STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075288	A. Building B. Wing	04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairview	235 Lestertown Rd Groton, CT 06340

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, review of facility documentation, review of facility policy/procedures and interviews for one sampled resident (Resident #103) reviewed for pressure injury, the facility failed to ensure a comprehensive person-centered care plan with measurable objectives and timeframes to meet the resident's medical, nursing, mental and psychosocial needs identified in the comprehensive assessment so that services provided maintain the resident's highest practicable physical, mental and psychosocial well-being and included any specialized services or specialized rehabilitative services. The findings include:Resident #103 was admitted to the facility on [DATE] with diagnoses that included acute on chronic diastolic congestive heart failure, acute and chronic respiratory failure with hypoxia, pulmonary edema, muscle weakness, abnormalities of gait and mobility, cognitive communication deficit and dementia.Physician's orders dated 11/29/24 directed a sodium restriction diet of regular texture and thin liquids consistency.Resident #103's care plan dated 12/2/24 identified Resident #103 had a self-care deficit related to activities of daily living (ADLs) related to activity intolerance. Care plan interventions directed an assist of one for bed mobility and transfers and indicated Resident #103 was non-ambulatory. The care plan interventions were dated 9/24 and were carried over from a previous admission and failed to reflect the occupational and physical therapy assessment dated [DATE].The admission MDS assessment dated [DATE] identified Resident #103 had moderately impaired cognition, was dependent on staff for toileting hygiene, shower/ bathing, transfers, position changes and mobility in the wheelchair. It further identified the resident was frequently incontinent of bowel and bladder, was at risk for developing pressure ulcers/injuries but did not have any pressure injuries and did not have any ulcers, wounds or skin problems, had a pressure reducing devices for wheelchair and bed. The assessment further identified Resident #103 was taking anticoagulant and diuretic medications. The assessment reflected that the care areas triggered included nutritional status, pressure ulcer, cognitive loss/dementia, ADL functional/rehabilitation potential and urinary incontinence. Mobility:The Braden Scale for predicting pressure ulcer risk evaluation dated 11/28/24 at 12:40 PM and completed by LPN#1 identified Resident #103 had a score of 16, which indicated Resident #103 was assessed a mild risk for developing a pressure injury. The Braden scoring identified Resident #103 had no sensory impairment, was occasionally moist, was chair fast and made frequent though slight changes in body or extremity position independently. The scoring included Resident #103 probably had inadequate nutrition and that friction and shear was a potential problem.The nursing clinical admission progress note dated 11/28/24 at 12:45 PM identified Resident #103 had two skin issues: right shin abrasion, buttocks red/blanchable wound present on admission and noted edema to the bilateral lower extremities (BLE). The physical therapy recommendation dated 11/29/24 directed Resident #103 to be transferred with a mechanical lift with 2 staff assist and to ambulate with therapy only. Additionally, the PT evaluation and plan of treatment identified Resident #103 was dependent with an assist of 2 for sit to lying, lying to sitting on side of bed and sitting to standing. The assessment indicated transfers were not attempted due to medical condition. The Occupational Therapy (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075288	A. Building B. Wing	04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairview	235 Lestertown Rd Groton, CT 06340

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Evaluation and plan of treatment dated 11/29/24 identified Resident #103 was dependent for transfers with a mobility performance score of 0 out of a range of 0 to 12; 12 being the highest function. OT encounter note identified Resident #103 participated in bed mobility requiring moderate assist of 2 for bed mobility and indicated an assist of 2 was provided for sit to stand, indicating Resident #103 reported BLE discomfort and demonstrated poor functional activity tolerance requiring seated rest periods due to fatigue and decreased O2 saturation to 86% on 3L via nasal canula and required a mechanical Hoyer lift for transfers out of bed with staff.Resident #103's care plan dated 12/2/24 identified Resident #103 had a self-care deficit related to activities of daily living (ADLs) related to activity intolerance. Care plan interventions dated 12/16/24 directed an assist of one for bed mobility, transfers, bathing/showering, dressing, and indicated Resident #103 was non-ambulatory. The care plan interventions failed to reflect Occupational and physical therapy assessments dated 11/29/24 which identified Resident #103 was an assist of 2 for bed mobility and assistance for care. The care plan meeting note dated 12/2/24 at 1:48 PM identified Resident #103 used a Hoyer lift for transfers. However, this was not reflected in the care plan.The nurse aide care card (don't have a date) directed Resident #103 was an assist of 1 for care and mobility and transfers to and from bed.The nursing progress note dated 12/16/24 at 3:29 PM identified nursing was approached by physical therapy due to Resident #103's refusal to get out of bed and indicated Resident #103 had mild back pain and was tired but refused pain medication and denied pain to nursing.The occupational therapy treatment note dated 12/19/24 identified Resident #103 required an assist of 2 for safety during car transfers and indicated Resident #103's son was educated on need for rolling walker due to Resident #103's new level of ability and fatigue and shortness of breath with just a transfer.The occupational therapy treatment note dated 12/21/24 at 3:46 PM identified Resident #103 had increased coughing and malaise with decreased tolerance to functional activities and indicated a Covid positive test.Resident #103's care plan failed to identify the resident need for assistance