STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075230	A. Building B. Wing	04/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ledgecrest Health Care Center	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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of the clinical record, facility documentation, facility policy and interviews for 1 of 2 sampled residents (Resident #47) reviewed for dignity, the facility failed to ensure toileting for a dependent resident was provided in a dignified manner. The findings include:Resident #47 ?s diagnoses included sepsis, calculus of the gallbladder with chronic cholecystitis without obstruction and generalized anxiety.The admission Nursing assessment dated [DATE] identified Resident #47 had a Brief Interview for Mental Status score of 8, indicating moderately cognitively impaired, required substantial maximal assistance with bed mobility, dressing, personal hygiene, was dependent on staff for toileting, and had episodes of both continence and incontinence. Resident #47 was Spanish speaking and required an interpreter for communication. The Resident Care Plan dated 4/10/26 identified Resident #47 needed staff assistance with Activities of Daily Living, assistive devices: wheelchair, and walker. Interventions included to assist as needed to meet toileting needs, incontinent care per policy, keeping commonly used/needed items within reach, Physical and Occupational Therapy as ordered, transfers per physician orders.A review of the Accident/Incident Report dated 4/10/26 identified a family member reported on 4/9/26 at 3:30 PM to Social Worker #1 (SW) that staff told Resident #47 to stay in bed for voiding.A review of NA #1's statement dated 4/9/26 indicated she asked NA #1 to assist with translating since Resident #47 was Spanish speaking only. NA #1 asked Resident #47 if he/she needed anything or if he/she wanted to use the bathroom. Resident #47 replied he/she did not want to go to the bathroom because of recent surgery, and he/she was in pain. NA #2 reassured Resident #47 not to worry that if he/she needed to, he/she could use the incontinent product he/she was wearing. NA #1 indicated she explained to Resident #47 how to use the call bell, and the NA would assist and change him/her as needed.A review of the Director of Nursing investigation dated 4/15/26 identified that a family member reported a concern that Resident #47 was instructed by staff to go in his/her brief. An investigation was immediately initiated. In the context of Resident #47 expressing discomfort and hesitation to move, NA #1 reassured Resident #47 if he/she experienced urgency and could not wait, staff would promptly assist with hygiene care and ensure he/she was cleaned and changed. This was intended to reduce anxiety given Resident #47's post operative status and new admission, not to discourage toileting or to replace assistance with the bathroom. The facility was not able to substantiate the allegation of neglect.Interview with Social Worker #1 on 4/14/26 at 9:45 AM identified that Resident #47 was Spanish speaking and a family member or a Spanish speaking staff member was able to translate. The family member came to her on Friday 4/9/26 very unhappy that the NA told Resident #47 to void in bed. SW #1 went to the Director of Nursing, and she took over the investigation.An interview with NA #2 on 4/14/26 at 12:53 PM indicated nothing happened on Friday 4/9/26 with Resident #47. When asked about the statement NA #1 had written, the phone disconnected. A reinterview was attempted but NA #1 did not answer the phone.An Interview with the Director of Nursing (DON) and Regional Nurse (RN #4) on 4/14/26 at 1:37 PM identified the Social Worker came to the DON with concerns from a family member identifying the staff had told Resident #47 to void in bed. Resident #47 was (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	upset because the staff told him/her to void in bed. The family member engaged the call bell and the staff came, took Resident #47 to the bathroom, and he/she voided. NA #2 was assigned to Resident #47, NA #1 (who translated) was not assigned to the resident. Review of NA #1's statement identified that NA #1 had written she instructed Resident #47 to void in his/her incontinent product. The DON and RN #4 indicated instructing Resident #47 to void in his/her diaper was not appropriate. Additionally, NA #1 failed to notify the nurse that Resident #47 was having pain, and this was why Resident #47 did not want to get up to use the bathroom. The DON indicated that Resident #47 was continent with incontinence and retention and had a urology follow up.An interview with NA #2 was attempted but not obtained.A review of the Resident's Rights policy directed, in part, you have the right to be treated with consideration, respect, full recognition of your dignity and individuality. You have the right to receive care and services with reasonable accommodation of your individual needs and preferences, except when your health or safety or the health or safety of others would be endangered by such accommodation

