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	04/22/2025

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and facility policy for 1 of 2 sampled residents (Resident #37) reviewed for choices, the facility failed to include a resident in the development and implementation of a person-centered Resident Care Plan. The findings included: Resident #37 diagnoses included abnormal posture, spinal instabilities, and pressure ulcer of the sacral region. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #37 was cognitively intact, required setup for eating and hygiene, and was dependent on staff for toileting and transfers. The Resident Care Plan (RCP) dated 2/4/25 failed to include resident discharge planning. Interview with the Director of Nurses (DNS) on 4/17/25 at 9:35 AM identified the facility does not currently have an MDS coordinator and the care planning and care plan schedules are created by the DNS, Rehabilitation Department, and social worker. Interview with Resident #37 on 4/17/25 at 9:45 AM identified staff had not discussed discharge home or invited him/her to a RCP meeting or discharge planning meeting even though he/she was ready to be discharged . The April 2025 and May 2025 RCP calendars provided identified care plan meetings scheduled on 4/24/25 and after but failed to identify prior calendars or care plan meeting dates. Interview and review of the Resident Care Conference attendance sheet with the DNS on 4/17/25 at 12:39 PM identified residents were involved in the care planning process by being invited to the quarterly care plan meetings. A review of the care conference signature sheet for Resident #37 failed to identify signatures or meetings after 10/24/24. During an interview with the Administrator on 4/22/25 at 10:33 AM he was unable to identify who was ultimately responsible for care plans and care plan meetings since there was no Director of Social Work and no MDS Coordinator in-house, stating it was a team effort. (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	04/22/2025

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview and care conference calendar schedule review with the MDS coordinator, Licensed Practical Nurse (LPN) #5 on 4/22/25 at 11:47 AM identified his last day as the MDS coordinator was 3/16/25, and he had not trained anyone for the position. LPN #5 identified he was in charge of the care plan conference calendars but could not provide copies of calendars prior to 4/24/25 as there was an issue with the computer, and neither he nor the receptionist had hard copies. Additionally, LPN #5 identified residents had documentation in their progress notes reflecting the invitation to the resident care conference. A review of the progress note dated 10/24/24 at 12:04 PM identified a quarterly care plan meeting was held with Resident #37, Nursing Department and social services. The electronic health record failed to identify any progress notes reflecting Resident #37 had a RCP meeting after 10/24/24. The Comprehensive Person-Centered Care Plan Policy directed, in part, that each resident's care plan will be consistent with the residents right to participate in the development and implementation of the care plan.

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	04/22/2025

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, clinical record review, and review of facility policy for 1 of 2 sampled residents (Resident #37) reviewed for choices, the facility failed to ensure the resident's wheelchair of choice was able to be utilized. The findings include: Resident #37 diagnoses included abnormal posture, spinal instabilities, and pressure ulcer of the sacral region. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #37 was cognitively intact, required setup for eating and hygiene, and was dependent on staff for toileting and transfers. The Resident Care Plan dated 2/5/25 identified Resident #37 required modified wheelchair positioning for proper body alignment. Interventions included referral to therapy as needed for change in wheelchair positioning, monitor for complaints of pain or evidence for skin breakdown, and transfer out of bed into the modified wheelchair as ordered. A physician's order dated 4/14/25 directed Resident #37 was to be out of bed to the adapted tilt in space wheelchair up to 1 hour to facilitate quality of life. Interview with Resident #37 on 4/14/25 at 9:53 AM identified he/she received an electric wheelchair (currently in the room) from a family member about a year ago, but he/she was unable to use it as the facility prohibited its use. Interview with the Director of Rehabilitation on 4/15/25 at 1:13 PM identified she was aware of Resident #37's desire to use the electric wheelchair, and he/she was evaluated when they first received the electric wheelchair, but did he/she not need an electric wheelchair. Additionally, to maintain function, the decision was made by staff to keep Resident #37 in the customized wheelchair (CWC) to deconditioniong. Review of the summary of skilled services (rehabilitation therapy) dated 6/24/24 at 2:58 PM identified, in part, that Resident #37 had received the electric wheelchair from his/her family, utilized the wheelchair over that weekend but lacked therapy approval or knowledge. Resident #37 was provided educated on inspection, education, and training for any new equipment brought into the facility, as well as extensive education on safety risks associated with the use of an electric wheelchair within a skilled nursing facility due to other residents. Additionally, therapy had concerns that the resident would develop muscle atrophy of the bilateral upper extremities, and he/she had a high risk for impairments, risk for joint deformity, pain and injury due to a lack of positioning devices. Resident #37 was receptive to all education provided and was educated on the need for further assessments to determine if the device was safe for him/her and other residents as well as further education on risk for impairments and injury making the electric wheelchair inappropriate for that environment. (Although multiple requests were made, the facility was unable to provide a screen, evaluation, or assessment of Resident #37 in the electric wheelchair). (continued on next page)

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	04/22/2025

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Nursing Assistant (NA) #1 on 4/16/25 at 9:22 AM identified she took care of Resident #37 on a regular basis, and he/she used to bring up using the electric wheelchair all the time when the wheelchair was first received. She identified it was always in Resident #37's room, but she did not believe he/she was ever evaluated by therapy for its use and questioned if electric wheelchairs were even allowed in the facility. Follow up interview Director of Rehabilitation on 4/16/25 at 1:48 PM identified Resident #37 was currently receiving therapy for strengthening, and although she was aware of Resident #37's desire to use the electric wheelchair, the facility wanted him/her to keep his/her independence. Additionally, she identified for a resident receiving a muscle relaxant and pain medication might not be appropriate to use an electric wheelchair, because he/she might fall asleep, and the facility needed to think about the safety of other residents. The Director of Rehabilitation identified Resident #37 was highly motivated to be discharged and could use the electric wheelchair in the community. Observation of Resident #37 on 4/15/25 at 2:11 PM identified him/her alert and conversing with staff in the hallway utilizing the wall railing to self-propel in the non-electric wheelchair. Additional observations on 4/16/25 at 11:05 AM identified Resident #37 alert and oriented during a wound treatment change and on 4/16/25 at 2:10 PM he/she was self-propelling in the hallway in his/her non-electric wheelchair. Observations failed to identify Resident #37 dozing off or sleeping any point. Follow up interview with Resident #37 on 4/17/25 at 9:45 AM identified he/she got the electric wheelchair because it was more comfortable than the wheelchair the facility was providing. He/she also identified no one assessed him in the chair, just explained that it was not appropriate due to his leaning, but he/she did not understand that because both the current wheelchair and the electric wheelchair reclined. Review of occupational therapy summaries of daily skilled services notes failed to identify that Resident #37 was assessed in the electric wheelchair after the initial education provided on 6/24/24. Review of the Americans with Disabilities Act (ADA) Requirements: indicated that Wheelchairs, mobility aids, and other power-driven mobility devices directed, in part, that people with disabilities have the right to choose whatever mobility device best suits their needs. Review of the Resident's [NAME] of Rights directed, in part, that residents can store and use their personal possessions and have the right to receive quality care and services with reasonable accommodations of individual needs 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	04/22/2025

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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on interview, review of facility documentation, and facility policy during a Resident Council meeting and review of Resident Council minutes, the facility failed to resolve ongoing issues with dietary, extended call bell wait times, locating staff for assistance, and inappropriate language used by staff. The findings include: Review of the Resident Council minutes for March 2024 through March 2025 identified that residents had dietary concerns in March 2024, May 2024, June 2024, July 2024, September 2024, October 2024, November 2024, December 2024, February 2025, and March 2025. Residents had concerns with staff using foul language in June 2024 and December 2024. Additionally, Residents had concerns with Nurse Aides for answering call bells, cell phone use on the units, breaks being taken at the same time, and the inability to locate staff when needed. During a Resident Council meeting conducted on 4/16/25 at 1:35 PM it was identified that the residents have been complaining about food issues for the past 2 years. Issues included taste, ability to get some items regularly (eggs), temperature, and liquid from vegetables not being drained and running into other items served on the same plate. Further residents identified that call bells were being answered timely while the surveyors were in the building, however 1 resident waited 20 minutes and almost fell, and several residents complained that the call bells were being shut off at the nurses stations. Residents indicated that staff members were using foul language, often could not be found, (indicating a staff member was found sleeping in a cubby) and that the noise level by staff was loud. Interview with the Administrator on 4/22/2025 at 2:48 PM identified that although in-services and monitoring occurred by staff management, he would possibly look into a food committee and that resident concerns should not occur on a continuing basis. Interview with the DNS on 4/22/2025 at 3:10 PM identified that she had conducted observations and had in-services, however, she would look into further measures to assist with resident satisfaction. Review of the Concern, Complaint and/or Grievance policy dated 11/25/2016, directed, in part, that it is the facility's intention to actively seek a resolution to a concern, complaint/grievance.

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	04/22/2025

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 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to manage his or her financial affairs. Based on review of the facility's Personal Funds Account, review of facility policy, and interviews, the facility failed to provide access to personal funds outside of the facilities posted banking hours. The findings include: Observation on 4/22/2025 at 11:00 AM identified a sign posted at the reception desk indicating banking hours were Monday through Friday from 8:00 AM to 7:00 PM, and Saturday and Sunday from 9:30 AM to 3:30 PM. Interview with the Business Office Manager on 4/22/2025 at 11:21 AM identified that residents had access to their personal bank account funds daily from 8:00 AM to 7:00 PM. The Business Office Manager reported that a petty cash lock box was kept at the reception desk to allow residents access to their funds when she was not available. She noted that, aside from herself, three facility receptionists had keys to the petty cash box. The Business Office Manager identified residents were unable to access their personal funds outside of the designated banking hours. Interview with Receptionist #1 on 4/22/2025 at 1:07 PM identified that the facility maintains a petty cash lock box for residents to access funds when the Business Office Manager was unavailable. She indicated that banking hours were Monday through Friday from 8:00 AM to 7:00 PM and Saturday and Sunday from 9:30 AM to 3:30 PM. Any resident requesting funds outside if this timeframe would have to wait until the following day when the receptionist or Business Office Manager were onsite. Interview with the Facility Administrator on 4/22/2025 at 2:57 PM identified that the only staff members who had access to the petty cash lock box were the receptionist and the Business Office Manager. Review of the Statement of Resident's Rights Regarding Personal Funds dated 7/2018 failed to indicate how residents get access to funds after their posted banking hours.

