

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075241	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/07/2025
NAME OF PROVIDER OR SUPPLIER  River Glen Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  162 South Britain Rd Southbury, CT 06488	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review, facility documentation, and staff interviews for one of three residents (Resident #1) reviewed for abuse, the facility failed to ensure the resident was free from verbal mistreatment. The findings include:</p> <p>Resident #1 was admitted to the facility during 6/2025 with diagnoses that included metabolic encephalopathy and a history of falls. The admission Minimum Data Set (MDS) dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of six (6), indicating severely impaired cognition, had no behaviors and required maximal assistance with transfers. The Resident Care Plan (RCP) dated 6/13/2025 identified cognitive loss related to metabolic encephalopathy, and a risk for falls. Interventions directed to use simple words, reinforce the need to call for assistance, and to assist the resident with ADLs.</p> <p>Facility reportable event dated 6/16/2025 at 2 AM identified Resident #1 was confused, trying to get out of bed, and yelling out for his/her spouse, and the roommate reported that LPN #1 was verbally abusive when caring for Resident #1.</p> <p>Facility written statement from NA #1 on 6/16/2025 identified when she was providing care for Resident #1's roommate, Resident #1 started yelling and LPN #1 responded to the room. LPN #1 stated he was sick and tired of Resident #1. NA #1 stated she then heard LPN #1 tell Resident #1 go ahead fall on the floor and break your hip so I can send you out. Please go ahead and fall on the floor and bust your hip. RN #1/RN supervisor came to the unit around 6:30 AM and NA #1 reported what had happened during the night.</p> <p>Cross reference F603.</p> <p>Social Services note dated 6/16/2025 at 10:40 AM identified Resident #1's roommate reported inappropriate actions between staff and Resident #1 during the night of 6/16/2025, due to Resident #1 was restless and trying to get out of bed. The note indicated Resident #1 had no recollection of the incident. Resident #1 was confused and had no distress.</p> <p>Record review identified Resident #2 was Resident #1's roommate and was alert and oriented, with a BIMS of 15 (no impairment).</p> <p>Facility incident summary dated 6/23/2025 identified the facility did not substantiate the allegation of verbal abuse, and indicated the comments were misheard or misinterpreted.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 075241
		If continuation sheet Page 1 of 8

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with LPN #1 on 7/7/2025 at 12:51 PM identified he was caring for Resident #1 during the early morning of 6/16/2025 and stated Resident #1 was trying to get out of bed throughout the shift. LPN #1 denied verbally abusing Resident #1 in any way, or witnessing anyone verbally abusing Resident #1. LPN #1 stated he did not tell Resident #1 to fall and break their hip when he went into the room.</p> <p>Interview with the Director of Social Services and Social Worker #1 on 7/7/2025 at 1:39 PM identified Resident #2 was alert and oriented stated Resident #1 was agitated and trying to get out of bed during the morning of 6/16/2025. Resident #2 stated he/she reported LPN #1 threaten Resident #1 by stating he hoped he/she falls so he can send Resident #1 back to the hospital.</p> <p>Interview and record review with the DNS on 7/7/2025 at 2:35 PM identified Resident #2 called the facility about 6:30 AM and spoke with RN #1, and then RN #1 then went to the residents room. Although the facility summary indicated the allegation of verbal abuse was not substantiated, however the DNS stated the allegation was substantiated.</p> <p>Although attempted, interviews with RN #1 and NA #1 were not obtained during the survey.</p> <p>Facility Abuse Prevention Program policy dated 4/5/2018 directed in part, residents have the right to be free from abuse, including verbal abuse.</p>		

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<p>F 0603</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from separation (from other residents, his/her room, or confinement to his/her room).</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review, facility documentation, and staff interviews for one of three residents (Resident #1) reviewed for abuse, the facility failed to ensure the resident was free from involuntary seclusion. The findings include:</p> <p>Resident #1 was admitted to the facility during 6/2025 with diagnoses that included metabolic encephalopathy and a history of falls. The admission Minimum Data Set (MDS) dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of six (6), indicating severely impaired cognition, had no behaviors and required maximal assistance with transfers. The Resident Care Plan (RCP) dated 6/13/2025 identified cognitive loss related to metabolic encephalopathy, and a risk for falls. Interventions directed to use simple words, reinforce the need to call for assistance, and to assist the resident with ADLs.