, preventing the sanitizing solution to dispense. Without that mechanism functioning, the plates and utensils were not sanitized. The issue was addressed and subsequently the dishwasher was functioning properly.An interview with Dishwasher Technician #1 on 7/28/2025 at 6:57 AM identified he last provided routine service to the dishwasher on 7/22/25 and there were no identified concerns. Dishwasher Technician #1 identified the wash and rinse cycle gauge measured in degrees only and should be maintained between 115 - 120 degrees F. Sanitation should be measured using strips with a recorded reading of 50 - 100ppm. Any reading outside of those ranges would not offer effective sanitizing.An interview with the FSD on 7/31/2025 at 2:17 PM identified she would expect dietary staff to perform sanitation procedures in accordance with infection control practices.A review of the manufacturer guidelines for the dishwasher identified sanitizer should be maintained at 50 ppm.A review of the manufacturer guidelines for the sanitation strips identified sanitizer should be maintained between 50 -100 ppm.Although requested. A policy for ensuring clean and sanitary plates and utensils was not provided.

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	075200	A. Building B. Wing	07/31/2025

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 4 residents (Resident #55) reviewed for dental, the facility failed to maintain a complete and readily accessible medical record. The findings include: Resident #55 was admitted to the facility on [DATE] with diagnoses that included partial loss of teeth, anxiety, and obesity. The care plan dated 4/20/25 identified Resident #55 should attend appointments without an escort. Interventions included to provide resident education about appointment status.The quarterly MDS dated [DATE] identified Resident #55 had intact cognition and had no mouth or facial pain, discomfort or difficulty with chewing.Interview with Resident #55 on 7/28/25 at 11:00 AM identified that the facility's Consultant Dentist extracted the incorrect tooth earlier this year (resident could not provide exact dates), and he/she had asked the facility's Scheduler to obtain his/her dental records, but there had been no follow-up from the facility on his/her request. Resident #55 indicated that following that extraction he/she began receiving dental services from a community dentist. Review of Resident #55's clinical record failed to identify documentation of the care and services provided by the Dental Consulting group from 2024 through 2025.Subsequent to surveyor inquiry on 7/28/25, dental records dated 6/12/24 through 7/14/25 were requested from the Consultant Dentist and were accessible on 7/29/25. Clinical Note dated 8/22/24 at 12:32 PM identified Resident #55 complained of pain on lower right, review of x-rays showed #29 had large filling near pulp, #29 was painful to touch, patient wants extraction, please get clearance and consent and we will extract #29 in facility. Clinical Note dated 10/1/24 identified patient having pain in #29. Consent and medical release signed, extracted #29, simple extraction, homeostasis. Consent for Extraction documentation dated 10/1/24 was signed by Resident #55 and identified Tooth #29 was to be extracted. Clinical Note dated 12/30/24 identified Resident #55 was scheduled for a hygiene visit but refused. Patient stated the dentist pulled the wrong tooth and #30 is the tooth that was bothering him/her, stated he/she wanted to see the dentist for pain on #30 and also a full upper denture and partial lower denture. Patient stated he/she had a full upper denture before but doesn't remember when it was made. Dentist to see for pain on #30 and denture evaluation. Reschedule hygiene visit since patient refused today.Interview with the facility's Scheduler on 7/29/25 at 11:18 AM failed to identify that Resident #55 had ever made a request for his/her dental records, and that Resident #55 now sees a community dentist and self-schedules his/her appointments.Interview with the DNS on 7/30/25 at 5:10 PM identified that she would expect Resident #55's dental records from the consulting dental provider to be accessible in his/her clinical record so facility staff could have immediate access. The DNS further identified that she will be having a meeting with all the consultants and re-educating them on the expectation that clinical notes are uploaded into the resident's clinical record after a service is provided, in a timely manner.The facility's Ancillary Services policy directs all ancillary services provided or coordinated will be documented in the resident's medical record, including the type of services and outcome.