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	04/22/2025

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 0568 Level of Harm - Potential for minimal harm Residents Affected - Some	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the facility's Personal Funds Account, review of facility documentation, and interviews for 13 of 22 sampled residents (Resident #3, #11, #14, #22, #30, #39, #45, #48, #49, #60, #62, #66, and #71), the facility failed to provide residents and/or their representatives with quarterly financial statements for personal funds held by the facility. The findings include: 1. Resident #3's diagnoses included osteoporosis, vertebral wedge compression fracture, and a cerebral infarction. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #3 had a Brief Interview for Mental Status (BIMS) score of 11, indicating moderate cognitive impairment. Resident #3 had clear speech and could usually understand and be understood by others. Resident #3 was responsible for him/herself. 2. Resident #11's diagnoses included dementia, dysphasia, and traumatic brain injury. The quarterly MDS assessment dated [DATE] identified Resident #11 had a BIMS score of 2 indicating severe cognitive impairment. Resident #11 was rarely able to understand but usually understood others. Resident #11 was conserved. 3. Resident #14's diagnoses included anxiety, depression, and muscle weakness. The quarterly MDS assessment dated [DATE] identified Resident #14 had a BIMS score of 15 indicating no cognitive impairment. Resident #14 had clear speech and could understand and be understood by others. Resident #14 was conserved. 4. Resident #22's diagnoses included depression, ataxia, and aphasia. The quarterly MDS assessment dated [DATE] identified Resident #22 was unable to complete a BIMS. Resident #22 was unable to speak but usually understood others. Resident #22 was conserved. 5. Resident #30's diagnoses included depression, epilepsy, and hemiplegia. The quarterly MDS assessment dated [DATE] identified Resident #30 had a BIMS score of 15 indicating no cognitive impairment. Resident #30 had clear speech, was able to be understood, and could understand others. Resident #30 was conserved. 6. Resident #39's diagnoses included cerebral aneurysm, hemiplegia, and cerebral infarction. The quarterly MDS assessment dated [DATE] identified Resident #39 had a BIMS score of 9 indicating moderate cognitive impairment. Resident #39 had clear speech, could understand and be understood by others. Resident #39 was conserved. 7. Resident #45's diagnoses included cerebral dementia, atrial fibrillation, and heart failure. (continued on next page)

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	04/22/2025

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 0568 Level of Harm - Potential for minimal harm Residents Affected - Some	The quarterly MDS assessment dated [DATE] identified Resident #45 had a BIMS score of 6 indicating severe cognitive impairment. Resident #45 had clear speech, could be understood by others, and usually understood others. Resident #45 was conserved. 8. Resident #48's diagnoses included depression, epilepsy, and hemiplegia. The quarterly MDS assessment dated [DATE] identified Resident #48 had a BIMS score of 14 indicating cognition was intact. Resident #48 had clear speech, was understood, and usually understood others. Resident #48 was conserved. 9. Resident #49's diagnoses included dementia, hypertension, and malnutrition. The quarterly MDS assessment dated [DATE] identified Resident #49 was unable to complete a BIMS. Resident #49 had clear speech and could usually understand and be understood by others. Resident #49 was conserved. 10. Resident #60's diagnoses included anxiety, depression, and dysphasia. The quarterly MDS assessment dated [DATE] identified Resident #60 had a BIMS score of 13 indicating cognition was intact. Resident #60 had clear speech, was understood, and usually understood others. Resident #60 was conserved. 11. Resident #62's diagnoses included muscle weakness, kidney failure, and diabetes. The quarterly MDS assessment dated [DATE] identified Resident #62 had a BIMS score of 15, indicating no cognitive impairment. Resident #62 had clear speech, was able to be understood, and could understand others. Resident #62 was conserved. 12. Resident #66's diagnoses included bilateral contractures, muscle weakness, and depression. The quarterly MDS assessment dated [DATE] identified Resident #66 had a BIMS score of 12 indicating moderate cognitive impairment. Resident #66 had clear speech, could understand and be understood by others, and was responsible for him/herself. 13. Resident #71's diagnoses included cerebral dementia, depression, and anxiety. The quarterly MDS assessment dated [DATE] identified Resident #71 had a BIMS score of 6 indicating severe cognitive impairment. Resident #71 had clear speech, could be understood by others, and usually understood others. Resident #71 was conserved. Interview with Resident #22's Power of Attorney (POA) on 4/16/2025 at 12:18 PM identified that the POA did not receive quarterly banking statements from the facility. (continued on next page)

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	04/22/2025

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 0568 Level of Harm - Potential for minimal harm Residents Affected - Some	Interview with the Business Office Manager on 4/22/2025 at 11:21 AM identified that she did not send quarterly statements to Resident #22's POA. In addition to Resident #22, it was determined the facility did not provide quarterly statements to Resident #3, #11, #14, #30, #39, #45, #48, #49, #60, #62, #66, and #71 for whom they managed personal funds. The Business Office Manager stated she did not send out the statements because she believed they were unnecessary since she was the representative payee. Re-interview with Resident #22's Power of Attorney (POA) on 4/22/2025 at 2:28 PM identified that family members had requested statements in the past, but that they had not received them. Interview with the Administrator on 4/22/2025 at 2:57 PM identified the Administrator was unaware that some residents or their representatives were not receiving quarterly statements. The Administrator stated this was due to a breakdown in training and orientation for the Business Office Manager role. Review of The Resident [NAME] of Rights directed, in part, residents have the right to a quarterly review of their account.

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	04/22/2025

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 0570 Level of Harm - Potential for minimal harm Residents Affected - Many	Assure the security of all personal funds of residents deposited with the facility. Based on review of the facility's Personal Funds Account, review of facility documentation, and interviews, the facility failed to ensure necessary coverage through a surety bond for the Resident Trust Accounts. The findings include: On 4/22/2025 at 11:21 AM, interview and review of the Resident Trust Account (RTA) balances with the Business Office Manager indicated that the RTA balance for the period of 10/1/2024 to 3/31/2025 ranged from $50,280.00 dollars to $119,643.34. During this time period, the RTA exceeded the surety bond value every month. The RTA balance for the period of 10/1/2024 - 10/31/2024 indicated a balance ranging from $73,816.80 to $114,629.60. The RTA balance for the period of 11/1/2024 - 11/30/2024 indicated a balance ranging from $75,505.75 to $99,861.55. The RTA balance for the period of 12/1/2024 - 12/31/2024 indicated a balance ranging from $76,472.47 to $122,434.28. The RTA balance for the period of 1/1/2025 - 1/31/2025 indicated a balance ranging from $50,280.00 to $119, 643.34. The RTA balance for the period of 2/1/2025 - 2/28/2025 indicated a balance ranging from $51,484.47 to $94, 160.22. The RTA balance for the period of 3/1/2025 - 3/31/2025 indicated a balance ranging from $56,521.97 to $100,813.85. Review of the facility's surety bond identified the RTA was insured for $80,000 effective October 30,2024 through October 30, 2025. Interview with the Business Office Manager on 4/22/2025 at 2:28 PM identified that she was not responsible for reviewing the monthly statements and monitoring the balances to ensure the account did not exceed the surety bond limit value. Interview with the Regional Director of Accounts Receivable on 4/22/2025 at 2:48 PM identified that the previous Director of Accounts Receivable would have been responsible for reconciling the monthly statements and would have been aware of the account balances, however, they had left the organization approximately one month earlier. She added the Surety Bond was managed at the corporate level, and that she would notify the cooperate office and let them know that the current bond value of $80,000.00 did not fully cover the RTA's maximum account balance. Interview with the Facility Administrator on 4/22/2025 at 2:57 PM identified that he was unaware of who was responsible for reviewing the RTA statements and monitoring the balances to ensure they did not exceed the surety bond limit value. He additionally was unaware that the RTA account frequently surpassed the $80,000 coverage limit of the bond.

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	04/22/2025

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review for 1 of 3 residents, (Resident #19), sampled for advanced directives, the facility failed to identify a code status in the electronic health record. The findings included: Resident #19's diagnoses included chronic obstructive pulmonary disease, anemia and dysphagia. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #19 was moderately cognitively impaired, and required substantial/ maximal assistance with dressing, eating and repositioning in bed. The Resident Care Plan dated 2/10/25 identified Resident #19's advance care planning code status was DNR/DNI/RNP (do not resuscitate, do not in tubate, Registered Nurse may pronounce). Interventions included a physician's order and documentation of the resident's code status and advance care planning in the resident's clinical record. The Resident Advance Directives form signed 3/7/24 identified Resident #19 had a code status of do not resuscitate (DNR). The physicians' orders failed to identify a code status. Interview and record review with Licensed Practical Nurse (LPN) #4 on 4/15/25 at 1:29 PM identified it is facility policy for advance directives to be in the electronic health record, entered by the charge nurse upon admission and passed on in report verbally. LPN #4 further identified in an emergency the protocol would be to check the electronic health record first. Resident #19's electronic record failed to identify code status. Interview and record review with the Director of Nursing (DNS) on 04/15/25 at 1:33 PM identified it is facility policy for advance directives to be in the chart and in the electronic health record, input by the RN supervisor within 24 hours of admission without exception. The DNS could not identify Resident #19's code status in the electronic health record, stating in an emergency, the nurse would have to check the physical chart. The Advance Directives Policy directed in part that an advance directive shall be displayed prominently in the medical record.

