STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075253	A. Building B. Wing	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Harrington Court	59 Harrington CT Colchester, CT 06415

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policies, and interviews for 1 of 8 residents (Resident #35) reviewed for abuse, the facility failed to ensure a resident was treated in a dignified manner by nursing staff. The findings include: Resident #35 was admitted to the facility in September 2024 with diagnoses that included atrial fibrillation, congestive heart failure, and encephalopathy. The quarterly MDS dated [DATE] identified Resident #35 had intact cognition, mood interview identified the following symptoms and frequency: little interest or pleasure in doing things (half or more days), feeling down, depressed, hopeless (several days), trouble falling asleep or staying asleep (several days), feeling tired or having little energy (half or more days), poor appetite or overeating (several days), feeling bad about yourself (several days), trouble concentrating on things (several days), and moving or speaking slowly that other people could have noticed (half or more days). The care plan dated 2/26/25 identified Resident #35 exhibited or was at risk for distressed/fluctuating mood symptoms related to: sadness/depression caused by functional changes, etc.). Interventions included refocusing resident to something positive and allowing time to express feelings, providing empathy, encouragement, and reassurance. Interview with Resident #110 on 4/6/25 at 10:26 AM identified that around 4:00 AM, he/she had heard an agency nurse aide and Resident #35 arguing. Resident #110 indicated that he/she heard Resident #35 ask the nurse aide for her name, but did not hear a response. Resident #110 further indicated that he heard Resident #35 say you're hurting me and being rude, to which the nurse aide replied, it's my first time here and I'm not being rude. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Resident #35 on 4/6/25 at 10:39 AM identified that an agency nurse (NA #18), whom he/she had never met before, entered his/her room around 4:00 AM, without a name badge, and when the resident asked her name, NA#18 responded, Pudding [NAME]. Resident #35 indicated that NA #18 had an attitude and was rude immediately upon entering the room, and NA #18 had told him/her, look, there are only 2 nurse aides here, you could have at least cleaned up your bed for me, referencing the resident's glasses and iPad that were laying on the bed. Resident #35 identified that he/she had asked NA #18 to leave his/her room, and NA #18 stated, why don't you like me, is it my voice or is it because I'm black? Resident #35 indicated that NA #18 then went to assist his/her roommate (Resident #8), and he/she could hear NA #18 making comments about him/her (Resident #35), and when NA #18 was finished providing care for Resident #8, NA #18 had seen him/her (Resident #35), crying and very nicely said, oh honey, why are you crying? Resident #35 indicated that he/she was confused as to why NA #18 was now acting nicely, and the resident reported the concerns to the night shift Nurse Supervisor. Interview with the 11:00 PM - 7:00 AM Nursing Supervisor (RN #12) on 4/6/25 at 10:55 AM identified that around 5:45 AM, Resident #35 had brought to her attention that NA #18 had an attitude while providing care and had made a racial comment. RN #12 indicated that Resident #35 asked NA #18 to leave and she left. RN #12 further indicated that Resident #35 required 2 staff members for care because the resident has made accusatory statements, but RN #12 indicated that NA #18 identified she did not ask another staff member to accompany her while providing care because they had been short staffed. The Psychiatric Evaluation and Consultation form dated 4/6/25 identified that Resident #35 was evaluated after making an allegation towards a nursing assistant. The resident rescinded the allegation and reported frustration with the nurse assistant because she was rude. There was no abuse reported. Interview with NA #17 on 4/8/25 at 12:50 PM identified that she was an agency nurse aide, and this was her first time working at the facility on 4/5/25 11:00 PM - 7:00 AM shift, and she was assigned to the west wing with NA #18. NA #17 denied witnessing any verbally abusive or disrespectful behavior from NA #18 towards Resident #35. NA #17 indicated that she assisted NA #18 to boost Resident #35 in bed. NA #17 indicated that Resident #35 reported that he/she had been crying because he/she had been in pain and was frustrated, and then Resident #35 asked both nurse aides to leave once they were done repositioning him/her in bed. Interview with NA #18 on 4/8/25 at 3:03 PM identified that she was an agency nurse aide and had worked at the facility on the 4/5/25 11:00PM - 7:00 AM shift, for the first time. NA #18 indicated that she was assigned to Resident #35, and that the resident began arguing with her, as soon as she walked into the room. NA #18 indicated that she told Resident #35 that the facility was short staffed and there were only 2 nurse aides on the floor, both from agencies. NA #18 indicated that she was not provided with a photo ID badge from her agency and could not recall if she told Resident #35 her name was Pudding [NAME] when the resident asked her name. NA #18 indicated that she did not ask Resident #35 why he/she did not clean up the bed before she came in, as cleaning up the resident's bed was her responsibility, and she always cleans up. NA #18 further indicated that she has a heavy voice and that she tried to explain that to Resident #35. NA #18 then asked Resident #35 if he/she was judging her because she was black, to which Resident #35 replied now you're pulling the race card. NA #18 indicated that Resident #35 was the only resident that took issue with her out of the 60 residents on that unit. NA #18 identified that when she spoke with RN #12, she identified that Resident #35 has made accusatory comments, in the past. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Resident #35's roommate (Resident #8) on 4/9/25 at 11:30 AM identified that he/she had been sleeping but could not remember hearing any verbal abuse or rude behavior, during the early morning of 4/6/25. Interview with the DNS on 4/10/25 at 10:44 AM identified that it is the expectation that facility and agency staff treat residents with dignity and respect. The facility's Promoting/Maintaining Resident Dignity policy directs all staff members to be involved in providing care to residents to promote and maintain resident dignity and respect resident rights. The policy further directs staff members to speak respectfully to residents. The facility's Professionalism-Customer Service policy directs the facility to provide professional, courteous service to all customers. Every employee is accountable for conducting themselves in a professional manner at all times. The facility is the resident's home and will be regarded as such. Each resident will be treated with compassion and respect at all times.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for 3 residents (Resident #9, 91 and 81) the facility failed to ensure the physician and resident representative were notified according to facility policy. For 1 of 5 residents (Resident #9) reviewed for medication administration, the facility failed to ensure the physician was notified when medications were not given per the physician order. For 1 of 3 residents (Resident #91) reviewed for pressure ulcer, the facility failed to ensure the physician and resident representative were notified when a new pressure ulcer was identified. For 1 of 5 residents (Resident #81) reviewed for unnecessary medications, the facility failed to notify the physician and resident representative with episodes of hypo and hyperglycemia, and when a medication was not administered. The findings include: 1. Resident #69 was admitted to the facility in February 2025 with diagnoses that included leg surgery, chronic kidney disease and dependent on dialysis, hypertension, and gastroparesis. A physician's order dated 2/13/25 directed to give Gabapentin 600 mg by mouth three times a day for phantom pain, Lactobacillus give 1 capsule by mouth one time a day for supplement, and Bumetanide 2 mg give 1 tablet two times a day for hypertension. The care plan dated 2/17/25 identified Resident #69 was at risk for impaired renal function and complications related to hemodialysis. Interventions included providing medications as ordered. The admission MDS dated [DATE] identified Resident #69 had intact cognition and required moderate assistance with toileting, dressing, and personal hygiene. Additionally, Resident #69 was on antibiotics, diuretics, opioids, and anticonvulsants. Review of the April 2025 MAR dated 4/6/25 at 11:48 PM identified Bumetanide 2 mg due to be administered twice daily for hypertension was not available. Medication observation with RN #4 on 4/7/25 at 9:17 AM indicated she had taken Resident #69's blood pressure earlier and it was 176/84. RN #4 prepared Resident #69's medications then identified she did not have the Gabapentin 600mg, Lactobacillus capsule, or the Bumetanide 2 mg available. RN #5 indicated that she had searched the medication cart and there was not any available and these medications were not in the emergency supply. An interview with RN #4 on 4/7/25 at 9:25 AM indicated that Resident #69 had not received the evening dose of Bumetanide 2 mg the day prior, and the Bumetanide 2 mg, the Lactobacillus Capsule, and Gabapentin 600 mg were not available. RN #4 indicated that the nurses were responsible for reordering medications before the resident ran out of a medication. RN #4 indicated that she would reorder the medications from the pharmacy. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the nurses' notes dated 4/6/25 to 4/7/25 failed to reflect the APRN or physician had been notified that the Bumetanide 2 mg, the Lactobacillus Capsule, and Gabapentin 600 mg were unavailable and had not been administered. Review of the MAR dated 4/7/25 at 9:28 AM identified RN #4 documented the scheduled 9:00 AM doses of Gabapentin 600 mg for phantom pain, Lactobacillus capsule for supplement, and Bumetanide 2mg's for hypertension were not available in facility and pharmacy was notified. Review of the MAR dated 4/7/25 identified Resident #69 did not receive the scheduled 1:00 PM dose of Gabapentin 600 mg. Interview with RN #5 (Regional corporate nurse) on 4/8/25 at 11:01 AM indicated that when a nurse does not have a medication available to give a resident per the physician order, he or she is responsible for notifying the pharmacy and the physician to see if there was an alternate medication(s) or could change the time of administration. Interview with APRN #1 on 4/8/25 at 11:18 AM indicated Resident #69 was on Bumetanide for fluid retention because of his/her diagnosis and if Bumetanide was not available nursing must notify her. APRN #1 indicated if Resident #69 misses a dose she would want to find out why and do an intervention and evaluate resident's blood pressures to see if it was elevated and if he/she has sustainable blood pressures with dialysis treatments. APRN #1 indicated that her expectation would be she must be notified if of any resident miss doses of medications. APRN #1 indicated that Resident #69 was on gabapentin for phantom pain due to the BKA. APRN #1 noted Resident #69 came into the facility on a low dose but because Resident #69 has complaints of pain the dose has been going up a couple of times, so it is important to give it and have it available, and the Lactobacillus is because nephrology ordered it from dialysis for the gastrointestinal system. APRN #1 indicated that she was not aware Resident #69 had missed the Bumetanide the evening of 4/6/25 or medications on 4/7/25 in the am or afternoon. APRN #1 indicated it was the nurse's responsibility to reorder the medications timely. APRN #1 indicated that the nurses were responsible for documenting who they notified and when if a resident had missed a scheduled medication. Interview with the DNS on 4/8/25 at 12:52 PM indicated that when a resident does not receive a dose of a scheduled medication the charge nurse is expected to notify the RN supervisor who must notify the APRN or physician and it needed get an order for an alternate medication or any other new orders from the provider and then write a nurses note with who the nurse spoke with and any recommendation or new orders from the provider. After clinical record review, the DNS indicated that from 4/6/to 4/8/24 she did not see the APRN, or physician were notified of the missed doses of medication. The DNS indicated that the Lactobacillus was house stock and if the nurse had asked the supervisor, she would have gotten it for RN #4. An interview with the DNS on 4/9/25 at 12:54 PM indicated her expectation was the nurses follow the physician orders and give the medications at the time they are scheduled within the hour before or hour after window. The DNS indicated the expectation was the nurses will reorder the medications when there are 6 doses left in the blister pack, so the resident does not run out of medications. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility Unavailable Medications Policy identified mediations may be unavailable for several reasons. Staff should take immediate action when it is known that the medication is unavailable. Notify the physician of inability to obtain medication upon notification or awareness that the medication is not available. Obtain alternate treatment orders and/or specific orders for monitoring residents while medication is on hold. If a resident misses a scheduled dose of the medication, staff shall follow procedures for medication errors, including physician/family notification, completion of a medication error report, and monitoring the resident for adverse reactions to omission of the medication. Review of the Medication Eror Policy identified the facility shall ensure medications will be administered according to the physician's orders. Medication that is administered not in accordance with the prescriber's order, for example a medication omission. 2. Resident #91 was admitted to the facility in July 2023 and a readmission to the facility on 1/30/25 with diagnoses that included fall with left femur fracture, and dementia. The quarterly MDS dated [DATE] identified Resident #91 had severely impaired cognition and required maximum assistance with perineal hygiene and dressing. Resident #91 was at risk for developing a pressure ulcer but did not have any pressure ulcers. The readmission nursing assessment dated [DATE] identified Resident #91's skin was intact except for periorbital bruising to the face status post fall. The assessment did not identify any open areas or pressure areas. The care plan dated 2/13/25 identified Resident #91 was at risk for skin breakdown related to decreased mobility and left hip surgical incision. Interventions included applying barrier cream after each incontinent episode, dietitian consultation as needed, and weekly skin checks by the licensed nurse. The weekly skin check assessment documented by RN #2 dated 2/15/25 identified Resident #91's left heel had a blister with slough measuring 6cm by 6cm intact. (first time noted wound) The weekly skin check assessment documented by LPN #1 dated 2/22/25 at 7:23 PM identified a previously identified wound to the left heel. (second time noted wound) The APRN note dated 2/24/25 at 1:04 PM identified she was notified by RN #1 and had seen Resident #91 for a deep tissue injury (DTI) to left heel today noted by nursing. Recommended Santyl topically with daily dressing change to facilitate until seen by wound provider later this week. Nursing to off load heels for Resident #91. The Change of Condition Evaluation documented by RN #1 dated 2/24/25 at 1:21 PM identified Resident #91 noted to have a new injury to his/her left heel. RN #1 noted this is the leg affected by his/her broken hip and surgical fixation. Left heel measurements were 2.5 cm by 1.4 cm by 0.1 cm. APRN in the facility and notified. Dressing order recommendation for Santyl and dry clean dressing in place and wound physician to evaluate. Resident representative was notified. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician's order dated 2/24/25 directed to cleanse left heel wound with normal saline, pat dry, apply Santyl to wound bed, and cover with dry clean dressing daily on evening shift for 30 days starting on 2/25/25. The dietitian note dated 4/2/25 identified Resident #91 triggers for significant weight loss over 1 month and pressure ulcer to the left heel. Resident #91 remains at risk for malnutrition related to unplanned weight loss and need for mechanically altered diet and requires total assistance for feeding. Recommendations included Glucerna once a day in the evening to assist with stability and protein supplement to support wound healing in view of pressure injury to left heel. A physician's order dated 4/2/25 directed to start Glucerna 1.5 give 8 ounces once a day and Prostat AWC (Advance Wound Care) 30 ml's 2 times a day for at risk for malnutrition. Interview with LPN #1 on 4/7/25 at 8:55 AM indicated that she did the weekly skin assessment on 2/22/25 for Resident #91. LPN #1 indicated that she thought the left heel was already noted and not new, so she did not call for an RN assessment, or call the APRN or Resident #91's representative. Interview with RN #1 on 4/7/25 at 9:46 AM indicated she had not been informed that Resident #91 had a pressure ulcer on the left heel until she found it on 2/24/25 when auditing the weekly skin assessments. RN #1 indicated after clinical record review on 2/24/25 she noted that the left heel pressure ulcer started on 2/15/25 in a weekly body audit. RN #1 indicated that she immediately went to Resident #91 to assess the left heel, and the blister had opened and was an unstageable DTI that measured 2.5 cm by 1.4 cm by 0.1 cm. RN #1 indicated that the first complete RN assessment for the left heel pressure area was completed on 2/24/25, 9 days after first found. RN #1 indicated that there was no treatment in place for the left heel from 2/15/25 to 2/24/25. RN #1 indicated that on 2/24/25 when she identified the area, she notified the APRN and resident representative. RN # 1 indicated that on 2/15/25 when the left heel pressure ulcer was first identified there should have been a complete wound assessment by an RN that day and shift with notification to the APRN or physician to obtain a treatment order. Further, the resident representative should have been notified at that time. Interview with the DNS on 4/7/25 at 11:21 AM indicated Resident #91 had a left heel pressure ulcer noted on 2/24/25 by the wound nurse, RN #1, on 2/24/25. The DNS indicated that when a pressure ulcer is first identified the charge nurse notifies the RN supervisor to do the initial wound assessment including measurements, description of wound and wound bed, and the surrounding skin. The DNS indicated that she thought the left heel started on 2/24/25 and she was first notified about it on 2/24/25. The DNS indicated that after the surveyor inquiry she started an investigation into the left heel and noted the left heel was first identified on 2/15/25 during the weekly body check by RN #2. The DNS indicated that RN #2 should have notified the RN supervisor to come assess the new pressure ulcer and do the change of condition assessment, notify the ADNS or physician and get a treatment order put into place that day, and notify the resident representative. The DNS indicated that the APRN and resident representative were not notified until 2/24/25, 9 days after being first found. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with RN #2 on 4/7/25 at 11:11 AM indicated that she was the charge nurse on the unit and was responsible on 2/15/25 to do the weekly body assessment on Resident #91. RN #2 indicated that she had noted an intact 6 cm by 6 cm blister with yellow drainage inside the blister but the skin under the blister was not viable skin. RN #2 indicated that she assumed the DTI to the left heel was old. RN #2 indicated that if it was new she would have told the supervisor so she could have done a change in condition assessment, get a treatment order, and notify the APRN and resident representative. RN #2 indicated that because she thought it was old she did not notify the RN supervisor or the APRN, or resident representative. RN #2 indicated that if she had she would have documented it. Interview with the Dietitian on 4/9/25 at 11:35 AM identified the wound nurse was responsible for providing her with a weekly wound report for all wounds that would include new wounds and if wounds are getting worse. The Dietitian indicated that she did not receive any wound reports for the month of February 2025 and only 1 report in March 2025. The Dietitian indicated the wound report for the week of 3/7/25 did not have Resident #91 on it. The Dietitian indicated that she had reported several times to the DNS that she was not receiving the weekly wound reports. The Dietitian indicated that if a resident receives a new facility acquired pressure ulcer and she is notified she would have seen the resident within a week at the most. The Dietitian indicated she would assess the resident and make sure the resident is meeting nutritional needs and would recommend some type of protein supplement based on the stage of the wound. The Dietitian indicated that Resident #91 was seen on 2/9/25 and 2/19/25 and was noted with no pressure ulcers. The Dietitian noted on 2/28/25 Resident #91 was only seen for weights and she was not aware of any wounds. The Dietitian indicated that on 4/2/25 after Resident #91 was readmitted on [DATE] she went to do the nutritional evaluation and noted the documentation of the left heel pressure ulcer. The Dietitian indicated at that time she had recommended the protein supplement (Prostat Advanced Wound Care) and the order was put into place. The Dietitian indicated that if she was aware on 2/15/25 when someone had first found the left heel, she would have seen Resident #91 right away. The Dietitian indicated that it is the protocol for stage 3, stage 4, or unstageable to immediately start the protein supplement to promote wound healing. Interview and clinical record review with DNS on 4/10/25 at 8:00 AM identified that Resident #91 had a DTI to the left heel identified on 2/15/24 which was not reported to the APRN and resident representative until 2/24/25. Further, she did not see that the dietitian was notified in any notes until a dietitian evaluation on 4/2/25. Review of the Notification of Change Policy identified the purpose was to ensure the facility promptly informs the resident, the physician, and the resident's representative when there is a change requiring notification. Review of the Facility Responsibilities Policy identified the facility will immediately inform the resident, physician, and resident representative a significant change in the residents physical, mental, or psychosocial status. Also, a need to alter a treatment such as a new, discontinue or change in an existing treatment. Review of Pressure Injury Prevention and Management Policy identified the facility as committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to promote treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injures. The attending physician will be notified of the presence of a new pressure injury identification. A review will be performed on each pressure injury that develops in the facility. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Nutritional Management Policy identified the facility promotes care and services to each resident to ensure the resident maintains acceptable parameters of nutritional status in his/her overall condition. A comprehensive nutritional assessment will be completed by the dietitian within 72 hours of admission, annually, and upon significant change in condition. Components of the assessment will include, but not limited to residents' general appearance, height, weight, cognitive, physical, and medical conditions, food and fluid intake, poor intake, weight loss, review of medications, and review of labs. 3. Resident # 81 was admitted to the facility in July 2023 with diagnoses that included COPD, diabetes with hyperglycemia, and dementia. The care plan dated 11/17/24 identified Resident #81 has a diagnosis of Insulin dependent diabetes and hyperglycemia. Interventions included monitoring signs and symptoms of hyper/hypoglycemia and report abnormal findings to the physician, assess and record blood glucose levels as ordered, and administer hypoglycemic medications as ordered. A physician's order dated 12/16/24 directed to inject Glucagon 1 mg (a medication used to treat low blood glucose) IM as needed for blood glucose less than 70 if Resident #81 was unable to swallow or was unresponsive, monitor vital signs and stay with the resident, notify the provider and recheck the blood glucose in 15 minutes, repeat protocol if less than 70 and document response in the progress notes. A physician's order dated 12/16/24 directed to administer Glucose oral gel 15 mg/32ml (a medication used to treat low blood glucose) one application by mouth as needed for blood glucose less than 70 if Resident #81 was asymptomatic or symptomatic but responsive with the ability to swallow. The order further directed to repeat the blood glucose level in 15 minutes, document the results, and if still below 70, notify the provider and administer a second dose of the glucose gel. A physician's order dated 12/19/24 directed for sliding scale Insulin Lispro (a short acting Insulin) to be administered with blood glucose checks 3 times daily (7:30 AM, 11:30 AM, 4:30 PM) before meals and administered for a blood glucose of: 150 - 200 = 2 units. 201 - 250 = 4 units. 251 - 300 = 6 units. 301 - 350 = 8 units. 351 -400 = 10 units. 401 - 450 = 12 units. 451+ = Call Provider for additional orders. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 5 day MDS dated [DATE] identified Resident #81 had intact cognition, was always incontinent of bowel and bladder and dependent on staff to assist with toileting, bathing, and dressing. An APRN note dated 12/28/24 at 11:58 AM identified that a telehealth visit was conducted with RN #7 due to Resident #81's blood glucose result of 480 on that date. The APRN note identified Resident #81 was asymptomatic and the treatment orders included a total of 14 units of Insulin Lispro, recheck blood glucose in one hour, if blood glucose was above 400 in 2 hours to contact telehealth APRN for further instructions, and notify a clinician of any change in condition. A nurse's note dated 12/28/24 at 12:03 PM by LPN #2 identified Resident #81's blood glucose was 480 and 12 units of Insulin Lispro were administered, the supervisor was notified, and the physician would be contacted. Review of the clinical record failed to identify any documentation that Resident #81's resident representative was notified related to Resident #81's hyperglycemic episode requiring treatment visit. A physician's order dated 1/31/25 directed for sliding scale Insulin Lispro (a short acting Insulin) to be administered with blood glucose checks 4 times daily (7:30 AM, 11:30 AM, 4:30 PM, and 9 PM) before meals, at bedtime, and administer for a blood glucose of: 150 - 200 = 2 units. 201 - 250 = 4 units. 251 - 300 = 6 units. 301 - 350 = 8 units. 351 -400 = 10 units. 401 - 450 = 12 units. 451+ = Call Provider for additional orders. The January 2025 MAR identified LPN #2 documented Resident #81 had a blood glucose of 459 on 1/31/25 at 4:30 PM and received a partial dose of Insulin Lispro. The MAR failed to identify the dose administered. Review of the clinical record failed to identify any additional documentation related to Resident #81's blood glucose of 459 on 1/31/25 including notification to the provider per the physician's order due to the blood glucose level above 450, or that Resident #81's resident representative was notified. The February 2025 MAR identified Resident #81 had a blood glucose of 63 on 2/13/25 at 7:30 AM. The MAR identified that the blood glucose parameters were out of range and no Insulin was administered. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Harrington Court	59 Harrington CT Colchester, CT 06415