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075200	A. Building B. Wing	07/31/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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	075200	A. Building B. Wing	07/31/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 3 residents (Resident #100) reviewed for non-pressure ulcers, the facility failed to ensure hand hygiene was performed when required during the treatment of wounds. The findings include: Resident #100 was admitted to the facility in April 2023 with diagnoses that included lymphedema and acute kidney injury, and hypertension.The annual MDS dated [DATE] identified Resident #100 had intact cognition, required maximum assistance for dressing, putting on footwear, and personal hygiene. Additionally, Resident #100 has 2 venous or atrial ulcers present.The care plan dated 5/20/25 identified Resident #100 has venous ulcers to his/her bilateral lower extremities. Interventions included providing wound treatments as ordered and wrapping bilateral legs with compression socks.A vascular consult dated 6/17/25 directed compression stockings and a venous ultrasound. The physician identified the resident is wheelchair bound and has long standing bilateral lower extremity edema with weeping blisters on legs. Currently there are no signs of cellulitis. Resident #100 needs compression stockings or ace wraps to legs from ankle to knee every morning and take off at bedtime. A physician's order dated 6/19/25 directed to cleanse the bilateral lower extremities with soap and water, rinse and dry well and apply ammonium lactate 12% lotion to intact skin. Apply Calcium Alginate with silver to open wounds, xeroform to any blisters, cover with a dry clean dressing and secure with cling twice a day and as needed. Apply ace wraps every morning from the base of the toes to the base of the knees and remove at bedtime. Monitor for signs and symptoms of infection.Observation of Resident #100 treatment being done on 7/28/25 at 2:05 PM by LPN #2. LPN #2 assisted Resident #100 from the wheelchair to the bed. After washing her hands, LPN #2 put on a new pair of gloves on and removed the dressing on the right leg. With the same gloves on, LPN #2 removed the dressing on the right leg which had visible drainage. With the same gloves, LPN #2 placed a garbage bag in the bedside garbage can and discarded all the old dressings. LPN #2 removed her gloves and without the benefit of hand washing put on a clean disposable gown without tying it around her neck or waist and put on a new pair of gloves. LPN #2 opened treatment supplies onto a clean surface on the overbed table. LPN #2 did not wash the legs with soap and water per the physician order. LPN #2 sprayed the left leg dressing with wound cleanser because it was adhered to the wound and removed the dressing discarding it in the garbage. LPN #2's gown fell forward leaving her upper half exposed. LPN #2 sprayed wound cleaner on the open left leg area and patted it dry 4 x 4 then she sprayed the old dressing on the right lower leg wound cleaner to remove it. LPN #2 removed the dirty gloves and yelled in the hallway for a nurse aide to bring more clean gloves. LPN #2 put on a clean pair of gloves without the benefit of handwashing. LPN #2 placed the Calcium Alginate on left leg followed by an ABD pad and kerlix wrap. LPN #2 placed Calcium Alginate to the left leg followed by an ABD and kerlix wrap. LPN #2 applied the ace wrap to the right and left foot leaving toes exposed bringing the ace wrap to just below the knee. LPN #2 placed Resident #100's grippy socks and shoes on over the ace wraps. LPN #2 removed the supplies off the overbed table, discarded them in the garbage and removed her gloves and gown. LPN #2 left the resident's room with the garbage bag and walked to the utility room. LPN #2 returned to the resident's room, went into the bathroom and washed her hands. Interview with the DNS on 7/30/25 at 10:25 AM indicated the nurse doing a wound treatment is expected to wash his/her hands every time he/she removes their gloves. The DNS indicated that the nurse is expected to wash her hands and apply new gloves prior to removing the old dressing. The DNS indicated after removing the old dressing the nurse is required to remove her gloves, wash her hands and put on a new pair of gloves. The DNS indicated after doing the treatment to one leg the nurse is required to remove gloves, wash hands and put on a new pair of gloves before doing the other treatment and remove gloves and wash her hands again when done. The DNS indicated that if the nurse wanted to wear a gown, she must wear it the right way, tied, and have it cover her front and shoulders. Review of the handwashing policy identified all staff, contractors, volunteers, and visitors must adhere to hand hygiene protocols before and after resident contact, after contact with potentially contaminated surfaces, and as otherwise indicated. The purpose is to prevent the spread of infections by ensuring all healthcare personnel follow proper hand hygiene practices in accordance with CDC and CMS guidelines. Hand hygiene must be performed before and after direct resident contact, before performing aseptic tasks like wound dressing, after exposure to body fluids, before donning and after removing gloves. Review of the wound treatment process policy identified to prepare by gathering treatment supplies per

