STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075316	A. Building B. Wing	09/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glastonbury Center for Health & Rehabilitation	1175 Hebron Ave Glastonbury, CT 06033

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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 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on the review of facility documentation and interviews, the facility failed to submit complete and accurate direct care staffing for PBJ during the quarter of 10/1/24 to 12/31/24. The findings include:The facility CMS PBJ Staffing Data Report dated 10/1/24 to 12/31/24 identified the facility triggered for one star staffing rating, no RN coverage, and failed to have licensed nursing coverage 24 hours a day. Interview with HR #1 on 9/22/25 at 7:30 AM indicated she had started at the facility on 8/24/25. HR #1 indicated that she will start training for PBJ tomorrow. HR #1 indicated that corporate was doing PBJ for the facility prior to her starting. Interview with the DNS on 9/22/25 at 9:48 AM indicated the prior owner did not do the submission of the payroll hours for the period of 10/1/24 to 10/10/24. The DNS indicated that there is always an RN in the facility. The DNS indicated if there was a registered nurse that had called out that another register nurse or manager would fill in for that shift. The DNS indicated that she was aware that the facility was a 1 star for staffing recently and after she investigated, she was informed it was from the prior owner not submitting staffing to PBJ. Review of the nursing schedules dated 10/1/24 to 10/10/24 identified there was not an RN assigned on the schedule for the following days.Wednesday 10/2/24 from 3:00 PM to 11:00 PM.Saturday 10/5/24 from 7:00 AM to 3:00 PM and from 3:00 PM to 11:00 PM.Sunday 10/6/24 from 7:00 AM to 3:00 PM and from 3:00 PM to 11:00 PM.Monday 10/7/24 from 7:00 AM to 3:00 PM and from 11:00 PM to 7:00 AM.Tuesday 10/8/24 from 7:00 AM to 3:00 PM, 3:00 PM to 11:00 PM, and from 11:00 PM to 7:00 AM.Wednesday 10/9/24 from 7:00 AM to 3:00 PM, 3:00 PM to 11:00 PM, and from 11:00 PM to 7:00 AMThursday 10/10/24 from 7:00 AM to 3:00 PM and from 11:00 PM to 7:00 AM.Interview with the DNS on 9/22/25 at 8:58 AM indicated that she works every other Wednesday to supervise on the 3:00 PM to 11:00 PM shift. The DNS indicated that she worked on 10/2/24 as the supervisor on the 3:00 PM to 11:00 PM shift. Review of the nursing schedules (actual working schedules) dated 10/1/24 to 10/10/24 with the DNS identified there were a lot of empty spots where an RN should have been listed as the supervisor, but she is positive there was an RN in the facility for those shifts. The DNS indicated there is always an RN in the facility even if a manager must come in. The DNS indicated she would not be able to show a punch detail for the Wednesday's she had picked up. Interview with the Administrator on 9/22/25 at 11:30 AM indicated that he was aware that the DNS picks up shifts on Wednesdays every other week for the 3:00 PM to 11:00 PM shift. The Administrator indicated that they do post overtime for staff to sign up for. The Administrator indicated he was not aware of any shift that did not have RN coverage. The Administrator indicated the RN managers will come in if needed to cover shifts.Review of the Employee Transactions and Totals Forms provided identified RN names and dates but did not provide punch details, only the amount paid to each nurse. Interview with the Administrator on 9/23/25 at 9:30 AM indicated that the prior owners were responsible to submit to CMS the PBJ from 10/1/24 through 10/10/24. The Administrator indicated the new company does not have access to the prior payroll system. Review of the Punch Detail Forms dated 10/1/24 to 10/10/24 identified that 10/6/24 from 7:00 AM to 3:00 PM and 10/10/24 from 11:00 PM to 7:00 AM did not have a punch detail. There was no punch details for the Wednesdays dated 10/2/24 or 10/9/24 from 3:00 PM to 11:00 PM. Interview with the DNS on 9/23/25 at 12:30 PM indicated she had (continued on next page)

