STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075236	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Noble Horizons	17 Cobble Rd Salisbury, CT 06068

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. Based on observation, clinical record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #1) reviewed for accidents, the facility failed to ensure the resident was treated with respect and dignity after a fall. The findings include: Resident #1 was admitted with diagnoses that included dementia. A resident care plan (RCP) dated 12/18/2025 identified Resident #1 was at risk for falls and required assistance for activities of daily living (ADL). Interventions included to anticipate Resident #1's needs and contact guard assist of two (2) for transfer. A significant change Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 3/10/2026 identified Resident # 1 had a Brief Interview for Mental Status (BIMS) score of four (4), indicated he/she had severe cognitive impairment, was dependent for personal hygiene, bed mobility and for transfer, and had an indwelling catheter to drain urine. A facility reportable event (RE) dated 3/25/2026 at 9:30 AM identified the DON had received a statement via email from RN #1 (the 3 to 11 PM supervisor) who expressed concern that on 3/24/2026 at 10:00 PM NA #1 had stated I hope you learned your lesson and was laughing at Resident #1 after Resident #1 had fallen. A RE summary dated 4/1/2026 identified on 3/24/2026 at 10 PM, indicated that RN #1/supervisor was on the phone when he heard NA #1 making a comment If you keep leaning forward, I am going to let you fall. After a loud noise, RN #1 went out and observed Resident #1 on the floor and NA #1 laughed. Resident #1 had no recollection of events leading up to fall or interaction with staff after the fall. After the fall, NA #2 and NA #3 observed NA #1 laughing at Resident #1's fall and had notified the RN #1 of their concerns. The investigation determined the allegation was unsubstantiated; the resident was unharmed and not affected by this interaction and NA #1 was reeducated to professionalism in the workplace and proper communication/dialogue with residents. Interview and review of facility documents with NA #1 on 4/23/2026 at 10:16 AM identified she was assigned to Resident #1 on 3/24/2026 on the 3:00 to 11:00 PM shift. Resident #1 was fidgeting and staff kept him/her up in the wheelchair by the nurse's station to monitor. Resident #1 kept leaning forward in the wheelchair, but did not follow NA #1's directions and NA #1 got up and went behind Resident #1 to attempt to reposition Resident #1 in the wheelchair. Resident #1 leaned too far forward and fell to the left onto the floor. NA #1 stated Resident #1 was too big for her to reposition alone and she did not call for assistance. NA #1 denied telling Resident #1 that she would let the resident fall or hoping he/she learned his/her lesson, and denied laughing after the fall occurred. Interview and record review with NA #3 on 4/23/2026 at 11:29 AM identified on 3/24/2026 she observed Resident #1 on the floor and NA #1 was laughing, and NA #1 stated Resident #1 leaned too far forward and fell out of the wheelchair. NA #3 stated she told NA #1 that it was not funny and to stop laughing. Interview with NA #2 on 4/3/2026 at 2:17 PM identified on 3/24/2026 she observed Resident #1 on the floor and she saw NA #1 was laughing. When NA #2 asked NA #1 what was going on, NA #1 responded Resident #1 had fallen out of the wheelchair and NA #2 told NA #1 that making fun of the situation didn't help. Interview and record review with the DON on 4/23/2026 at 1:02 PM identified RN #1 reported she heard NA #1 say to Resident #1, If you keep leaning forward, I'm going to let you fall. RN #1 reported he then heard a loud noise and then heard NA #1 say I told you before. RN #1 then observed Resident (continued on next page)