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the clinical record for 2/13/25 failed to identify any additional documentation including directions according to the physician's order dated 12/16/24 or that the provider or Resident #81's representative were notified. The February 2025 MAR identified Resident #81 had a blood glucose of 50 obtained by LPN #2 on 2/17/25 at 7:30 AM. Further review of the MAR identified LPN #2 documented that the blood glucose was within range and no Insulin was administered. Review of the clinical record for 2/17/25 failed to identify any additional documentation including directions according to the physician's order dated 12/16/24 or that the provider or Resident #81's representative were notified. The February 2025 MAR identified Resident #81 had a blood glucose of 47 obtained by LPN #2 on 2/18/25 at 7:30 AM. Further review of the MAR identified LPN #2 documented that the blood glucose was within range and no Insulin was administered. Review of the clinical record for 2/18/25 failed to identify any additional documentation including directions according to the physician's order dated 12/16/24 or that the provider or Resident #81's representative were notified. The February 2025 MAR identified Resident #81 had a blood glucose of 51 obtained by LPN #2 on 2/22/25 at 7:30 AM. Further review of the MAR identified LPN #2 documented that the blood glucose was within range and no Insulin was administered. Review of the clinical record for 2/22/25 failed to identify any additional documentation including directions according to the physician's order dated 12/16/24 or that the provider or Resident #81's representative were notified. A nurse's note dated 3/3/25 at 10:26 PM by LPN #1 identified that Resident #81 had a blood glucose of 54. The note identified glucose gel was administered. Review the clinical record for 3/3/25 failed to identify any additional documentation that the provider or Resident #81's resident representative was notified. A nurse's note dated 3/14/25 at 8:52 AM by RN #12 identified Resident #81 had a morning blood glucose of 45, that Resident #81 was given juice and breakfast, a repeat blood glucose 15 minutes later was 78, and that the APRN was notified. Further review of the clinical record failed to identify that Resident #81's resident representative was notified of the hypoglycemic episode. The March 2025 MAR identified Resident #81 had a blood glucose of 62 on 3/16/25 at 11:30 AM. Further review of the MAR identified that the blood glucose was within range and no Insulin was administered. Review of the clinical record for 3/16/25 failed to identify any additional documentation including directions according to the physician's order dated 12/16/24 or that the provider or Resident #81's representative were notified. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The March 2025 MAR identified Resident #81 had a blood glucose of 68 obtained by LPN #2 on 3/17/25 at 7:30 AM. Further review of the MAR identified LPN #2 documented that the blood glucose was within range and no Insulin was administered. Review of the clinical record for 3/17/25 failed to identify any additional documentation including directions according to the physician's order dated 12/16/24 or that the provider or Resident #81's representative were notified. The March 2025 MAR identified Resident #81 had a blood glucose of 55 obtained by LPN #2 on 3/20/25 at 7:30 AM. Further review of the MAR identified LPN #2 documented that the blood glucose was within range and no Insulin was administered. Review of the clinical record for 3/20/25 failed to identify any additional documentation including that the provider or Resident #81's representative were notified. A nurse's note dated 3/21/25 at 3:49 AM by RN #12 identified Resident #81 had a blood glucose of 53 at 3:00 AM. The note also identified that an IM Glucagon injection was given, and Resident #81 had a repeat blood glucose of 112 at 3:45 AM. Further review of the clinical record for 3/21/25 failed to identify any documentation that the provider or Resident #81's resident representative were notified. A nurse's note dated 3/22/25 at 7:54 AM by RN #12 identified that at 3:30 AM, Resident #81 was observed to be alert but lethargic with skin warm to the touch but clammy. The note further identified Resident #81 had a blood glucose of 50 and was administered glucose gel, and a recheck 20 minutes later identified a blood glucose of 69. The note identified Resident #81 reported feeling better and was offered orange juice, and a repeat blood glucose was 112 after an hour. The note also identified Resident #81 received Insulin Glargine 52 units at bedtime and that Resident #81 had a blood glucose of 149 at 7:30 AM. Review of the clinical record for 3/22/25 failed to identify that the provider or Resident #81's resident representative were notified. The March 2025 MAR identified on 3/22/25 at 8:00 PM that 52 units of Insulin Glargine was held by LPN #3 due to Resident #81's blood glucose levels dropping to 50 overnight. The clinical record failed to identify that the provider was notified that Resident #81 did not receive his/her nightly dose of Insulin Glargine on 3/22/25 or that Resident #81's resident representative was notified of the medication hold due to hypoglycemia. Review of the clinical record and MAR for March 2025 identified on 3/23/25 at 1:30 AM, LPN #3 identified Resident #81 had a blood glucose level of 50 and was administered glucose gel. Review of the clinical record identified on 3/23/25 at 2:00 AM, LPN #3 documented Resident #81 had a blood glucose recheck of 63. A nurse's note dated 3/23/25 at 2:32 AM by LPN #3 identified Resident #81 was clammy, cold, and lethargic and glucose gel was administered. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the clinical record identified on 3/23/25 at 2:30 AM, RN #12 documented Resident #81 had a blood glucose of 112. Review of the clinical record for 3/23/25 failed to identify any documentation that the provider or Resident #81's resident representative were notified of Resident #81's hypoglycemic episode. Review of the clinical record identified on 3/25/25 at 2:00 AM LPN #3 documented Resident #81 had a blood glucose of 45. Further review of the clinical record identified a recheck by LPN #3 done at 3:44 AM was 70. Review of the clinical record and March 2025 MAR for 3/25/25 failed to identify any documentation that the provider or Resident #81's resident representative were notified of Resident #81's hypoglycemic episode. A nurse's note dated 3/26/25 at 1:20 AM by LPN #1 identified she was notified by a nurse aide that Resident #81 was profusely sweating. LPN #1 identified that Resident #81 had blood glucose check of 41, that emergency glucose was given immediately, and that a recheck would be done in a few minutes. The March 2025 MAR identified LPN #1 administered glucose gel on 3/26/25 at 1:20 AM. A nurse's note dated 3/26/25 at 1:45 AM by LPN #6 identified Resident #81 had a repeat blood glucose check of 54. Further review of the nurse's note identified LPN #1 documented a repeat blood glucose check of 131 at 2:14 AM. Review of the clinical record for 3/26/25 failed to identify any documentation that the provider or Resident #81's resident representative were notified of Resident #81's hypoglycemic episode. The March 2025 MAR identified Resident #81 had a blood glucose of 67 obtained by LPN #2 on 3/31/25 at 11:30 AM. Further review of the MAR identified LPN #2 documented that the blood glucose was within range and no Insulin was administered. Review of the clinical record for 3/31/25 failed to identify any documentation that Resident #81's resident representative was notified of Resident #81's hypoglycemic episode. Interview with APRN #1 on 4/8/25 at 11:52 AM identified that she was aware that Resident #81 had variable blood glucose levels but felt these were related to dietary noncompliance and a recent course of antibiotics. APRN #1 identified she could not remember if she was notified that if Resident #81 received IM Glucagon or of all the blood glucose levels under 70 since 2/13/25, but if the resident had a blood glucose above 450 or below 70, she would expect that the nurses would assess the resident to ensure he/she was not symptomatic and that she or the on call provider would be notified if the resident had symptoms. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LPN #1 on 4/9/25 at 10:50 AM identified that she was assigned to Resident #81 on 3/3 and 3/26/25. LPN #1 identified that LPNs in the facility were not allowed to complete an assessment of the residents or contact the physician/APRN and resident representative regarding a change in condition, so that should have been completed by the RN. LPN #1 identified she was unsure who she reported Resident #81's hypoglycemic episodes to and she did not document the information in the clinical record. Interview with RN #12 on 4/9/25 at 11:56 AM identified that she was the nurse assigned to Resident #81 on 3/20/25 on the 11:00 PM - 7:00 AM shift and was the RN supervisor working with LPN #3 on 3/22/25 on the 11:00 PM - 7:00 AM shift. RN #12 identified on 3/21/25 at 3:00 AM a nurse aide notified her that Resident #81 was very lethargic, and she administered IM Glucagon which was the standard order for all diabetics in the facility for hypoglycemia. RN #12 identified she obtained vital signs on Resident #81 and completed a repeat blood glucose check at 3:45 AM and documented a progress note. RN #12 identified that on 3/23/25 Resident #81 had a similar hypoglycemic episode with LPN #3 overnight and required glucose gel and juice. RN #12 identified she did not notify the on-call provider or Resident #81's resident representative regarding Resident #81's hypoglycemic episodes on 3/21 or 3/23/25 and that she would have passed the information on in morning report to the day shift or told APRN #1 in person if she was in the facility at shift change. RN #12 identified that she did not feel that it was necessary to notify the on-call provider but was aware that the physician orders and facility protocol for hypoglycemia directed to contact the physician or APRN for a blood glucose less than 70 Interview with LPN #2 on 4/9/25 at 12:15 PM identified she could not remember any blood glucose issues for Resident #81 from 12/28/24, 1/31/25, 2/2025, or 3/2025. LPN #2 identified that unless she noticed a specific issue or it was listed in her tasks in the MAR or TAR, she did not document a note or assess Resident #81 related to blood glucose issues. LPN #2 identified any documentation would be in a progress note, and that she would notify the RN superviso[TRUNCATED]