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	04/22/2025

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 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 clinical records, facility documentation, facility policy, and interviews for 2 of 3 sampled residents, (Resident #28 and Resident #63), reviewed for abuse, for Resident #28, the facility failed to report an allegation of misappropriation of funds, and for Resident #63, the facility failed to report an allegation of neglect in a timely manner. The findings include: 1. Resident #28's diagnosis included depression, stroke, and spinal cord dysfunction. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #28 had a Brief Interview of Mental Status (BIMS) score of 14 indicating cognition was intact, was independent with eating after set up, was dependent on staff for dressing and transfers, and used a wheelchair for mobility. The Resident Care Plan dated 9/10/2024 identified Resident #28 had impaired Activities of Daily Living (ADL's) requiring assistance related to a history of a stroke. Interventions directed staff to assist with bathing, dressing, and personal hygiene. Interview with Resident #28 on 4/14/2025 at 11:07 AM identified that he/she had $40.00 missing from the bedside table that was going to be used to pay the hairdresser. Resident #28 indicated that due to the missing money, he/she was unable to attend the appointment. Further the missing money had been reported NA #5 approximately 6 months ago, but the facility had taken no action. Interview with Nurse Aide (NA) #5 on 4/16/2025 at 2:44 PM identified that Resident #28 requested her help to get his/her money from inside a cell phone case. When NA #5 opened the case, she explained to Resident #28 that there was no money inside. Resident #28 stated he/she was sure the money had been stored in the cell phone case. NA #5 indicated that she searched for the money in the resident's room, but no money was found. NA #5 stated she reported the incident to either the charge nurse or nursing supervisor, though she could not recall exactly to whom she reported the incident. Additionally, NA #5 stated that she had also completed a written statement and gave it to the nursing supervisor. Interview with LPN #7 on 4/16/2025 at 2:57 PM identified she did not recall being informed about the missing money. Interview with RN #1 on 4/16/2025 at 3:16 PM identified she did not recall NA #5 reporting the missing money. Re-interview with RN #1 on 4/17/2025 3:04 PM identified that the facility failed to provide any written documentation for the missing money being reported or investigated. An interview with the Administrator on 4/17/2025 at 3:08 PM identified that he was unaware of Resident #28's allegation of misappropriation so he would not have reported it to the state agency. (continued on next page)

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	04/22/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Director of Nursing Services (DNS) on 4/17/2025 at 5:51 PM identified that she could not explain why the policy for misappropriation [abuse] was not followed and the allegation was not immediately reported to the state agency. Subsequent to Surveyor inquiry, a reportable event was reported to the Department of Public Health (state agency) on 4/16/2025 and the police were notified. 2. Resident #63's diagnoses included dementia, adjustment disorder with anxiety, depressed mood and irritable bowel syndrome. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #63 had a Brief Interview for Mental Status (BIMS) score of 1 indicating severe cognitive impaired and required partial moderate assistance with transfers, substantial maximum assistance with bed mobility, and was totally dependent on staff for toileting. Additionally, Resident #63 was frequently incontinent of bowel and bladder. The elimination Resident Care Plan in effect on 9/26/2023 identified Resident #63 was incontinent of bowel and bladder related to impaired cognition and mobility. Interventions included toileting and incontinent care every 2 hours and as needed, disposable adult incontinence brief, and applying barrier skin protection following incontinent care. Review of the grievance concern form dated 10/6/2023 identified that on 9/26/2023 a family member had reported to LPN #3 (the day of the incident) that Resident #63 was neglected for many hours and lacked incontinence care, position changes, or hygiene. When Resident #63's brief was changed, it was noted to have a foul odor, was saturated through to his/her clothes and seat cushion, and a new irritation and open areas were noted. Further review of the grievance form identified that the incident had been reported to the Supervising Registered Nurse, (RN #1) on 9/29/23 (3 days after the initial allegation) and to the Director of Nursing (DNS) on 10/3/23 (7 days after the initial allegation). Review of the Reportable Event form dated 10/6/2023 identified a family member reported to the social worker that there was a delay in providing incontinence care to Resident #63 on 9/26/23. Further, the incident had already been reported to a staff member on 9/26/2023. The Reportable Event form indicated that although the incident had been reported on 9/26/2023, the allegation had not been reported to the state agency until 10/6/23 (3 days after the grievance form was completed on 10/6/2023 and 10 days following the initial allegation on 9/26/2023). An interview with the DNS on 4/17/25 at 10:28 AM identified she could not explain why the allegation of neglect had not been reported to the state agency, per the facility policy, within the requirement of 2 hours following when the neglect was first known by staff. Review of the abuse policy directed, in part, an allegation must be reported immediately to the administrator/DNS and will be entered into the DPH (state agency) reporting system (FLIS) within 2 hours.

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	04/22/2025

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 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 clinical records, facility documentation, facility policy and interviews for 1 of 2 sampled residents (Resident #28) reviewed for personal property, the facility failed to investigate an allegation of misappropriation of funds, and for the only sampled resident (Resident #63) reviewed for abuse, the facility failed to thoroughly investigate an allegation of neglect, investigate an allegation of neglect in a timely manner, and prevent access to the resident by the staff member following the allegation of neglect. The findings include: 1. Resident #28's diagnosis included depression, stroke, and spinal cord dysfunction. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #28 had a Brief Interview of Mental Status (BIMS) score of 14 indicating cognition was intact, was independent with eating after set up, was dependent on staff for dressing and transfers, and used a wheelchair for mobility. The Resident Care Plan dated 9/10/2024 identified Resident #28 had impaired Activities of Daily Living (ADL's) requiring assistance related to a history of a stroke. Interventions directed staff to assist with bathing, dressing, and personal hygiene. Interview with Resident #28 on 4/14/2025 at 11:07 AM identified that he/she had $40.00 missing from the bedside table that was going to be used to pay for a hairdresser appointment. Resident #28 indicated that due to the missing money, he/she was unable to attend the appointment. Further the missing money had been reported NA #5 approximately 6 months ago, but the facility had taken no action. Interview with Nurse Aide (NA) #5 on 4/16/2025 at 2:44 PM identified that Resident #28 requested her help to get his/her money from inside a cell phone case. When NA #5 opened the case, she explained to Resident #28 that there was no money inside. Resident #28 stated he/she was sure the money had been stored in the cell phone case. NA #5 indicated that she searched for the money in the resident's room, but no money was found. NA #5 stated she reported the incident to either the charge nurse or nursing supervisor, though she could not recall exactly to whom she reported the incident. Additionally, NA #5 stated that she had also completed a written statement and gave it to the nursing supervisor. Interview with LPN #7 on 4/16/2025 at 2:57 PM identified she did not recall being informed about the missing money. Interview with RN #1 on 4/16/2025 at 3:16 PM identified she did not recall NA #5 reporting the missing money. Re-interview with RN #1 on 4/17/2025 3:04 PM identified that the facility failed to have any written documentation for Resident #28's missing money being reported or investigated. An interview with the Administrator on 4/17/2025 at 3:08 PM identified that he was unaware of Resident #28's allegation of misappropriation so the facility would not have investigated the circumstances surrounding the missing money. (continued on next page)

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	04/22/2025

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Director of Nursing Services (DNS) on 4/17/2025 at 5:51 PM identified that she could not explain why the policy was not followed and the allegation was not immediately investigated. Subsequent to Surveyor inquiry, a reportable event form was completed, and the facility began their investigation into the missing money. 2. Resident #63's diagnoses included dementia, adjustment disorder with anxiety, depressed mood and irritable bowel syndrome. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #63 had a Brief Interview for Mental Status (BIMS) score of 1 indicating severe cognitive impaired and required partial moderate assistance with transfers, substantial maximum assistance with bed mobility, and was totally dependent on staff for toileting. Additionally, Resident #63 was frequently incontinent of bowel and bladder. The elimination Resident Care Plan in effect on 9/26/23 identified Resident #63 was incontinent of bowel and bladder related to impaired cognition and mobility. Interventions included toileting and incontinent care every 2 hours and as needed, disposable adult incontinence brief, and applying barrier skin protection following incontinent care. Review of the grievance concern form dated 10/6/23 identified that on 9/26/23 a family member had reported to LPN #3 (the day of the incident) that Resident #63 was neglected for many hours and lacked incontinence care, position changes, or hygiene. When Resident #63's brief was changed, it was noted to have a foul odor, was saturated through to his/her clothes and seat cushion, and a new irritation and open areas were noted. Further review of the grievance form identified that the incident had been reported to the Supervising Registered Nurse, (RN #1) on 9/29/23 (3 days after the initial allegation) and to the Director of Nursing (DNS) on 10/3/23 (7 days after the initial allegation). Review of the Reportable Event form dated 10/6/23 identified a family member reported to the social worker that there was a delay in providing incontinence care to Resident #63 on 9/26/23. Further, the incident had already been reported to a staff member on 9/26/23. The Reportable Event form indicated that although the incident had been reported on 9/26/23, the allegation had not been reported to the state agency until 10/6/23 (3 days after the grievance form was completed and 10 days following the initial allegation). Review of the facility investigation attached with the Reportable Event, conducted by the DNS included written statements. Review of the written statements identified NA #6's statement was dated 10/4/25, LPN #3's statement was dated 10/4/25, RN #1's statement was dated 10/6/25, NA #7's statement was dated 10/10/25, and NA #8's statement was dated 10/10/25. None of the statements reviewed indicated that the investigation had been started until 8 days after the allegation had been reported to staff. RN #1's written statement dated 10/6/23 identified that on 9/26/23 Resident #63's family member mentioned a delay in care a day in the last week, a skin check was performed on 9/27/23, and an order was entered to treat redness of the skin. (continued on next page)