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	#1 on the floor and NA #1 was observed in a reclined position with her feet elevated and did not appear to have made any attempt to prevent Resident #1's fall. NA #1 laughed following the incident and another NA responded, That's not funny. NA #1 then responded to Resident #1 stating I hope you learned your lesson. The DON stated the comments and laughing at a resident after a fall was disrespectful, and NA #1 should not have responded in that manner. Although attempted, RN #1 and LPN #1 (charge nurse) were unavailable for interview during survey. The facility's Resident [NAME] of Rights dated 6/3/2003 directed in part, that residents have the right to be treated with consideration, respect and full recognition of their dignity and individuality.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on observation, clinical record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #1) reviewed for accidents, the facility failed to ensure staff reported an allegation of mistreatment timely. The findings include: Resident #1 was admitted with diagnoses that included dementia. A resident care plan (RCP) dated 12/18/2025 identified Resident #1 was at risk for falls and required assistance for activities of daily living (ADL). Interventions included to anticipate Resident #1's needs and contact guard assist of two (2) for transfer. A significant change Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 3/10/2026 identified Resident # 1 had a Brief Interview for Mental Status (BIMS) score of four (4), indicated he/she had severe cognitive impairment, was dependent for personal hygiene, bed mobility and for transfer, and had an indwelling catheter to drain urine. A facility reportable event (RE) dated 3/25/2026 at 9:30 AM identified a Class B (abuse) event occurred. The RE indicated on 3/24/2026 at 10:00 PM there was an allegation of mistreatment, and the DON was not notified until she received a statement via email from RN #1 (the 3 to 11 PM supervisor) on 3/25/2026 at 9:30 AM. The email identified a concern that on 3/24/2026 at 10:00 PM NA #1 had stated I hope you learned your lesson and was laughing at Resident #1 after Resident #1 had fallen. A RE summary dated 4/1/2026 identified on 3/24/2026 at 10 PM, indicated that RN #1/supervisor was on the phone when he heard NA #1 making a comment If you keep leaning forward, I am going to let you fall. After a loud noise, RN #1 went out and observed Resident #1 on the floor and NA #1 laughed. Resident #1 had no recollection of events leading up to fall or interaction with staff after the fall. After the fall, NA #2 and NA #3 observed NA #1 laughing at Resident #1's fall and had notified the RN #1 of their concerns. The investigation determined the allegation was unsubstantiated; the resident was unharmed and not affected by this interaction and NA #1 was reeducated to professionalism in the workplace and proper communication/dialogue with residents. Interview and record review with the DON on 4/23/2026 at 1:02 PM identified she did not receive the email until the morning of 3/25/2026 about 9:30 AM (11 hours and 30 minutes after the incident was reported to have occurred). Upon reading the email, the DON immediately implemented the facility's abuse policy including suspending NA #1, and reporting the allegation to local and State authorities, the provider and family as required and initiated an investigation. The DON stated she did not know why RN #1 did not report the concerns when it occurred, and it should have been reported immediately. Although attempted, an interview with RN #1 was unable to be obtained during survey. The facility's Abuse policy dated 6/6/2024 directed in part, reports of alleged abuse by a resident or family member will be immediately reported to the DON, ADON, Administrator and/or supervisor. Verbal abuse was defined as the use or oral, written or gestured language that willfully includes disparaging and derogatory terms to the resident or within hearing distance. Examples include but are not limited to threats of hard and saying things to frighten a resident.

