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	02/27/2026

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

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide and implement an infection prevention and control program. Based on facility documentation review, staff interviews, and observations, the facility failed to develop and implement a water management plan to prevent, identify, and mitigate Legionella contamination in the facility water system, resulting in Immediate Jeopardy to resident health and safety. Water testing performed in June 2024 and June 2025 identified multiple locations positive for Legionella, including Legionella pneumophila serogroups 1-14, at levels requiring immediate action in a highˆrisk healthcare setting; however, facility leadership did not recognize the significance of the results, did not implement corrective measures, and did not communicate findings to the Infection Preventionist or Medical Director. During this period, 26 residents were diagnosed with pneumonia without evaluation for possible Legionella exposure. The facility's failure to establish a water management plan or to respond to known contamination created a likelihood of serious harm to residents, resulting in findings of Immediate Jeopardy. The findings include:A tour of the facility and review of facility documentation on 2/26/26 at 10:12 AM, identified the second floor consisted of 4 resident units, with one unit not in use, and a census of 61. Review of the facility's water sampling test results collected from June 2024 to June 2025 noted the following: a. Water sample report dated 6/3/24 at 9:00 AM identified water samples were collected from three (3) locations and revealed the Exam Room was positive for Legionella (non-Legionella pneumophila) with a result of 2 Colony Forming Units per milliliter (CFU/mL) and the Chapel was positive for Legionella pneumophila (serogroups 1–14) with a result of 96 CFU/mL. b. Water sample report dated 6/30/25 at 10:40 AM identified water samples were collected from three (3) locations and revealed the Dining room was positive for Legionella (non-Legionella pneumophila) with a result 62.5 CFU/ml and the Chapel was positive for Legionella pneumophila (serogroups 1–14) with a result of 148.5 CFU/mL. Interview with the Director of Physical Plant on 2/26/26 at 11:10 AM identified he had been employed at the facility since 2018. The Director of Physical Plant identified the facility did not have a water management plan and indicated he was not aware a water management plan was required. The Director of Physical Plant identified he was responsible for reviewing the water sample results. The Director of Physical Plant indicated he reviewed the water sample lab reports for June 2024 and June 2025 and noted that 2 of 3 water samples were positive for Legionella in both reports. The Director of Physical Plant indicated that because the results were not that high, he believed there was no Legionella growth in the water. The Director of Physical Plant identified he assumed the laboratory would have notified him if Legionella was present in the water. The Director of Physical Plant identified he did not do anything about the positive water sample results in June 2024 or June 2025. Interview with the Administrator on 2/26/26 at 11:40 AM identified he had been employed at the (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	facility since 2018. The Administrator identified that the facility did not have a water management plan and he was not aware that one was required. The Administrator identified although the Director of Physical Plant shared the last annual water testing results, he was not aware they were abnormal results. Interview and review of facility documentation with RN #2 (Infection Preventionist) on 2/26/26 at 2:28 PM identified from 6/1/26 through 2/26/26 there were 26 residents with pneumonia. RN #2 identified she was not aware of the positive water samples. Interview with the Medical Director on 2/26/26 at 3:22 PM identified he was not aware the facility water samples in June 2024 and June 2025 were positive for Legionella or that the facility did not have a water management plan. The Medical Director identified he would have expected the facility to have a water management plan in place. Subsequent to the surveyor's inquiry, the Medical Director indicated that any resident with respiratory symptoms will be tested for Legionella using a urine antigen test. According to the Centers for Disease Control and Prevention (CDC) there is no safe level of Legionella, any result over 1 CFU/mL is considered high in a high-risk setting like a nursing home. Water sampled detected with Legionella pneumophila (serogroups 1–14) and non-Legionella pneumophila indicate that the water system is colonized with bacteria capable of causing severe respiratory illness, particularly in vulnerable elderly residents. CDC guidelines for healthcare facilities (including nursing homes) the detection of Legionella in water samples requires an immediate, structured response, particularly because these levels exceed the 1 CFU/mL threshold. Although requested a facility water management plan was not provided. The Immediate Jeopardy Template was presented to the Administrator on February 26, 2026, at 2:51 PM for F880 -Infection Control for failure to develop and implement a water management plan to prevent the potential development of Legionella related illnesses and failed to address high levels of Legionella species in the water constituted Immediate Jeopardy to the health and safety of the residents. An immediate removal plan was requested by the state agency. The facility submitted a removal plan on February 26, 2026 that included: -Remove all water pitchers from resident rooms -Ice has been purchased and will be utilized in-house -Remove ice from all machines, secure empty machines, tag out -Close off sink in Chapel, turn off water, and tag out -Dining room kitchen sinks to be secured and tagged out on the empty unit -Bottled water to be distributed to each resident -Temporary discontinuation of all showers. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-Distribute hand sanitizers to units, fill wall mounted sanitizers -FCS to be on site this afternoon by 330-4pm to implement water management plan -Medical Director has been informed. -One resident currently has respiratory symptoms in -house and Dr. has ordered an antigen urine test -FCS will guide us for filters for all sinks/shower heads upon arrival -All shower heads will have filters and the faucets tested positive will also get filters. The immediate action plan was accepted by the state agency during an on-site visit on February 26, 2026, at 3:53 PM. Review of facility documentation, staff interviews, and observations validated the implementation of the removal plan. The Immediate Jeopardy was removed on 2/27/2026 at 10:00 AM

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F 0689 Level of Harm - 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 record review, staff interviews, and facility documentation, the facility failed to ensure Resident #27 received the level of assistance identified in the care plan to prevent accidents, when staff provided only oneˆperson's assistance during a transfer despite the resident's assessed need for twoˆperson assistance. The MDS, therapy caregiver training, and the resident's care plan all directed that two staff assist with transfers using a walker; however, on 8/17/25 NA #1 attempted to transfer the resident alone, resulting in the resident losing balance, falling, and sustaining a right clavicle fracture that required pain management, orthopedic followˆup, sling immobilization, and a change to mechanicalˆlift transfers. The findings include:Resident #27 had diagnoses that included a stroke with memory, speech, and language deficits, dementia, and abnormalities of gait and mobility. The quarterly MDS assessment dated [DATE] identified Resident #27 had moderately impaired cognition, was dependent on staff for toileting and showering, and required maximum assistance with personal hygiene, dressing, and transfers.The RCP dated 7/15/25 identified Resident #27 was dependent on staff for transfers, with interventions that directed two (2) staff to assist with transfers using a rolling walker.Review of Resident #27's caregiver training record dated 7/15/25 identified Resident #27 required the assistance of two (2) staff with use of a walker for ambulating and transfers and for bed mobility, dressing, and bathing. NA #1 did not sign the training record.Review of the Facility's Accident and Incident Form dated 8/17/25 at 7:00 AM identified Resident #27 required the assistance of 2 staff for transfers and ADLs. On 8/17/25, during morning care NA #1 assisted Resident #27 to stand from the bed while pulling up his/her pants, reaching for the wheelchair, without the assistance of another staff member. Resident #27 subsequently fell hitting his/her head on the wall. Review of RN #7's nurse's note dated 8/17/25 at 7:14 AM identified she responded to Resident #27's room after a fall. NA #1 assisted Resident #27 to stand from the bed with one hand on Resident #27's arm; as she reached for the resident's pants, Resident #27 tilted to the right and fell into the wall near the doorway. Resident #27 hit the right side of his/her forehead and appeared to land on his/her right shoulder. Resident #27 did not lose consciousness and denied head or shoulder pain. Resident #27's hand grasps were equal and strong, arms and shoulders had full range of motion without discomfort, and legs were equal in length, and range of motion was intact. RN #7 indicated MD #2 and Person #2 were notified and no new orders were obtained.A facility written statement by NA #1 dated 8/17/25 identified NA #1 assisted Resident #27 to stand from the bed, pulled up the resident's brief and pants, took a step to turn with one hand on the resident, stepped behind the resident to get the wheelchair, grabbed the back of the resident's pants, and Resident #27 fell to the right side.A nurse's note dated 8/17/25 at 9:54 PM identified Resident #27 was status post fall and neurological assessment was within normal limits. Resident #27 reported right shoulder pain, which was relieved with scheduled Tylenol.A nurse's note dated 8/19/25 at 12:46 PM identified Person #1 requested an X-ray of Resident #27's right shoulder due to right shoulder pain following the recent fall. MD #1 was faxed awaiting response.The physician's order dated 8/19/25 directed an X-ray of the right shoulder and administer Tylenol Arthritis extended release 650 mg every 8 hours.A nurse's note dated 8/20/25 at 3:37 PM identified Resident #27's right shoulder X-ray results were pending.A nurse's note dated 8/21/25 at 4:49 AM identified Resident #27's right shoulder was firm to the touch and slightly swollen. Resident #27 reported tenderness and continued scheduled Tylenol Arthritis.Review of Resident #27's radiology report dated 8/22/25 at 12:28 PM identified a right clavicle fracture.A nurse's note dated 8/22/25 at 12:55 PM identified Resident #27's X-ray results were reviewed with MD #2; new orders were obtained for either an orthopedic consultation or transfer to the emergency room.A nurse's note written by RN #5 (former DNS) dated 8/22/25 at 1:01 PM identified Resident #27's X-ray showed an acute clavicle fracture. MD #2 was notified; he ordered a follow-up with an (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	