of 2 people for transfers, mobility and care related to Resident #103's inability to move due to fatigue and shortness of breath with activity.The facility policy for comprehensive care plans directed the facility to develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The policy indicated that all areas triggered by the MDS will be considered in developing the plan of care in addition to other factors identified by the interdisciplinary team. The policy identified the care plan will include measurable objectives and timeframes to meet the resident needs and alternate interventions will be documented as needed. The policy further identified qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made.The facility policy for pressure injury prevention identified risk assessments and other risk factors would be used to develop a care plan that includes measurable goals for prevention with appropriate interventions. The policy further identified the ADNS was responsible for reviewing all relevant documentation regarding skin assessments, pressure injury risks and compliance and indicated that interventions would be modified as needed. Skin condition:The Braden Scale for predicting pressure ulcer risk evaluation dated 11/28/24 at 12:40 PM and completed by LPN#1 identified Resident #103 had a score of 16, which indicated Resident #103 had a mild risk for developing a pressure sore. The Braden scoring identified Resident #103 had no sensory impairment, was occasionally moist, was chairfast and made frequent though slight changes in body or extremity position independently. The scoring included Resident #103 probably had inadequate nutrition and that friction and shear was a potential problem.Nursing clinical admission progress notes dated 11/28/24 at 12:45 PM identified Resident had skin issues that included: a right shin abrasion, buttocks red/blanchable wound present on admission. wound is new, left breast mastectomy, right front axilla bruising, left shin bruising, and edema to BLE. The nursing progress note dated 11/29/24 at 7:31 AM identified Resident #103 was (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075288	A. Building B. Wing	04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairview	235 Lestertown Rd Groton, CT 06340

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	incontinent with bladder and upper and lower extremities were swollen and indicated Resident #103's legs were kept elevated.The physician's progress note dated 11/29/24 at 1:56 PM identified Resident #103 was assessed in bed, had no dermatitis, had bilateral upper extremity pitting edema and bilateral lower extremity edema.Resident #103's care plan dated 12/2/24 identified Resident #103 was at risk for potential impairment to skin integrity related to impaired mobility and significant edema. Care plan interventions directed ACE wraps as tolerated to keep skin clean and dry, provide pressure relieving/reducing mattress, turn and reposition resident frequently as tolerated, encourage good nutrition and hydration in order to promote healthier skin and identify/document potential causative factors and eliminate/resolve where possible. The care plan failed to identify Resident #103 had open skin areas and was being treated by the wound doctor, was generalized and not individualized, failed to be individualized to represent Resident #103's open wounds being treated by the wound MD and failed to direct appropriate interventions for care.Wound care specialist's initial assessment note dated 12/4/24 at 1:45 PM identified skin problem to the right lower leg identified and provided wound care. The note identified a right lower leg wound with measurements 0.7cm x 0.3 cm x 0.1 cm with treatment recommendation to cleanse wound, apply silver hydrogel to base of the wound, secure with dry clean dressing and change every other day and as needed for soiling, saturation or accidental removal.The Braden Scale for predicting pressure ulcer risk evaluation dated 12/5/24 at 12:53 PM identified Resident #103 had a score of 17 indicating a mild risk for developing pressure injury. The assessment identified Resident #103 had no sensory impairment, was occasionally moist, chairfast and made frequent though slight changes in body or extremity position independently. The assessment further indicated Resident #103's nutrition was adequate and that friction and shear was a potential problem.Based on the admission assessment, Physical therapy assessment, occupational assessment and nursing notes my Braden scale assessment for Resident #103 scored a score of 10, which indicated Resident #103 was a high risk for pressure injury development. Nursing notes identified Resident #103 was not able to feel when he/she had a bowel movement or incontinence, indicated Resident #103's extremities were +3 pitting edema with some open areas and requiring ace wraps to BLE and BUE would indicate a very limited sensory perception (2). Resident #103 would have occasionally moist moisture indicating skin is occasionally moist requiring a linen change once daily (3). Based on physician notes identifying Resident #103 was bedfast, the activity level would be Bedfast (1). Based on occupational therapy and physical therapy notes Resident #103's mobility is very limited (2) and makes occasional slight changes in body or extremity position but is unable to make frequent or significant changes independently. Resident #103's nutrition is probably inadequate (2) and friction and shear is a problem (1) and required moderate to maximum assistance in moving as identified in the PT and OT assessments dated 11/29/24. This would indicate a Braden score of 11 which identified Resident #103 was a high risk for pressure injury development. The wound physician's note dated 12/18/24 at 2:36 PM identified Resident #103 was being treated for a right lower leg excoriation and indicated the assessment and plan to include a registered dietician consultation to optimize nutrition and avoid friction/sheer/traumatic forces.The nursing advanced skilled evaluation dated 12/24/24 at 10:37 PM identified Resident #103 had a skin issue that had not been evaluated to the right coccyx moisture associated skin damage that was painful and burning and directed interventions of change in position. The wound measurements were documented as 1.3 cm x 1.5 cm. The note identified an additional skin issue to the left coccyx moisture associated skin damage that was painful and burning with measurements of 2.1 cm x 1.7 cm.The nursing progress note dated 12/25/24 at 11:13 PM identified Resident #103 had a skin issue that had not been evaluated to the right coccyx moisture associated skin damage that was painful and burning and directed interventions of change in position. The wound measurements were documented as 1.3 cm x 1.5 cm. The note identified an additional skin issue to the left coccyx moisture associated skin damage that was painful and burning with measurements of 2.1 cm x 1.7 cm with intervention of position change. The note additionally indicated Resident #103 was bedfast at all or most of the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075288	A. Building B. Wing	04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairview	235 Lestertown Rd Groton, CT 06340