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	04/22/2025

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the DNS on 4/16/25 at 2:24 PM identified that NA #6 had not been immediately suspended at the time of the allegation, per the facility policy, and had subsequently been suspended on 10/7/23, 10/8/23, and 10/9/25 (10 days after the allegation was reported and allowing access to the resident prior to determining an outcome). The DNS further indicated that on 10/9/23 the family member of Resident #63 called the facility and stated they felt the NA involved could continue to work with Resident #63 and the incident was caused by a lack of communication. Resident #63's care plan was updated to include a toileting plan and rest time during the day. The DNS identified that the alleged neglect was unsubstantiated. Re-interview with the DNS on 4/17/25 at 10:28AM identified that the investigation consisted of incomplete investigation areas for a psychosocial service summary of interview with residents, summary of interviews with staff, summary of interview with resident's roommate, summary of interview with resident's family member, summary of interview with the alleged perpetrator, summary of interview with other resident's/family members care for by the alleged perpetrator and the conclusion of the event. Additionally, a summary of the investigation and the root cause/conclusion and corrective actions was missing on the investigation form. The DNS failed to identify a summary of the investigation or a conclusion that determined whether the allegation of neglect was or was not substantiated. The DNS indicated because the family member changed their mind about the allegation and felt comfortable with the alleged NA working with Resident #63 there was no neglect and no reason to continue the investigation. The DNS could not identify why care was not given. Review of the abuse policy directed, in part, all reports of abuse, neglect, misappropriations of resident's property and injuries of known or unknown source shall be promptly and thoroughly investigated by facility management. An incident of abuse neglect, misappropriation of resident's property or injury of known or unknown source, the Administrator or designee will appoint a member of management to investigate the alleged incident. Employees of this facility who have been accused of the alleged resident abuse will be suspended from duty until the results of the investigation have been reviewed by the Administrator.

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	04/22/2025

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and review of facility policy for 5 of 5 residents, (Resident #26, #30, #50, and #70), reviewed for Resident Care Planning (RCP), the facility failed to provide documentation that quarterly Resident Care Conferences (RCCs) were held and failed to ensure revisions to the Resident Care Plan (RCP) within 7 days after completion of the resident's comprehensive assessment. The findings include: 1. Resident #26's diagnoses included Parkinson's Disease, dementia, and hypertensive heart disease with heart failure. Review of the Minimum Data Set (MDS) assessment dated [DATE] identified Resident #26 was dependent with personal hygiene, dressing, and rolling left and right. Review of the MDS assessment dated [DATE] identified Resident #25 required substantial assistance with personal hygiene and dressing, and moderate assistance with rolling left and right. a. The RCP in effect from 11/12/2024 through 4/17/2025 failed to reflect the changes in the amount of assistance Resident #26 required with Activities of Daily Living (ADL). b. A review of the RCC sign in sheet failed to identify that a Resident Care Conference (RCC) was held following the 1/29/25 MDS assessment. An interview with Social Worker #1 on 4/16/2025 at 10:43 AM identified Resident #26's RCP was last completed on 12/10/2024 and he/she should have received a quarterly RCP in March, 3 months from the 12/10/2024 date. She further identified that the MDS coordinator was responsible for scheduling RCP updates. Social Worker #1 failed to identify why an RCP was not completed for Resident #26 in 2025. Attempts to schedule an interview with the MDS coordinator were unsuccessful as the facility had only remote MDS Coordinators, and no permanent MDS Coordinator in the facility. An interview with the Director of Nursing Services (DNS) on 4/16/2025 at 1:56 PM identified that Resident #26's last care plan meeting was 11/12/2024 and his/her care plan meetings were not being held on a quarterly basis. The DNS further identified no care plan had been completed for Resident #26 after 12/10/2024. The DNS failed to identify why RCCs were not being held on a quarterly basis and why no RCP had been completed in 2025. 2. Resident #30's diagnoses included epilepsy, left sided hemiplegia, and chronic obstructive pulmonary disease. a. The admission MDS assessment dated [DATE] identified Resident #30 had a Brief Interview of Mental Status (BIMS) score of 13 indicating no cognitive impairment, required moderate assistance with upper body dressing and moving from a sitting to lying position, and was dependent with transfers. (continued on next page)

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	04/22/2025

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The quarterly MDS assessment dated [DATE] identified Resident #30 had a Brief Interview of Mental Status (BIMS) score of 13 indicating no cognitive impairment, required maximal assistance with upper body dressing and moving from a sitting to lying position, and was dependent with transfers. a. The RCP in effect from 7/7/2023 through 4/17/2025 failed to reflect the RCP had been revised to include the changes in the amount of assistance Resident #30 required with Activities of Daily Living (ADL). b. A review of the RCC sign in sheets failed to identify that although Resident #30 had MDS assessments on 12/20/2024 and 3/21/2025 that a meeting was held following the assessment or anytime during 2025. An interview with Social Worker #1 on 4/16/2025 at 10:43 AM identified Resident #30's did not have an RCP completed in 2025 and prior RCPs were not consistently completed within 7 days of his/her MDS submission. Further, she identified the MDS coordinator was responsible for scheduling RCP updates. Social Worker #1 failed to identify why an RCP was not completed for Resident #30 in 2025. 3. Resident #50's diagnoses included atherosclerotic heart disease with angina pectoris, chronic obstructive pulmonary disease, and major depressive disorder. a. The quarterly MDS assessment dated [DATE] identified Resident #50 had a Brief Interview of Mental Status (BIMS) score of 15 indicating no cognitive impairment, was independent with upper and lower body dressing, moving from a sitting to lying position, and wheeling 150 feet in a manual wheelchair. The quarterly MDS assessment dated [DATE] identified Resident #50 had a Brief Interview of Mental Status (BIMS) score of 15 indicating no cognitive impairment, required touching assistance with upper body dressing and moving from a sitting lying position, required moderate assistance with lower body dressing. The RCP in effect from 2/28/2023 through 4/17/2025 failed to reflect the RCP had been revised to include a review and revision to cardiac status and failed to include changes in the amount of assistance Resident #50 required with Activities of Daily Living (ADL). b. A review of the RCC sign in sheets for the time period of 1/1/2024 through 4/17/2025 identified RCP meetings for Resident #50 were held on 2/1/2024, 7/26/2024, 11/4/2024, and 2/20/2025. A review of MDS submissions for Resident #50 identified that MDSs were completed on 2/21/2024, 3/29/2024, 4/25/2024, 7/24/2024, 10/21/2024, and 1/27/2025. An interview on 4/22/2025 at 3:08 PM with Social Worker #2 identified that RCPs should be completed between 7 to 10 days after the MDS was completed. She further identified that although an RCP was completed on 5/9/24 (not within the allotted time), the facility failed to meet the requirement for RCP meetings for 6 out of 7 opportunities (2/21/2024, 03/29/2024, 4/25/2024, 7/24/2024, 10/21/2024, and 1/27/2025). 4. Resident #70's diagnoses included multiple sclerosis, depression, and chronic pain. (continued on next page)

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	04/22/2025

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. The admission MDS assessment dated [DATE] identified Resident #70 had a Brief Interview of Mental Status (BIMS) score of 15 indicating no cognitive impairment, was dependent with lower body dressing, and was dependent on staff wheeling 150 feet in a manual wheelchair. The quarterly MDS assessment dated [DATE] identified Resident #70 had a BIMS score of 15 indicating no cognitive impairment, required substantial assistance with lower body dressing, and required partial assistance with wheeling 150 feet in a manual wheelchair. The RCP in effect from 4/9/2024 through 4/17/2025 failed to identify that a review and revision of the care plan related to multiple sclerosis and changes in the amount of ADL assistance required by Resident #70 had been completed since admission. b. A review of MDS submissions for Resident #70 identified that MDSs were completed on 6/6/2024, 9/12/2024, 10/3/2024, and 12/31/24. A review of social service progress notes for the time period of 4/1/2024 through 4/17/25 identified RCP meetings for Resident #70 were held on 7/17/2024, 9/12/2024, and 12/6/2024 but failed to meet the time requirement for RCP meetings. The RCC sign in sheets for the time period of 4/1/2024 through 4/17/2025 were requested, however, the facility failed to provide the requested sign-in sheets. An interview on 4/22/25 at 11:47 AM with the former MDS coordinator LPN #5 identified he was responsible for sending a list of Residents needing an RCC and RCP to the social worker and receptionist for scheduling off of a calendar he created. LPN #5 failed to produce a copy of any past calendar for RCC and RCP scheduling and indicated he erased the calendar from his computer at the end of every month. An interview with Social Worker #2 on 4/22/2024 at 3:08 PM identified that there was a facility expectation for RCPs to be revised the same day a resident has a RCC, although quarterly revisions instead are often made the same week, no later than 10 days, but should be completed between 7 to 10 days after a MDS was completed. She further identified RCPs were completed for Resident #70 on 4/9/2024, 7/19/2024, 10/16/2024, and 1/4/2025 and that the facility failed to meet 3 out of 4 opportunities (6/6/2024, 9/12/2024, 10/3/2024) for timely RCP completions. Review of the Facility's Comprehensive Person-Centered Care Plan Policy identified in part that care plans should incorporate identified problem areas, and aid in preventing or decline in a Resident's functional status and/or functional levels. The policy further identified that comprehensive person-centered care plans should be developed within 7 days of a Resident's completed MDS.