orthopedic specialist or transfer to the emergency room. Person #2 was notified he/she agreed with an orthopedic follow-up.A nurse's note dated 8/23/25 at 2:49 PM identified Resident #27 was non-weight bearing with the sling in place for a right clavicle fracture. Resident #27 requires assistance from two (2) staff for ADL's and transfers using a mechanical lift. Orthopedic consultation dated 8/25/25 identified Resident #27 was evaluated for a right clavicle fracture and instructed to continue wearing the sling as needed and to use the arm as tolerated. Follow-up X-rays were scheduled in three weeks, with the next appointment on 9/15/25.Interviews with Physical Therapist (PT) #1 and PT #2 on 2/27/26 at 9:50 AM identified therapy had treated Resident #27 before the fall on 8/17/25. PT #2 identified as of 7/15/25, Resident #27 required (2) staff for transfers and standing. PT #2 indicated on 7/15/25 therapy staff educated nursing staff on Resident #27's transfer status. PT #1 identified therapy completes caregiver training forms when a resident status changes, and emails it the Director of Nursing (DNS), supervisor, and care plan committee. PT #2 identified therapy is responsible for ensuring nursing staff receive education and sign the form to confirm they were informed of changes in a resident's level of care. PT #2 identified after the fall on 8/17/25, Resident #27 required a mechanical lift for transfers.Interview RN # 7 on 2/27/26 at 10:13 AM identified on 8/17/25 a nurse aide (NA) #1 was providing morning care and assisted Resident #27 stand from the bed to pull up his/her pants, Resident #27 fell to the right hitting his/her head on the wall. RN #7 indicated NA #1 activated the call light, so she responded to the room. RN #7 identified Resident #27 complained of right shoulder pain; but the resident had a history of right shoulder pain, so she was unsure whether the pain was new. RN #7 indicated Resident #27 could move both arms, but with movement his/her right shoulder was sore. RN #7 identified NA #1 did not follow the plan of care, the resident fell and sustained a clavicle fracture. RN #7 identified NA #1 should have had another staff member assist with the transfer.Interview with DNS on 2/27/26 at 10:39 AM identified she was not the DNS at the facility at the time of the fall. The DNS indicated she reviewed Resident #27's fall investigation and medical record. The DNS identified on 8/17/25, Resident #27 required assistance from two (2) staff for transfers, and NA #1 did not follow the plan of care for transferring, and the resident fell. The DNS identified NA #1 should have had another staff member assist with the transfer. The DNS further identified that she expects that all nurse aides review a resident's plan of care prior to providing care.Although attempted, interviews with RN #5 (prior DNS) and NA #1 were not obtained. Review of the facility Care Giver Training (CGT) Policy identified this will provide recommendations and guidance for activities of daily living status. When a care giver training is provided by rehab the nursing supervisor will update the care plans for the specific care area. Once the CGT has been updated with the care plan and new orders have been written, the supervisor will respond to rehab's email that the care plan was updated.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **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 1 resident (Resident #97) reviewed for hospitalizations and had multiple hospitalizations, the facility failed to ensure the resident and/or resident representative were provided with the written information regarding the bed hold policy at the time the resident was sent to the hospital and failed to ensure the ombudsman was notified of discharges at least monthly. The findings include:1.Resident #97 was admitted to the facility in November 2023 with diagnoses that included heart failure, dementia, and pneumonia.The annual MDS assessment dated [DATE] identified Resident #97 had severely impaired cognition and was dependent on staff for all activities of daily living.The Resident Care Plan dated 12/11/24 identified Resident #97 as a long-term care resident and had some confusion with interventions that included orient the resident to the facility, staff, and routine.a. The nurse's note dated 2/2/25 at 1:42 PM identified Resident #97 was sitting in the wheelchair with his/her representative. Resident #97's had a temperature of 100.1 degrees Fahrenheit, oxygen saturation of 73% on room air, pale skin, and rhonchi in the left lung. Oxygen was applied and the Advanced Practice Registered Nurse (APRN) was notified. The resident was transferred via ambulance at 2:40 PM. A physician's order dated 2/2/25 directed to transfer Resident #97 to the hospital for evaluation and treatment.Review of the Census Report identified Resident #97 was transferred to the hospital on 2/2/25. Review of the nurse's notes from 2/2/25 through 2/5/25 failed to provide documentation Resident #97 or the resident's representative was provided with the Bed Hold Policy at the time of transfer. Review of social work notes during the same period failed to provide documentation Resident #97 or the resident's representative was provided with the bed hold policy.A nurse's note dated 2/5/25 at 6:30 PM identified Resident #97 was re-admitted to the facility. b. Review of the Census Report identified Resident #97 was transferred to the hospital on 6/10/25. A physician's order dated 6/10/25 directed to transfer Resident #97 to the emergency room for evaluation and treatment.The nurse's note dated 6/10/25 at 7:36 PM identified Resident #97 was admitted to the hospital with a diagnosis of pneumonia.Review of the nurse's notes from 6/10/25 through 6/13/25 failed to provide documentation Resident #97 or the resident's representative was provided with the Bed Hold Policy at the time of transfer. Review of social work notes during the same period failed to provide documentation Resident #97 or the resident's representative was provided with the bed hold policy.Interview with RN #1 (supervisor) on 2/26/26 at 10:05 AM identified she does not provide the bed hold notice at the time of transfer to the hospital. RN #1 indicated that the responsibility belonged to the social worker.Interview and clinical record review with the DNS on 2/26/26 at 10:10 AM identified the supervisor is responsible for completing the paperwork and providing the bed hold notice to the resident or resident representative at the time of transfer. The DNS identified on 2/2/25 and 6/10/25 Resident #97 was transferred to the hospital, and the bed hold notices were not provided to the resident or representative. The DNS was unable to explain why the bed hold notices had not been provided. Interview with SW #1 on 2/26/26 at 10:33 AM indicated that nursing was responsible for giving the bed hold notice to the resident at time of discharge to the hospital and then the next day she is in the facility she will reach out to the resident or resident representative to discuss the bed hold policy. SW #1 identified she had not spoken with Resident #27's representative for the hospitalizations on 2/2/25 and 6/10/25. SW #1 indicated she was not aware she was responsible for sending a copy of the hold notice provided at time of discharge or transfer to the Ombudsman's office in addition to the monthly report. 2. Interview with SW #1 on 2/24/26 at 9:00 AM surveyor requested the Ombudsman's monthly notification records and verification of transmissions from 1/1/25 to 2/24/26. Interview with SW #1 on 2/25/26 at 1:00 PM identified she was responsible for sending the monthly report to the ombudsman's office via the portal monthly. SW #1 indicated that she is aware (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	she was not updating the ombudsman's office of resident discharges monthly but was doing it every few months. SW #1 indicated that she is aware she is not in compliance. SW #1 indicated this week she submitted to the ombudsman portal the last few months of resident discharged . SW #1 indicated that she would provide the verification of transmission to the ombudsman's office.Subsequent to surveyor inquiry, SW #1 provided the Ombudsman Monthly Notification Report that identified the following: Residents discharged from 1/1/25 to 3/13/25 were transmitted to the Ombudsman on 4/9/25. Residents discharged from 4/1/25 to 6/30/25 were transmitted on 7/22/25.Resident discharged from 7/1/25 to 1/31/26 were transmitted on 2/24/26. Review of facility Emergency Transfer, Notice of Bed Hold Policy identified when residents are discharged to the hospital for any reason, they will be notified of the right to reserve their bed and return to the same bed at the facility providing their conditions allow. Upon discharge from the unit the charge nurse or the shift supervisor will remove the Notice of Immediate Emergency Transfer Form and the Bed hold Policy notification form. The charge nurse or shift supervisor will complete the necessary blanks and copy the forms. They will place the original in an envelope and give it to the resident upon discharge to the hospital. If a responsible family member is present the forms may be given to them. A copy of the completed forms will be left for the DNS. The DNS will give it to the Director of social services/admissions. Review of the facility Bed Hold Policy identified the resident name and dated will be placed on the form. It is the responsibility of the facility to inform the resident or resident representative at the time of admission and at the time of hospital transfer, that their bed will be held during their absence from the facility due to hospitalization whenever payment is available to reserve the bed. The form explains if a resident is private pay versus Medicaid regarding payment for holding the bed. Then a representative from the facility has to sign the form. Review of facility Notice of Immediate Emergency Transfer Form identified the resident is being transferred to (a blank line to fill in hospital name) hospital date (a blank line to fill in the date). The immediate transfer is being made for your welfare to meet the residents' needs, which requires care at the hospital. The law requires we give the residents this notice. You are also receiving notice about the facility policy to hold your bed while you're at the hospital. Although requested, the ombudsman notification of discharges policy was not provided.