

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075230	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2025
NAME OF PROVIDER OR SUPPLIER Ledgecrest Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 154 Kensington Rd Kensington, CT 06037	
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 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 clinical record reviews, facility documentation, facility policy, and interviews for one (1) of three (3) sampled residents (Resident #2) who was a new admission, the facility failed to develop and implement interventions to address a resident who was incontinent of urine. The findings include: Resident #2's diagnoses included dementia and benign prostatic hyperplasia. The admission nursing assessment dated [DATE] identified Resident #2 was incontinent of bowel and bladder. Review of the baseline care plan given to the resident/representative on 6/23/25 identified Resident #2 was at risk for skin breakdown. Interventions directed to keep the skin clean and dry and apply barrier cream with incontinent care. Upon further review, the care plan failed to address Resident #2's incontinence. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #2 had a Brief Interview for Mental Status (BIMS) score of eight (8) out of fifteen (15) indicating Resident #2 had poor memory recall deficits, required extensive assistance of one (1) staff for toilet use, limited one (1) person assistance with transfers, and was occasionally incontinent of urine and frequently incontinent of bowel. Review of the bladder flowsheets from 9/10/25 through 9/30/25 identified Resident #2 was incontinent of urine on at least one (1) shift for twelve (12) out of twenty-one (21) days and four (4) out of twenty-one (21) days did not have any documentation for the 3-11:00 PM shift. Review of the Accident and Incident (A&I) form dated 10/3/25 at 12:20 AM identified Resident #2 attempted to go to the bathroom unassisted and fell. Although the risk for falls care plan was updated on 10/8/25 with the intervention to offer and assist with toileting at the beginning of third shift, the care plan failed to identify Resident #2's incontinence was addressed. Interview and record review with the Corporate Nurse on 10/9/25 at 1:45 PM identified upon review of Resident #2's care plan, the only information it contained in regards to Resident #2's incontinence was under the skin breakdown care plan with the intervention to apply barrier cream with incontinence episodes. Review of the care planning policy directed that a comprehensive and individualized plan of care will be developed for each resident. The care plan will guide caregivers to assist residents to achieve or maintain their highest practical level of wellbeing. The policy directed that the care plan will include a statement of the problem/focus, reasonable and measurable goals, interventions to achieve these goals and the discipline(s) responsible for carrying out the interventions.		

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 clinical record reviews, facility documentation, facility policy, and interviews for one (1) of two (2) sampled residents (Resident #1) who received a scheduled and as needed pain medication, the facility failed to document the administration and follow up of the as needed pain medication. The findings include: Resident #1's diagnoses included malignant cancer and lumbar radiculopathy (compression of nerves in lower back). The annual Minimum Data Set assessment dated [DATE] identified Resident #1 had no memory recall deficits, received a scheduled and as needed pain medication regimen, the pain was frequent, occasionally effected the sleep pattern, almost constantly interfered with day-to-day activities, and rated the pain on the scale, seven (7) out of ten (10). The Resident Care Plan dated 8/20/25 identified Resident #1 was at risk for pain and discomfort. Interventions directed to administer medications as ordered and determine the level of pain using the pain scale before administering the medications. Review of the September 2025 control drug record identified on 9/26/25 Resident #1 received Oxycodone 5 milligrams (mg) at 9:30 PM. Review of the September 2025 Medication Administration Record (MAR) failed to identify documentation that the Oxycodone was administered at 9:30 PM and a follow up response (effective or ineffective) to the as needed medication. Interview with the 3-11PM nurse, Registered Nurse (RN) #1, on 10/9/25 at 12:45 PM identified on 9/26/25 she administered 5 mg of Oxycodone to Resident #1 around 9:30 PM. RN #1 explained she forgot to enter the administration of the medication into MAR and she believed she had followed up with Resident #1 about an hour later and Resident #1 was resting in bed. Interview with the Corporate Nurse on 10/9/25 at 1:45 PM identified narcotic sheets are not part of the resident's clinical record and when a medication is administered this should be documented on the MAR or in a nurse's note. Review of the liberalized medication administration policy directed PRN (as needed) medications are administered as needed for physician's order, with documentation reflecting indication and effectiveness. Review of the pain management policy directed to document all findings in the resident's medical record. Reassess pain levels after any intervention to evaluate effectiveness. Document all pain assessments, interventions and resident responses in the medical record.		