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075200	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. (continued on next page)

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	075200	A. Building B. Wing	07/31/2025

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on review of facility documentation, facility policy, and interview, the facility failed to ensure ongoing tracking and surveillance of antibiotic usage from 1/1/23 to 12/31/24 and failed to ensure staff education on antibiotic stewardship. The findings include: Interview with the Infection Control Nurse (LPN #1) on 7/29/25 at 7:40 AM indicated that she started at the facility in March 2025. LPN #1 identified she was responsible for monitoring and tracking all antibiotic usage and infections based on McGeer's criteria on a daily to weekly basis and consulting with the provider about if the antibiotic was appropriate or not at the time the infection started. LPN #1 indicated when she started working at the facility there were not any monthly surveillance reports of antibiotic use from 1/1/23 through 12/31/24. There were no statistics or monthly infection control meeting minutes to identify that antibiotic usage had been reviewed, reported, or determined to have been appropriately used or not. LPN #1 indicated her position was responsible to educate the residents and staff at least annually on the ongoing stewardship program and if there were concerns with over antibiotic use. LPN #1 indicated there was no documentation regarding antibiotic stewardship education with the residents or staff that she could find. Interview with the DNS on 7/31/25 at 8:20 AM indicated the infection control nurse was responsible to do a daily but at least a weekly review of all antibiotic use and speak with the providers to determine if the appropriate antibiotic was being used for the resident's infection. The DNS indicated the infection control nurse would determine if a resident met the McGeer's criteria for an infection to be eligible to receive the antibiotic. The DNS indicated if the resident did not meet requirements the infection control nurse was expected to contact the provide and document the outcome. The DNS indicated her expectation was the infection control nurse would have a monthly infection control committee meeting to review the antibiotic use and data collected. The DNS indicated the infection control nurse was responsible to present the data quarterly for number of infections, comparisons to other months, and analyzing the data to present with a report at the QAA and medical staff meeting. The DNS indicated she did not have an antibiotic line lists or education for 2023 or 2024. Interview with the Administrator on 7/31/25 at 8:25 AM indicated QAA and QAPI meet quarterly with the medical staff meeting. The Administrator indicated that it was the infection control nurse or DNS's responsibility to present the ongoing infection rates, comparisons to other months or quarters, any outbreaks since prior quarter, and statistics or over prescribing of an antibiotic with the providers. After review from 1/1/23 to 12/31/24 the Administrator could not provide documentation of any infection control report or that the infection control nurse verbally had presented during the meeting based on the minutes from the meetings. The Administrator indicated that the infection control nurse was responsible to present a quarterly report based on her daily, weekly, and monthly surveillance of antibiotic usage and analyzing the data for any trends in infections or antibiotic usage by providers for the antibiotic stewardship program. The Administrator indicated that the infection control nurse did sign in to some of the quarterly QAA meetings, but she did not present any information related to the antibiotic stewardship statistics to the committee. Review of the Antibiotic Stewardship Policy identified the facility shall work to ensure the safe, effective use of antibiotics, and shall actively seek to minimize the inappropriate use of antibiotics through ongoing assessment, education, and leadership activities as part of the facility infection prevention and control program. The facility medical director, in conjunction with the infection preventionist, director of nursing, and consultant pharmacist shall assume the leadership roles in antibiotic stewardship. Antibiotic stewardship activities will be coordinated through the pharmacy committee and the infection control committee. Antibiotic stewardship activities shall include: regular review of antibiotic utilization patterns and sensitivity patterns at the committee meetings, reports from the laboratory on sensitivity and resistant patterns over time (quarterly, yearly, and past years), review of antibiotic utilization over the past (quarter, year, and past years), distribution of educational materials to staff and clinicians on improving safe, effective use of antibiotics as well as material on prevention of overprescribing on a regular basis in conjunction and coordination with annual in-service education. Additionally, reports back to the provider on potential mis-prescribing or over-prescribing as identified by the infection control committee. Review of the Infection Prevention Program Policy identified the infection prevention program will identify, protect, and control infections. The infection prevention and control must maintain and document an infection control program which has its goal the prevention and control of infection and communicable diseases. The facility must maintain surveillance, identification, prevention, control, and investigation of infections and communicable diseases. The facility must provide infection control education to staff, residents, and caregivers. Surveillance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075200	A. Building B. Wing	07/31/2025

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on review of facility documentation, facility policy, and interview, the facility failed to ensure that a nurse aide was provided at least 12 hours annual in-service education, and competency evaluations were completed at least annually. The findings include: A review of education and in-service documentation for 2023, 2024, and 2025 failed to identify education and competencies had been completed for NA #14, who began employment at the facility on 12/5/22.Interview with LPN #1 on 7/30/25 at 7:15 AM identified she worked in a dual role as the staff development and infection control nurse. LPN #1 identified that the DNS and ADNS provided assistance to help her with staff development as they were able, but education was done as time allowed. LPN #1 identified that other than the actual in-service sign-in-sheets and competency packets, she did not have any tracking mechanisms to determine which staff required updated annual competencies or in services, or if all nurse aides in the facility had completed the required 12 hours of in-service training annually.Interview with the ADNS on 7/30/25 at 2:41 PM identified that she had provided some assistance to LPN #1 regarding in service and annual competencies for the facility nursing staff, however she was helping as time allowed. The ADNS identified that she was required to fill multiple roles at the facility which included the ADNS role, RN supervisor, wound care nurse, and had recently been tasked with tracking documentation for outside consultations including ophthalmology and dental visits due to issues that had been identified during the survey.Interview with the DNS on 7/31/25 at 9:27 AM identified she was not aware of any issues related to in services and education. The DNS identified she had notified LPN #1 several times that if she needed assistance to please notify the DNS and that the ADNS was also available to assist with education. The DNS identified that all clinical staff should have required education, in-services, and competencies following hire and then annually.The facility assessment tool directed that the facility would provide annual in-servicing, training, and competencies and the staff development nurse would be responsible to maintain competencies. The assessment tool also directed that staff education would be provided upon hire, annually, and as needed.