</p> <p>Facility reportable event dated 6/16/2025 at 2 AM identified Resident #1 was confused, trying to get out of bed, and yelling out for his/her spouse, and the roommate reported that LPN #1 was verbally abusive when caring for Resident #1.</p> <p>Facility written statement from NA #1 dated 6/16/2025 identified when she was providing care for Resident #1's roommate, Resident #1 started yelling and LPN #1 responded to the room. The statement indicated she heard LPN #1 state he was sick and tired of Resident #1 and to go ahead fall on the floor and break your hip so I can send you out. Further, NA #1 observed LPN #1 placed items around Resident #1's bed. LPN #1 pushed Resident #1's bed and pushed items in the room included two (2) wheelchairs, one nightstand against the sides of Resident #1's bed below the side rails (the sides of the bed were blocked by raised side rails, wheelchairs and a nightstand). LPN #1 then pushed Resident #2's bed against the wheelchair that was against Resident #1's side of the bed. The statement indicated that RN #1/RN supervisor came to the unit around 6:30 AM and NA #1 reported what had happened during the night and RN #1 helped NA #1 remove all the items surrounding Resident #1's bed.</p> <p>Facility incident summary dated 6/23/2025 identified on 6/16/2025 at approximately 9 AM, Resident #2 (alert and oriented with BIMS score 15) reported to the social worker that LPN #1 had yelled at Resident #1. The investigation indicated that Resident #1 was restless, attempting to climb out of bed, and yelling out during the 11 PM to 7 AM shift and NA #1 positioned herself outside the room. The investigation identified that LPN #1 had pushed items against Resident #1's bed (wheelchairs and a nightstand), and both quarter side rails were raised on the upper portion of the bed. The summary indicated that the allegation of abuse was not substantiated.</p> <p>Cross reference F600.</p> <p>Social Services note dated 6/16/2025 at 10:40 AM identified Resident #1's roommate reported inappropriate actions between staff and Resident #1 during the night of 6/16/2025, due to Resident #1 was restless and trying to get out of bed. The note indicated Resident #1 had no recollection of the incident. Resident #1 was confused and had no distress.</p> <p>(continued on next page)</p>		

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<p>F 0603</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Statement from RN #1 on 6/18/2025 identified she received a call about 6:40 AM from Resident #2 (Resident #1's roommate). Resident #2 requested to see RN #1, and RN #1 went to the room. The statement indicated when RN #1 entered the room she observed a bedside stand was wedged with a wheelchair between the bed and bedside stand and in-between the two (2) beds was another wheelchair on the opposite side. RN #1 then rearranged the wheelchairs and furniture.</p> <p>Interview with LPN #1 on 7/7/2025 at 12:51 PM identified he was caring for Resident #1 during the early morning of 6/16/2025 and stated Resident #1 was trying to get out of bed throughout the shift. LPN #1 stated about 4:30 AM he took Resident #1's nightstand and placed it on the right side of the bed against the bed. He then took the resident's wheelchair and placed it on the right side of the bed below the nightstand running along the resident's bed below the quarter side rail. Then, LPN #1 stated he placed the roommate's wheelchair on the left side of the bed below the quarter side rail running and indicated the position of the wheelchairs and nightstand prevented the resident from being able to exit his/her bed. LPN #1 stated he placed the items against the bed to prevent the resident from falling, and stated he was not supposed to place items against the bed to prevent the resident from getting up because it could be considered involuntary seclusion or a restraint. LPN #1 further indicated he did not attempt any other interventions for Resident #1's attempts to get out of bed (i.e. getting the resident out of bed or calling the physician), and thought he was handling the situation.</p> <p>Interview and record review with the DNS on 7/7/2025 at 2:35 PM identified LPN #1 had barricaded Resident #1 in his/her bed which prevented the resident from getting out of bed. The DNS indicated the incident was witnessed by NA #1 around 4 AM to 4:30 AM. When RN #1 was notified, she responded to the room around 6:30 AM and started removing the wheelchairs and furniture from the bed. The DNS stated the facility substantiated the allegation of involuntary seclusion.