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	time.The wound physician's note dated 12/27/24 at 4:50 PM identified Resident #103 was seen for a coccyx wound and indicated it was a stage 3 pressure wound. The note identified Resident #103 had edema and pressure associated signs and symptoms indicating pain in the new wound, Covid positive, incontinent and with decreased activity. Measurements of the coccyx wound were 2.7 cm x 3.2 cm x 0.3 cm with exposed subcutaneous tissues with a moderate amount of serosanguineous exudate. The note further directed wound care to cleanse wound, apply triad to peri wound, calcium alginate with silver to base of the wound, secure with dry clean dressing and change daily and as needed for soiling, saturation or accidental removal. Additional recommendations for a registered dietician consultation to optimize nutrition and pressure redistribution mattress per facility protocol.Resident #103's care plan identified Resident #103 was at risk for skin alteration and was not revised to include the development of wounds that required additional interventions or daily care.Interview with MDS#2 on 4/13/26 at 10:19 AM identified she was responsible for the short-term rehab admissions, completing assessments, putting in care plans and setting up the admission in the computer. MDS#2 indicated she got her skin information from the clinical admission and further indicated that all residents at the facility is at some risk for pressure and every resident gets a care plan for the potential impairment to skin integrity. MDS#2 identified she looks for skin tears, surgical wounds or pressure injuries and completes the baseline care plans and, based on the assessment, fills out the comprehensive care plan. MDS#2 indicated that RN supervisors were supposed to start the care plans and MDS adds additional information. MDS#2 further identified that open areas and residents seen by the wound MD should be reflected in the care plan designating wound care but that she doesn't always add the intervention. MDS#2 indicated that care plans can't be too pigeonholed and are vague and the items in the care plan direct the Kardex information. MDS#2 could not identify why Resident #103's wounds and mobility status were not updated. MDS#2 indicated that although her partner (MDS#1) was more diligent about updating the care plans, she was not.Interview with RN#2, RN supervisor, on 4/13/26 at 10:57 AM identified that care plans can be added to by nursing and interventions should be based on the needs of the resident. RN#2 indicated that interventions in the care plan carry over to the Kardex for direction of care for the NAs. RN#2 identified that all care should be verbally discussed with staff in the event there are changes.Interview with MDS#1 on 4/13/26 at 11:56 AM identified that she was responsible for the long-term residents. MDS#1 indicated that she adds the specific wound, date of occurrence and interventions for care. MDS#1 identified care plans should be specific to the resident.Interview with the ADNS on 4/13/26 at 2:01 PM identified that on further review of Resident #103's clinical record, the Braden assessments were not accurate. And indicated the score should have been a lower score identifying a higher risk for pressure injury development. The ADNS would not identify what an accurate score would have been. The ADNS indicated that there were inconsistencies in Resident #103's documentation was conflicting. The ADNS further identified that although the care plan directed turning and repositioning and assist for mobility, the interventions did not align with the assessments and that interventions for mobility would be directed by therapy. The ADNS identified MDS was primarily responsible for care planning but indicated that nursing had the ability to amend them.The facility policy for comprehensive care plans directed the facility to develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The policy indicated that all areas triggered by the MDS will be considered in developing the plan of care in addition to other factors identified by the interdisciplinary team. The policy identified the care plan will include measurable objectives and timeframes to meet the resident needs and alternate interventions will be documented as needed. The policy further identified qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made.The facility policy for pressure injury prevention identified Interventions for (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075288	A. Building B. Wing	04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairview	235 Lestertown Rd Groton, CT 06340

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	prevention and to promote healing and indicated that after completing a thorough assessment/evaluation, the interdisciplinary team shall develop a relevant care plan that includes measurable goals for prevention with appropriate interventions. The policy identifies basic or routine care interventions to include redistribute pressure such as repositioning or offloading, minimize exposure to moisture and keep skin clean, provide appropriate, pressure redistributing support surfaces, provide non-irritating surfaces and maintain or improve nutrition and hydration status. The policy further identified the ADNS was responsible for reviewing all relevant documentation regarding skin assessments, pressure injury risks and compliance and indicated that interventions would be modified as needed.The facility policy for skin integrity identified interventions for prevention and promote healing identified categories of interventions to consider included to provide a safe environment, maintain nutrition and hydration, and protect from self-inflicted injury or injury incurred during routine care. The policy further directed that interventions will be modified in a resident's plan of care as needed and indicated considerations for needed modifications may include changes in medical condition or factors affecting the risk, new onset or recurrent, changes in the resident's goals and preferences.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075288	A. Building B. Wing	04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairview	235 Lestertown Rd Groton, CT 06340