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. Based on review of the clinical record, facility documentation, facility policy, and interviews for five (5) of fifteen (15) residents (Resident #4, Resident #47, Resident #58, Resident #68, and Resident #79) reviewed for resident assessment, the facility failed to complete comprehensive assessments within 14 days after admission and at least annually for each resident. The findings include:1.Resident #4 was admitted with diagnoses that included presence of right artificial knee joint, age related cognitive decline, diabetes mellitus, and hypertension.The MDS status report identified the 5-day Minimum Data Set (MDS) assessment for Resident #4, with an Assessment Reference Date (ARD) of 9/9/2025, was completed and submitted on 2/2/2026. The MDS assessment was 185 days late.2. Resident #47 was admitted with diagnoses that included dementia and heart failure.The MDS status report identified the admission the 5-day MDS assessment for Resident #47, with an ARD of 12/8/2025 was documented completed on 2/19/2026 and submitted on 2/20/2026. The MDS assessment was 123 days late.3.Resident #58 was admitted with diagnoses that included cancer of the digestive system and chronic pain.The MDS status report identified the admission MDS assessment for Resident #58, with an ARD of 9/18/2025 was still in process, not yet completed, and as of 2/26/2026 the MDS assessment was 55 days late.4. Resident #68 was admitted with diagnoses that included heart failure, chronic kidney disease, and arthritis.The MDS status report identified an annual MDS assessment for Resident #68, with an ARD of 9/12/2025 was completed and submitted on 11/14/2025 (59 days late).5. Resident #79 was admitted to the facility with diagnoses that included dementia, heart failure, and arthritis.The MDS Status report identified an admission MDS with an ARD of 10/31/2025 for Resident #79 that was identified as finalized. A review of the medical record identified the 10/31/2025 MDS was not signed as completed, and as of 2/26/2026 the MDS assessment was 112 days late.Interview with the LPN #3 (MDS coordinator) on 2/26/2026 at 2:00 PM identified she was responsible for coordinating MDS submissions according to CMS requirements. LPN #3 identified that MDS assessments must be completed no later than three (3) months after the last quarterly assessment, within 14 days of admission, and at least annually and must accurately reflect the resident's status. When asked to provide an MDS submission report LPN #3 identified that most of the identified residents' MDS assessments had not been completed or submitted. LPN #3 indicated a new MDS staff member had recently been hired and she had been doing the best she could.Review of a facility policy titled, Resident assessment dated 2018, directed in part, that a comprehensive, accurate assessment is completed for each resident within 14 days for admission, quarterly and comprehensive assessments. A quarterly update will be completed every 92 days from admission, and an annual update will be completed every 365 days from the comprehensive.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure that each resident?s assessment is updated at least once every 3 months. Based on clinical record review, facility documentation review, facility policy review, and interviews for six (6) of fifteen (15) residents (Resident #3, Resident #4, Resident #27, Resident #32, Resident #68, and Resident #75) reviewed for resident assessment, the facility failed to complete quarterly Minimum Data Set (MDS) assessments timely. The findings include: 1.Resident #3 had diagnoses that included stroke and chronic obstructive pulmonary disease (COPD).The Minimum Data Set (MDS) status report identified the quarterly MDS assessment with an Assessment Reference date (ARD) of 12/23/2025 for Resident #3 was still in process and had not yet been completed on 2/26/2026. The last submitted quarterly MDS assessment had an ARD of 9/24/2025. 2. Resident #4 had diagnoses that included presence of right artificial knee joint, age related cognitive decline, diabetes mellitus, and hypertension.The MDS status report identified the quarterly MDS assessment with an ARD of 11/26/2025 for Resident #4 was still in process and had been completed as of 2/26/2026. The last submitted quarterly MDS assessment had an ARD of 9/9/2025. 3. Resident #27 had diagnoses that included displaced fracture of the left femur, dysphagia and stroke.The MDS status report identified the quarterly MDS assessment with an ARD of 11/28/2025 for Resident #27 was still in process and had not been completed as of 2/26/2026. The last submitted quarterly MDS assessment had an ARD of 9/25/2025.4. Resident #32 had diagnoses that included displaced fracture of the left femur and stroke.The MDS status report identified the quarterly MDS assessment with an ARD of 11/03/2025 for Resident #32 was still in process and had not been completed as of 2/26/2026. The last submitted comprehensive 5-day MDS assessment had an ARD of 10/22/2025.5. Resident #68 had diagnoses that included heart failure, chronic kidney disease, and arthritis.The MDS status report identified the quarterly MDS assessment with an ARD of 12/11/2025 for Resident #68 was still in process and had not been completed as of 2/26/2026. The last submitted annual MDS assessment had an ARD of 9/12/2025.6. Resident #75 had diagnoses that included diabetes mellitus, surgical aftercare, following mouth surgery and hypertension.a. The MDS Status report identified a quarterly MDS with an ARD of 8/29/2025 for Resident #75 was completed on 11/14/2025. The last submitted quarterly MDS assessment had an ARD of 6/2/2025. b. The MDS Status report identified a quarterly MDS with an ARD of 11/28/2025 for Resident #75 was still in process and had not been completed as of 2/26/2026. The last submitted quarterly MDS had an ARD of 8/29/2025.Interview with the LPN #3 (MDS coordinator) on 2/26/2026 at 2:00 PM identified she was responsible for coordinating MDS submissions according to CMS requirements. LPN #3 identified that MDS assessments must be completed no later than three (3) months after the last quarterly assessment, within 14 days of admission, and at least annually and must accurately reflect the resident's status. When asked to provide an MDS submission, LPN #3 identified that most of the identified residents' MDS assessments had not been completed or submitted. LPN #3 indicated a new MDS staff member had recently been hired and she had been doing the best she could. Review of a facility policy titled, Resident assessment dated 2018, directed in part, that a comprehensive, accurate assessment is completed for each resident within 14 days for admission, quarterly and comprehensive assessments. A quarterly update will be completed every 92 days from admission, and an annual update will be completed every 365 days from the comprehensive.

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	075236	A. Building B. Wing	02/27/2026

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

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. Based on a review of the clinical record, facility documentation, facility policy, and interviews for six (6) of fifteen (15) residents (Resident#21, Resident #24, Resident #36, #73, Resident #79, and Resident #87) reviewed for resident assessment, the facility failed to complete and transmit Minimum Data Set (MDS) assessments timely. The findings include:1.Resident #21 was admitted with diagnoses that included heart failure and atrial fibrillation (fast irregular heartbeat).The last submitted MDS assessment for Resident #21 was a 5-day assessment with an ARD of 8/29/2025. Resident #21 had a discharge MDS assessment with an ARD of 9/20/2025 that was still in process and incomplete during the survey on 2/26/2026. Resident #21 was discharged on 9/25/2025 and had not resided in the facility for over five months. 2. Resident #24 was admitted with diagnoses that included rhabdomyolysis (muscle damage releasing toxins into the blood, affecting kidneys) and dysphagia.The last submitted MDS assessment for Resident #24 was a 5-day assessment with an ARD of 8/29/2025. Resident #24 had a discharge MDS assessment with an ARD of 9/20/2025 that was still in process and incomplete during the survey on 2/26/2026. Resident #24 was discharged on 9/20/2025 and had not resided in the facility for over five months.3. Resident #36 was admitted with diagnoses that included endocarditis (heart infection) and heart failure.The last submitted MDS assessment for Resident #36 was a 5-day assessment with an ARD of 9/12/2025. Resident #36 had an MDS with an ARD of 9/16/2025 that was completed on 2/19/2026 and submitted on 2/20/2026 (143 days late).4. Resident #73 was admitted with diagnoses that included joint replacement surgery and bipolar disorder.The last submitted MDS assessment for Resident #73 was a 5-day assessment with an ARD of 10/21/2025. Resident #73 had a discharge MDS with an ARD of 11/23/2025 that was in process and incomplete during the survey on 2/26/2026.5. Resident #79 was admitted to the facility with diagnoses that included dementia, heart failure, and arthritis.The MDS status report identified a death-in-facility MDS assessment for Resident #79 with an ARD of 1/2/2026, marked as finalized. Medical record review on 2/26/2026 identified the MDS assessment had not yet been signed as completed.6. Resident #87 was admitted with diagnoses that included diabetes mellitus, asthma and hypertension.The MDS status report identified Resident #87 had a discharge MDS assessment with an ARD of 9/24/2025 that was in process and not completed as of 2/26/2026.Interview with LPN #3 (MDS coordinator) on 2/26/2026 at 2:00 PM identified she was responsible for coordinating MDS submissions according to CMS requirements. LPN #3 identified that MDS assessments must be completed no later than three (3) months after the last quarterly assessment, within 14 days of admission, and at least annually and must accurately reflect the resident's status. When asked to provide an MDS submission report LPN #3 identified that most of the identified residents' MDS assessments had not been completed or submitted. LPN #3 indicated a new MDS staff member had recently been hired and she had been doing the best she could.Review of a facility policy titled, Resident assessment dated 2018, directed in part, a comprehensive, accurate assessment is completed for each resident within 14 days for admission, quarterly and comprehensive assessments. A quarterly update will be completed every 92 days from admission, and an annual update will be completed every 365 days from the comprehensive.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, review of facility documentation, and interview the facility failed to implement a system to consistently and accurately reconcile controlled substances for 2 of 2 medication carts. The findings include:Although requested, the facility was unable to provide the facility monthly or bi-monthly audits of controlled substances for January 2026 or February 2026 and indicated that any previous audits could not be located at time of survey.Interview with the DNS on 2/27/2026 at 10:15 AM identified she has not reconciled any controlled substances or conducted audits since starting 31/2 months ago. The DNS identified she could not locate any bimonthly audits from the past year. The DNS indicated the controlled substance audit process involves counting the controlled substances in the two medication carts and verifying the count matches the controlled substance disposition record (CSDR). The DNS indicated that the pharmacy emailed her audit tools to reconcile and audit controlled substances. The DNS identified that without these audits, the facility cannot verify the accuracy of its controlled substances inventory. The DNS could not explain why the audits had not been completed. Although requested, a facility Controlled Substance Reconciliation and Audit policy was not provided.