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	04/22/2025

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 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 observations, review of clinical records, facility policy, and interviews for the only sampled resident, (Resident #28), reviewed for urinary catheter care, the facility failed to perform weekly skin assessments; for the only sampled resident, (Resident #35), reviewed for positioning, the facility failed to ensure a positioning plan for a resident in a customized wheelchair was followed, for the only sampled resident, (Resident #42), reviewed for a non-pressure skin related condition, the facility failed to report a change in a resident's skin condition to a licensed nurse, and for 2 of 2 sampled residents, (Resident #28 and #63) reviewed for abuse, the facility failed to provide timely incontinent care. The findings included: 1. Resident #28's diagnosis included stroke, spinal cord dysfunction, and hemiplegia. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #28 had a Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive impairment. The Resident required a wheelchair for mobility, was dependent with dressing and all transfers. The Resident Care Plan dated 1/15/2025 identified that Resident #28 was at risk for impaired skin integrity related to a history of skin tears and moisture-associated skin damage. Interventions included the use of a low air loss mattress, repositioning to meet the resident's needs, application of a pressure redistribution device, and staff were to report any new skin changes to the physician or nurse. A physician's order dated 3/17/2025 directed staff to perform weekly skin checks, complete the weekly skin evaluation form, and notify the Registered (RN) of any new findings. Review of clinical record from 3/19/2025 through 4/17/2025 identified staff did not complete weekly skin checks for Resident #28 on 3/26/2025 and 4/16/2025. The Treatment Administration Record (TAR) dated 4/1/2025 through 4/22/2025 identified that LPN #7 had signed that a skin check had been completed on 4/16/2025. Interview and review of clinical record on 4/17/2025 at 9:37 AM with RN #2 identified that the last fully documented weekly skin check for Resident #28 was performed on 4/9/2025 and that LPN #7 had not documented the completion of a Skin Check Evaluation form on 4/16/2025 as signed. Additionally, the skin check scheduled for 3/26/2025 had not been completed. RN #2 failed to identify why the weekly skin checks had not been completed per the physician order. RN #2 indicated that charge nurses were responsible for performing weekly skin assessments and if an assessment could not be completed on the day shift, communication through shift to shift handoff procedure was expected to ensure completion by the subsequent shift. An interview and review of the clinical record with LPN #7 on 4/17/2025 at 10:18 AM identified that she was responsible for the 4/16/2025 weekly skin check but did not complete the skin check. LPN #7 indicated that she had signed the skin check as complete on 4/16/25 but had not completed the skin check evaluation. She reported that she had intended to complete the skin check but was likely interrupted and failed to return to Resident #28 to complete the task. (continued on next page)

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	04/22/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 4/17/2025 at 5:37 PM with the Director of Nursing (DNS) stated that weekly skin checks must be performed by the charge nurse and stated it was unacceptable to document a task as completed without performing the actual task. The DNS identified that a communication breakdown had occurred. Review of the facility's Weekly Skin Audit Policy dated 7/2020 directed, in part, that licensed nurses were required to perform weekly full-body skin audits. Nurses were instructed to initial the TAR to indicate task completion and to complete the Skin Evaluation Assessment. 2. Resident #35's diagnoses included abnormal posture, repeated falls, and end stage renal disease. A Wheeled Mobility Letter of Medical Necessity dated 12/13/24 identified a pelvic belt was provided to Resident #35 for pelvic stabilization and safety while in the wheelchair to reduce any risk of sliding. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #35 had a BIMS score of 3 indicating severe cognitive impairment and required substantial/maximal assistance from staff with transfers, set up clean up assistance with bed mobility, and was unable to walk. The Resident Care Plan dated 2/11/25 identified Resident #35 required modified wheelchair positioning for proper body alignment when out of bed. Interventions included out of bed to a modified wheelchair every morning, and referral to therapy as needed for changes in wheelchair positioning, complaints of pain, or evidence for skin breakdown. The Custom Wheelchair (CWC) Positioning Plan dated 3/21/25 directed the pelvic positioning belt be fastened snug across the resident's hips for proper skeletal alignment, leg rests on during periods of fatigue or being mobilized by a caregiver, and that leg rests could be removed during periods of alertness for wheelchair mobility and tilt the CWC as tolerated. The Nursing Assistant (NA) Care Card dated 3/24/25 identified Resident #35 was to be up out of bed to a CWC, pelvic positioning belt to be placed snug across the resident's hips at all times, and the positioning plan was to be followed. A physician's order dated 4/14/25 directed Resident #35 to be out of bed to a CWC according to the 24-hour positioning plan, head rest in place at all times, place a pelvic positioning belt fastened snug across the hips for proper pelvic positioning and alignment, provide leg rests during periods of fatigue/caregiver assistance for mobility, and remove leg rests during periods of alertness to facilitate use of bilateral lower extremities for wheelchair mobility every shift. Observation on 4/14/25 at 9:47 AM and 4/14/25 at 11:38 AM identified Resident #35 out of bed in the CWC, sitting on a transfer sling, self-propelling in the hallway without the benefit of the positioning belt being fastened and with both leg rests in place and not removed for independent wheelchair mobility. (continued on next page)

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	04/22/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 4/14/25 at 12:03 PM identified Resident #35 self-propelling the CWC in the dining room, sitting on a transfer sling, with the trunk of his/her body in a slouched position, his/her head was approximately 2 inches below the headrest, and without the benefit of a seat belt worn. At 12:08 PM and 12:17 PM Nursing Assistant (NA) #2 approached Resident #35 and with the help of a second NA boosted him/her to a more upright position by utilizing the transfer sling, no belt was noted to be worn or removed for repositioning. Interview and observation with Person #1 on 4/16/25 at 9:50 AM identified Resident #35 in his/her room, out of bed to the CWC, the seatbelt was unbuckled and hanging on the outside of the wheelchair. Person #1 stated he/she pulled the belt out from under the transfer sling that was left under Resident #35 but was unable to fasten it him/herself, and now the seatbelt kept getting caught in the wheelchair wheels. Interview with Licensed Practical Nurse (LPN) #2 on 4/16/25 at 9:59 AM identified NA #2 was responsible for applying Resident #35's seatbelt per the NA Care Card located inside the closet, LPN #2 subsequently applied the seatbelt snugly across Resident #35's lap. Interview and review of the NA Care Card with NA #2 on 4/16/25 at 10:05 AM identified she worked at the facility for about a year, was the regular NA for Resident #35, and never applied Resident #35's seatbelt because it would be a restriction. Additionally, she identified that resident care information was inside the resident's closet. Review of Resident #35's NA Care Card with NA #2 identified a positing plan directing the resident be out of bed to the customized wheelchair, a pelvic positioning belt was to be placed snug across his/her hips at all times, and the positioning plan was to be followed. Additionally, a copy of the physician's order for the pelvic positioning belt was with the NA Care Cark. NA #2 could not identify why she did not follow the Care Card as instructed. Interview with the Director of Rehabilitation on 4/16/25 at 10:41 AM identified Resident #35 had a 24-hour positioning plan that included the belt to be on snug across the lap and failure to follow the plan of care would impede optimal body alignment. Additionally, nursing was responsible to ensure the application of the belt and education was still ongoing. The Customized Wheelchairs Policy directed, in part, the purpose of a CWC was to promote proper body alignment for resident's who are unable to be positioned in a standard wheelchair. 3. Resident #42's diagnosis included osteoporosis with a right arm humerus fracture, muscle weakness, and difficulty walking. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #42 had a Brief Interview for Mental Status (BIMS) score of 12 indicating Resident #42 was moderately cognitively impaired. The Resident required a wheelchair for mobility, was dependent with dressing, bathing, and toileting, and required maximal assistance with bed mobility including sit to stand and chair to bed transfers. The Resident Care plan dated 3/17/2025 identified Resident #42 was at risk for alteration in skin integrity. Interventions included the use of a pressure reduction cushion in the wheelchair, float heels off bed, apply moisture barrier per protocol, and perform a daily skin inspection during morning and evening care; staff were to report any changes in skin integrity. (continued on next page)

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	04/22/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician's order currently in effect directed staff to perform weekly skin checks, complete the weekly skin evaluation, and notify the RN of any new findings. Observation and interview with Resident #42 on 4/14/2025 at 9:47 AM identified Resident #42 awake, in bed, and complaining of redness and inflammation to the buttocks and genital region. Resident #42 reported nursing staff had applied powder to the affected areas twice in one day a few weeks ago, but no further treatment had been provided. Resident #42 reported telling the nurse that the issue still remained, but nothing had been done. Interview with Licensed Practical Nurse (LPN) #7 on 4/16/2025 at 11:13 AM identified that LPN #7 was unaware Resident #42 was experiencing discomfort in the groin and buttocks region. LPN #7 stated she would follow up with Nursing Assistant (NA) #4, who had provided care to the resident earlier that morning. Interview with NA #4 on 4/16/2025 at 11:22 AM identified she had provided bathroom assistance to Resident #42 that morning. NA #4 stated she did not observe redness to the resident's genital area but noted the buttocks were red and raw. NA #4 did not report any skin integrity issues to the LPN or RN. Although NA #4 was aware of the requirement to escalate these types of findings to licensed nursing staff, NA #4 stated she forgot to do so in this instance. Subsequent to surveyor interview, a nurses note dated 4/21/2025, identified genital irritation requiring antifungal treatment and the left buttock wound would be followed by Wound primary care physician. Review of the Incontinent Care Policy dated 3/2021 directed, in part, that staff who are providing incontinent care were expected to immediately report any reddened, abraded, or broken skin areas to the nurse. 4. Resident #63's diagnoses included dementia, adjustment disorder with anxiety, depressed mood and irritable bowel syndrome. A physician's order dated 3/1/25 directed to apply Triad (protective) ointment to the sacral area every day and evening with skin care until seen by the wound nurse. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #63 was severely cognitively impaired with a Brief Interview for Mental Status (BIMS score of 0) and required substantial maximum assistance for personal hygiene, dressing, toileting, bed mobility, and transfers. The Resident Care Plan (RCP) dated 4/5/23 identified Resident #63 had impaired Activities of Daily Living (ADL's). Interventions included to assist Resident #63 with bathing, dressing, hygiene, and transfers, Constant observations by the surveyors on 4/16/25 from 8:46 AM until 12:16 PM identified Resident #63 lying in bed, on his/her back, with the head of the bed raised approximately 90 degrees. Staff failed to provide incontinence care or turning and repositioning, and Resident #63 remained in the same position throughout the observation (3 and ½ hours). (continued on next page)