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, review of facility documentation, review of facility policy/procedures and interviews for the only sampled resident (Resident #103) reviewed for pressure injuries, the facility failed to ensure accurate assessments were completed to direct care and failed to ensure the Braden assessments were reviewed by an RN when completed by an LPN. The findings include:Resident #103 was admitted to the facility on [DATE] with diagnoses that included acute on chronic diastolic congestive heart failure, acute and chronic respiratory failure with hypoxia, pulmonary edema, muscle weakness, abnormalities of gait and mobility, difficulty in walking, cognitive communication deficit and dementia.The Braden Scale for predicting pressure ulcer risk evaluation dated 11/28/24 at 12:40 PM and completed by LPN#1 identified Resident #103 had a score of 16, which indicated Resident #103 was a mild risk for developing a pressure injury. The Braden scoring identified Resident #103 had no sensory impairment, was occasionally moist, was chairfast and made frequent though slight changes in body or extremity position independently, had inadequate nutrition and friction and shear were a potential problem. The assessment was completed by LPN #1.The physical therapy recommendation dated 11/29/24 directed Resident #103 to be transferred with a mechanical lift with 2 a person assist and to ambulate with therapy only. Additionally, the PT evaluation and plan of treatment identified Resident #103 was dependent with an assist of 2 for sit to lying, lying to sitting on side of be and sit to stand. The assessment indicated transfers were not attempted due to medical conditions.The nursing progress note dated 11/29/24 at 7:31 AM identified Resident #103 was incontinent of bladder and the upper and lower extremities were swollen.The physician's progress note dated 11/29/24 at 1:56 PM identified Resident #103 was assessed in bed, had no dermatitis, had bilateral upper extremity pitting edema and bilateral lower extremity edema.The nursing advanced skilled evaluation dated 11/30/24 at 10:42 PM identified Resident #103 was bedfast most of the time and was incontinent of urine and used adult briefs and the bedpan.The physical therapy treatment encounter note dated 11/30/24 at 11:25 AM identified Resident #103 used a bed pan with NA assistance and indicated limited memory recall of using the bed pan and needed reminders on a variety of things like using the call bell. The note further indicated Resident #103 was easily short of breath with minimal exertion and remained in bed.The care plan meeting note dated 12/2/24 at 1:48 PM identified Resident #103 used a Hoyer lift for transfers.Resident #103's care plan dated 12/2/24 identified Resident #103 had a self-care deficit related to activities of daily living (ADLs) related to activity intolerance. Care plan interventions directed an assist of one for bed mobility and transfers and indicated Resident #103 was non-ambulatory. Care plan interventions were dated 9/24 and were carried over from a previous admission. The interventions failed to reflect the recommendation of physical therapy for mechanical lift transfers (Hoyer), and bed mobility with the assistance of two staff members.The admission MDS assessment dated [DATE] identified Resident #103 had moderately impaired cognition, was dependent on staff for toileting hygiene, showers/bathing, transfers, position changes and mobility in the wheelchair, was frequently incontinent of bowel and bladder. The assessment further identified Resident #103 was at risk for developing pressure ulcers/injuries but did not have any pressure injuries and did not have any ulcers, wounds or skin problems and utilized a pressure reducing device for chair and bed. The occupational therapy recommendations dated 12/5/24 directed Resident #103 to transfer from bed to wheelchair and back, wheelchair to commode and back, bed to commode and back using the etac stander with an assist of 2 and to ambulate only with therapy. The Braden Scale for predicting pressure ulcer risk evaluation dated 12/5/24 at 12:53 PM identified Resident #103 had a score of 17 indicating a mild risk for developing pressure injury. The assessment identified Resident #103 had no sensory impairment, was occasionally moist, chairfast and made frequent slight changes in body or extremity position independently. The assessment further indicated Resident #103's nutrition was adequate and that (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075288	A. Building B. Wing	04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairview	235 Lestertown Rd Groton, CT 06340

