STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075214	A. Building B. Wing	03/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Portland Care & Rehab Centre, Inc	333 Main St Portland, CT 06480

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for 3 of 5 residents (Residents #3, 33 and 12) reviewed for unnecessary medications, for Resident #3 and 33, the facility failed to ensure monthly pharmacy medication regimen reviews were completed for 5 of the 12 months reviewed and for 1 of 5 residents Resident #12 the facility failed to ensure monthly pharmacy medication reviews were completed 11 of 12 months. The findings include: 1. Resident #3 was admitted to the facility in December 2023 with diagnoses that included thrombophilia, severe dementia with mood disturbance, and hypothyroidism. The quarterly MDS dated [DATE] identified Resident #3 had severely impaired cognition and was receiving antipsychotic, hypnotic, and anticoagulant medications. The care plan dated 3/10/26 identified Resident #3 was taking an anticoagulant medication, with interventions that included reviewing the medication list for adverse interactions and was taking an antipsychotic medication, with interventions that included monitoring, recording, and reporting to the physician side effects and adverse reactions of the psychoactive medications. Review of Resident #3's clinical record failed to identify a monthly medication regimen review was completed by the Consultant Pharmacist in 9/2025, 11/2025, 12/2025, 1/2026, and 2/2026. 2. Resident #33 was admitted to the facility in December 2022 with diagnoses that included hypertensive heart and chronic kidney disease with heart failure, schizophrenia, and anxiety. The annual MDS dated [DATE] identified Resident #33 had intact cognition and was receiving antipsychotic, antidepressant, anticoagulant, diuretic, and antiplatelet medications. The care plan dated 12/9/25 identified Resident #33 was taking an anticoagulant medication, with interventions that included reviewing the medication list for adverse interactions and was taking psychotropic medications and antipsychotic medications, with interventions that included monitoring, recording, and reporting to the physician side effects and adverse reactions of psychoactive medications. Review of Resident #33's clinical record failed to identify a monthly medication regimen review was completed by the Consultant Pharmacist in 9/2025, 11/2025, 12/2025, 1/2026, and 2/2026. Interview with the DNS on 3/10/26 at 6:29 AM identified that the medication regimen reviews were (continued on next page)

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

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

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	received from the Consultant Pharmacist via encrypted email, monthly; she was unable to find the Consultant Pharmacist's monthly recommendations, for Residents #3 and #33, from 9/2025, 11/2025, 12/2025, 1/2026, and 2/2026. The DNS indicated that she had not been getting the monthly pharmacy medication regimen reviews for the long-term care residents and had only been receiving the reviews for the newly admitted residents, which were completed by a different Consultant Pharmacist, from the same company. The DNS further indicated that she had called the Consultant Pharmacist #1, in December, and notified him that she had not been receiving the monthly reviews for the long-term residents, and she verbally followed up with the Supervising Pharmacy Consultant at the end of January; he said he was looking into it. The DNS further indicated that the Consultant Pharmacist #1 sent her the medication regimen review that was completed in 10/2025, but she was missing the reviews from 9/2025, 11/2025, 12/2025, 1/2026, and 2/2026, for the long-term care residents. Although attempted an interview with the Consultant Pharmacist #1 was not obtained. Interview with Supervising Pharmacy Consultant #1 on 3/11/26 at 2:59 PM identified the Consultant Pharmacist was responsible for completing monthly pharmacy medication reviews and sending them electronically following their review. Supervising Pharmacy Consultant #1 identified sometime in December 2025, Pharmacy Consultant #1 reported experiencing computer issues when, during repair, the hard drive was cleared of work-related information. Supervising Pharmacy Consultant #1 directed Pharmacy Consultant #1 to retrieve previously completed medication reviews from past emails. Supervising Pharmacy Consultant #1 periodically followed up on the status of the lost files and was informed the matter was being addressed. Supervising Pharmacy Consultant #1 indicated while he was not made aware the issue remained unresolved until after surveyor inquiry, there were no reports of irregularities not being addressed and was attempting to recover lost data. Pharmacy Consultant #1 was terminated. The Consultant Pharmacist Services Provider Requirements policy directs that regular and reliable consultant pharmacist services are provided to residents; specific activities that the consultant pharmacist performs include, but is not limited to: reviewing the medication regimen of each resident at least monthly, or more frequently under certain conditions, incorporating federally mandated standards of care in addition to other applicable professional standards as outlined in the procedure for medication regimen review, and documenting the review and the findings