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a tour of the Dietary Department and Nourishment rooms, review of facility policy, and staff interview, the facility failed to ensure stored food was labeled and dated when opened, expired food was discarded and failed to ensure nourishment refrigerators were maintained in a clean sanitary manner. The findings included:A tour of the Dietary Department on 2/24/26 at 7:40 AM with [NAME] #1 identified:1. Refrigerator #1 was observed to have the following items: a. one hard plastic cup with a lid not labeled but dated 2/20/26 (expired)b. one large pitcher of brown liquid covered with saran wrap not labeled or datedc. one large pitcher with brown liquid not covered, labeled or dated 2. Refrigerator #2 was observed to have the following items:a. 2 cups of yellow liquid not labeled or datedb. one cup of red liquid not labeled or dated 3. Refrigerator #3 was observed to have the following items: a. one large gallon sized plastic clear container covered with saran wrap with what appeared to be peaches dated 2/19/26 (expired)b. one large gallon sized plastic clear container covered with saran wrap with what appeared to be pears dated 2/19/26 (expired)Interview with [NAME] #1 on 2/24/26 at 7:50 AM identified that all food items are required to be labeled and dated. [NAME] #1 identified opened food must be discarded after 3 days. [NAME] #1 indicated she does not know who placed the items into the refrigerators without covering, labeling, or dating them. [NAME] #1 identified because the items were not labeled, or dated, she does not know how long they have been stored. [NAME] #1 identified the dietary staff are responsible for discarding any items found in the refrigerator that have exceeded the 3-day limit.Subsequent to surveyor inquiry, [NAME] #1 discarded the food and drink items that were not labeled and dated. A tour of with the Director of Dietary (DOD) on 2/24/26 at 8:00 AM identified: 4. Nourishment refrigerator #1 was observed to have the following items being stored in the refrigerator and were not labeled, not dated when they were opened, and did not contain an expiration date: a. one yogurt container partially eatenb. Chocolate pudding container (not facility) opened partially eatenc. bottom drawers inside the refrigerator had dried up spilt liquids and food crumbs 5. Nourishment refrigerator #2 was observed to have the following items being stored in the refrigerator and were not labeled, not dated when they were opened, and did not contain an expiration date: a. 3 separate loaves of bread partially usedb. one opened can of soda c. one glass bottle of coconut milk 1/2 full d. one cup of cantaloupe cut up and covered with plastic wrape. a plastic bag with dried cranberries or raisins f. one cup of mixed fruit covered with plastic wrap g. one English muffin h. inside the freezer was a [NAME] candy bar; a paper cup not covered with a frozen yellow liquid frozen. i. the bottom shelf in the freezer had dried brown liquidInterview with DOD on 2/24/26 at 8:10 AM identified she is responsible daily for cleaning and maintaining the nourishment refrigerators and checking that items are labeled and dated. The DOD indicated she had been off for the last 3 days. The DOD identified she would have expected dietary staff to clean the nourishment refrigerators and freezers. The DOD indicated nursing and dietary staff have been educated that all items placed in the nourishment refrigerator must be covered, labeled, dated, and discarded after 3 days. The DOD was unable to explain why the items were not covered, labeled, and dated. Review of the facility Dietary Services Policy identified the dietary aide is responsible to remove all outdated items and rotating items as needed each day when restocking the nourishment refrigerator. Food storage areas shall always be clean. All food must be dated when it is opened and dated when it is stored. The dietary staff for safe food storage will label and date food. The dietary refrigeration inspection log is kept in the kitchen and is completed by the cook. Discarding outdated food will be the responsibility of the cook. Food and beverages brought in from outside sources in the facility will be monitored by the nursing and dietary staff for proper labeling, dating, storage, and discarding of food.Review of the facility Outside Food Policy identified it is the policy of the dietary department to prepare and deliver food safely to our residents, families, and staff. This (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	policy will ensure proper handling, serving and storage of any food items brought into the facility. It is the resident s right to have outside food brought into the facility Food and beverages brought in must be labeled with resident's name, room number, and dated by staff with the current date the item was brought in. All cooked or prepared food brought in for a resident and stored in the facility refrigerators will be dated when accepted for storage and discarded after 72 hours /3 days.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility documentation review, facility policy review, and interviews for 1 of 3 nurse aides (NA#1), reviewed for In-service training the facility failed to ensure the nurse aide received the required In-service training. The findings include: Review of facility documentation and interview with RN #2, Infection control/staff development nurse, on 2/25/2026 at 2:00 PM identified that all NA's are required to receive a minimum of twelve (12) hours of in-service education annually. RN #2 was unable to locate in-service education for NA #1 for 2024 or 2025 that documented that NA #1 received the minimum 12 hours of Inservice education. RN #2 identified that NA #1's education file lacked documentation of education. RN #2 further stated that she should have ensured all the NAs received the minimum of 12 hours annually and had sent an email to the DNS that NA #1 had not completed the 12-hour requirement each year. She could only locate educational documents for NA #1 from 2016. Interview with the DNS on 2/26/3036 at 10:45 AM identified there was she was unaware that NA #1 had not completed the required education however the expectation was that all NAs should have a minimum of 12 hours of education annually.The facility's policy In-service Education dated 6/16/2021 directed in part that each employee must acquire 12 hours of in-service credit annually. All employees must attend at least one (1) mandatory in-service in the following areas: Infection control, pain, workplace violence, corporate compliance, abuse, neglect prevention, hospice, safety, oral hygiene, choking emergencies, quality improvement, effective communication, dealing with residents with dementia and mental/psychosocial disorders, restraint free environments and cultural diversity. The Facility assessment dated [DATE] directed in part that required in-service ed must be sufficient to ensure the competence of nursing aides but must be no less than twelve (12) hours per year and include dementia training, resident abuse prevention training, cultural competence, identification of changes in condition and providing services to residents with cognitive impairments.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, review of facility documentation, review of facility policy/procedures and interviews for 2 of 2 sampled residents (Residents #27 and Resident #104) reviewed for Advance Directives, the facility failed to ensure the resident/resident representative were educated and the residents wishes were identified. The findings include1.Resident #27 had diagnoses that included a stroke with memory, speech, and language deficits and dementia. a. A nurse's note dated [DATE] at 4:04 PM identified Resident #27 was admitted to the facility with complaints of weakness to the right side of his/her body. Resident #27 is alert, essentially oriented, but per report he/she has some confusion at night. Review of the nurse's notes and social worker notes dated [DATE] through [DATE] failed to provide documentation that Person #1 (power of attorney) was provided with education on advance directives and that the code status form was signed to identify the resident or resident representative's wishes. Review of the nurse's notes and social worker notes dated [DATE] through [DATE] failed to provide documentation Person #1 was provided with education on advanced directives and that the code status form was signed to identify the resident or resident representative's wishes. b. A physician's note dated [DATE] at 12:15 PM directed Do not Resuscitate (DNR). A nurse's note dated [DATE] at 4:20 PM identified Resident #27 was re-admitted to the facility. Resident #27 was alert, oriented, with confusion. Resident #27's representative was at the bedside.Review of the Advance Directives Consent Form dated [DATE] identified the DNR box was checked off for Resident #27, signed by RN #10, and MD #1. The form further identified MD #1 indicated verbal consent was obtained from Person #1 on [DATE]. The form had not been signed by Resident #27 or Person #1. A physician's order dated [DATE] directed Resident #71's DNR must be renewed annually on the 12th of the month.The APRN note dated [DATE] at 10:28 AM identified Resident #27 is a DNR per chart documentation. The significant change MDS assessment dated [DATE] identified Resident #27 had moderately impaired cognition.Review of the nurse's notes and social worker notes dated [DATE] through [DATE] failed to provide documentation Person #1 was provided with education on advanced directives and that the code status form was signed to identify the resident or resident representative's wishes. The RCP dated [DATE] identified Resident #27 had a stroke with interventions that directed to review code status and advance directives.Interview and clinical record review with DNS on [DATE] at 2:00 PM identified the code status and advance directive form must be signed by the resident or resident's representative within 24 hours of admission or re-admission. The DNS indicated if the resident's representative cannot come to the facility, two (2) nurses may call the representative to verify the resident's wishes, and both nurses must sign the form and document the conversation in a progress note. The DNS stated the APRN or physician is responsible for educating the resident or representative about CPR (cardiopulmonary resuscitation) versus DNR and ensuring they understand the difference. The DNS identified the APRN or physician must then sign the form and document the resident's code status in a progress note. The DNS identified there was no code status documented or signed by Resident # 27 or Person #1 (resident's representative) on the admission dates of [DATE] and [DATE]. The DNS stated that although RN #10 completed the code status form on [DATE]; Resident #27's representative did not sign the form. The DNS identified RN #10 should have presented the form to Person #1 for signature to confirm the DNR code status reflected Resident #27's wishes. 