STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075310	A. Building B. Wing	06/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center of Plainfield, LLC	16 Windsor Ave Plainfield, CT 06374

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 Note: The nursing home is disputing this citation.	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 clinical record, facility documentation, facility policy and interview for 2 of 3 residents (Resident #19/victim and Resident #71/victim) reviewed for abuse, the facility failed to protect Resident #19 from physical abuse by Resident #9/perpetrator, who had a history of pinching and for Resident #71 the facility failed to protect Resident #71 from physical abuse by Resident #68/perpetrator. The findings include: 1a. Resident #19's diagnoses included chronic obstructive pulmonary disease, anxiety disorder and post-traumatic stress disorder The admission MDS dated [DATE] identified Resident #19 had intact cognition, and required partial to moderate assistance with transfers, toileting, and bed mobility. The care plan dated 8/26/25 identified Resident #19 had a potential for social isolation and depression. Interventions included to invite/encourage the resident to attend activities, provide monthly activity calendar, and assist the resident in developing a program of activities that was meaningful and of interest. A nurses note written by RN #4 dated 9/22/25 at 11:45 AM identified Resident #19 was self-propelling in the dining room and was close to another resident. The other resident proceeded to reach out and pinch Resident #19 twice on the right upper arm. Resident #19 told the other resident (that's not nice, and you can't do that). The other resident proceeded to reach out and pinch Resident #19 again. The note indicated Resident #19 denied pain or discomfort and did not have any redness or swelling to his/her skin. APRN #1 and Resident #19's responsible party were notified. b. Resident #9's diagnoses included dementia with psychosis, and intellectual disabilities. The change in condition MDS dated [DATE] identified Resident #9 had severely impaired cognition and was dependent with transfers, toileting and bed mobility. Review of the clinical record dated 6/17/25 to present identified Resident #9 had multiple episodes of pinching other residents. The care plan dated 7/14/25 identified Resident #9 had a behavior problem related to pinching, scratching, hitting, refusing care and throwing items. Interventions included the resident was to be 1:1 with staff for supervision when out of bed, in the wheelchair in the hallway, and not to be in arms reach of other residents. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 Note: The nursing home is disputing this citation.	A nurses note, written by RN #4 dated 9/22/25 at 11:45 AM identified Resident #9 was involved in a resident-to-resident altercation. Another resident was self-propelling in the dining room and was close to Resident #9 who proceeded to reach out and pinch the other resident twice on the right upper arm. The resident that was pinched told Resident #9 (that's not nice and you can't do that) and Resident #9 proceeded to reach out and pinch the resident again. The care plan was updated to include intervening as necessary to protect the rights and safety of other residents and to remove Resident #9 from situations as necessary. A nurses note written by RN #4 dated 9/22/25 at 2:33 PM identified Resident #9 had a virtual appointment with the behavioral health advanced practice registered nurse (APRN), and a new order was received for Resident 9 to continue on 1:1 staff supervision while out of bed and remove from 1:1 staff supervision while in bed. A social service progress note dated 9/22/25 at 5:00 PM identified Resident #9 was met with after being involved in a negative peer interaction. Resident #9 presented as remorseful and stated he/she wanted to stay in his/her room and that he/she liked people. A physician's order dated 9/22/25 directed Resident #9 was to be 1:1 until cleared by behavioral health. The Reportable Event Report dated 9/22/25 at 11:47 AM identified Resident #19 as the alleged victim and Resident #9 as the alleged perpetrator. The event description indicated Resident #19 was in the dining room and when Resident #9 came close to Resident #19 and he/she reached out with his/her left hand and pinched Resident #9 on the upper right arm. Resident #19 was on 1:1 staff supervision at the time and was removed from the situation (this is in conflict with the interview with NA #3 who was assigned the 1:1 staff supervision with Resident #9. NA in an interview indicated she was on the computer charting and had her back to Resident #9 at the time of the incident). The Summary Report dated 9/24/25 at 12:00 AM identified