STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075252	A. Building B. Wing	06/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westside Care Center	349 Bidwell Street Manchester, CT 06040

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, review of facility policy and staff interview, the facility failed to ensure that a section of the kitchen undergoing construction was appropriately sealed off from food preparation and storage areas to prevent the spread of infection. The findings include: On 6/15/2026 at 9:55 AM, a tour of the kitchen with the Dietary Director identified an area of the kitchen undergoing construction. The area undergoing construction contained multiple surfaces and fixtures with a visible accumulation of dust and debris, including stainless steel equipment, surrounding pipes, and portions of the tile floor.The temporary plastic barrier separating the construction area from the operational kitchen was torn in several areas and secured with loose or partially detached tape. The torn sections and unsecured edges created large visible gaps in the plastic barrier between the construction area and the adjacent operational portion of the kitchen.A fan was positioned in the operational portion of the kitchen; the fan, which was in operation and mounted on the wall, faced the operational area with the torn plastic barrier behind it. The fan's casing and blades showed visible dust and residue.An interview with the Dietary Director identified that the dish room was undergoing construction for a replacement dishwasher and that construction had started in May 2026, but the director could not recall the exact date. The Dietary Director further indicated work had been done on the floor, plumbing, and electrical. Additionally, the Dietary Director indicated that the plastic barrier was intended to contain the construction area away from the operational kitchen.On 6/15/2026 at 10:30 AM, an interview with the Director of Maintenance indicated the plastic barrier had been intact when he last worked on 6/12/2026, and he thought that it may have been torn when a contractor brought the new dishwasher over the weekend.On 6/15/2026 at 2:50 PM, an interview with the Administrator indicated that construction had begun on 5/7/2026 and that construction included removing part of the floor. The administrator further indicated that construction on the floor had been completed on 6/8/2026 and that, after surveyor's inquiry, the facility would be cleaning the dust and debris from the unsealed construction area.No policy for the management of construction debris was provided by the facility upon request.

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interview, observations, review of facility documentation and staff interviews for (9 of 13) air conditioners on all units sampled, the facility failed to ensure the hallway and dining room air conditioners were maintained in a clean and sanitary manner. The facility also failed to ensure the laundry area was clean and dust free. The findings include: 1.On [DATE] at 11:19 AM, Resident #115 was interviewed on the B wing and stated that the facility's air conditioners were moldy. Resident #115 moved to the dining room and turned on the wall mounted mini split in one corner above a piano. When turned on, a distinct mildew smell was noted. Soft, black debris was seen coming from the vents and landing on the piano below. Inspection of the mini split's interior revealed black stains inside the vents and more black debris.Further observations identified there were a total of 8 residents in the dining room at the time. Three of the residents (Residents #20, 99, and 105) were readily adjacent to the mini split.On [DATE] at 12:00 PM, an observation with the Administrator and Director of Nursing Services (DNS)was completed of the first-floor dining room mini split, including observing the black debris inside the vents and on top of the piano. On [DATE] at 1:10 PM, an interview with the Director of Maintenance indicated the air conditioners are serviced on a regular basis and the first-floor dining room air conditioner may have just been overlooked. The Director of maintenance further indicated that it was an outside company that performed the service but was not sure when the last time they came. Additionally, the Director of Maintenance indicated that cleaning of the air conditioners was performed by the housekeeping department.A review of the facilities' Monthly Heating Ventilation and Air Conditioning (HVAC) P.M. maintenance log for 2026 indicated the HVAC units in the first and second floor dining rooms and nursing units were cleaned monthly. The log indicated HVAC filters were cleaned and coils inspected on [DATE] and [DATE].On [DATE], one day after documentation indicating the air conditioners had been cleaned, an observation in all four nursing units identified eight ceiling-mounted air conditioners with thick visible dust on the filters and black stains and debris in the vents: three in Unit A, two in Unit B, two in Unit C, and one in Unit D.On [DATE] at 10:30 AM, an interview and review of the Monthly HVAC P.M maintenance log for 2026 with the Director of Housekeeping indicated that monthly maintenance of the air conditioners included cleaning the outside and vacuuming the filters. The Director of Housekeeping indicated he had performed the cleaning of the air conditioners on [DATE] and [DATE] and that all air conditioners were cleaned the same day. The Director of Housekeeping indicated that he had cleaned the dining room mini split on [DATE] after being notified of the observed black debris and stains and indicated that he did not know what the black debris and stains were. The Director of Housing Keeping further indicated he had not seen the air conditioners with the black debris and stains on any of the days he had cleaned it.On [DATE] at 10:48 AM, an observation of the nursing unit air conditioners with the Administrator and the Director of Housekeeping identified an air conditioning unit in Unit D noted with a thick layer of dust covering the entire filter. The Director of Housekeeping indicated that it was possible the amount of dust on the filter had accumulated over two days.A policy for air conditioner cleaning and maintenance was not available at the facility when requested. 2. During a tour of the laundry facilities, observation on [DATE] at 11:39 AM observation identified the following:A semi-clear dirty pitcher with an unknown substance dried on the edges located between two washing machinesClean mop area had a clean mop head on the floorA drying area with clothes and medical equipment visibly uncovered in the same room as the clean laundry dryersUncovered sheets and towels above boxes on a metal rack in the folding areaThick pipes covered with a large amount of visible dust in the clean laundry folding roomTwo bags of dirty curtains are located between two washing machines waiting to be cleanedA yellow mop bucket with a garbage can liner filled with rags and another garbage can linerAn old washing machine frame filled with a large black trash bag (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	containing used clothing, a blue purse, a sneaker with a red sole, and other unidentified clothing itemsAn open door to an outside area covered in asphalt with brown and black visibly soiled plastic curtains and a visibly soiled doorTwo uncovered racks of resident clothing, labeled, to be distributed to residents on 2 floorsBlinds visibly covered with a heavy layer of dust in the clean folding roomA dusty air conditioner under dusty blinds surrounded by sheets and blankets with a water bottle and bottle of lotion on the windowsill surrounding the air conditionerA dirty mop located in the corner beside lockers in the clean laundry folding roomUncovered bins in the labeling area with unidentified resident clothing itemsCobwebs were visibly noticeable on the windowsills behind the washing machinesInactive wired phone system located in the label/ storage room for missing and extra resident clothing and socksA wall mounted fan with blades covered in visible dust mounted in the washing machine areaInterview with Director of Maintenance on [DATE] at 11:50 AM identified that housekeeping was responsible for keeping the laundry area clean.Interview with the Housekeeper #1 on [DATE] at 12:12 PM identified the facility was aware of the items located in the washing machine room and identified the items as belonging to expired residents and were held there in case the families wanted to claim the items. Housekeeper #1 identified these items had been in the washing machine area for at least over 1 month. Housekeeper #1 identified that it was her general practice to keep the door to the washing machine area open while in use. She identified that she would use the door with the plastic curtains to bring out clean laundry and bring in dirty laundry for washing. Interview with Housekeeper #2 on [DATE] at 12:18 PM identified housekeeping was responsible for maintaining and cleaning the laundry area.Review of Personal Laundry and Handling Policy dated [DATE] directed, in part, that the facility should handle linens and personal items according to manufacturers' recommendations, wear appropriate Personal Protective Equipment such as gloves and gowns when handling soiled items, and that all clean linen should be covered with a wrapper or sheet for storage and transport.After surveyor inquiry, the facility removed items stored in the washingˆmachine room; removed dust from blinds; removed cobwebs from windowsills; removed and rewashed the clean mop head found on the floor;