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	friction and shear were potential problems. This was completed by LPN#1.Resident #103's care plan dated 12/5/24 identified Resident #103 was at risk for potential impairment to skin integrity related to impaired mobility and significant edema. Care plan interventions directed to keep skin clean and dry, provide pressure relieving/reducing mattress, turn and reposition resident frequently as tolerated, encourage good nutrition and hydration in order to promote healthier skin and identify/document potential causative factors and eliminate/resolve where possible.The nursing progress note dated 12/8/24 at 3:17 AM identified Resident #103 had plus 3 pitting edema in all extremities and was encouraged to keep extremities elevated. The Braden Scale for predicting pressure ulcer risk evaluation dated 12/19/24 at 2:47 PM identified Resident #103 had a score of 16 which indicated a mild risk for developing a pressure injury.Based on the admission assessment, Physical therapy assessment, occupational assessment and nursing notes my Braden scale assessment for Resident #103 scored a score of 10, which indicated Resident #103 was a high risk for pressure injury development. Nursing notes identified Resident #103 was not able to feel when he/she had a bowel movement or incontinence, indicated Resident #103's extremities were +3 pitting edema with some open areas and requiring ace wraps to BLE and BUE would indicate a very limited sensory perception (2). Resident #103 would have occasionally moist moisture indicating skin is occasionally moist requiring a linen change once daily (3). Based on physician notes identifying Resident #103 was bedfast, the activity level would be Bedfast (1). Based on occupational therapy and physical therapy notes Resident #103's mobility is very limited (2) and makes occasional slight changes in body or extremity position but is unable to make frequent or significant changes independently. Resident #103's nutrition is probably inadequate (2) and friction and shear is a problem (1) and required moderate to maximum assistance in moving as identified in the PT and OT assessments dated 11/29/24. This would indicate a Braden score of 11 which identified Resident #103 was a high risk for pressure injury development. Interview with the DNS on 4/9/24 at 1:20 PM identified LPNs are able to complete the Braden assessments because they are not assessments, but evaluations and do not require a co-sign by an RN. The DNS indicated that the admission assessment is co-signed by the RN.Interview with LPN#1 on 4/10/26 at 11:22 AM identified LPN#1 was the nurse who completed the admission assessment and the Braden scales dated 11/28/24 and 12/5/24. LPN #1 identified that a lower Braden score would increase interventions that would have included a positioning plan for getting out of bed more frequently, skin barrier protection and turning and repositioning. LPN#1 identified that recommendations from providers would be handled by the nursing supervisor. LPN #1 indicated that the admission assessment is signed off by the supervisor but other assessments, including the Braden scale, are completed and locked by the nurse completing them and do not have to be co-signed by the RN.Interview with the Assistant Director of Nursing (ADNS) on 4/10/26 at 2:47 PM identified that the ADNS identified the facility does frequent skin checks and NA's check the skin with all care provided. The ADNS reviewed Resident #103's Braden score and admission assessment and declined to comment on whether the assessments were accurate, indicating she was unable to remember. The ADNS indicated that Resident #103 was admitted to the facility several times and that the ADNS would need to review the clinical record. The ADNS identified that a resident who was at moderate or high risk for pressure injury would have an overlay mattress or an air mattress depending on presentation and further indicated that Resident #103 had a pressure-reducing mattress, not an overlay or an air mattress.Interview with RN#2, RN supervisor, on 4/13/26 at 10:57 AM identified she reviewed the admission assessment and co-signed the document and presented any concerns to the MD. RN#2 indicated that Braden scale assessments did not need to be co-signed and further indicated that she did not review the LPN documentation for accuracy or consistency.Interview with the ADNS on 4/13/26 at 2:01 PM identified that on further review of Resident #103's clinical record, the Braden assessments were not accurate. The ADNS would not identify what an accurate score would have been but indicated that the score would have been lower and Resident #103 would be at greater risk for pressure injury development. The ADNS indicated that (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075288	A. Building B. Wing	04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairview	235 Lestertown Rd Groton, CT 06340

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	there were inconsistencies in Resident #103's documentation was conflicting. The ADNS identified the score on the Braden scale assessment directs interventions for prevention of pressure injury. The ADNS further identified that Braden scale assessments were not reviewed or co-signed by the RN, when completed by the LPN and that she would expect the Braden to reflect the resident's status.The facility policy for pressure injury prevention and management identified licensed nurses will conduct a pressure injury risk assessment, using the Braden, on all residents upon admission/re-admission, weekly x 4 weeks, then quarterly or whenever the resident's condition changes significantly.According to the State of CT General Statutes Volume 7 Title 20 chapter 387 Section 20-87a (4) (c) The practice of nursing by a licensed practical nurse is defined as the performing of selected tasks and sharing of responsibility under the direction of a registered nurse or an advanced practice registered nurse and within the framework of supportive and restorative care, health counseling and teaching, case finding and referral, collaborating in the implementation of the total health care regimen and executing the medical regimen under the direction of a licensed physician, physician assistant, podiatrist, optometrist or dentist. A licensed practical nurse may also execute dietary orders written in a patient's chart by a certified dietitian-nutritionist.The CT LPN Practice Act identified that LPNs are properly allowed to participate in all phases of the nursing process under the direction of a registered nurse (RN) and indicated that an LPN can contribute to the nursing assessment by collecting, reporting, and recording subjective and objective patient-related data in an accurate and timely manner. But an LPN cannot perform the assessment independently.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075288	A. Building B. Wing	04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairview	235 Lestertown Rd Groton, CT 06340