upon investigation, the nurse aide (NA #3) assigned 1:1 supervision with Resident #9 at time of the incident indicated she felt the conversation between the two residents was pleasant in nature so she did not feel the need to separate Resident #9 and Resident #19 prior to the incident. Interview with RN #4 on 6/8/26 at 11:53 AM identified she was the RN Supervisor on duty when the incident between Resident #9 and Resident #19 occurred on 9/22/25. RN #4 indicated Resident #19 was on 1:1 staff supervision at the time of the incident and NA #3 was the assigned nurse aide. RN #4 stated NA #3 was in the dining room charting on the computer and was not focused on and did not have eyes on Resident #9 when he/she pinched Resident #19. RN #4 identified NA #3 should have been aware of Resident #19's surroundings and not allow any residents to come within arm's reach of Resident #9 (due to his/her history of pinching). RN #4 further indicated NA #3 was given a written warning after the incident and although NA #3 was apologizing after the incident occurred, NA #3 stated she was busy and charting and did not see it happen. Interview and review of reportable event documentation with the Director of Nurses (DNS) on 6/8/26 at 12:29 PM identified she was working in the facility but was not present when the resident-to-resident altercation between Resident #9 and Resident #19 occurred on 9/22/25. The DNS indicated although NA #3 was assigned to provide 1:1 supervision for Resident #19, she did not have eyes on the resident and was focused on completing her charting at the time the incident occurred. The DNS stated when Resident #19 came within arms reach of Resident #9, NA #3 should have asked (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Resident #19 to move away or backed Resident #9 away from Resident #19 (as per the plan of care, Resident #19 was not to be in arms reach of other residents). In a subsequent interview with the DNS on 6/8/26 at 1:00 PM the DNS indicated she had located a facility employee warning notice for NA #3 which was completed by RN #4 on 9/22/25. The notice identified NA #3 was assigned 1:1 supervision for Resident #19 and failed to follow protocol for 1:1 supervision. The notice indicated NA #3 was re-educated by RN #4 on the importance of complying with 1:1 supervision protocol. Interview and review of witness statement with NA #3 on 6/9/26 at 4:08 PM identified she was assigned 1:1 supervision of Resident #9 on 9/22/25 when the incident occurred. NA #3 indicated although she was aware Resident #9 had a history of pinching people and was not to be within arms reach of other residents, she was on the computer charting and had her back to Resident #9 when the incident occurred. NA #3 identified she was aware Resident #19 was close to and talking to Resident #9, but she did not separate them and only knew Resident #9 had pinched Resident #19 when she heard Resident #19 say something which then made her turn around. Additionally, NA #3 indicated RN #4 gave her a written warning after the incident and she was told her main focus should have been Resident #9 and she should not have been charting on the computer, but NA #3 stated she was busy and just trying to get her work done. Review of the Abuse Prohibition policy dated 7/27/23 directed to prohibit abuse, neglect, involuntary seclusion, and misappropriation of property for all residents through the following: Training of employees and prevention of occurrences. The center will ensure staff are doing all that is within their control to prevent occurrences of abuse. Staff actions to prevent abuse will include identifying, correcting and intervening in situations in which abuse is more likely to occur. Definition of abuse-the willful infliction of physical, verbal, mental, sexual injury or harm, that may or may not include mental anguish or discomfort associated with such actions. Mental anguish is defined as mental suffering which includes fright, feeling of distress, anxiety, depression, grief and/or psychosomatic physical symptoms. Discomfort is defined as something that disturbs one's comfort, an annoyance. 2a. Resident #71 was admitted on [DATE] with diagnosis that included hepatic encephalopathy, and respiratory failure with hypoxia. The significant change MDS dated [DATE] identified Resident #71 had severely impaired cognition, required partial to moderate assistance with transfers, used a wheelchair and was independent for eating, bathing, dressing, toileting and personal hygiene. The care plan dated 5/19/26 identified Resident #71 has chronic alteration in pulmonary function related to asthma. Interventions included to monitor sign/symptoms of respiratory insufficiency, anxiety, confusion, restlessness, monitor lungs sounds and vitals as needed. A nurse's note dated 5/25/26 at 10:45 AM written by RN #4 identified Resident #71was a victim involved in a resident-to-resident altercation. Resident #71 yelled help for the nurse. A staff member arrived in Resident #68 and Resident#71's room and Resident #68 was behind Resident #71. Resident #71 was yelling that Resident #68 choked him/her and told the staff she/he was going toward the bathroom when Resident #68 came up behind him/her and grabbed the hospital gown at the neck area, pulling back on it. RN #4 completed an assessment of Resident #71 who had light red marks noted on her/his neck which quickly dissipated. