STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075221	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pines at Bristol for Nursing & Rehabilitation, The	61 Bellevue Avenue Bristol, CT 06010

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation review, facility policy review and interviews for three of five residents (Residents #5, #6 and #7) reviewed for misappropriation, the facility failed to prevent the misappropriation of the residents' controlled narcotic medications. The findings include: Resident #5 was admitted with diagnoses that included lumbar intervertebral disc painful compression and stenosis (narrowing of the spinal canal) and heart failure. A nursing admission/readmission evaluation dated 1/4/2026 at 4:06 PM identified Resident #5 was alert and oriented to person, place, time and situation and needed moderate assistance for walking. An APRN note dated 1/4/2026 at 8:45 AM identified Resident #5 was hospitalized for intractable back pain and several falls at home. Resident #5 was diagnosed with a compression fracture of the lower back (lumbar or L5) and treated with a back brace and pain management. A physician order dated 1/4/2026 directed to administer Hydromorphone HCl (a narcotic pain medication) two (2) milligrams (mg) tablet by mouth every six hours (6) hours as needed. A Resident care plan (RCP) dated 1/5/2026 identified Resident #5 had pain. Interventions directed to administer pain medications as ordered. A physician order dated 1/6/2026 at 12:14 PM directed to discontinue use of Hydromorphone. A facility reportable event (RE) form dated 1/6/2026 at 3:15 PM identified an incidence of misappropriation; during controlled medication audit it was identified that a white original copy of the Controlled Substance Disposition Record (Proof of Use Sheet) was missing, and the associated blister card of 28 tablets of Hydromorphone 2 mg was missing from the medication lock box in the medication cart. LPN #3 was assigned as the unit charge nurse for Resident #5's unit on 1/6/2026 on the 7:00 AM to 3:00 PM shift. Notifications were completed to the Administrator, local law enforcement, state Consumer Protection Agency Drug Control Division (drug control) and the medical director. Interview and facility documentation review with the DON on 3/11/2026 at 9:10 AM identified two (2) nurses complete a shift-to-shift reconciliation (narcotic count) at the change of each shift. The shift process required a count of the narcotics in the medication lock box compared to the number of medication tablets listed as remaining on the Controlled Substance Disposition Record (Proof of Use Sheet). The process also included a count of the Proof of Use Sheets and required sign off by the off-going and on-coming nurse at shift change. The supervisor would be notified of any count discrepancy between the actual number of tablets in the lock box and the Proof of Use Sheet, so an investigation could be initiated immediately. On 1/6/2026 at 7:10 AM, a narcotic count reconciliation was completed on Resident #5's unit medication cart by LPN #3 and the off-going 11-7 AM nurse, LPN #4, and the reconciliation identified the count was correct. At 9:40 AM an audit was performed by the ADNS who verified that the count and Proof of Use Sheets were correct. At 3:05 PM on 1/6/2026, an audit was performed by the DON of the Proof of Use Sheets prior to the nurse-to-nurse end of shift narcotic count. The DON identified that the Proof of Use Sheet (#1514816) for Resident #5's Hydromorphone 2 mg (unused medication) blister packet with 28 tablets was not in controlled medication book, and she did not observe the blister pack with the Hydromorphone at that time (the box was locked). The DON then observed the shift change narcotic count at 3:15 PM completed by LPN #3 and the oncoming 3-11 PM nurse and they indicated the count was correct. The DON then checked the locked medication box (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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	after LPN #3 left the unit and identified the Hydromorphone 2 mg 28 tablets that should have been in the lock box (related to the missing Proof of Use sheet) was not in the box. LPN #3 was the only nurse who had the keys to access the narcotic book and the medications in the lock box on 1/6/2026 during the 7 AM to 3 PM shift, and she was also the nurse who noted the new physician order to discontinue the Hydromorphone. The DON concluded that LPN #3 had diverted Resident #5's Hydromorphone 2 mg blister pack. LPN #3 was an agency nurse, she notified the employer, and stated during a subsequent call with the agency she was notified the agency was unable to contact LPN #3. Interview with CT Drug Control Agent #1 on 3/11/2026 at 1:00 PM identified she had