STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075275	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grimes Center	1354 Chapel St New Haven, CT 06511

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 3 residents (Resident #7) reviewed for abuse, the facility failed to protect Resident #7 from verbal abuse and intimidation by Resident #6 after Resident #6 (who resides on a different unit), sat outside Resident #7's room and was verbally aggressive, intimidating and used sexually explicit profanity towards Resident #7. The findings include: a. Resident #6 was admitted to the facility on [DATE] with diagnoses that included dementia with agitation, adjustment disorder, and anxiety disorder.The annual MDS dated [DATE] identified Resident #6 had intact cognition, was independent with transfers and used a walker and a wheelchair for mobility. The care plan dated 8/14/25 identified Resident #6 was at risk for behavior issues related to history of mental illness and cognitive deficits. Interventions included to monitor behavior episodes, attempt to determine the underlying cause, and document the behavior and potential causes. Review of the census list identified Resident #6 resided on the 3rd floor unit on 9/7/25.A nurse's note dated 9/7/25 at 5:37 PM written by RN #8 identified that Resident #6 had an incident that morning when he/she was verbally aggressive and used profanity towards another resident. RN #8 identified she counseled and reminded Resident #6 about the behavior and redirected Resident #6 back to his/her room. RN #8 identified that she placed a note in the psychiatric communication book and updated the ADNS. A social work note dated 9/8/25 at 5:11 PM identified she had spoken to Resident #6 that morning related to the incident that Resident #6 provoked on 9/7/25 at 8:00 AM on 2nd floor unit. SW #1 identified that Resident #6 used vulgar and aggressive language and was resistant to leave the unit when staff approached him/her. The note further identified that SW #1 and the ADNS informed Resident #6 that the language used and behaviors were not acceptable. Further, Resident #6 does not respond well to boundaries and tries to be intimidating. The note further identified that Resident #6 again attempted behaviors on 9/8/25 in the evening when he/she thought staff were not present and was taken off the unit. Staff aware if resident resists or is intimidating or aggressive to contact security.Resident #6's care plan, revision dated 9/8/25, identified the resident was at risk for behavior issues related to history of mental illness and cognitive deficits. Interventions added included to encourage Resident #6 to avoid other units.A psychiatric note dated 9/11/25 by APRN #1 identified she was asked to see Resident #6 due to use of profanity towards another resident. Nurse interviewed and reports resident was upset and told another resident to (sexually inappropriate profanity). APRN #1 identified there were no other outbursts or physical aggression and that she advised Resident #6 was counseled on treating others with respect. A referral was placed for talk therapy. Further review of the clinical record failed to identify additional documentation related to the incidents involving Resident #6 and another resident, including the identity of the other resident involved. Review of the state agency reportable events portal failed to identify incidents related to Resident #6 and any other residents of the facility for 2025.Review of the facility accident and incident reports failed to identify incidents involving Resident #6 and any other residents of the facility for 2025. b. Resident #7 was admitted to the facility on [DATE] with diagnoses that included borderline personality disorder, anxiety disorder, and bipolar (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	disorder. The quarterly MDS dated [DATE] identified Resident #7 had intact cognition, was independent with transfers and required use of a walker and a wheelchair for mobility. The care plan dated 8/20/25 identified Resident #7 was at risk for alteration in psychosocial wellbeing due to history of depression, anxiety, psychosis, PTSD, and borderline personality disorder. Interventions included providing the opportunity to verbalize feelings and concerns.Review of the census list identified that Resident #7 resided on the 2nd floor unit on 9/7/25.A social work note dated 9/8/25 at 5:17 PM by SW #1 identified that she and the ADNS approached Resident #7 regarding an incident that occurred on 9/7/25. The note identified Resident #7 had a verbal altercation with another resident and the other resident made a vulgar comment, intimidated Resident #7 and facility staff had to remove the other resident. The note further identified that Resident #7 came to the social work office on 9/8/25 at 5:00 PM to report that the other resident was attempting to retaliate against him/her (Resident #7). The note identified that SW #1 and Resident #7 returned to Resident #7's floor and a supervisor was removing the other resident from a room. Further review of the clinical record failed to identify additional documentation related to the incident involving Resident #7 and another resident, including the identity of the other resident involved. A psychiatric note dated 9/11/25 by APRN #1 identified she was asked to see Resident #7 urgently due to Resident #7 requesting to restart Risperdal (an antipsychotic medication). The note identified Resident #7 had a history of suicide attempts, suicidal ideations, and homicidal ideations that included pushing strangers into traffic. The note further identified Resident #7 requested to restart Risperdal due to having increased feelings of anger and delusions. Resident #7 also reported increased anxiety and paranoia, and felt people were staring through his/her room window. APRN #1 identified the treatment plan included a restart of Risperdal and monitoring of target behaviors which included paranoia, delusions, hallucinations, and physical/verbal aggression. A psychiatric note dated 9/12/25 by Psychologist #1 identified Resident #7 reported struggling with affective dysregulation and intrusive negative thoughts following events on his/her unit. The note further identified that Resident #7 met with the APRN to discuss medication management and identified the treatment plan included to identify feeling triggers associated with social boundaries. Interview with the DNS on 1/30/26 at 8:40 AM regarding the incidents with Resident #6 and Resident #7 identified she was not aware of any incidents including verbal altercations that occurred between the residents, and she did not have reportable event reports regarding the incidents. The DNS identified that SW #1 and the ADNS would have addressed the issues and completed the reports as the ADNS was acting DNS at that time. Interview with SW #1 on 1/30/26 at 8:50 AM identified she was aware of the incidents involving Resident #6 and Resident #7. SW #1 identified that Resident #6 resided on the 3rd floor unit and had a significant history of antagonizing and being verbally aggressive with other residents. SW #1 identified that Resident #6 had bullying behavior and a history of specifically targeting Resident #7 by pushing his/her buttons but failed to provide any specifics regarding this. SW #1 identified she recalled one incident that occurred between Resident #6 and Resident #7 on 9/7/25 in the afternoon. SW #1 identified that Resident #7 came down to her office on 9/8/25 in the afternoon to report the incident and reported the following: The evening of 9/7/25 (a Sunday), Resident #6 was playing loud music on a smartphone while in his/her wheelchair directly outside of Resident #7's room. Resident #7 told Resident #6 to turn the music off, and Resident #6 started yelling and using profanity towards Resident #7. Resident #7 then yelled back and shortly after facility nursing staff attempted to remove Resident #6 from the hallway and return him/her back to the 3rd floor. SW #1 identified that the incident on 9/7/25 was the only issue that occurred between the residents and that the facility staff had been able to separate the residents, and that Resident #7 had identified when speaking with SW #1 in her office that he/she just wanted to make sure SW #1 was aware of the incident. SW #1 identified that she did not complete an incident report since the issue was addressed and did not complete any investigation or documentation related to the incident. SW #1 further identified that while she was aware she identified in Resident #7's clinical record that Resident #6's behavior (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Grimes Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1354 Chapel St New Haven, CT 06511	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	included attempts to intimidate and retaliate against Resident #7, SW #1 felt that the behaviors were not abusive towards Resident #7 and did not report the incident to the state agency. SW #1 further identified she did not report any incidents that she was notified of between residents, specifically incidents between Resident #7 and other residents, because I would be reporting every day. But I guess going forward I will report all of them within 2 hours. SW #1 declined to provide any additional information regarding specific incidents that would have required reporting. SW #1 also identified that she was not aware of any additional incidents between the residents, and that facility staff was able to successfully redirect Resident #6 from going to Resident #7's unit.Interview with the ADNS on 1/30/26 at 9:28 AM identified she was aware of one incident that occurred on 9/7/25 during breakfast between Resident #6 and Resident #7. The DNS identified that she was initially notified of the incident by the 7:00 AM - 3:00 PM weekend nursing supervisor, RN #8. The ADNS identified that she and SW #1 went to Resident #7's room on 9/8/25 in the afternoon to speak with him/her regarding the incident and that Resident #7 reported the following: ADNS identified that she did not inquire or ask any follow up questions regarding any additional incidents between the residents and did not complete an investigation or an incident report related to the incident on 9/7/25. The ADNS further identified that since Resident #7 did not identify any additional issues, she did not feel that the incident required any investigation or reporting to the state agency. The ADNS also identified that on 9/8/25 she did recall checking with Resident #7, but it was not specific to follow up for the 9/7/25 incident and did not attempt any additional follow up.Interview with APRN #1 on 1/30/26 at 9:45 AM identified she did not recall any incidents related to Resident #7 having altercations with Resident #6 in 9/2025. APRN #1 identified that she did remember verbal incidents with Resident #7 and another resident of the facility but identified a resident who was not Resident #6. APRN #1 identified she did see Resident #7 on 9/11/25 due to a request by Psychologist #1 for medication management but did not recall any incidents reported during those visits involving any other residents. APRN #1 also identified she only handled medication