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, review of facility documents, review of policy and staff interviews for 1of 3 residents (Resident # 117) reviewed for Abuse, the facility failed to ensure Resident # 59 was free from abuse. The findings include: 1. Resident #59's diagnoses included anxiety, major depression, Post Traumatic Stress Disorder (PTSD) and bipolar disorder. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #5 was cognitively intact and had no mood or behavioral symptoms. The care plan dated 11/05/2025 indicated Resident #5 was independent for all activities of daily living including transfer and locomotion on the unit. The care plan further indicated Resident #59 enjoys conversing with his/her peers and can pursue his/her own activities without facility intervention. Intervention included: to monitor mood as needed for increased anger, labile mood or agitation, or thoughts of wanting to hurt others. A facility Incident Report dated 1/23/2026 indicated at 8:30 PM Resident #5(the alleged victim) and Resident #117 (the alleged perpetrator) were in the dining room involved in a physical altercation from which no injuries were found on either resident. The residents were separated and both placed on 15-minute checks per the facility resident to resident protocol. The Advanced Practice Registered Nurse (APRN), family and police were notified and an investigation was started. The Registered Nurse (RN) supervisor, RN #5 completed an investigation sheet dated 1/23/2026 at 8:30 PM indicating Resident #5 and Resident #117 had an altercation in the dining room at 8:30 PM and Resident #117 had confronted Resident #5 about an incident that occurred months ago which on the current day resulted in a physical altercation. Staff interviews were conducted with no staff seeing the incident but a staff member indicated Resident (#115) had witnessed the altercation. A physician's order dated 1/24/2026 at 12:30 AM (effective 1/23/2026 at 11:00 PM) directed to provide neurological checks every shift for 3 days due to altercation. The care plan dated 1/29/2026 indicated Resident #59 was involved in a resident-to-resident altercation. Intervention included: to allow the resident to discuss frustrations, Social Worker and psychiatric services along with medications as needed. A late entry Registered Nurse (RN) nursing note with effective date of 1/23/2026 at 11:10 PM indicated Resident #5 was observed to be involved in a negative community altercation with another (Resident #117). Both residents were separated once staff arrived on scene. Vital signs taken and assessed for injuries with none noted. The APRN was notified with new orders for vital signs, neurological checks every shift for 3 days and a psychiatric referral. The Conservator of Person (COP) was notified along with notification of the police. An eInteract SBAR summary for providers notes completed on 1/23/2026 at 11:29 PM noted a report of a change of condition including vital signs, APRN notification and physician's orders directing staff to follow facility protocol for a resident-to-resident altercation. Facility documentation of 15-minute checks used as a nursing measure for both Resident #59 and Resident #117 were put into place and continued until the psychiatric evaluations were completed. A resident statement/interview form completed by Social Worker (SW #2)on 1/27/2026 at 11:00AM indicated Resident #59 said s/he was walking down the hallway and Resident #117 swung his/her cane at Resident #5 at which time s/he pushed Resident #117 and punched him/her in the face a couple of times while the other resident pushed during the interaction. A late entry psychosocial note dated effective date of 1/27/2026 at 2:35 PM indicated the social worker followed up with Resident #59 who indicated the two residents apologized and are on amical terms. The social worker documented subsequent follow-up visits on 1/28/2026 at 2:35 PM and 1/29/2026 at 2:37 PM with no issues or concerns. On 2/03/2026 the social worker note indicated s/he was following up regarding a room change but Resident #5 still declined a room change. Resident #59 had a psychiatric visit note dated 1/27/2026 signed at 4:09 PM indicating the resident was being evaluated due to a peer-to-peer incident. Resident #5 indicated there was no change in his/her mood, alternative ways to handle the (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	situation were discussed, Resident #5 indicated feeling safe in the current environment with no latent psychological concerns from the incident. Resident #5 was found not a risk to others or danger to him or herself. On 1/27/2026 the psychotherapist visited Resident #59 with the visit note signed at 4:48PM indicating had followed up with Resident #59 regarding the recent altercation and discussed steps to take to help reduce escalation of an event in the future. Subsequent visit to Resident #59 occurred on 1/29/2026 with the note signed at 4:48 PM and on 2/03/2026 Signed at 1:40 PM both visits without any new concerns. 2. Resident #117's diagnosis includes depressive episodes. The annual MDS assessment dated [DATE] indicated Resident #117 was cognitively intact and had some depressive symptoms but no behavioral symptoms. The care plan dated 11/20/2025 indicted Resident #117 had a self-care deficit due to weakness and depression but was able to self-transfer with a walker. The care plan further indicated Resident #117 pursued his/her own leisure activities and enjoyed the coffee social and exhibits verbal aggression including yelling at staff during periods of frustration or emotional dysregulation. Interventions, in part, included for the social worker to meet weekly or as needed to discuss triggers, coping skills and emotional regulation, and reinforce expectations for respectful communication. The resident interview conducted by SW#2 on 1/27/2026 at 11:15 AM indicated Resident #117 was not forth coming with any information regarding the incident and only indicated Resident #59 was a thief. The social worker note indicated education and support was provided and the administrator and Director of Nursing Services (DNS) were updated. The psychosocial note written by SW #2 on 1/27/2026 at 2:38 PM indicated Resident #117 stated s/he was now on amical terms with Resident #5 further follow up visit notes by SW#2 were documented on 1/28/2026 at 2:41 PM and 1/29/2026 at 2:42 PM with no concerns noted. A psychiatric visit note dated 1/27/2026, signed at 4:22 PM, indicated visiting the resident on this day due to a peer-to-peer incident. The note indicated Resident #117 was not very engaging and did not want to provide any details about the event but affirmed feeling safe in the facility. The resident did indicate having increased anxiety and a medication adjustment was made with recommendations to continue psychotherapy. A psychotherapy visit note on 1/29/2026 signed at 5:16 PM indicated some conversation regarding Resident #117's perspective regarding the past incident. An interview with Resident #115 on 6/22/26 at 9:50 AM indicated she/he did recall the incident but no details. An interview, facility document and clinical record review with the Director of Nursing Services (DNS) on 6/22/26 at 9:51 AM indicated Resident #117 allegedly had a history of sharing his/her items with others and mistakenly accused and then approached Resident #59 of taking his/her coffee grounds. The resident witness (Resident # 115) had indicated in a statement Resident #117 had an open palm to the shoulder at Resident #5. The residents made up the next day, and it was identified the coffee grounds had been given by Resident #117 to another resident. The DNS indicated there were no staff in the dining room as they were transporting