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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 review of the clinical record, facility documentation, facility policy, and interviews for residents 4 of 8 residents (Resident #42, 88, 92 and 99,) reviewed for allegations of abuse, the facility failed to ensure the residents were free from abuse. The findings include: 1a. Resident #7 was admitted to the facility in August 2024 with diagnoses that included paranoid schizophrenia, borderline personality disorder, and diabetes. The care plan dated 11/7/24 identified Resident #7 exhibits or has the potential to exhibit physical behaviors related to psychiatric disorder and is combative with care. Interventions include postponing care/activity and allowing time to regain composure. The quarterly MDS dated [DATE] identified Resident #7 had intact cognition and was independent walking 150 feet. The physician's order dated 1/1/25 directed to monitor behavior for hitting and swatting every shift. Review of the change in condition evaluation form dated 1/15/25 identified Resident #7 was observed by nursing staff striking his/her roommate (Resident #88). Resident #7 indicated he/she asked Resident #88 to get off his/her bed and identified he/she only touched Resident #88's leg to get off the bed. The APRN and conservator of person were notified. Resident #7 is on 1:1 monitoring until psychiatric evaluation. b. Resident #88 was admitted to the facility in May 2023 with diagnoses that included wandering, dementia, psychotic disturbance, mood disturbance, and anxiety disorder. The care plan dated 11/9/24 identified Resident #88 was an elopement risk and wanderer related to impaired safety awareness and wanders aimlessly. Intervention included wanderguard to left wrist, distract resident from wandering by offering pleasant diversions, and structured activities. Further, the care plan identified Resident #88 had a behavior problem related to dementia and could be difficult to redirect when anxious. Interventions included intervene as necessary to protect the rights and safety of others, approach and speak in a calm manner, divert attention, remove from situation and take to an alternate location as needed. The care plan dated 11/26/24 identified Resident #88 had the potential to exhibit physical behaviors related to cognitive loss and dementia. Resident #88 exhibited physical aggression toward another resident without injury. Interventions included gently guiding the resident from the environment while speaking in a calm, measuring voice, divert resident by giving alternative objects or activities. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The quarterly MDS dated [DATE] identified Resident #88 had severely impaired cognition and was independent with walking 150 feet. Additionally, Resident #88 had no physical or verbal behaviors directed at others and had exhibited no wandering behavior. (This is in conflict with the care plan that identified Resident #88 wanders aimlessly and exhibited physical aggression toward another resident). The physician's order dated 1/1/25 directed to monitor behavior for wandering and exit seeking at the end of each shift for anxiety, monitor behavior for nighttime restlessness every evening and night shift and monitor behavior for anxious and panic every shift. Review of the change in condition evaluation form dated 1/15/25 identified Resident #88 was struck by roommate (Resident #7). The APRN, police, and resident representative were notified. Resident #88 will be evaluated by psychiatric APRN. The reportable event form dated 1/15/25 at 4:15 PM identified staff overheard yelling coming from Resident #7 and Resident #88's room. Upon entering the room, Resident #7 was observed hitting Resident #88 on the left shoulder twice with an open hand. Resident #7 indicated that Resident #88 was lying in his/her bed and when she asked Resident #88 to move the resident became upset and began yelling. Resident #7 was placed on 1:1 supervision pending psychiatrist evaluation. Both residents were evaluated for injury with none found. The APRN, police, Administrator, and conservator of person, and resident representative were notified. Neither resident was injured in the incident. Resident #7 has been moved to a different hallway. Both residents were evaluated by psychiatrist services. Resident #88 was given a one-time dose of Ativan with positive effect. Both residents will continue to receive psychiatric services. A written statement by LPN #4 dated 1/15/25 identified at approximately 3:50 PM she heard loud yelling and arguing coming from Resident #7 and Resident #88 room. LPN #4 indicated she approached the room and witnessed Resident #7 hitting Resident #88 while Resident #88 was on the floor. LPN #4 indicated she ran and called for help. A written statement by LPN #5 dated 1/15/25 identified she was in the middle of medication pass when LPN #5 indicated she was informed by another nurse at 3:50 PM that there was a resident-to-resident altercation between Resident #7 and Resident #88. LPN #5 indicated the supervisor informed her that Resident #88 would be on every 15 minutes monitoring for the remainder of the evening, and Resident #7 would be relocated to the 400 wing. The social service note dated 1/15/25 at 4:42 PM identified SW #2 spoke with Resident #7's conservator of person regarding incident that occurred between his/her and roommate. A room change was initiated for Resident #7. SW #2 will follow up with Resident #7 and the resident has been added to the psychiatrist book to be seen. The nurse's note by RN #10 dated 1/15/25 at 5:23 PM identified it was reported to her from LPN #4 that Resident #7 was observed in a physical altercation with roommate (Resident #88) at 4:15 PM. Resident #7 indicated Resident #88 sat on his/her bed, and he/she moved Resident #88's leg off the bed and Resident #88 sat on the floor. Resident #7 denies striking roommate. Both residents were separated at the time of the incident. Resident #7 was cleared by the psychiatrist with no new orders. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nurse's note by RN #10 dated 1/15/25 at 5:27 PM identified it was reported to her from LPN #4 that Resident #88 was observed in a physical altercation with Resident #7 at 4:15 PM. Resident #88 has no recollection of the event and was calm, and cooperative. The summary report dated 1/22/25 at 3:45 PM identified Resident #88 began yelling at Resident #7. Staff responded to the yelling and witnessed Resident #7 slapping Resident #88 on the left shoulder twice with an open hand. Both residents were immediately separated and placed on 1:1 supervision pending on psychiatrist evaluation. Both residents were evaluated for injury with none found. Both residents were evaluated by the psychiatrist and cleared from 1:1 monitoring. Resident #88 was given a dose of Ativan with positive effect. Resident #7's room has been relocated to a different hallway. Both residents will continue to receive psychiatric services. Behaviors will continue to be monitored. Interview with RN #10 on 4/14/25 at 12:18 PM identified she does remember the resident-to-resident physical and verbal altercation due to it was so long ago. 2a. Resident #42 was admitted to the facility in September 2022, with diagnoses that included anxiety disorder, depressive disorder, and chronic kidney failure disease stage 4. The quarterly MDS dated [DATE] identified Resident #42 had intact cognition and required substantial/maximum assistance with personal hygiene. The care plan dated 11/25/24 identified Resident #42 has the potential to exhibit physical behaviors related to ineffective coping skills, (example poor anger management). Resident #42 was in a physical altercation with another resident without injury. Interventions include monitor for emotional distress as ordered. Review of the change in condition evaluation form dated 11/26/24 identified Resident #42 was involved in a resident-to-resident altercation. The APRN, police, and the resident representative were notified. Resident #42 was monitored for emotional distress every shift for 72 hours. b. Resident #88 was admitted to the facility in May 2023, with diagnoses that included wandering, dementia, psychotic disturbance, mood disturbance, and anxiety disorder. The quarterly MDS dated [DATE] identified Resident #88 had severely impaired cognition and was independent with walking 150 feet. Additionally, Resident #88 had no behaviors (physical or verbal) directed at others, and no wandering behavior. The care plan dated 10/16/24 identified Resident #88 was an elopement risk with wandering related to impaired safety awareness and wanders aimlessly. Intervention included wanderguard to left wrist, distracting resident from wandering by offering pleasant diversions, and structured activities. Additionally, Resident #88 had a behavioral problem related to dementia and could be difficult to redirect when anxious. Interventions included intervening as necessary to protect the rights and safety of others, approach and speak in a calm manner, divert attention, remove from situation and take to an alternate location as needed. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The physician's order dated 11/1/24 directed to monitor for wandering/exit seeking each shift for anxiety, monitor behavior for nighttime restlessness every evening and night shift and monitor behavior for anxiety and panic every shift. The reportable event form dated 11/26/24 at 8:00 PM identified Resident #88 wandered into Resident #42's room. When Resident #42 asked Resident #88 to leave and stop touching him/her belongings, Resident #88 struck Resident #42 on the arm. Staff responded to yelling from Resident #42's room. Resident #42 reported that Resident #88 had wandered into his/her room and sat in his/her wheelchair. Resident #42 reported he/she grabbed Resident #88's arm to stop and guide him/her out of the room, when Resident #88 struck him/her on the left arm. Both residents were immediately redirected away from each other and assessed for injuries. No injuries were found on either resident. Resident #88 was placed on 1:1 supervision pending psychiatric evaluation. Investigation initiated. The APRN, Administrator, police, and resident representatives were notified. The LCSW #1 progress note dated 11/26/24 at 8:00 PM - 8:16 PM identified she met with Resident #88 in response to screaming in the hallway of the 500 wing. Resident #88 was screaming help, help and attempting to push his/her way past a nursing staff who was blocking the doorway to Resident #42's room. LCSW #1 redirected Resident #88 to walk with her to the day room area and participated in a breathing activity and it was successful. LCSW #1 provided Resident #88 with a cheese and cracker snack as a distraction. Resident #88 continues to be increasingly confused and agitated. Resident #88 was observed to wander in and out of resident rooms. Resident #88's roommate indicated Resident #88 wanders in the night hours and moves things in the room. It was reported that Resident #88 wandered into Resident #42's room thinking that it was his/her room, attempted to get into Resident #42's roommates bed after redirection Resident #88 sat in Resident #42's wheelchair. Resident #42 touched Resident #88's arm to redirect the resident to leave and Resident #88 reacted and assaulted Resident #42. The LCSW #1 progress note dated 11/26/24 at 8:53 PM - 9:12 PM identified Resident #42 was assaulted by Resident #88 while he/she was in bed. LCSW #1 met with Resident #42 to offer supportive therapy and provide support after the incident. Resident #42 was presented as anxious with constricted affect, was alert and oriented and friendly. Resident #42 indicated Resident #88 wandered into his/her room and attempted to lay in the roommate's bed. Resident #42's roommate redirected Resident #88 to leave, however, Resident #88 sat in Resident #42's wheelchair. Resident #42 touched Resident #88's arm to redirect him/her from sitting in the wheelchair and to leave the room. Resident #88 was agitated, confused and hit Resident #42 in response to being touched. Resident #42 indicated he/she was not expecting to be assaulted, but it did not hurt and there was no physical injury. Resident #42 indicated that Resident #88 often wanders into his/her room and Resident #42 verbalized the fear that it will happen again, noting that Resident #88's room was directly across from his/her room. A written statement by RN #4 dated 11/26/24 identified she was notified by RN #10 that there was an unwitnessed resident to resident altercation between Resident #88 and Resident #42. Resident #88 wandered into Resident #42's room and began sitting in his/her wheelchair. Resident #42 was shocked, annoyed, and grabbed Resident #88's arm to try and remove him/her out of the room. Resident #88 hit Resident #42 multiple times on the left arm. Resident #42 screamed, and NA #8 came into the room. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A written statement by NA #8 dated 11/26/24 at 8:15 PM identified she last check on Resident #88 at 7:45 PM who was sitting at the nurse's desk eating a snack. NA #8 indicated she did not witness the incident. NA #8 indicated she heard Resident #88 screaming in the hallway. NA #8 indicated Resident #88 was physically aggressive towards her because she was blocking Resident #42's room door to prevent him/her from entering the room again. The psychiatric APRN note dated 11/27/24 identified urgent telehealth visit with Resident #42 after Resident #88 came into his/her room and sat in his/her wheelchair and would not leave. Resident #42 indicated she recalled the incident and asked Resident #88 to leave. Resident #42 indicated he/she grabbed Resident #88's arm to get Resident #88 to leave and Resident #88 slapped him/her in the face. Both residents were screaming at each other and the nursing staff came in and separated them. The psychiatrist APRN note dated 11/27/24 identified urgent telehealth visit With Resident #88 after a resident-to-resident incident last evening. It was reported that Resident #88 went into Resident #42's room and sat in his/her wheelchair and refused to leave. Resident #42 attempted to get Resident #88 to leave, and Resident #88 allegedly slapped him/her in the face. This was not witnessed by staff. Review of the summary report dated 12/4/24 at 1:24 PM identified on 11/26/24 at 8:00 PM Resident #88 wandered into Resident #42's room and sat in his/her wheelchair. Resident #42 touched Resident #88 right arm and asked him/her to leave. Resident #88 started yelling at Resident #42 and lightly swatted his/her on the left arm with an open hand. Resident #42 indicated staff immediately responded to the yelling and redirected Resident #88 out of the room. Resident #88 was placed on 1:1 supervision pending psychiatric evaluation and both were assessed for injury with none found. Resident #88 remains on every 15 minutes checks. Resident #88 continues to receive psychiatric services, and psychoactive medication has been reviewed. A Velcro stop sign was ordered for Resident #42's room door. Interview with the DNS on 4/9/25 at 8:00 AM identified Resident #88 is alert, confused, ambulates independently, and has a history of wandering. The DNS indicated Resident #88 wandered into Resident #42 room and sat in his/her wheelchair. Resident #42 attempted to have Resident #88 leave the room when Resident #88 hit him/her on the arm. The DNS indicated the social service department has met with Resident #88 representative regarding searching for another facility with a dementia secure unit. The DNS indicated the facility is addressing Resident #88 wandering behavior with ongoing staff monitoring the resident throughout the day, and Resident #88 attending recreation activities of his/her choice. 3. Resident #92 was admitted to the facility in August 2023 with diagnoses that included dementia with behavioral disturbance, psychotic disturbance, mood disturbance, anxiety disorder, and cerebrovascular disease. The quarterly MDS dated [DATE] identified Resident #92 had severely impaired cognition and required setup or clean-up assistance with toileting hygiene. Additionally, Resident #92 had exhibited no physical or verbal behavior symptoms directed toward others. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Harrington Court	59 Harrington CT Colchester, CT 06415

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The care plan dated 3/19/25 identified Resident #92 requires assistance for ADL care related to dementia, decreased ability to perform ADL'S. Interventions included providing extensive assistance of 1 for bed mobility, toileting and hygiene. The care plan dated 3/19/25 identified Resident #92 was resistive to care related to dementia. Refusing care at times. Interventions included to give a clear explanation of all care activities prior to and as they occur during each contact. Further, Resident #92 had the potential to be physically aggressive related to dementia, and poor impulse control. Interventions included giving the resident as many choices as possible about care and activities. The physician's order dated 4/1/25 directed to monitor behavior for anxiety, resistive/combative with care, and emotional distress every shift. The reportable event form dated 4/8/25 at 12:00 PM identified Resident #92 was alert, oriented to self, pleasant, and cooperative. Resident #110, who resides across the hallway from Resident #92, reported to the social worker between 2:00 AM and 3:00 AM that he/she overheard NA #3 telling Resident #92 to shut up and be quiet. The care plan dated 4/8/25 identified Resident #92 was involved in an alleged verbal incident involving a staff member. Interventions included to monitor for emotional distress. The psychiatric APRN note dated 4/8/25 identified Resident #92 was seen for alleged negative interaction with staff member. Resident #92 was seen in bed, alert, smiling upon approach, calm, and cooperative. Resident #92 was unable to accurately state day, month, year. Resident #92 does not recall having a negative interaction with staff. A statement by LPN #1 dated 4/8/25 identified she worked on 4/7/25 on the 11:00 PM - 7:00 AM shift on the [NAME] wing. LPN #1 indicated RN #6 came over to the unit. LPN #1 indicated Resident #110 reported to her that NA #3 was in Resident #92's room and was aggressive with Resident #92 and told him/her to shut up. LPN #1 indicated she reported to RN #6 that Resident #110 reported to her that NA #3 was in Resident #92's room and was aggressive with Resident #92 and told him/her to shut up. A statement by NA #3 dated 4/8/25 at 5:01 PM identified she provided care to Resident #92 around 1:00 AM and 5:00 AM as she does every morning when she works. NA #3 indicated some mornings Resident #92 can be a bit loud talking to his/herself as he/she was on the morning of 4/8/25. NA #3 indicated she had to go to the resident room several times to reassure him/her that it was in the middle of the night, and he/she had to be quiet. NA #3 indicated she sat with Resident #92 and gave him/her a tuna sandwich and a drink. NA #3 indicated she put the television on animal planet with no volume, and Resident #92 eventually fell asleep. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LPN #1 on 4/10/25 at 10:57 AM identified she worked on 4/7/25 on the 11:00 PM - 7:00 AM shift on the [NAME] wing. LPN #1 indicated she observed NA #3 had an attitude towards her during the shift. LPN #1 indicated NA #3 was yelling, screaming, cursing profanity, and argumentative. LPN #1 indicated NA #3 was very upset because the agency nurse aide left and went home, leaving the [NAME] wing with only with 2 nurse aides instead of 3 nurse aides. LPN #1 indicated she gave a written statement to the DNS regarding everything that happened on the shift with NA #3. LPN #1 indicated RN #6 was at the nurse's station while NA #3 was still yelling and talking inappropriately. LPN #1 indicated she reported to RN #6 that Resident #110 reported to her that NA #3 told Resident #92 to shut up and NA #3 yanked Resident #99's wheelchair and told Resident #99 to act like a damn man and that he/she was behaving like a child. LPN #1 indicated RN #6 stated that NA #3 and her (LPN #1) need to get along and she will address the issue with the DNS in the morning. LPN #1 indicated that was not the first time she has witnessed NA #3 yelling, using profanity, and being argumentative with agency nurse aides or other staff on the 11:00 PM - 7:00 AM shift on the [NAME] wing. Interview with Resident #110 on 4/10/25 at 9:55 AM identified he/she does not sleep throughout the night, so he/she ambulates up and down the hallway and watches television in the common area on the wing (which is across from the nurse's station). Resident #110 indicated on Monday night his/her bedroom door was open, and Resident #92's bedroom door was also open. Resident #110 indicated Resident #92 was talking out loud to his/herself which the resident does sometimes. Resident #110 indicated around 2:00 AM or 3:00 AM overheard NA #3 across the hallway in Resident #92's room yelling at Resident #92 to shut up and be quiet. Resident #110 indicated NA #3 said it four times to Resident #92. Resident #110 indicated he/she got up and stood in the doorway of his/her bedroom and listened. Resident #110 indicated afterward NA #3 left Resident #92's room. Resident #110 indicated a little while later he/she witnessed and heard NA #3 was yelling and arguing with LPN #1 in front of the nurse's station saying who is going to clean Resident #99 and the urine on the floor. Resident #110 indicated Resident #99 was sitting in the wheelchair at the nurse's station. Resident #110 indicated he/she reported to LPN #1 that he/she overheard NA #3 in Resident #92's room yelling at Resident #92 to shut up and be quiet. Resident #110 indicated he/she told SW #2 that morning that he/she overheard NA #3 in Resident #92's room yelling at Resident #92 to shut up and be quit, and NA #3 was yelling and arguing with LPN #1 in front of the nurse's station saying who is going to clean Resident #99 and the urine on the floor. Interview with the DNS on 4/10/25 at 12:00 PM identified she was made aware on 4/8/25 at 12:00 PM that Resident #110 had reported to SW #1 between 2:00 AM and 3:00 AM he/she overheard NA #3 telling Resident #92 to shut up and be quiet. The DNS indicated she reported the allegation of verbal abuse to the survey team immediately. The DNS indicated she placed NA #3 on administrative leave immediately. The DNS indicated RN #6, and LPN #1 did not inform her of the allegation by Resident #110. The DNS indicated she must investigate and see if LPN #1 had reported the allegation of staff to resident abuse to RN #6. DNS indicated RN #6 did not inform her that there was an argument between LPN #1 and NA #3 on the unit and residents were present. The DNS indicated that the expectation of the facility is that when there is an allegation of abuse the staff member is to be removed from the unit and sent home immediately. The DNS indicated NA #3 should have been removed from the unit and sent home until further notice. DNS indicated she is not aware if LPN #1 had reported to RN #6 about the alleged staff to resident abuse of Resident #99. DNS indicated RN #6 did not inform her that there was an argument between LPN #1 and NA #3 on the unit and residents were present. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility abuse, neglect, and exploitation policy identified facility to provide protection for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical arm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. 4. Resident #99 was admitted to the facility in January 2024 with diagnoses that included Parkinson's disease, dementia, mood disturbance, anxiety disorder, hallucinations, delusional disorders, psychotic disorder with delusions, depressive disorder, and wandering in disease. The quarterly MDS dated [DATE] identified Resident #99 was moderately cognitively impaired and required partial/moderate assistance with toileting hygiene. Additionally, Resident #99 had no behaviors of physical or verbal symptoms directed towards others, and no wandering. Further Resident #99 does not use a wheelchair. The care plan dated 2/26/25 identified Resident #99 is at risk for complications related to the use of psychotropic drugs: antipsychotic and antidepressant for agitation, restlessness, and sleeplessness. Interventions included monitor for continued need of medication as related to behavior and mood. Resident #99 exhibits or is at risk for distress/fluctuating mood symptoms related to sadness, depression caused by current medical diagnoses and functional decline. Interventions included refer to behavioral health specialists as needed. Resident #99 has bowel incontinence and mixed bladder incontinence related to confusion, impaired mobility, and Parkinson's disease. Interventions included to provide peri-care with each incontinent episode. The physician's order dated 4/1/25 directed to monitor behavior for agitation, resistive, excessive wandering, intrusive behavior, and sleeplessness every shift. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A statement by LPN #1 dated 4/8/25 identified she worked 4/7/25 on the 11:00 PM - 7:00 AM shift and indicated Resident #99 was sitting at the nurse's station when she came arrived. LPN #1 indicated Resident #99 had a fall and hit his/her head and sustained a laceration at the beginning of the shift. LPN #1 indicated Resident #99 was restless and would not remain still. LPN #1 indicated NA #3 was getting very agitated and aggressive with Resident #99 because the resident was grabbing everything and pushing chairs and at some point Resident #99 was yelling out another resident's name and yelling help. LPN #1 indicated that is when she observed NA #3 turn around and pull/yank Resident #99's wheelchair and say to Resident #99 (act like a damn man you're behaving like a child). LPN #1 told NA #3 that Resident #99 has dementia and will not understand her and that was inappropriate. LPN #1 indicated at 5:00 AM she started her medication pass and heard Resident #99 saying that he/she needed to go to the bathroom. LPN #1 informed NA #3 of the resident's request, however, NA #3 walked by her and ignored her. LPN #1 indicated at some point she walked by Resident #99 and observed a puddle of urine on the floor. LPN #1 indicated she notified NA #3 and NA #4 that Resident #99 had urinated on the floor, and again she got no response from the nurse aides. LPN #1 indicated she placed a few towels on the floor and underneath Resident #99's wheelchair and the resident's feet to soak up the urine. LPN #1 indicated that is when NA #3 approached her and stated, (oh you couldn't pick the piss off the damn floor). Resident #99 was present and could hear this comment. LPN #1 indicated she told NA #3 that she was in the middle of a medication pass and that if she had taken Resident #99 to the bathroom when he/she asked, the resident would not have urinated on the floor. LPN #1 indicated NA #3 insisted that LPN #1 provide incontinent care to Resident #99 and clean the floor with the urine. LPN #1 indicated she told NA #3 that she was in the middle of medication pass and that she (NA #3) was assigned to the resident. LPN #1 indicated NA #3 began shouting, cursing, speaking inappropriately to her in the [NAME] wing hallway in front of the nurse's station with Resident #99 present. LPN #1 indicated she told NA #3 that she would be calling the RN supervisor. LPN #1 indicated she walked down to the 400 wing with NA #3 still screaming at her while NA #3 was pushing Resident #99 down the hallway to the 600 wing to go and provide incontinent care to the resident. LPN #1 identified she called RN #6 to report the incident with NA #3. LPN #1 indicated Resident #110 reported to her that NA #3 had been in Resident #92's room and was aggressive with Resident #92 and told the resident to shut up. LPN #1 indicated Resident #110 also reported that NA #3 was yelling and screaming being disrespectful to the nurse and he/she was going to report NA #3 to the DNS. Interview with NA #3 on 4/9/25 at 11:23 AM identified she worked 4/7/25 during the 11:00 PM - 7:00 AM shift and was not assigned to Resident #99. NA #3 indicated at the beginning of the shift there were 3 nurse aides, and one of the aides, the agency nurse aide, left and went home which NA #3 indicated is an on-going issue with the agency nurse aides. NA #3 indicated Resident #110 was ambulating on the wing and was in the common area watching television. NA #3 indicated she was upset and probably loud when Resident #99, who was at the nurse's station in a wheelchair, urinated on himself/herself and the floor. NA #3 indicated LPN #1 placed a towel down on the floor and left it there. NA #3 indicated there was only 2 nurse aides overseeing the 400, 500, and 600 wings answering call lights and providing care, and she expected LPN #1 to help. NA #3 indicated she and LPN #1 had words. Interview with RN #6 on 4/9/25 at 11:50 AM identified she worked on 4/7/25 during the 11:00 PM - 7:00 AM shift as the RN supervisor. RN #6 indicated LPN #1 called her to the [NAME] wing because NA #3 was being disrespectful towards her. RN #6 indicated LPN #1 reported Resident #99 had urinated on the floor and she placed a towel on the floor and NA #3 told her it was everyone's job to provide resident care. RN #6 indicated LPN #1 never informed her that NA #3 (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was getting very agitated and aggressive with Resident #99 and pulled/yanked Resident #99's wheelchair and said to Resident #99 (act like a damn man you're behaving like a child). Further, RN #6 identified LPN #1 did not report to her that Resident #110 reported NA #3 was verbally abusive to Resident #92. RN #6 indicated she told LPN #1 and NA #3 to work out their issues or take it to Human Resource in the morning. RN #6 indicated she educated LPN #1 not to discussed what took place between her and NA #3. The reportable event form dated 4/10/25 at 11:30 AM identified during another investigation, it was discovered that LPN #1 witnessed NA #3 allegedly yank Resident #99's wheelchair and told the resident to (act like a damn man, you're behaving like a child). LPN #1, and NA #3 remain on administrative leave pending an investigation. Resident #99 was evaluated by psychiatrist and social services. The APRN, Administrator, police, and the resident Power of Attorney were notified. A statement by NA #3 dated 4/10/25 at 11:29 AM identified that she denied the allegations. Interview with LPN #1 on 4/10/25 at 10:57 AM identified she worked 4/7/25 during the 11:00 PM - 7:00 AM shift and NA #3 had an attitude towards her during the shift. LPN #1 indicated NA #3 was yelling, screaming, cursing profanity, and argumentative. LPN #1 indicated NA #3 was very upset because the agency nurse aide left and went home leaving the [NAME] wing with only 2 nurse aides instead of three. LPN #1 indicated NA #3 had an attitude and was upset that Resident #99 was at the nurse's station for monitoring. LPN #1 indicated she observed NA #3 pull/yank Resident #99's wheelchair and said to the resident (act like a damn man and that he/she was acting like a child). LPN #1 indicated she gave a written statement to the DNS regarding everything that happened on the shift with NA #3. LPN #1 indicated RN #6 was at the nurse's station while NA #3 was still yelling and talking inappropriately. LPN #1 indicated she reported to RN #6 that Resident #110 reported to her that NA #3 told Resident #92 to shut up and NA #3 yanked Resident #99's wheelchair and told Resident #99 to (act like a damn man and that he/she was behaving like a child). LPN #1 indicated RN #6 stated that she and NA #3 need to get along and s[TRUNCATED]