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	04/22/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with LPN #3 on 4/16/25 at 12:16 PM she was informed that Resident #63 had not received incontinent care or turning and repositioning since the 8:46 AM constant surveyor's observations began. LPN #3 identified that NA #3 was assigned to Resident #63. Interview with NA #3 on 4/16/25 at 12:20 PM identified that she provided Resident #63 with morning care as soon as she came in at 7:00 AM and Resident # 63 was ready for breakfast. Although the surveyors had constant observations of Resident #63, NA #3 stated she had checked Resident #63 at 9:30 AM. During an observation of incontinence care being performed on Resident #63 by NA #3 on 4/16/25 at 12:22 PM an orange color could be seen through the outside of the resident's brief. When Resident #63's brief was removed, it was noted to be saturated and slight redness was noted to the resident's genitals and groin area. Re-interview with NA #3 on 4/16/25 at 2:00 PM identified that incontinent care should be provided to residents every 2-3 hours, but she did not have a chance to go back in to check Resident #63 after the initial incontinence care she had provided at 7:00 AM, and that this was an oversight on her part. NA #3 indicated that staffing was at a normal level as written on the schedule. Review of the Incontinence Care policy revised on 3/21 directed, in part, incontinence care will be provided at a minimum of every 2-3 hours and as soon as possible after episodes of incontinence.

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	04/22/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review for 1 of 3 sampled residents, (Resident #68), reviewed for accidents, the facility failed to follow a post fall care plan for safety interventions. The findings included: Resident # 68 diagnoses included dementia, lack of coordination, and Parkinsonism. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #68 was moderately cognitively impaired, and required partial/moderate assistance with transfers, toileting, and changing position in bed. The Resident Care Plan dated 3/15/25 identified that Resident #68 was a fall/safety risk. Interventions included keeping the bed at the lowest position and place floor pads to each side of bed. The Accident and Incident Reportable Event dated 12/21/24 identified Resident #68 was found on the floor next to the bed on 12/21/24 at 7:30 AM positioned on her/his right shoulder, stating she/he was getting out of bed and slipped due to a tissue that was on the floor. Observations on 4/15/25 at 9:14 AM and 4/16/25 at 5:45 AM identified Resident #68 in bed with a floor mat on the curtain side of the bed, but without the benefit of a floor mat by the window side of the bed. Interview with Registered Nurse (RN) Supervisor #1 on 4/16/25 at 9:33 AM identified the facility policy was for the supervisor to immediately put a post fall intervention in place. The interdisciplinary team would review the supervisors intervention and decide to implement that intervention or come up with a different permanent intervention. Additionally, following a fall, the new intervention was placed on the Nurse Aide (NA) Resident Care Card (inside the resident's closet) so the NA could implement the intervention. The charge nurse was also responsible for checking that interventions which had been put in place were being utilized. Subsequent to surveyor inquiry a second floor mat was placed in Resident #68's room, on the floor, at the bedside by the window. Interview and review of the clinical record on 4/16/25 at 12:23 PM with Licensed Practical Nurse (LPN) #2 identified that she was unaware of what the facility policy was regarding floor mats. On review of the clinical record, LPN #2 indicated she was unsure of what was in the Resident Care Plan but stated interventions were placed in the physicians order. During a record review of Resident #68's physicians orders LPN #2 indicated there was no order for floor mats. Follow up interview with RN #1 on 4/16/25 at 1:32 PM identified there should have been a physicians order for Resident #68's floor mats. Upon clinical record review RN #1 was unable to locate a physicians order. RN #1 indicated, that per the facility policy, a physicians order for floor mats for Resident #63 should have been in place to alert staff of the need to implement the fall intervention. Subsequent to surveyor inquiry a physician's order was put in place on 4/16/25 for bilateral floor mats on the floor next to the bed when the patient was in bed, every shift for safety. (continued on next page)

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	04/22/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Assessing Falls and Their Cause policy directed, in part, documentation in the resident's medical record should include appropriate interventions taken to prevent future falls.

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	04/22/2025

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 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 observations, review of clinical record, facility policy and interviews for the only sampled resident (Resident #133) reviewed for respiratory care, the facility failed to obtain a physician's order for a resident who received oxygen. The findings include: Resident #133 was newly admitted , diagnosis included a fracture of the sacrum, muscle weakness and difficulty walking. The admission assessment dated [DATE] identified Resident #133 was cognitively alert, lungs were clear, denied shortness of breath, and was not on oxygen. The Resident Care Plan initiated on 4/11/2025 identified Resident #133 was at risk for cardiac issues related to hypertension. Interventions included administering oxygen as ordered, administering medications as ordered, and observing for signs and symptoms of cardiac/respiratory distress. Observation of Resident #133 on 4/14/2025 at 12:16 PM identified the administration of oxygen at 2 liters per minute via nasal cannula. Interview and review of the clinical record with LPN #7 identified that she did not know why the resident was receiving oxygen. LPN #7 identified that an order from the physician was required to administer oxygen but was unable to locate an order in the record or on the Medication/Treatment Administration Records. Subsequent to the surveyor inquiry, a physician's order dated 4/14/2024 at 4:42 PM directed staff to titrate Resident #133's oxygen to maintain an oxygen saturation equal to or greater than 90%. Interview with RN #1 on 4/16/2025 at 3:17 PM identified Resident #133's oxygen desaturated unexpectedly over the weekend and oxygen was placed on the resident. Following the placement of oxygen, the licensed nurse should have notified the provider to request an order, however, the weekend fill in RN Supervisor had failed to request an order. Interview with the Director of Nursing (DNS) on 4/17/2024 at 5:37 PM identified that the facility policy required that a nurse must have an order to administer oxygen. She stated it would have been the nurse's responsibility to inform the provider of the situation and request the appropriate order, which the staff would then place in the clinical record. The DNS indicated that moving forward, education would be provided to ensure all staff understand the importance of obtaining an order for administering oxygen. Review of the Oxygen Administration Policy dated 10/2010 directed, in part, staff to verify there is a physician's order and review the order before oxygen administration.

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	04/22/2025

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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and review of facility policy for 2 of 2 residents (Resident#37 and #50) reviewed for choices, the facility failed to provide medically related social services to facilitate discharge. The findings included: 1. Resident # 37 diagnoses included abnormal posture, spinal instabilities, and pressure ulcer of the sacral region. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #37 was cognitively intact, required setup for eating and hygiene and was dependent on staff for toileting, and transfers. Additionally, the MDS identified Resident #37's overall goal was to return to the community and active discharge planning already occurred. The Resident Care Plan dated 2/4/25 failed to identify a discharge plan. Interview with Resident #37 on 4/14/25 at 9:53 AM identified that he/she was waiting for a representative from Money Follows the Person (MFP), (a federal Medicaid program designed to help individuals transition out of nursing homes into home and community-based settings), to see him/her tomorrow so he/she could get back to the community. Interview with Social Worker #1 on 4/16/25 at 12:38 PM identified she was not versed in Money Follows the Person (MFP) because her supervisor oversaw that process. Social Worker #1 indicated that since her supervisor left, [the previous social workers last day was 3/28/25], the facility did not have a Director of Social Work. Additionally, she identified the Rehabilitation Department was helping with discharges since she was only in the facility for 8 hours a week. Social Worker #1 could not identify any discharge plans for Resident #37, or if he/she had MFP. Interview with the Administrator on 4/16/25 at 12:42 PM identified the facility policy for residents with MFP was to have the social worker follow them and assist with the process. Additionally, he identified the new social worker was starting 4/24/25 and until then the facility was pulling it together between the different departments, and he was not aware of any discharge plans for Resident #37. Interview with the Director of Rehabilitation on 4/16/25 at 1:48 PM identified Resident #37 was waiting for MFP, and was highly motivated to be discharged into the community but could not identify if a discharge plan was initiated since the facility did not have a social worker. Interview with Resident #37 on 4/17/25 at 9:45 AM identified no one had spoken to him/her about going home or invited him/her to meetings about discharge planning even though he/she was ready to go bacl to the community, and aside from setting up housing there was nothing keeping him/her in the facility. Additionally, Resident #37 identified that the case worker from MFP was supposed to come see him/her on 4/15/25 but never showed up for the meeting. (continued on next page)