residents and providing care at the time per the statements when the incident occurred. However, when staff members heard Resident # 5 and Resident # 117 discussion escalate, they came in and separated the residents although the statements and incident reports did not indicate what staff separated the residents and no documentation of Resident #5's or Resident #117's statement of what occurred on that date. A full statement provided by Resident #5 to SW#2 on 1/27/2026 (upon return to work after the weekend off) indicated Resident # 117 had raised a cane at him/her and pushed the Resident # 59 then Resident # 59 punched Resident # 117 in the face a couple times. During the resident and witness statement inquiry the DNS indicated since there was a witness who said it was an open palm on a shoulder versus the incident described during SW#2's interview on 1/27/2026 with Resident #115 with Resident #117 not being forthcoming with any details they had to go with the witness statement. The DNS indicated RN #8 the supervisor on duty during the incident and the charge nurse on duty LPN #5 might have more information since no detailed interviews were taken and documented from Resident #59 or Resident #117 at the time of the incident which would have been most accurate, the DNS indicated RN #8 was on vacation through the week and weekend but would try to reach him/her. The (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DNS indicated psychiatric services followed up with both residents and they are given all the investigative documents before they see the residents. At 12:05 PM the DNS indicated s/he was unable to reach RN #8. On 6/22/26 at 10:59 AM an interview with SW#2 who no longer employed by the facility indicated she/he could not recall the written interview with Resident # 59. When surveyor read the interview to SW # 2 she/he still indicated she/he could not recall. SW#2 did indicate after the interview s/he did update the DNS and administrator. An interview with the DNS on 6/24/2026 indicated she/he called the staffing agency of LPN #5 to work but was unsuccessful in obtaining LPN #5 phone number. An interview at 12:07 PM on 6/24/2026 with charge nurse on the other unit, LPN #4 indicated she recalled hearing Resident #117 yelling and when she/he went toward the dining room, the residents were already being separated by the agency charge nurse (LPN #5) on the other unit. LPN #4 indicated Resident # 115 who resided on the charge nurse's unit told him/her what occurred when LPN #4 entered the dining room but at this time cannot remember exactly what was said or who the other resident was since it was not on her unit. LPN #4 then recalled something that was said about a walking stick and Resident #117 might have been threatening to hit another resident with it. Interview with RN #8 during the survey was unsuccessful.The facility provided documented education of staff regarding the abuse policy and recreation staff had met with some residents to remind them to obtain a staff member when an altercation occurs. The facility policy labeled Abuse indicated in part notes residents will not be subjected to abuse (example- verbal or physical) by anyone including other residents. Allegations of abuse will be reported immediately and thoroughly investigated. The alleged abuser would be removed from the other residents, consultation with law enforcement, family physician and the state agency as required. Social Work staff will assess the resident for psychological effects and provide supportive counseling as needed. The facility during the survey alleged Past Non-Compliance based on the following below:Date of Alleged Incident 1/23/261.Resident # 117 continues to receive care in the facility and report feeling safe, comfortable at the facility and had no psycho-social effects from the alleged incident.2. Resident # 5 the offending party has been educated by the social worker, local police department, psychiatric APRN pertaining to her/his actions. In addition, Resident # 5 told to have no contact with Resident # 117. Both Resident # 117 and Resident # 5 were offered room changes, but both parties declined. Resident # 117 and Resident # 5 care plans have been updated.3. Any resident who has diagnosis of bipolar disorder with an adjustment disorder and is seeking to resolve an incident with their peers, without staff mediation has the potential to be affected by the alleged deficient practice.4. Residents will be educated on informing staff regarding any issue or concerns they may potentially have with their peers, rather than addressing the concerns independently to avoid any altercations. Facility staff will be educated on the facility abuse policy, and the importance of resident-to-resident altercations not occurring with immediate intervention. Education will be completed by January 23, 2026.5. To ensure compliance, weekly random audits will be conducted to ensure Resident # 5 and other residents feel comfortable in their surroundings amongst their peers. These audits will commence on January 29,26 and will continue for the next 30 days until substantial compliance has been achieved. Results of these audits results will be forwarded to QAPI Committee for review. The DNS is responsible for this plan of action. Based on the following information above the facility provided the necessary information for Past Non- Compliance.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, review of facility documentation, review of policy and staff interviews, the facility failed to conduct a thorough Resident-to-Resident abuse investigation when Resident # 59 told RN # 5 she/he hit Resident # 117 when Resident # 117 attempted to strike at her/him with a cane. The findings include: Resident #59's diagnoses included anxiety, major depression, Post Traumatic Stress Disorder (PTSD) and bipolar disorder. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #5 was cognitively intact and had no mood or behavioral symptoms. The care plan dated 11/05/2025 indicated Resident #5 was independent for all activities of daily living including transfer and locomotion on the unit. The care plan further indicated Resident #59 enjoys conversing with his/her peers and can pursue his/her own activities without facility intervention. Intervention included: to monitor mood as needed for increased anger, labile mood or agitation, or thoughts of wanting to hurt others. A facility Incident Report dated 1/23/2026 indicated at 8:30 PM Resident #5(the alleged victim) and Resident #117 (the alleged perpetrator) were in the dining room involved in a physical altercation from which no injuries were found on either resident. The residents were separated and both placed on 15-minute checks per the facility resident to resident protocol. The Advanced Practice Registered Nurse (APRN), family and police were notified and an investigation was started. The Registered Nurse (RN) supervisor, RN #5 completed an investigation sheet dated 1/23/2026 at 8:30 PM indicating Resident #5 and Resident #117 had an altercation in the dining room at 8:30 PM and Resident #117 had confronted Resident #5 about an incident that occurred months ago which on the current day resulted in a physical altercation. Staff interviews were conducted with no staff seeing the incident, but a staff member indicated Resident (115) had witnessed the altercation. A physician's order dated 1/24/2026 at 12:30 AM (effective 1/23/2026 at 11:00 PM) directed to provide neurological checks every shift for 3 days due to altercation. The care plan dated 1/29/2026 indicated Resident #59 was involved in a resident-to-resident altercation. Intervention included: to allow the resident to discuss frustrations, Social Worker and psychiatric services along with medications as needed. A late entry Registered Nurse (RN) nursing note with effective date of 1/23/2026 at 11:10 PM indicated Resident #5 was observed to be involved in a negative community altercation with another (Resident #117). Both residents were separated once staff arrived on scene. Vital signs taken and assessed for injuries with none noted. The APRN was notified with new orders for vital signs, neurological checks every shift for 3 days and a psychiatric referral. The Conservator of Person (COP) was notified along with notification of the police. An eInteract SBAR summary for providers notes completed on 1/23/2026 at 11:29 PM noted a report of a change of condition including vital signs, APRN notification and physician's orders directing staff to follow facility protocol for a resident-to-resident altercation. Facility documentation of 15-minute checks used as a nursing measure for both Resident #59 and Resident #117 were put into place and