management for Resident #7 and did not discuss any specific issues or incidents with Resident #7, and that Psychologist #1 might have more information. Interview with Psychologist #1 on 1/30/26 at 10 AM identified that Resident #7 had reported multiple incidents with Resident #6 that included verbal altercations and attempts to intimidate but was unable to provide specific information. Psychologist #1 identified that Resident #6 had a long psychiatric history that included paranoia and fear of others. Psychologist #1 identified that due to his/her history, Resident #7 had avoidant behaviors with others due to fear that he/she might be harmed, and further identified Resident #7 had a history of physical aggression and was triggered when he/she was in fear or worried for his/her safety. Psychologist #1 identified that Resident #7 was seen by her on 9/12/25 and had reported the incidents on 9/7 and 9/8/25 with Resident #6 and identified Resident #7 reported struggling with his/her reactions subsequently. Psychologist #1 identified that Resident #7 has requested to restart Risperdal due to ongoing issues with paranoia and delusions, and while these issues were longstanding, the incidents with Resident #6 did contribute to Resident #7's exacerbation in symptoms. Interview with RN #8 on 1/30/26 at 10:50 AM identified she was the nursing supervisor for the facility on 9/7/25 when the incident between Resident #6 and Resident #7 occurred. RN #8 identified she was notified by a staff member on Resident #7's unit that Resident #6 was on the unit yelling and using profanity towards Resident #7. RN #8 identified she arrived on the 2nd floor and by the time she arrived, the incident was over and Resident #6 had been removed from the unit. RN #8 identified she spoke with Resident #7, who identified he/she had told Resident #6 that the music he/she was playing was too loud. Resident #7 reported Resident #6 then got mad and began to yell at him/her and use profanity. RN #8 identified that she apologized for the incident to Resident #7, identified she would address the issue, and offered Resident #7 a room change, but he/she declined. RN #8 identified she spoke with Resident #6 and documented the note regarding that discussion in the clinical record. RN #8 also identified she placed a note in the psychiatric APRN communication book for APRN #1 to see Resident #6 and notified the ADNS via text message on (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9/7/25 regarding the incident. RN #8 identified that when she spoke with Resident #7 following the 9/7/25 incident, he/she reported no issues and that he/she was okay but also identified that there had been ongoing issues with Resident #6 yelling and antagonizing Resident #7 both before and after the 9/7/25 incident, and Resident #6 would often come to Resident #7's unit and yell at him/her and staff often had to redirect Resident #6 to leave the unit. RN #8 identified that Resident #6 would travel to the 2 other units of the facility at least daily, often multiple times a day, and that she had seen him/her on the 4th floor unit prior to this interview. Although attempted, an interview with Resident #7 was not obtained. The facility policy on abuse directed that residents had the right to be free from mental and verbal abuse, and abuse or mistreatment of any kind towards a resident was strictly prohibited. The policy defined abuse as the willful infliction of injury, intimidation, or mental anguish, and instances of abuse, irrespective of any mental condition, cause pain or mental anguish. The policy further defined that willful was used in the definition of abuse to mean that an individual acted deliberately. The policy defined verbal abuse was defined as the use of oral, written or gestured language that willfully included disparaging and derogatory terms to the resident and examples of verbal abuse included saying things to frighten a resident. The policy defined mental abuse included but was not limited to humiliation, harassment, threats of punishment, or deprivation. The policy directed that anyone witnessing or having knowledge of abuse or mistreatment of any kind towards a resident would report the incident immediately to a supervisor and an accident/incident report would be completed for each resident involved. The policy also directed that a description of the incident would be documented in each resident's clinical record as a nurse's note. The policy also directed the Administrator and DNS to be notified, and the DNS or designee would notify the resident's responsible party, physician, the state agency, and law enforcement, and the Administrator/DNS or designee would conduct an investigation immediately upon submission of the report. The policy further directed the investigation would include interviewing all witnesses, including the person accused of abuse; all other parties who may have knowledge useful to the investigation; and dated and signed statements of all involved staff. The policy also directed that the conclusion of the investigation should be documented along with actions taken on the internal investigation form and reporting of the incident should occur immediately, but not less than 2 hours for allegations that involve abuse. The facility policy on accident/incident reports directed that accidents/incident reports were completed for allegations of abuse and resident to resident altercations. The policy further directed that Class B reportable events included a complaint of abuse or an event that involved an abusive act to a resident by any person and for the purpose of a Class B classification, abuse included the willful infliction of injury, intimidation, or mental anguish, and willful was defined as an individual acting deliberately. The facility policy on resident rights directed that residents of the facility had the right to be free from verbal, sexual, physical, and mental abuse.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 3 residents (Resident #7) reviewed for abuse, the facility failed to immediately report when Resident #6 (who resides on a different unit), sat outside Resident #7's room and was verbally aggressive, intimidating and used sexually explicit profanity towards Resident #7. The findings include:a. Resident #6 was admitted to the facility on [DATE] with diagnoses that included dementia with agitation, adjustment disorder, and anxiety disorder.The annual MDS dated [DATE] identified Resident #6 had intact cognition. The care plan dated 8/14/25 identified Resident #6 was at risk for behavior issues related to history of mental illness and cognitive deficits. Interventions included to monitor behavior episodes, attempt to determine the underlying cause, and document the behavior and potential causes. Review of the census list identified Resident #6 resided on the 3rd floor unit on 9/7/25.A nurse's note dated 9/7/25 at 5:37 PM written by RN #8 identified that Resident #6 had an incident that morning when he/she was verbally aggressive and used profanity towards another resident. RN #8 identified she counseled and reminded Resident #6 about the behavior and redirected Resident #6 back to his/her room. RN #8 identified that she placed a note in the psychiatric communication book and updated the ADNS. A social work note dated 9/8/25 at 5:11 PM identified she had spoken to Resident #6 that morning related to the incident that Resident #6 provoked on 9/7/25 at 8:00 AM on 2nd floor unit. SW #1 identified that Resident #6 used vulgar and aggressive language and was resistant to leave the unit when staff approached him/her. The note further identified that SW #1 and the ADNS informed Resident #6 that the language used and behaviors were not acceptable. Further, Resident #6 does not respond well to boundaries and tries to be intimidating. The note further identified that Resident #6 again attempted behaviors on 9/8/25 in the evening when he/she thought staff were not present and was taken off the unit. Staff aware if resident resists or is intimidating or aggressive to contact security.Resident #6's care plan, revision dated 9/8/25, identified the resident was at risk for behavior issues related to history of mental illness and cognitive deficits. Interventions added included to encourage Resident #6 to avoid other units.A psychiatric note dated 9/11/25 by APRN #1 identified she was asked to see Resident #6 due to use of profanity towards another resident. Nurse interviewed and reports resident was upset and told another resident to (sexually inappropriate profanity). APRN #1 identified there were no other outbursts or physical aggression and that she advised Resident #6 was counseled on treating others with respect. A referral was placed for talk therapy. b. Resident #7 was admitted to the facility on [DATE] with diagnoses that included borderline personality disorder, anxiety disorder, and bipolar disorder.The quarterly MDS dated [DATE] identified Resident #7 had intact cognition, was independent with transfers and required use of a walker and a wheelchair for mobility. The care plan dated 8/20/25 identified Resident #7 was at risk for alteration in psychosocial wellbeing due to history of depression, anxiety, psychosis, PTSD, and borderline personality disorder. Interventions included providing the opportunity to verbalize feelings and concerns.Review of the census list identified that Resident #7 resided on the 2nd floor unit on 9/7/25.A social work note dated 9/8/25 at 5:17 PM by SW #1 identified that she and the ADNS approached Resident #7 regarding an incident that occurred on 9/7/25. The note identified Resident #7 had a verbal altercation with another resident and the other resident made a vulgar comment, intimidated Resident #7 and facility staff had to remove the other resident. The note further identified that Resident #7 came to the social work office on 9/8/25 at 5:00 PM to report that the other resident was attempting to retaliate against him/her (Resident #7). The note identified that SW #1 and Resident #7 returned to Resident #7's floor and a supervisor was removing the other resident from a room. A psychiatric note dated 9/11/25 by APRN #1 identified she was asked to see Resident #7 urgently due to Resident #7 requesting to restart Risperdal (an (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	antipsychotic medication). The note identified Resident #7 had a history of suicide attempts, suicidal ideations, and homicidal ideations that included pushing strangers into traffic. The note further identified Resident #7 requested to restart Risperdal due to having increased feelings of anger and delusions. Resident #7 also reported increased anxiety and paranoia, and felt people were staring through his/her room window. APRN #1 identified the treatment plan included a restart of Risperdal and monitoring of target behaviors which included paranoia, delusions, hallucinations, and physical/verbal aggression. A psychiatric note dated 9/12/25 by Psychologist #1 identified Resident #7 reported struggling with affective dysregulation and intrusive negative thoughts following events on his/her unit. The note further identified that Resident #7 met with the APRN to discuss medication management and