been in contact with the local police who identified that LPN #3 had no explanation for the 28 missing Hydromorphone 2 mg tablets. Drug Control Agent #1 stated attempts to contact LPN #3 were unsuccessful, and she concluded that LPN #3 must have diverted Resident #5's 28 tablets of Hydromorphone 2mg on 1/6/2026, 2. Resident #6 was admitted with diagnoses that included after care after joint replacement right hip and osteoarthritis. A nursing admission evaluation dated 12/18/2025 at 6:45 PM identified Resident #6 was alert and oriented to person, place, time and situation and needed moderate assistance for walking. An APRN note dated 12/19/2025 at 5:55 PM identified Resident #6 had a right hip replacement and had effective pain control with the current medication regimen. A physician order dated 12/18/2025 directed to administer Hydromorphone HCl give two (2) mg by mouth every four (4) hours as needed for moderate pain, and give four (4) mg tablet by mouth every four hours (4) hours as needed for severe pain (7- 10 out of 10 possible levels). A physician order dated 12/19/2025 directed to administer Hydromorphone HCl give two (2) mg by mouth every four (4) hours as needed for moderate pain (scale of 4 to6 out of 10 possible levels) for fourteen (14) days, hold for sedation or shortness of breath (sob) and report to provider. The order further directed to give four (4) mg tablet by mouth every four hours (4) hours as needed for severe pain (7- 10 out of 10 possible levels) for fourteen (14) days and hold for sedation or shortness of breath (sob) and report to provider. The RCP dated 12/22/2025 identified that Resident #6 had pain due to osteoarthritis and medical procedure. Interventions directed to administer medications as ordered. A facility reportable event (RE) dated 12/22/2025 at 1 PM identified an incident of misappropriation; during a narcotic audit it was identified that Resident #6's new blister pack of fifteen (15) Hydromorphone HCL (Dilaudid) 2 mg and the white disposition sheet were missing from the unit narcotics lock box. The MD, local police and the state drug control were notified, and an investigation was initiated. A facility RE summary dated 12/31/2025 identified Resident #6 had no adverse effects of the missing medication as there was an additional supply that was available for use as ordered. An audit of the entire facility controlled medications was completed and no other controlled medications were unaccounted for, and the State drug control completed an audit on 12/29/2025. The summary failed to identify how the medication was missing. Interview and facility documentation review on 3/11/2026 at 11:27 AM with the DON identified she completed the investigation regarding missing Hydromorphone for Resident #6. The Hydromorphone HCL 2 mg fifteen (15) tablets blister pack was received from the pharmacy on 12/19/2025. The audit completed on 12/22/2025 identified the Proof of Use Sheet was missing (#1494923) from the narcotic book, 3 days after the medication was delivered. The DON stated she compared staff assigned to that unit and narrowed the list to three (3) possible nurses, including one (1) nurse that was involved with a prior narcotic diversion, but she was unable to identify which nurse was involved. Review of a state Division of Consumer Protection, Drug Control Division report case number 2025-2550 dated 2/25/2026 identified the pharmacy delivered two (2) blister pack cards Hydromorphone, fifteen (15) tablets each card, to the facility on [DATE]. The order was confirmed on 12/19/2025 at 3:43 PM by LPN #3 who was scheduled on the 3 to11 PM shift on 12/19/2025, on Resident #6's unit, and LPN #3 had received the Hydromorphone delivered by the pharmacy. 3. Resident # 7 was admitted with diagnoses that included status post displaced fracture of the left femur and left hip replacement. A 5-day Minimum Data Set (MDS) assessment dated [DATE] identified Resident #7 had a Brief Interview for Mental Status (BIMS) score of 15 (was alert and (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	oriented), and had reported occasional pain in the past five (5) days. The RCP dated 11/28/2025 identified Resident #7 had pain related to the fracture with interventions that directed to evaluate the effectiveness of pain relief and respond immediately to complaints of pain. A physician order dated 12/2/2025 directed Oxycodone HCL (opioid medication for pain) 5 mg, give 1 tablet every 4 hours as needed for moderate hip pain and give 2 tablets by mouth for severe hip pain. A facility reportable event (RE) dated 12/11/2205 identified an incident of misappropriation; Resident #7's new blister pack of fifteen (15) tablets of Oxycodone 5 mg was missing from the narcotic lock box, and the matching white Proof of Use Sheet (#1366669) was missing. On 12/5/2025 the facility received two (2) blister packs of Oxycodone 5 mg, each blister pack contained 15 tablets, and only one (1) card of 15 tablets was present in the narcotic lock box - 15 tablets were missing. Review of the Medication Administration Record (MAR) identified no Oxycodone was administered and an investigation was initiated. A facility RE summary dated 12/21/2025 identified an house-wide controlled medication audit was completed, and no other controlled medications were unaccounted for. The summary failed to identify how the medication was missing. Interview and facility documentation review with the DON on 3/13/2026 at 10:26 AM identified she completed the investigation. The DON stated two (2) blister pack cards of 15 tablets of Oxycodone were delivered to the facility on [DATE]. An audit completed on 12/11/2025 identified the white Proof of Use Sheet #1366669 was missing from the unit controlled substance book, and the matching Oxycodone 5 mg, 15 tablet blister pack was missing. The DON suspected a diversion, and her investigation identified the white Proof of Use Sheet was not included in the narcotic count on 12/9/2025 at 11 PM (there were 13 sheets at 3 PM, and at 11 PM there were only 12 sheets in the book). Interview failed to identify how the Oxycodone was missing. Interview and documentation review with the DON on 3/13/2026 at 11:00 AM identified that LPN #3 was identified in each investigation above. The DON stated the facility had systems in place to attempt to prevent misappropriation of controlled medications, and she concluded that the missing narcotics for Resident #5, Resident #6 and Resident #7 were likely all taken by LPN #3. Although attempted, interviews with LPN #3 were not obtained during the survey. The facility Abuse Policy dated 12/2023 directed in part, that each resident has the right to be free from misappropriation of resident property. Misappropriation of Resident Property was defined as the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings without the resident's consent.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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 clinical record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #1) reviewed for a change in condition, facility failed to ensure medication was administered in timely accordance with physician orders, and failed to ensure the resident was transferred to the hospital after Narcan was administered two times, in accordance with facility policy. The findings include: Resident #1's diagnoses included overactive bladder and chronic pain syndrome. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of fifteen out of fifteen, indicative of no cognitive impairment, and received an opiod medication. The Resident Care Plan (RCP) dated 2/4/2026 identified chronic pain. Interventions directed to administer medication as ordered and to notify physicians if interventions are unsuccessful or of a significant change from residents past pain experience. A physician order dated 1/29/2026 directed Oxycodone HCl give 2.5 mg by mouth every four (4) hours for pain. Review of the Medication Administration Record (MAR) identified the Oxycodone 2.5 mg was scheduled to be administered every four (4) hours at midnight, 4 AM, 8 AM, 12 PM, 4 PM and 8 PM. Review of February 2026 Medication Administration Record (MAR) identified the scheduled the 4 AM dose of Oxycodone 2.5 mg was signed as administered at an unidentified time. Interview and record review on 3/3/2026 at 3:15 PM with RN #3, identified on 2/4/2026 she was the supervisor on the 11 PM to 7 AM shift and she accessed the automated medication machine to obtain an Oxycodone 5 mg tablet for Resident #1. RN #3 stated she and another nurse broke the tablet in half, and gave the half dose (2.5 mg) to LPN #1 to administer to Resident #1. RN #1 stated she did not recall if LPN #1 was late with administering scheduled medications. Interview and record review with LPN #2 on 3/3/2026 at 1:46 PM identified she was the charge nurse on 2/4/2026 and was late with passing morning medications when Resident #1 had pain and required Oxycodone 2.5 mg to be administered about 6:30 AM. Review of Resident #1's MAR identified an Oxycodone 2.5 mg tablet was obtained at 6:30 AM from the facility automated medication machine by the supervisor and another nurse for administration. LPN #2 stated she did not recall the time she administered the medication to Resident #1. Interview and review of pharmacy Activity Transaction Report dated 2/4/2026 for Resident #1 with Pharmacist (RPH) #1 on 3/3/2026 at 1:23 PM identified an Oxycodone 5 mg tablet was removed/used from the automated medication dispenser unit with a Used On Date of 2/4/2026 at 6:30 AM by RN #2 and the