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for 3 of 8 residents (Resident #69, 99 and 269) reviewed for abuse and misappropriation, the facility failed to immediately report the allegations of abuse and misappropriation to the Administrator and the State Agency according to established timeframes. The findings include: 1. Resident #69 was admitted to the facility in February 2025 with diagnoses that included chronic kidney disease, diabetes, and surgery of the left leg. A physician's order dated 2/13/25 directed Resident #69 may go on a leave of absence with medications and responsible party. The admission MDS dated [DATE] identified Resident #69 had intact cognition and required moderate assistance with toileting, lower body dressing, transfers, and personal hygiene. The care plan dated 2/20/25 identified Resident #69 is resistive to care. Interventions included providing consistent, trusted caregiver, and structured daily routine, when possible. The social worker note dated 4/3/25 at 12:38 PM indicated that she met with Resident #69 to discuss concerns related to money being missing from his/her wallet. Resident #69 states that he/she had $152 and now is missing $150. Resident #69 reported last seeing his/her wallet in his/her backpack, and now only $2 dollars were left. Resident #69 was unsure if he/she had dropped it in the reception area prior to going out for an appointment but he/she is adamant that it was in his/her backpack. The Missing Item Form dated 4/3/25 identified at approximately at 9:00 AM Resident #69 reported he/she was missing $150, and it was one $100 bill and a $50 dollar bill. Attached was a statement from SW #1 that indicated she had spoken with RN #11 who reported that Resident #69 had told her that $150 was missing from his/her wallet. RN #11 reported that the wallet was given to her by a staff member, and that she had returned it to Resident #69 who said there was money missing. The social worker note dated 4/7/25 at 9:12 AM identified this social worker met with the resident following the allegation of stolen money. This writer will continue to follow-up with Resident#69 and offer support as needed. Interview with the Administrator on 4/8/25 at 2:20 PM indicated that she was responsible to complete an investigation related to Resident #69's missing money, and that she did it as a grievance because SW #1 informed her that the money was missing, not that it was stolen. The Administrator indicated that she did not know when Resident #69 last had seen the money or where Resident #69 kept his/her wallet. The Administrator indicated that she does not know if the resident really had the money or not because he does not keep it in the facility's account. The Administrator indicated that Resident #69 could have dropped it in the lobby that day when going out for an appointment. The Administrator indicated that the wallet was found by Laundry #1, and he opened it to see who it belonged to and brought it to the supervisor RN #11. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reviewing the investigation and missing item form, the Administrator could not provide statements from the supervisor RN #11 or Laundry #1. The Administrator indicated that she does not know how Resident #69's wallet had gotten out of the backpack into the laundry. The Administrator indicated that she could not confirm or deny if Resident #69 had the $150 but she was not informed until yesterday that the money was stolen, she thought it was just missing. The Administrator indicated that if she was informed on 4/3/25 that the money had been stolen, she would have immediately reported it to the State Agency, called the police, the regional team, DSS, and the Medical Director. Interview with Resident #69 on 4/9/25 at 1:00 PM indicated that he/she did not know his/her wallet was gone until the nurse brought the wallet to him/her after returning from an appointment Thursday morning on 4/3/25 about 11:00 AM when the charge nurse was giving him/her the morning medications. Resident #69 indicated that when the nurse stated that someone found the wallet in the laundry, he/she opened the wallet and reported there was $150 missing. Resident #69 indicated that he/she cannot make sense of how his/her wallet was found in the laundry. Resident #69 indicated that someone here took my $150 because he/she knew exactly how much he/she had the evening before. Resident #69 indicated that his/her wallet had $152 in it the evening before and was in his/her backpack in the pocket where it is always kept. The interview with SW #2 on 4/9/25 at 1:05 PM indicated that the supervisor, RN #11, had informed her that Resident #69 was missing money, and she could not name or identify who given it to her. SW #2 indicated that the wallet was found in the laundry and Laundry #1 had given the wallet to RN #11. Interview with SW #2 on 4/10/25 at 7:45 AM indicated that she was informed by RN #11 at approximate 11:00 AM that Resident #69 had reported there was $150 missing from his/her wallet. SW #2 indicated she immediately went and informed the DNS that Resident #69 had reported there was $150 missing from his/her wallet and then went to see Resident #69. SW #2 indicated Resident #69 had informed her maybe the wallet had fallen in the lobby before going to the appointment the morning of 4/3/25, but he/she always keeps the wallet in the backpack, and the backpack in always with him/her. SW #2 indicated Resident #69 was missing a $100 dollar bill and a $50 dollar bill and in the wallet was left the two $1 bills. SW #2 indicated that Resident #69 was adamant that his/her wallet was kept in his/her backpack in a specific area. Interview with RN #11 on 4/10/25 at 8:46 AM indicated the morning of 4/3/25, a guy with shorts brought her a wallet found outside and placed it on the desk and stated the owner of wallet, so she kept the wallet on her table and brought the wallet to Resident #69 when he/she returned from an appointment. RN #11 indicated she gave Resident #11 the wallet in the hallway while the nurse was giving medications, and Resident #69 immediately opened the wallet and reported there was $150 in there and it was gone. RN #11 indicated that she told the DNS and was not told to write a statement. RN #11 indicated then she informed SW #2. RN #11 indicated that Resident #69 reported he/she was not aware the wallet was missing until she handed it to him/her. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility Abuse, Neglect, and Exploitation Policy identified it is the policy of the facility to provide protection for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. Misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful, temporary or permanent, use of a resident's belongings or money without the residents' consent. The abuse prevention coordinator designee was responsible for reporting allegations or suspected abuse, neglect, or exploitation to the state agency and other officials in accordance with the state law. Investigation of alleged abuse identified the staff responsible for the investigation identifying and interviewing all involved people, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegation. Focusing the investigation on determining if abuse, neglect, and/or mistreatment has occurred, the extent, and cause. Providing complete and through documentation of the investigation. Reporting all alleged violations to the Administrator, state agency, adult protective services law enforcement within specified timeframes: immediately, but not later than 2 hours after the allegation is made and not later than 24 hours if the event that causes the allegation do not involve abuse and do not result in serious bodily injury. Review of the Compliance with Reporting Allegations of Abuse, Neglect, or exploitation Policy identified the facility will report all allegations of abuse, neglect, or exploitation or mistreatment and misappropriation of resident property are reported immediately to the Administrator of the facility and appropriate agencies in accordance with current state and federal regulations within prescribed timeframes. 2. Resident #99 was admitted to the facility in January 2024 with diagnoses that included Parkinson's disease, dementia, mood disturbance, anxiety disorder, hallucinations, delusional disorders, psychotic disorder with delusions, depressive disorder, and wandering in disease. The quarterly MDS dated [DATE] identified Resident #99 was moderately cognitively impaired and required partial/moderate assistance with toileting hygiene. Additionally, Resident #99 had no behaviors of physical or verbal symptoms directed towards others, and no wandering. Further Resident #99 does not use a wheelchair. The care plan dated 2/26/25 identified Resident #99 is at risk for complications related to the use of psychotropic drugs: antipsychotic and antidepressant for agitation, restlessness, and sleeplessness. Interventions included monitor for continued need of medication as related to behavior and mood. Resident #99 exhibits or is at risk for distress/fluctuating mood symptoms related to sadness, depression caused by current medical diagnoses and functional decline. Interventions included refer to behavioral health specialists as needed. Resident #99 has bowel incontinence and mixed bladder incontinence related to confusion, impaired mobility, and Parkinson's disease. Interventions included to provide peri-care with each incontinent episode. The physician's order dated 4/1/25 directed to monitor behavior for agitation, resistive, excessive wandering, intrusive behavior, and sleeplessness every shift. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075253	A. Building B. Wing	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Harrington Court	59 Harrington CT Colchester, CT 06415

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A statement by LPN #1 dated 4/8/25 identified she worked 4/7/25 on the 11:00 PM - 7:00 AM shift and indicated Resident #99 was sitting at the nurse's station when she arrived. LPN #1 indicated Resident #99 had a fall and hit his/her head and sustained a laceration at the beginning of the shift. LPN #1 indicated Resident #99 was restless and would not remain still. LPN #1 indicated NA #3 was getting very agitated and aggressive with Resident #99 because the resident was grabbing everything and pushing chairs and at some point Resident #99 was yelling out another resident's name and yelling help. LPN #1 indicated that is when she observed NA #3 turn around and pull/yank Resident #99's wheelchair and say to Resident #99 (act like a damn man you're behaving like a child). LPN #1 told NA #3 that Resident #99 has dementia and will not understand her and that was inappropriate. LPN #1 indicated at 5:00 AM she started her medication pass and heard Resident #99 saying that he/she needed to go to the bathroom. LPN #1 informed NA #3 of the resident's request, however, NA #3 walked by her and ignored her. LPN #1 indicated at some point she walked by Resident #99 and observed a puddle of urine on the floor. LPN #1 indicated she notified NA #3 and NA #4 that Resident #99 had urinated on the floor, and again she got no response from the nurse aides. LPN #1 indicated she placed a few towels on the floor and underneath Resident #99's wheelchair and the resident's feet to soak up the urine. LPN #1 indicated that is when NA #3 approached her and stated, (oh you couldn't pick the piss off the damn floor). Resident #99 was present and could hear this comment. LPN #1 indicated she told NA #3 that she was in the middle of a medication pass and that if she had taken Resident #99 to the bathroom when he/she asked, the resident would not have urinated on the floor. LPN #1 indicated NA #3 insisted that LPN #1 provide incontinent care to Resident #99 and clean the floor with the urine. LPN #1 indicated she told NA #3 that she was in the middle of medication pass and that she (NA #3) was assigned to the resident. LPN #1 indicated NA #3 began shouting, cursing, speaking inappropriately to her in the [NAME] wing hallway in front of the nurse's station with Resident #99 present. LPN #1 indicated she told NA #3 that she would be calling the RN supervisor. LPN #1 indicated she walked down to the 400 wing with NA #3 still screaming at her while NA #3 was pushing Resident #99 down the hallway to the 600 wing to go and provide incontinent care to the resident. LPN #1 identified she called RN #6 to report the incident with NA #3. LPN #1 indicated Resident #110 reported to her that NA #3 had been in Resident #92's room and was aggressive with Resident #92 and told the resident to shut up. LPN #1 indicated Resident #110 also reported that NA #3 was yelling and screaming being disrespectful to the nurse and he/she was going to report NA #3 to the DNS. Interview with NA #3 on 4/9/25 at 11:23 AM identified she worked 4/7/25 during the 11:00 PM - 7:00 AM shift and was not assigned to Resident #99. NA #3 indicated at the beginning of the shift there were 3 nurse aides, and one of the aides, the agency nurse aide, left and went home which NA #3 indicated is an on-going issue with the agency nurse aides. NA #3 indicated Resident #110 was ambulating on the wing and was in the common area watching television. NA #3 indicated she was upset and probably loud when Resident #99, who was at the nurse's station in a wheelchair, urinated on himself/herself and the floor. NA #3 indicated LPN #1 placed a towel down on the floor and left it there. NA #3 indicated there was only 2 nurse aides overseeing the 400, 500, and 600 wings answering call lights and providing care, and she expected LPN #1 to help. NA #3 indicated she and LPN #1 had words. Interview with RN #6 on 4/9/25 at 11:50 AM identified she worked on 4/7/25 during the 11:00 PM - 7:00 AM shift as the RN supervisor. RN #6 indicated LPN #1 called her to the [NAME] wing because NA #3 was being disrespectful towards her. RN #6 indicated LPN #1 reported Resident #99 had urinated on the floor and she placed a towel on the floor and NA #3 told her it was everyone's job to provide resident care. RN #6 indicated LPN #1 never informed her that NA #3 was getting very agitated and aggressive with Resident #99 and pulled/yanked Resident #99's wheelchair and said to Resident #99 (act like a damn man you're behaving like a child). (continued on next page)

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Complete Care at Harrington Court	59 Harrington CT Colchester, CT 06415