in the resident's medical record or in a readily retrievable format if utilizing electronic documentation, communicating to the responsible prescriber and the facility leadership potential or actual problems detected in other findings related to medication therapy orders including recommendations for changes in medication therapy and monitoring of medication therapy as well as regulatory compliance issues at least monthly. The policy further directs the consultant pharmacist to document activities performed and services provided on behalf of the residents and the facility, a written or electronic report of findings and recommendations resulting from the activities as described above is given to the attending physician, director of nursing, and others as may be appropriate at least monthly, and the facility has a process to ensure that the findings are acted upon. Resident specific recommendations are documented in the resident's active medical record. 3. Resident #12 was admitted to the facility in December 2024 with diagnoses that included chronic obstructive pulmonary disease, type II diabetes and chronic kidney disease. The quarterly MDS dated [DATE] identified Resident #12 was cognitively intact and received medications daily to manage multiple comorbidities. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The care plan dated 9/23/25 identified Resident #12 had an alteration in endocrine status, received an anticoagulant and was prescribed antidepressant medication. Interventions included to administer medications as ordered and monitor for effectiveness and side effects consider gradual dose reductions if indicated. Resident #12 was a long-term resident. Pharmacy medication review dated 10/1/25 identified no irregularities with no other documented review. Review of the clinical record identified no other documented pharmacy medication reviews from 3/20/25 to 9/2025 and 11/2025 to 2/2026. Interview and clinical documentation review with the DNS on 3/10/26 6:29 AM identified Pharmacy Consultant #1 completed medication reviews for all long-term care residents monthly. Once complete, the reviews were sent to the DNS electronically for review and dissemination to the appropriate units for provider review. The DNS identified in 12/2025, she noticed she had not received any pharmacy reviews from 9/2025. The DNS contacted the Pharmacy Consultant #1 who indicated he would investigate the matter and subsequently received one pharmacy medication review dated 10/1/2025. The DNS followed up with Pharmacy Consultant #1 in 1/2026 and was told he was still looking into the matter. The DNS had not addressed the matter any further, was unable to provide any documentation of her efforts to address the problem and had no explanation of documentation regarding the status of any other pharmacy medication reviews prior to 9/2025 for Resident #12. Interview with Supervising Pharmacy Consultant #1 on 3/11/26 at 2:59 PM identified the pharmacy consultant was responsible for completing monthly pharmacy medication reviews and sending them electronically following their review. Supervising Pharmacy Consultant #1 identified sometime in December 2025, Pharmacy Consultant #1 reported experiencing computer issues when, during repair, the hard drive was cleared of work-related information. Supervising Pharmacy Consultant #1 directed Pharmacy Consultant #1 to retrieve previously completed medication reviews from past emails. Supervising Pharmacy Consultant #1 periodically followed up on the status of the lost files and was informed the matter was being addressed. Supervising Pharmacy Consultant #1 indicated while he was not made aware the issue remained unresolved until after surveyor inquiry, there were no reports of irregularities not being addressed and was attempting to recover lost data. The Consultant Pharmacist Services Provider Requirements policy directs that regular and reliable consultant pharmacist services are provided to residents; specific activities that the consultant pharmacist performs include, but is not limited to: reviewing the medication regimen of each resident at least monthly, or more frequently under certain conditions, incorporating federally mandated standards of care in addition to other applicable professional standards as outlined in the procedure for medication regimen review, and documenting the review and the findings in the resident's medical record or in a readily retrievable format if utilizing electronic documentation, communicating to the responsible prescriber and the facility leadership potential or actual problems detected in other findings related to medication therapy orders including recommendations for changes in medication therapy and monitoring of medication therapy as well as regulatory compliance issues at least monthly. The policy further directs the consultant pharmacist to document activities performed and services provided on behalf of the residents and the facility, a written or electronic report of findings and recommendations resulting from the activities as described above is given to the attending physician, director of nursing, and others as may be appropriate at least monthly, and the facility has a process to ensure that the findings are acted upon. Resident specific recommendations are documented in the resident's active medical record. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Efforts to interview Pharmacy Consultant #1 were unsuccessful.