2. Resident #104 was admitted to the facility in [DATE] with diagnoses that included dementia, heart failure, and depression. The RCP dated [DATE] failed to identify a code status or wishes for a code status. Review of the Advance Directives Consent Form dated [DATE] at 12:42 PM indicated verbal consent was obtained from Resident #104's representative. The form was not signed. Review of the physician's and APRN notes dated [DATE] through [DATE] was unable to reflect Resident #104's representative was contacted (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and provided with education on code status or what Resident #104's wishes were. A physician's order dated [DATE] directed Do not Resuscitate (DNR), Do not intubate (DNI), and RN pronouncement. The quarterly MDS dated [DATE] identified Resident #104 had severely impaired cognition. Interview and clinical record review with RN #1 (day supervisor) on [DATE] at 1:23 PM identified she completes code status only at admission, not on readmission. RN #1 indicated if the resident is confused, she uses the hospital W-10 form to determine code status. RN #1 indicated if the W-10 indicates the resident is a full code or DNR, RN #1 contacts the POA (Power of Attorney) immediately, usually within the same shift, but no later than 24 hours. RN #1 indicated she instructs the resident representative to come in to sign the code status form. RN #1 indicated she recalled a situation where the APRN had to contact multiple resident representatives to obtain signatures on unsigned code status forms. RN #1 identified she signed Resident #104's code status form but did not write the statement regarding code status, as she was not present when the APRN spoke with the resident representative. RN #1 indicated the APRN told RN #1 to sign the form, but RN #1 does not recall the APRN's name, and the APRN's handwriting on the form was not legible. RN #1 indicated she did not recall crossing off CPR multiple times; indicated that the form should have been discarded and a new one completed. RN #1 indicated the APRN wrote the physician order for DNR/DNI, but RN #1 noted there is no progress note from the APRN documenting the change from full code to DNR. RN #1 indicated the APRN just told her to sign it and she did. RN #1 indicated that the APRN wrote on Resident #104's form but she does not recall the APRN's name and it was not legible. RN #1 indicated she does not recall crossing off CPR after it was checked off and then crossed off multiple times with black ink, she indicated that this form should have been discarded and a new form should have been filled out. RN #1 indicated that APRN wrote the physician order for DNR/DNI but does not have progress note written by the APRN who changed Resident #104s code status from a full code (CPR) to a do not resuscitate (DNR). RN #1 indicated that she does not do verbal consent for a code status in person or on the phone, she tells families they have to come in and sign the code status. Interview and clinical record review with DNS on [DATE] at 2:00 PM identified the code status and advance directive form must be signed by the resident or resident's representative within 24 hours of admission or re-admission. The DNS indicated if the resident's representative cannot come to the facility, two (2) nurses may call the representative to verify the resident's wishes, and both nurses must sign the form and document the conversation in a progress note. The DNS stated the APRN or physician is responsible for educating the resident or representative about CPR (cardiopulmonary resuscitation) versus DNR and ensuring they understand the difference. The DNS identified the APRN or physician must then sign the form and document the resident's code status in a progress note. The DNS identified Resident #104's Advance Directives Consent Form was signed by 1 nurse, the APRN crossed off CPR multiple times and did not initial, and form was not signed by the representative. The DNS indicated if the resident is confused, has a representative then 2 nurses will call the resident representative, obtain verbal consent, sign the form, and write a progress note. Review of facility Advanced Directive Policy identified the objective was to comply with the residents' wishes regarding their choice for an advanced directive. When a resident is not competent then a resident representative will be provided with the advanced directive education and form. Upon application to the facility and again upon admission, residents/representatives will be asked if they have or would like to make advanced directives concerning their health care. A DNR and or the RNMP order will be written in the physician's order section of the clinical record and the electronic medical record. CPR will be performed in the absence of a DNR or advanced directives on all levels of care.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, facility documentation, facility policy, and interviews for 1 of 4 residents (Resident # 71) reviewed for medication administration, the facility failed to ensure the physician and resident representatives were notified of medication omissions. The findings include: Resident #71 had diagnoses that included stoke, Parkinson's disease, depression, and cancer.The Resident Care Plan dated 1/18/25 identified Resident #71 had a diagnosis of Parkinson's disease (neurological disorder that causes a depletion in circulating dopamine levels in the brain) with interventions that directed to monitor for signs and symptoms of shuffling gait, pill rolling tremors, lip smacking, loss of voluntary movements, blank facial expressions, drooling, difficulty swallowing, feeling weak, easily fatigued, feeling heavy and stiff, and notify physician if any changes.The physician's orders dated 1/19/26 directed to administer Acyclovir (antiviral) 200 milligram (mg) twice a day; Amlodipine (used to lower blood pressure) 5 mg once daily; Calcium Acetate (used to lower high blood phosphorus) 667 mg 2 tablets three times a day; Eliquis (blood thinner) 5 mg twice a day; Fludrocortisone (used to treat low blood pressure) 0.2 mg once a day; Midodrine (used to treat low blood pressure) 10 mg three times a day; Potassium Chloride (mineral supplement) 20 milliequivalent (mEq) extended release once a day, Trelegy Ellipta (used to treat chronic obstructive pulmonary disease) inhaler one dose inhaled once daily; Droxidopa (used to treat orthostatic blood pressure) 200 mg three times a day ; and Sertraline (used to treat depression) 100 mg daily. The quarterly MDS assessment dated [DATE] identified Resident #71 had intact cognition and required maximum assistance with toileting, dressing, and personal hygiene. Review of the electronic Medication Administration Record dated 2/1/26 to 2/26/26 identified the following medications were omitted:on 2/17/26 Amlodipine (high blood pressure) 5 mg scheduled at 6:00 PM documented as not available and not administeredon 2/18/26 Amlodipine 5 mg scheduled at 6:00 PM documented as not available and supervisor was notifiedon 2/22/26 Droxidopa 200 mg scheduled at 2:00 PM, and 10:00 PM documented as not available and not administeredon 2/23/26 Droxidopa 200 mg scheduled at 8:00 AM, 2:00 PM, and 10:00 PM documented as not available and not administeredon 2/24/26 Droxidopa 200 mg scheduled at 8:00 AM, 2:00 PM, and 10:00 PM documented as not available and not administeredon 2/25/26 Droxidopa 200 mg scheduled at 8:00 AM, 2:00 PM, and 10:00 PM documented as not available and not administeredon 2/26/26 Sertraline 100 mg daily at 8:00 AM identified documented as not available and not administeredon 2/26/26 Droxidopa 200 mg scheduled at 8:00 AM documented as not available and not administeredReview of the nursing progress notes dated 2/1/26 to 2/25/26 were unable to provide documentation to reflect the pharmacy, physician, or resident's representative were notified when Resident #71's medications were not available and were not administered in accordance with physician's orders.Observation of the medication administration with LPN #2 on 2/26/26 at 8:00 AM identified she introduced herself to Resident #71 and asked if he/she was ready for morning medications. LPN #2 went back to the medication cart in the hallway and used hand sanitizer. LPN #2 prepared Resident #71's medications and indicated she did not have available the Sertraline 100 mg daily and did not have the Droxidopa 200 mg available. LPN #2 gave Resident #71 the medications she had prepared. LPN #2 indicated a couple of days ago she notified the supervisor (RN #1) that Resident #71's Droxidopa was not available. Interview with RN #1 on 2/26/26 at 10:40 AM indicated she was not notified by LPN #2 that some of Resident #71's medications were unavailable. RN #1 stated during the medication pass, if a resident's medication is not available, it is the nurse's responsibility to notify her so she can check the emergency medication box to determine whether the medication is available. RN #1 further stated if the medication was still unavailable, she would contact the pharmacy, the physician or APRN, and the resident's representative. RN #1 also stated she would document the issue in the resident's medical record.Subsequent to surveyor inquiry, (continued on next page)

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	02/27/2026

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a nurse's note written by RN #1 dated 2/26/26 at 11:10 AM indicated she contacted the pharmacy and ordered Resident #71's Droxidopa, Potassium, and Sertraline. RN #1 documented MD #1 was notified that Resident #71 had missed 12 doses of Droxidopa 200 mg, 2 doses of Amlodipine 5 mg, and 1 dose of Sertraline 100 mg. RN #1 further documented Resident #71's representative was notified.Interview and review of the clinical record with the Director of Nursing Services (DNS) on 2/26/2026 at 2:00 PM indicated that if a nurse does not have a medication available during the medication pass, the nurse should first check the medication cart and medication room. The DNS stated that if the medication is still not available, the nurse should notify the nursing supervisor so the supervisor can contact the pharmacy to determine when the medication will be available. The DNS further stated the supervisor should then notify the physician to determine whether the medication administration time should be adjusted or if an alternative medication should be ordered. The DNS indicated the supervisor should also notify the resident's representative if a medication is unavailable and inform them of the plan of care. The DNS stated the supervisor must document contact with the pharmacy, the physician, and the resident's representative in the resident's progress notes. Upon review of the clinical record, the DNS stated she was not aware that Resident #71 had not received his/her Parkinson's medication since 2/22/26 and had missed 12 doses. The DNS indicated that on 2/22/26 the nurse or supervisor should have notified the pharmacy, the physician, and the resident's representative and documented these actions in the progress notes. The DNS was unable to explain why on 2/17/26, 2/18/26, 2/22/26, 2/23/26, 2/24/26, 2/25/26, and 2/26/26 she was not aware Resident #71 had omitted medications and was unable to explain why she was not notified the medications were omitted.Interview with MD #1 on 2/26/26 at 2:15 PM identified medications should be administered in accordance with physician/APRN orders. MD identified he was not aware the listed medications were not administered to Resident #71 on 2/17/26, 2/18/26, 2/22/26, 2/23/26, 2/24/26, 2/25/26, and 2/26/26. MD #1 identified he would have expected to be notified, and if he was notified, he would have given additional orders. Review of the facility Notification of Change in Resident Condition Policy identified that the physician and resident's representative will be kept informed of the resident's condition. The person notified, the time, and date of notification will be documented in the clinical record. Review of the facility Medication Administration Policy identified all medications are properly administered and documented on the electronic medication administration record. All medications will be properly administered per the physician/APRN orders. If a medication is unavailable per pharmacy the nursing supervisor or designee will call the physician/APRN and the resident/resident's representative to update them.

