STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075258	A. Building B. Wing	08/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Douglas Manor	103 North Road Windham, CT 06280

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, facility documentation, facility policy and interviews for one (1) of four (4) sampled residents (Resident #1) who were reviewed for Preadmission Screening and Resident Review (PASRR), the facility failed to complete a PASRR Level 2 screening when the initial screen expired causing a delay in Resident #1's transfer to another long term care facility. The findings include:Resident #1's diagnoses included congestive heart failure, chronic obstructive pulmonary disease, depression, post-traumatic stress disorder, and bipolar disorder. The admission Minimum Data Set assessment dated [DATE] identified Resident #1 had some memory deficits and received anti-anxiety and anti-depressant medications. The PASRR Level 1 notice of action dated [DATE] identified Resident #1 received his/her approval for a period of seven (7) days and a Level 2 referral was not needed with this screening. The notice identified the admitting nursing facility was responsible for submitting the updated Level I/PASRR and LOC at admission so a Level 2 referral may be initiated. The social service note dated [DATE] at 10:28 AM identified Resident #1 was issued a Notice of Medicare Non-Coverage (NOMNC) on [DATE] and an appeal form was completed. The social service note dated [DATE] at 4:35 PM identified Resident #1 lost the appeal and was considered private pay. The note indicated the family was attempting to get Resident #1 into a facility that was Veteran Affairs (VA) connected. The PASRR Level 1 review dated [DATE] identified a previous PASRR short term approval for nursing facility stay is expiring or has expired, a PASRR Level 2 should have been conducted upon expiration of the PASSR Level 1 on [DATE]. The Grievance/Concern Form dated [DATE] identified Resident #1 and family members alleged social service was not assisting with transfers to another facility. The notice of the PASRR Level 2 dated [DATE] identified Resident #1 required the level of services provided in a nursing facility, did not need special services for serious mental health issues and was approved, therefore Resident #1 could choose the nursing facility. The social service note dated [DATE] at 10:19 AM identified Resident #1 was discharged to another long-term care facility. Interview with the Director of Social Services on [DATE] at 2:25 PM identified the process at the facility for PASRR screenings was, upon admission the Director of Social Services was responsible for looking at the PASSR Level 1 screening to determine if further screening was required. The Director of Social Services identified she failed to recognize Resident #1's PASRR Level 1 was approved for seven (7) days and due to Resident #1's psychiatric diagnoses a PASSR Level 2 screening was required. The Director of Social Services explained she did not discover this error until Resident #1's notice of Medicare non-coverage was issued and Resident #1's family requested to transfer Resident #1 to a facility with VA benefits. The Director of Social Services identified she contacted several VA facilities and one facility identified they were able to accept Resident #1 and requested a copy of the PASRR Level 2. The Director of Social Services explained the receiving facility was unable to accept Resident #1 until the PASRR Level 2 was completed, Resident #1 had to remain at the current facility as private pay from [DATE] to [DATE] for a total of fifteen (15) days until the process was completed. The Director of Social Services identified the facility failed to follow the requirements for filing a PASRR Level 2 when due. Interview with the Administrator on [DATE] at 2:55 PM identified the facility failed to follow the requirements for filing a PASRR Level 2 for Resident #1 which caused Resident #1 to have to pay privately until Resident #1 was able to be accepted at a VA facility. The facility Resident Rights policy identified residents have the right to a safe transfer or discharge through sufficient preparation by the nursing home.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, facility documentation, facility policy and interviews for one (1) of four (4) sampled residents (Resident #1) who were reviewed for coordination of the plan of care, the facility failed provide the baseline and comprehensive care plans to the resident or the resident's family within forty-eight hours of admission to promote continuity of care and communication with the staff. The findings include:Resident #1's diagnoses included congestive heart failure, chronic obstructive pulmonary disease, depression, and bipolar disorder. The baseline Resident Care Plan dated 5/28/25 identified Resident #1 had a colostomy, was incontinent of bladder, had bipolar disorder, and had a self-care deficit. Interventions directed to toilet the resident every two (2) hours, provide incontinent care, apply barrier protection after care, obtain lab work as ordered, administer medications as ordered, monitor behaviors, psychiatric consults as needed, and assist with daily living skills. The admission Minimum Data Set assessment dated [DATE] identified Resident #1 had some memory deficits, required moderate assistance with personal hygiene and bed mobility, maximum assistance for dressing, was dependent on toileting, showers, transfers, and ambulation, had a colostomy, and was always incontinent of bladder. Review of the clinical record from 5/28/25 when the baseline care plan was developed through 7/28/25 failed to reflect documentation a meeting was held with Resident #1 and the family to discuss Resident #1's care or a copy of the care plans were provided until the 7/28/25 meeting. The Care Plan Meeting Invitation form identified the facility had a meeting with Resident #1 and family members on 7/28/25 and addressed concerns Resident #1 and his/her family had. Interview with the Director of Social Services on 8/18/25 at 2:25 PM identified she thought a meeting was held; however, she could not be sure because she did not document in the clinical record that a meeting occurred. The Director of Social Services checked further with the therapy department as they attended all care plan meetings, and the therapy department had no record of the meeting being held. Review of the facility Resident Rights policy identified the resident had the right to participate in their own care-planning and treatment. Review of the facility Care Plan policy identified the resident had the right to participate in the development and implementation of his/her plan of care.