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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 - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, clinical record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #1) reviewed for accidents, the facility failed to ensure repositioning was provided safely and adequate supervision was provided to prevent a fall. The findings include: Resident #1 was admitted with diagnoses that included dementia. A resident care plan (RCP) dated 12/18/2025 identified Resident #1 was at risk for falls and required assistance for activities of daily living (ADL). Interventions included to anticipate Resident #1's needs and contact guard assist of two (2) for transfer. A significant change Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 3/10/2026 identified Resident # 1 had a Brief Interview for Mental Status (BIMS) score of four (4), indicated he/she had severe cognitive impairment, and was dependent for personal hygiene, bed mobility, moving side to side, and for transfers, and had a foley catheter for urinary drainage. Further, the MDS indicated Resident #1 was 67 inches (5 foot, 7 inches) tall and weight 199 pounds. A facility reportable event (RE) dated 3/24/2026 at 9:30 AM identified Resident #1 had a fall. Resident #1 was seated at the nurse's station with NA #1 seated next to him/her due to fidgeting behaviors. Resident #1 kept sliding forward in the wheelchair and leaning forward. RN #1 reported he heard NA #1 say to Resident #1, If you keep leaning forward, I am going to let you fall. NA #1 reported I got up to help him/her move back, but he/she just kept leaning forward. I was trying to hold him/her up while trying to pull Resident #1 back, but she/she was too heavy to move alone. Resident #1 fell forward and to the left side into a door headfirst. RN #1 was notified, and an assessment was completed. No injury was noted from the fall. A RE summary dated 4/1/2026 identified on 3/24/2026 at 10 PM, indicated that RN #1/supervisor was on the phone when he heard NA #1 making a comment If you keep leaning forward, I am going to let you fall. After a loud noise, RN #1 went out and observed Resident #1 on the floor and NA #1 laughed. Resident #1 had no recollection of events leading up to the fall or interaction with staff after the fall. After the fall, NA #2 and NA #3 observed NA #1 laughing at Resident #1's fall and had notified the RN #1 of their concerns. NA #1 explained she was sitting with two residents who were both trying to stand and both residents had been recently toileted. NA #2 and NA #3, the other NAs on the unit, were attending to another resident. Resident #1 kept sliding forward in her/his wheelchair and leaning forward. NA #1 attempted to redirect Resident #1 to not lean forward and to slide back in the wheelchair. NA #1 got up to try to help him/her move back, but Resident #1 just kept leaning forwards. NA #1 attempted to hold Resident #1 up while trying to pull him/her back, but Resident #1 was too heavy for NA #1. Resident #1 fell forward and to the left side into the door headfirst. Interview and review of facility documents with NA #1 on 4/23/2026 at 10:16 AM identified she was assigned to Resident #1 on 3/24/2026 during the 3:00 to 11:00 PM shift, and due to Resident #1's continued fidgeting, he/she was in a the wheelchair by the nurse's station. Resident #1 kept leaning forward in the wheelchair and seemed to be focused on the urinary catheter. NA #1 redirected Resident #1 multiple times to sit further back in the chair and to sit up. NA #1 stated the foley catheter was positioned correctly. At around 10:00 PM, NA #1 was sitting next to Resident #1, but when Resident #1 did not respond to directions to sit up or move back in the wheelchair, NA #1 got up and went behind Resident #1 to attempt to assist Resident #1 to mover her/his bottom to the back of the wheelchair. NA #1 stated Resident #1 was too far forward and fell to the left onto the floor and hit his/her head on the door. NA #1 then called for assistance. NA #1 stated Resident #1 was too big for her to reposition by herself and she did not call for assistance to reposition Resident #1. NA #1 stated she should have asked another staff member to assist her to reposition Resident #1, and she should not have tried to reposition Resident by herself. Interview failed to identify why NA #1 did not request assistance to reposition Resident #1, and failed to identify why NA #1 was sitting in a reclined position next to Resident #1 with her feet elevated after Resident #1 fell. Interview and record review (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with NA #3 on 4/23/2026 at 11:29 AM identified for NA #1 did not ask for assistance prior to attempting to reposition Resident #1 in the wheelchair on 3/24/2026. Interview with NA #2 on 4/3/2026 at 2:17 PM identified NA #1 did not ask for assistance prior to Resident #1's fall on 3/24/2026. Interview and record review with PT #1 on 