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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 (1) of three (3) residents (Resident #10) reviewed for accidents, the facility failed to report an injury of unknown origin. The findings include:Resident #10 was admitted with diagnoses that included dementia, chronic obstructive pulmonary disease (COPD), systemic lupus erythematosus (lupus- a chronic autoimmune disease where healthy tissue was inflamed and damaged) and peripheral vascular disease (arteries in leg and arms become blocked).The RCP dated 9/20/3035 identified Resident #10 was at risk for impaired skin due to fragile skin secondary to long term steroid use with interventions that included to monitor skin with transfers and during care reporting any changes.The significant change Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 10/6/2025 identified Resident # 10 had a Brief Interview for Mental Status (BIMS) score of 11 indicative of moderately impaired cognition, required substantial assistance for transfer and was dependent on staff for mobility in the wheelchair. The facility incident report dated 12/15/2025 at 5:00 AM identified during care, staff observed a bruise on the right side of Resident #10's face. The bruise measured three (3) centimeters (cm) by 3 cm near the chin line. Resident #10 reported that she/he did not know how it happened. Resident #10 was alert with confusion and oriented to name per baseline. An investigation form completed by RN #4 identified Resident #10 was on Eliquis (blood thinner) as a causative factor, but the actual cause was unknown. The APRN was notified. No additional investigative documents were included in t incident file.A nurse's note dated 12/15/25 at 6:30 AM indicated Resident #10's family was notified of the bruise.A nursing note dated 12/18/25 at 2:23 PM written by RN #1 identified the bruise on Resident #10's right lower face was stable, and the resident reported no pain.A nursing note dated 12/19/25 at 2:39 PM written by RN #1 indicated that an ecchymotic area on Resident #10's right lower face was stable, the skin was intact, and no swelling was noted.Interview with APRN #1 on 2/26/2026 at 2:30 PM identified Resident #10 had fragile skin due to long term steroid use and had experienced multiple skin tears on her/his extremities despite use of protective interventions. APRN #1 indicated she could not recall being informed of any facial bruising on Resident #10. APRN #1 stated nursing may not have reported bruises separately when documenting frequent skin tears. APRN #1 identified a bruise on the face, torso, or one measuring 3 cm in length by 3 cm in width, would be unusual, potentially suspicious, and require further medical evaluation, as it may not be related to long-term steroid use for Resident #10's Lupus diagnosis.Interview and review of the clinical record with RN #1 on 2/27/2026 at 8:00 AM identified she recalled evaluating Resident #10's facial bruise on 12/18/2025 and 12/19/2025. RN #1 indicated Resident #10's bruise was resolving and she had documented daily per protocol for any identified skin issue. RN #1 identified if a staff member identifies a change in a resident's skin integrity such as a bruise or skin tear; the supervisor is notified. RN #1 indicated the supervisor completes a facility incident report and investigation to determine possible causes, updates the care plan, completes the necessary notifications, and initiates every shift evaluation in the electronic medical record. RN #1 indicated Resident #10 was self-propelling in the wheelchair and had fragile skin prone to tearing but could not recall observing any facial bruises on Resident #10. RN #1 indicated she was unaware that a bruise of unknown origin was defined in the facility abuse policy and the facility abuse policy should have been followed. Interview, review of the clinical record, and facility incident report with the DNS on 2/27/2026 at 11:00 AM identified that she was not aware on 12/15/2025, Resident #10 had a facial bruise. The DNS identified based on the incident report Resident #10 did not know how the bruise occurred, so the cause of the facial bruise was of unknown origin. The DNS identified the investigation lacked staff interviews, and the facial bruise was determined to be of unknown origin. The DNS indicated she was unaware that a bruise of unknown origin is considered an injury of unknown origin, but that the facility Abuse Policy should be followed. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DNS identified there was insufficient information to determine the cause of the bruise and that the facility Abuse Policy should have been followed for reporting.Interview and review of the clinical record with RN #4 on 2/27/2026 at 12:00 PM identified she was the supervisor on 12/15/2025 at 5:00 AM when Resident #10's facial bruise was identified by the charge nurse on the unit during care. RN #4 identified she was called to the unit to evaluate the area and Resident #10 was unable to explain how the bruise occurred. RN #4 indicated she asked staff if they had observed anything that could have caused the bruise or if any incidents happened during care. RN #4 indicated staff reported they had not witnessed anything unusual during the shift. RN #4 indicated the APRN and the family were notified and she left the incident report in the nursing office. RN #4 could not recall notifying anyone else. 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. Signs of abuse included but were not limited to suspicious or unexplained bruising. Definitions of abuse and neglect included an injury of unknown origin when the source of the injury was not observed and could not be explained by the resident. For injuries of unknown origin or suspicious injuries, a state report was initiated as determined by the results of the investigation. Classification and categories of abuse are determined upon investigation. An investigation is used to determine what happened and include who was involved, interviews and written statements from staff and residents as applicable and completed applicable observations.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on observation, clinical record review, facility documentation review, facility policy review, and interviews for one (1) of three (3) residents (Resident #10) reviewed for accidents, the facility failed to complete a thorough investigation for an injury of unknown origin. The findings include: Resident #10 was admitted with diagnoses that included dementia, chronic obstructive pulmonary disease (COPD), systemic lupus erythematosus (lupus- a chronic autoimmune disease where healthy tissue was inflamed and damaged) and peripheral vascular disease (arteries in leg and arms become blocked).The RCP dated 9/20/3035 identified Resident #10 was at risk for impaired skin due to fragile skin secondary to long term steroid use with interventions that included to monitor skin with transfers and during care reporting any changes.The significant change Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 10/6/2025 identified Resident # 10 had a Brief Interview for Mental Status (BIMS) score of 11 indicative of moderately impaired cognition, required substantial assistance for transfer and was dependent on staff for mobility in the wheelchair. The facility incident report dated 12/15/2025 at 5:00 AM identified during care, staff observed a bruise on the right side of Resident #10's face. The bruise measured three (3) centimeters (cm) by 3 cm near the chin line. Resident #10 reported that she/he did not know how it happened. Resident #10 was alert with confusion and oriented to name per baseline. An investigation form completed by RN #4 identified Resident #10 was on Eliquis (blood thinner) as a causative factor, but the actual cause was unknown. The APRN was notified. No additional investigative documents were included in t incident file.A nurse's note dated 12/15/25 at 6:30 AM indicated Resident #10's family was notified of the bruise.Interview with APRN #1 on 2/26/2026 at 2:30 PM identified Resident #10 had fragile skin due to long term steroid use and had experienced multiple skin tears on her/his extremities despite use of protective interventions. APRN #1 indicated she could not recall being informed of any facial bruising on Resident #10. APRN #1 stated nursing may not have reported bruises separately when documenting frequent skin tears. APRN #1 identified a bruise on the face, torso, or one measuring 3 cm in length by 3 cm in width, would be unusual, potentially suspicious, and require further medical evaluation, as it may not be related to long-term steroid use for Resident #10's Lupus diagnosis.Interview and review of the clinical record with RN #1 on 2/27/2026 at 8:00 AM identified she recalled evaluating Resident #10's facial bruise on 12/18/2025 and 12/19/2025. RN #1 indicated Resident #10's bruise was resolving and she had documented daily per protocol for any identified skin issue. RN #1 identified if a staff member identifies a change in a resident's skin integrity such as a bruise or skin tear; the supervisor is notified. RN #1 indicated the supervisor completes a facility incident report and investigation to determine possible causes, updates the care plan, completes the necessary notifications, and initiates every shift evaluation in the electronic medical record. RN #1 indicated she was unaware that a bruise of unknown origin was defined in the facility abuse policy and the facility abuse policy should have been followed. RN #1 identified had she been aware, she would have completed a thorough investigation. Interview, review of the clinical record, and facility incident report with the DNS on 2/27/2026 at 11:00 AM identified that she was not aware on 12/15/2025, Resident #10 had a facial bruise. The DNS identified based on the incident report Resident #10 did not know how the bruise occurred, so the cause of the facial bruise was of unknown origin. The DNS identified the investigation lacked staff interviews, and the facial bruise was determined to be of unknown origin. The DNS identified that had she been aware, she would have expected a complete and thorough investigation of Resident #10's injury of unknown origin. Interview and review of the clinical record with RN #4 on 2/27/2026 at 12:00 PM identified she was the supervisor on 12/15/2025 at 5:00 AM when Resident #10's facial bruise was identified by the charge nurse on the unit during care. RN #4 identified she was called to the unit to evaluate the area and Resident #10 was unable to explain how the bruise occurred. RN #4 indicated she asked staff if they had observed anything that could have caused the bruise or if any incidents happened during care. RN (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#4 indicated staff reported they had not witnessed anything unusual during the shift. RN #4 indicated the APRN and the family were notified and she left the incident report in the nursing office. RN #4 could not recall notifying anyone else. Review of facility Abuse policy dated 6/6/2024, directed in part, that signs of abuse include but were not limited to suspicious or unexplained bruising. Definitions of abuse and neglect include an injury of unknown origin when the source of the injury was not observed and could not be explained by the resident. For injuries of unknown origin or suspicious injuries, a state report was initiated as determined by the results of the investigation. An investigation is used to determine what happened and include who was involved, interviews and written statements from staff and residents as applicable and completed applicable observations.