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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. (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, facility documentation, facility policies and interviews for one (1) of four (4) sampled residents (Resident #1) who was symptomatic for a urinary tract infection and had an order to collect a urine specimen, the facility failed to collect the urine at the time of the order or notify the physician of the delay with obtaining the specimen. The findings include:Resident #1's diagnoses included chronic kidney disease, congestive heart failure, and diabetes mellitus. The baseline Resident Care Plan dated 5/28/25 identified Resident #1 had a colostomy, was incontinent of bladder, and had a self-care deficit. Interventions directed to toilet the resident every two (2) hours, provide incontinent care, apply barrier protection after care, obtain lab work as ordered, and assist with daily living skills as needed. A physician's order dated 5/28/25 directed staff may straight catheterize Resident #1 if unable to obtain a urine specimen for urinalysis or culture and sensitivity as needed. The admission Minimum Data Set assessment dated [DATE] identified Resident #1 had some memory deficits, required moderate assistance with personal hygiene, maximum assistance for dressing, was dependent on toileting, and was always incontinent of bladder. The nurse's note dated 6/4/25 at 9:19 PM identified the 3-11PM charge nurse, Licensed Practical Nurse (LPN) #1, noted Resident #1 was very lethargic and hard to arouse around 9:00 PM during the medication pass. The note indicated when the nurse aide attempted to provide care Resident #1 became agitated and attempted to strike the nurse aide. The note identified Resident #1 was approached a second time and refused all medications. The plan was to continue to monitor Resident #1. The nurse's note dated 6/5/25 at 5:15 PM identified the 7AM-3PM charge nurse, LPN #2, noticed Resident #1 was listless throughout the day with a flat affect, responded appropriately to questions, complained of dysuria when being toileted in the morning, and was encouraged to increase fluid intake. The note identified the Advanced Practice Registered Nurse (APRN) was notified and directed labs and urine specimens to be done in the morning. The nurse's note dated 6/5/25 at 11:16 PM identified Resident #1 was lethargic during the shift and was found a couple of times with his/her feet dangling out of the bed. Review of the nurse's notes for 6/6/25 and 6/7/25 failed to identify attempts were made to collect a urine sample or there was notification to the APRN regarding the status. The nurse's note dated 6/8/25 at 2:24 PM by the 7AM-3PM floor nurse, LPN #4, identified a family member was in to visit and voiced concerns over Resident #1's increased confusion. The note indicated there was still the need to obtain a urine specimen. A physician's progress note dated 6/9/25 at 11:15 AM identified the urinalysis was positive for bacteria, and the culture and sensitivity were pending. The physician directed to continue to monitor and appropriate antibiotic treatment would be initiated once the culture and sensitivity results were back. The nurse's note dated 6/9/25 at 4:54 PM identified Resident #1 complained of dysuria and required extensive assistance for morning care. A urine specimen was obtained and sent to the lab, four (4) days after the initial order. The lab result dated 6/9/25 identified a positive urinary tract infection. The nurse's note dated 6/10/25 at 9:51 AM identified Resident #1's culture was rejected by the lab and the facility received an order to obtain another urine. The nurse's note dated 6/11/25 at 3:59 PM identified Resident #1 had periods of confusion during the shift and family member had also reported Resident #1 was having more confusion. A physician's progress note dated 6/12/25 at 8:30 AM identified the facility received the results of the urine culture and sensitivity and the APRN directed to administer Rocephin IM for four (4) days. The urine culture and sensitivity lab results dated 6/13/25 identified multiple gram-positive bacteria was noted in the urine. The Grievance/Concern Form dated 7/28/25 identified family members alleged when a urinalysis test was requested there was a delay in obtaining the specimen. Interview with LPN #2 on 8/18/25 at 1:40 PM identified the length of time from the urinalysis being ordered on 6/5/25 until treatment was ordered on 6/12/25 was longer than usual. Interview with LPN #1 on 8/18/25 at 2:00 PM identified she could not recall if she attempted to get a urine sample and noted if she had and was unsuccessful, she would have documented that in the clinical record. Interview with the Infection Control Nurse, Registered Nurse (RN) #1, on 8/18/25 at 2:18 PM identified the facility expectation to collect a urine sample once ordered was within twenty-four (24) hours. RN #1 indicated the physician should have been notified of the delay and inquire if the physician wanted Resident #1 to be straight cathed due to Resident #1's incontinence. RN #1 identified failure to follow proper protocol caused a delay in treating Resident #1. Review of the facility policy Resident Rights identified the resident had the right to receive adequate and appropriate care.