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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 policies, and interviews, the facility failed to ensure food service staff were wearing hair restraints while preparing food and failed to ensure a low temperature dishwasher was operating in accordance with the manufacturer's recommendation. The findings include: 1. [NAME] #1 was hired in October 2012.Dietary Aide #1 was hired in November 2023.Observation on 3/8/26 at 9:00 AM, in the first-floor dining room, identified Dietary Aide #1, serving breakfast from the steam table, without the benefit of a hair guard.Interview with Dietary Aide #1 on 3/8/26 at 9:08 AM identified that she was aware that she should be wearing a hair net while serving food, but today she had arrived late and they were short staffed, so she forgot to put it on. Dietary Aide #1 indicated that she always wears a hair net.Observation on 3/9/26 at 11:40 AM identified [NAME] #1, in the kitchen, temping food on the steam table, without the benefit of a beard guard.Interview with [NAME] #1 on 3/9/26 at 11:40 AM identified that he always puts on a beard guard right after he puts on his hair net, but today the bag for the beard guards was not available and he needed to grab a new bag, therefore he forgot to put on a beard guard before starting work.Interview with the Dietary Director on 3/10/26 at 10:30 AM identified that it was his expectation that food service staff wear hair restraints while in the kitchen and while preparing, cooking, and plating food. The Dietary Director further identified that he had reeducated food service staff on the hair restraint policy. Interview with the Administrator on 3/10/26 at 10:00 AM identified that he would expect the food service staff to follow the hair restraint policy and wear the appropriate hair restraints while in the kitchen and preparing and serving food.The Hair Restraints policy directs hair restraints will be put on when entering the kitchen and when preparing, cooking and plating food. All staff preparing, cooking, and plating food will wear hair restraints or a head cover. All facial hair will be covered using a hair restraint, all staff entering the kitchen will put on a hair restraint to cover head and facial hair as provided at the entrance of the kitchen, any time kitchen staff needs to manage their hair restraint, head covering or facial hair they will step away from the food area and remove and discard their gloves and hair restraints period. Prior to returning to the food area the employee will wash their hands with soap and water or hand disinfectant, apply a new hair restraint and new gloves. 2. Dietary Aide #2 was hired in March 2023.Review of the Dietary Aide Orientation dated 3/14/23 identified Dietary Aide #2 had been educated on the use and care of the dishwasher, which included proper temperature, use of detergents, and sanitation.Observation on 3/9/26 at 1:40 PM identified Dietary Aide #2 washing the dirty dishes and utensils in the low temperature dishwasher, with a sanitizer reading within normal limits (WNL), but a maximum temperature of 90 degrees Fahrenheit, (low temperature dishwashers should operate at a minimum temperature 120 degrees Fahrenheit and also use chemical sanitizer to ensure food safety). Three additional observations from 1:45 PM through 2:00 PM identified the maximum dishwasher temperature achieved was 90 degrees F (temperature confirmation obtained with a digital thermometer).Interview with the Dietary Director on 3/9/26 at 2:05 PM identified that the low temperature dishwasher should be operating at a minimum of 120 degrees F, and that he notified the Administrator and the Director of Maintenance that the dishwasher temperature was reading at 90 F. The Dietary Director further identified that until the dishwasher was operating at a proper temperature, all food and drink services would be served using disposable plates, cutlery, cups, napkins, and lids. The Dietary Director further indicated that all dishes and utensils would be rewashed once the dishwasher was running at the appropriate temperature.Review of the March 2026 Dish Machine Temperature and Sanitizing Record directed to run the wash and rinse cycle empty twice prior to use, upon completion of this process, record below for the appropriate meals, do no wash any dishes before the required temperature and sanitizer levels were met. The Record failed to identify documentation that a temperature and sanitizer level were obtained before the breakfast dishes were washed and before the lunch dishes (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	were washed, on 3/9/26.Interview with Dietary Aide #2 on 3/9/26 at 2:30 PM identified that he checked the dishwasher temperature before washing the breakfast dishes and that the reading was 90 degrees he planned on rechecking the temperature after the lunch dishes were washed, and if it was still 90 degrees, he was going to tell someone.Interview with the Administrator on 3/9/26 at 3:20 PM identified he was getting a reading of 117 degrees F, after adjusting the mixer valve, and he placed a call for the plumber to evaluate the system. The Administrator further indicated that until the dishwasher was functioning at the appropriate temperature, all food and drink services would be served on disposable plates and cups.Observation with the Dietary Director on 3/10/26 at 10:30 AM identified the low temperature dishwasher was