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further, RN #6 identified LPN #1 did not report to her that Resident #110 reported NA #3 was verbally abusive to Resident #92. RN #6 indicated she told LPN #1 and NA #3 to work out their issues or take it to Human Resource in the morning. RN #6 indicated she educated LPN #1 not to discussed what took place between her and NA #3. The reportable event form dated 4/10/25 at 11:30 AM identified during another investigation, it was discovered that LPN #1 witnessed NA #3 allegedly yank Resident #99's wheelchair and told the resident to (act like a damn man, you're behaving like a child). LPN #1, and NA #3 remain on administrative leave pending an investigation. Resident #99 was evaluated by psychiatrist and social services. The APRN, Administrator, police, and the resident Power of Attorney were notified. A statement by NA #3 dated 4/10/25 at 11:29 AM identified that she denied the allegations. Interview with LPN #1 on 4/10/25 at 10:57 AM identified she worked 4/7/25 during the 11:00 PM - 7:00 AM shift and NA #3 had an attitude towards her during the shift. LPN #1 indicated NA #3 was yelling, screaming, cursing profanity, and argumentative. LPN #1 indicated NA #3 was very upset because the agency nurse aide left and went home leaving the [NAME] wing with only 2 nurse aides instead of three. LPN #1 indicated NA #3 had an attitude and was upset that Resident #99 was at the nurse's station for monitoring. LPN #1 indicated she observed NA #3 pull/yank Resident #99's wheelchair and said to the resident (act like a damn man and that he/she was acting like a child). LPN #1 indicated she gave a written statement to the DNS regarding everything that happened on the shift with NA #3. LPN #1 indicated RN #6 was at the nurse's station while NA #3 was still yelling and talking inappropriately. LPN #1 indicated she reported to RN #6 that Resident #110 reported to her that NA #3 told Resident #92 to shut up and NA #3 yanked Resident #99's wheelchair and told Resident #99 to (act like a damn man and that he/she was behaving like a child). LPN #1 indicated RN #6 stated that she and NA #3 need to get along and she will address the issue with the DNS in the morning. LPN #1 indicated that was not the first time she has witnessed NA #3 yelling, using profanity, and being argumentative with agency nurse aides or other staff on the 11:00 PM - 7:00 AM shift on the [NAME] wing. Interview with Resident #110 on 4/10/25 at 9:55 AM identified he/she does not sleep throughout the night, so he/she ambulates up and down the hallway and the common areas on the unit. Resident #110 indicated on Monday night he/she overheard NA #3 yelling and arguing with LPN #1 at the nurse's station and the hallway. Resident #110 indicated Resident #99 was sitting in a wheelchair at the nurse's station and NA #3 continued yelling, arguing, and was disrespectful to LPN #1 about who was going to clean Resident #99 and clean the urine off the floor. Resident #110 indicated NA #3 she was yelling, very angry and had an attitude that night. Interview with the DNS on 4/10/25 at 12:22 PM identified she was not aware that NA #3 was witnessed to pull/yank Resident #99's wheelchair and say to the resident (act like a damn man you're acting like a child) because until surveyor inquiry, she had not read LPN #1's statement that was written on 4/8/25. The DNS indicated NA #3 was not removed from the facility after LPN #1 witnessed NA #3 pull/yank Resident #99's wheelchair and say to the resident (act like a damn man, you're acting like a child). The DNS indicated that the expectation of the facility is that when there is an allegation of abuse, the staff member is to be removed and sent home immediately. The DNS indicated NA #3 should have been removed from the unit and sent home until further notice. The DNS indicated she is not aware if LPN #1 had reported the incident to RN #6. The DNS indicated RN #6 did not inform her that there was an argument between LPN #1 and NA #3 on the unit and residents were present. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility abuse, neglect, and exploitation policy identified facility to provide protection for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical arm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. The facility abuse, neglect, and exploitation policy identified the facility will provide protection for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Mistreatment means inappropriate treatment or exploitation of a resident. Verbal abuse means the use of oral, written or gestured communication or sounds that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability. The facility will have written procedures that include reporting of all alleged violations to the Administrator, State Agency, adult protective services and to all other required agencies (e.g. law enforcement when applicable) within specified timeframes. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury. 3. Resident #269 was admitted to the facility on [DATE] with diagnoses that included cerebrovascular disease and dementia. The care plan dated 4/1/25 identified Resident #269 was at risk for decreased ability to perform ADLs in grooming, bathing, personal hygiene, transfers. Interventions included providing assist of 1 for transfers using a rolling walker. Additionally, Resident #269 it was important that he/she had the opportunity to engage in daily routines that are meaningful relative to his/her preference. Resident #269 expressed it was important for staff to know which of his/her personal belongings he/she prefers to take care of him/herself. The admission MDS dated [DATE] identified Resident #269 had moderately impaired cognition and was dependent on staff for toileting and dressing and required maximum assistance with bathing and personal hygiene. Additionally, the MDS did not identify any psychiatric or mood disorders. Residents' overall goal indicated from Resident #269 was to be discharged to the community. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Resident #269 on 4/6/25 at 10:30 AM indicated that he/she had been robbed. Resident #269 was lying in bed with sheets covering him/her and his/her pocketbook was on the bed at his/her left side. Resident #269 indicated that when he/she went to bed, his/her pocketbook was at his/her left side and when he/she woke up this morning it was on the bedside chair to the right side of the bed. Resident #269 indicated that he/she asked the nurse aide this morning to get the pocketbook from the bedside chair in the corner of room and place it back on the bed next to him/her. Resident #269 indicated that she felt uneasy about it because he/she did not know how it got over to the bedside chair during the night, so he/she checked the pocket when he/she kept the money and found it was missing $80. Resident #269 indicated that since then this surveyor was the first person in the room to inform about being robbed during the night last night. Surveyor reported the allegation of Resident #269 being robbed $80 to the charge nurse, LPN #2, on 4/6/25 at 10:40 AM. LPN #2 stated she would inform the supervisor immediately and started walking down the hallway towards the nurse's station. The interview with RN #11 on 4/7/25 at 12:55 PM indicated that she was the day supervisor on Sunday 4/6/25 from 7:00 AM to 3:00 PM. RN #11 indicated that there was a lot going on yesterday but did not remember LPN #2 reporting to her anything about Resident #269 or that Resident #269 had stolen or missing money. RN #11 indicated that if LPN #2 had reported stolen money she would have immediately reported it to the DNS because it was a reportable event. A Reportable Event Form dated 4/7/25 at 2:00 PM identified resident reported to a visitor that he/she had been robbed and was missing money. Resident #269 reported he/she had been robbed. Resident #269 reported he/she usually keeps the purse in bed with him/her, but when he/he woke up the purse was in the chair and reported $80 missing. Interview with DNS on 4/7/25 at 2:22 PM indicated that she was not aware there was an allegation from Resident #269 of being robbed or stolen money on 4/6/25 of $80. Interviewed with LPN #2 with the DNS present on 4/7/25 at 2:30 PM indicated that she did recall being informed that Resident #269 had reported being robbed but could not recall how much it was if it was $40 or $80. LPN #2 indicated that she had immediately gone to RN #11 and informed her that Resident #269 was reporting money was taken, but RN #11 informed her she was busy with 3 admissions and would talk to Resident #269 later. LPN #2 indicated that she did not question Resident #269 regarding the money because she thought the RN supervisor would. Interview with the DNS on 4/7/25 at 2:45 PM indicated that she had not reported the allegation to the State Agency and would do so now and start an investigation. The social worker note dated 4/7/25 at 3:10 PM indicated it was a late entry for 4/6/25 at 3:08 PM as a follow up to Resident #269 reporting to charge nurse LPN #2 he/she noticed $40 cash missing from purse this morning. Resident #269 reported to this writer it was $80 he/she reported this morning. Resident #269 informed this writer that he/she knows he/she had it when admitted in his/her wallet. Resident #269 reports that he/she always leaves his/her purse in his/her bed next to him/her so he/she can access the tissues inside when he/she needs them. Resident #269 presents as alert and cooperative during this interview. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The social worker note dated 4/7/25 at 3:27 PM identified as a late entry for 4/6/25 Resident #269 was alert and oriented times two and was lying in bed. Resident #269 reported he/she had $80 inside his/her wallet inside the purse that was always kept with him/her in the bed. Resident #269 had shown social worker the wallet that had some change. Interview with the DNS on 4/10/25 at 9:49 AM indicated her expectation with any allegation involving money or abuse that staff would immediately report the allegation to the RN supervisor who she would expect to notify her immediately. The DNS indicated that the allegation occurred on 4/6/25 in the morning and she was not notified until 4/7/25 in the afternoon. The DNS indicated that she was aware she only had 2 hours from the time of the initial allegation and her staff were aware. The DNS indicated that she would have expected to be notified immediately. The DNS stated she spoke with the resident representative who verified that Resident #269 had $38 or $39 in his/her pocketbook when he/she left the assisted living to go to the hospital then came to the facility. The DNS indicated that they looked in Resident #269's pocketbook and there was no money left. The DNS indicated that she does not believe Resident #269 had spent any money at the hospital and something happened between the assisted living when the resident had the money and the facility. The DNS indicated that she was still working on the investigation. Review of the Abuse, Neglect, and Exploitation Policy identified it is the policy of the facility to provide protection for health, welfare, and rights of each resident by developing and implementing in written policies that prohibit ad prevent abuse, neglect, and misappropriation of resident's property. Misappropriation of residents' property means the deliberate misplacement, exploitation, or wrongful, temporary or permanent, use of a resident's belongings or money without the residents' consent. Reporting all alleged violations to the Administrator, state agency, and to all other required agencies within the specified timeframes would be immediately, but no later than 2 hours after the allegation is made. The facility will designate an Abuse Prevention Coordinator in the facility who is responsible for reporting allegations or suspected abuse, neglect, or exploitation to the state agency and other officials in accordance with state law.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for 1 of 8 residents (Resident # 99) reviewed for abuse, the facility failed to take immediate steps to prevent further abuse from occurring while the investigation was in progress. The findings include: Resident #99 was admitted to the facility in January 2024 with diagnoses that included Parkinson's disease, dementia, mood disturbance, anxiety disorder, hallucinations, delusional disorders, psychotic disorder with delusions, depressive disorder, and wandering in disease. The quarterly MDS dated [DATE] identified Resident #99 was moderately cognitively impaired and required partial/moderate assistance with toileting hygiene. Additionally, Resident #99 had no behaviors of physical or verbal symptoms directed towards others, and no wandering. Further Resident #99 does not use a wheelchair. The care plan dated 2/26/25 identified Resident #99 is at risk for complications related to the use of psychotropic drugs: antipsychotic and antidepressant for agitation, restlessness, and sleeplessness. Interventions included monitor for continued need of medication as related to behavior and mood. Resident #99 exhibits or is at risk for distress/fluctuating mood symptoms related to sadness, depression caused by current medical diagnoses and functional decline. Interventions included refer to behavioral health specialists as needed. Resident #99 has bowel incontinence and mixed bladder incontinence related to confusion, impaired mobility, and Parkinson's disease. Interventions included to provide peri-care with each incontinent episode. The physician's order dated 4/1/25 directed to monitor behavior for agitation, resistive, excessive wandering, intrusive behavior, and sleeplessness every shift. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A statement by LPN #1 dated 4/8/25 identified she worked 4/7/25 on the 11:00 PM - 7:00 AM shift and indicated Resident #99 was sitting at the nurse's station when she arrived. LPN #1 indicated Resident #99 had a fall and hit his/her head and sustained a laceration at the beginning of the shift. LPN #1 indicated Resident #99 was restless and would not remain still. LPN #1 indicated NA #3 was getting very agitated and aggressive with Resident #99 because the resident was grabbing everything and pushing chairs and at some point, Resident #99 was yelling out another resident's name and yelling help. LPN #1 indicated that is when she observed NA #3 turn around and pull/yank Resident #99's wheelchair and say to Resident #99 (act like a damn man you're behaving like a child). LPN #1 told NA #3 that Resident #99 has dementia and will not understand her and that was inappropriate. LPN #1 indicated at 5:00 AM she started her medication pass and heard Resident #99 saying that he/she needed to go to the bathroom. LPN #1 informed NA #3 of the resident's request, however, NA #3 walked by her and ignored her. LPN #1 indicated at some point she walked by Resident #99 and observed a puddle of urine on the floor. LPN #1 indicated she notified NA #3 and NA #4 that Resident #99 had urinated on the floor, and again she got no response from the nurse aides. LPN #1 indicated she placed a few towels on the floor and underneath Resident #99's wheelchair and the resident's feet to soak up the urine. LPN #1 indicated that is when NA #3 approached her and stated, (oh you couldn't pick the piss off the damn floor). Resident #99 was present and could hear this comment. LPN #1 indicated she told NA #3 that she was in the middle of a medication pass and that if she had taken Resident #99 to the bathroom when he/she asked, the resident would not have urinated on the floor. LPN #1 indicated NA #3 insisted that LPN #1 provide incontinent care to Resident #99 and clean the floor with the urine. LPN #1 indicated she told NA #3 that she was in the middle of medication pass and that she (NA #3) was assigned to the resident. LPN #1 indicated NA #3 began shouting, cursing, speaking inappropriately to her in the [NAME] wing hallway in front of the nurse's station with Resident #99 present. LPN #1 indicated she told NA #3 that she would be calling the RN supervisor. LPN #1 indicated she walked down to the 400 wing with NA #3 still screaming at her while NA #3 was pushing Resident #99 down the hallway to the 600 wing to go and provide incontinent care to the resident. LPN #1 identified she called RN #6 to report the incident with NA #3. LPN #1 indicated Resident #110 reported to her that NA #3 had been in Resident #92's room and was aggressive with Resident #92 and told the resident to shut up. LPN #1 indicated Resident #110 also reported that NA #3 was yelling and screaming being disrespectful to the nurse, and he/she was going to report NA #3 to the DNS. Interview with NA #3 on 4/9/25 at 11:23 AM identified she worked 4/7/25 during the 11:00 PM - 7:00 AM shift and was not assigned to Resident #99. NA #3 indicated at the beginning of the shift there were 3 nurse aides, and one of the aides, the agency nurse aide, left and went home which NA #3 indicated is an on-going issue with the agency nurse aides. NA #3 indicated Resident #110 was ambulating on the wing and was in the common area watching television. NA #3 indicated she was upset and probably loud when Resident #99, who was at the nurse's station in a wheelchair, urinated on himself/herself and the floor. NA #3 indicated LPN #1 placed a towel down on the floor and left it there. NA #3 indicated there was only 2 nurse aides overseeing the 400, 500, and 600 wings answering call lights and providing care, and she expected LPN #1 to help. NA #3 indicated she and LPN #1 had words. Interview with RN #6 on 4/9/25 at 11:50 AM identified she worked on 4/7/25 during the 11:00 PM - 7:00 AM shift as the RN supervisor. RN #6 indicated LPN #1 called her to the [NAME] wing because NA #3 was being disrespectful towards her. RN #6 indicated LPN #1 reported Resident #99 had urinated on the floor and she placed a towel on the floor and NA #3 told her it was everyone's job to provide resident care. RN #6 indicated LPN #1 never informed her that NA #3 was getting very agitated and aggressive with Resident #99 and pulled/yanked Resident #99's wheelchair and said to Resident #99 (act like a damn man you're behaving like a child). (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further, RN #6 identified LPN #1 did not report to her that Resident #110 reported NA #3 was verbally abusive to Resident #92. RN #6 indicated she told LPN #1 and NA #3 to work out their issues or take it to Human Resource in the morning. RN #6 indicated she educated LPN #1 not to discuss what took place between her and NA #3. The reportable event form dated 4/10/25 at 11:30 AM identified during another investigation, it was discovered that LPN #1 witnessed NA #3 allegedly yank Resident #99's wheelchair and told the resident to (act like a damn man, you're behaving like a child). LPN #1, and NA #3 remain on administrative leave pending an investigation. Resident #99 was evaluated by psychiatrist and social services. The APRN, Administrator, police, and the resident Power of Attorney were notified. A statement by NA #3 dated 4/10/25 at 11:29 AM identified that she denied the allegations. Interview with LPN #1 on 4/10/25 at 10:57 AM identified she worked 4/7/25 during the 11:00 PM - 7:00 AM shift and NA #3 had an attitude towards her during the shift. LPN #1 indicated NA #3 was yelling, screaming, cursing profanity, and argumentative. LPN #1 indicated NA #3 was very upset because the agency nurse aide left and went home leaving the [NAME] wing with only 2 nurse aides instead of three. LPN #1 indicated NA #3 had an attitude and was upset that Resident #99 was at the nurse's station for monitoring. LPN #1 indicated she observed NA #3 pull/yank Resident #99's wheelchair and said to the resident (act like a damn man and that he/she was acting like a child). LPN #1 indicated she gave a written statement to the DNS regarding everything that happened on the shift with NA #3. LPN #1 indicated RN #6 was at the nurse's station while NA #3 was still yelling and talking inappropriately. LPN #1 indicated she reported to RN #6 that Resident #110 reported to her that NA #3 told Resident #92 to shut up and NA #3 yanked Resident #99's wheelchair and told Resident #99 to (act like a damn man and that he/she was behaving like a child). LPN #1 indicated RN #6 stated that she and NA #3 need to get along and she will address the issue with the DNS in the morning. LPN #1 indicated that was not the first time she has witnessed NA #3 yelling, using profanity, and being argumentative with agency nurse aides or other staff on the 11:00 PM - 7:00 AM shift on the [NAME] wing. Interview with Resident #110 on 4/10/25 at 9:55 AM identified he/she does not sleep throughout the night, so he/she ambulates up and down the hallway and the common areas on the unit. Resident #110 indicated on Monday night he/she overheard NA #3 yelling and arguing with LPN #1 at the nurse's station and the hallway. Resident #110 indicated Resident #99 was sitting in a wheelchair at the nurse's station and NA #3 continued yelling, arguing, and was disrespectful to LPN #1 about who was going to clean Resident #99 and clean the urine off the floor. Resident #110 indicated NA #3 she was yelling, very angry and had an attitude that night. Interview with the DNS on 4/10/25 at 12:22 PM identified she was not aware that NA #3 was witnessed to pull/yank Resident #99's wheelchair and say to the resident (act like a damn man you're acting like a child) because until surveyor inquiry, she had not read LPN #1's statement that was written on 4/8/25. The DNS indicated NA #3 was not removed from the facility after LPN #1 witnessed NA #3 pull/yank Resident #99's wheelchair and say to the resident (act like a damn man, you're acting like a child). The DNS indicated that the expectation of the facility is that when there is an allegation of abuse, the staff member is to be removed off the unit and sent home immediately. The DNS indicated NA #3 should have been removed from the unit and sent home until further notice. The DNS indicated she is not aware if LPN #1 had reported the incident to RN #6. The DNS indicated RN #6 did not inform her that there was an argument between LPN #1 and NA #3 on the unit and residents were present. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Harrington Court	59 Harrington CT Colchester, CT 06415

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility abuse, neglect, and exploitation policy identified facility to provide protection for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical arm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. The facility abuse, neglect, and exploitation policy identified the facility will provide protection for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Mistreatment means inappropriate treatment or exploitation of a resident. Verbal abuse means the use of oral, written or gestured communication or sounds that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability. The facility will have written procedures that include reporting of all alleged violations to the Administrator, State Agency, adult protective services and to all other required agencies (e.g. law enforcement when applicable) within specified timeframes. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include but are not limited to: Responding immediately to protect the alleged victim and integrity of the investigation.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility policy, and interviews for 2 of 3 residents (Resident #38 and 65) reviewed for Pre-admission Screening and Record Review (PASARR), the facility failed to ensure a PASARR rescreen was completed upon admission to the facility for a resident with a long-standing history of a serious mental health diagnosis and after a new mental health diagnosis was identified. The findings include: 1. Resident 38 was admitted to the facility in July 2024 with diagnoses that included chronic obstructive pulmonary disease, tracheostomy, and body dysmorphic disorder. Review of a PASARR level 1 screen outcome dated 7/10/24, prior to admission to the facility, identified that Resident #38 had not received any mental health services in the past and did not have any legal intervention due to mental health symptoms or behaviors. The PASARR level 1 outcome determined a level II was not required due to no evidence of a PASARR condition related to an intellectual disability or serious behavioral health condition. Review of the clinical record identified that Resident #38 had court appointed Conservator of Person and Estate in place upon admission to the facility due to bipolar illness and executive deficits. A psychiatric APRN note dated 7/19/24 identified that Resident #38 was seen as a new referral to the facility. The note identified that Resident #38 had a history of delusional disorders, dysthymic disorder, and anxiety disorder. The note identified that Resident #38 had chronic psychiatric illness and required medication that included Abilify (an antipsychotic medication) 5 mg daily. The quarterly MDS dated [DATE] identified Resident #38 had intact cognition, was always continent of bowel and bladder, required moderate staff assistance with toileting, dressing, and set up assistance with bathing. The MDS also identified that Resident #38 required antipsychotics on a routine basis. The care plan dated 2/12/25 identified that Resident #38 was at risk for complications related to the use of antipsychotic and anxiolytic medications for history of depression, dysthymic disorder, and anxiety. Interventions included monitoring for the continued need for medication for behavior and mood, and monitoring for changes in mental status and function and reporting to the physician as indicated. Review of the clinical record failed to identify any documentation related to a PASARR re- screen being initiated or completed following Resident #38's admission to the facility. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Social Work Director (SW #1) on 4/7/25 at 12:00 PM identified that she was unaware that Resident #38 had a significant psychiatric history. SW #1 identified she was aware that Resident #38 had a Conservator of Person and Estate and had a history of depression and anxiety but was not aware that Resident #38 had a history of bipolar illness or executive deficits, or that Resident #38 had psychiatric treatment prior to admission to the facility. SW #1 identified while it was the responsibility of the social work department to initiate the PASARR re-screen, the psychiatric provider and facility staff did not notify her of the resident's previous psychiatric history. SW #1 identified that Resident #38 should have had a PASARR rescreen completed upon admission to the facility. The facility policy on Resident Assessment- Coordination with PASARR Program directed that the facility coordinated assessments with the preadmission screening and resident review program under Medicaid to ensure that individuals with a mental disorder or related condition received care and services in the most integrated setting appropriate to their needs. The policy further directed that any resident with a newly evident or possible serious mental disorder would be referred for a level II review. Examples included: a resident whose related condition was not previously identified through PASARR, and a resident who is behavioral, psychiatric, or mood related symptoms were related to the presence of a mental disorder where dementia was not the primary diagnosis. 2. Resident #65 was admitted to the facility on [DATE] with diagnoses that included anxiety disorder, dysthymic disorder, and post-traumatic stress disorder (PTSD). The quarterly MDS dated [DATE] identified Resident #65 had intact cognition, and the resident mood interview identified the following symptoms and frequency: little interest or pleasure in doing things (several days) and feeling down, depressed, or hopeless (several days). The care plan dated 3/27/25 identified Resident #65 was at risk for distressed/fluctuating mood symptoms related to diagnoses of dysthymic disorder, generalized anxiety disorder, and PTSD. Interventions included observing for signs and symptoms of a new psychiatric disorder or worsening symptoms of current psychiatric disorder and encouraging resident to seek staff support for distressed mood. The care plan further identified that Resident #65 used psychotropic medications related to depression and anxiety. Interventions included administering psychotropic medications as ordered by the physician and to monitor, document, and report any adverse reactions to the medications. The Notice of PASRR Level 1 Screen Outcome dated 5/31/22 indicated that a PASARR disability was not present because of the following reason: there is no evidence of a PASARR condition of an intellectual/developmental disability or a serious behavioral health condition. If changes occur or new information refutes these findings, a new screen must be submitted. No Level II required. Review of the clinical record identified Resident #65 was diagnosed with major depressive disorder on 7/28/23. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and clinical record review with the Director of Social Services (SW #1) on 4/07/25 at 10:41 AM identified that at the time Resident #65's major depressive disorder diagnoses was identified, she was not his/her social worker, so she was not aware that Resident #65 had a new mental health diagnosis with no PASARR rescreen submitted, but she would have expected the social worker to have submitted a new Level 1 PASARR upon the identification of a new mental health diagnosis. SW #1 indicated that she would submit another Level 1 PASARR for Resident #65, subsequent to surveyor inquiry. The facility's Resident Assessment-Coordination with PASARR Program policy directs the facility coordinate assessments with the preadmission screening and resident review (PASARR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receive care and services in the most integrated setting appropriate to their needs. Any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or related condition will be referred promptly to the state mental health or intellectual disability authority for a level II resident review. Examples include: a resident who exhibits behavioral, psychiatric, or mood related symptoms suggesting the presence of a mental disorder (where dementia is not the primary diagnosis), a resident whose intellectual disability or related condition was not previously identified and evaluated through PASARR, and a resident transferred, admitted , or readmitted to the facility following an inpatient psychiatric stay, or equally intensive treatment. The social services director shall be responsible for keeping track of each resident's PASARR screening status and referring to the appropriate authority.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, facility policy, and interviews for 1 of 5 residents (Resident #77) reviewed for medication administration, the facility failed to ensure a medication was administered in accordance with the physician's orders. The findings include: Resident #77 was admitted to the facility in November 2024 with diagnoses that included fractures of the left lower leg and patella, anemia, and bipolar disorder. A completed physician's order dated 1/24/25 with an end date of 2/21/25 directed to administer Cefadroxil oral capsule (antibiotic), give 500mg by mouth twice daily for four weeks, for septic arthritis. The quarterly MDS dated [DATE] identified Resident #77 had intact cognition and was currently taking an antibiotic. The care plan dated 3/12/25 identified Resident #77 was at risk for impaired skin integrity due to immobility and presence of cam boot (orthopedic footwear used to immobilize the foot and ankle). Interventions included turning and repositioning 4 times per shift. A physician's order dated 4/3/25 directed to administer Cephalexin oral capsule (antibiotic), give 500mg by mouth four times daily for 14 days, for cellulitis. Medication administration observation of LPN #2 on 4/7/25 at 8:38 AM identified LPN #2 reviewed the orders for Resident #77's morning medication pass which included the administration of the following medications: Ascorbic acid tablet 500mg give 1 tablet by mouth once daily for supplement. Cephalexin oral capsule 500mg by mouth four times daily for 14 days, for cellulitis. Trazadone HCL 50mg give 1 tablet by mouth once daily for bipolar. LPN #2 was observed removing a 500mg capsule of Cefadroxil from Resident #77's bubble pack into a medication cup and returned the bubble pack into the medication cart, then removed Resident #77's Trazadone bubble pack from the medication cart, removed the medication from the package into the medication cup, and returned the package into the medication cart. Subsequent to surveyor inquiry because LPN #2 had removed the incorrect antibiotic and placed it into the cup to be administered, LPN #2 removed the Cefadroxil bubble pack from the medication cart, again, and reviewed the physician's orders, for a second time. LPN #2 went back into the medication cart and identified a bubble pack containing 500mg of Cephalexin for Resident #77. LPN #2 reviewed Resident #77's discontinued and completed medication orders and identified that Resident #77 was no longer taking Cefadroxil. LPN #2 indicated that this was not the usual unit where she was assigned, and she would have expected that a discontinued medication would have been removed from the medication cart. LPN #2 removed the 500mg capsule of Cefadroxil from the medication cup and replaced it with the 500mg Cephalexin capsule. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DNS on 4/7/25 at 8:55AM identified that she would expect the nurse to adhere to the 5 right of medication administration and to double check the accuracy of the medication and ensure it matches the physician's order. The DNS further indicated that discontinued medications should be removed from the medication cart. The facility's Medication Administration policy directed that medications are administered by licensed nurses, or other staff who are legally authorized to do so in the state, as ordered by the physician and in accordance with standards of practice. Ensure that the six rights of medication administration are followed: right resident, drug, dosage, route, time, and documentation. Review MAR to identify medication to be administered and compare medication source (bubble pack, vial, etc.) with MAR to verify resident name, medication name, form, dose, route and time. Refer to drug reference material if unfamiliar with the medication.