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

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	worked the dates of 10/2/24 and 10/9/24 from 3:00 PM to 11:00 PM. The DNS indicated she does not have punch details for the 2 dates missing 10/6/24 and 10/10/24. Although requested, the PBJ staffing policy was not provided.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, review of facility documentation, facility policy and interview, the facility failed to maintain a clean and sanitary kitchen, failed to ensure refrigerated food items were dated, and failed to ensure staff used beard guards according to infection control standards. The findings include: 1. A tour of the facility kitchen on 9/21/25 at 7:12 AM with the Food Service Director (FSD) identified the following.a. Reach in refrigerator next to the oven contained a pint-sized metal container of chopped onion/tomatoes and a large container of gravy, both undated.b. Beverage refrigerator: 10 of 14 pitchers of juice were undated.c. Left side of the warming oven adjacent to the stove had a large amount of dried white and brown buildup extending down the side next to oven.d. Right side of the reach in refrigerator had a moderate amount of white buildup.e. Right side of refrigerator adjacent to the stove had a large amount brown buildup down the sides.f. Large, uncovered bucket of grease set in front of stove, large open grease funnel extending from stove to bucket.g. Stove knobs with a large amount of crusted brown buildup including surrounding surface area. Interview with the FSD on 9/21/25 at 7:12 AM identified all food items must be dated by dietary staff prior to refrigeration and kitchen equipment should be cleaned daily by the dietary staff with the grease bucket emptied daily. The FSD further identified it was his responsibility to ensure tasks were completed but had not set up a routine cleaning schedule, adding he was new to the facility and still familiarizing himself with daily operations.Review of the facility policy for Sanitation of Kitchen, Food Service Equipment and Work Surfaces directed equipment and work surfaces are to be cleaned and sanitized to reduce the risk of pathogens and food contamination. Surfaces are to be washed, rinsed and sanitized. Although requested, a policy for dating refrigerated food items was not provided. 2. A tour of the facility kitchen on 9/21/25 at 7:12 AM with the FSD during breakfast preparation identified Dietary Aide #2 with a full beard approximately 3/4 to 1 inch in length at the chin, in the area where food was being prepared, without a beard guard. Interview with Dietary Aide #2 on 9/21/25 at 7:12 AM identified he was unaware of a requirement for a beard guard had never used one previously. Interview with the FSD on 9/21/25 at 7:12 AM identified he would need to refer to the policy regarding use of beard guards. The FSD subsequently purchased beard guards for the kitchen staff.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interview for 1 of 3 residents (Resident #10) reviewed for activities of daily living, the facility failed to file a grievance and ensure a prompt response after the resident reported concerns with incontinent care. The findings include:Resident #10 was admitted to the facility in August 2025 with diagnoses that included fecal impaction, functional diarrhea, and retention of urine. The APRN note dated 8/24/25 at 11:49 AM identified Resided #12 was admitted to the facility with moisture associated skin damage to the buttocks, the gluteal area, and the buttock cleft. Recommendations included to apply Triad cream to buttocks twice a day and as needed after each incontinent episodes, reposition resident every 2 hours, and limit sitting in a chair to less than 2 hours. A physician's order dated 8/24/25 directed to apply Triad cream to the buttocks area twice a day and as needed after incontinent episodes.The nurse's note dated 8/24/25 at 1:30 PM identified Resident #10 was admitted from the hospital with a diagnosis of fecal impaction. Resident #10 is alert and oriented to person, place, time, and event. Resident #10 is incontinent of bowel and bladder.The nurse's note written by RN #2 dated 8/26/25 at 10:50 AM indicated Person #1 was visiting with Resident #10. Resident #10 had complained of burning on urination and difficulty voiding. The APRN was updated and a new order for urinalysis with culture and sensitivity was obtained. Person #1 was made aware. The physician order dated 8/27/25 directed to obtain a flat plate (x ray) of the abdomen due to loose stools. The admission MDS dated [DATE] identified Resident #10 had intact cognition, was frequently incontinent of bowel and bladder and required maximum assistance with toileting, transfers, and rolling side to side in bed.The care plan dated 9/10/25 identified Resident #10 has incontinence of bowel and diarrhea, with interventions that included staff to document bowel movements amount, describe the color, and consistency. Nurses will follow the facility bowel protocol and apply barrier cream to the coccyx for prevention of skin breakdown. Interview with Resident #10 on 9/21/25 at 8:16 AM indicated he/she and Person #1 were upset a couple of weeks ago regarding care not being provided. Resident #10 indicated that Person #1 had called the facility to speak with the DNS regarding the lack of care. Resident #10 indicated he/she and Person #1 were upset because he/she was left sitting in a soiled brief and staff would not change him/her during the dinner meal. Resident #10 indicated staff had refused to change him/her a couple of times after admission during mealtimes but did not recall the staff person's names. Resident #10 indicated if you did not go to the bathroom before a meal, you then must wait an hour and a half or longer to get changed. Resident #10 indicated the complaint was given to the head nurse he/she believes is the DNS, but was not sure if a grievance form was filled out. Interview with the DNS on 9/22/25 at 9:28 AM indicated she does not recall Person #1 calling her regarding Resident #10's concerns with incontinent care. The DNS indicated that during any mealtime, a resident should be toileted or changed if requested or needed. The DNS indicated if she was informed of the complaint, she would have started a grievance form, started the investigation, and talked with Resident #10 directly. The DNS indicated the investigation would start immediately and should be completed within a few business days. The DNS indicated Resident #10, and Person #1 would be informed of the outcome of the investigation once completed. The DNS indicated that the information would be documented on the grievance form. The DNS indicated she was never made aware that Resident #10 and Person #1 had made any complaints or wanted to file a grievance. Interview with the Administrator on 9/22/25 at 9:31 AM indicated he was not informed by staff or Person #1 that Resident #10 had complaints regarding care. The Administrator indicated there was not a grievance form filed for Resident #10 that he was aware of. Interview with ADNS on 9/22/25 at 9:37 AM indicated that Person #1 had not called her. Interview with SW #1 on 9/23/25 at 8:30 AM indicated that Resident #10 has only had compliments regarding the facility and has not had any complaints (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	regarding care or being changed for incontinence during meals. SW #1 indicated that she has never received a call from Person #1. SW #1 indicated there was not a grievance form filed on behalf of Resident #10 from admission until now. Interview with Person #1 on 9/23/25 at 8:42 AM indicated that he/she had not called the DNS but did speak with the evening supervisor RN #2. Person #1 indicated that he/she visits every evening and on approximately day 3 after admission, Resident #10 was sitting in the wheelchair and had requested to be changed due to incontinence of stool, but it was dinner time. Person #1 indicated that a staff member had entered the room and informed Resident #10 he/she could not be changed until after dinner. Person #1 indicated that he/she was upset because Resident #10 had to sit in a stooled brief until after dinner to be changed. Person #1 indicated he/she does not know the name of that person. Person #1 indicated that he/she had gone to the nurse's station and had spoken to RN #2, the evening nursing supervisor. Person #1 indicated he/she had informed RN #2 he/she was upset that a urine sample was supposed to be done a couple of days prior and was not done yet and Resident #10 had to sit in a soiled brief through dinner because staff would not change Resident #10 during meals. RN #2 asked Person #1 was he/she wanted a grievance to be initiated and Person #1 indicated she informed RN #2 he/she did want a grievance filed. Interview with the DNS on 9/23/25 at 10:08 AM indicated that the resident, family member, or staff can fill out the grievance form and it would go to the social worker. The DNS indicated if it has to do with nursing it would be given to her by the social worker. The DNS indicated that if the resident representative informed the supervisor of the concerns related to not being provided incontinent care during meals, the supervisor would be responsible to fill out the grievance form and/or call her to report the issue. The DNS indicated if the supervisor had called her, she would have filled out the grievance form.Although attempted, an interview with RN #2 it was not obtained. Review of the Grievance Policy identified the residents have the right to voice grievances without discrimination or reprisal of fear of discrimination. Such grievances may include issues of care or treatment that has been received or not received, the behavior of staff or other resident's and other concerns regarding the residents stay at the facility. The facility will make prompt efforts to resolve any grievances in accordance with this policy. The facility will appoint a grievance officer (the social worker) who is responsible for overseeing the grievance process including: receiving and tracking the grievance until conclusion, conducting any necessary investigations, maintaining the confidentiality of information associated with the grievance, and issuing written grievance decisions to the resident if requested. Residents will be notified individually or through postings in prominent locations throughout the facility of the following: the right to file a grievance orally or in writing, the right to file the grievance anonymously, the contact information of the grievance officer, a reasonable expected time frame for completing the review of the grievance, and the right to obtain written decision regarding his/her grievances. Upon receipt of a grievance, the staff person receiving the grievance shall immediately notify the grievance officer. The grievance officer shall begin the grievance process by logging a summary of the grievance, the date the grievance was received and by initiating an investigation. The grievance officer will be responsible for ensuring that the resident's rights are protected while the grievance is being investigated. This may include, but not limited to, suspending any staff person alleged to have violated a resident's rights or limiting access to the resident by another resident. Review of any grievances filed should be completed within 7 days. If the review cannot be completed within this timeframe, the grievance officer should communicate the status of the review and an updated time in which it is expected review will be completed. Upon completion of the review, the grievance officer should document the following: the date the grievance was received, a summary of the resident's grievance, steps taken to investigate, a summary of the pertinent findings or the conclusion, and any corrective action taken. Review of the Resident Rights Policy identified residents have the right to be treated with dignity and respect. Residents have the right to have prompt efforts made by the facility to resolve any grievances you may have, including those about other residents, staff, or other concerns regarding the residents stay at the facility.