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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 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. Based on review of the clinical record, facility documentation, facility policies, and interviews for one (1) of five (5) residents (Resident #4) reviewed for unnecessary medications, the facility failed to develop and implement a comprehensive care plan to address the resident's diagnosis of dementia. The findings include:Resident #4 was admitted with diagnoses that included dementia, presence of right artificial knee joint, age related cognitive decline, diabetes mellitus, and hypertension.The admission orders dated 8/21/25 identified Resident #10 had a diagnosis of dementia.The nursing admission note dated 8/21/2025 at 4:14 PM identified Resident #10 had diagnoses that included weakness, diabetes, chronic kidney disease, and dementia. The note further identified Resident #10's family provided consent for psychiatric evaluation.The admission Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 8/28/25 identified that Resident #4 had a Brief Interview for Mental Status (BIMS) score of 8, indicating moderately impaired cognition, and an active diagnosis of non-Alzheimer's dementia.The RCP dated 9/3/25 identified that Resident #10 was newly admitted to the facility with a diagnosis of depression. Interventions directed staff to orient the resident to the facility and provide psychiatric services as needed. The RCP did not include the resident's diagnosis of dementia or any interventions to address dementia-related needs.Interview and review of the medical record with APRN #2 (psychiatric) on 2/26/2026 at 10:41 AM identified she evaluated Resident #4 on 10/15/2025 due to depression and cognitive decline. APRN #2 stated on 10/15/2025 her evaluation revealed significant cognitive problems consistent with Resident #4's diagnoses of unspecified dementia without behavioral disturbances.Interview with the Director of Nursing (DNS) on 2/26/26 at 2:00 PM identified that if a resident has a diagnosis of dementia, she expects the care plan to include specific interventions to address the resident's needs related to that diagnosis. The DNS was unable to explain why a comprehensive care plan was not implemented to address Resident #4's diagnosis of dementia.Review of the facility Resident Care Plan policy dated 5/17/2024, directed in part, that the RCP shall ensure maintenance of high quality, individualized care plan that utilized standard assessments and MDS to complete. The care plan will be reviewed and revised based on the changing needs of the resident. The care plan includes goals for resident care, approached to accomplish the goals consistent with resident's rehabilitation potential to ensure the highest level of function possible.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation review, facility policy review and interviews for 1 of 4 residents (Residents #71) reviewed for medication administration, the facility failed to ensure medications were administered in accordance with physician orders. The findings include: Resident #71 had diagnoses that included stoke, Parkinson's disease, depression, and cancer. The Resident Care Plan dated 1/18/25 identified Resident #71 had a diagnosis of Parkinson's disease (neurological disorder that causes a depletion in circulating dopamine levels in the brain) with interventions that directed to monitor for signs and symptoms of shuffling gait, pill rolling tremors, lip smacking, loss of voluntary movements, blank facial expressions, drooling, difficulty swallowing, feeling weak, easily fatigued, feeling heavy and stiff, and notify physician if any changes.The physician's orders dated 1/19/26 directed to administer Acyclovir (antiviral) 200 milligram (mg) twice a day; Amlodipine (used to lower blood pressure) 5 mg once daily; Calcium Acetate (used to lower high blood phosphorus) 667 mg 2 tablets three times a day; Eliquis (blood thinner) 5 mg twice a day; Fludrocortisone (used to treat low blood pressure) 0.2 mg once a day; Midodrine (used to treat low blood pressure) 10 mg three times a day; Potassium Chloride (mineral supplement) 20 milliequivalent (mEq) extended release once a day, Trelegy Ellipta (used to treat chronic obstructive pulmonary disease) inhaler one dose inhaled once daily; Droxidopa (used to treat orthostatic blood pressure) 200 mg three times a day ; and Sertraline (used to treat depression) 100 mg daily. The quarterly MDS assessment dated [DATE] identified Resident #71 had intact cognition and required maximum assistance with toileting, dressing, and personal hygiene. Review of the electronic Medication Administration Record dated 2/1/26 to 2/26/26 identified the following medications were omitted:on 2/17/26 Amlodipine (high blood pressure) 5 mg scheduled at 6:00 PM documented as not available and not administered on 2/18/26 Amlodipine 5 mg scheduled at 6:00 PM documented as not available and supervisor was notifiedon 2/22/26 Droxidopa 200 mg scheduled at 2:00 PM, and 10:00 PM documented as not available and not administered on 2/23/26 Droxidopa 200 mg scheduled at 8:00 AM, 2:00 PM, and 10:00 PM documented as not available and not administeredon 2/24/26 Droxidopa 200 mg scheduled at 8:00 AM, 2:00 PM, and 10:00 PM documented as not available and not administeredon 2/25/26 Droxidopa 200 mg scheduled at 8:00 AM, 2:00 PM, and 10:00 PM documented as not available and not administeredon 2/26/26 Sertraline 100 mg daily at 8:00 AM identified documented as not available and not administeredon 2/26/26 Droxidopa 200 mg scheduled at 8:00 AM documented as not available and not administered Review of the nursing progress notes dated 2/1/26 to 2/25/26 were unable to provide documentation to reflect the pharmacy, physician, or resident's representative were notified when Resident #71's medications were not available and were not administered in accordance with physician's orders. Observation of the medication administration with LPN #2 on 2/26/26 at 8:00 AM identified she introduced herself to Resident #71 and asked if he/she was ready for morning medications. LPN #2 went back to the medication cart in the hallway and used hand sanitizer. LPN #2 prepared Resident #71's medications and indicated she did not have available the Sertraline 100 mg daily and did not have the Droxidopa 200 mg available. LPN #2 indicated a couple of days ago she notified the supervisor that Resident #71's Droxidopa was not available. LPN #2 gave Resident #71's the medications she had prepared. Interview with RN #1 on 2/26/26 at 10:40 AM indicated she was not notified by LPN #2 that some of Resident #71's medications were unavailable. RN #1 stated during the medication pass, if a resident's medication is not available, it is the nurse's responsibility to notify her so she can check the emergency medication box to determine whether the medication is available. RN #1 further stated if the medication was still unavailable, she would contact the pharmacy, the physician or APRN, and the resident's representative. RN #1 also stated she would document the issue in the resident's medical record. Subsequent to surveyor inquiry, a nurse's note written by RN #1 dated 2/26/26 at 11:10 AM indicated she contacted the pharmacy and ordered (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #71's Droxidopa, Potassium, and Sertraline. RN #1 documented MD #1 was notified that Resident #71 had missed 12 doses of Droxidopa 200 mg, 2 doses of Amlodipine 5 mg, and 1 dose of Sertraline 100 mg. RN #1 further documented Resident #71's representative was notified.Interview and review of the clinical record with the Director of Nursing Services (DNS) on 2/26/2026 at 2:00 PM indicated that if a nurse does not have a medication available during the medication pass, the nurse should first check the medication cart and medication room. The DNS stated that if the medication is still not available, the nurse should notify the nursing supervisor so the supervisor can contact the pharmacy to determine when the medication will be available. The DNS further stated the supervisor should then notify the physician to determine whether the medication administration time should be adjusted or if an alternative medication should be ordered. The DNS indicated the supervisor should also notify the resident's representative if a medication is unavailable and inform them of the plan of care. The DNS stated the supervisor must document contact with the pharmacy, the physician, and the resident's representative in the resident's progress notes. Upon review of the clinical record, the DNS stated she was not aware that Resident #71 had not received his/her Parkinson's medication since 2/22/26 and had missed 12 doses or that Resident #71 had not received the additional listed medications. The DNS indicated that on 2/17/26 and 2/22/26 the nurse or supervisor should have notified the pharmacy, the physician, and the resident's representative and documented these actions in the progress notes. The DNS identified the omission of a medication is a medication error.Interview with Pharmacist #1 on 2/26/26 at 1:53 PM indicated the pharmacy does not contact the facility when medications require refilling. Pharmacist #1 identified it is the responsibility of the facility nurses to contact the pharmacy to request medication refills when a resident's supply is running low or has been depleted. Interview with MD #1 on 2/26/26 at 2:15 PM identified medications should be administered in accordance with physician/APRN orders. MD identified he was not aware the listed medications were not administered to Resident #71 on 2/17/26, 2/18/26, 2/22/26, 2/23/26, 2/24/26, and 2/26/26. MD #1 identified that if Resident #71 was not administered Droxidopa, it could result in an increase in Parkinson's disease symptoms; but had not at this time. MD #1 indicated that the medication had been ordered and would be delivered to the facility today. MD #1 further indicated that once the medication arrives at the facility, a dose will be administered to the resident. Review of the facility Medication Error Policy identified is to provide the appropriate identification, documentation, and assessment of medication errors, as well as for the education and systems improvement necessary to minimize and respond effectively to medication errors that occur. All medication errors are to be reported to the supervisor upon finding. The supervisor will notify the DNS and the attending physician or APRN. Examples of medication errors include wrong medication, wrong dose, omission of ordered dose, unordered medication, extra dose, wrong time of administration, and the wrong route of administration. When a medication error is made, the following will occur notify the physician or APRN, notify the residents representative, notify the DNS, supervisor will complete the medication error report, and resident will be placed on vital signs and charting every shift. Review of the facility Medication Administration Policy identified all medications are properly administered and documented on the electronic medication administration record. All medications will be properly administered per the physician/APRN orders. If a medication is unavailable per pharmacy the nursing supervisor or designee will call the physician/APRN and the resident/resident's representative to update them.