continued until the psychiatric evaluations were completed. A resident statement/interview form completed by Social Worker (SW #2)on 1/27/2026 at 11:00AM indicated Resident #59 said s/he was walking down the hallway and Resident #117 swung his/her cane at Resident #5 at which time s/he pushed Resident #117 and punched him/her in the face a couple of times while the other resident pushed during the interaction. A late entry psychosocial note dated effective date of 1/27/2026 at 2:35 PM indicated the social worker followed up with Resident #59 who indicated the two residents apologized and are on amical terms. The social worker documented subsequent follow-up visits on 1/28/2026 at 2:35 PM and 1/29/2026 at 2:37 PM with no issues or concerns. On 2/03/2026 the social worker note indicated s/he was following up regarding a room change but Resident #5 still declined a room change. Resident #59 had a psychiatric visit note dated 1/27/2026 signed at 4:09 PM indicating the resident was being evaluated due to a peer-to-peer incident. Resident #5 indicated there was no change in his/her mood, alternative ways to handle the (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	situation were discussed, Resident #5 indicated feeling safe in the current environment with no latent psychological concerns from the incident. Resident #5 was found not a risk to others or danger to him or herself. On 1/27/2026 the psychotherapist visited Resident #59 with the visit note signed at 4:48PM indicating had followed up with Resident #59 regarding the recent altercation and discussed steps to take to help reduce escalation of an event in the future. Subsequent visit to Resident #59 occurred on 1/29/2026 with the note signed at 4:48 PM and on 2/03/2026 Signed at 1:40 PM both visits without any new concerns. 2. Resident #117's diagnosis includes depressive episodes. The annual MDS assessment dated [DATE] indicated Resident #117 was cognitively intact and had some depressive symptoms but no behavioral symptoms. The care plan dated 11/20/2025 indicted Resident #117 had a self-care deficit due to weakness and depression but was able to self-transfer with a walker. The care plan further indicated Resident #117 pursued his/her own leisure activities and enjoyed the coffee social and exhibits verbal aggression including yelling at staff during periods of frustration or emotional dysregulation. Interventions, in part, included for the social worker to meet weekly or as needed to discuss triggers, coping skills and emotional regulation, and reinforce expectations for respectful communication. The resident interview conducted by SW#2 on 1/27/2026 at 11:15 AM indicated Resident #117 was not forth coming with any information regarding the incident and only indicated Resident #59 was a thief. The social worker note indicated education and support was provided and the administrator and Director of Nursing Services (DNS) were updated. The psychosocial note written by SW #2 on 1/27/2026 at 2:38 PM indicated Resident #117 stated s/he was now on amical terms with Resident #5 further follow up visit notes by SW#2 were documented on 1/28/2026 at 2:41 PM and 1/29/2026 at 2:42 PM with no concerns noted. A psychiatric visit note dated 1/27/2026, signed at 4:22 PM, indicated visiting the resident on this day due to a peer-to-peer incident. The note indicated Resident #117 was not very engaging and did not want to provide any details about the event but affirmed feeling safe in the facility. The resident did indicate having increased anxiety and a medication adjustment was made with recommendations to continue psychotherapy. A psychotherapy visit note on 1/29/2026 signed at 5:16 PM indicated some conversation regarding Resident #117's perspective regarding the past incident. An interview with Resident #115 on 6/22/26 at 9:50 AM indicated she/he did recall the incident but no details. An interview, facility document and clinical record review with the Director of Nursing Services (DNS) on 6/22/26 at 9:51 AM indicated Resident #117 allegedly had a history of sharing his/her items with others and mistakenly accused and then approached Resident #59 of taking his/her coffee grounds. The resident witness (Resident # 115) had indicated in a statement Resident #117 had an open palm to the shoulder at Resident #5. The residents made up the next day, and it was identified the coffee grounds had been given by Resident #117 to another resident. The DNS indicated there were no staff in the dining room as they were transporting residents and providing care at the time per the statements when the incident occurred. However, when staff members heard Resident # 5 and Resident # 117 discussion escalate, they came in and separated the residents although the statements and incident reports did not indicate what staff separated the residents and no documentation of Resident #5's or Resident #117's statement of what occurred on that date. A full statement provided by Resident #5 to SW#2 on 1/27/2026 (upon return to work after the weekend off) indicated Resident # 117 had raised a cane at him/her and pushed the Resident # 59 then Resident # 59 punched Resident # 117 in the face a couple times. During the resident and witness statement inquiry the DNS indicated since there was a witness who said it was an open palm on a shoulder versus the incident described during SW#2's interview on 1/27/2026 (3 days later) with Resident #115 with Resident #117 not being forthcoming with any details they had to go with the witness statement. The DNS indicated RN #8 the supervisor on duty during the incident and the charge nurse on duty LPN #5 might have more information since no detailed interviews were taken and documented from Resident #59 or Resident #117 at the time of the incident which would have been most accurate, the DNS indicated RN #8 was on vacation through the week and weekend but would try to reach (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	him/her. The DNS indicated psychiatric services followed up with both residents and they are given all the investigative documents before they see the residents. At 12:05 PM the DNS indicated s/he was unable to reach RN #8. On 6/22/26 at 10:59 AM an interview with SW#2 who no longer employed by the facility indicated she/he could not recall the written interview with Resident # 59. When surveyor read the interview to SW # 2 she/he still indicated she/he could not recall. SW#2 did indicate after the interview s/he did update the DNS and administrator. Interview with RN # 5 on 6/29/26 at 10:12 AM identified that when she entered the dining room after hearing commotion, she saw Resident # 117 on the floor and Resident # 59 told her when Resident # 117 attempted to hit Resident # 59 she/he grabbed the cane from Resident #117 and hit her/him. Interview with the DNS on 7/1/26 with the Administrator at 2:31 PM identified they were not made aware of RN # 5 statement Resident # 5 grabbed the cane from Resident # 117 and hit her/him. The DNS indicated she/he would have expected the licensed nurse to interview the residents involved in the incident at the time of the incident. Interview with the Administrator and the DNS on 7/2/26 at 2:30 PM identified they were not unaware that Resident # 59 grabbed the cane from Resident # 117 and hit Resident # 117 until today and when they spoke with the surveyor on 7/1/26 there was no mention about a cane. They also mention that when Resident # 117 was interviewed about the incident she/he did not want to discuss the incident. After inquiry, the DNS indicated that RN # 5 was educated on 7/1/26 to report statements given by residents during abuse resident to resident altercation and fall so the facility can conduct a thorough investigation. The facility policy labeled Abuse indicated in part notes residents will not be subjected to abuse (example- verbal or physical) by anyone including other residents. Allegations of abuse will be reported immediately and thoroughly investigated. The alleged abuser would be removed from the other residents, consultation with law enforcement, family physicians and the state agency as required. Social Work staff will assess the resident for psychological effects and provide supportive counseling as needed.