4/23/2026 at 3:15 PM identified if Resident #1 was leaning too far forward, and was not responding to staff directions, two (2) staff were required to reposition him/her in the wheelchair. Interview and record review with the DON on 4/23/2026 at 1:02 PM identified Resident #1 required two (2) staff assistance for repositioning. On 3/24/2026, at about 10 PM, Resident #1 was leaning forward in the wheelchair and sliding, and NA #1 attempted to reposition Resident #1 without obtaining any additional staff assistance. RN #1 (shift supervisor) reported was in his office when he heard NA #1 say to Resident #1, If you keep leaning forward I'm going to let you fall. He then heard a loud noise and heard NA #1 state I told you before. Upon exiting the office, he observed Resident #1 on the floor. NA #1 was observed in a reclined position with her feet elevated and did not appear to have made any attempt to prevent Resident #1's fall. NA #1 laughed following the incident and another NA responded, That's not funny. NA #1 then responded to Resident #1 stating I hope you learned your lesson. The DON stated NA #1 should have requested assistance to reposition Resident #1, especially if Resident #1 had not been responsive to redirection and NA #1 would not have been able to reposition Resident #1 alone safely. Interview failed to identify why NA #1 did not request assistance to reposition Resident #1, and failed to identify why NA #1 was sitting in a reclined position next to Resident #1 with her feet elevated after Resident #1 fell. The facility Fall prevention policy dated 1/2020 is the policy of the facility to provide residents with a safe environment eliminating risk factors that led to a fall. A person-centered approach was used for each resident based on a thorough assessment of fall risk factors.

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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. Based on clinical record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #1) reviewed for accidents, the facility failed to ensure the clinical record was complete and accurate to include documentation of an RN assessment after a fall. The findings include: Resident #1 was admitted with diagnoses that included dementia. A resident care plan (RCP) dated 12/18/2025 identified Resident #1 was at risk for falls and required assistance for activities of daily living (ADL). Interventions included to anticipate Resident #1's needs and contact guard assist of two (2) for transfer. A significant change Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 3/10/2026 identified Resident # 1 had a Brief Interview for Mental Status (BIMS) score of four (4), indicated he/she had severe cognitive impairment, and was dependent for personal hygiene, bed mobility, moving side to side, and for transfers, and had a foley catheter for urinary drainage. Further, the MDS indicated Resident #1 was 67 inches (5 foot, 7 inches) tall and weight 199 pounds. A facility reportable event (RE) dated 3/24/2026 at 9:30 AM identified Resident #1 had a fall. Resident #1 was seated at the nurse's station with NA #1 seated next to him/her due to fidgeting behaviors. Resident #1 kept sliding forward in the wheelchair and leaning forward. RN #1 reported he heard NA #1 say to Resident #1, If you keep leaning forward, I am going to let you fall. NA #1 reported I got up to help him/her move back, but he/she just kept leaning forward. I was trying to hold him/her up while trying to pull Resident #1 back, but she/she was too heavy to move alone. Resident #1 fell forward and to the left side into a door headfirst. RN #1 was notified, and an assessment was completed. No injury was noted from the fall. A RE summary dated 4/1/2026 identified on 3/24/2026 at 10 PM, indicated that RN #1/supervisor was on the phone when he heard NA #1 making a comment If you keep leaning forward, I am going to let you fall. After a loud noise, RN #1 went out and observed Resident #1 on the floor. Resident #1 had no recollection of events leading up to the fall or interaction with staff after the fall. RN assessment was completed and no injuries were identified. Although attempted, an interview with RN was unable to be completed during the survey. Interview and record review with the DON on 4/23/2026 at 1:02 PM identified Resident #1 required two (2) staff assistance for repositioning. On 3/24/2026, at about 10 PM, Resident #1 was leaning forward in the wheelchair and sliding, and NA #1 attempted to reposition Resident #1 without obtaining any additional staff assistance and Resident #1 fell to the floor. The DON stated that RN #1 completed an RN assessment after the fall, but did not document the assessment. The DON stated she did not know why RN #1 did not document his assessment, and she expected staff to document assessments in the medical record. The policy Nursing Documentation dated 3/4/2014 directed in part, to complete nursing documentation to reflect the resident's assessment.