identified the treatment plan included to identify feeling triggers associated with social boundaries. Review of the state agency reportable events portal failed to identify the 9/7/25 incident when Resident #6 was verbally aggressive and used profanity towards Resident #7 had been reported. Interview with the DNS on 1/30/26 at 8:40 AM regarding the incidents with Resident #6 and Resident #7 identified she was not aware of any incidents including verbal altercations that occurred between the residents, and she did not have reportable event reports regarding the incident. The DNS identified that SW #1 and the ADNS would have addressed the issues and completed the reports as the ADNS was acting DNS at that time. Interview with SW #1 on 1/30/26 at 8:50 AM identified she was aware of the incident involving Resident #6 and Resident #7. SW #1 identified that Resident #6 resided on the 3rd floor unit and had a significant history of antagonizing and being verbally aggressive with other residents. SW #1 identified that Resident #6 had bullying behaviors and a history of specifically targeting Resident #7 by pushing his/her buttons but failed to provide any specifics. SW #1 identified she recalled one incident that occurred between Resident #6 and Resident #7 on 9/7/25 in the afternoon. SW #1 identified that Resident #7 came down to her office on 9/8/25 in the afternoon to report the incident and reported the following: The evening of 9/7/25 (a Sunday), Resident #6 was playing loud music on a smartphone while in his/her wheelchair directly outside of Resident #7's room. Resident #7 told Resident #6 to turn the music off, and Resident #6 started yelling and using profanity towards Resident #7. Resident #7 yelled back and shortly after facility nursing staff attempted to remove Resident #6 from the hallway and return him/her back to the 3rd floor. SW #1 identified that the incident on 9/7/25 was the only issue that occurred between the residents and that the facility staff had been able to separate the residents, and that Resident #7 had identified when speaking with SW #1 in her office that he/she just wanted to make sure SW #1 was aware of the incident. SW #1 identified that she did not complete an incident report since the issue was addressed and did not complete any investigation or documentation related to the incident. SW #1 further identified that while she was aware she identified in Resident #7's clinical record that Resident #6's behavior included attempts to intimidate and retaliate against Resident #7, SW #1 felt that the behaviors were not abusive towards Resident #7. SW #1 further identified she did not report any incidents that she was notified of between residents, specifically incidents between Resident #7 and other residents, because I would be reporting every day. But I guess going forward I will report all of them within 2 hours. SW #1 declined to provide any additional information regarding specific incidents that would have required reporting. Interview with the ADNS on 1/30/26 at 9:28 AM identified she was aware of one incident that occurred on 9/7/25 during breakfast between Resident #6 and Resident #7. The DNS identified that she was initially notified of the incident by the 7:00 AM - 3:00 PM weekend nursing supervisor, RN #8. The ADNS identified that she and SW #1 went to Resident #7's room on 9/8/25 in the afternoon to speak with him/her regarding the incident and that Resident #7 reported the following: ADNS identified that she did not inquire or ask any follow up questions regarding any additional incidents between the residents and did not complete an investigation or an incident report related to the incident on 9/7/25. The ADNS further identified that since Resident #7 did not identify any additional issues, she did not feel that the incident required any investigation or reporting to the state agency. The ADNS also identified that on 9/8/25 she did recall (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	checking with Resident #7, but it was not specific to follow up for the 9/7/25 incident and did not attempt any additional follow up.Interview with APRN #1 on 1/30/26 at 9:45 AM identified she did not recall any incidents related to Resident #7 having altercations with Resident #6 in 9/2025. APRN #1 identified that she did remember verbal incidents with Resident #7 and another resident of the facility but identified a resident who was not Resident #6. APRN #1 identified she did see Resident #7 on 9/11/25 due to a request by Psychologist #1 for medication management but did not recall any incidents reported during those visits involving any other residents. APRN #1 also identified she only handled medication management for Resident #7 and did not discuss any specific issues or incidents with Resident #7, and that Psychologist #1 might have more information. Interview with Psychologist #1 on 1/30/26 at 10 AM identified that Resident #7 had reported multiple incidents with Resident #6 that included verbal altercations and attempts to intimidate but was unable to provide specific information. Psychologist #1 identified that Resident #6 had a long psychiatric history that included paranoia and fear of others. Psychologist #1 identified that due to his/her history, Resident #7 had avoidant behaviors with others due to fear that he/she might be harmed, and further identified Resident #7 had a history of physical aggression and was triggered when he/she was in fear or worried for his/her safety. Psychologist #1 identified that Resident #7 was seen by her on 9/12/25 and had reported the incidents on 9/7 and 9/8/25 with Resident #6 and identified Resident #7 reported struggling with his/her reactions subsequently. Psychologist #1 identified that Resident #7 has requested to restart Risperdal due to ongoing issues with paranoia and delusions, and while these issues were longstanding, the incidents with Resident #6 did contribute to Resident #7's exacerbation in symptoms. Interview with RN #8 on 1/30/26 at 10:50 AM identified she was the nursing supervisor for the facility on 9/7/25 when the incident between Resident #6 and Resident #7 occurred. RN #8 identified she was notified by a staff member on Resident #7's unit that Resident #6 was on the unit yelling and using profanity towards Resident #7. RN #8 identified she arrived on the 2nd floor and by the time she arrived, the incident was over and Resident #6 had been removed from the unit. RN #8 identified she spoke with Resident #7, who identified he/she had told Resident #6 that the music he/she was playing was too loud. Resident #7 reported Resident #6 then got mad and began to yell at him/her and use profanity. RN #8 identified that she apologized for the incident to Resident #7, identified she would address the issue, and offered Resident #7 a room change, but he/she declined. RN #8 identified she spoke with Resident #6 and documented the note regarding that discussion in the clinical record. RN #8 also identified she placed a note in the psychiatric APRN communication book for APRN #1 to see Resident #6 and notified the ADNS via text message on 9/7/25 regarding the incident. RN #8 identified that when she spoke with Resident #7 following the 9/7/25 incident, he/she reported no issues and that he/she was okay but also identified that there had been ongoing issues with Resident #6 yelling and antagonizing Resident #7 both before and after the 9/7/25 incident, and Resident #6 would often come to Resident #7's unit and yell at him/her and staff often had to redirect Resident #6 to leave the unit. RN #8 identified that Resident #6 would travel to the 2 other units of the facility at least daily, often multiple times a day, and that she had seen him/her on the 4th floor unit prior to this interview. Although attempted, an interview with Resident #7 was not obtained. The facility policy on abuse directed that residents had the right to be free from mental and verbal abuse, and abuse or mistreatment of any kind towards a resident was strictly prohibited. The policy defined abuse as the willful infliction of injury, intimidation, or mental anguish, and instances of abuse, irrespective of any mental condition, cause pain or mental anguish. The policy further defined that willful was used in the definition of abuse to mean that an individual acted deliberately. The policy defined verbal abuse was defined as the use of oral, written or gestured language that willfully included disparaging and derogatory terms to the resident and examples of verbal abuse included saying things to frighten a resident. The policy defined mental abuse included but was not limited to humiliation, harassment, threats of punishment, or deprivation. The policy directed that anyone witnessing or having knowledge of abuse or mistreatment of any kind towards a resident would report (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the incident immediately to a supervisor and an accident/incident report would be completed for each resident involved. The policy also directed that a description of the incident would be documented in each resident's clinical record as a nurse's note. The policy also directed the Administrator and DNS to be notified, and the DNS or designee would notify the resident's responsible party, physician, the state agency, and law enforcement, and the Administrator/DNS or designee would conduct an investigation immediately upon submission of the report. The policy further directed the investigation would include interviewing all witnesses, including the person accused of abuse; all other parties who may have knowledge useful to the investigation; and dated and signed statements of all involved staff. The policy also directed that the conclusion of the investigation should be documented along with actions taken on the internal investigation form and reporting of the incident should occur immediately, but not less than 2 hours for allegations that involve abuse. The facility policy on accident/incident reports directed that accidents/incident reports were completed for allegations of abuse and resident to resident altercations. The policy further directed that Class B reportable events included a complaint of abuse or an event that involved an abusive act to a resident by any person and for the purpose of a Class B classification, abuse included the willful infliction of injury, intimidation, or mental anguish, and willful was defined as an individual acting deliberately. The policy further directed that immediate notice but not later than 2 hours would be provided to the state agency, and a written report would be provided within 72 hours of the event. The policy also directed that an incident was defined as any happening, not consistent with the routine operation of a long-term care facility, that does not result in bodily injury or property damage, and physical or mental mistreatment of a resident (abuse, actual or suspected) was considered an incident. The policy also directed that for situations of resident abuse, an accident/incident report would be completed, and the police would be notified for cases of confirmed abuse and for resident-to-resident altercations (if the perpetrator was cognitively intact and intended to cause harm).