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility policy and staff interviews for 1 of 2 residents (Resident #96) reviewed for pressure ulcers, the facility failed to develop a timely comprehensive, preventative care plan for a resident at risk for skin breakdown to prevent skin impairment on the heels that resulted in a pressure ulcer development. The findings Include: Resident #96's diagnosis included displaced fracture of the right femur (hip fracture), end stage renal disease, diabetes mellitus, and congestive heart failure. The Nursing admission assessment dated [DATE] at 8:37 PM indicated Resident #96 skin was warm and moist, had a surgical incision on the right hip and a bruise on the right iliac crest A Braden Scale of 18 (15-18 indicate mild risk) for predicting pressure ulcer risk evaluation was completed on 3/18/2026 at 6:26 PM indicating Resident #96 had no impairment in sensory perception, skin was occasionally moist, s/he was chair fast for activity, had no limitations in the ability make changes on position, had adequate nutrition and had a potential problem with friction and shear upon movement due to requiring assist during moves due to sliding on surfaces during movement. No focuses or interventions were documented. Another Braden scale for predicting pressure ulcer risk evaluation was completed on 3/25/2026 with the score of 19 (19-23 no risk). The baseline care plan dated 3/19/2026 indicated in the skin section Resident #96 required assistance to change positions with a goal to have skin remain intact through the next review. Intervention included to offer Resident #96 assistance to the bathroom and offering treatments as ordered. The care plan dated 3/19/2026 indicated Resident #96 had a self-care performance deficit in activities of daily living due to limited mobility. Interventions included assisting resident with toileting at bed level and transfers with 2 staff assisting with a mechanical lift. The Nurse Aide (NA) care card indicated Resident #96 needed monitoring, reminders, or assistance to turn and reposition more often as needed or requested and required a mechanical lift transfer with 2 staff person assistance The admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #96 as cognitively intact and required substantial/ maximum assistance with rolling left and right, moving from sitting to standing going from lying to sitting on the side of the bed, going from sit to standing and was dependent for moving to and from the bed and chair. The assessment also noted no pressure ulcers but noted the resident was at risk for developing pressure ulcers. The MDS further indicated since Resident #96 was at risk for pressure ulcers the facility would proceed in developing an interdisciplinary care plan. The care plan did not address Resident #96's risk for skin breakdown/pressure ulcer development. An Advanced Practice Registered Nurse (APRN) visit note dated effective 4/01/2026 at 1:00 PM (signed on 4/04/26 at 1:35:36 PM, 2 days 35 minutes after the evaluation and recommendation visit) identified Resident #96 was noted with a blister on the right heel after complaining of heel pain while on the specialized treatment chair (outside of the facility). The APRN noted upon examination of the blister noted the area was open and asked the infection control nurse to follow up with applying skin prep now, providing pressure relieving boots, providing an air mattress due to decreased mobility and to have the wound physician see the resident The note did not indicate if the left heel was observed. No new physician orders were dated 4/01/2026. A nutrition/dietary note dated 4/02/2026 at 12:42 PM indicated Resident #96 had new deep tissue injuries (DTI's) to bilateral heels and his/her nutritional status was evaluated and the resident refused further changes to his/her current meals or supplements for wound healing. An APRN visit note dated 4/02/2026 at 1:00 PM signed on 4/05/2026at 8:14 AM, 2 days 19 hours after the visit) indicating Resident # 96's chief complaint was the right heel wound and constipation with the skin assessment indicating the right heel had a superficial open spot and to provide a boot and an air mattress for the right heel wound and to add MiraLAX 17 grams daily for the constipation. No documentation about the left-heel skin integrity was observed. 3 days and 2 hours after the right heel open blister was noticed, physician's orders dated (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/04/2026 at 3:00 PM directed to check the low air loss mattress setting to Resident #96's weight and to check functioning for appropriate inflation every shift. A physician's order dated 4/04/2026 at 3:00 PM directed to observe the dressing on the right heel to ensure it was clean, dry and intact and to observe the surrounding skin for signs of infection and evaluate for associate pain every shift. A physician's order dated 4/04/2026 at 7:08 PM directed to provide treatment to the open area on the right heel by cleansing with normal saline, pat dry then apply calcium alginate followed by a foam dressing daily and as needed, reporting any signs of infection to the physician. A physician's order dated 4/04/2026 at 7:10 PM directed to cleanse the left heel with normal saline then apply skin prep daily and leave open to air every day to start the treatment on 4/05/2026. No documentation of the left heel condition was found within the clinical record or having notified the physician. The lack of documentation had no clear timeline of the pressure ulcer development. A care plan dated 4/06/2026 (no time) indicated Resident #96 had a stage 2 pressure ulcer of the right and left heel and had potential to develop further pressure ulcers. Interventions included in part to administer treatments as ordered, monitor wound healing, obtaining wound measurements, follow facility protocols and policies regarding prevention and treatment of skin breakdown, pressure relieving devices to bed and chair. An additional care plan dated 4/06/2026 indicated Resident #96 had actual skin breakdown related to wounds of the heels. Interventions included to offer to assist with repositioning as tolerated, and to float heels as appropriate to relieve heel pressure. A care plan meeting note dated 4/06/2026 at 12:50 PM Indicated the resident family member and the interdisciplinary team were in attendance with Resident #96's care plan and advanced directives reviewed. A wound care specialist note dated 4/06/2026 at 3:34 PM indicated the resident was being seen for consultation for evaluation and management of Resident #96's wounds. The report indicated the following. Wound #1: the left heel, first evaluated on 4/06/2026 was a new stage 2 pressure ulcer (superficial layer of skin missing) with erythema (redness). Size of the wound was 4 Centimeter (cm) x 2 cm by 0.1 cm deep. Wound #2: A new Right heel stage 2 pressure ulcer(superficial layer of skin missing or a fluid filled blister) with no indicated measurements noted erythema surrounding the wound. Treatment recommendations included cleanse with normal saline then apply calcium alginate with silver to the base of the wound secured with a dry clean dressing to be changed daily. Further interventions included providing facility pressure ulcer prevention, a pressure relieving mattress, offloading heels per facility protocol and to offload pressure repositioning to Resident #96 every 2 hours. The evaluation indicated Resident #96 had decreased sensation of the lower extremities due to diabetes mellitus. Additionally noted the wound care orders were entered on this date. The first weekly skin observation tool completed since admission was documented on 4/08/2026 at 9:19 PM indicating Resident #96 had bilateral heel deep tissue injuries (skin with purple discoloration) due to pressure. An interview and record review with the Director of Nursing Services (DNS) on 6/16/2026 2:06 PM identified no weekly skin assessments of Resident #96 were completed after admission on [DATE] until 4/08/2026 (3 weeks 1 day or 22 days after admission) and Resident #96 had developed 2 pressure ulcers. The DNS also indicated Resident # 96 was admitted without any pressure ulcers. An interview and record review on 6/16/2026 at 2:25 PM with Licensed Practical Nurse (LPN #2), the nurse who completes the MDS assessment, found the admission MDS assessment had indicated Resident #96 was at risk for pressure ulcers and the Care Area Assessments(CAAs) indicated the facility was to proceed with care planning for risk for developing pressure ulcer. However, she was unable to locate a preventative care plan to prevent the development of a pressure ulcer or skin breakdown until after the pressure ulcers were found on 4/1/2026 (nurse practitioner note) right heel and the left heel but noted no documentation of date.The facility policy labeled pressure ulcer prevention revised on 12/26/2025 indicated the policy of the facility was to promote prevention of pressure injury development by identifying and providing needed care and services required by each resident. The facility would ensure that based on the results of a comprehensive assessment residents would receive care consistent with professional standards of practice. Upon admission and weekly thereafter, the nurse (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	would conduct a complete head to toe skin check to identify any new or preexisting skin issues, any new alteration would be assessed by the Registered Nurse(RN) and treatment initiated per physician orders. Resident would be evaluated by the licensed nurse for risk of skin breakdown using the Braden scale on admission and weekly x 4 weeks. Interventions to minimize and/or eliminate contributing factors for pressure ulcer development would be included on the resident's individualized care plan and those residents at risk for pressure injury would receive routine repositioning and pressure relief based on the resident's condition, mobility, tolerance and care plan.