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, review of facility documentation, review of facility policy/procedures and interviews for one sampled resident (Resident #103) reviewed for pressure injury, the facility failed to accurately assess the resident's risk for pressure injury development, and failed to implement measures to prevent the development of a pressure injury to the sacrum resulting in the development of a stage 3 pressure ulcer to the sacrum. The findings include:Resident #103 was admitted to the facility on [DATE] with diagnoses that included acute on chronic diastolic congestive heart failure, acute and chronic respiratory failure with hypoxia, pulmonary edema, muscle weakness, abnormalities of gait and mobility, difficulty in walking, cognitive communication deficit and dementia.The Braden Scale for predicting pressure ulcer risk evaluation dated 11/28/24 at 12:40 PM completed by LPN#1 identified Resident #103 had a score of 16, which indicated Resident #103 had a mild risk for developing a pressure sore. The Braden scoring identified Resident #103 had no sensory impairment, was occasionally moist, was chairfast and made frequent though slight changes in body or extremity position independently. The scoring included Resident #103 probably had inadequate nutrition and that friction and shear was a potential problem.Nursing clinical admission progress notes dated 11/28/24 at 12:45 PM identified Resident had skin issues to #1 right shin abrasion, 2 buttocks red/blanchable wound present on admission. wound is new. #3 left breast mastectomy, 4 right front axilla bruising, #5 Left shin bruising. Edema to BLE. Physician's orders dated 11/29/24 directed a sodium restriction diet of regular texture, thin liquids consistency.The physical therapy recommendation dated 11/29/24 directed Resident #103 to be transferred with a mechanical lift with 2 people assist and to ambulate with therapy only. Additionally, the PT evaluation and plan of treatment identified Resident #103 was dependent with an assist of 2 for sit to lying, lying to sitting on side of be and sit to stand. The assessment indicated transfers were not attempted due to medical conditionsThe Occupational Therapy Evaluation and plan of treatment dated 11/29/24 identified Resident #103 was dependent for transfers with a mobility performance score of 0 out of a range of 0 to 12; 12 being the highest function. OT encounter note identified Resident #103 participated in bed mobility requiring moderate assist of 2 for bed mobility and indicated an assist of 2 was provided for sit to stand indicating Resident #103 reported BLE discomfort and demonstrated poor functional activity tolerance requiring seated rest period due to fatigue and decreased O2 saturation to 86% on 3L via nasal canula and required a mechanical Hoyer lift for transfers out of bed with staff.The nursing progress note dated 11/29/24 at 7:31 AM identified Resident #103 was incontinent with bladder and upper and lower extremities were swollen and indicated Resident #103's legs were kept elevated.The physician's progress note dated 11/29/24 at 1:56 PM identified Resident #103 was assessed in bed, had no dermatitis, did have bilateral upper extremity pitting edema and bilateral lower extremity edemaThe nursing advanced skilled evaluation dated 11/30/24 at 10:42 PM identified Resident #103 was bedfast most of the time and was incontinent of urine and used adult briefs and the bedpan.The physical therapy treatment encounter note dated 11/30/24 at 11:25 AM identified Resident #103 used a bed pan with NA assistance and indicated limited memory recall of using the bed pan and needing reminders on a variety of things like using the call bell. The note further indicated Resident #103 was easily short of breath with minimal exertion and remained in bed.Resident #103's care plan dated 12/2/24 identified Resident #103 had a self-care deficit related to activities of daily living (ADLs) related to activity intolerance. Care plan interventions directed an assist of one for bed mobility and transfers and indicated Resident #103 was non-ambulatory. The care plan interventions were dated 9/24 and were carried over from a previous admission and failed to reflect the current therapy recommendations or resident status.The care plan meeting note dated 12/2/24 at 1:48 PM identified Resident #103used a Hoyer lift for transfers.The dietary progress note dated 12/4/24 at 9:46 AM identified nutrition interventions for Resident #103 were to continue cardiac (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075288	A. Building B. Wing	04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairview	235 Lestertown Rd Groton, CT 06340

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sodium restricted diet and provide follow up diet education and support as indicated and monitor need for fluid restriction.The Braden Scale for predicting pressure ulcer risk evaluation dated 12/5/24 at 12:53 PM identified Resident #103 had a score of 17 indicating a mild risk for developing pressure injury. The assessment identified Resident #103 had no sensory impairment, was occasionally moist, chairfast and made frequent slight changes in body or extremity position independently. The assessment further indicated Resident #103's nutrition was adequate and that friction and shear was a potential problem.The admission MDS assessment dated [DATE] identified Resident #103 had moderately impaired cognition, was dependent for toileting hygiene, shower/bathing, transfers, position changes and mobility in the wheelchair, was frequently incontinent of bowel and bladder. The assessment further identified Resident #103 was at risk for developing pressure ulcers/injuries but did not have any pressure injuries and did not have any ulcers, wounds or skin problems and did utilize a pressure reducing device for chair and bed and was receiving an application of nonsurgical dressings other than to feet. The assessment further identified Resident #103 was taking anticoagulant and diuretic and indicated that the care areas triggered included nutritional status, pressure ulcer, cognitive loss/dementia, ADL functional/rehabilitation potential and urinary incontinence.The occupational therapy recommendations dated 12/5/24 directed Resident #103 to transfer from bed to wheelchair and back, wheelchair to commode and back, bed to commode and back using the etac stander with an assist of 2 and to ambulate only with therapy. Treatment encounter notes this day identified Resident #103 was incontinent of bowel without being aware and required