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A Social Worker note dated 5/26/26 at 10:22 AM by the social worker identified she met with Resident #71 after a negative peer interaction (victim). Resident #71 was able to express that another resident came up behind him/her and pulled his/her hospital gown from the back. Also, identifying Resident #71 was initially frightened by the incident but was now verbalizing he/she felt safe. b. Resident #68 was admitted in April 2026 with diagnosis including Alzheimer's disease, anxiety and depression. The care plan dated 4/14/26 identified potential for social isolation related to personal preference to remain in the room and not participate. Interventions included to invite/encourage the resident to attend activities with residents in order to support participation, provide monthly activity calendar, and assist/escort resident to activities. The admission MDS dated [DATE] identified Resident #68 had severely impaired cognition, required partial moderate assistance for toileting and showering, required set-up assistance for eating, independent for transferring, supervision for dressing and personal hygiene. A nurse's note dated 5/22/26 at 7:15 AM, written by the DNS identified Resident #68 was wandering the halls and in other residents' rooms without his/her walker frequently throughout the night. Resident #68 was very restless. A nurse's note, written by RN #4 dated 5/25/26 at 10:28 AM identified Resident #68 was the aggressor in a resident-to-resident altercation. Resident #68's roommate, Resident #71, was in her/his wheelchair going towards the bathroom and Resident #68 went behind Resident #71 grabbing at the neck of the hospital gown and was pulling back on it. Resident #71 yelled for help from the nurse and told the staff member Resident #68 had choked her/him. The residents were separated and Resident #68 was placed on 1:1 and sent to the emergency room for evaluation. Interview on 6/5/26 at 10:34 AM with LPN #1 identified she was on duty when the resident-to-resident altercation transpired on 5/25/26. LPN #1 indicated Resident #68 was acting calm, sitting in his/her chair and taking all his/her medications. Resident #71 came out of the room upset, stating that Resident #68 choked him/her. Interview with NA #2 on 6/5/26 at 11:13 AM identified she did work on 5/25/26. NA #2 indicated Resident #68 had angry outburst in the past but was calm, quiet, lying in the bed the last time she saw him/her before the incident. NA #2 indicated Resident #68 had not ever been physically aggressive before this resident-to-resident altercation. Interview with the DNS on 6/5/26 at 11:51 AM identified she was not working on the day of the resident-to resident altercation. The DNS indicated Resident #68 has had no other resident-to-resident altercations since the altercation on 5/25/26. Resident #68 was sent to the emergency room and cleared of being a danger to herself or others. Interview with RN #4 on 6/8/26 at 12:59 PM identified she was working on 5/25/26 when the resident-to resident altercation occurred and the floor nurse, LPN #1, told her that Resident #71 was yelling that Resident #68 choked him/her. RN #4 indicated no one witnessed the incident but when she assessed Resident #71 he/she had red marks on his/her neck from where the hospital gown had been pulled. RN #4 indicated when she last observed Resident #68, he/she was sleeping and identified Resident #68 had no prior history of being aggressive but was a wanderer. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Interview with NA #4 on 6/8/26 at 1:15 PM identified she was 2 rooms down the hall when she heard Resident #71 yelling for help. Resident #68 was behind Resident #71 who was stating that Resident #68 choked him/her. When she looked at Resident #71's neck it was red. Further, she separated Resident #71 from Resident #68 who was confused but not acting aggressive and had never acted aggressive before this incident. Review of the Abuse Prohibition dated 7/27/23 directed to prohibit abuse, neglect, involuntary seclusion, and misappropriation of property for all residents through the following: prevention of occurrences. Definition of abuse-the willful infliction of physical, verbal, mental, sexual injury or harm, that may or may not include mental anguish or discomfort associated with such actions. Mental anguish is defined as mental suffering which includes fright, feeling of distress, anxiety, depression, grief and/or psychosomatic physical symptoms. Discomfort is defined as something that disturbs one's comfort, an annoyance.