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, review of facility policy and staff interviews for 1 resident (Resident # 5) reviewed for Continuous Positive Airway Pressure (CPAP) a non-invasive machine that uses air pressure to keep the airways open to treat periods of non-breathing during sleep with machine, the facility failed to revise the resident care plan to address the utilization of the CPAP. The findings included: Resident #5's diagnosis included Obstructive Sleep Apnea (OSA). The physician's order dated 2/09/2026 directed to apply a Continuous Positive Airway Pressure (CPAP) is a non-invasive machine that uses air pressure to keep the airways open to treat periods of non-breathing during sleep with machine settings set at 12:0 at bedtime and to remove in the morning. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #5 was cognitively intact and did not receive noninvasive respiratory treatment of CPAP (Continuous Positive Airway Pressure). An interview and clinical record review on 06/18/2026 at 11:25 AM with the regional clinical reimbursement and case management nurse, RN #4, indicated a physician order was in place from 2/09/2026 (146 days or 4 months, 23 days ago) for Resident #5 to receive CPAP. During clinical record review RN #4 indicated Resident #5's care plan should have been revised when the order was received to accurately reflect the resident needs.The facility policy titled Care Plan Policy indicated in part the facility policy was to develop a comprehensive person-centered plan of care for its residents and update and revise.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation and staff interviews for 1 sampled resident (Resident # 11) reviewed for Hospice Care, the facility failed to ensure continuation and implementation of hospiceˆdirected medication as directed by the physican orders for comfort care. The findings include:ensure comfort measure during end of life. The findings include:Resident #11's diagnoses included chronic lung disease, dementia, muscle weakness, and depression.A physician's order dated [DATE] directed that Resident #11 be admitted to hospice.Review of a nurse's note dated [DATE] documented admission to routine hospice care and directed the following: to discontinue blood draws, discontinue rehabilitation therapies, discontinue Vitamin B12 and discontinue Vitamin D3 and start atropine drops for secretions. Additionally, the nurse's notes noted to start Lorazepam Intensol Oral Concentrate 2 MG/ML (Lorazepam) Controlled Drug Give 0.25 ml by mouth every 6 hours as needed for anxiety and restlessness for 30 Days will reevaluate as needed and to start Morphine Sulfate (Concentrate) Solution 20 MG/ML Controlled Drug Give 0.25 ml by mouth every 3 hours as needed for Pain/SOB for 30 Days Will reevaluate as needed.The Minimum Data Set assessment dated [DATE] identified the resident as moderately cognitively impaired, with a BIMS score of 11, requiring setup and cleanup assistance for eating, toileting, and personal hygiene.The Resident Care Plan dated [DATE] identified Do Not Resuscitate, Do Not Intubate, Do Not Hospitalize, and Nurse May Pronounce Death. The care plan did not identify Resident #11 as receiving hospice care, despite an active hospice admission.A review of the clinical record failed to identify that the Lorazepam Intensol Oral Concentrate 2 MG/ML (Lorazepam) Controlled Drug Give 0.25 ml by mouth every 6 hours as needed for anxiety and restlessness for 30 Days will reevaluate as needed and to start Morphine Sulfate (Concentrate) Solution 20 MG/ML Controlled Drug Give 0.25 ml by mouth every 3 hours as needed for Pain/SOB for 30 Days had been re-evaluated and reordered by the physician. A clinical record review and interview with the Assistant Director of Nursing Services (ADNS) on [DATE] at 11:35 AM identified the clinical record did not reflect active hospice comfortˆmedication orders for lorazepam for anxiety or morphine for shortness of breath or pain. Review of hospice documentation indicated the plan of care should continue, and medications were not to be discontinued. Lorazepam and morphine orders expired on [DATE].The ADNS identified there was no documented reason for the discontinuation of these medications and no provider or hospice notes indicating a decision to discontinue. Inspection of the medication cart and narcotic log with the ADNS identified oral lorazepam present in the narcotic drawer with a narcotic log, indicating the medication remained available, despite discontinued orders. The ADNS stated there was no reason documented for discontinuation. An interview with the Director of Nursing (DNS) on [DATE] at 12:55 PM identified that Nursing Supervisors were responsible for reviewing, maintaining, and entering hospice orders. She stated hospice narcotic and benzodiazepine orders were written for 30 days and required review by the Nursing Supervisor and the provider. She also stated that hospice nurses and hospice providers did not have access to the electronic medical record and could not enter orders themselves.During an interview with the hospice nurse (RN #6), she stated hospice was unaware that physician's orders for lorazepam and morphine had been discontinued.A review of the Home Health and Hospice Contract dated [DATE] directed, in part, that hospice would make recommendations for the resident and the facility would honor and fulfill hospice requests on behalf of the resident. The contract further directed the facility to contact hospice for clarification when questions arose and to provide safe services for all residents in their care.After Surveyor inquiry, an physician's order was placed on [DATE] at 8:42 PM for Lorazepam and Morphine.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility policy review and interview for 1 of 2 residents for (Resident #96) reviewed for pressure ulcer, the facility failed to complete weekly skin checks, develop a preventative skin breakdown care plan for a resident at risk and when pressure ulcers were identified, physician's orders for treatment were delayed for 3 days. The findings include: Resident #96's diagnosis included displaced fracture of the right femur (hip fracture), end stage renal disease, diabetes mellitus, and congestive heart failure. The Nursing admission assessment dated [DATE] at 8:37 PM indicated Resident #96 skin was warm and moist, had a surgical incision on the right hip and a bruise on the right iliac crest A Braden Scale of 18 (15-18 indicate mild risk) for predicting pressure ulcer risk evaluation was completed on 3/18/2026 at 6:26 PM indicating Resident #96 had no impairment in sensory perception, skin was occasionally moist, s/he was chair fast for activity, had no limitations in the ability make changes on position, had adequate nutrition and had a potential problem with friction and shear upon movement due to requiring assist during moves due to sliding on surfaces during movement. No focuses or interventions were documented. Another Braden scale for predicting pressure ulcer risk evaluation was completed on 3/25/2026 with the score of 19 (19-23 no risk). The baseline care plan dated 3/19/2026 indicated in the skin section Resident #96 required assistance to change positions with a goal to have skin remain intact through the next review. Intervention included to offer Resident #96 assistance to the bathroom and offering treatments as ordered. The care plan dated 3/19/2026 indicated Resident #96 had a self-care performance deficit in activities of daily living due to limited mobility. Interventions included assisting resident with toileting at bed level and transfers with 2 staff assisting with a mechanical lift. The Nurse Aide (NA) care card indicated Resident #96 needed monitoring, reminders, or assistance to turn and reposition more often as needed or requested and required a mechanical lift transfer