extra time due to the resident's cognitive status.Resident #103's care plan dated 12/5/24 identified Resident #103 was at risk for potential impairment to skin integrity related to impaired mobility and significant edema. Care plan interventions directed to keep skin clean and dry, provide pressure relieving/reducing mattress, turn and reposition resident frequently as tolerated, encourage good nutrition and hydration in order to promote healthier skin and identify/document potential causative factors and eliminate/resolve where possible. The care plan failed to identify Resident #103 had open skin areas and was being treated by the wound doctor, was generalized and not individualized.The nursing progress note dated 12/8/24 at 3:17 AM identified Resident #103 had all extremities with 3 plus pitting edema and was encouraged to keep elevated. The note further indicated that Resident #103 was sleeping in long naps.The occupational therapy recommendation dated 12/10/24 directed Resident #103 to transfer with assist of 2 with grab bar or rolling walker and to ambulate only with therapy.The nursing progress note dated 12/16/24 at 3:29 PM identified nursing was approached by physical therapy due to Resident #103's refusal to get out of bed and indicated Resident #103 had mild back pain and was tired but refused pain medication and denied pain to nursing The occupational therapy treatment encounter note dated 12/21/24 at 3:46 PM identified Resident #103 had increased coughing and malaise with decreased tolerance to functional activities and indicated a Covid positive test. The nursing advanced skilled evaluation dated 12/24/24 at 10:37 PM identified Resident #103 had a skin issue that had not been evaluated that consisted of moisture associated skin damage (MASD)to the right coccyx that was painful and burning. An intervention to change position was implemented. The wound measurements were documented as 1.3 cm x 1.5 cm. The note further identified Resident #103 also had moisture associated skin damage that was painful and burning with measurements of 2.1 cm x 1.7 cm to the left coccyx.The physician's order dated 12/24/24 directed to cleanse the coccyx/buttocks (MASD) area with normal saline and pat dry, apply triad paste every shift followed by a foam dressing for 7 days and then re-evaluate.The nursing progress note dated 12/25/24 at 11:13 PM identified Resident #103 had a skin issue that had not been evaluated to the right coccyx moisture associated skin damage that was painful and burning and directed interventions of change in position. The wound measurements were documented as 1.3 cm x 1.5 cm. The note identified an additional skin issue to the left coccyx moisture associated skin damage that was painful and burning with measurements of 2.1 cm x 1.7 cm with intervention of position change. The note additionally indicated Resident #103 was bedfast at all or most of the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075288	A. Building B. Wing	04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairview	235 Lestertown Rd Groton, CT 06340

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	time.The wound physician's note dated 12/27/24 at 4:50 PM identified Resident #103 was seen for a coccyx wound and indicated it was a stage 3 pressure wound. The note identified Resident #103 had edema and pressure associated signs and symptoms indicating pain in the new wound, Covid positive, incontinent and with decreased activity. Measurements of the coccyx wound were 2.7 cm x 3.2 cm x 0.3 cm with exposed subcutaneous tissues with a moderate amount of serosanguineous exudate. The note further directed wound care to cleanse wound, apply triad to peri wound, calcium alginate with silver to base of the wound, secure with a dry clean dressing and change daily and as needed for soiling, saturation or accidental removal. Additional recommendations for a registered dietician consultation to optimize nutrition and pressure redistribution mattress per facility protocol.The physician's order dated 12/27/24 directed use of an air mattress.The physician's order dated 12/30/24 directed an air mattress and a function check every shift to maintain pressure reduction and evaluate for bottoming out with hand check.The physical therapy recommendations dated 12/31/24 directed transfers with mechanical lift with an assist of 2 and identified Resident #103 was non-ambulatory.The dietician progress note dated 1/14/25 at 10:55 AM identified Resident #103's nutritional interventions to continue diet as ordered and monitor wights as ordered and Prostat (liquid protein) 30 ml every day.Interview with the dietician on 4/9/26 at 12:15 PM identified she was responsible for monitoring weight, intake and wounds, whether or not they need a nutritional intervention. The dietician indicated that she should be notified when something is non-blanchable and should have been notified of Resident #103's stage 3 wound. The dietician indicated that wounds are on a report to be seen more frequently and indicated she was not aware of the wound MD's request for a dietary consultation. The dietician identified that interventions for wounds would include additional protein and monitoring intake, output and weights.Interview with the DNS on 4/9/26 at 1:20 PM identified the criteria for referral to the wound MD for care is the clinical judgement of the nurse and indicated the facility did not have a policy that directs the referral. The DNS identified the ADNS was the wound nurse and could better answer the questions.Interview with LPN#1 on 4/10/26 at 11:22 AM identified LPN#1 was the nurse who completed the admission assessment and the first two Braden scales dated 11/28/24 and 12/5/24. LPN#1 was not able to access the resident clinical record on her computer and utilized mine for review. LPN #1 identified that a lower Braden score would increase interventions that would have included a positioning plan for getting out of bed more frequently, skin barrier protection and turning and repositioning. LPN#1 indicated that turning and repositioning was not documented but was considered a standard of care and was unable to identify who was responsible for ensuring it was completed. LPN#1 identified that recommendations from providers would be handled by the nursing supervisor or for wounds, the wound nurse.Interview with the Assistant Director