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	04/08/2026

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 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 clinical record review, facility documentation/policies and interviews for one (1) of two (2) sampled residents (Resident #2) reviewed for abuse, the facility failed to ensure the resident was treated with dignity and respect when a staff member caused repeated discomfort when repositioning the resident and did not respect the resident's right to refuse care. The findings include:Resident #2's diagnoses included Parkinson's Disease, dysphagia, and depression.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 as moderately cognitively impaired (Brief Interview for Mental Status (BIMS) score of 11), required maximum assistance with bed mobility, hygiene and dressing, and was bed bound.The Resident Care Plan (RCP) dated 2/17/26 identified Resident #2 required assistance for hygiene, bathing, dressing, toileting, bed mobility, and transfers. A BIMS score of fourteen (14) dated 3/20/26 identified Resident #2 as cognitively intact.The Social Service note dated 3/20/26 at 9:15 AM identified Resident #2 asked to see the Director of Social Services (DSS) due to a concern regarding care. The DSS met with Resident #2 along with the supervisor and identified Resident #2's concern was going to be investigated.Th facility incident report dated 3/20/26 at 10:45 AM by RN #2 identified on the night of 3/18/26 during the 11:00 PM to 7:00 AM shift, NA #1 picked up Resident #2's right leg to place it back in bed and hit the leg on the bedside table. Resident #2 further identified NA #1 did the same thing on 3/19/26 while Resident #2 was asleep causing Resident #2's leg to hit the bedside table and shifting the laptop which was seated on top of the bedside table.The nurses note dated 3/20/26 at 11:15 AM by RN #2 identified that a skin check to both legs was completed and there were no redness or signs of trauma to the legs.Interview with the DSS on 4/8/26 at 11:20 AM identified on 3/18/26 while in the process of moving Resident #2's right leg back into the bed, NA #1 hit Resident #2's leg on the bedside table. Resident #2 did not feel that was done maliciously. On 3/19/26, NA #1 woke Resident #2 while she was in the process of moving Resident #2's right leg back into bed and hit it on the bedside table. Resident #2 voiced that he/she was angry because NA #1 woke him up when doing this. Resident #2 further identified to the DSS that NA #1 was abrupt and always seemed to be in a hurry. The DSS identified other residents in the past had voiced concerns over the approach NA #1 took when providing care and had identified NA #1 was abrupt and made them feel like they were a burden.Interview with Resident #2 on 4/8/26 at 12:10 PM identified Resident #2 recalled the events of 3/18/26 and 3/19/26 as they had been described previously. Resident #2 identified on 3/18/26 when NA #1 informed him/her that she was going to move Resident #2's right leg back on the bed, Resident #2 told NA #1 not to move the leg, but she proceeded to anyways and, in the process, hit Resident #2's leg on the bedside table. Resident #2 told NA #1 to leave the room. On 3/19/26 while Resident #2 was asleep, NA #1 came into his/her room and woke Resident #2 who was in a sound sleep, while NA #1 was moving Resident #2's leg back into bed. NA #1 hit Resident #2's leg on the bedside table again so hard that his/her lap top and camera equipment on the table moved. Resident #2 told NA #1 to leave his/her room again and requested a new NA. Upon observation and interview with Resident #2, he/she could move his/her right leg on and off the mattress, and he/she indicated it is easier to have help, however, often preferred the right leg (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
	075258	A. Building B. Wing	04/08/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to hang slightly off the bed for comfort. Resident #2, who was primarily bed-bound, kept two overbed tables positioned directly over the bed. One table had a laptop and camera on it and the other had personal items and was used at mealtimes. This set up was purposeful for Resident #2 so he/she had the ability to access whatever is needed.Interview with the Director of Nursing on 4/8/26 at 1:00 PM identified the facility had prior patient care concerns brought to their attention regarding NA #1. NA #1 would often provide care to residents without first informing them or asking for their permission. The DON identified NA #1 failed to provide care in a dignified manner and failed to respect Resident #2's rights when he/she asked NA #1 to stop performing a certain duty and NA #1 continued the care. The facility subsequently terminated NA #1.Although attempted, an interview with NA #1 was not obtained.Review of the facility Resident's [NAME] of Rights identified that residents have the right to be treated with consideration, respect and dignity, recognizing each resident's individuality, wishes, and preferences.

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	04/08/2026

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policies, and interviews for one (1) of three (3) sampled residents (Resident #1) reviewed for allegations of abuse, the facility failed to ensure concerns reported by a resident representative were identified, documented, and investigated through the grievance process in accordance with facility policy. The findings include:Resident #1's diagnoses included intramedullary nailing following left intertrochanteric femur fracture, intellectual disability, and legal blindness.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 as cognitively intact (Brief Interview for Mental Status (BIMS) score of 13), independent with bed mobility, touching assistance with transfers, and required moderate assistance with toileting hygiene and dressing.The Resident Care Plan (RCP) dated 1/29/26 identified Resident #1 was at risk for safety due to cognitive deficits and was legally blind. Interventions directed to introduce self when providing care, approach in a calm manner, explain what is being done, anticipate needs, maintain privacy and dignity, orient resident to room, tv remote, bed remote, and call bell.Review of the facilities grievance log for the prior six (6) months failed to identify grievances filed on behalf of Resident #1.Interview with Person #2 (resident representative) on 4/8/26 at 10:20 AM identified she visited Resident #1 on several occasions while Resident #1 was at the facility. Person #2 identified during one visit she was in Resident #1's room and Resident #1 was screaming, two facility staff members went into the room and one of them said, yell, yell, yell. That's all we have to listen to. Person #2 informed the two staff members that Resident #1 was in a lot of pain, which was the reason he/she was yelling.Person #2 identified during another visit, two (2) staff members where with Resident #1 and one staff member began to wheel Resident #1 down the hall to obtain a weight but there were no leg rests on the wheel chair so when they pushed the wheel chair, Resident #1's legs were dragging on the floor and Resident #1 was yelling. One of the staff members said to Resident #1, here you go yelling and screaming at which Person #2 responded to the staff member that Resident #1 was in a lot of pain following the recent femur surgery. Person #2 further identified one of the staff members asked her who she was and when she identified which family member she was, the staff member stopped talking, retrieved leg rests and took the resident to the room. Person #2 further identified she reported to the Director of Social Services (DSS) that she did not like the way staff spoke to Resident #1and felt it was inappropriate. The DSS agreed with Person #2. Person #2 was unable to identify dates, times or who the specific staff members were that were involved in these instances but identified she brought her concerns to the DSS immediately.Interview with the DSS on 4/8/26 at 11:09 AM identified she recalled during a meeting with Person #2 that Person #2 reported comments staff made to Resident #1. The DSS acknowledged replying that the comments were not appropriate. The DSS did not file a grievance because she thought the comments were going to be included in a separate allegation of abuse that was being investigated. The DSS further identified the concern brought to her by Person #2 was not investigated and it should have been investigated.Interview with the Director of Nursing (DON) on 4/8/26 at 12:45 PM identified she was never informed by the DSS of the concern from Person #2 regarding how facility staff members spoke to Resident #2. The DON identified a grievance should have been filed and an investigation should have immediately been initiated. The DON further identified the facility did not follow its grievance policy.Although an interview with Resident #1 was attempted, he/she could not recall specific events during his/her stay at the facility.The facility Resident Rights Policy identified the resident had the right to have the facility resolve their grievance.The facility Grievance Policy identified the facility supports the right for residents or family members to voice grievances and would actively work toward resolution of the grievance. The Policy further identified grievances may be filed verbally to a staff member and the staff member receiving the grievance will file the grievance form.