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	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 clinical record, facility documentation, facility policy and interviews, for 3 residents (Resident #9, 1 and 50), the facility failed to administer medications and/or monitor blood sugar according to professional standards and physician's orders. For 1 resident (Resident #9) reviewed for medication errors, the facility failed to ensure staff followed the physician's order for Xanax (antianxiety medication) administration after a change in the dose. For 1 of 5 residents (Resident #1) who were reviewed for unnecessary medications, the facility failed to ensure blood glucose monitoring was performed as prescribed by the provider. For 1 of 7 residents (Resident #50) reviewed for medications, the facility failed to hold the Metoprolol (a medication that lowers your blood pressure and heart rate) according to the physician's order, when the residents heart rate was below the identified parameters. The findings include: 1. Resident #9 was admitted in November 2018 with diagnoses that include dementia with behavioral disturbances, intellectual disabilities and anxiety disorder. The quarterly MDS dated [DATE] identified that Resident #9 had severely impaired cognition, was totally dependent on staff for all activities of daily living (ADLS) except requiring supervision with eating and received antianxiety medication 7 days a week. Review of the June 2025 physician's orders directed to administer Xanax (antianxiety medication) 0.25mg two times a day. The care plan dated 6/24/25 identified the resident receives antianxiety medications related to anxiety disorder with interventions that included to administer antianxiety medications as ordered by the physician and monitor and document any adverse reactions and unexpected side effects to antianxiety therapy. The physician's order dated 6/28/25 directed to discontinue Xanax 0.25mg twice daily and begin Xanax 0.5 mg (antianxiety medication) twice a day and Xanax 0.25mg as needed every 8 hours for agitation, anxiety, and yelling for 14 days. A nurse's note dated 7/5/25 at 10:26 AM by RN #8 indicated that Resident #9 received the wrong dose of Xanax. Resident #9 had an increase in Xanax from 0.25mg two times a day to Xanax 0.5mg two times a day. The nurses administer the wrong dose on 6/30/25, 7/1/25, 7/2/25, and 7/3/25. The RCP dated 7/5/25 identified that Resident #9 had a medication error and received the incorrect dose of Xanax. The intervention related to the medication error was to monitor for any adverse effects for 72 hours. Review of the nurse's notes dated 7/5/25 through 7/9/25 identified no changes in behaviors or vital signs. Interview with LPN #8 on 6/8/26 at 10:30AM identified she did not recall administering the wrong (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	dose of Xanax to Resident #9 but indicated that the DNS was on top of it and she certainly would have received education related to the medication error. Interview with LPN #7 on 6/8/26 at 10:45AM identified she recalled the medication errors related to the Xanax for Resident #9. LPN #7 identified that she received education related to ensuring medication label on the medication blister pack is compared to the medication order and the importance of re-reading the dosage to ensure it is correct prior to administering medications. Interview with LPN #10 on 6/8/26 at 10:55AM identified she recalled the medication errors with the Xanax with Resident #9. LPN #10 indicated that she had become distracted and did not read the label properly. LPN #10 indicated that the medication error was reviewed with her, but she did not recall who reviewed the error with her. Interview with the Pharmacy Consultant on 6/8/26 at 11:15AM indicated that adverse reactions to certain medications are patient specific and that the medication error was not significant in nature. The Pharmacy Consultant stated that Resident #9 may have experienced an increase in behaviors or his/her anxiety related to receiving a lower dose. Interview with the DNS on 6/8/26 at 12:00PM indicated that education was provided to nursing staff after the medication error and random audits of medication orders/medication administration but could not locate the audits at the time of inquiry. A review of Medication Errors and Drug Reaction policy dated 6/30/22 directed that the facility will report and record medication errors, drug interactions and/or adverse effects of any medication in accordance with State and Federal regulations. If a medication error occurs a Medication Error report will be completed and a Change in Resident Condition form. The supervisor will notify the DNS, the physician, and responsible party. The resident will be monitored for a minimum of 72 hours or until symptoms subside for 24 hours. The charge nurse is responsible for updating the resident's care plan with all the appropriate information and documenting the resident's condition every shift for the next 72 hours or longer until the problem is resolved. 