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	075236	A. Building B. Wing	02/27/2026

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

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on review of facility documentation, facility policy and interviews for three (3) of three (3) nurse aides (NA #1, NA #2 and NA #3), the facility failed to complete performance reviews at least once every 12 months as required. The findings include: Review of NA #1's personnel file identified a hire date of 11/14/2008. NA#1 was listed on the current nursing staff contact list.Review of NA #2's personnel file identified a hire date of 7/6/1992. NA# was listed on the current nursing staff contact list. Review of NA #3's personnel file identified a hire date of 7/17/2001. NA# was listed on the current nursing staff contact list. Interview with the Administrator on 2/25/26 at 10:00 AM identified that the Director of Nursing (DNS) is responsible for ensuring annual performance reviews are completed. The Administrator stated he was not surprised that NA #1, NA #2, and NA #3 had not received recent performance reviews because there had been recent transition in the DNS position. due to a recent transition in the DNS position. Interview and review of the employee files with the Human Resources Director on 2/25/2026 at 11:00AM identified that NA #1, NA#2 and NA #3 lacked documentation of an annual evaluation for 2024 and 2025. The facility Performance Appraisals policy directed in part, that the employee's supervisor was required to formally evaluate the employee's job performance before the end of sixty working days and then at least annually.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on clinical record review, facility documentation review, facility policy review, and interviews for facility Administration review, the facility failed to ensure the facility administered its resources effectively and to ensure effective administrative oversight of staff and resident care timely to maintain the highest practicable physical, mental, and psychosocial well-being of residents. The findings include: Based on clinical record review, facility documentation review, facility policy review, and interviews for facility Administration review, the facility failed to ensure the facility administered its resources effectively and to ensure effective administrative oversight of staff and resident care timely to maintain the highest practicable physical, mental, and psychosocial well-being of residents. The findings include: The facility administration failed to: Develop and implement a water management plan.Prevent and mitigate Legionella growth in the facility's water.Ensure the State Agency was notified, in a timely manner, of reportable events.Ensure injuries of unknown origin were investigated timely and thoroughly.Ensure medications were administered timely and according to professional standards.Ensure bimonthly narcotic audits were performed.Ensure required In-Service Training for all Nurse Aides was completed.Ensure Nurse Aide evaluations for all Nurse Aides employed over two (2) years were completed timely.Ensure care plans were reviewed and updated in a timely manner.Ensure the kitchen was maintained in a sanitary condition.Ensure a comprehensive infection control program was developed and maintained to include an antibiotic stewardship program.Ensure residents were educated and offered Influenza and Pneumococcal Immunizations.Ensure Minimum Data Set Comprehensive Assessments were completed and transmitted as per Center for Medicare and Medicaid Services (CMS) requirements.Please cross reference F580, F609, F610, F636, F638, F640, F656, F658, F689, F730, F755, F812, F880, F881, F883, and F947.Based on the deficiencies during the survey, immediate jeopardy was identified in: Infection Prevention and control.Interview with the Administrator on 2/26/26 at 11:40 AM identified he had been employed at the facility since 2018. The Administrator identified the facility did not have a water management plan because he was not aware the facility should have a water management plan. The Administrator identified although the Director of Physical Plant shared the last annual water testing results, he was not aware they were abnormal results.The facility failed to utilize resources effectively to attain/maintain the resident's well-being.Review of the Administrator Job Description identified the responsibility of the Administrator was to plan, organize, develop, direct, control and supervise the general operations of the facility in accordance with current federal, state, and local laws, regulations, standards and guidelines, and ensure the highest degree of quality resident life is maintained.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. Based on review of the clinical records, facility documentation, facility policy, and interviews, the facility failed to ensure the antibiotic stewardship program included a process for tracking antibiotic use, protocols, trends, and outcomes, and failed to develop, promote, and implement a facility-wide system to monitor the use of antibiotics. The findings include: Interview and review of the facility infection control program with RN #2 (Infection Preventionist) on 2/25/26 at 11:30 AM identified the facility does not maintain current or complete tracking of antibiotic use. RN #2 identified she has not implemented antibiotic stewardship principles to reduce adverse events, including antibiotic-resistant organisms, resulting from unnecessary or inappropriate antibiotic use. RN #2 identified the facility does not have a facility-wide system to monitor antibiotic use.Interview with RN #2 on 2/25/26 at 12:28 PM identified the facility uses a 3-day urine protocol (a diagnostic or surveillance approach focused on indwelling catheters) to prevent overuse of antibiotics; however, no other tracking logs exist for the 3-day urine protocol. RN #2 indicated the APRN reviews the culture and sensitivity reports (lab tests to identify specific bacteria in order to treat with the correct antibiotic) to confirm that the prescribed antibiotic targets the identified bacteria appropriately. RN #2 identified no additional tracking of antibiotic use occurs. Interview with RN #2 on 2/26/26 at 2:28 PM identified that the facility had 28 cases of pneumonia from 6/1/25 through 2/26/26. RN #2 identified she does not maintain an active line list, log, statistical reports to track infections, monitor antibiotic use, assess appropriateness, or evaluate outcomes. RN #2 indicated she does not keep any log or statistical reports to identify infections trends and does not use specific to monitor antibiotic use, appropriateness, or outcomes. RN #2 indicated that one APRN applies the McGeer's criteria (standardized criteria for antibiotic use) for antibiotic prescribing but does not track the information. RN #2 identified she does not maintain logs for multi-drug-resistant organisms (MDRO) but she is aware of residents' infection histories. Subsequent to surveyor inquiry, on 2/27/26 at 3:10 PM the Director of Nursing (DNS) provided a master line list dated 12/28/25, which listed 6 residents who were tested for Flu and Covid-19 during December 2025. RN #2 and the DNS did not provide any other lines lists or infection tracking. The DNS was unable to explain why the antibiotic stewardship program did not include a process for tracking antibiotic use protocols, and why a the facility failed to develop, promote, and implement a facility-wide system to monitor the use of antibiotics Review of facility Infection Control Surveillance Program policy dated 2/15/22, in part, directed that the objective was to have a process and outcome surveillance program that finds, analyzes, prevents and controls the spread of infectious disease and confirms resolution of identified infections. Review of facility Antibiotic Stewardship policy dated 11/2017, in part, directed that the facility antibiotic stewardship program promoted the appropriate use of antibiotics and a system of monitoring to improve resident outcomes and reduce antibiotic resistance. The Antibiotic Stewardship Program will be incorporated in the overall infection prevention and control program and reviewed and an annual basis and as needed. The nurse will utilize the McGeer's infection criteria protocol to determine if it is necessary to treat with antibiotics or if adjustments in therapy are to be made.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical record, facility policy, facility documentation, and interviews for 3 of 5 residents (Resident #9, #26, and #100) reviewed for pneumococcal immunizations, the facility failed to ensure the resident and/or resident representatives were educated and given an opportunity to consent or decline the pneumococcal vaccine and for 1 of 5 residents (Resident #26) reviewed for influenza immunizations, the facility failed to offer the influenza immunization to the resident upon admission. The findings include: 1.Resident #9 was admitted to the facility on [DATE] and had diagnoses that included hypertension, stroke, and arthritis.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #9 had intact cognition and Resident #9 had received the pneumococcal vaccine.Review of Resident #9's immunization record identified the resident had a pneumococcal vaccine on 1/1/2018. However, the clinical records and consent records failed to identify Resident #11 was offered the pneumococcal vaccine as to complete pneumococcal vaccine series on admission and which pneumococcal vaccine had been administered on 1/1/2018. Review of Resident #9's immunization consents, clinical record, and interview with the Infection Preventionist (RN #2) on 2/27/26 at 2:10 PM failed to identify that the pneumococcal vaccine was offered to the resident on admission or declination was obtained upon admission. 2. Resident #26 was admitted to the facility on [DATE] and had diagnosis that included progressive lung disease, lung cancer, and hypertension.The quarterly MDS assessment dated [DATE] identified Resident #26 had intact cognition, the pneumococcal vaccine was offered, and Resident #26 had declined. a. Review of Resident #26's clinical records and consent records failed to identify Resident #26 was offered the pneumococcal vaccine or a declination was obtained upon admission. b. Review of Resident #26's clinical records and consent records failed to identify Resident #26 was offered the influenza vaccine or a declination was obtained upon admissionA nurse's note dated 2/19/26 at 2:22 PM written the Infection Preventionist (RN#2) identified the CT wiz (a secure online system for managing immunization data) was active for Resident #26 and the resident had no immunization history documented.Review of Resident #26's clinical record, and interview with the Infection Preventionist (RN #2) on 2/27/26 at 2:10 PM failed to identify that the pneumococcal and influenza vaccines were offered to the resident on admission, and consent or declination was obtained upon admission. 3. Resident #100 was admitted to the facility on [DATE] and had diagnosis of chronic pain, arthritis and insomnia.The quarterly MDS assessment dated [DATE] identified Resident #100 had intact cognition. The MDS assessment further identified Resident #100 had no vaccine history listed. Review of Resident #100's immunization record identified the resident had a pneumococcal vaccine on 1/1/2018. However, the clinical records and consent records failed to identify Resident #100 was offered the pneumococcal vaccine to complete the pneumococcal vaccine series on admission and which pneumococcal vaccine had been administered on 1/1/2018. Review of Resident #100's clinical records and consent records failed to identify Resident #26 was offered the pneumococcal vaccine or a declination was obtained upon admission. Review of Resident #100's immunization consents, clinical record, and interview with the Infection Preventionist (RN #2) on 2/27/26 at 2:10 PM failed to identify that the pneumococcal vaccine was offered to the resident on admission or a declination was obtained upon admission.Interview with RN #2 on 2/27/26 at 2:27 PM identified she was responsible for ensuring residents are offered the pneumococcal and influenza vaccines on admission. RN #2 identified based on that information the pneumococcal and/or influenza vaccines should had been offered to the residents when admitted to the facility. RN #2 was unable to explain why the residents had not been educated and given an opportunity to consent or decline the pneumococcal or influenza vaccines. Subsequent to surveyor inquiry, on 2/27/26 at 3:10 PM, RN #2 provided a Resident Immunization Tracking log she had created using the facility's electronic medical record system. Review of the facility Infection Control Resident Vaccinations Policy directed that the influenza vaccine would be (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	offered starting 10/1 of each year when available through 3/31, unless medically contraindicated or has already been immunized. The pneumococcal vaccines would be offered to all residents on admission, according to CDC recommendations. Unless medically contraindicated or the resident had already been immunized or if the resident refused. To prevent the transmission of influenza and bacterial pneumonia within the facility. Resident vaccination protocols are monitored by the Infection Preventionist and or designee.