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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 documentation, facility policy and interviews, for 1 resident (Resident #36) reviewed for dysphagia, the facility failed to develop a comprehensive care plan with interventions to address the residents swallowing disorder to ensure the resident received the correct consistency liquid. The findings include:Resident #36 was admitted to the facility in August 2025 with diagnoses that included dysphagia, pain in the left arm, malignant melanoma of the skin, and malignant neoplasm of the pancreas and bronchus or lung. The admission MDS dated [DATE] identified Resident #36 had moderately impaired cognition, required set-up or clean-up assistance with eating, had a mechanically altered diet requiring a change in texture of food or liquids, and had the following signs and symptoms of a possible swallowing disorder: holding food in mouth/cheeks or residual food in mouth after meals and complaints of difficulty or pain when swallowing.A physician's order dated 9/3/25 directed for a house (regular) diet easy to chew (L7 texture), mildly thick (nectar) consistency liquid, allow fruit plate, and recommend alternating bites and sips; patient must clear throat and re swallow following liquid intake.The care plan dated 9/11/25 failed to identify interventions and goals for Resident #36's dysphagia diagnosis, had been developed.Review of Resident #36's Visual/Bedside Kardex Report dated 9/22/25 identified the following eating/nutrition special instruction: set-up and clean-up help only (1 staff member), encouraging and providing fluid intake throughout the day, and providing feeding/dining assistance as need; the report failed to identify special instructions related to his/her physician's order for mildly thick (nectar) consistency liquids.Observation with LPN # 2 on 9/22/25 at 9:10 AM identified a water pitcher, approximately half full of water and a plastic cup approximately one quarter full of water on top of Resident #36's bedside table; LPN #2 verified the water in both the pitcher and cup were thin consistency. LPN #2 removed the water pitcher and cup containing thin liquids from the bedside table.Interview with LPN #2 on 9/22/25 at 9:11 AM indicated Resident #36 had swallowing issues and was followed by the SLP. LPN #2 further identified that Resident #36 should only receive nectar thick liquids, per the physician's order, and he/she should not have thin liquids, at the bedside. LPN #2 indicated that the 11:00 PM - 7:00 AM nurse aide was responsible for filling the residents' water pitchers, every morning. LPN #2 further indicated that Resident #36 had issues with pain to his/her arm, but when his/her pain was controlled Resident #36 would have the physical capacity to pour water from the pitcher into a cup and drink it.Interview with the Tally Clerk/Dietary Aide (DA #1) on 9/22/25 at 2:08 PM identified that with each meal pass, a list of residents, by unit, identifying the resident's diet, allergies/adaptive equipment, and fluid consistency was included on the beverage service cart. DA #1 indicated that the list does not go up to the units on the water pitcher cart, but she would be happy to include the list with the water pitcher cart, in the future.Clinical record review with the DNS on 9/22/25 at 2:29 PM failed to identify a comprehensive care plan, including interventions and goals for Resident #36's dysphagia diagnosis, had been developed and failed to identify Resident #36's Visual/Bedside Kardex Report included special instructions related to his/her physician's order for mildly thick (nectar) consistency liquids.Interview with the DNS on 9/22/2025 at 2:29 PM identified that she would expect a comprehensive care plan to have been developed for Resident #36's dysphagia diagnosis and would have expected the special instructions for the thickened liquids to have carried over to the Kardex. The DNS further identified that the nursing supervisor or MDS coordinator were responsible for updating resident care plans; whoever took off the order was responsible for notifying the supervisor of the change or updating the care plan. The DNS indicated that it was the responsibility of the 11:00 PM - 7:00 AM nurse aide to fill the water pitcher, and her expectation would have been for the nurse aide to read the Kardex or double check with the nurse to verify a resident's liquid consistency; since the Kardex did not reflect the order for thickened liquids (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the 11:00 PM - 7:00 AM nurse aide may not have known to thicken Resident #36's water pitcher.Although attempted an interview with the 11:00 PM - 7:00 AM nurse aide (NA #3) was not obtained.The facility's Baseline/Comprehensive Person-Centered Care Plan policy directs that the interdisciplinary team will utilize the comprehensive person-centered care planning process to address resident strengths, needs and/or problems as identified on the admission discharge summary, as well as other professional assessments and orders from the health care provider, dietary team, therapy, social services, and MDS. The person-centered care plan is developed to include information necessary to properly care for the resident and will address the resident's preferences, goals, desired outcomes, and plan for discharge. The comprehensive person-centered care plan will be implemented by qualified members of facility staff and will periodically be reviewed and revised based on the MDS assessments, reassessments, and upon any changes in status.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **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 #12) reviewed for activities of daily living, the facility failed to ensure a resident was offered and provided showers weekly. The findings include: Resident #12 was admitted to the facility in August 2025 with diagnoses that included post laminectomy and spinal stenosis. Review of the nurse's notes dated 8/25/25 to 9/21/25 failed to reflect Resident #12 was offered or had refused showers. The admission MDS dated [DATE] identified Resident #12 had intact cognition and was totally dependent on staff for showers and needed maximum assistance for transfers. The shower transfers were not attempted due to medical condition or safety concerns. Review of the nurse aide flow sheet dated 8/25/25 to 9/22/25 identified Resident #12 had a bed bath on the 7:00 AM to 3:00 PM shift on 9/8/25 and 9/15/25 by NA #4. Additionally, Resident #12 did not receive a shower from 8/25/25 to 9/22/25. The care plan dated 9/16/25 identified Resident #12 has self-care deficits, with interventions that included Resident #12 needed assist of 1 for showering and bathing. The nurse's note dated 9/19/25 at 2:34 PM identified Resident #12 had returned from the follow-up surgical appointment with the surgeon. Recommendations included to continue with physical and occupational therapy and continue with wound care. The facility staff were instructed to call the spine surgeon if they had any questions or concerns regarding Resident #12's care. A physician's order dated 9/19/25 directed to call spine surgeon if there are any questions. The physician's orders did not reflect that Resident #12 could not take showers. Interview with Resident #12 on 9/21/25 at 8:15 AM indicated he/she has not had a shower since admission and must go to the hairdresser and pay to have his/her hair washed. Resident #12 indicated she would take a shower if it was offered and the staff could assist him/her in the shower stall or tub. Resident #12 indicated he/she could not stand for a shower. Resident #12 indicated he/she could not step over the hump to get into a stand-up shower or step over the edge of a tub. Resident #12 indicated if there was a shower chair he/she would take a shower. Resident #12 indicated staff have not offered him/her a shower. Interview with NA #4 on 9/21/25 at 8:25 AM indicated there was a shower with a bench to sit on in every resident room on the rehab unit. NA #4 showed there was a shower with a bench in Resident #12's room. NA #4 indicated if a resident needed or preferred a shower chair on wheels there are a couple available on the unit. NA #4 indicated Resident #12 has not had a shower since admission because therapy must do an assessment to determine that Resident #12 can go in the shower safely and Resident #12 would have to be able to do toilet transfers first. Additionally, NA #4 indicated she has not offered Resident #12 a shower because Resident #12 has a wound with a dressing, and she did not want to get it wet. Interview with NA #4 on 9/21/25 at 2:30 PM indicated that when therapy was working with Resident #12 this morning, she asked the therapist if she could evaluate Resident #12 for safe transfers in the bathroom and in the shower. NA #4 indicated that after therapy worked with Resident #12 the therapist said Resident #12 would be safe in the bathroom for toilet transfers and the shower. NA #4 indicated that once the orders from therapy were updated in the EMR she would give Resident #12 a shower. NA #4 indicated she did not realize Resident #12 really wanted a shower. NA #4 indicated that Resident #12 is due for a shower on Tuesday's during the 7:00 AM to 3:00 PM shift and she would be responsible to give the shower. Interview with LPN #3 on 9/21/25 at 2:37 PM indicated NA #4 had talked to the OTA this morning regarding whether Resident #12 was safe to transfer for a shower. LPN #3 indicated that when a resident refuses a shower the nurse must document the refusal. LPN #3 indicated she had not documented that Resident #12 has refused a shower, but she had encouraged Resident #12 in the past to take showers. Interview with OT #1 (Director of Rehab Services) on 9/22/25 at 8:46 AM indicated the nursing staff are to follow a resident's transfer status from the hospital discharge paperwork unless nursing uses its judgement and felt a resident needed more assistance. OT #1 indicated showers can be given based off the nursing policy and the resident's (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	transfer status. After reviewing the OTA progress note dated 9/21/25, OT #1 indicated the therapist worked on toilet transfers with Resident #12 yesterday and it does not mention showers. Interview with DNS on 9/22/25 at 9:02 AM indicated that the rehab residents have showers in their rooms. The DNS indicated residents are assigned showers based on their room and bed assignment. The DNS indicated Resident #12 was assigned to have a shower Tuesdays during the 7:00 AM to 3:00 PM shift. The DNS indicated there was a shower book at the nurse's station for the nurse aide to be informed which residents get a shower each day and on which shift. The DNS indicated the shower day, and time are on the resident's care card. The DNS indicated that all residents are offered a shower at least weekly unless there was a physician order directing a resident not to have showers until seen by the surgeon. After reviewing the physician orders, the DNS indicated there was not an order for Resident #12 not to have a shower. The DNS indicated the nurse aide could have covered the dressing with plastic and taped it on the resident to provide the shower. The DNS indicated when the shower was completed the nurse could go and do a dressing change. The DNS indicated if a resident had refused a shower her expectation was the nurse would go speak to the resident and find out why the resident was refusing the shower. The DNS indicated her expectation was that the nurse would educate the resident on importance of showers for skin integrity and encourage the resident to take a shower. The DNS indicated the nurse must document the education and if the resident still refused the shower. After reviewing the clinical record, the DNS indicated she did not see that Resident #12 had refused a shower or was educated regarding showers. The DNS indicated NA #4 had documented a bed bath was given twice since admission but no showers. Interview with NA #4 with the DNS present on 9/22/25 at 9:24 AM indicated she could have given Resident #12 a shower using the mechanical lift, but Resident #12 has wounds, so she did not offer a shower. NA #4 decided to give Resident #12 a bed bath and assumed Resident #12 could not have showers due to the dressing on Resident #12's body. NA #4 indicated she did not offer Resident #12 a shower and she did not ask any of the nurses if Resident #12 could or could not receive showers. NA #4 indicated she did not wash Resident #12's hair as part of the bed bath. The DNS indicated the wounds could have been covered with plastic and the showers could have been given. The Recovery Shower Sheet identified Resident #12 was scheduled for showers weekly on Tuesdays during the 7:00 AM to 3:00 PM shift. Review of the Activities of Daily Living identified ADLs are the essential tasks that each person needs to perform, on a regular basis, to sustain basic survival and well-being. The term, ADL's helps healthcare professionals quickly communicate the level of assistance an individual might need or how their health is impacting their day-to-day life. The purpose is to provide the level of care required by each individual resident. Staff who provide assistance to complete ADL activities are broken down into eight areas they are bathing/showering, toileting, dressing, eating, feeding, functional mobility, personal devices, and personal hygiene.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075316	A. Building B. Wing	09/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 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 2 of 3 residents, (Resident #13 and 52) reviewed for contractures, for Resident #13 the facility failed to ensure palm protectors were applied in accordance with physician orders, and for Resident #52, the facility failed to ensure a resident with a known contracture was re-evaluated for continued use following readmission after a hospitalization. The findings include: 1. Resident #13 was admitted to the facility in January 2021 with diagnoses that included contracture of the left hand and dementia.The quarterly MDS dated [DATE] identified Resident #13 was severely cognitively impaired and required two person assist with bed mobility, dressing and did not utilize a splint or brace.The care plan dated 8/1/25 identified Resident #13 had an ADL deficit with interventions that included bilateral hand rolls in place at all times, to be replaced for skin checks and hand hygiene.Physician's order dated 9/10/25 directed bilateral palm protectors at all times per tolerance, except for care, nursing to check skin every shift.Occupational Therapy Discharge summary dated [DATE] identified Resident #13 had plateaued regarding the application of palm protectors with caregivers receiving training on their use.Observation on 9/21/25 at 8:11 AM identified Resident #13 was in bed sleeping, without the benefit of the bilateral palm protectors which were at the bedside.Subsequent observation on 9/22/25 at 10:23 AM identified Resident #13 was up sitting in the wheelchair without bilateral palm protectors in place.The Long-Term Care Refusal Log for nurse aide documentation dated 9/18/25 through 9/23/25 noted no documented refusals regarding the application of the palm protectors.Interview with LPN #4 on 9/22/25 at 11:50 AM identified she was the assigned nurse for Resident #13 during the 7:00 AM to 3:00 PM on 9/22/25. LPN #4 was unsure if Resident #13 was supposed to be wearing palm protectors and indicated it was the responsibility of the nurse aides to place the devices.Interview with NA #11 on 9/22/25 at 11:55 AM identified that she was not assigned to Resident #13 during the 7:00 AM to 3:00 PM shift on 9/22/25 but was aware Resident #13 wore palm protectors. NA #11 provided assistance to the assigned aide in applying the palm protectors to Resident #13's hands prior to getting Resident #13 up for the day. NA #11 further identified nurse aides were responsible for applying the palm protectors prior to getting Resident #13 up for lunch.An interview with NA #10 on 9/22/25 at 11:59 AM identified she was the assigned nurse aide for the 7:00 AM to 3:00 PM shift on 9/22/25. NA #10 identified she provided personal care to Resident #13 at 9:00 AM but did not check the care card to see if palm protectors were required for Resident #13. NA #10 observed the devices on Resident #13's wheelchair when getting him/her up for lunch and asked NA #11 for assistance with their application which Resident #13 tolerated well without refusing. NA #10 identified she should have reviewed the care card in morning and ensured the palm protectors were worn according to scheduled times.An interview and facility documentation review with Certified Occupational Therapy Assistant ([NAME] #1) on 9/22/25 at 1:14 PM identified Resident #13 had contractures and increased tone. Bilateral palm guards were recently added to the treatment plan to decrease further contractures and were to be worn at all times with skin checks and skin hygiene. [NAME] #1 identified staff were educated and reference materials were placed in the room, care card, chart, and provided to the DNS. Facility documentation noted NA #10 and NA #11 participated in training.An interview with the DNS on 9/23/25 at 10:15 AM identified she would expect Resident 13's palm protectors to be maintained according to physician orders.Although requested, a policy for the use of assistive devices for limited mobility was not provided.Attempts to interview NA #12, assigned 11:00 PM to 7:00 AM, 9/20/25 overnight to 9/22/25, were unsuccessful. 2. Resident #52 was admitted in April 2024 with diagnoses that included hemiplegia and hemiparesis (weakness and paralysis) and dementia.The quarterly MDS dated [DATE] identified Resident #52 was severely cognitively impaired and required one person assist with bed mobility, dressing, and did not utilize a (continued on next page)