operating at 123 F, all meal and drink services had been served using disposable items, and that the plumber was on his way to look at the system; disposable cups and plates would remain in place until the plumber looked at the system. The Dietary Director indicated that Dietary Aide #2 had received a written warning for not notifying him of the low dishwasher temperature, and all food service staff had been reeducated on the dishwasher temperatures and timely reporting when the temperature was out of range. The Dietary Director identified that for the next 5 days, he would check the dishwasher temperature every 15 minutes, while in use, to ensure temperature stability.Interview with the Administrator on 3/10/26 at 10:00 AM indicated that adjusting the mixer valve resolved the low water temperature issue, but the plumber would be on-site within the hour to evaluate the system. The Administrator indicated that, according to the guidance written on top of the Dish Machine Temperature and Sanitizing Record, he would expect that any temperature reading below 120 F would be immediately reported to the Dietary Director and dishwashing would not be resumed until the temperature was 120 F or greater.Interview with the Administrator and the plumber from an outside service on 3/10/26 at 11:40 AM identified that there were no mechanical issues identified with the low temperature dishwasher, and that the mixer valve adjustment had corrected the issue; the water temperature was now measuring 125 F.The Low Temperature Dishwasher Machine Operational Requirements directed the wash temperature to be 120 F minimum and required 50 ppm available chlorine rinse.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, review of facility documentation and interviews the facility failed to ensure a clean and homelike environment. The findings include:Observation on 3/10/26 11:37 AM with the facility Administrator/Owner identified 3 of 4 upholstered chairs in the solarium (sitting room) and 5 of 10 upholstered chairs in the dining room were marked with heavy brown/black staining on the seat, and back of chairs.Interview with the Administrator on 3/10/26 11:37 AM identified he was aware the chairs were heavily soiled and had recently been researching replacements indicating they were costly. The Administrator further identified although his efforts were ongoing, he was unable to provide any documentation regarding progress towards replacement.Although requested, a policy on maintaining a clean homelike environment was not provided.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for 1 of 6 residents (Resident #12) reviewed for accidents, the facility failed to ensure a resident with a customized wheelchair was re-assessed for safe transfers after implementing a new standing mechanical lift and sling harness resulting in staff having to lower the resident on a firm surface near the floor. The findings include:Resident #12 was admitted to the facility in December 2024 with diagnoses that included morbid obesity and osteoarthritisPhysical Therapy Evaluation dated 6/24/25 identified Resident #12 was assessed with the use of a mechanical stand lift assist and was able to stand 1-3 minutes with total dependence.The quarterly MDS dated [DATE] identified Resident #12 was cognitively intact and required two person assist with transfers, utilized a motorized wheelchair for mobility and had not experienced any falls since admission.The care plan dated 9/23/25 identified Resident #12 was non ambulatory, at risk for falls and required assistance with mobility and transfers. Interventions included providing transfers as ordered a custom power wheelchair, tilt in space motorized with adjustable head rest, pelvic positioning belt, Roho cushion and elevating split foot plates.Physical Therapy Progress Report and Updated Therapy plan dated 11/21/25 identified skills services were recommended, in part due to balance deficits, decreased functional capacity and the need to maintain the ability to stand while in the stand assist lift was being repaired. The report further identified on 11/21/25, Resident #12 stood at a standing table for up to 22 minutes.Physician's order dated 11/22/25 (original 7/9/25) directed stand assist lift bed to/from the wheelchair. May use total mechanical lift as needed.Invoice dated 12/10/25 identified two new (different manufacturer and model) electric mechanical stand lifts were purchased and delivered on 12/12/25.Inservice Report dated 12/16/25 at 2:50 PM to 3:05 PM identified nursing staff were educated on the use of the new stand lift, specifically, sling, power button, hand controls and charge indicator.Nurse's note dated 12/16/25 at 5:45 PM identified while transferring Resident #12 to the wheelchair, his/her lower back and buttock were hitting the wheelchair seat rather than rising above with the mechanical lift at maximum height, then the resident slowly sliped out of the lift's (upper body) sling harness after no longer being able to hold his/her own weight. NA #1 applied a gait belt and Resident #12 was lowered slowly onto the footrests of the chair. Upon assessment resident denied any pain or discomfort, A body audit was performed, small flat 1cm x 1cm bruise was noted at right gluteal fold, range of motion was present in all extremities. A Hoyer pad was applied following assessment and Resident #12 was transferred into his/her wheelchair. The APRN was notified and the mechanical stand lift