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 3 residents (Resident #7) reviewed for abuse, the facility failed to complete a thorough investigation and protect Resident #7 from further potential abuse by Resident #6 after Resident #6 (who resides on a different unit), sat outside Resident #7's room and was verbally aggressive, intimidating and used sexually explicit profanity towards Resident #7. The findings include:a. Resident #6 was admitted to the facility on [DATE] with diagnoses that included dementia with agitation, adjustment disorder, and anxiety disorder.The annual MDS dated [DATE] identified Resident #6 had intact cognition, was independent with transfers and used a walker and a wheelchair for mobility. The care plan dated 8/14/25 identified Resident #6 was at risk for behavior issues related to history of mental illness and cognitive deficits. Interventions included to monitor behavior episodes, attempt to determine the underlying cause, and document the behavior and potential causes. Review of the census list identified Resident #6 resided on the 3rd floor unit on 9/7/25.A nurse's note dated 9/7/25 at 5:37 PM written by RN #8 identified that Resident #6 had an incident that morning when he/she was verbally aggressive and used profanity towards another resident. RN #8 identified she counseled and reminded Resident #6 about the behavior and redirected Resident #6 back to his/her room. RN #8 identified that she placed a note in the psychiatric communication book and updated the ADNS. A social work note dated 9/8/25 at 5:11 PM identified she had spoken to Resident #6 that morning related to the incident that Resident #6 provoked on 9/7/25 at 8:00 AM on 2nd floor unit. SW #1 identified that Resident #6 used vulgar and aggressive language and was resistant to leave the unit when staff approached him/her. The note further identified that SW #1 and the ADNS informed Resident #6 that the language used and behaviors were not acceptable. Further, Resident #6 does not respond well to boundaries and tries to be intimidating. The note further identified that Resident #6 again attempted behaviors on 9/8/25 in the evening when he/she thought staff were not present and was taken off the unit. Staff aware if resident resists or is intimidating or aggressive to contact security.Resident #6's care plan, revision dated 9/8/25, identified the resident was at risk for behavior issues related to history of mental illness and cognitive deficits. Interventions added included to encourage Resident #6 to avoid other units.A psychiatric note dated 9/11/25 by APRN #1 identified she was asked to see Resident #6 due to use of profanity towards another resident. Nurse interviewed and reports resident was upset and told another resident to (sexually inappropriate profanity). APRN #1 identified there were no other outbursts or physical aggression and that she advised Resident #6 was counseled on treating others with respect. A referral was placed for talk therapy. Further review of the clinical record failed to identify additional documentation related to the incidents involving Resident #6 and another resident, including the identity of the other resident involved. Review of the state agency reportable events portal failed to identify incidents related to Resident #6 and any other residents of the facility for 2025.Review of the facility accident and incident reports failed to identify incidents involving Resident #6 and any other residents of the facility for 2025. b. Resident #7 was admitted to the facility on [DATE] with diagnoses that included borderline personality disorder, anxiety disorder, and bipolar disorder. The quarterly MDS dated [DATE] identified Resident #7 had intact cognition, was independent with transfers and required use of a walker and a wheelchair for mobility. The care plan dated 8/20/25 identified Resident #7 was at risk for alteration in psychosocial wellbeing due to history of depression, anxiety, psychosis, PTSD, and borderline personality disorder. Interventions included providing the opportunity to verbalize feelings and concerns.Review of the census list identified that Resident #7 resided on the 2nd floor unit on 9/7/25.A social work note dated 9/8/25 at 5:17 PM by SW #1 identified that she and the ADNS approached Resident #7 regarding an incident that occurred on 9/7/25. The note identified Resident #7 had a verbal altercation with another resident and the other resident made a vulgar comment, intimidated Resident #7 and facility staff had to (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	remove the other resident. The note further identified that Resident #7 came to the social work office on 9/8/25 at 5:00 PM to report that the other resident was attempting to retaliate against him/her (Resident #7). The note identified that SW #1 and Resident #7 returned to Resident #7's floor and a supervisor was removing the other resident from a room. Further review of the clinical record failed to identify additional documentation related to the incident involving Resident #7 and another resident, including the identity of the other resident involved. A psychiatric note dated 9/11/25 by APRN #1 identified she was asked to see Resident #7 urgently due to Resident #7 requesting to restart Risperdal (an antipsychotic medication). The note identified Resident #7 had a history of suicide attempts, suicidal ideations, and homicidal ideations that included pushing strangers into traffic. The note further identified Resident #7 requested to restart Risperdal due to having increased feelings of anger and delusions. Resident #7 also reported increased anxiety and paranoia, and felt people were staring through his/her room window. APRN #1 identified the treatment plan included a restart of Risperdal and monitoring of target behaviors which included paranoia, delusions, hallucinations, and physical/verbal aggression. A psychiatric note dated 9/12/25 by Psychologist #1 identified Resident #7 reported struggling with affective dysregulation and intrusive negative thoughts following events on his/her unit. The note further identified that Resident #7 met with the APRN to discuss medication management and identified the treatment plan included to identify feeling triggers associated with social boundaries. Interview with the DNS on 1/30/26 at 8:40 AM regarding the incidents with Resident #6 and Resident #7 identified she was not aware of any incidents including verbal altercations that occurred between the residents, and she did not have reportable event reports regarding the incidents. The DNS identified that SW #1 and the ADNS would have addressed the issues and completed the reports as the ADNS was acting DNS at that time. Interview with SW #1 on 1/30/26 at 8:50 AM identified she was aware of the incidents involving Resident #6 and Resident #7. SW #1 identified that Resident #6 resided on the 3rd floor unit and had a significant history of antagonizing and being verbally aggressive with other residents. SW #1 identified that Resident #6 had bullying behavior and a history of specifically targeting Resident #7 by pushing his/her buttons but failed to provide any specifics regarding this. SW #1 identified she recalled one incident that occurred between Resident #6 and Resident #7 on 9/7/25 in the afternoon. SW #1 identified that Resident #7 came down to her office on 9/8/25 in the afternoon to report the incident and reported the following: The evening of 9/7/25 (a Sunday), Resident #6 was playing loud music on a smartphone while in his/her wheelchair directly outside of Resident #7's room. Resident #7 told Resident #6 to turn the music off, and Resident #6 started yelling and using profanity towards Resident #7. Resident #7 then yelled back and shortly after facility nursing staff attempted to remove Resident #6 from the hallway and return him/her back to the 3rd floor. SW #1 identified that the incident on 9/7/25 was the only issue that occurred between the residents and that the facility staff had been able to separate the residents, and that Resident #7 had identified when speaking with SW #1 in her office that he/she just wanted to make sure SW #1 was aware of the incident. SW #1 identified that she did not complete an incident report since the issue was addressed and did not complete any investigation or documentation related to the incident. SW #1 further identified that while she was aware she identified in Resident #7's clinical record that Resident #6's behavior included attempts to intimidate and retaliate against Resident #7, SW #1 felt that the behaviors were not abusive towards Resident #7 and did not report the incident to the state agency. SW #1 further identified she did not report any incidents that she was notified of between residents, specifically incidents between Resident #7 and other residents, because I would be reporting every day. But I guess going forward I will report all of them within 2 hours. SW #1 declined to provide any additional information regarding specific incidents that would have required reporting. SW #1 also identified that she was not aware of any additional incidents between the residents, and that facility staff was able to successfully redirect Resident #6 from going to Resident #7's unit.Interview with the ADNS on 1/30/26 at 9:28 AM identified she was aware of one incident that occurred on 9/7/25 during (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	breakfast between Resident #6 and Resident #7. The DNS identified that she was initially notified of the incident by the 7:00 AM - 3:00 PM weekend nursing supervisor, RN #8. The ADNS identified that she and SW #1 went to Resident #7's room on 9/8/25 in the afternoon to speak with him/her regarding the incident and that Resident #7 reported the following: ADNS identified that she did not inquire or ask any follow up questions regarding any additional incidents between the residents and did not complete an investigation or an incident report related to the incident on 9/7/25. The ADNS further identified that since Resident #7 did not identify any additional issues, she did not feel that the incident required any investigation or reporting to the state agency. The ADNS also identified that on 9/8/25 she did recall checking with Resident #7, but it was not specific to follow up for the 9/7/25 incident and did not attempt any additional follow up.Interview with APRN #1 on 1/30/26 at 9:45 AM identified she did not recall any incidents related to Resident #7 having altercations with Resident #6 in 9/2025. APRN #1 identified that she did remember verbal incidents with Resident #7 and another resident of the facility but identified a resident who was not Resident #6. APRN #1 identified she did see Resident #7 on 9/11/25 due to a request by Psychologist #1 for medication management but did not recall any incidents reported during those visits involving any other residents. APRN #1 also identified she only handled medication management for Resident #7 and did not discuss any specific issues or incidents with Resident #7, and that Psychologist #1 might have more information. Interview with Psychologist #1 on 1/30/26 at 10 AM identified that Resident #7 had reported multiple incidents with Resident #6 that included verbal altercations and attempts to intimidate but was unable to provide specific information. Psychologist #1 identified that Resident #6 had a long psychiatric history that included paranoia and fear of others. Psychologist #1 identified that due to his/her history, Resident #7 had avoidant behaviors with others due to fear that he/she might be harmed, and further identified Resident #7 had a history of physical aggression and was triggered when he/she was in fear or worried for his/her safety. Psychologist #1 identified that Resident #7 was seen by her on 9/12/25 and had reported the incidents on 9/7 and 9/8/25 with Resident #6 and identified Resident #7 reported struggling with his/her reactions subsequently. Psychologist #1 identified that Resident #7 has requested to restart Risperdal due to ongoing issues with paranoia and delusions, and while these issues were longstanding, the incidents with Resident #6 did contribute to Resident #7's exacerbation in symptoms. Interview with RN #8 on 1/30/26 at 10:50 AM identified she was the nursing supervisor for the facility on 9/7/25 when the incident between Resident #6 and Resident #7 occurred. RN #8 identified she was notified by a staff member on Resident #7's unit that Resident #6 was on the unit yelling and using profanity towards Resident #7. RN #8 identified she arrived on