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	075316	A. Building B. Wing	09/23/2025

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	splint or brace.The care plan dated 2/24/25 identified Resident #52 had an ADL deficit related to hemiparesis and hemiplegia affecting the right dominant side. Interventions included OT evaluation and treatment as ordered.Occupational Therapy Evaluation dated 2/26/25 identified Resident #52 was receiving services that included trialing a new hand splint to prevent further contractures.Occupation Therapy Treatment Notes dated 3/7/25 through 3/20/25 identified Resident #52 was agreeable to trialing a splint, tolerated range of motion and splinting over two hours with no documented refusals.Nurse's note dated 3/23/25 at 4:25 PM identified Resident #52 was transferred to the hospital for further evaluation for left sided face and neck swelling.Occupational Discharge summary dated [DATE] identified Resident #52 was receiving services which included right hand and wrist splinting and that progress was slow prior to hospitalization.Nurse's note dated 4/5/25 at 2:50 PM identified Resident #52 was readmitted back to the facility following care and treatment of a neck mass.A review of the clinical record failed to identify an occupational therapy assessment following readmission back to the facility on 4/5/25 or thereafter to determine continued use of the splint.Observation of Resident #52 on 9/23/25 at 9:36 AM identified he/she was not wearing a splint.Interview with the Director of Rehabilitation on 9/23/25 at 9:30 AM identified all residents readmitted from the hospital including those with contractures, were to be screened by occupational therapy. Resident #52 had been trialing a right-hand splint prior to hospitalization. Upon re-admission, the Director of Rehabilitation, also the occupational therapist at the time, could not recall if a screen was completed but indicated it should have been documented in the clinical record.Interview with the DNS on 9/23/25 11:11 AM identified she expected all residents to be re-evaluated by rehabilitation services hospitalization.Although requested, a policy for resident re-evaluation post hospitalization by rehabilitation services was not provided.Although requested, a policy for the use of assistive devices for limited mobility was not provided.

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	075316	A. Building B. Wing	09/23/2025

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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **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 #106) reviewed for a specialty medical treatment, the facility failed to ensure the arteriovenous fistula (AVF) was monitored every shift per facility policy and failed to ensure there was an emergency kit in the resident's room. The findings include:Resident #106 was admitted to the facility in March 2025 with diagnoses that included end stage renal disease and was dependent of dialysis. The Nursing admission Evaluation dated 3/2/25 at 1:15 PM identified Resident #106 had an AVF (abnormal connection between an artery and a vein) to the right upper extremity for hemodialysis three times a week. The care plan dated 3/2/25 identified Resident #106 requires dialysis. Interventions include monitoring the AVF site access dressing and checking for a bruit and thrill daily and as needed. Additionally, observe the AVF access site for signs and symptoms of infection or bleeding, and if bleeding occurs apply pressure and notify the physician.A physician's order dated 3/2/25 directed for Resident #106 to go to hemodialysis three times a week on Monday, Wednesday, and Friday. The admission MDS dated [DATE] identified Resident #106 had intact cognition. Resident #106 required moderate assistance with dressing. Additionally, Resident #106 receives hemodialysis. a. Review of the physician's order dated 3/2/25 until 9/22/25 failed to direct the monitoring of the AVF for a bruit or thrill. Review of the MAR and TAR dated 3/2/25 - 9/22/25 failed to reflect the monitoring of the AVF for a bruit and thrill every shift. Interview with LPN #5 on 9/21/25 at 10:57 AM indicated Resident #106 goes to dialysis on Monday, Wednesday, and Friday. LPN #5 indicated Resident #106 leaves the facility between 3:00 PM and 3:30 PM on dialysis days. LPN #5 indicated that she fills out the pre dialysis form with a set of vital signs and if there were any medication changes. Interview with the DNS on 9/22/25 at 9:52 AM identified Resident #106 goes to dialysis in the afternoon and comes back later in the day on Monday, Wednesday, and Friday's. The DNS indicated the nurses were responsible to fill out the communication form prior to Resident #106 leaving for dialysis and when Resident #106 returns the nurses are responsible to see if there are any new orders on the form from dialysis. The DNS indicated Resident #106 has a dialysis communication book that the forms are kept in. The DNS indicated the form requires a set of vital signs and notation if there were any changes. The DNS indicated the communication form does not require an assessment of the AVF for a bruit and thrill. Interview with the DNS on 9/23/25 at 7:10 AM indicated on admission the supervisor was responsible to input the admission orders from the hospital. The DNS indicated that the admission nurse does the medication reconciliation and puts in the dialysis orders. The DNS indicated another nurse will verify and check the orders for accuracy and completeness. The DNS indicated the next day the ADNS will review the new admission chart including the physician orders to make sure it was accurate and complete. The DNS indicated the nurse was responsible for checking and assessing the AVF site every shift, checking for the bruit and thrill every shift, and documenting the assessments on the TAR. The DNS indicated these assessments would be part of the admission orders. The DNS indicated that when Resident #106 returns from dialysis the nurse is responsible to check the communication book and check the AVF site for bleeding. After reviewing the medical record, the DNS indicated the physician orders did not direct to check of the bruit and thrill at the AVF site since the residents admission in March 2025. The DNS indicated that with the prior company there was a premade template for dialysis residents that the nurse just had to click on for the admission physician orders. The DNS indicated the new system does not have the template premade for dialysis residents, so the admission nurse did not put all the orders for dialysis residents. b. Observation on 9/21/25 at 10:57 AM failed to reflect an emergency kit in Resident #106's room. Interview with the DNS on 9/23/25 at 7:25 AM indicated the expectation was there would always be an emergency kit in the room in case the AVF site starts bleeding or swelling. The DNS indicated the kit includes a set of blue clamps and absorbent pads. The DNS indicated the (continued on next page)