report indicated half of the dose was discarded at 6:32 AM (2.5 hours after the 4 AM dose was scheduled to be administered) by RN #3 and another nurse (unidentified). The DNS and ADNS were unavailable for interview during the survey. Interview and record review with RN #4/Infection Control Nurse identified the Oxycodone that was removed from the automated emergency medication machine was removed at 6:32 AM (2 hours and 32 minutes after the dose was scheduled), and the dose was scheduled at 4 AM, indicating the dose was administered late. A physician order dated 2/4/2026 directed Oxycodone HCl oral tablet 5 milligrams (mg) orally one-time only, for pain. Additional order directed Naloxone HCl Liquid 4 mg/1 milliliter (ml) one (1) spray in nostril as needed for known or suspected opioid overdose with signs of breathing problems and severe sleepiness. Repeat after three (3) minutes if no or minimal response. Review of February 2026 Medication Administration Record (MAR) identified the scheduled 8 AM dose Oxycodone HCl 2.5 mg was changed to give the one-time five (5) mg dose and was administered on 2/4/2026 at 9:16 AM by LPN #1. Additional review identified although Resident #1 received the 4 AM dose of Oxycodone 2.5 mg at an unidentified time, he/she received the one-time dose of Oxycodone 5 mg at 9:16 AM. The nursing note dated 2/4/2026 at 1:03 PM by LPN #1 identified resident had a one-time dose of Oxycodone 5 mg in the morning and was very sedated from the medication. Blood pressure (BP) was 89/56, at 12:20. APRN #1 was notified and directed to administer Narcan via left nostril. Repeat blood pressure was 120/56, pulse 55, respirations 8, and Resident #1 was not responsive to Narcan administration. At (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	12:55 PM this writer was instructed to administer a second dose of Narcan via the right nostril. Vital signs after Narcan administration were BP 115/71, pulse 68, respirations 16, resident responsive to second Narcan dose and Resident #1 was actively talking and responding to questions, alert, oriented times four (4) (person/place/time/situation). Nursing note dated 2/4/2026 at 2:48 PM, written by RN #1, identified Resident #1 was lethargic and slow to respond after administration of Oxycodone 5 mg for pain, vital signs indicated low oxygen saturation and respirations were 12 (normal 12 to 20). Resident #1 was placed on oxygen and slowly continued to respond. The APRN was notified, reassessed resident, and ordered Narcan for resident, not responsive at first, second dose ordered, resident slowly responded and awakened, alert and oriented, no adverse effects noted since recovery. Review of February 2026 MAR identified Naloxone HCl Liquid (Narcan) 4 mg/1 milliliter (ml) one (1) spray was administered at 12:20 PM and at 12:40 PM. Record review failed to identify Resident #1 was transferred to the hospital for evaluation after the Narcan was administered. Interview, review of record on 3/3/2026 at 11:56 AM with RN #2 identified that she covers the first-floor unit from 7 AM to 9 AM. RN #2 stated on 2/4/2026 LPN #1 had indicated Resident #1 was in pain, and was awaiting refill/delivery of scheduled Oxycodone 2.5 mg. RN #2 obtained an order from APRN #1 to administer Oxycodone 5 mg one time only. RN #2 stated LPN #1 did not have access to the automated emergency medication dispenser, so she and another nurse obtained the Oxycodone 5 mg tablet from dispenser, and LPN #2 administered the medication to the patient. Review of pharmacy Activity Transaction Report dated 2/4/2026 for Resident #1 indicated Oxycodone 5 mg tablet was Used On Date 2/4/2026 at 9:13 AM. Interview and record review with LPN #1 on 3/3/2026 at 12:08 PM identified on 2/4/2026 Resident #1 was experiencing pain (scale #7 out of 10) and Resident #1's regularly scheduled Oxycodone 2.5 mg dose was not available in the medication cart. LPN #1 notified RN #2/supervisor who obtained an order for Oxycodone 5 mg from the APRN. RN #2 obtained the Oxycodone 5 mg from the emergency dispenser system and LPN #1 then administered the Oxycodone 5 mg to Resident #1 at 9:16 AM. LPN #1 stated prior to lunch Resident #1 was not responding, the supervisor assessed Resident #1, and APRN #1 arrived on the unit. APRN #1 gave new orders to administer Narcan, and after 20 minutes APRN #1 said to give a resident a second dose. LPN #1 stated there was no discussion regarding facility policy, calling 911 or sending Resident #1 to the emergency department for evaluation after the Narcan administration. LPN #1 stated after the incident, she was notified if a patient/resident requires Narcan, the resident must be sent to the hospital for evaluation after administration. Interview, record review and facility policy review on 3/3/2026 at 12:35 PM