</p> <p>Facility Abuse Prevention Program policy dated 4/5/2018 directed in part, that residents have the right to be free from abuse, including involuntary seclusion.</p> <p>Facility Involuntary Seclusion policy dated September 2022 directed examples of involuntary seclusion include any attempt to keep a resident confined to a certain area by blocking the exit with furniture or a closed door.</p> <p>Review of facility documentation identified an QAPI meeting was held on 6/16/2025, education was initiated on 6/18/2025 for all staff regarding abuse and involuntary seclusion. Audits were initiated on 6/24/2025. Based on review, past non-compliance was identified.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review, facility documentation, and staff interviews for 1 of 3 residents (Resident #1) reviewed for abuse, the facility failed to ensure staff reported an allegation of abuse timely. The findings include:</p> <p>Resident #1 was admitted to the facility during 6/2025 with diagnoses that included metabolic encephalopathy and a history of falls. The admission Minimum Data Set (MDS) dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of six (6), indicating severely impaired cognition, had no behaviors and required maximal assistance with transfers. The Resident Care Plan (RCP) dated 6/13/2025 identified cognitive loss related to metabolic encephalopathy, and a risk for falls. Interventions directed to use simple words, reinforce the need to call for assistance, and to assist the resident with ADLs.</p> <p>Facility reportable event dated 6/16/2025 at 2 AM identified Resident #1 was confused, trying to get out of bed, and yelling out for his/her spouse, and the roommate reported that LPN #1 was verbally abusive when caring for Resident #1.</p> <p>Facility written statement from NA #1 dated 6/16/2025 identified when she was providing care for Resident #1's roommate, Resident #1 started yelling and LPN #1 responded to the room. The statement indicated she heard LPN #1 state he was sick and tired of Resident #1 and to go ahead fall on the floor and break your hip so I can send you out. Further, NA #1 observed LPN #1 placed items around Resident #1's bed. LPN #1 pushed Resident #1's bed and pushed items in the room included two (2) wheelchairs, one nightstand against the sides of Resident #1's bed below the side rails (the sides of the bed were blocked by raised side rails, wheelchairs and a nightstand). LPN #1 then pushed Resident #2's bed against the wheelchair that was against Resident #1's side of the bed. The statement indicated that RN #1/RN supervisor came to the unit around 6:30 AM and NA #1 reported what had happened during the night and RN #1 helped NA #1 remove all the items surrounding Resident #1's bed.</p> <p>Facility incident summary dated 6/23/2025 identified on 6/16/2025 at approximately 9 AM, Resident #2 (alert and oriented with BIMS score 15) reported to the social worker that LPN #1 had yelled at Resident #1. The investigation indicated that Resident #1 was restless, attempting to climb out of bed, and yelling out during the 11 PM to 7 AM shift and NA #1 positioned herself outside the room. The investigation identified that LPN #1 had pushed items against Resident #1's bed (wheelchairs and a nightstand), and both quarter side rails were raised on the upper portion of the bed. The summary indicated that the allegation of abuse was not substantiated.</p> <p>Statement from RN #1 on 6/18/2025 identified she received a call about 6:40 AM from Resident #2 (Resident #1's roommate). Resident #2 requested to see RN #1, and RN #1 went to the room. The statement indicated when RN #1 entered the room she observed a bedside stand was wedged with a wheelchair between the bed and bedside stand and in-between the two (2) beds was another wheelchair on the opposite side. RN #1 then rearranged the wheelchairs and furniture.</p> <p>Review of the CT Department of Public Health, Facility Licensing and Investigation Section events report tracking system identified the incident occurred on 6/16/2025 at 2 AM. An additional review identified the incident was reported at 9:24 AM.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview and record review with the DNS on 7/7/2025 at 2:35 PM identified although NA #1 witnessed the incident at approximately 4:30 AM, NA #1 did not notify the RN supervisor at that time. Further, RN #1 became aware of the allegation at 6:30 AM. The DNS stated she and the Administrator were not notified of the allegation until approximately 9 AM, and she then notified the Stated Agency. The DNS stated NA #1 should have reported the allegation when it occurred, and RN #1 should have reported the allegation when she became aware at 6:30 AM. Interview failed to identify why NA #1 and RN #1 did not report the abuse timely.</p> <p>Review of Abuse Investigation and Reporting policy dated July 2017 directed in part, that staff are to notify Administration immediately of an allegation of abuse.