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	075316	A. Building B. Wing	09/23/2025

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	emergency kit would be found above Resident #106's bed on the wall. Observation with the DNS on 9/23/25 at 7:30 AM identified entered room and the DNS indicated the kit was not present and probably did not get moved when Resident #106 had changed rooms either in April 2025 or July 2025. Review of the Hemodialysis Policy identified a resident who is admitted to the facility requiring hemodialysis will have their dialysis needs met. The residents will not have blood work or blood pressures taken in the av fistula arm. If the AV site begins to bleed apply firm pressure with a clean gauze pad until it stops. Do not press so hard that the blood flow through the graft stops. You should be able to feel the thrill or buzz while you are holding pressure. Notify the physician and send resident to the emergency room. If swelling suddenly begins around the fistula, apply firm pressure over the stick site until swelling stops. You should still feel the thrill or buzz while you hold pressure. The licensed nurse will obtain the physician orders for hemodialysis which would include the following: dialysis days, with the scheduled time, possible fluid restriction, labs if needed, clarify with physician the dialysis medications to be given pre-dialysis, and a renal diet. After initial assessment the care plan will include which arm to use for blood pressures, obtaining post weights as dialysis will do a pre-weight, and vital signs and assessing dialyzing site. The licensed nurse assesses the AVF daily for signs or symptoms of infection and documents it on the TAR which includes redness, warmth, swelling, drainage, fever, or pain, or tenderness. The licensed nurse will assess the AVF for a thrill and bruit every shift and document on the TAR. The licensed nurse will feel for the thrill by palpation every shift and the bruit with a stethoscope every shift. Notify the physician immediately if you cannot feel the thrill or buzz or hear the bruit. If bleeding or sudden swelling occurs, or if you notice any signs of infection.

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	075316	A. Building B. Wing	09/23/2025

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, facility policy, and interviews for 1 of 2 residents (Resident #36) reviewed for food, the facility failed to ensure fluids were served in a consistency that was in accordance with the physician's order. The findings include:Resident #36 was admitted to the facility in August 2025 with diagnoses that included dysphagia, pain in the left arm, malignant melanoma of the skin, and malignant neoplasm of the pancreas and bronchus or lung.A physician's order dated 8/28/25 directed for a house (regular) diet pureed (L4 texture), mildly thick (nectar) consistency, allow fruit plate, and recommend alternating bites and sips.The admission MDS dated [DATE] identified Resident #36 had moderately impaired cognition, required set-up or clean-up assistance with eating, had a mechanically altered diet requiring a change in texture of food or liquids, and had the following signs and symptoms of a possible swallowing disorder: holding food in mouth/cheeks or residual food in mouth after meals and complaints of difficulty or pain when swallowing.The Functional Fiberoptic Endoscopic Evaluation of Swallowing (FEES) report dated 9/3/25 identified Resident #36's oral containment was intact; control of thin liquids was challenging with resultant secondary aspiration of residues that migrated into the airway before he/she could trigger a re swallow. Thicker liquids, even a slightly thick health shake, were consumed without pharyngeal residual and no airway invasion occurred. Most impressive was Resident #36's excellent clearance of solids.A physician's order dated 9/3/25 directed for a house (regular) diet easy to chew (L7 texture), mildly thick (nectar) consistency, allow fruit plate, and recommend alternating bites and sips; patient must clear throat re swallow following liquid intake.The care plan dated 9/11/25 failed to identify interventions and goals for Resident #36's dysphagia diagnosis. The care plan identified Resident #36 was at risk for malnutrition related to metastatic cancer, dysphagia, weight loss prior to admission, diagnosis of protein calorie malnutrition, and variable oral intake, with interventions that included encouraging and providing intake of fluids throughout the day and providing safe swallow strategies, per the Speech-Language Pathologist's (SLP) recommendation.The Speech-Language Pathologist Discharge summary dated [DATE] identified Resident #36's received services from 8/27/25 through 9/8/25. Over the course of therapy, Resident #36's diet was advanced to level 7EC with minced and moist meats, with mildly thick liquids. Trials of thin liquids were provided; however, Resident #36 remains on a modified diet for maximum safety during oral intake. Positive response to training in swallow strategies and oropharyngeal strengthening exercises, and he/she has reached the highest practical level and will be discharged from speech therapy services on 9/8/25.Observation with LPN # 2 on 9/22/25 at 9:10 AM identified a water pitcher, approximately half full of water and a plastic cup approximately one quarter full of water on top of Resident #36's bedside table; LPN #2 verified the water in both the pitcher and cup were thin consistency. LPN #2 removed the water pitcher and cup containing the thin liquids from the bedside table.Interview with LPN #2 on 9/22/25 at 9:11 AM indicated Resident #36 had swallowing issues and was followed by the SLP. LPN #2 further identified that Resident #36 should only receive nectar thick liquids, per the physician's order, and he/she should not have thin liquids, at the bedside. LPN #2 indicated that Resident #36 had issues with pain to his/her arm, but when his/her pain was well controlled Resident #36 would have the physical capacity to pour water from the pitcher into a cup and drink it. LPN #2 further indicated that the 11:00 PM-7:00 AM nurse aide was responsible for filling the residents' water pitchers, every morning.Interview with the Director of Rehabilitation Services (OT#1) on 9/22/25 at 9:40 AM identified that Resident #36 should be served mildly thick nectar liquids, based off his review of the physician's orders, SLP evaluation, and the results of the FEES report. OT #1 indicated that while he was not a SLP, he would be concerned for Resident #36 being at risk for dysphagia pneumonia following the consumption of thin liquids.Interview with the Dietitian (RD #1) on 9/22/25 at 1:26 PM (continued on next page)

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	075316	A. Building B. Wing	09/23/2025