the 2nd floor and by the time she arrived, the incident was over and Resident #6 had been removed from the unit. RN #8 identified she spoke with Resident #7, who identified he/she had told Resident #6 that the music he/she was playing was too loud. Resident #7 reported Resident #6 then got mad and began to yell at him/her and use profanity. RN #8 identified that she apologized for the incident to Resident #7, identified she would address the issue, and offered Resident #7 a room change, but he/she declined. RN #8 identified she spoke with Resident #6 and documented the note regarding that discussion in the clinical record. RN #8 also identified she placed a note in the psychiatric APRN communication book for APRN #1 to see Resident #6 and notified the ADNS via text message on 9/7/25 regarding the incident. RN #8 identified that when she spoke with Resident #7 following the 9/7/25 incident, he/she reported no issues and that he/she was okay but also identified that there had been ongoing issues with Resident #6 yelling and antagonizing Resident #7 both before and after the 9/7/25 incident, and Resident #6 would often come to Resident #7's unit and yell at him/her and staff often had to redirect Resident #6 to leave the unit. RN #8 identified that Resident #6 would travel to the 2 other units of the facility at least daily, often multiple times a day, and that she had seen him/her on the 4th floor unit prior to this interview. Although attempted, an interview with Resident #7 was not obtained. The facility policy on abuse directed that residents had the right to be free from mental and verbal abuse, and abuse or mistreatment of any kind towards a resident was strictly (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	prohibited. The policy defined abuse as the willful infliction of injury, intimidation, or mental anguish, and instances of abuse, irrespective of any mental condition, cause pain or mental anguish. The policy further defined that willful was used in the definition of abuse to mean that an individual acted deliberately. The policy defined verbal abuse was defined as the use of oral, written or gestured language that willfully included disparaging and derogatory terms to the resident and examples of verbal abuse included saying things to frighten a resident. The policy defined mental abuse included but was not limited to humiliation, harassment, threats of punishment, or deprivation. The policy directed that anyone witnessing or having knowledge of abuse or mistreatment of any kind towards a resident would report the incident immediately to a supervisor and an accident/incident report would be completed for each resident involved. The policy also directed that a description of the incident would be documented in each resident's clinical record as a nurse's note. The policy also directed the Administrator and DNS to be notified, and the DNS or designee would notify the resident's responsible party, physician, the state agency, and law enforcement, and the Administrator/DNS or designee would conduct an investigation immediately upon submission of the report. The policy further directed the investigation would include interviewing all witnesses, including the person accused of abuse; all other parties who may have knowledge useful to the investigation; and dated and signed statements of all involved staff. The policy also directed that the conclusion of the investigation should be documented along with actions taken on the internal investigation form and reporting of the incident should occur immediately, but not less than 2 hours for allegations that involve abuse. The facility policy on resident rights directed that residents of the facility had the right to be free from verbal, sexual, physical, and mental abuse.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 5 residents (Resident #7) reviewed for Pre-admission Screening and Resident Review (PASARR), the facility failed to incorporate the recommendations from the PASARR level II determination into the resident assessment and care plan for a resident with a history of harm directed behaviors and substance abuse. The findings include:Resident #7 was admitted to the facility in November 2024 with diagnoses that included borderline personality disorder, anxiety disorder, and bipolar disorder. The annual MDS dated [DATE] identified Resident #7 had intact cognition, was always continent of bowel and bladder, required set up with bathing, and was independent with toileting and transfers. The MDS further identified Resident #7 had active diagnosis that included bipolar disorder and psychotic disorder and required anti-psychotic medication daily. The MDS failed to identify the resident had a serious mental illness according to the state Level II PASARR process. The care plan dated 10/29/25 identified Resident #7 was at risk for alteration in psychosocial well being due to history of depression, anxiety, psychosis, PTSD, and borderline personality disorder. Interventions included providing the opportunity to verbalize feelings and concerns.a. Review of the clinical record identified a positive Level II PASARR dated 11/26/25 which identified Resident #7 had additional diagnoses which included cocaine use, opioid use, alcohol abuse, suicide attempts, and attempts at harming others by pistol whipping and pushing people into oncoming traffic. The PASARR recommended services and supports that included crisis intervention and a safety plan due to the resident's history of attempting to harm self and others, and the plan should include monitoring for an increase in symptoms or changes in behaviors and steps for the resident and facility staff to take when this happened. Review of the clinical record failed to identify that the Level II PASARR recommendations, including those related to crisis intervention and safety planning, had been reviewed, addressed, or implemented. b. Review of the clinical record identified that Resident #7's history of suicidal ideation, suicide attempts, homicidal ideations, and substance abuse were documented in the treatment notes by both APRN #1 and Psychologist #1 since Resident #7's admission to the facility in November 2024. An initial psychiatric evaluation by APRN #1 on 11/11/24 identified that Resident #7 had a history of suicide with an attempt to shoot his/herself and 2 suicide attempts by intentional overdose, most recently 8 years ago. The note further identified Resident #7 had a history of homicidal ideation and reported to APRN #1 that he/she had a history of physical violence against random strangers that included pushing people into traffic and pistol-whipping people. The evaluation also identified that Resident #7 had a longstanding history of cocaine dependence with chronic heavy use as well as consistent illicit substance use for several years. The treatment plan included a verbal contract with Resident #7 to notify someone if he/she had violent thoughts or might act aggressively, and to start talk therapy and substance abuse support. An initial psychotherapy assessment by Psychologist #1 on 11/19/24 identified Resident #7 has a history of drug use since his/her teen years and a history of active crack cocaine use. Resident #7 also identified that he/she had a history of violence and could still be triggered. The treatment plan included therapy visits 4x monthly with interventions including substance abuse counseling, relapse prevention, psychosocial education, and cognitive behavioral therapy.Review of the clinical record failed to identify a care plan in place that referenced or addressed Resident #7's history of suicidal ideation, suicide attempts, homicidal ideation, harm directed behaviors towards strangers, or long-standing history of cocaine and illicit substance use following Resident #7's initial psychiatric and psychotherapy evaluations in 11/2024. Further review of the clinical record also failed to identify that Resident #7's care plan had been revised with interventions following the positive Level II PASARR on 11/26/25 which also identified Resident #7's history related to these issues. Interview with RN #9 (MDS Coordinator) on 1/30/26 at 7:50 AM (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	identified she was responsible to update the resident's plan of care with positive Level II PASARR findings. RN #9 identified she was not aware that Resident #7 had a Level II PASARR and this was an oversight on her part but that the PASARR should be reviewed by the social worker, psychiatric APRN, physician or PA, and any other providers involved in the resident care as well as the recommendations being added to the resident's care plan. RN #9 identified the providers, and social work would be responsible for addressing the actual crisis intervention and safety planning. RN #9 further identified that while she was aware of Resident #7's history of mental illness, she was not aware of any previous history related to substance abuse disorder, suicidal ideation or attempts, or homicidal ideation, and that the care plan should have reflected the need for treatment and interventions related to those issues. Interview with SW #1 on 1/30/26 at 8:50 AM identified she was aware of Resident #7's positive Level II PASARR but was not aware of any of the recommendations that were provided to the facility, including the need for crisis intervention and a safety plan. SW #1 identified that these should have been put into place, but that Resident #7 had never exhibited any behaviors of self-harm or attempted to harm any other residents. While SW #1 identified that Resident #7 had not exhibited behaviors, she identified when she was with Resident #7, she made sure to keep her guard up due to the resident's history. Interview with APRN #1 on 1/30/26 at 9:45 AM identified she was aware that Resident #7 had a history of suicide attempts and harming others. APRN #1 identified that she had an informal verbal safety plan with Resident #7 and that the resident agreed to notify her if he/she had any thoughts of self-harm. APRN #1 identified that she always completed verbal safety planning with her residents, but no formal planning was developed or documented, and APRN #1 failed to identify that she addressed or developed any crisis intervention planning. APRN #1 identified she was not aware that Resident #7 had a positive Level II PASARR and had not completed any review of the PASARR or the recommendations. Interview with Psychologist #1 on 1/30/26 at 10 AM identified that Resident #7 had reported multiple incidents with Resident #6 that included verbal altercations and attempts to intimidate before and after the incidents in 9/2025 but was unable to provide specific information. Psychologist #1 identified that Resident #6 had a long psychiatric history that included paranoia and fear of others. Psychologist #1 identified that due to his/her history, Resident #7 had avoidant behaviors with others due to fear that he/she might be harmed, and further identified Resident #7 had a history of physical aggression and was triggered when he/she was in fear or worried for his/her safety. Psychologist #1 identified she was not aware that Resident #7 had a positive Level II PASARR and had not completed any review of the PASARR or the recommendations that were outlined in the report. Psychologist #1 also identified she did not have any formal safety plan or interventions in place, but that she saw Resident #7 frequently and Resident #7 knew to contact her if he/she felt the urge to harm self or others. Psychologist #1 identified she did not know how to develop or add a formal safety plan for Resident #7 and identified she had never done so for any of her patients and would have to research this further. Although attempted, an interview with Resident #7 was not obtained. Although requested, the facility failed to provide a policy related to PASARR recommendations.Although requested, the facility failed to provide a policy related to behavior monitoring.The facility policy on care plan that a comprehensive and individualized plan of care would be developed for each resident and would guide the resident's caregivers to assist in achieving or maintaining the resident's highest practicable level of wellbeing. The policy further directed that the care plan was developed by the interdisciplinary team, which included the social worker, and that the care plan was developed in collaboration with the resident's physician/provider. The policy further directed the care plan was updated at least quarterly and as necessary to reflect any changes in the resident's status.