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation/policy, and interviews for one (1) of one (1) sampled resident (Resident #53) reviewed for adequate supervision, the facility failed to ensure adequate supervision and implementation of interventions following an initial physical altercation, when staff did not maintain continuous observation of Resident #53 despite known agitation and violent behavior. This failure was not in accordance with facility policy requiring one-to-one supervision during emergent situations and subsequently Resident #53 re-engaged in violent behavior, resulting in a second altercation and injuries to both the resident and a staff member. The findings include:Resident #53's diagnoses included vascular dementia, history of a traumatic brain injury, and chronic kidney disease.The quarterly Minimum Data Set assessment dated [DATE] identified Resident #53 had moderately impaired cognitive function (Brief Interview for Mental Status (BIMS) score of 12) and was independent with all care including bed mobility and transfers in and out of the bed and chair.The Resident Care Plan dated 12/23/25 identified Resident #53 had anxiety, dementia and was at risk for mood changes. Interventions directed to encourage relaxation techniques such as music therapy, talking with the resident, medications as ordered, use of short and simple sentences, offer support, and report changes in mental status.The nurse's note dated 3/24/26 at 10:37 PM by RN #5 (the 3:00 PM to 11:00 PM supervisor) identified at approximately 7:00 PM, Resident #53 was seen by NA #4 taking food from another resident who was sleeping. Resident #53 became upset and threw the croissant at NA #4 hitting NA #4 in the face. RN #5 summoned LPN #1 (the 3:00 PM to 11:00 PM charge nurse) for assistance. The situation was diffused and the police were called. Next, Resident #53 was witnessed grabbing a pencil from the desk and trying to stab NA #4. The police arrived and Resident #53 and NA #4 were separated. Resident #53 was taken to the hospital to be evaluated.The nurse's note dated 3/24/26 at 11:39 PM by LPN #1 identified he/she was called to deescalate a situation with Resident #53 and escort him/her back to his/her room. Shortly after, there was another commotion and NA #4 and Resident #53 were seen standing in front of the nurse's station holding onto each other's clothing. LPN #1 observed blood coming from Resident #53's forehead and left wrist and separated them. The police arrived on scene and prevented further altercation.An interview with NA #5 (the 3:00 PM to 11:00 PM nurse aide) on 4/20/26 at 11:15 AM identified on 3/24/26 NA #4 went to the break room and told NA #5 that she saw Resident #53 go into another resident's room and take a croissant that his/her family provided. NA #4 told Resident #53 to put it back and when NA #4 tried to take it from Resident #53, Resident #53 struck NA #4. While discussing the incident, NA #5 witnessed Resident #53 charge at NA #4 who was standing at the open door of the break room. Resident #53 began punching NA #4 and NA #4 was shielding herself with her hands. LPN #1 arrived and tried to pull Resident #53 away from NA #4 while NA #5 and another staff member tried to pull NA #4 away from Resident #53. Once separated, NA #4 went to the bathroom which was near the nurse's station to tend to her bleeding mouth. As she walked out of the bathroom, Resident #53 grabbed a pencil from the nurse's station and tried to run towards NA #4 but was stopped by LPN #1. NA #5 further identified during the altercation that NA #4 inadvertently struck Resident #53 while trying to protect herself because Resident #53 kept charging at her and saying, I'm going to kill you.An interview with LPN #1 on 4/20/26 at 11:30 AM identified on 3/24/26 RN #5 asked him/her to assist with Resident #53 and escort Resident #53 back to his/her room to prevent agitation because there had been an altercation between Resident #53 and NA #4. During the walk back to the room Resident #53 repeatedly expressed he/she was not a thief. LPN #1 left Resident #53 in his/her room and proceeded to pass medications. When LPN #1 walked past the nurses station, LPN #1 overheard NA #4 state she was going to call the police because Resident #53 struck her. LPN #1 did not return to Resident #53's room and Resident #53 was left unattended for approximately ten (10) to fifteen (15) minutes before (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN #1 saw that Resident #53 exited his/her room and was in front of the nurse's station holding NA #4 by the shirt collar. NA #4 was attempting to pry Resident #53's fingers off and LPN #1 was trying to separate them. Other staff were present and tried to assist until the police arrived. During the altercation Resident #53's glasses were broken and Resident #53 sustained a scrape to the head and wrist. NA #4 was injured with a cut to the forehead. RN #5 was present throughout the entire event and never directed LPN #1 to stay with Resident #53. LPN #1 could not recall if he had been trained to stay with a resident during an emergency until Emergency Medical Services (EMS) arrived.Interview with the Assistant Director of Nursing (ADON) on 4/20/26 at 12:00 PM identified on 3/24/26 NA #4 reported the sequence of events that occurred. The ADON viewed video footage and identified Resident #53 and NA #4 were in the hallway when Resident #53 threw a croissant at NA #4 then struck NA #4 several times and tried to grab NA #4. NA #4 raised her hands trying to block Resident #53. Resident #53 then grabbed a pencil from the nurses station and went after NA #4. The remainder of the incident was out of video frame. Video footage supported that Resident #53 grabbed and struck NA #4. No one stayed with Resident #53 after the initial altercation in the hallway and the ADON identified a staff member should have remained with Resident #53 until EMS arrived. The ADON further identified the facility failed to follow its Emergency Policy.Review of annual training for LPN #1 identified he received emergency training within the year.Although attempted, interviews with RN #5, NA #4, or by Person #1 were not obtained.Review of the facility policy titled Emergency Care identified the Nursing Supervisor or designee will direct the provision of emergency care until relieved by EMS to include assessing & ensuring scene safety - protect resident, visitors, and staff and ongoing monitoring. The policy further identified condition specific emergency response for Psychiatric Emergencies (acute disturbance) would include calling 911, removing potential harmful objects and providing 1:1 supervision.