of Nursing (ADNS) on 4/10/26 at 2:47 PM identified that turning and repositioning was not documented at the facility and indicated that it was considered a standard of care and that the nurses were responsible for making sure it was being completed. The ADNS identified the facility does frequent skin checks and NA's check the skin with all care provided. The ADNS reviewed Resident #103's Braden score and admission assessment and declined to comment on whether the assessments were accurate, indicating she was unable to remember. The ADNS indicated that Resident #103 was admitted to the facility several times and that the ADNS would need to review the clinical record. The ADNS identified that a resident who was at moderate or high risk for pressure injury would have an overlay mattress or an air mattress depending on presentation and further indicated that Resident #103 had a pressure-reducing mattress, not an overlay or an air mattress.Interview with MDS#2 on 4/13/26 at 10:19 AM identified she was responsible for the short-term rehab admissions, completing assessments, putting in care plans and setting up the admission in the computer. MDS#2 indicated she got her skin information from the clinical admission and further indicated that all residents at the facility is at some risk for pressure and every resident gets a care plan for the potential impairment to skin integrity. MDS#2 identified she looks for skin tears, surgical wounds or pressure injuries and completes the baseline care plans and, based on the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075288	A. Building B. Wing	04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairview	235 Lestertown Rd Groton, CT 06340

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessment, fills out the comprehensive care plan. MDS#2 indicated that RN supervisors were supposed to start the care plans and MDS adds additional information. MDS#2 further identified that open areas and residents seen by the wound MD should be reflected in the care plan designating wound care. MDS#2 indicated that care plans can't be too pigeonholed and are vague and the items in the care plan direct the Kardex information. MDS#2 could not identify why Resident #103's wounds and mobility status were not updated.Interview with MDS#1 on 4/13/26 at 11:56 AM identified that she was responsible for the long-term residents. MDS#1 indicated that she adds the specific wound, date of occurrence and interventions for care. MDS#1 identified care plans should be specific to the resident.Interview with the wound MD, MD#2, on 4/13/26 at 1:05 PM identified he was not in a position to review a specific resident record but answered general questions. MD#2 identified the facility is responsible for interpreting the Braden score and implementing interventions according to facility policy. MD#2 indicated that skin deteriorates for all sorts of reasons medically and it would be the responsibility of the facility to ensure residents were evaluated accurately and appropriate interventions were put in place. MD#2 identified that edema may effect mobility in addition to tissue that has been deprived of oxygen and presence of toxic metabolites all contribute to developing a wound.Interview with the ADNS on 4/13/26 at 2:01 PM identified that on further review of Resident #103's clinical record, the Braden assessments were not accurate. The ADNS would not identify what an accurate score would have been. The ADNS indicated that there were inconsistencies in Resident #103's documentation was conflicting. The ADNS further identified that although the care plan directed turning and repositioning, the clinical record documentation failed to demonstrate turning and repositioning was being completed and indicated that a lower Braden score would have prompted a discussion for implementation of an overlay mattress or air mattress.The facility policy for pressure injury prevention and management identified the facility shall establish and utilize a systematic approach for pressure injury prevention and management. The policy further identified that licensed nurses would conduct a pressure injury risk assessment, using the [NAME], on all residents upon admission/re-admission, weekly x four weeks, then quarterly or whenever the resident's condition changes significantly. The policy indicated the tool will be used in conjunction with other risk factors not captured by the risk assessment. Examples of risk factors include but are not limited to: Impaired/decreased mobility and decreased functional ability, Co-morbid conditions such as diabetes mellitus, Impaired diffuse or localized blood flow, cognitive impairment, exposure of skin to urinary and fecal incontinence, nutrition and hydration deficits and presence of a previously healed pressure injury. The policy identified Interventions for prevention and to promote healing and indicated that after completing a thorough assessment/evaluation, the interdisciplinary team shall develop a relevant care plan that includes measurable goals for prevention with appropriate interventions. The policy identifies basic or routine care interventions to include redistribute pressure such as repositioning or offloading, minimize exposure to moisture and keep skin clean, provide appropriate, pressure redistributing support surfaces, provide non-irritating surfaces and maintain or improve nutrition and hydration status. The policy further identified the ADNS was responsible for reviewing all relevant documentation regarding skin assessments, pressure injury risks and compliance and indicated that interventions would be modified as needed. The facility failed to ensure Resident #103 was assessed correctly. The care plan that directs care was vague and did not represent Resident #103's actual status and ability, therefore the Kardex was not complete and did not direct care as needed. Referrals made by the wound MD failed to be implemented. The facility was unable to demonstrate turning and repositioning and as Resident #103's condition deteriorated, there were not additional interventions put in place to address the increased immobility, confusion, incontinence and potential for pressure injury development. Had the assessments been accurate and/or reviewed for accuracy, the interventions would have been in place to minimize development of the pressure injury.