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	identified that all of Resident #36's liquids should be thickened, including the water in the bedside water pitcher, unless an exception was identified by the SLP and written in the physician's orders. RD #1 indicated that she was not aware of Resident #36 being allowed thin liquids by the SLP.Interview with the DNS on 9/22/25 at 1:34 PM identified that she would expect that only nectar thick liquids would be served to Resident #36, and that she had already begun education with the nursing staff to ensure residents were served their therapeutic diet/drink orders. The DNS further identified that it was the responsibility of the 11:00 PM - 7:00 AM nurse aide to fill the water pitchers, and that she would expect the nurse aide to read the resident's care card to ensure the liquid consistency being served matched the physician's order. The DNS indicated that the 11:00 PM to 7:00 AM nurse aide (NA #3) that worked on Resident #36's unit was hired within the last year and had received education on therapeutic diets during orientation, including food and liquid consistencies and the significance of why the therapeutic diet orders matter.Interview with the Tally Clerk/Dietary Aide (DA #1) on 9/22/25 at 2:08 PM identified that with each meal pass, a list of residents, by unit, identifying the resident's diet, allergies/adaptive equipment, and fluid consistency was included on the beverage service cart. DA #1 indicated that the list does not go up to the units on the water pitcher cart, but she would be happy to include the list with the water pitcher cart, in the future.Although attempted an interview with the 11:00 PM - 7:00 AM nurse aide (NA #3) was not obtained.Although multiple attempts were made, an interview with SLP #1 was not obtained.The facility's Culinary and Nutrition policy directs that the facility maintains acceptable parameters of nutritional status, such as usual or desirable body weight range, and electrolyte balance, for the residents unless the resident's clinical condition demonstrates that it is not possible or resident preferences indicate otherwise. Therapeutic diet refers to a diet ordered by a physician or other delegated provider that is part of the treatment for a disease or clinical condition, to eliminate, decrease, or increase certain substances in the diet, or to provide mechanically altered food when indicated. The interdisciplinary team facilitates communication of the implementation and evaluation of nutrition interventions amongst the team and other facility personnel through established communication tools and meetings.Although requested a therapeutic diet policy was not provided.

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	075316	A. Building B. Wing	09/23/2025

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, facility policy, and interviews for 1 of 2 residents (Resident #37) reviewed for food, the facility failed to ensure food preferences were accommodated. The findings include: Resident #37 was admitted to the facility in August 2025 with diagnoses that included type 2 diabetes mellitus, chronic diastolic heart failure (CHF), and Parkinson's disease. A physician's order dated 8/24/25 directed that Resident #37 receive a 2-gram Sodium (2 GM Na+) diet, regular texture.The Nutrition Screening and Food Preferences document dated 8/27/25 identified Resident #37 did not like the following foods: eggs, rice, spinach, pot pie, and soup. The Nutrition Screening and Food Preferences document further identified that Resident #37's preferences included toast, banana, muffin, pancakes, or waffles, when available.The admission MDS dated [DATE] identified Resident #37 had intact cognition, required set up or clean up assistance for eating, and was on a therapeutic diet, while a resident at the facility.The care plan dated 9/16/25 identified that Resident #37 had type 2 diabetes mellitus, with interventions that included a dietary consultation for nutritional regimen and monitoring, documenting, and reporting signs and symptoms of hypoglycemia or hyperglycemia. The care plan further identified that Resident #37 was at risk for malnutrition related to his/her diagnoses of CHF and Parkinson's disease and being on a therapeutic diet, with interventions that included providing a diet per the physician's order and obtaining, providing, honoring, and monitoring his/her food and beverage preferences and eating patterns.Interview with Resident #37 on 9/21/25 at 8:43 AM identified that he/she hates eggs and that he/she had been served eggs every day, and he/she has sent the eggs right back to the kitchen. Resident #37 indicated that he/she has told multiple staff members that he/she does not like eggs. Resident #37 further indicated that he/she was served baked eggs for breakfast and told the nurse aide to send it back to the kitchen.Interview with NA #1 on 9/21/25 at 8:45 AM identified that Resident #37 did not like the baked eggs that were served for breakfast, and he/she sent them back to the kitchen. NA #1 was not sure if Resident #37 did not like the baked eggs served for breakfast or if he/she disliked eggs, in general. Review of Resident #37's Dietary Profile dated 9/22/25 identified the following: do not serve hot cereal, hard cooked eggs, visible eggs, or rice and please include a banana when available (breakfast), meal notes included no eggs.Observation with LPN #2 on 9/22/25 at 8:15 AM identified that Resident #37's 9/22/25 breakfast ticket read 4 fluid ounces of juice of choice, 3/4 cup of corn flakes, scrambled eggs, 1 slice of cinnamon wheat toast, and 8 oz of choice beverage; the ticket identified no eggs. Observation of Resident #37's breakfast tray included 4 half pieces of toast, corn flakes, and juice. Interview with LPN #2 on 9/22/5 at 8:15 AM identified that she was not sure why scrambled eggs were listed on Resident #37's breakfast ticket if he/she doesn't like eggs, and that she would expect that another protein would have been served as a substitute for the scrambled eggs; LPN #2 immediately notified the kitchen staff of concern.Interview with Resident #37 on 9/22/25 at 8:17 AM identified that he/she was served cold toast for breakfast, did not want corn flakes, and would have liked a substitute for the scrambled eggs. Resident #37 indicated that his/her representative had filled out the weekly Heart Healthy Dietary Menu, and he/she had written, on the top of the menu, that Resident #37 does not want eggs but that he/she would like a banana with breakfast.Interview with the Food Service Director on 9/22/25 at 1:04 PM identified that he had worked at the facility for approximately 4 weeks, and that he would expect food preferences that were communicated to nursing or dietary staff, by residents or resident representatives, to be entered into the facility's electronic system which generates the meal tickets. The Food Service Director indicated that resident food dislikes should be listed on the meal tickets, so the cooks, dietary staff, and nursing staff know not to serve food items that have been identified as a dislike. The Food Service Director further indicated that a plate of toast would not be an acceptable breakfast for (continued on next page)

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	075316	A. Building B. Wing	09/23/2025