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review, facility documentation, and staff interviews for one of three residents (Resident #1) reviewed for abuse, the facility failed to ensure the medical record was complete and accurate to include documentation of an allegation of abuse timely. The findings include:</p> <p>Resident #1 was admitted to the facility during 6/2025 with diagnoses that included metabolic encephalopathy and a history of falls. The admission Minimum Data Set (MDS) dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of six (6), indicating severely impaired cognition, had no behaviors and required maximal assistance with transfers. The Resident Care Plan (RCP) dated 6/13/2025 identified cognitive loss related to metabolic encephalopathy, and a risk for falls. Interventions directed to use simple words, reinforce the need to call for assistance, and to assist the resident with ADLs.</p> <p>Facility reportable event dated 6/16/2025 at 2 AM identified Resident #1 was confused, trying to get out of bed, and yelling out for his/her spouse, and the roommate reported that LPN #1 was verbally abusive when caring for Resident #1.</p> <p>Facility written statement from NA #1 dated 6/16/2025 identified when she was providing care for Resident #1's roommate, Resident #1 started yelling and LPN #1 responded to the room. The statement indicated she heard LPN #1 state he was sick and tired of Resident #1 and to go ahead fall on the floor and break your hip so I can send you out. Further, NA #1 observed LPN #1 placed items around Resident #1's bed. LPN #1 pushed Resident #1's bed and pushed items in the room included two (2) wheelchairs, one nightstand against the sides of Resident #1's bed below the side rails (the sides of the bed were blocked by raised side rails, wheelchairs and a nightstand). LPN #1 then pushed Resident #2's bed against the wheelchair that was against Resident #1's side of the bed. The statement indicated that RN #1/RN supervisor came to the unit around 6:30 AM and NA #1 reported what had happened during the night and RN #1 helped NA #1 remove all the items surrounding Resident #1's bed.</p> <p>Social Services note dated 6/16/2025 at 10:40 AM identified Resident #1's roommate reported inappropriate actions between staff and Resident #1 during the night of 6/16/2025, due to Resident #1 was restless and trying to get out of bed. The note indicated Resident #1 had no recollection of the incident. Resident #1 was confused and had no distress.</p> <p>Facility incident summary dated 6/23/2025 identified on 6/16/2025 at approximately 9 AM, Resident #2 (alert and oriented with BIMS score 15) reported to the social worker that LPN #1 had yelled at Resident #1. The investigation indicated that Resident #1 was restless, attempting to climb out of bed, and yelling out during the 11 PM to 7 AM shift and NA #1 positioned herself outside the room. The investigation identified that LPN #1 had pushed items against Resident #1's bed (wheelchairs and a nightstand), and both quarter side rails were raised on the upper portion of the bed. The summary indicated that the allegation of abuse was not substantiated.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Statement from RN #1 on 6/18/2025 identified she received a call about 6:40 AM from Resident #2 (Resident #1's roommate). Resident #2 requested to see RN #1, and RN #1 went to the room. The statement indicated when RN #1 entered the room she observed a bedside stand was wedged with a wheelchair between the bed and bedside stand and in-between the two (2) beds was another wheelchair on the opposite side. RN #1 then rearranged the wheelchairs and furniture.</p> <p>Record review identified although NA #1 alleged to have witnessed the incident between LPN #1 and Resident #1, and RN #1 observed the furniture against the bed that prevented Resident #1's egress from the bed, the clinical record failed to identify the incident prior to the social service note dated 6/16/2025 at 10:40 AM. Review failed to identify the allegation, and failed to identify the physician and responsible party were notified.</p> <p>Although attempted, an interview with RN #1 was not obtained during the survey.</p> <p>Interview and record review with the DNS on 7/7/2025 at 2:35 PM identified RN #1 was aware of the incident on 6/16/2025 at 6:30 AM. The DNS was unable to provide documentation that RN #1 wrote a nursing note, to include that the physician and responsible party were notified. Further, the DNS indicated RN #1 should have written a nursing note and she did not know why it was not done.</p> <p>Facility Charting and Documentation policy dated July 2017 directed in part, information was to be documented in the resident's medical record, events, incidents or accidents involving the resident and notification of the family.</p>		