was removed from service until assessed by physical therapy.Rehabilitation progress note dated 12/17/25 at 10:45 AM identified an assessment of mechanical stand assist lift determined that a smaller sling was needed or trial of different connecting point and order a smaller sling harness.Physician orders dated 12/22/25 directed the use of a mechanical Hoyer lift for all transfers.Interview with the Director of Rehabilitation on 3/9/26 at 8:55 AM identified nursing staff were previously responsible for determining the appropriate sling harness size used during resident transfers. The Director of Rehabilitation indicated two new mechanical stand lifts from a different manufacturer were ordered and staff received in-service training prior to implementation, with Resident #12 being the first resident the lift was used with. The Director of Rehabilitation identified he did not re-assess the use of the lift and sling harness with Resident #12 following the incident. However, determined the sling harness provided with the mechanical stand lift as one unit was too long and not appropriate to safely secure the resident and subsequently ordered shorter sling harnesses.Interview with NA #1 on 3/09/2026 at 10:42 AM identified she was working during the 3:00 PM to 11:00 PM shift on 12/16/25 at the time of the incident. NA #1 indicated while she was not the assigned nurse aide, she assisted NA #2 by standing behind and securing the wheelchair during the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	transfer while NA #2 operated the lift. NA #1 identified she noticed there was insufficient clearance between the top of the wheelchair seat and the bottom of the harness where Resident #12 was being supported to allow him/ her to be lowered safely onto the wheelchair seat while the lift was at maximum height. Resident #12 was unable to stand and began sliding out of the sling harness. NA #1 grabbed a nearby gait belt, secured it around Resident #12's waist to assist with lowering where he/she came to rest on the footrests of the wheelchair. NA #1 further identified the lift and sling harness were new but looked different than what she was used to using. NA #1 was not included in the list of staff who were in-service.Interview with NA #2 on 3/09/26 at 11:57 AM identified she was the assigned nurse aide for Resident #12 during the 3:00 PM to 11:00 PM shift on 12/16/25. NA #2 indicated she used the new mechanical stand lift for the first time with Resident #12 after receiving in servicing. NA #2 indicated Resident #12 was on sitting the bed, dressed, wearing his/her orthotic footwear with both feet planted on the floor and secured in the sling harness. NA #2 enabled the lifting mechanism of the mechanical stand lift to raise Resident #12 to assist in transferring him/her from the bed to the wheelchair. NA #2 noticed at its maximum height, the lift was unable to clear the top of Resident #12's wheelchair seat. Resident #12 was unable to stand and began slipping out of the harness. NA #2 further identified a gait belt was used to lower Resident #12 who came to rest on the footrests of the wheelchair.Interview with the DNS on 03/10/26 at 7:49 AM identified she initially speculated the batteries stopped functioning when the chair was in the elevated position and purchased new batteries. The DNS later had to consider that the lift could not fully extend because the customized wheelchair for Resident #12 was too high to clear the seat to allow Resident #12 to be safely lowered onto the seat of the wheelchair. The DNS later was later informed by the Director of Rehabilitation that the sling harness for the new lift was too long. Shorter slings had since been purchased and the Director of Rehabilitation was responsible for ensuring the proper size and fit of the sling harness prior to use.Subsequent interview with the Director of Rehabilitation on 3/10/26 at 7:59 AM identified residents were evaluated by OT/PT for functional level and transfer status, with recommendations provided to nursing staff. Residents using a mechanical stand lift were assessed to ensure safe use of the equipment. Resident #12 had previously been assessed using his/her customized wheelchair and mechanical stand lift in part, to ensure adequate clearance between the wheelchair seat and resident while in the harness during a transfer. Nursing staff were then responsible for making adjustments to the sling harness up or down using a loop mechanism located on the side of the harness to accommodate the individual size of the resident and secure placement before transfer. The Director of Rehabilitation further identified he did not re-assess Resident #12's ability to complete a safe transfer using the new model and sling harness prior to its implementation lift, nor did he require staff to demonstrate competency during the in-service. Additionally, no further in servicing was provided to staff after the incident with the implementation of the new, shorter slings.The facility policy for Fall Management and Standards for Fall Reduction direct, in part to assess a resident's risk fir fall, implement interventions to reduce falls and periodically reassess effectiveness.Review of the facility policy for Total Mechanical Lifts and Sit to Stand Lifts directed all residents will be sized for the proper sling pad for sit to stand lifts by the rehabilitation department. Orders will be placed in the electronic clinical record and nurse aide care card.