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NAME OF PROVIDER OR SUPPLIER: Grimes Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 1354 Chapel St New Haven, CT 06511	

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility policies, and interviews for 1 of 3 residents (Resident #63) reviewed for pressure ulcers, the facility failed to ensure the care plan was reflective of interventions to address pressure ulcers including a Deep Tissue Injury (DTI) and for 1 of 3 resident (Resident #38) reviewed for nutrition, the facility failed to ensure the care plan was reflective of interventions related to congestive heart failure (CHF). The findings include: Resident #38 was admitted to the facility in January 2026 with diagnoses that included bilateral humerus fractures, atrial fibrillation, and chronic diastolic congestive heart failure. The physician's orders dated 1/15/26 directed Congestive Heart Failure protocol as follows. Check oxygen saturation every shift. Obtain daily weights at 6:30 AM and notify the MD/APRN of weight gain of 3 lbs. or more in one day or 5 lbs. in a week. Monitor edema to the abdomen, legs, ankles, and feet every shift. Monitor fatigue every shift. Monitor for shortness of breath and cough every shift. Monitor lung sounds every shift. The admission MDS dated [DATE] identified Resident #38 had severely impaired cognition, was frequently incontinent of bowel, occasionally incontinent of bladder and was dependent on facility staff to assist with eating, bathing, and toileting. Review of the care plan failed to identify the congestive heart failure diagnoses or interventions to address such. Review of the clinical record and interview with RN #9 (MDS Coordinator) on 1/30/26 at 7:50 AM identified she was responsible to update the resident's baseline care plan upon admission and with the admission MDS assessment. RN #9 identified the care plan should have included a history of CHF and that the CHF protocol had been ordered. RN #9 identified that she was unsure what happened as it appeared that the diagnosis and interventions were not added due to an oversight, and she would address the issue. The facility policy on care plan that a comprehensive and individualized plan of care would be developed for each resident and would guide the resident's caregivers to assist in achieving or maintaining the resident's highest practicable level of wellbeing. The policy further directed that the care plan was developed by the interdisciplinary team, which included the social worker, and that the care plan was developed in collaboration with the resident's physician/provider. The policy further directed the care plan was updated at least quarterly and as necessary to reflect any changes in the resident's status. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #63 was admitted to the facility in January 2026 with diagnoses that included difficulty in walking and protein-calorie malnutrition. The Nursing admission assessment dated [DATE] identified Resident #63 complained of tenderness to heels; the skin was intact, will off load. The care plan dated 1/16/26 identified Resident #63 was at risk for impaired skin related to decreased mobility, with interventions that included preventative treatments per MD orders, staff to encourage and assist with positioning, and completing weekly skin audits. The physician's admission note dated 1/16/26 identified Resident #63 had reported ongoing burning to his/her bilateral heels; Lidocaine 4% topical patch to both heels, every 12 hours was ordered. The admission MDS dated [DATE] identified Resident #63 had intact cognition, required substantial/maximal assistance with rolling left to right, lying to sitting and sitting to standing, had no unhealed pressure ulcers, and was at risk for pressure ulcers/injury The nurse's note dated 1/22/26 at 5:52 PM identified Resident #63 was alert and oriented, scheduled Tylenol was given for foot pain. Pain, redness (looks ruptured) blisters were noted on both heels. Both heels elevated with pillow to relieve pressure. A physician's order dated 1/22/26 directed for offloading Bolster BLE (bilateral lower extremities) when in bed, check for placement every shift. The Skin Grid dated 1/23/26 identified Resident #63 had a right suspected deep tissue injury measuring 1.2cm x 1.2cm, slight red/maroon area, fluctuant, the peri wound was intact, no odor or drainage noted, wound pain reported with pressure. Current treatment to offload heels and refer to the wound specialist. The physician's progress note dated 1/23/26 identified Resident #63 reported that he/she continued to have bilateral heel pain worse with ambulation, no different from baseline. The physical exam identified a small fluid-filled blister to the right heel and no blister to the left heel, but bogginess was appreciated and was tender to palpation. Bogginess and blisters were concerning for pressure injury, wound care was following. Plan to continue offloading heels at rest, follow-up with wound care, and continue with as needed Acetaminophen and Gabapentin. A physician's order dated 1/24/26 directed to apply skin prep spray to the right heel followed by Opti-foam dressing every 2 days and as needed. The care plan with a revision date of 1/27/26 failed to identify interventions following the identification of the deep tissue injury (DTI) to the right heel. Interview with the Wound Nurse (RN #1) on 1/28/26 at 9:35 AM identified that typically it would be the MDS staff that would develop and update care plans for DTIs following morning report. Interview with the DNS on 1/30/26 at 10:41 identified that Resident #63's care plan should have been updated to reflect the DTI that was identified on 1/22/26. The DNS indicated that it was the responsibility of the nursing supervisor that admitted the resident to initiate a baseline care plan and the MDS Coordinator would follow up and develop the comprehensive care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Clinical record review with the MDS Coordinator (RN # 9) on 1/30/26 at 10:49 AM failed to identify that a comprehensive care plan was put into place following the identification of the DTI to the right heel, on 1/22/26. Interview with RN # 9 on 1/30/26 at 10:49 AM identified that a care plan should be in place for Resident #63's DTI. RN #9 identified that there were 2 MDS coordinators, and both attended morning report where status changes and resident conditions would be discussed and information would be learned to update the resident's care plan. RN #9 indicated that she could not recall if Resident #63's DTI had been discussed during morning report. RN #9 identified that Resident #63's care plan would be updated to reflect his/her DTI. The facility's Care Plan policy directs a comprehensive and individualized plan of care will be developed for each patient/resident. The care plan will guide caregivers to assist patients/residents to achieve or maintain their highest practical level of well-being. The care plan will include a statement of the problem; reasonable and measurable goals, interventions to achieve these goals and disciplines responsible for carrying out the interventions. CNA assignment sheets will be updated as needed to reflect changes made to the patient/resident's plan of care. The facility's Protocols for Pressure Injuries policy directs for the highest quality of wound care for patients with pressure ulcers and defines a deep tissue injury as a purple or maroon localized discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy and warmer or cooler compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin. Evolution may include a thin blister over dark wound. The wound may further evolve and be covered with thin eschar, evolution may be rapid, exposing additional layers of tissue even with optimal treatment. Prevention and interventions include updating the care plan in CNA report sheets with interventions.

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident?s advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, facility documentation, facility policy and interview for 1 resident (Resident #2) reviewed for death, the facility failed to utilize a hard surface (backboard) beneath the resident while performing cardiopulmonary resuscitation (CPR) according to the American Heart Association current guidelines. The findings include:Resident #2 was admitted to the facility in 6/2025 with diagnoses that included malignant neoplasm of glottis (region of the larynx or voice box containing vocal cords) and history of acute and chronic respiratory failure with a tracheostomy placement.The quarterly MDS dated [DATE] identified Resident #2 was cognitively intact, independent with bed mobility, transfers and ambulation without assistance and received tracheostomy care.The care plan dated [DATE] identified Resident #2 had a potential for altered respiratory status secondary to having a tracheostomy (trach) and history of respiratory failure. Interventions included monitoring respiratory status and reporting changes to the physician. Advance directives specified a full code status, meaning CPR would be initiated for life saving measures if necessary.A physician's order dated [DATE] directed to complete trach care every shift by cleaning the non-disposable inner cannula, around stoma (opening) and under flange of the trach with sterile water and change the 4x4 drainage sponge, suction trach once every shift and as needed and provide cool mist aerosol via air compressor at 2 liters/min via trach mask every evening shift. The physician's order also directed full code status.Facility video surveillance dated [DATE] at 6:13 AM identified NA #6 enter Resident #2's room with a weight scale and vital sign machine and later exit.Nurse's note dated [DATE] at 6:15 AM identified Acetaminophen 800 mg was administered via g-tube for pain level of 2.Nurses note dated [DATE] at 6:55 AM identified follow up pain assessment was effective post administration of Acetaminophen.Facility video surveillance dated [DATE] at 8:11 AM identified LPN #4 retrieving the emergency cart and oxygen tank. A backboard was not visualized on top of or attached to the cart.Nurse's note dated [DATE] at 11:55 AM identified at 8:12 AM, Resident #2 was found unresponsive in the recliner chair in his/her room. A medical alert was paged overhead. Resident #2 was transferred into bed by staff and CPR was initiated. Emergency medical services (EMS) were dispatched. High flow oxygen was delivered via Ambu bag (aides in delivery of breaths and oxygen), and an automated external defibrillator or AED was applied (used for treatment when in cardiac arrest by delivering an electric shock to restore normal heart rhythm). No shock was advised. At 8:28 AM EMS arrived and assumed CPR with intermittent suctioning via the trach and orally. Interosseous (in the bone marrow) fluids 0.9% normal saline were initiated, five rounds of epinephrine and one round of bicarbonate (medications that aid in restarting the heart) total were administered. A LUCAS device (automated CPR machine designed to deliver consistent chest compressions during CPR) was applied at 8:41 AM. Resident #2 was intubated (mechanically creates an open airway) at 8:49 AM. EMS contacted the hospital physician, CPR was discontinued and the resident was pronounced at 8:58 AM. Next of kin was notified, postmortem care provided, and the body was subsequently released to the funeral home at 11:15 AM.The death certificated dated [DATE] at 8:58 AM identified the cause of death as mucous plugging, tracheostomy and laryngeal cancer and manner of death as natural.Observation of the emergency carts on [DATE] at 9:00 AM on the second and third floors identified the CPR backboards (used to provide a firm surface during CPR) were was not attached to the emergency cart and instead next to the emergency cart leaning up against the wall.Interview with RN #1 on [DATE] at 9:54 AM identified she was working the 7:00 AM to 3:00 PM shift on [DATE] in her role as the infection preventionist when she heard a medical alert paged overhead indicating a medical emergency. RN #1 responded to the area where she observed Resident #2 sitting in a recliner in his/her room unresponsive. RN #1 indicated she assisted in transferring Resident #2 directly onto the bed cover but did not participate in delivering CPR. RN #1 (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	further identified she did not see a backboard in use at any time and when asked about the backboard she indicated she would have to refer