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #37, and that an alternative heart healthy item or protein should have been served. The Food Service Director identified that he would expect resident preferences to be honored.Interview with the Dietitian (RD #1) on 9/22/2025 at 1:17 PM identified that the Tally Clerk rounds on all new admissions to determine food preferences and enters residents' dislikes, allergies, and intolerances into the electronic system. RD #1 indicated that Resident #37's dislikes of hot cereal, hard boiled eggs, and rice were listed in the electronic system, so she would expect those preferences to be honored. RD #1 further indicated that fresh fruit, cottage cheese, and yogurt would be acceptable items to substitute for eggs for a resident on a heart healthy diet.Interview with the Tally Clerk/Dietary Aide (DA #1) on 9/22/25 at 2:08 PM identified that she conducts dietary preference interviews on all the new admissions, completes the Nutrition Screening and Food Preferences document, and enters all the relevant information, including preferences, dislikes, allergies, and intolerances, into the facility's electronic system. DA #1 further identified that she also updates the system, as needed, when nurse aides, a resident, or family member identify new food preferences or dislikes. DA #1 indicated that Resident #37's dislikes were listed under his/her profile in the electronic system, and she was unsure why eggs would continue to show up on the printed ticket. DA #1 further indicated that there may be a glitch in the system; she would work with the Food Service Director to fix the issue, and in the meantime, she would manually cross off eggs from Resident #37's printed meal tickets, to ensure his/her food preferences were met.The facility's Menu Development and Nutrition Adequacy policy directs that planned menus are developed and used to provide each resident with a nourishing, palatable, well-balanced diet that meets his/her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. Menus are: planned in advance for both regular and therapeutic diets according to established national guidelines and the National Health Care Associates approved diet manual, reflect based on the facility's reasonable efforts, the religious, cultural, and ethnic needs of the resident population, as well as, input received from residents and resident groups, updated periodically, and followed. The policy further directs the facility to make a reasonable and good faith effort to develop a menu to meet resident preferences. Residents provide input into menu development through resident council or a separate food committee, interviews with residents, their families and significant others by the Food Service Director, Registered Dietitian, or their designee, and throughout resident satisfaction surveys. Resident food and beverage preferences are obtained directly from the resident and/or a family/legal representative or indirectly by center staff. Additionally, culinary services determine food and beverage preferences based on resident observation at mealtimes. Food preferences are documented on the resident tray card/ticket and other applicable documents. Reasonable alternative food items that reasonably accommodate individual resident needs, allergies, intolerance and preferences are available and offered to residents at each meal if the primary menu or immediate selections for a particular meal are not to the resident's liking. Alternate options are appealing and of similar nutritive value.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075316	A. Building B. Wing	09/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glastonbury Center for Health & Rehabilitation	1175 Hebron Ave Glastonbury, CT 06033

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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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observation, review of facility documentation, facility policy and interview, the facility failed to ensure refuse was properly contained in outside dumpsters. The findings include:A tour of the outside grounds on 9/21/25 at 7:12 AM with the FSD identified a dumpster with a large opening on the side with a moderate amount of debris including dirty food containers, paper, and foil wrap which was scattered around the area.An interview with the FSD on 9/21/25 at 7:12 AM identified it was the responsibility of dietary staff to empty the garbage to ensure the surrounding areas were clear of debris. It was his responsibility to oversee but was new to the facility still familiarizing himself with daily operations.Review of the facility policy for Environmental Management directed a process in place to inspect and maintain clean grounds including areas where compacters, dumpsters or collection containers are located.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075316	A. Building B. Wing	09/23/2025

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F 0730 Level of Harm - Potential for minimal harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on review of facility documentation, facility policy, and interview for 4 of 6 nurse aides, the facility failed to ensure annual performance evaluations were completed. The findings include:Interview with the Administrator on 9/22/25 at 11:25 AM indicated that all employees receive an annual performance evaluation from the department head that oversees the employees. The Administrator indicated each department was responsible to make sure the employee evaluations were completed annually based on hire date and placed in the employee file. Review of the employee files identified the following.a. NA #1 date of hire was 6/16/22. There were no annual performance evaluations on file for 2023, 2024, or 2025. b. NA # 6 date of hire was 6/6/24. There was not an annual performance evaluation on file. c. NA #17 date of hire was 7/18/22. There were no annual evaluations on file for 2023, 2024, or 2025. d. NA #19 dated of hire 7/19/22. There was no employee file or annual performance evaluations for 2023, 2024, or 2025. Interview with HR #1 on 9/23/25 at 11:51 AM indicated the department heads were responsible to do the annual performance evaluations for all employees in their departments. HR #1 indicated the annual performance evaluations are to be completed on the employee's anniversary date every year. Interview with the DNS on 9/23/25 at 12:08 PM indicated she was responsible to make sure all nursing staff have their annual performance evaluations in the month they were hired every year. The DNS indicated that she has a spread sheet to keep track of when employees were due for their annual performance evaluation. The DNS indicated NA #1 and NA #6 were due for their annual performance evaluations in June 2025 and NA #17 and 19 were due in July 2025. The DNS indicated they were not done. The DNS indicated that she was a little behind with getting the annual performance evaluations completed. The policy identified the purpose of a performance review is to assure the employee that his/her efforts are being recognized by the facility and to assure the facility that the employee is properly placed in his/her current position. The facility strives to review the performance of each staff member at the end of the first 3 months of employment and at least once a year thereafter. Regular attendance, attitude, and job performance will be among the most important factors considered in the review. Review of the Performance Evaluation policy identified the performance review period as annual. Performance factors included knowledge of work duties, dependability and reliability, communication skills, customer service, teamwork, interpersonal skills, motivation and interest in position and role, initiative and openness to learning. These areas will receive a rating, and the managers can make overall comments. The employee can add comments at the end. The manager and the employee will sign and date the performance review.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0947 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility documentation, facility policy, facility assessment and interviews, the facility failed to provide nurse aide training of no less than 12 hours per year. The findings include:Interview with LPN #1 (staff development nurse) on 9/22/25 at 7:38 AM indicated that she is responsible for education and competencies of all the nurse aides. LPN #1 indicated the facility just had a change of ownership in October 2024 and since the change of ownership she had just been working on all the mandatory education which includes the dementia training education for all staff, and competencies for the nursing staff. LPN #1 indicated that since October 2024 she did not have a tool for keeping track of the nurse aide education hours. LPN #1 indicated the nurse aide mandatory education, including dementia training as part of the mandatories, and competencies takes about 8 hours. LPN #1 indicated that it was the only education she has been working on. LPN #1 indicated she did not have any sheets or spreadsheets tracking the number of hours for the nurse aides for 2024 or 2025. LPN #1 indicated she would ask the ADNS if she has any tracking took for the nurse aide educational hours. Interview with the ADNS on 9/22/25 at 9:40 AM indicated she was responsible for the oversight of LPN #1 for the staff development of the nurse aides. The ADNS indicated that LPN #1 does mandatory education, and she was responsible to check and making sure the post tests were completed and corrected. The ADNS indicated she does not have a tracking system in place for the year 2024 or 2025 for the nurse aides to make sure they have received the minimum required 12 hours per year of education. The ADNS was unable to verify the nurse aides received 12 hours of education for 2024 or 2025.Interview with the DNS on 9/22/25 at 9:44 AM indicated that they did education, but they do not tally the number of hours per nurse aide to make sure they meet the minimally required 12 hours per year for 2024 or 2025.Review of the Facility assessment dated [DATE] identified the facility staffing training and education and competencies include the following topics:*Communication - effective communication for all staff.*Resident rights and facility responsibilities- ensure that staff members are educated on the rights of the resident and the responsibility of the facility to properly care for its residents.*Abuse, neglect, and exploitation- training that at a minimum activity that constitutes abuse, neglect, exploitation, or the misappropriation of resident's property, Additionally, procedures for reporting incidents of abuse, neglect, exploitation, or misappropriation of residents' property.*Infection Control -training on the infection control program, written standards and policies*Required in-service training for nurse aides. In-service training must be sufficient to ensure the continuing competence of the nurse aides but must be no less than 12 hours per year.