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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 observation, review of the clinical record, facility policy, and interviews for 4 residents (Resident #39, 69, 81, 268) the facility failed to provide care according to professional standards, facility policy and physician's orders. For 1 of 2 residents, Resident #39) reviewed for falls, the facility failed to ensure the functionality of a remote cardiac transmission device. For 1 resident (Resident #69) the facility failed to administer medications according to the physician's orders. For 1 of 5 residents (Resident #81) reviewed for unnecessary medications, the facility failed to follow the physician's orders and complete RN assessments when the resident had multiple episodes of hyperglycemia and hypoglycemia that required additional treatment. For 1 of 5 residents (Resident #268) reviewed for medication administration, the facility failed to ensure medications were administered per the physician's order. The findings include: 1. Resident #39 was admitted to the facility in January 2016 with diagnoses that included the presence of a cardiac pacemaker, paroxysmal atrial fibrillation, and tachycardia. A cardiology consultant study dated 11/8/24 identified Resident #39's routine pacemaker remote transmission was received. Battery voltage and impedance stable, battery longevity 11.8 months, normal pacemaker function, no arrythmias noted, and to continue routine monitoring. The ECG 12 lead tracing document dated 1/13/25 identified AV dual-paced rhythm, abnormal ECG when compared with ECG of 9/25/24, no significant change was found. A physician's order dated 1/16/25 directed for a pacer transmission on 2/8/25 at 8:00 AM with a specialty provider remote card device. The quarterly MDS dated [DATE] identified Resident #39 had intact cognition and was taking an antiplatelet medication. The care plan dated 3/12/25 identified Resident #39 had a pacemaker related to a heart block diagnosis. Interventions included checking the pacemaker per physician's order and documenting in the chart: heart rate, rhythm, and battery check. The care plan further identified Resident #39 was at risk for cardiovascular symptoms or complications related to heart block, hypertension, tachycardia, pacemaker, and receiving aspirin and antiplatelet medications. Interventions included pacer checks as ordered and ensure transmitter is plugged in daily. Resident #39's clinical record December 2024 through April 2025 failed to identify documentation that the cardiac transmitter had been monitored for functionality. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 4/8/25 at 9:55 AM identified a transmitter on the bedside table, with no indicator that the machine had power. Resident #39 indicated that the machine at his/her bedside was a device the heart doctor had given him/her years ago, and it hadn't worked in over a month. Interview with LPN #11 on 4/8/25 at 10:00 AM identified that she was the nurse assigned to Resident #39, but she was an agency nurse and was not familiar with the resident and could not answer questions about Resident #39's cardiac device or the transmitter. Interview with RN #4 on 4/8/25 at 10:05 AM identified that Resident #39 had an internal pacemaker and the device on his/her bedside table was a transmitter for his/her pacemaker. Observation at that time with RN #4 identified that usually a light would illuminate on the front of the device to indicate that it was on, but no light was visible. RN #4 identified that she was unaware that the transmitter was off, and that she would expect the charge nurse to be checking the transmitter daily, to ensure it is on, and to notify the supervisor if the device was not on. Interview with RN #4 and Person #2 (representative from the cardiac transmitter company) on 4/8/25 at 10:11 AM identified that 12/17/24 was the last time there was a connection from Resident #39's transmitter device to the transmitter company. A follow-up interview with RN #4 on 4/8/25 at 11:45 AM identified that a replacement part for the transmitter was ordered and that she was able to schedule an appointment for Resident #39 with the cardiologist on 4/25/25, for an in-person device check. Interview with Person #1 (medical assistant from the cardiology practice) on 4/9/25 at 11:49 AM identified that remote transmissions from Resident #39's device were scheduled for every 3 months however the last transmission reading received from the resident's device was on 11/8/24, 5 months ago. Person #1 indicated that a remote transmission was scheduled for 2/8/25, which was not completed, and that she did not have documentation identifying that the facility or Resident #39's resident representative were alerted that the transmission was missed. Person #1 identified that the medical assistant (Person #4) that would have been responsible for notifying the facility was currently out of the office and not available for an interview. Person #1 further indicated that the facility had reached out to their office on 4/8/25, and Resident #39 was scheduled for an in-person device check on 4/25/25. Interview with the DNS on 4/10/25 at 10:35 AM identified that the manufacturer's manual for the transmitter identified that the device would beep if there was a failed transmission, and that she was not aware that the device had alerted the staff that the transmission had failed. The DNS further indicated that there were no concerns identified with the device during the 11/8/24 transmission, and it was functioning properly during Resident #39's January 2025 hospital admission. The DNS identified that the nursing staff should be checking the device to ensure it is on and further investigate why the device is not on if they discover it is not functioning and report it to the supervisor. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Cardiology APRN (APRN #4) on 04/10/25 at 11:45 AM identified that Resident #39 had remote transmissions scheduled every 3 months, as a supplement to annual office checks, to monitor the functionality and condition of his/her pacemaker. APRN #4 further identified that Resident #39's last transmission was due in February of 2025 but was not completed and the last transmission completed, in November of 2024, identified that the pacemaker looked good and had approximately 1 year of battery life remaining. APRN #4 indicated that the home monitor would also ping the device daily looking for alert conditions, such as if the battery needed elective replacement or if the automatic measurement parameters were detected. APRN #4 was unable to identify which measurement parameters had been programmed on Resident #39's device, but if he/she had an episode that met that alert criteria it would also ping the system. APRN #4 identified that it is the standard of care for the pacemaker to be evaluated in the office, annually, and by remote transmissions every 3 months, which the transmission device would have to be turned on in order for the transmission to occur. Although attempted, an interview with Person #4 was not obtained. The transmitter user's manual identified the device records and stores heart data. The transmitter will securely send information to the doctor or clinic on a routine basis, typically every three months. It also does a quick check of the device on a nightly basis and will send information only if an event (as defined by your doctor) is detected. The facility's Remote Cardiac Telemetry policy directs the facility staff to notify the ordering provider if the device becomes damaged or does not appear to be working. 2. Resident #69 was admitted to the facility in February 2025 with diagnoses that included leg surgery, chronic kidney disease and dependent on dialysis, hypertension, and gastroparesis. A physician's order dated 2/13/25 directed to give Gabapentin 600 mg by mouth three times a day for phantom pain, Lactobacillus give 1 capsule by mouth one time a day for supplement, and Bumetanide 2 mg give 1 tablet two times a day for hypertension. The care plan dated 2/17/25 identified Resident #69 was at risk for impaired renal function and complications related to hemodialysis. Interventions included providing medications as ordered. The admission MDS dated [DATE] identified Resident #69 had intact cognition and required moderate assistance with toileting, dressing, and personal hygiene. Additionally, Resident #69 was on antibiotics, diuretics, opioids, and anticonvulsants. Review of the April 2025 MAR dated 4/6/25 at 11:48 PM identified Bumetanide 2 mg due to be administered twice daily for hypertension was not available. Medication observation with RN #4 on 4/7/25 at 9:17 AM indicated she had taken Resident #69's blood pressure earlier and it was 176/84. RN #4 prepared Resident #69's medications then identified she did not have the Gabapentin 600mg, Lactobacillus capsule, or the Bumetanide 2 mg available. RN #5 indicated that she had searched the medication cart and there was not any available and these medications were not in the emergency supply. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with RN #4 on 4/7/25 at 9:25 AM indicated that Resident #69 had not received the evening dose of Bumetanide 2 mg the day prior, and the Bumetanide 2 mg, the Lactobacillus Capsule, and Gabapentin 600 mg were not available. RN #4 indicated that the nurses were responsible for reordering medications before the resident ran out of a medication. RN #4 indicated that she would reorder the medications from the pharmacy. Review of the nurses' notes dated 4/6/25 to 4/7/25 failed to reflect the APRN or physician had been notified that the Bumetanide 2 mg, the Lactobacillus Capsule, and Gabapentin 600 mg were unavailable and had not been administered. Review of the MAR dated 4/7/25 at 9:28 AM identified RN #4 documented the scheduled 9:00 AM doses of Gabapentin 600 mg for phantom pain, Lactobacillus capsule for supplement, and Bumetanide 2mg's for hypertension were not available in facility and pharmacy was notified. Review of the MAR dated 4/7/25 identified Resident #69 did not receive the scheduled 1:00 PM dose of Gabapentin 600 mg. Interview with RN #5 (Regional corporate nurse) on 4/8/25 at 11:01 AM indicated that when a nurse does not have a medication available to give a resident per the physician order, he or she is responsible for notifying the pharmacy and the physician to see if there was an alternate medication(s) or could change the time of administration. Interview with APRN #1 on 4/8/25 at 11:18 AM indicated Resident #69 was on Bumetanide for fluid retention because of his/her diagnosis and if Bumetanide was not available nursing must notify her. APRN #1 indicated if Resident #69 misses a dose she would want to find out why and do an intervention and evaluate resident's blood pressures to see if it was elevated and if he/she has sustainable blood pressures with dialysis treatments. APRN #1 indicated that her expectation would be she must be notified if of any resident miss doses of medications. APRN #1 indicated that Resident #69 was on gabapentin for phantom pain due to the BKA. APRN #1 noted Resident #69 came into the facility on a low dose but because Resident #69 has complaints of pain the dose has been going up a couple of times, so it is important to give it and have it available, and the Lactobacillus is because nephrology ordered it from dialysis for the gastrointestinal system. APRN #1 indicated that she was not aware Resident #69 had missed the Bumetanide the evening of 4/6/25 or medications on 4/7/25 in the am or afternoon. APRN #1 indicated it was the nurse's responsibility to reorder the medications timely. APRN #1 indicated that the nurses were responsible for documenting who they notified and when if a resident had missed a scheduled medication. Interview with the DNS on 4/8/25 at 12:52 PM indicated that when a resident does not receive a dose of a scheduled medication the charge nurse is expected to notify the RN supervisor who must notify the APRN or physician and it needed get an order for an alternate medication or any other new orders from the provider and then write a nurses note with who the nurse spoke with and any recommendation or new orders from the provider. After clinical record review, the DNS indicated that from 4/6/to 4/8/24 she did not see the APRN, or physician were notified of the missed doses of medication. The DNS indicated that the Lactobacillus was house stock and if the nurse had asked the supervisor, she would have gotten it for RN #4. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the DNS on 4/9/25 at 12:54 PM indicated her expectation was the nurses follow the physician orders and give the medications at the time they are scheduled within the hour before or hour after window. The DNS indicated the expectation was the nurses will reorder the medications when there are 6 doses left in the blister pack, so the resident does not run out of medications. Review of the facility Unavailable Medications Policy identified mediations may be unavailable for several reasons. Staff should take immediate action when it is known that the medication is unavailable. Notify the physician of inability to obtain medication upon notification or awareness that the medication is not available. Obtain alternate treatment orders and/or specific orders for monitoring residents while medication is on hold. If a resident misses a scheduled dose of the medication, staff shall follow procedures for medication errors, including physician/family notification, completion of a medication error report, and monitoring the resident for adverse reactions to omission of the medication. Review of the Medication Eror Policy identified the facility shall ensure medications will be administered according to the physician's orders. Medication that is administered not in accordance with the prescriber's order, for example a medication omission. 3. Resident # 81 was admitted to the facility in July 2023 with diagnoses that included COPD, diabetes with hyperglycemia, and dementia. The care plan dated 11/17/24 identified Resident #81 has a diagnosis of Insulin dependent diabetes and hyperglycemia. Interventions included monitoring signs and symptoms of hyper/hypoglycemia and report abnormal findings to the physician, assess and record blood glucose levels as ordered, and administer hypoglycemic medications as ordered. A physician's order dated 12/16/24 directed to inject Glucagon 1 mg (a medication used to treat low blood glucose) IM as needed for blood glucose less than 70 if Resident #81 was unable to swallow or was unresponsive, monitor vital signs and stay with the resident, notify the provider and recheck the blood glucose in 15 minutes, repeat protocol if less than 70 and document response in the progress notes. A physician's order dated 12/16/24 directed to administer Glucose oral gel 15 mg/32ml (a medication used to treat low blood glucose) one application by mouth as needed for blood glucose less than 70 if Resident #81 was asymptomatic or symptomatic but responsive with the ability to swallow. The order further directed to repeat the blood glucose level in 15 minutes, document the results, and if still below 70, notify the provider and administer a second dose of the glucose gel. A physician's order dated 12/19/24 directed for sliding scale Insulin Lispro (a short acting Insulin) to be administered with blood glucose checks 3 times daily (7:30 AM, 11:30 AM, 4:30 PM) before meals and administered for a blood glucose of: 150 - 200 = 2 units. 201 - 250 = 4 units. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	251 - 300 = 6 units. 301 - 350 = 8 units. 351 -400 = 10 units. 401 - 450 = 12 units. 451+ = Call Provider for additional orders. The 5 day MDS dated [DATE] identified Resident #81 had intact cognition, was always incontinent of bowel and bladder and dependent on staff to assist with toileting, bathing, and dressing. An APRN note dated 12/28/24 at 11:58 AM identified that a telehealth visit was conducted with RN #7 due to Resident #81's blood glucose result of 480 on that date. The APRN note identified Resident #81 was asymptomatic and the treatment orders included a total of 14 units of Insulin Lispro, recheck blood glucose in one hour, if blood glucose was above 400 in 2 hours to contact telehealth APRN for further instructions, and notify a clinician of any change in condition. A nurse's note dated 12/28/24 at 12:03 PM by LPN #2 identified Resident #81's blood glucose was 480 and 12 units of Insulin Lispro were administered, the supervisor was notified, and the physician would be contacted. Review of the clinical record failed to identify any documentation that Resident #81's resident representative was notified related to Resident #81's hyperglycemic episode requiring treatment visit. A physician's order dated 1/31/25 directed for sliding scale Insulin Lispro (a short acting Insulin) to be administered with blood glucose checks 4 times daily (7:30 AM, 11:30 AM, 4:30 PM, and 9 PM) before meals, at bedtime, and administer for a blood glucose of: 150 - 200 = 2 units. 201 - 250 = 4 units. 251 - 300 = 6 units. 301 - 350 = 8 units. 351 -400 = 10 units. 401 - 450 = 12 units. 451+ = Call Provider for additional orders. The January 2025 MAR identified LPN #2 documented Resident #81 had a blood glucose of 459 on 1/31/25 at 4:30 PM and received a partial dose of Insulin Lispro. The MAR failed to identify the dose administered. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the clinical record failed to identify any additional documentation related to Resident #81's blood glucose of 459 on 1/31/25 including notification to the provider per the physician's order due to the blood glucose level above 450, or that Resident #81's resident representative was notified. The February 2025 MAR identified Resident #81 had a blood glucose of 63 on 2/13/25 at 7:30 AM. The MAR identified that the blood glucose parameters were out of range and no Insulin was administered. Review of the clinical record for 2/13/25 failed to identify any additional documentation including directions according to the physician's order dated 12/16/24 or that the provider or Resident #81's representative were notified. The February 2025 MAR identified Resident #81 had a blood glucose of 50 obtained by LPN #2 on 2/17/25 at 7:30 AM. Further review of the MAR identified LPN #2 documented that the blood glucose was within range and no Insulin was administered. Review of the clinical record for 2/17/25 failed to identify any additional documentation including directions according to the physician's order dated 12/16/24 or that the provider or Resident #81's representative were notified. The February 2025 MAR identified Resident #81 had a blood glucose of 47 obtained by LPN #2 on 2/18/25 at 7:30 AM. Further review of the MAR identified LPN #2 documented that the blood glucose was within range and no Insulin was administered. Review of the clinical record for 2/18/25 failed to identify any additional documentation including directions according to the physician's order dated 12/16/24 or that the provider or Resident #81's representative were notified. The February 2025 MAR identified Resident #81 had a blood glucose of 51 obtained by LPN #2 on 2/22/25 at 7:30 AM. Further review of the MAR identified LPN #2 documented that the blood glucose was within range and no Insulin was administered. Review of the clinical record for 2/22/25 failed to identify any additional documentation including directions according to the physician's order dated 12/16/24 or that the provider or Resident #81's representative were notified. A nurse's note dated 3/3/25 at 10:26 PM by LPN #1 identified that Resident #81 had a blood glucose of 54. The note identified glucose gel was administered. Review the clinical record for 3/3/25 failed to identify any additional documentation that the provider or Resident #81's resident representative was notified. A nurse's note dated 3/14/25 at 8:52 AM by RN #12 identified Resident #81 had a morning blood glucose of 45, that Resident #81 was given juice and breakfast, a repeat blood glucose 15 minutes later was 78, and that the APRN was notified. Further review of the clinical record failed to identify that Resident #81's resident representative was notified of the hypoglycemic episode. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The March 2025 MAR identified Resident #81 had a blood glucose of 62 on 3/16/25 at 11:30 AM. Further review of the MAR identified that the blood glucose was within range and no Insulin was administered. Review of the clinical record for 3/16/25 failed to identify any additional documentation including directions according to the physician's order dated 12/16/24 or that the provider or Resident #81's representative were notified. The March 2025 MAR identified Resident #81 had a blood glucose of 68 obtained by LPN #2 on 3/17/25 at 7:30 AM. Further review of the MAR identified LPN #2 documented that the blood glucose was within range and no Insulin was administered. Review of the clinical record for 3/17/25 failed to identify any additional documentation including directions according to the physician's order dated 12/16/24 or that the provider or Resident #81's representative were notified. The March 2025 MAR identified Resident #81 had a blood glucose of 55 obtained by LPN #2 on 3/20/25 at 7:30 AM. Further review of the MAR identified LPN #2 documented that the blood glucose was within range and no Insulin was administered. Review of the clinical record for 3/20/25 failed to identify any additional documentation including that the provider or Resident #81's representative were notified. A nurse's note dated 3/21/25 at 3:49 AM by RN #12 identified Resident #81 had a blood glucose of 53 at 3:00 AM. The note also identified that an IM Glucagon injection was given, and Resident #81 had a repeat blood glucose of 112 at 3:45 AM. Further review of the clinical record for 3/21/25 failed to identify any documentation that the provider or Resident #81's resident representative were notified. A nurse's note dated 3/22/25 at 7:54 AM by RN #12 identified that at 3:30 AM, Resident #81 was observed to be alert but lethargic with skin warm to the touch but clammy. The note further identified Resident #81 had a blood glucose of 50 and was administered glucose gel, and a recheck 20 minutes later identified a blood glucose of 69. The note identified Resident #81 reported feeling better and was offered orange juice, and a repeat blood glucose was 112 after an hour. The note also identified Resident #81 received Insulin Glargine 52 units at bedtime and that Resident #81 had a blood glucose of 149 at 7:30 AM. Review of the clinical record for 3/22/25 failed to identify that the provider or Resident #81's resident representative were notified. The March 2025 MAR identified on 3/22/25 at 8:00 PM that 52 units of Insulin Glargine was held by LPN #3 due to Resident #81's blood glucose levels dropping to 50 overnight. The clinical record failed to identify that the provider was notified that Resident #81 did not receive his/her nightly dose of Insulin Glargine on 3/22/25 or that Resident #81's resident representative was notified of the medication hold due to hypoglycemia. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the clinical record and MAR for March 2025 identified on 3/23/25 at 1:30 AM, LPN #3 identified Resident #81 had a blood glucose level of 50 and was administered glucose gel. Review of the clinical record identified on 3/23/25 at 2:00 AM, LPN #3 documented Resident #81 had a blood glucose recheck of 63. A nurse's note dated 3/23/25 at 2:32 AM by LPN #3 identified Resident #81 was clammy, cold, and lethargic and glucose gel was administered. Review of the clinical record identified on 3/23/25 at 2:30 AM, RN #12 documented Resident #81 had a blood glucose of 112. Review of the clinical record for 3/23/25 failed to identify any documentation that the provider or Resident #81's resident representative were notified of Resident #81's hypoglycemic episode. Review of the clinical record identified on 3/25/25 at 2:00 AM LPN #3 documented Resident #81 had a blood glucose of 45. Further review of the clinical record identified a recheck by LPN #3 done at 3:44 AM was 70. Review of the clinical record and March 2025 MAR for 3/25/25 failed to identify any documentation that the provider or Resident #81's resident representative were notified of Resident #81's hypoglycemic episode. A nurse's note dated 3/26/25 at 1:20 AM by LPN #1 identified she was notified by a nurse aide that Resident #81 was profusely sweating. LPN #1 identified that Resident #81 had blood glucose check of 41, that emergency glucose was given immediately, and that a recheck would be done in a few minutes. The March 2025 MAR identified LPN #1 administered glucose gel on 3/26/25 at 1:20 AM. A nurse's note dated 3/26/25 at 1:45 AM by LPN #6 identified Resident #81 had a repeat blood glucose check of 54. Further review of the nurse's note identified LPN #1 documented a repeat blood glucose check of 131 at 2:14 AM. Review of the clinical record for 3/26/25 failed to identify any documentation that the provider or Resident #81's resident representative were notified of Resident #81's hypoglycemic episode. The March 2025 MAR identified Resident #81 had a blood glucose of 67 obtained by LPN #2 on 3/31/25 at 11:30 AM. Further review of the MAR identified LPN #2 documented that the blood glucose was within range and no Insulin was administered. Review of the clinical record for 3/31/25 failed to identify any documentation that Resident #81's resident representative was notified of Resident #81's hypoglycemic episode. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with APRN #1 on 4/8/25 at 11:52 AM identified that she was aware that Resident #81 had variable blood glucose levels but felt these were related to dietary noncompliance and a recent course of antibiotics. APRN #1 identified she could not remember if she was notified that if Resident #81 received IM Glucagon or of all the blood glucose levels under 70 since 2/13/25, but if the resident had a blood glucose above 450 or below 70, she would expect that the nurses would assess the resident to ensure he/she was not symptomatic and that she or the on call provider would be notified if the resident had symptoms. Interview with LPN #1 on 4/9/25 at 10:50 AM identified that she was assigned to Resident #81 on 3/3 and 3/26/25. LPN #1 identified that LPNs in the facility were not allowed to complete an assessment of the residents or contact the physician/APRN and resident representative regarding a change in condition, so that should have been completed by the RN. LPN #1 identified she was unsure who she reported Resident #81's hypoglycemic episodes to and she did not document the information in the clinical record. Interview with RN #12 on 4/9/25 at 11:56 AM identified that she was the nurse assigned to Resident #81 on 3/20/25 on the 11:00 PM - 7:00 AM shift and was the RN supervisor working with LPN #3 on 3/22/25 on the 11:00 PM - 7:00 AM shift. RN #12 identified on 3/21/25 at 3:00 AM a nurse aide notified her that Resident #81 was very lethargic, and she administered IM Glucagon which was the standard order for all diabetics in the facility for hypoglycemia. RN #12 identified she obtained vital signs on Resident #81 and completed a repeat blood glucose check at 3:45 AM and documented a progress note. RN #12 identified that on 3/23/25 Resident #81 had a similar hypoglycemic episode with LPN #3 overnight and required glucose gel and juice. RN #12 identified she did not notify the on-call provider or Resident #81's resident representative regarding Resident #81's hypoglycemic episodes on 3/21 or 3/23/25 and that she would have passed the information on in morning report to the day shift or told APRN #1 in person if she was in the facility at shift change. RN #12 identified that she did not feel that it was necessary to notify the on-call provider but was aware that the physician orders and facility protocol for hypoglycemia directed to contact the physician or APRN for a blood glucose less than 70 Interview with LPN #2 on 4/9/25 at 12:15 PM identified she could not remember any blood glucose issues for Resident #81 from 12/28/24, 1/31/25, 2/2025, or 3/2025. LPN #2 identified that unless she noticed a specific issue or it was listed in her tasks in the MAR or TAR, she did not document a note or assess Resident #81 related to blood glucose issues. LPN #2 identified any documentation would be in a progress note, and that she would notify the RN supervisor. LPN #2 identified LPNs in the facility were not allowed to contact the physician/APRN of any issues with a resident and only the RN supervisor was allowed to contact the provider. LPN #2 also identified that Resident #81 typically had high blood glucose levels due to his/her resident representative bringing in a [NAME] Donuts coffee in daily. Interview with RN #7 on 4/9/25 at 12:54 PM identified that she vaguely remembered Resident #81 having an episode of hyperglycemia on 12/28/24. RN #7 identified that LPN #2 notified her, she then contacted the telehealth APRN and assisted with the visit, and notified LPN #2, who was assigned to Resident #81, of the orders including the additional 2 units of Insulin and rechecks. RN #7 identified that she could not remember any additional information regarding LPN #2, the telehealth orders, or contacting Resident #81's resident representative. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LPN #3 on 4/9/25 at 1:01 PM identified that she was present with RN #12 on 3/20/25 and was assigned to care for Resident #81 on 3/22/25 on the 11:00 PM - 7:00 AM shifts. LPN #3 identified that Resident #81 was very lethargic and not responsive during the 3/21/25 hypoglycemic episode and she went in to assist RN #12. LPN #3 identified it was very hectic and scary, but following the IM Glucagon administration, Resident #81 improved. LPN #3 identified that later in the shift, she reviewed Resident #81's Insulin orders and blood glucose levels and noted that Resident #81 had multiple episodes of hypoglycemia dating back to January or February 2025. LPN #3 identified she printed out all the blood glucose levels and provided them to RN #12 for review. LPN #3 identified she did not know if RN #12 notified the physician, APRN, or Resident #81's resident representative, and that LPNs in the facility had been instructed they were not supposed to contact the providers or assess any of the residents following a change of condition, and that this was only to be done by RNs in the facility. LPN #3 identified that on 3/22/25, she was assigned Resident #81 for the first time, and since she had been present for the hypoglycemic episode on 3/21/25, she decided to hold Resident #81's bedtime Insulin Glargine, but that Resident #81 still had a hypoglycemic episode very similar to the one on 3/21/25. LPN #3 identified that she did notify RN #6 or RN #12 related to holding Resident #81's Insulin but could not remember who. Interview with the DNS and RN #5 (Regional Resource Nurse) on 4/9/25 at 1:35 PM identified that provider notification for blood glucose levels depended on the resident's orders. The DNS identified that for Resident #81, she would expect the nurses to notify the provider for any blood glucose levels under 70 or over 450, and that the nurses would assess the resident for symptoms of hypo or hyperglycemia. The DNS identified that LPNs in the facility did have the authority to notify the provider but to notify the RN. The DNS further identified if an RN assessment of the resident was needed due to a change in condition, the LPNs had been instructed to not bypass the RN and that the RN should be notified that the resident had a change that required an RN assessment. The DNS further identified that provider notification usually took place in person with APRN #1 when she was in the building. The facility policy on Hypoglycemia directed that the purpose of the policy was to a standard care routine for management of episodes of hypoglycemia based on the