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	04/22/2025

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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Community Care Case Manager for MFP on 4/17/25 at 12:19 PM identified Resident #37's application was started 3/9/25, a case worker was supposed to come out 4/15/25, for the initial assessment but rescheduled to 4/24/25 and a message had been left with the receptionist due to the facility's lack of a social worker. Interview with the DNS on 4/17/25 at 12:39 PM identified she was not aware Resident #37 was highly motivated to be discharged , not aware of any MFP visits set up or rescheduled visits, identifying it was the responsibility of the social worker to follow up and it was missed due to lack of communication. Interview with the Administrator on 4/22/25 at 10:33 AM identified that in the absence of a Director of Social Work he was stepping in, even though he had a bachelor's degree in business administration and not in social work. Additionally, he identified there was a social worker in the facility one day a week but residents with MFP were falling through the cracks. Follow up interview with Resident #37 on 4/22/25 at 12:06 PM identified that although the MFP case worker had notified the facility that Resident #37's meeting was to be rescheduled, he/she had never been notified about the rescheduled MFP appointment, and no one in the facility had been speaking to him/her regarding discharge. 2. Resident #50's diagnoses included atherosclerotic heart disease with angina, chronic obstructive pulmonary disease, and major depressive disorder. The Resident Care Plan (RCP) dated 7/15/2024 identified Resident #50's discharge planning included working with Money Follows the Person (MFP) to return to the community. Interventions included collaborating with the Interdisciplinary Team (IDT), resident, and family to collaborate on a plan, goals, and progress, and to set up home care as ordered. The quarterly MDS assessment dated [DATE] identified Resident #50 had a Brief Interview of Mental Status (BIMS) score of 15 indicating no cognitive impairment, was independent with upper and lower body dressing and chair/bed to chair transfers and required touching assistance when walking 150 feet. An interview with Resident #50 on 4/14/2025 at 10:42 AM identified he/she wanted to discharge from the facility using the MFP program and was informed by the facility there was no one that could assist with his/her request. An interview on 4/16/2025 at 2:15 PM with the Director of Nursing Services identified she was not aware Resident #50 wanted to use the MFP program and stated she would look into Resident #50's request. Subsequent to surveyor inquiry, on 4/19/2025 at 11:56 AM, a facility representative spoke with Resident #50, and he/she relayed the location to where he/she wished to be discharged . An interview on 4/22/2025 at 1:43 PM with the Regional Clinical Registered Nurse (RN) #6 identified she was not aware of what the process was when a Resident had an MFP request but identified Social Work should be responsible for all MFP requests. RN #6 further indicated the facility had no MFP policy. (continued on next page)

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	04/22/2025

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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the Administrator on 4/22/25 at 10:33 AM identified he was aware that staff was not assisting residents with MFP requests due to being short staffed, and stated it is falling through the gap. An interview with Social Worker #2 on 4/22/2025 at 1:45 PM confirmed there was no MFP policy and identified social workers would assist residents with identifying if they would benefit from MFP and assisting them with filling out the paperwork. Further she identified that once social work mailed a resident's paperwork to MFP a scheduler would call within a couple of days to arrange a meeting, after which the social worker met with the MFP Case Manager. Social Worker #2 identified the facility received notification in November of 2024 that Resident #50 needed to submit a voucher to MFP, but the facility failed to assist him/her in sending the voucher and instead informed the resident there was no housing manager at the facility to help him with MFP. Social Worker #2 failed to identify why social work had not assisted Resident #50 with his/her discharge request. The facility did not have a policy on Money Follows the Person discharges. The Process for Discharge policy directed, in part, that social services set up services and developed a discharge care plan (in the absence of social services, nursing, or MDS was to fill in). The social worker job description identified duties and responsibilities included in part, participating in discharge planning, development of social care plans and resident assessments.

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	04/22/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and facility policy for medication storage and labeling, the facility failed to ensure medication carts were locked when unattended and narcotics were secured properly. The findings include: 1. An observation on 4/14/2025 at 10:00 AM identified an unattended and unlocked medication cart outside the door of room [ROOM NUMBER] in the hallway. Two unsupervised residents were in the hallway, 1 resident rolled past the unlocked cart in his/her wheelchair. An interview with Licensed Practical Nurse (LPN) #1 on 4/14/25 at 10:13 AM identified that she forgot to lock the medication cart before entering a different room to provide routine care for a resident because she was rushing. She indicated she was aware of the facility policy to lock medication carts when not in use, not in view, and unattended. 2. An observation on 4/14/2025 at 11:22 AM identified an unattended and unlocked medication cart and an unattended and unlocked treatment cart in the Frog Lane hallway. An observation of the treatment cart with LPN #1 identified that multiple Resident prescription and non-prescription medications were in the unlocked treatment cart. An interview with LPN #1 on 4/14/2025 at 11:22 AM identified that she forgot to lock both carts after use. She further identified that she was aware of the facility policy to lock medication carts and treatment carts when not in use, not in view, and unattended. 3. An observation on 4/15/2025 at 8:04 AM identified the Frog Lane treatment cart was unlocked. One resident was present in the hallway. An inspection of the Frog Lane treatment cart drawers with LPN #2 identified nystatin and other resident medications present in the cart but there were no narcotics. An interview with LPN #2 on 4/15/2025 at 8:04 AM identified that she just got to the facility and should have locked the cart. She further identified that she was aware of the facility policy to lock medication carts and treatment carts when not in use, not in view, and unattended. 4. An observation on 4/16/2025 at 5:15 AM identified the Frog Lane medication cart was unlocked. One resident was watching tv in the activity room and there were no residents in the hallway. An interview with LPN #6 identified that she forgot to lock the cart. She further identified that she was aware of the facility policy to lock medication carts when not in use, not in view, and unattended. 5. An observation on 4/16/2025 at 5:23 AM identified the second floor [NAME] medication cart was unlocked. There were no residents in the hallway. (continued on next page)

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	04/22/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with Registered Nurse (RN) #5 identified that many nurses don't lock the carts and [although this was not observed by the surveyor], indicated nurses keep keys to the medication carts in the cart itself. She further stated that there had not been a recent in-service provided to nurses locking medication carts when leaving them unattended. She identified that she was aware of the facility policy to lock medication carts when not in use, not in view, and unattended. RN #5 failed to identify a reason why the second floor medication cart was left unattended and unlocked. 6. An observation on 4/16/2025 at 5:41 AM identified the [NAME] Road medication cart was unattended and unlocked. Four unidentified pills were on top of the cart in a white medication cup. No residents were near the [NAME] Road medication cart. An interview with RN #5 identified that the cart was unlocked and should be locked per policy. Subsequent to surveyor inquiry the medication cup with the unidentified medications was placed into the medication cart and locked. 7. An interview with the Director of Nursing Services (DNS) on 4/16/2025 at 2:18 PM identified that it was permissible for medication carts to be unlocked if a nurse has visual contact with the cart, but once a nurse walked away, the cart should have been locked. The DNS indicated that nurses do receive education on locking medication carts. Subsequent to surveyor inquiry the DNS stated she will add the issue of unlocked medication carts to a QAPI plan and perform audits. Review of the facility's Medication Administration Policy identified in part that keys to the medication carts should be in the possession of the nurse at all times, carts are never to be left unattended in resident care areas, and when not in full view and in control of the nurse the cart, must remain locked.

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	04/22/2025

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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interviews, and review of facility policy for the only sampled Resident, (Resident #30), reviewed for dental services, the facility failed to accurately assess the residents oral status upon admission, failed to include a comprehensive Resident Care Plan (RCP) related to oral status, failed to code the Minimum Data Set (MDS) accurately related to dentition, and failed to ensure dental services were provided, as required, according to payor type. The findings include: Resident #30's diagnoses included epilepsy, left sided hemiplegia, and chronic obstructive pulmonary disease. A. The Nursing Clinical admission assessment dated [DATE] identified Resident #30 had all his/her own teeth, did not have dentures or partials, but failed to include an examination of Resident #30's oral/dental status. B. Review of the RCP in effect from 7/7/2023 through 4/17/2025 failed to address Resident #30's edentulous (without teeth) status. C. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #30 had a Brief Interview of Mental Status (BIMS) score of 13 indicating no cognitive impairment, required moderate assistance with oral hygiene, but failed to identify that Resident #30 was edentulous. All Subsequent MDS assessments failed to identify that Resident #30 was edentulous. D. Review of the clinical record failed to include that Resident #30 had seen by a dentist. An observation and interview with Resident #30 on 4/14/2025 at 12:15 PM identified the resident's oral status as edentulous with no tooth fragments visible in his/her mouth. Resident #30 identified he/she wanted dentures as his/her previous dentures had been thrown away prior to being admitted to the facility. Although the resident indicated he/she had requested assistance from the nurse to replace his/her dentures Resident #30 had never been seen by the dentist or been offered dental services An observation and interview on 4/17/2025 at 12:23 PM with Registered Nurse (RN) #1 and Resident #30, identified Resident #30 was edentulous and that RN #1 was unaware of his/her dental status. Resident #30 verbalized he/she has not had teeth at any point during his/her time at the facility. An interview with Register Nurse (RN) #1 on 4/17/2025 at 12:23 PM identified that both the MDS and Nursing admission Assessment indicated that Resident #30 had all his/her own natural teeth. Further, she identified that both the admitting Licensed Practical Nurse (LPN), and RN performed the admission nursing assessment together and were responsible for the accuracy of the assessment and that the information collected was inaccurate. RN #1 stated there was an in-house dentist within the facility and residents or their family member needed to request a dental visit to be seen. Subsequent to surveyor inquiry, RN #1 stated that she would place Resident #30 on the list to see a dentist. (continued on next page)

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	04/22/2025

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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview and review of the clinical record with the Director of Nursing Services (DNS) and RN #6 on 4/17/2025 at 1:17 PM identified that nursing should complete an assessment of Resident #30's teeth and gums upon admission and before every MDS completion but was unable to explain why further assessments of Resident #30's teeth and gums were not performed. Further, it was the expectation for edentulous residents to receive a consultation with dental services. Review of the clinical record failed to identify that a comprehensive RCP had been developed for oral care since his/her admission, or that Resident #30 had received any dental services, routine or emergency. Subsequent to surveyor inquiry, the DNS stated she would speak with Resident #30 to ask his/her preference for an appointment with the in-house dentist or an outside dentist. Review of the Facility's admission Assessment and Follow Up Policy identified, in part, that a physical assessment should be performed by nurses, including the teeth and gums, for completion of the MDS. Attempts to interview the previous MDS Coordinator were unsuccessful, and the facility did not have a current in-house MDS Coordinator. The facility uses the Resident Assessment Instrument manual for MDS coding and assessments. Review of the Dental Services Policy identified in part that routine and emergency dental services are provided to Residents through a contract with a dentist that comes to the facility monthly. If dentures are damaged or lost, residents will be referred for dental services within 3 days.