to the facility policies for its indication.Interview with LPN #5 on [DATE] at 10:23 AM identified she was the assigned nurse 7:00 AM to 3:00 PM shift on [DATE]. LPN #5 indicated she had seen Resident #2 sitting upright in a recliner in his/her room when she arrived at the unit at 7:30 AM but was unable to determine if Resident #2 was awake and responsive. LPN #5 was informed in report by the off going nurse that trach care had been provided during the 11:00 PM to 7:00 AM shift without complications. At 8:12 AM, LPN #4 was alerted by NA #3 that Resident #2 was ?slumped' in the chair and staff were unable to obtain vital signs. LPN #5 went to Resident #2's room, found him/her unresponsive, checked for a carotid pulse and determined it was absent. LPN #5 remained with Resident #2 and instructed NA #3 to call a medical emergency. Staff responded immediately. Resident #2 was subsequently transferred directly onto the bed and CPR was initiated. LPN #5 further identified a backboard was not used during CPR and she would need to ?circle back' to discuss its rationale.An interview with the Administration on [DATE] at 10:30 AM identified a post incident debriefing and review of the incident was not completed to evaluate whether effective CPR was delivered as there was no indication to do so.Interview with MD #2 on [DATE] at 11:15 AM identified on [DATE], she had arrived at 8:05 AM and a short time later she heard a medical emergency announcement overhead. MD #2 responded to Resident #2's room where she observed the resident sitting unresponsive in a recliner pale and pulseless. Staff transferred Resident #2 onto the bed and initiated CPR. MD #2 provided direction and continued to oversee all activities related to the timing and compression intervals of CPR including performing a cycle herself until EMS arrived and assumed care. MD #2 did observe there was no backboard in use and inquired about its absence and was told someone was getting it. MD #2 indicated that although lack of a hard surface likely did not affect the outcome as Resident #2 was pale, only slightly warm and compressions appeared effective, staff should have utilized a backboard during CPR, and she should have followed up on its status when one did not arrive.Interview with OT #1 on [DATE] at 11:43 AM identified she was working during the 7:00 AM to 3:00 PM shift on [DATE] when she heard a medical emergency announced. OT #1 went to Resident #2's room where she observed him/her to be unresponsive in the chair. OT #1 assisted staff in transferring Resident #2 directly onto the bed without the benefit of a backboard. Additionally, she delivered a cycle of CPR and could not recall being present when MD #2 requested a backboard. OT #1 further identified she would need to refer to facility policy to discuss a backboard's indication for use.Interview with RN #7 on [DATE] at 2:34 PM identified she was working during the 7:00 AM to 3:00 PM shift on [DATE] when she heard a medical emergency announced. Upon arrival, nursing staff were already present in Resident #2's room and the emergency cart had been brought to the area. RN #7 did not observe a backboard attached to the cart or in use. RN #7 assisted in transferring Resident #2 directly onto the bed but did not participate in delivering CPR. RN #7 indicated she observed the bed rise and fall during chest compressions, and the compressions themselves appeared ineffective. EMS subsequently arrived and assumed care. RN #7 further identified that although she was aware the use of a backboard was essential to delivering effective chest compressions, she did not make efforts to initiate its use during the transfer, prioritizing placement of the resident safely on the bed before initiating CPR.Interview with LPN #4 on [DATE] at 3:13 PM identified she worked [DATE] to [DATE] but was not assigned nurse. LPN #4 was on the unit when the medical emergency was announced and brought the emergency cart and oxygen to Resident #2's room, without a backboard. LPN #4 further identified that although she was aware a backboard or hard surface should be used during CPR, she was unable to explain the rationale for its use.Interview with LPN #6 on [DATE] at 6:35 AM identified she worked as the assigned nurse during overnight [DATE] to [DATE] from 11:00 PM to 7:00 AM. LPN #6 indicated she provided routine care and suctioning for Resident #2 during the shift and administered Tylenol for mild discomfort with effect. It was routine for Resident #2 to elect to remain in his/her recliner during the overnight hours and commonly request Tylenol for generalized pain and there was nothing unusual noted during care. (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN #6 also responded when the medical emergency was announced and assisted in transferring Resident #2 back to bed, without a backboard. LPN #6 indicated the backboard should be attached to the emergency cart and used prior to initiating CPR but was unable to explain what occurred in this case and why it was not used.Interview and facility documentation review with the facility certified CPR instructor for the American Heart Association (AHA) on [DATE] at 9:52 AM identified he was responsible for basic life support certifications to the facility staff including CPR. The CPR instructor identified that a resident must be placed on a hard surface during CPR in a clinical setting to deliver effective chest compressions to profuse the heart, brain and other body organs. Without a hard surface chest compression would be less effective.A subsequent interview with MD #2 on [DATE] at 10:14 AM confirmed she was told by RN #1 that the backboard was being retrieved by RN #2. MD #2 did not follow up with administration to provide a debriefing related to the absence of a backboard as it slipped her mind and she was involved with other post incident tasks.Interview with RN #2 on [DATE] 10:58 AM identified she was the assigned unit manager on [DATE] when she heard a medical emergency announced. RN #2 arrived at Resident #2's room and nursing staff were already present, and the emergency cart was nearby. RN #2 did not assist transferring Resident #2 to bed but assisted by clearing the room of furniture and delivering oxygenation during CPR. RN #2 also delivered a two-minute cycle of CPR but did not notice if the compressions were rising and falling with the bed. Additionally, although aware of the need for a hard surface, RN #2 was not thinking about using a backboard and did not recall being asked to acquire one.Interview with NA #3 on [DATE] at 11:19 AM identified she was the assigned aide working 7:00 AM to 3:00 PM on [DATE]. NA #3 had not received report from the night shift aide, NA #6, from the preceding shift and had not seen Resident #2 previously. NA #3 indicated at approximately 8:15 AM she knocked and entered Resident #2's room where she found him/her unresponsive and leaning to the side. NA #3 indicated the skin was pale and felt cold to the touch. NA #3 immediately summoned housekeeping staff to call for help while she remained with Resident #2. Nursing staff arrived immediately, and NA #3 left the area.Interview and policy review with the DNS on [DATE] at 12:05 PM identified she would defer to the facility policies when discussing the need for a hard surface during CPR. However, noted the requirement for a hard surface was not included in the current the policy.A subsequent interview and facility documentation review with the Administrator on [DATE] at 12:05 PM identified that while her independent research indicated a hard surface was preferred but not regulatory, she did not disagree with AHA standard of practice of a hard surface during CPR as crucial for effective profusion.Subsequent to survey inquiry, the facility policy was revised to include the requirement of a hard surface before initiating CPR, backboards on all units were secured on the emergency cart and new emergency carts were ordered.A review of the facility policy for Cardiopulmonary Resuscitation directed CPR to be instituted in cases of cardiac/pulmonary arrest to sustain or support a residents cardiac/pulmonary function until advanced life support is available. In the event of cardiac arrest, CPR is initiated immediately, supervisor pages STAT (immediately) three times and CPR was to continue until life-support systems are available and operable.American Heart Association current guidelines for CPR directs that performing CPR on a hard surface is crucial for effective resuscitation. A hard surface allows for better compression depth and reduces rescuer fatigue. When CPR is performed on compliant surfaces like mattresses, the quality of compressions can be compromised, leading to less effective resuscitation.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interview for 1 of 3 residents (Resident #38) reviewed for nutrition, the facility failed to ensure that daily weights were obtained and documented per the physician's order. The findings include:Resident #38 was admitted to the facility in January 2026 with diagnoses that included bilateral humerus fractures, atrial fibrillation, and chronic diastolic congestive heart failure. The physician's order dated 1/15/26 directed to obtain daily weights at 6:30 AM and notify the MD/APRN of weight gain of 3 lbs. or more in one day or 5 lbs. in a week.The admission MDS dated [DATE] identified Resident #38 had severely impaired cognition, was frequently incontinent of bowel, occasionally incontinent of bladder and was dependent on facility staff to assist with eating, bathing, and toileting.Review of the care plan failed to identify interventions related to congestive heart failure or the need for daily weights. Review of the clinical record failed to identify daily weights had been obtained on the following dates: 1/17, 1/18, 1/19, 1/20, 1/22, 1/25 and 1/28/26. Further, the clinical record failed to identify why the weights were not obtained on those dates.Interview with RN #3 (Unit Manager for Resident #38's unit) on 1/30/26 at 12:05 PM identified she was aware of the issue regarding the missing weight documentation for Resident #38. RN #3 identified that for the first few days following admission, it was difficult to obtain the weights because Resident #38 had bilateral humerus fractures with pain on movement. RN #3 identified that after the first 3-4 days, Resident #38 was able to tolerate more movement and at that point the weights should have been done daily. RN #3 identified that if the nursing staff were unable to obtain the weights, the rationale should have been documented in the clinical record, and the provider should have been made aware. Although requested, the facility failed to provide a policy on accurate documentation in the clinical record.The facility policy on weighing residents directed that the purpose of the policy was to monitor residents for weight loss or gains and that weights would be recorded in the electronic medical record.