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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 documentation, facility policy, and interviews for 1 of 3 residents (Resident #91) reviewed for pressure ulcer, the facility failed to ensure appropriate care according to professional standards and facility policy when a new pressure ulcer was identified. The findings include: Resident #91 was admitted to the facility on [DATE] and readmission on [DATE] with diagnoses that included fall with left femur fracture, and dementia. The quarterly MDS dated [DATE] identified Resident #91 had severely impaired cognition, was always incontinent of bowel and bladder and required moderate assistance with rolling left to right and transfers chair/bed to chair transfers. Additionally, Resident #91 required maximum assistance with perineal hygiene and dressing. Resident #91 was at risk for developing a pressure ulcer but did not have any pressure ulcers. The readmission nursing assessment dated [DATE] identified Resident #91's skin was intact except for periorbital bruising to the face status post fall. The assessment did not identify any open areas or pressure areas. A physician's order dated 1/31/25 directed for skin prep to bilateral heels daily on evening shift for 14 days last day 2/12/25. The care plan dated 2/13/25 identified Resident #91 was at risk for skin breakdown related to decreased mobility and left hip surgical incision. Interventions included applying barrier cream after each incontinent episode, dietitian consultation as needed, and weekly skin checks by the licensed nurse. The weekly skin check assessment documented by RN #2 dated 2/15/25 identified Resident #91's left heel had a blister with slough measuring 6.0 cm by 6.0 cm intact. (first identified) The weekly skin check assessment documented by LPN #1 dated 2/22/25 at 7:23 PM identified a previously identified wound to the left heel. (second time identified) Interview with LPN #1 on 4/7/25 at 8:55 AM indicated that she did the weekly skin assessment on 2/22/25 for Resident #91. LPN #1 indicated that she thought the left heel was already noted and not new, so she did not call for an RN assessment. An interview with RN #2 on 4/7/25 at 11:11 AM indicated that she was the charge nurse on the unit and was responsible on 2/15/25 to do the weekly body assessment on Resident #91. RN #2 indicated that she had noted an intact 6 cm by 6 cm blister with yellow drainage inside the blister but the skin under the blister was not viable skin. RN #2 indicated that she assumed the DTI to the left heel was old. RN #2 indicated that if it was new she would have told the supervisor so she could have done a change in condition assessment, get a treatment order. RN #2 indicated that because she thought it was old she did not notify the RN supervisor to do the change of condition RN assessment. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The APRN note dated 2/24/25 at 1:04 PM identified she was notified by RN #1 and had seen Resident #91 for a deep tissue injury (DTI) to left heel today noted by nursing. Recommended Santyl topically with daily dressing change to facilitate until seen by wound provider later this week. Nursing to off load heels for Resident #91. The Change of Condition Evaluation documented by RN #1 dated 2/24/25 at 1:21 PM identified Resident #91 noted to have a new injury to his/her left heel. RN #1 noted this is the leg affected by his/her broken hip and surgical fixation. Left heel unstageable DTI measuring 2.5 cm by 1.4 cm by 0.1cm. The Wound Integrity Report written by RN #1 dated 2/24/25 identified Resident #91 had a new unstageable DTI to the left heel measuring 2.5 cm by 1.4 cm by 0.1 cm with sloughy appearance in wound bed, moderate amount of serous drainage, macerated surrounding tissue, and wound had no odor. Review of the nurse's and dietitian notes dated 2/15/25 to 4/1/25 identified the dietitian did not evaluate the residents nutritional status in relation to the new pressure ulcer until 4/2/25 (49 days later). The dietitian note dated 4/2/25 identified Resident #91 triggers for significant weight loss times 1 month and pressure ulcer to the left heel, resident was at risk for malnutrition. Resident #91 remains at risk for malnutrition related to unplanned weight loss and need for mechanically altered diet and requires total assistance for feeding. Recommendations included Glucerna once day in the evening to assist with stability and protein supplements to support wound healing in view of pressure injury to left heel. Interview with the Dietitian on 4/9/25 at 11:35 AM identified the wound nurse was responsible to provide her with a weekly wound report for all wounds that would include new wounds and if wounds are getting worse. The Dietitian indicated that she did not receive any wound reports for the month of February 2025 and only 1 report in March 2025. The Dietitian indicated the wound report for the week of 3/7/25 did not include Resident #91. The Dietitian indicated that notified the DNS that she was not receiving the weekly wound reports. The Dietitian indicated that if a resident receives a new facility acquired pressure ulcer and she was notified she would have seen the resident within a week at the most. The Dietitian indicated she would assess the resident and make sure the resident is meeting nutritional needs and would recommend some type of protein supplement based on the stage of the wound. The Dietitian indicated that on 4/2/25 after Resident #91 was readmitted on [DATE] she went to do the nutritional evaluation and noted the documentation of the left heel pressure ulcer. The Dietitian indicated at that time she had recommended the protein supplement (Prostat Advanced Wound Care) and the order was put into place. The Dietitian indicated that if she was aware on 2/15/25 when someone had first found the left heel, she would have seen Resident #91. The Dietitian indicated that it is the protocol for stage 3, stage 4, or unstageable to immediately start the protein supplement to promote wound healing. (continued on next page)

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Complete Care at Harrington Court	59 Harrington CT Colchester, CT 06415