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	04/22/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews, record review, and facility policy for 2 residents requiring precautions (Resident #15, #70), who were reviewed for infection control practices, the facility failed to ensure the appropriate precaution sign was placed outside the door for 2 residents with a history of a Multi Drug Resistant Organism (MDRO) and 1 resident with an indwelling medical device. The findings include: 1. Resident #15's diagnoses included hemiplegia and hemiparesis, chronic obstructive pulmonary disease, frequent urinary tract infections, and type 2 diabetes. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #15 had a Brief Interview of Mental Status (BIMS) score of 15 indicating no cognitive impairment, was dependent on upper and lower body dressing and toileting hygiene and required maximal assistance with rolling left and right. A Resident Care Plan (RCP) dated 2/17/2025 identified Resident #15 had a history of a MDRO, Extended Spectrum Beta-Lactamase (ESBL), bacteria in his/her urine. Interventions included monitoring urine color, odor, frequency, burning, intake and output as ordered, and medications as ordered. The RCP focus was marked resolved on 2/17/2025. The RCP lacked a current precautions problem for Enhanced Barrier Precautions for the history of ESBL. A review of physician orders failed to identify that Resident #15 was on any special precautions for the history of ESBL. 2. Resident #70's diagnoses included multiple sclerosis, urinary tract infection, and depression. The quarterly MDS assessment dated [DATE] identified Resident #70 had a BIMS score of 15 indicating no cognitive impairment, required substantial assistance with lower body dressing, required moderate assistance with chair/bed-to-chair transfers, and required partial assistance wheeling 150 feet with a manual wheelchair. A Resident Care Plan (RCP) dated 2/1/2025 identified Resident #70 had a history of Extended Spectrum Beta-Lactamase (ESBL) in his/her urine. Interventions included administering antibiotics, encouraging fluids, and monitoring vital signs. The RCP focus was marked resolved on 1/14/2025. Further, the RCP identified that the resident had an indwelling medical device. Interventions included indwelling medical device care per the facility protocol, and incontinent care every 2 hours and as needed. The RCP lacked a current precautions problem for Enhanced Barrier Precautions for the history of ESBL. A review of physician orders for November 2024 identified an order for ESBL contact precautions. A review physician orders from 3/1/2025 to 4/14/2025 failed to identify that the ESBL contact precautions were in place or that an order for Enhanced Barrier Precautions for Resident #70's indwelling medical device had been placed. (continued on next page)

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	04/22/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. An observation on 4/14/2025 at 11:18 AM identified signage posted outside of Resident #15 and Resident #70's door (roommates), visible prior to entry which stated droplet and contact precautions for unknown Covid-19 with directions that providers and staff must wear a facemask, eye protection, gloves, and a gown for high-contact resident care activities. Further it was identified that LPN #8 was exiting the room wearing gloves and gown, without a mask or eye protection. An interview with LPN #8 on 4/14/2025 at 11:18 AM identified that the contact and droplet sign was placed outside Resident #15 and #70's door because a resident had an MDRO with ESBL. LPN #8 further identified she never wore a face mask or eye protection when entering the room because she knew that the sign incorrectly identified potential Covid-19. She indicated that eye protection might be included on the sign in the event staff were subjected to splashing of bodily fluid while changing the indwelling medical device but did not know why the incorrect signage was posted. A second observation on 4/14/2025 at 11:25 AM identified new signage posted outside of Resident #15 and Resident #70's door stating enteric contact precautions (for fecal infections) with directions that providers and staff must perform hand hygiene before entering the room and wash hands with soap and water after leaving the room, wear gloves whenever entering the room and whenever touching the patients intact skin, surfaces, or articles in close proximity to the resident, wear a gown when entering the room or cubicle and whenever anticipating that clothing will touch the patient or potentially contaminated environmental surfaces, and use patient-dedicated or single use disposable shared equipment or clean and disinfect shared equipment between patients. An interview with LPN #8 on 4/14/2025 at 11:25 AM identified the sign had been changed because the Resident did not have Covid-19. She further identified the precaution sign was being used for Resident #70 and not Resident #15 [although both residents had a history of ESBL]. LPN #8 indicated that precaution signs fall down frequently, and someone must have hung up an incorrect sign in error. LPN #8 failed to identify what the policy or procedure was for precaution signs and stated the only way to know what precaution a resident may be on was through communication during the shift handoff report. An interview with Registered Nurse (RN) #1 on 4/14/25 at 12:55 PM identified precautions for Residents were identified during report and the RN Supervisor and Infection Preventionist (IP) were responsible for alerting staff, bringing out the personal protective equipment (PPE) bin, and hanging the correct precautions sign according to the type of infection. She further identified the IP audited precaution signs to ensure the correct type of precautions required was being implemented. RN #1 indicated the nurse assigned to Resident #70 (LPN #8) should have been aware the sign was incorrect and although the IP was responsible to ensure correct signage was used, she should have alerted the IP he had hung the incorrect precaution sign for Resident #15 and Resident #70. An interview with the Infection Preventionist, RN #2, on 4/15/25 at 2:19 PM identified he was the responsible staff member for placing the correct precaution sign outside a resident's door. He further identified he received a report every morning indicating which residents should be on precautions and performed audits on precaution signs to ensure the correct signage had been placed. RN #2 stated he was made aware earlier by the nurses that an incorrect precaution sign was hanging outside Residents #15 and #70's door and he replaced it with the enteric contact precautions sign that was currently hung. He indicated the reason an incorrect sign was hung may have been because the correct sign fell down. RN #2 did not indicate why enteric precaution sign was used for Resident #15 and #70, but stated when droplet precautions were used the facility placed a report to nurse sign. (continued on next page)

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	04/22/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 4/16/25 at 5:44 AM with RN #5 identified that there was no process to inform visitors when to use correct PPE [as nurses received during report] when visiting or which resident required the precautions. She further identified she instructed her staff to gown and glove for both residents in a shared room if they saw a precaution sign hung. An interview on 4/16/25 at 9:33 AM with RN #2 identified that visitors should don whatever PPE was listed on the precaution sign before entering a room and if a visitor has any questions they should ask a nurse. Although requested, the facility failed to provide a policy for Enhanced Barrier Precautions, Contact Precautions, or Droplet Precautions.

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	04/22/2025

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 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program for all new and existing staff members. Based on review of facility documentation, facility policy and interviews for 4 of 5 employee files, the facility failed to ensure that the mandatory employee training/in-services were completed. The findings include: 1. LPN #1's date of hire was 11/11/2021. Review of facility documentation for LPN #1 identified that she worked in the facility between 11/11/2021 and 4/22/25. Review of the employee file for LPN #1 failed to identify that in-service training had been provided (Resident Rights, Communication and Behavioral Health) and included in the files from 2023 until present. 2. NA #1's date of hire was 8/8/2019. Review of facility documentation for NA #1 identified that she worked in the facility between 8/8/2019 and 4/22/25. Review of the employee file for NA #1 failed to identify that in-service training had been provided (Resident Rights, Communication and Behavioral Health) and included in the files from 2023 until present. 3. NA #3's date of hire was 10/11/2023. Review of facility documentation for NA #3 identified that she worked in the facility between 10/11/2023 and 4/22/25. Review of the employee file for NA #3 failed to identify that in-service training had been provided (Resident Rights, Communication and Behavioral Health) and included in the files from 2023 until present. 4. NA #4's date of hire was 11/23/2020. Review of facility documentation for NA #4 identified that she worked in the facility between 11/2020 and 4/22/25. Review of the employee file for NA #4 failed to identify that in-service training had been provided (Resident Rights, Communication and Behavioral Health) and included in the files from 2023 until present. Although requested, the facility could not provide documentation that current required trainings (mandatory inservices) had been completed for LPN#1, NA#1, NA#3 and NA#4. Interview and review of facility documentation with the Staff Development RN (RN #2) on 4/22/25 at 1:20 PM identified that required in-service trainings are provided upon hire and annually. RN#2 was unable to provide current documentation for the mandatoryt annual in-service training for LPN #1, NA #1, NA #3 and NA #4. RN #2 indicated that it was his responsibility to ensure the required in-service trainings were completed, documented, and placed in the employees' files for review. Interview and review of facility documentation with the Director of Nurses (DNS) on 4/22/25 at 2:30 PM identified that she was unable to locate the current mandatory annual in-service training documentation for LPN #1, NA#1, NA#3 and NA#4 and identified that RN#2 was responsible for ensuring that employees required in-service trainings were completed, documented, and placed in the employees' files. The DNS identified it is facility policy that staff complete the required in-service trainings upon hire and annually and that she and RN #2 would work on them. Although requested, facility's policy on employees' in-service trainings was not provided.