with 2 staff person assistance The admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #96 as cognitively intact and required substantial/ maximum assistance with rolling left and right, moving from sitting to standing going from lying to sitting on the side of the bed, going from sit to standing and was dependent for moving to and from the bed and chair. The assessment also noted no pressure ulcers but noted the resident was at risk for developing pressure ulcers. The MDS further indicated since Resident #96 was at risk for pressure ulcers the facility would proceed in developing an interdisciplinary care plan. The care plan did not address Resident #96's risk for skin breakdown/pressure ulcer development. An Advanced Practice Registered Nurse (APRN) visit note dated effective 4/01/2026 at 1:00 PM (signed on 4/04/26 at 1:35:36 PM, 2 days 35 minutes after the evaluation and recommendation visit) identified Resident #96 was noted with a blister on the right heel after complaining of heel pain while on the specialized treatment chair (outside of the facility). The APRN noted upon examination of the blister noted the area was open and asked the infection control nurse to follow up with applying skin prep now, providing pressure relieving boots, providing an air mattress due to decreased mobility and to have the wound physician see the resident The note did not indicate if the left heel was observed. No new physician orders were dated 4/01/2026. A nutrition/dietary note dated 4/02/2026 at 12:42 PM indicated Resident #96 had new deep tissue injuries (DTI's) to bilateral heels and his/her nutritional status was evaluated and the resident refused further changes to his/her current meals or supplements for wound healing. An APRN visit note dated 4/02/2026 at 1:00 PM signed on 4/05/2026at 8:14 AM, 2 days 19 hours after the visit) indicating Resident # 96's chief complaint was the right heel wound and constipation with the skin assessment indicating the right heel had a superficial open spot and to provide a boot and an air mattress for the right heel wound and to add MiraLAX 17 grams daily for the constipation. No documentation about the left-heel skin integrity was observed. 3 days and 2 hours after the right heel open blister was noticed, physician's orders dated 4/04/2026 at 3:00 PM directed to check the low air (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	loss mattress setting to Resident #96's weight and to check functioning for appropriate inflation every shift. A physician's order dated 4/04/2026 at 3:00 PM directed to observe the dressing on the right heel to ensure it was clean, dry and intact and to observe the surrounding skin for signs of infection and evaluate for associate pain every shift. A physician's order dated 4/04/2026 at 7:08 PM directed to provide treatment to the open area on the right heel by cleansing with normal saline, pat dry then apply calcium alginate followed by a foam dressing daily and as needed, reporting any signs of infection to the physician. A physician's order dated 4/04/2026 at 7:10 PM directed to cleanse the left heel with normal saline then apply skin prep daily and leave open to air every day to start the treatment on 4/05/2026. No documentation of the left heel condition was found within the clinical record or having notified the physician. The lack of documentation had no clear timeline of the pressure ulcer development. A care plan dated 4/06/2026 (no time) indicated Resident #96 had a stage 2 pressure ulcer of the right and left heel and had potential to develop further pressure ulcers. Interventions included in part to administer treatments as ordered, monitor wound healing, obtaining wound measurements, follow facility protocols and policies regarding prevention and treatment of skin breakdown, pressure relieving devices to bed and chair. An additional care plan dated 4/06/2026 indicated Resident #96 had actual skin breakdown related to wounds of the heels. Interventions included to offer to assist with repositioning as tolerated, and to float heels as appropriate to relieve heel pressure. A care plan meeting note dated 4/06/2026 at 12:50 PM Indicated the resident family member and the interdisciplinary team were in attendance with Resident #96's care plan and advanced directives reviewed. A wound care specialist note dated 4/06/2026 at 3:34 PM indicated the resident was being seen for consultation for evaluation and management of Resident #96's wounds. The report indicated the following. Wound #1: the left heel, first evaluated on 4/06/2026 was a new stage 2 pressure ulcer (superficial layer of skin missing) with erythema (redness). Size of the wound was 4 Centimeter (cm) x 2 cm by 0.1 cm deep. Wound #2: A new Right heel stage 2 pressure ulcer(superficial layer of skin missing or a fluid filled blister) with no indicated measurements noted erythema surrounding the wound. Treatment recommendations included cleanse with normal saline then apply calcium alginate with silver to the base of the wound secured with a dry clean dressing to be changed daily. Further interventions included providing facility pressure ulcer prevention, a pressure relieving mattress, offloading heels per facility protocol and to offload pressure repositioning to Resident #96 every 2 hours. The evaluation indicated Resident #96 had decreased sensation of the lower extremities due to diabetes mellitus. Additionally noted the wound care orders were entered on this date. The first weekly skin observation tool completed since admission was documented on 4/08/2026 at 9:19 PM indicating Resident #96 had bilateral heel deep tissue injuries (skin with purple discoloration) due to pressure. An interview and record review with the Director of Nursing Services (DNS) on 6/16/2026 2:06 PM identified no weekly skin assessments of Resident #96 were completed after admission on [DATE] until 4/08/2026 (3 weeks 1 day or 22 days after admission) and Resident #96 had developed 2 pressure ulcers. The DNS also indicated Resident # 96 was admitted without any pressure ulcers. An interview and record review on 6/16/2026 at 2:25 PM with Licensed Practical Nurse (LPN #2), the nurse who completes the MDS assessment, found the admission MDS assessment had indicated Resident #96 was at risk for pressure ulcers and the Care Area Assessments(CAAs) indicated the facility was to proceed with care planning for risk for developing pressure ulcer. However, she was unable to locate a preventative care plan to prevent the development of a pressure ulcer or skin breakdown until after the pressure ulcers were found on 4/1/2026 (nurse practitioner note) right heel and the left heel but noted no documentation of date. An interview with Medical Doctor (MD #2) the wound physician on 6/18/2026 at 2:56 PM indicated Resident #96's medical conditions being diabetic, requiring specialized treatments, recent surgery with limited mobility were some of the reasons Resident #96 was at risk for skin breakdown. MD#2 further indicated Resident #96's not having his/her heels offloaded while receiving specialized treatment out of the facility in addition to not having a preventative skin breakdown plan in place at (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westside Care Center	349 Bidwell Street Manchester, CT 06040

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the facility all contributed to the skin breakdown, but the facility was not the only cause. MD #2 indicated having preventative measures in place(in the facility and at specialized treatment) may have prevented the breakdown. An interview with the regional Infection preventionist/wound nurse Registered Nurse (RN #1) and the DNS on 6/18/2026 at 2:45 PM indicated the wound tracking document the infection preventionist/wound nurses only consider the wound physician visits and does not track the initial date of the identification of the wounds. Since no nursing assessments, weekly skin assessments or notes were found in the clinical record, it was not clear when each pressure ulcer was first identified. The right heel was documented by the nurse practitioner on 4/01/2026 as a blister that had opened after the resident complained of pain while at the specialized treatment, and there was no documentation of the description of the left heel or the date it was identified. The DNS indicated s/he would have expected nursing to have made a note or complete the change of condition assessment in the electronic system including skin measurements. The DNS further indicated the resident or responsible party would be updated and Resident #96 was responsible for self. The facility policy labeled pressure ulcer prevention revised on 12/26/2025 notes the policy of the facility was to promote prevention of pressure injury development by identifying and providing needed care and services required by each resident. The facility would ensure that based on the results of a comprehensive assessment, residents would receive care consistent with professional standards of practice. Upon admission and weekly thereafter, the nurse would conduct a complete head to toe skin check to identify any new or preexisting skin issues, any new alteration would be assessed by the Registered Nurse(RN) and treatment initiated per physician orders. The resident would be evaluated by the licensed nurse for risk of skin breakdown using the Braden scale on admission and weekly x 4 weeks. Interventions to minimize and eliminate contributing factors for pressure ulcer development would be included on the resident's individualized care plan and those residents at risk for pressure injury would receive routine repositioning and pressure relief based on the resident's condition, mobility, tolerance and care plan.