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, facility documentation, facility policy and interviews for 1 resident (Resident #11) reviewed for range of motion, the facility failed to ensure an adaptive device for limited mobility of the right hand was applied according to physician's orders. The findings include.Resident #11 was admitted to the facility in 10/2024 with diagnoses that included cerebral infarction and disorders of the automatic nervous system.The quarterly MDS dated [DATE] identified Resident #11 was severely cognitively impaired, had limited range of motion in the upper and lower extremities and required two person assist for bed mobility, transfers, and dressing.The care plan dated 1/3/26 identified Resident #11 required ADL assistance related to decreased mobility with cognitive deficits. Interventions included providing supportive care, assistance with mobility as needed and PT/OT referral, evaluation and treatment as ordered.A physician's order dated 1/4/26 (original date 4/11/25) directed a right C-grip hand splint to be applied every day shift after morning care for up to four hours.The schedule for the assistive device posted on the inside of Resident #11's closet with images directed the right-hand device to be applied after morning care for up to four hours. Staff were to make sure straps were not tight, follow numbers when applying, check skin for breakdown and notify the supervisor for any questions.The nurse aide care card did not include the C-grip schedule for application/removal or corresponding care. Observation on 1/27/26 at 12:15 PM identified Resident #11 was up and dressed sitting in his/her wheelchair without the benefit of the prescribed right-hand C-grip.Interview with NA #2 on 1/27/26 at 12:15 PM identified Resident #2 was able to make needs known, was originally resistive to wanting to get changed earlier in the day but later was agreeable without any refusals.Observation on 1/28/26 at 11:30 AM identified Resident #11 was still in bed. The right hand was not visualized.A subsequent observation on 1/28/26 at 1:46 PM identified Resident #11 was up in his/her chair and dressed without the benefit of the C-grip to the right hand.An interview with NA #2 on 1/28/26 at 1:46 PM identified Resident #11 did not experience any complications or refusals during morning care. NA #2 indicated that while direction for use of the C-grip was not on the nurse aide card, she was aware the device was to be applied after morning care as directions were posted on the inside of Resident #2's closet. NA #2 further identified she did not routinely apply the C-grip when assigned, was unsure who was responsible for its placement, would not know where to find the C-grip, was never formally in-serviced and had not reported any of these concerns to the charge nurse. Interview with RN #2 on 1/29/26 at 207 PM identified she worked as unit manager during the day shift. RN #2 indicated rehabilitation staff were responsible for entering orders into the system regarding use of any adaptive device. The assigned charge nurse was then responsible for transcribing the orders and placing information on the nurse aide care card. Nurse aides were responsible for the application of the adaptive device and nursing staff were responsible for ensuring its application and skin check were completed during the shift.Interview and clinical record review with OTR #1 on 1/29/26 at 2: 23 PM identified Resident #11 had a right-hand splint that was to be applied during the day up to four hours as tolerated and was trialed before assigning care to nursing staff. On 6/18/25, supervisory nursing staff were educated on the program and demonstrated good understanding. Instructions for use were documented in the clinical record and in Resident #2's room.Review of the nursing staff in-service for the application and care of Resident #2's C-grip did not include NA #2.Interview and clinical record review with the DNS on 1/29/26 at 2:34 PM identified she would expect nurse aide staff to apply the C-grip in accordance with physician orders and to notify the nurse for any refusal or inability to locate.Interview with LPN #5 on 1/30/26 at 2:40 PM identified she was the assigned nurse on 1/29/26 during the 7:00 AM to 3:00 PM shift. LPN #5 indicated that although aware nursing staff were responsible for overseeing the placement of the C-grip and to perform a skin check, she did not do so on 1/29/26 as no concerns related to the assistive device (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075275	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grimes Center	1354 Chapel St New Haven, CT 06511

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were reported.A review of the facility policy for splints directed that residents are issued splints to improve range of motion or prevent further contracture, prevent skin breakdown and maintain/improve hygiene. Rehabilitation staff may trial new splints to ensure tolerance, comfort and function. Rehabilitation staff will in-service nursing staff as needed regarding purpose, donning and doffing, wear schedule and care. Rehabilitation staff may provide written instructions and photographs. Physician orders will be obtained for the wear schedule. Orders will be transcribed to the resident care plan and nurse aide assignment sheet. Nursing will refer any splinting issues back to the therapy department as needed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075275	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/30/2026

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 review of the clinical record, facility documentation, facility policy, and interviews for the only sampled resident (Resident #8) reviewed for antibiotic use, the facility failed to ensure the resident with an indwelling medical device and chronic wound was placed on Enhanced Barrier Precautions (EBP), and for the only sampled resident (Resident #16) reviewed for dialysis, the facility failed to ensure a resident with an indwelling medical device was placed on EBP.1. Resident #8 was admitted to the facility on 12/2025 with diagnoses that included a non-pressure chronic ulcer of the left and right heel and left and right midfoot with bone involvement.A physician's order dated 12/26/25 directed to change the dressing to the right foot wound daily, every shift, and to change the wound vac (125 mmHg) dressing to the left foot every Monday, Wednesday, and Friday. The physician's orders identified that Resident #8 had a single lumen Peripherally Inserted Central Catheter (PICC) to the right upper chest with an order that directed for transparent dressing changes: 24-hours post insertion or admission, then weekly and as needed. The physician's order failed to direct EBP. The admission MDS dated [DATE] identified Resident #8 had intact cognition, required substantial/maximal assistance with toileting hygiene, showering/bathing, and lower body dressing, required partial/moderate assistance with upper body dressing and personal hygiene, had a foot infection, required surgical wound care and the application of foot dressings, was receiving an antibiotic, and had intravenous (IV) access. The care plan dated 1/7/26 identified Resident #8 had an alteration in skin integrity related to: surgical incision to the bilateral feet, with interventions that included dressing changes as ordered and wound vacuum (a negative pressure wound therapy device used for treatment of acute, chronic, and surgical wounds) if appropriate, and Resident #8 had an IV Hickman line (a central line used for long-term direct access to the blood stream), with interventions that included administering medications and fluids per the MD order, changing the dressing and IV site per the policy and as needed, and flushing per policy. The care plan failed to identify EBP was included as a care plan focus or intervention. The Internal Medicine progress note dated 1/28/26 identified Resident #8 underwent bilateral foot debridement on 6/5/25 and was closely followed in the outpatient setting with frequent debridement to the chronic heel wounds; a left calcaneal biopsy was completed on 11/26/25 and showed evidence of acute osteomyelitis. On 12/8/25 Resident #8 was sent to the ED with necrotic heel wounds and increasing purulent drainage coming from the right foot. On 12/8/25 Resident #8 started on Vancomycin/Zosyn (antibiotics), and then on 12/9/25, he/she was taken to the OR for right foot incision and drainage. Podiatry took Resident #8 to the OR on 12/18/25, status post left partial calcanectomy, right foot with excisional debridement of nonviable soft tissue with application of biological grafts to bilateral heel wounds and negative pressure wound-VAC therapy-open. Resident #8 was discharged to short term rehab on IV Unasyn and Vanco. Interview with LPN #7 on 1/30/26 at 6:45 AM identified that she was not aware of Resident #8 being placed on EBP or if he/she met the criteria for EBP, and she was not aware of any residents on her 4th floor assignment requiring EBP. Interview with RN #10 on 1/30/26 at 10:08 AM identified that she was not aware of Resident #8 being placed on EBP and she was not sure if he/she met the criteria for EBP. 2. Resident #16 was admitted to the facility on 01/2026 with diagnoses that included end-stage renal disease and dependance on renal dialysis.A physician's order dated 1/19/26 directed to change transparent dressing: resident has a permacath to right upper chest wall, check dressing integrity and date of the last dressing change every shift. The admission MDS dated [DATE] identified Resident #16 had intact cognition, required substantial/maximal assistance with toileting hygiene, showering/bathing, upper and lower body dressing, and personal hygiene, and was receiving hemodialysis. The care plan dated 2/2/26 identified Resident #16 had an arteriovenous (AV) fistula to the left arm related to dialysis (right AV fistula not used), with interventions that included monitoring the chest venous port side every shift and as needed for signs and symptoms of infection and (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Grimes Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1354 Chapel St New Haven, CT 06511	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bleeding. Interview with RN #1 on 1/27/26 at 10:14 AM identified that Resident #16's AV fistula was not in use due to an evacuation of a hematoma, and he/she was dialyzed through a permacath. Interview with LPN #8 on 1/30/26 at 6:46 AM identified that she was not aware of Resident #16 being placed on EBP or if he/she met the criteria for EBP, and she was not aware of any residents on the 4th floor that required EBP since she began working at the facility, a little less than a year ago. Interview with RN #8 on 1/30/26 at 8:10 AM identified that Resident #16 was not on EBP and was not sure if he/she had met the criteria for EBP. Review of the facility's EBP education documentation with the Infection Control Preventionist (RN #1) and the ADNS (covering staff development) on 1/30/26 at 9:15 AM, identified education was provided to all nursing staff on the topic of EBP from October 2025 through December 2025, including the criteria for implementing EBP, which includes residents with chronic wounds and indwelling medical devices. Interview with RN #1 on 1/30/26 at 10:02 AM identified that due to the high turnover of admissions and discharges and her interpretation of the CDC's EBP FAQ sheet, which identified that the CDC did not recommend implementation of Enhanced Barrier Precautions (EBP) in other healthcare settings aside from nursing homes, and since the facility's long term care residents resided only on the 3rd floor, she did not place the residents residing on the short term rehab floors (2nd and 4th floors) on EBP, when applicable. RN #1 indicated that the facility was a licensed chronic and convalescent nursing home, and residents requiring transmission-based precautions (TBP) were not limited to the 3rd floor and could be placed in rooms on the 2nd and 4th floors, with TBP in place. RN #1 identified that Resident #8 should be on EBP due his/her PICC line (an indwelling medical device), and Resident #16 should also be on EBP due to his/her dialysis permcath (an indwelling medical device). RN #1 identified that she would place Residents #8 and #16 on EBP, as well as any residents on the short-term rehab floors meeting the EBP criteria and would initiate reeducation on EBP for all nursing staff, therapy, and housekeeping. Interview with the DNS on 1/30/26 at 10:38 AM identified that Residents #8 and 16 should have been placed on EBP due to their indwelling medical devices. The DNS indicated that Residents #8 and #16 were at the facility for short term rehab, not long-term care, and due to the fluidity of resident status changes and the volume of turnover due to admissions and discharges, residents on the short-term rehab floors had not been placed on EBP. The DNS indicated that the plan moving forward would be to implement EBP, when appropriate, on the short-term rehab floors, as well. The facility's Enhanced Barrier Precautions policy directs that EBP will be used for all patients with infection or colonization with a novel or targeted MDRO when contact precautions do not apply on long term care units/long term care patients, and EBP will also be used for patients with wounds or indwelling medical devices regardless of MDRO colonization status, if on units with patients that require transmission based precautions. Staff will don appropriate PPE for these patients prior to high contact care activities. These patients do not always require a private room and this does not require restrictions for movement throughout facility or participation in activities within the facility's policy. High contact patient care activities are defined as follows: dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use of a device: central line, urinary catheter, feeding tube, tracheostomy, ventilator, and wound care: any opening requiring a dressing slash major chronic wounds (pressure injuries, diabetic ulcers, on healed surgical wounds, and chronic venous stasis ulcers).