2. Resident #1's diagnosis included Type 2 diabetes mellitus. The care plan dated 9/25/25 identified Type 2 diabetes as an endocrine status focus. Interventions included monitor/document/report as needed for signs and symptoms of hyperglycemia and hypoglycemia. The quarterly MDS dated [DATE] identified Resident #1 had intact cognition, had an active diagnosis of Type 2 diabetes and was prescribed medications to treat high blood sugar. A physician's order dated 3/9/26 directed blood glucose checks to be performed twice weekly, morning and evening on Tuesday and Friday with results reported to provider for blood glucose less than 70 milligrams per deciliter (mg/dl), or greater than 400 mg/dl. An interview and clinical record review with RN #2 on 6/5/26 at 10:45 AM failed to reflect documentation that blood glucose monitoring had been done, as ordered, from 3/10/26 through 6/5/26, 3 months. Further interview with RN #2 noted that blood glucose monitoring was not completed because the physician's order was transcribed on the Diagnostic Imaging Administration Record (DIAR) rather than the Medication Administration (MAR)/Treatment Administration Record (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	(TAR) therefore, blood glucose monitoring was not completed. Interview with the DNS on 6/5/26 at 11:20 AM indicated the order for blood glucose monitoring should have been transcribed in the MAR rather than the DIAR. The DNS indicated the providers were responsible for reviewing orders for accuracy and completion monthly. Interview with Advanced Practice Registered Nurse, APRN #1 on 6/5/26 at 12:54 PM indicated she failed to review Resident #1's blood glucose levels after the order was placed. APRN #1 stated she typically reviews blood glucose monitoring during resident visits however, if the visit was not pertaining to Type 2 diabetes, she may not review them. Additionally, she indicated she was not aware that blood glucose testing had not been completed since March 10, 2026. She indicated there would be potential for hyperglycemia (elevated blood sugar levels), and hypoglycemia (low blood sugar levels), with a variety of different outcomes related to not obtaining the blood glucose as ordered. Interview with RN #5 on 6/8/26 at 11:04 AM indicated she failed to enter the order properly into the Electronic Health record (EHR). Subsequent to surveyor inquiry, RN #2 communicated with the provider and transcribed the blood glucose order to the correct location in the EHR. Review of the Medication Administration and Documentation policy directed Licensed Nursing staff to review provider orders and compare against the MAR. Review of the Physicians Orders – Transcribing EHR (Electronic Health Record) policy dated 06/05/2023 directed Responsibility to the RN Supervisor for transcribing orders including medication/ treatment to the MAR/TAR from the provider order sheet or other referring documentation source. The policy directed orders are to be transcribed to MAR/TAR and if required, supplementary documentation or instructions as indicated by provider or per facility policy established process. The policy also directed all orders to be reviewed and transcribed to the appropriate locations (MAR/TAR, etc.). 3. Resident #50's diagnoses included hypertensive heart disease with heart failure, cardiomyopathy and atrial fibrillation. A significant change in status MDS dated [DATE] identified Resident #50 had severely impaired cognition, was dependent with bed mobility, toileting and transfers and had diagnoses of heart failure, hypertension, cardiomyopathy, and atrial fibrillation. The care plan dated 11/18/25 identified Resident #50 had an altered cardiovascular status related to congestive heart failure, hypertension and hyperlipidemia. Interventions included to administer medications as ordered and to monitor vital signs prior to giving Metoprolol and to notify the physician of significant abnormalities. The care plan further directed Metoprolol was to be held (not administered) for a systolic blood pressure below 90 or a heart rate below 55. A physician's order dated 12/11/25 directed to administer Metoprolol Succinate ER extended release 24 hour, 25mg daily and 50 mg daily (for a total dose of 75mg daily) for essential hypertension. Hold for systolic blood pressure less than 90 or heart rate less than 55. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Review of the MAR's dated 12/11/25 through 5/11/26 identified Metoprolol 75mg had been administered outside of the physician's ordered parameters 12 times on the following dates: 12/23/25 heart rate 52. 12/25/25 heart rate 50. 12/30/25 heart rate 53. 2/18/26 heart rate 44. 2/25/26 heart rate 52. 2/28/26 heart rate 53. 3/2/26 heart rate 41. 3/4/26 heart rate 45. 3/14/26 heart rate 52. 3/15/26 heart rate 54. 4/15/26 heart rate 52. 5/10/26 heart rate 48. Interview and review of the clinical record with the DNS on 6/5/26 at 3:11 PM identified the following: LPN #2 administered the Metoprolol 75 mg dose outside of the physician's ordered parameters on 3/14/26 and 3/15/26. LPN #3 administered the Metoprolol 75 mg dose outside of the physician's ordered parameters on 2/18/26, 2/25/26, 2/28/26, 3/2/26, and 3/4/26 and was no longer employed at the facility. LPN #4 administered the Metoprolol 75 mg dose outside of the physician's ordered parameters on 12/23/25. The remaining staff (3 LPN's) who administered the Metoprolol 75 mg dose outside of the physician's ordered parameters on 12/25/25, 12/30/25 and 4/15/26 and 5/10/26 worked for a nursing agency. The DNS further identified per the physician's order, if Resident #50's heart rate was below 55 the medication should have been held, and the MAR should have reflected that. In addition, the nursing supervisor or physician should have been notified. Review of Resident #50's MAR with the DNS indicated the Metoprolol had been administered to Resident #50 despite the resident's heart rate being below 55 for all dates identified. The DNS indicated she was not aware of the medication errors, and the nurse responsible for administering medications should have followed the physician's order and held the Metoprolol for Resident #50 on all dates identified. (continued on next page)

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Colonial Health & Rehab Center of Plainfield, LLC	16 Windsor Ave Plainfield, CT 06374

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Interview and review of the clinical record with licensed practical LPN #2 on 6/8/26 at 10:28 AM identified she was the charge nurse for Resident #50 and had administered morning medications to the resident on 3/14/26 and 3/15/26. LPN #2 indicated she was new at the facility and not familiar with the system being used and indicated she may have given the Metoprolol in error because of that. Review of the MAR with LPN #2 indicated on 3/14/26 the residents heart rate was recorded as 52 and on 3/15/26 the residents heart rate was recorded as 54. LPN #2 indicated that had she held the medication she would have notified her supervisor and written a progress note. Review of the clinical record with LPN #2 failed to identify she wrote a progress note in the clinical record for 3/14/26 or 3/15/26. LPN #2 further stated if she signed the Metoprolol as administered on the MAR then she had administered the medication but should not have. Interview with APRN #1 on 3/8/26 at 11:29 AM identified she was not aware Resident #50 had received the Metoprolol dose in error when his/her heart rate was below 55. APRN #1 indicated if Resident #50 received Metoprolol 75 mg when his/her heart rate was below 55, it could have caused the residents heart rate to go lower and resulted in hypotension (low blood pressure), dizziness, syncope or cardiac arrest. APRN #1 identified the nurse responsible for administering medications should not have administered the Metoprolol if the residents heart rate was below 55, and the physician's order clearly stated that. APRN #1 was unsure why the physician's order for the Metoprolol was not followed and indicated she would need to follow-up with the DNS. Attempts to contact LPN #3 and LPN #4 were unsuccessful. Review of the Medication Administration and Documentation policy, undated, directed medication administration and documentation occurs in a timely and accurate manner. The medication administration record (MAR) is the form on which all medication orders are poured and administered and on which medication doses are charted. The MAR is a permanent part of the resident's medical record. Vital signs are to be monitored and recorded when appropriate prior to medication administration and if any medications are not administered a reason should be documented. All held or refused medications should be documented on the MAR and the physician should be informed in a timely manner when medications are held, refused, or otherwise unavailable for administration.