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with RN #1 on 4/7/25 at 9:46 AM indicated that no one had informed her of Resident #91's left heel pressure ulcer and that she had found it when auditing the weekly skin assessments that are completed weekly. RN #1 indicated that on 2/24/25 she noted that the left heel started on 2/15/25 and when she assessed the heel the blister had opened and was unstageable and measured 2.5 cm by 1.4 cm by 0.1 cm. RN #1 indicated that the first complete RN assessment for the left heel pressure area was completed on 2/24/25 that was 9 days after first found. RN #1 indicated that the wound assessment would have included measurements of wound measuring it by length by width by depth, description of wound bed, any drainage noted, if resident had any pain, appearance, undermining, surrounding tissue, or any odor. RN #1 indicated that there was no treatment in place for the left heel from 2/15/25 to 2/24/25. RN #1 indicated that when the wound physician saw the left heel on 2/27/25 he staged it as an unstageable DTI. RN #1 indicated that on 2/15/25 when the left heel pressure ulcer was first identified there should have immediately been an RN change of condition assessment with a complete wound assessment, and the physician should have been notified. Interview with the DNS on 4/7/25 at 11:21 AM indicated Resident #91 had a left heel noted on 2/24/25 by the wound nurse RN #1 on 2/24/25. The DNS indicated that when a pressure ulcer is first identified the charge nurse notifies the RN supervisor to do the initial wound assessment including measurements, description of wound and wound bed, and the surrounding skin. The DNS indicated that she thought Resident #91's left heel started on 2/24/25 and she was first notified about it on 2/24/25. Review of Pressure Injury Prevention and Management Policy identified the facility as committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to promote treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injures. Pressure injury refers to localized damage to skin and/or underlying soft tissue usually over a bony prominence. Licensed nurses will conduct a full body skin assessment on all residents upon admission/readmission, weekly, and after newly identified pressure injury. Findings will be documented in the medical record. Assessments of pressure injuries will be documented with the stage of the pressure injury will be clearly identified. Evidence based treatments in accordance with current standards of practice will be provided for all residents who have a pressure injury present. Treatment decisions will be based on the characteristics of the wound, including the stage, size, exudate, presence of pain, signs of infection, wound bed, wound edges, and surrounding tissue characteristics. The goals and preferences of the resident and/or resident representative will be included in the care plan. The RN unit manager or designee will review all relevant documentation regarding skin assessments, pressure injury risks, progression of wound healing, and compliance at least weekly, and document a summary of findings in the medical record. The attending physician will be notified of the presence of a new pressure injury identification. A review will be performed on each pressure injury that develops in the facility. Findings will be reported in the monthly QAA committee meetings. Review of the Nutritional Management Policy identified the facility promotes care and services to each resident to ensure the resident maintains acceptable parameters of nutritional status in his/her overall condition. A comprehensive nutritional assessment will be completed by the dietitian within 72 hours of admission, annually, and upon significant change in condition. Components of the assessment will include, but not limited to residents' general appearance, height, weight, cognitive, physical, and medical conditions, food and fluid intake, poor intake, weight loss, review of medications, and review of labs.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, facility policy, and interviews for 2 of 3 residents (Resident #22 and 65) reviewed for respiratory care, the facility failed to ensure the CPAP (continuous positive airway pressure) tubing, filter, and mask were changed in accordance with the manufacturer's recommendations. The findings include: 1. Resident #22 was admitted to the facility on [DATE] with diagnoses that included sleep apnea, obesity, and chronic obstructive pulmonary disease (COPD). The annual MDS dated [DATE] identified Resident # 22 had intact cognition and required a non-invasive mechanical ventilator (CPAP or Bi-pap). The quarterly MDS dated [DATE] identified Resident #22 had intact cognition and required maximum assistance with toileting, bathing, and personal hygiene. and required a non-invasive mechanical ventilator (CPAP or Bi pap). The care plan dated 2/3/25 identified Resident #22 has altered respiratory status and difficulty breathing related to COPD and sleep apnea. Interventions included Resident #22 utilizes a CPAP machine at bedtime. A physician's order dated 2/12/25 (original date 11/3/24) directed a CPAP at bedtime and remove in the morning. Nurses are directed to change or clean intake filter and disposable supplies (i.e. tubing) per manufacturers guidelines every Sunday between 11:00 PM and 7:00 AM and or if soiled as needed. Additionally, clean CPAP reservoir weekly every Wednesday between 11:00 PM to 7:00 AM. Review of the MAR dated 3/1/25 to 3/31/25 identified that RN #8 had signed off as cleaning or changing the CPAP intake filter, tubing, and any disposable equipment on 3/2, 3/16, and 3/30/25. Observation on 4/6/25 at 8:00 AM identified a CPAP mask on the nightstand without the benefit of being bagged. Additionally, there wasn't a date on the mask or head gear and at the base of the heated tubing it was dated 7/31/24, over 8 months ago. Observation on 4/7/25 at 10:00 AM identified a CPAP mask on the nightstand without the benefit of being bagged. There was no date on the mask or headgear and the heated tubing was dated 7/31/24 to identify when it last changed. Interview with LPN #1 on 4/8/25 at 2:30 PM indicated that the 7:00 AM to 3:00 PM nurses do not touch the CPAP equipment or machine for Resident #22 and the night nurse or management were responsible to order the equipment and change the equipment but was she did not know when. Observation of Resident #22's CPAP equipment and machine, LPN #1 identified that the tubing at the base in black marker was dated 7/31/24 and she indicated that was the last time the tubing was changed then she opened the air filter chamber and indicated the filter should be white but it was the color grey but could not identify when the disposable air filter was last changed or when the water chamber was last cleaned. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DNS on 4/8/25 at 2:55 PM indicated that Respiratory Therapist #1 was responsible to maintain the CPAP or BIPAP machines and equipment. The DNS wasn't able to explain when the mask, tubing, and air filter were to be changed and indicated to speak with Respiratory Therapist #1 that comes to the facility once a week. Interview with Respiratory Therapist #1 on 4/8/25 at 3:04 PM indicated that she came to the facility to initially set up the BIPAP and CPAP machines and then the nursing facility's nurses were responsible to clean and change the disposable parts such as the mask, head gear, tubing, and air filter. Respiratory Therapist #1 indicated the mask, head gear and tubing must be changed every 3 months and the air filter at least every 6 months if non disposable and can be washed but recommends changing the air filter while changing the other equipment every 3 months. Respiratory Therapist #1 indicated that her company only set up Resident #22's machine on admission, but the nurses were responsible for the routine changes of equipment. Observation of Resident #22's equipment and machine, Respiratory Therapist #1 indicated that the mask was not bagged and should be bagged when not in use. Respiratory Therapist #1 identified the mask and tubing were last changed on 7/31/24 and the air filter was a disposable air filter appears a dark grey instead of white and based on appearance and the sticker was last changed on 9/10/24. Respiratory Therapist #1 indicated that she will discard all the equipment and the air filter and get new equipment. Interview with RN #8 on 4/9/25 at 10:34 AM indicated that she works the 11:00 PM to 7:00 AM shift and verified she had worked on 3/2, 3/16, and 3/30/25 on Resident #22's unit. RN #8 indicated that she did sign off as cleaning or changing the equipment for the CPAP, but she did not. RN #8 indicated that there was no CPAP disposable equipment available to change the equipment and she had informed the supervisors and that she never cleaned any equipment because Resident #22 was sleeping before 11:00 PM and slept through past 7:00 AM. RN #8 indicated that although the order says to clean equipment during the 11:00 PM to 7:00 AM shift, the residents are using the equipment. RN #8 indicated that she does not recall the last time she had changed or cleaned the residents' CPAP or BiPAP equipment. Interview with RN #9 (Regional Nurse) on 4/9/25 at 11:00 AM indicated that the orders for Resident #22's CPAP was too broad and was not specific enough for the nurses to clearly change the air filter every 2 weeks and sign off, and change the humidified tubing every 3 months, and change the head gear and mask every 3 months. RN# 9 indicated the tubing, mask, and water reservoir were to be washed and cleaned weekly but should not be scheduled on night shift but should be done during the day when it has time to completely dry before the resident needs it that evening. Although attempted, an interview with LPN #3 was not obtained. Review of the facility CPAP and BiPAP Cleaning Policy identified the facility will clean CPAP/BiPAP equipment in accordance with current CDC guidelines and manufacturer recommendations to prevent the occurrence or spread of infection. CPAP is continuous positive airway pressure. Replace equipment general guidelines are the face mask and tubing are to be changed every 3 months, the headgear and humidifier chamber to be changed every 6 months, and the disposable filter changed twice a month. Additionally, the nurse will document the use of the machine, residents' tolerance, skin integrity, respiratory or other changes and responses. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Manufacturer Guide for CPAP indicated cleaning the device and components according to the schedules shown in this guide to maintain the quality of the device and to prevent growth of germs that can adversely affect your health. Clean daily the humidifier tub and wipe it thoroughly with a clean disposable cloth. Allow it to dry out of direct sunlight. Refill them with distilled water only. Weekly wash the air tubing, humidifier tub and outlet connector in warm water using mild dishwashing liquid. Rinse each component thoroughly in water and allow to air dry. Change every month the mask cushions or nasal pillows and the disposable filter, every 3 months change the CPAP tubing, and every 6 months change the mask headgear and the humidifier water tub. 2. Resident #65 was admitted to the facility in November 2021 with diagnoses that included chronic obstructive pulmonary disease (COPD) and obstructive sleep apnea (OSA). The quarterly MDS dated [DATE] identified Resident #65 had intact cognition, and received a special treatment, procedure, or program: a non-invasive mechanical ventilator, while a resident at the facility. The care plan dated 3/27/25 identified Resident #65 had the potential for altered respiratory status/difficulty breathing related to diagnosis of OSA and required CPAP. Interventions included monitoring for signs and symptoms of respiratory distress, encouraging sustained deep breathing, and respiratory consultations as ordered. Physician's orders dated 3/31/25 directed to administer CPAP_10CM pressure, apply at night and remove in the morning: full face mask humidification (if appropriate) heated or cool fill humidifier with sterile or distilled water. The physician's orders further directed to clean CPAP/BIPAP reservoir weekly, every Wednesday night shift and to change or clean intake filer and disposable supplies (tubing) per manufacturers guidelines, or if soiled and as needed every night shift, on Wednesday. Observation and interview with Resident #65 on 4/8/25 at 2:25 PM identified that no staff member had cleaned his/her CPAP in months. Resident #65's CPAP tubing was dated 7/31/24, over 8 months, and the mask, which was uncovered, was dated 7/31/24. Resident 65 indicated that 7/31/24 must be the last time anyone had cleaned or changed the CPAP equipment. Observation and interview with RN #1 on 4/8/25 at 2:45 PM identified the date 7/31/24 on Resident #65's CPAP mask and tubing would indicate the date the mask and tubing were last changed. RN #1 further indicated that the cleaning and changing of the CPAP tubing and mask were scheduled to be completed during the overnight shift, but RN #1 was unsure how the CPAP tubing and mask could be cleaned and have time to adequately dry during the night shift while the resident would be sleeping. RN #1 identified she would have to review the facility's policy. Interview with the Clinical Manager of the consulting respiratory therapy group (RT #1) on 4/8/25 at 2:50 PM identified that she would expect a weekly soaking of the CPAP tubing, the mask to be wiped daily with a cloth and the mask to be bagged when not in use. RT #1 further indicated that the CPAP tubing and face mask should be changed according to the facility policy and manufacturer's recommendations, which was typically every 3 months or if the pieces remain soiled after cleaning. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with RN #1 on 4/10/25 at 9:29 AM identified that the orders to change Resident #65's mask and tubing were broad and said per manufacturer's guidelines. RN #1 indicated that there was no system in place for CPAP masks and tubing to be changed every 3 months. RN #1 indicated that the last time Resident #65's CPAP tubing and mask were changed was on 7/31/24. RN #1 further indicated that the policy for CPAP equipment cleaning and changes was, currently, being revised. Interview with the DNS on 04/10/25 at 10:44 AM identified that Resident #65's CPAP tubing and mask were not changed in accordance with the manufacturer's recommendations. The DNS indicated that the physician's order directed the disposable equipment to be cleaned per the manufacturer's recommendations and did not give a timeframe. The DNS identified that the facility is revamping the policy. The facility's CPAP/BiPAP Cleaning policy directs the facility to clean the CPAP/BiPAP equipment in accordance with the current CDC guidelines and manufacturer recommendations in order to prevent the occurrence or spread of infection; respiratory therapy equipment can become colonized with infectious organisms and serve as a source of respiratory infections. The policy further directs the facility to clean the mask frame daily after use with a CPAP cleaning wipe or soap and water, dry well, and cover with plastic bag or completely enclosed in machine storage when not in use. Weekly cleaning activities include washing head gear/straps and tubing in warm, soapy water and air dry. The policy directs for equipment to be replaced routinely in accordance with the manufacturer recommendations; general guidelines: face mask and tubing-once every 3 months, headgear, non-disposable filters, and humidifier chamber-once every 6 months, and disposable filters-twice monthly. Replace equipment immediately when it is broken or malfunctions, or if visible soiling remains after cleaning.

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility policies, and interviews for 1 of 5 residents (Resident #65) reviewed for unnecessary medications, the facility failed to ensure a medication for the treatment of a mental health diagnosis was administered per the physician's order. The findings include: Resident #65 was admitted to the facility in November 2021 with diagnoses that included anxiety disorder, dysthymic disorder, major depressive mood disorder (MDD), and post-traumatic stress disorder (PTSD). The quarterly MDS dated [DATE] identified Resident #65 had intact cognition, and the resident mood interview identified the following symptoms and frequency: little interest or pleasure in doing things (several days) and feeling down, depressed, or hopeless (several days). The care plan dated 3/27/25 identified Resident #65 was at risk for distressed/fluctuating mood symptoms related to diagnoses of dysthymic disorder, generalized anxiety disorder, and PTSD. Interventions included observing for signs and symptoms of a new psychiatric disorder or worsening symptoms of current psychiatric disorder and encouraging the resident to seek staff support for distressed mood. The care plan further identified that Resident #65 used psychotropic medications related to depression and anxiety. Interventions included administering psychotropic medications as ordered by the physician and to monitor, document, and report any adverse reactions to the medications. A physician's order dated 6/28/24 directed to administer Rexulti oral tablet 1mg, give 1 tablet by mouth at bedtime for depression. The March 2025 MAR identified Resident #65 did not receive Rexulti 1mg on 3/22/25 (medication not available), 3/23/25 (on order), or on 3/24/25. The nurse's note dated 3/23/25 at 10:12 PM identified the writer spoke with the on-call APRN who directed the administration of Clonazepam 1mg tablet by mouth, now. The Psychiatric Evaluation and Consultation dated 3/24/25 identified Resident #65 had a psychiatric history including MDD, anxiety, PTSD, and sleep terrors with current exacerbation of anxiety related to Rexulti not being properly refilled due to insurance/pharmacy mix-up. Resident #65 is currently taking Rexulti as an adjunct therapy for MDD and was requesting something for anxiety/depression in the meantime until the Rexulti is refilled. Options were discussed and settled on Trazadone. Resident #65 denied SI/HI/AVH and was happy at the end of the visit and pleased medications were being adjusted. Collaboration with the nursing supervisor, the DNS, and pharmacy staff resolved the situation and the pharmacy will send the Rexulti dose later this evening. Interview with Resident #65 on 4/6/25 at 9:55 AM identified that he/she did not receive Rexulti from 3/19/25 through 3/24/25 before bed as prescribed. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and review of Resident #65's Rexulti refill history with the Consulting Pharmacist (Pharmacist #2) on 4/9/25 at 9:24 AM failed to identify that a request from the facility to refill the Rexulti was completed from 3/19/25 through 3/23/25. Pharmacist #2 indicated that the facility had made a 7-day supply refill request on 3/11/25, which arrived at the facility on 3/12/25 at 2:00 AM and the next 7-day supply refill request was made on 3/24/25 at 12:42 PM, which arrived at the facility on 3/25/25 at 2:29 AM. Pharmacist #2 further indicated that in November of 2024, Resident #65's Rexulti refill quantity changed to a 7-day supply, and submitting a medication refill request should be completed 2 - 3 days prior to the medication running out, to allow time for delivery and ensure the medication does not run out. Interview with the DNS on 4/9/25 at 1:10 PM identified that Resident #65 had missed Rexulti doses from 3/22/25 through 3/24/25, 3 doses, because the facility did not have it. The DNS indicated that when APRN #3 notified her of the missing doses on 3/24/25, she called the pharmacy to address the issue. The DNS indicated that medication refill requests should be completed in a timely manner to ensure medications are available for their scheduled administration times. The facility's Pharmacy Services policy directs the pharmacist, in collaboration with the facility and medical director, should include within its services to strive to assure medications are requested, received, and administered in a timely manner. The facility's Medication Administration policy directs medications are to be administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 5 residents (Resident #269) reviewed for unnecessary medications, the facility failed to conduct a gradual dose reduction of Risperidone upon admission when the clinical record failed to reflect a psychiatric diagnosis. The findings include: Resident #269 was admitted to the facility on [DATE] with diagnoses that included cerebrovascular disease and dementia. Notice of PASRR Level 1 Screen Outcome dated 3/31/25 identified Resident #269 had no mental health diagnosis that was known or suspected. A physician's order dated 4/1/25 directed to give Risperidone (antipsychotic medication) 0.25mg by mouth 3 times a day. The psychiatric APRN #2 note dated 4/1/25 identified Resident #269 was seen and assessed today for initial evaluation and will continue Risperidone 0.25mg by mouth three times a day for a diagnosis of Bipolar (this diagnosis is in conflict with the hospital and facility clinical records). The care plan dated 4/1/25 identified Resident #269 was at risk for complications related to the use of psychotropic medications. Interventions included monitor for continued need for medication as related to mood and behavior and obtain psychiatric evaluation. The admission MDS dated [DATE] identified Resident #269 had moderately impaired cognition and was dependent on staff for toileting and dressing and required maximum assistance with bathing and personal hygiene. Additionally, the MDS did not identify any psychiatric or mood disorders. Residents' overall goal indicated from Resident #269 was to be discharged to the community. Interview with APRN #2 on 4/8/25 at 11:39 AM after clinical record review APRN #2 indicated that Resident #269 was admitted on [DATE] and Resident #269 was taking the medication Risperidone at the hospital before coming to this facility. APRN #2 indicated that she did not review the hospital discharge paperwork to confirm a psychiatric diagnosis for the antipsychotic medication she just saw the Risperidone was in the orders from the hospital. APRN #2 indicated that she did not verify or give Resident #269 the diagnosis of Bipolar but just continued the diagnosis and continued the antipsychotic medication without trying to discontinue the antipsychotic medication. Interview with APRN #1 on 4/8/25 at 1:01 PM indicated Resident #269 was admitted on Risperidone without a diagnosis, so she referred the resident to APRN #2. APRN #1 indicated that the psychiatric APRN, APRN #2, had documented on 4/1/25 that Resident #269 was on Risperidone for Bipolar disorder. APRN #2 indicated that if Resident #269 does not have the diagnosis of Bipolar her expectation would be that Resident #269 must be weaned off Risperidone. (continued on next page)

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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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The interview with APRN #2 on 4/8/25 at 1:04 PM indicated that she could not speak to the surveyor and must leave the facility immediately. APRN #2 packed up her belongings and headed to the front lobby area/exit. APRN #2 refused to speak to the surveyor and identified she was told by her boss she must leave immediately and not speak to the surveyor. RN #5, who was present, indicated that he does not know why APRN #2 must leave and that he would call her boss. The interview with RN #5 on 4/8/25 at 1:30 PM indicated the psychiatric group was sending someone out to reevaluate Resident #269 today regarding the diagnosis of Bipolar disease and being on the antipsychotic medication Risperidone. After surveyor inquiry, the psychiatric APRN, APRN #5's note dated 4/8/25 indicated that prior to hospitalization Resident #269 was at an assisted living where Resident #269 had started Risperidone 0.25 mg 3 times a day for agitation. Chart reviewed for psychiatric diagnosis and psychotropic medications. Diagnosis of Bipolar disorder was erroneously added to Resident #269's record. There is no record of Bipolar disorder noted in hospital notes dated 3/30/25 nor on the PASARR. Resident #269 carries a diagnosis of Dementia without behavioral disturbances and is prescribed Donepezil. Resident #269 was prescribed Risperidone 0.25mg 3 times a day for agitation. APRN #5 indicated that she will trial a gradual dose reduction of Risperidone as diagnosis does not support its use. Plan is to decrease Risperidone 0. 25mg to twice a day with plan to continue gradual dose reduction. After surveyor inquiry, a physician's order dated 4/9/25 directed to decrease the Risperidone 0.25mg by mouth 2 times a day. The interview with APRN #5 on 4/10/25 at 10:28 AM indicated after APRN #2 had left the facility unplanned, she came in to evaluate Resident #269 on 4/8/25 and she could not find a diagnosis of Bipolar for Resident #269 to justify the use of the medication Risperidone. APRN #5 indicated that Resident #269 should not have been on for Risperidone for Bipolar because Resident #269 does not have Bipolar. APRN #5 indicated that APRN #2 should have reviewed all the hospital discharge documentation to determine if Resident #269 had a diagnosis of Bipolar which he/she did not. APRN #5 indicated that since Resident #269 does not have a diagnosis of Bipolar and APRN #2 on her visit on 4/1/25 should have started a gradual dose reduction to get Resident #269 off the Risperidone. APRN #5 indicated that the expectation would be to do a gradual dose reduction when seen by APRN #2 on 4/1/25 because Resident #269 only had a diagnosis of Dementia and not Bipolar. Review of the Use of Psychotropic Medications Policy identified residents are not given psychotropic medications unless the medication is necessary to treat a specific condition, as diagnosed and documented in the clinical record, and the medication is beneficial to the residents, as demonstrated by monitoring and documentation of the resident's response to the medication. Resident and/or representatives shall be educated on the risks and benefits of psychotropic medications use, as well as alternative treatments/non-pharma logical interventions. Residents who use psychotropic drugs shall receive gradual dose reductions, unless clinically contraindicated, to discontinue these drugs. Use of psychotropic medications an evaluation shall be documented to determine that the resident's expressions or indications of distress are not due to a medical condition or problems that can be expected to improve or resolve as the underlying condition is treated, or the offending medications are discontinued. New admissions the facility shall identify the indication for use by pre-admission screening and other pre-admission data. The physician in collaboration with the consultant pharmacist shall re-evaluate the use of the medication and consider whether or not the medication can be reduced or discontinued upon admission or soon after admission.