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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 clinical record review, observations, facility documentation, review of policy and interviews for 1 of 2 residents (Resident # 2), reviewed for dining observation, the facility failed to follow dietary guidelines and restrict the use of Styrofoam products during dining to prevent a potential accident. The findings include: Resident #2?s diagnoses included dementia, speech disorder, restlessness, agitation, and bipolar disorder.The comprehensive Minimum Data Set assessment dated [DATE] identified Resident #2 was cognitively impaired and required set up assistance for eating and required substantial assistance for personal hygiene and toileting and noted independence with transfer and walking.The Resident Care Plan dated 6/2/26 identified Resident #2 would require assistance with activities of daily living related to dementia. Interventions included setting up for eating with no Styrofoam products.A physician's order dated 5/29/26 was directed to have no Styrofoam products for Resident #2.Observation on 6/15/26 at 11:55 AM identified a nurse's aide observed clearing Resident #2's lunch, which had been served in a Styrofoam box. The meal ticket had been discarded and was not available for inspection.Observation on 6/15/26 at 2:10 PM, the kitchen dishwasher was observed to be nonˆfunctional, and dietary staff reported it had been broken since 12/25, resulting in the facility serving meals in disposable Styrofoam containers.Observation on 6/16/26 at 9:02 AM, the meal ticket for Resident #2 stated no Styrofoam products. No leftovers were present for inspection.Observation on 6/16/26 at 11:42 AM, four staff were noted wearing red shirts and protective hair and beard covers transporting Styrofoam lunch containers from the steam table to residents. Resident #2 was seated at a table with another resident as two nurse aides and the Assistant Director of Nursing assisted residents. Resident #2 was again served using Styrofoam products.During an interview with the Director of Dietary Services on 6/16/26 at 11:57 AM, she stated Resident #2's dietary slip indicated no Styrofoam. She confirmed the resident had been served in a Styrofoam container and plate. She stated that nursing and nurse aides were responsible for ensuring residents receive meals according to dietary interventions. She reported that Speech Therapy entered dietary orders into the medical record.During an interview with the Speechˆ Language Pathologist on 6/18/26 at 11:19 AM, she stated she entered all dietary orders into the electronic medical record and completed a dietary slip for the kitchen. She stated she placed the no Styrofoam order on 5/29/26 after observing the resident chewing on Styrofoam. The Speech-Language Pathologist also stated she provided oral education to staff at that time.Although requested, a facility policy for Dietary to address no Styrofoam was not provided.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of facility documentation facility policy and staff interviews for 1 of 5 residents (Resident # 5) reviewed for Infection control, the facility failed to ensure staff served food items on a resident table where no urinary items were stored, the facility failed to ensure CPAP machine, bedside table were not kept clean and mask stored in a clean bag. The facility also failed to ensure staff handled resident food appropriately when peeling a hard-boiled egg while preparing a resident breakfast tray to serve. The findings include: Resident #5's diagnosis included spinal stenosis(narrowing of the nerve pathway in the spine) and paraplegia (partial or complete loss of motor and sensory function of on half of the body. The annual Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #5 was cognitively intact. The care plan dated 2/03/2026 revised on 5/07/2026 indicated Resident #5 required extensive 2 staff person assistance for bed mobility, was dependent and required 2 staff person assistance with dressing and toileting and was independent for eating once meal tray was set up. a.An observation on 6/16/2026 at 8:40 AM of Resident #5's room including the over the bed table identified 2 empty urinals on the over the bed table and other items including an open bag of snacks. While talking with Resident #5 NA#1 came into the room with breakfast and started to place it onto the over bed table next to the 2 urinals when Resident #5 had asked if instead it could be placed on his/her lap. NA#1 indicated s/he could squeeze the breakfast meal containers next to the urinal and after placed on the table left the room. An observation and interview with RN #3 on 08/16/2026 a9:05 AM in Resident #5's room the nursing supervisor indicated the urinal should not have been on the table with the breakfast and s/he would get another table to place the urinal and towel on. She/he would, with Resident #5's permission, wipe off the table with breakfast. RN #3 further indicated that education would be provided to staff to prevent this from happening again.b.Observation and interview on 6/16/2026 at 08:46 AM with Resident #5 after observation of medication administration identified Resident #5 was wearing the CPAP mask and had removed it when the medication nurse woke him/her for medication administration. Further observation identified the CPAP machine on bedside table was uncovered with a dust-like substance.An interview and clinical record review with RN #3 at 10:53 AM and review of Resident #5's physician orders for the CPAP directed the CPAP mask to be wiped clean with soap and water and bagged after use. Upon observation of the CPAP machine, mask and table it was on inside Resident #5's room, RN #5 ran a finger on the bedside table and noted accumulated dust like material. RN# 5 further it was housekeeping's responsibility to keep the machine and table clean, and she/he would contact them to come clean. RN #3 further indicated s/he would find a clean bag to place the mask in and it was the 11PM-7:00 AM shift nurses' responsibility to change the tubing and bags. RN # 5 also indicated education would be provided to staff . Facility policy titled CPAP BiPAP revised 3/03/2026 indicated in part the CPAP unit will be cleaned weekly by using slightly dampened cloth with water and mild detergent to wipe the outside of the case. The mask would be cleaned daily and as needed for soiling using water and mild detergent and after thorough rinsing, allowing the mask to dry air.c.After going to get the supervisor and going back to the unit to see Resident #5 an observation on 6/16/2026 at 9:00 AM identified Nurse Aide NA#1 standing at the nurse's station with a small food cart peeling a hardboiled egg within a Styrofoam food plate for a resident with his/her bare hands and very long nails well past the finger tips. The Nursing Supervisor RN #3 was standing near NA#1 and the surveyor. RN #3 after inquiry indicated NA #1 should not have been handling the egg and peeling it with bare hand and her/his nails that were too long. After further inquiry with RN #3 RN #3 she/he indicated NA#1 should have donned gloves when handling the egg then instructed NA #1 to don gloves at which she/he proceeded to do without the benefit of washing his/her hands first ,then after prompting RN #3 s/he asked NA#1 to wash hands then apply new gloves. RN #3 also indicated after inquiry, staff should not serve the egg peeled by NA#1 and indicates she/he would call the kitchen for (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a new hardboiled egg for the resident.Although a facility policy was requested regarding handling of food one was not provided.