with APRN #3 (Corporate ARPN) and APRN #2 identified they both provide services at the facility. APRN #3 stated when a resident experiences a significant change in condition and requires Narcan administration, the decision to send them to the hospital depends on how the resident responds, if resident becomes more alert, more towards baseline, vital signs and neuro stabilized. APRN #2 stated it was not unusual to give two (2) doses of Narcan, and the second dose should be given right away if the resident does not respond. APRN #2 stated the facility policy directed the second dose of Narcan should be given within two (2) to three (3) minutes of the first dose. Interview and record review with RN #1 on 3/3/2026 at 1:05 PM identified she was the supervisor on 2/4/2026 when the Nurse Aide (NA) reported Resident #1 was not waking up, opened his/her eyes but fell back to sleep. RN #1 assessed Resident #1 and APRN #1 assessed Resident #1 and ordered Narcan administration. The first dose was given without effect and a second dose was administered. RN #1 stated she asked APRN #1 if he wanted to send Resident #1 to the hospital and he responded no. After the second dose of Narcan, Resident #1 slowly woke up which took about three (3) to five (5) minutes. RN #1 stated she left the room after the first dose of Narcan was administered, and LPN #1 and APRN #1 stayed with Resident #1. RN #1 stated the facility policy directs a resident should be transferred to the hospital if Narcan is administered. Further, RN #1 stated review of the facility automated medication machine identified although a dose of Oxycodone 5 mg was taken out of the emergency dispenser at 6:30 AM for Resident #1, and the second dose taken out at 9:13 AM. RN #1 stated based on the (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	emergency dispenser information, the Oxycodone was administered too early, it was not administered every four (4) hours as per physician orders. Interview and review of pharmacy Activity Transaction Report dated 2/4/2026 for Resident #1 with Pharmacist (RPH) #1 on 3/3/2026 at 1:23 PM identified an Oxycodone 5 mg tablet was removed/used from the automated medication dispenser unit with a Used On Date of 2/4/2026 at 9:13 AM by RN #2 and another nurse. RPH #1 stated the automated medication machine report identified that an additional Oxycodone 5 mg was removed at 6:30 AM by RN #2 and the report indicated half of the dose was discarded at 6:32 AM (2.5 hours after the 4 AM dose was scheduled to be administered) by RN #3 and another nurse (unidentified). Interview and record review on 3/4/2026 at 12:47 PM with APRN #3 (corporate) and APRN #1 identified APRN #1 ordered the one-time 5 mg dose of Oxycodone. APRN #1 stated he assessed Resident #1 and he ordered the Narcan to be administered. APRN #1 stated he was not aware of the facility Narcan (Naloxone) Administration Policy facility policy directed if a second dose of Narcan was needed that it was to be administered three (3) minutes after the initial dose. The DNS and ADNS were unavailable for interviews during the survey. Interview and record review with RN #4/Infection Control Nurse identified Resident #1 remained sedated after the initial Narcan dose was administered, and required a second dose to be administered. The first dose was administered at 12:20 PM, and the second dose was administered at 12:55 PM. RN #4 stated facility policy directed a second dose to be administered two (2) to three (3) minutes after the first dose. Interview failed to identify why there was a delay in administering the second dose. RN #4 further stated Resident #1 was not transferred to the hospital per the APRN direction. RN #4 stated the Oxycodone that was removed from the automated emergency medication machine was removed at 6:32 AM (2 hours and 32 minutes after the dose was scheduled), and the dose was scheduled at 4 AM, indicating the dose was administered late, and the next dose that was due at 8 AM was administered at 9:13 AM (2 hours and 41 minutes later). RN #4 indicated the gap between the 6:32 AM and 9:13 AM Oxycodone doses was less than the every four (4) hours ordered, and the medications should have been administered on time. Review of facility Narcan (Naloxone) Administration Policy directed in part, residents who receive naloxone must be evaluated for transport to an emergency department. Review of facility Naloxone Standing Order: Administration of Intranasal Naloxone to Any Person Suspected of Opioid Overdose directed in part, a licensed clinical staff member must stay with the patient and assess effects of naloxone. After 3 minutes, if there is no response, or only a partial response* to the first dose of naloxone, a second dose may be administered by a provider into the alternate nostril.