STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075318	A. Building B. Wing	05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pomperaug Woods Health Center	80 Heritage Rd Southbury, CT 06488

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for one (1) of three (3) residents (Resident #8) reviewed for abuse, the facility failed to ensure a resident was treated in a respectful and dignified manner. The findings include:Resident #8 had diagnoses that included major depressive disorder, right femur fracture, difficulty walking, fracture of the first lumbar vertebrae, bilateral sacral fractures, and sacral insufficiency fracture. The Resident Care Plan (RCP) dated 3/5/26 identified Resident #8 had a functional ADL decline related to fractures and recent surgery with interventions that directed to provide the assistance of one with ADLs and toileting. The quarterly Minimum Data Set (MDS) dated [DATE] identified Resident #8 had a Brief Interview for Mental Status (BIMS) score of 15 indicative of intact cognition, was always continent of bowel and bladder, required moderate assistance with personal hygiene, and touching assistance for toileting and toileting hygiene. A change in condition evaluation dated 4/1/26 at 1:00 PM, completed by Registered Nurse (RN) #5, identified Resident #8 had a change in condition related to an allegation of abuse. The assessment indicated an investigation was initiated and the alleged perpetrator, Nurse Aide (NA) #6, was placed on administrative leave pending the outcome of the investigation. The assessment indicated Resident #8 had a skin assessment completed, and vital signs were obtained. RN #5 indicated an interview with Resident #8 was conducted with his/her daughter present at the bedside and Resident #8 declined police involvement. Interviews with additional residents and staff members were initiated. The assessment indicated that the Medical Director, APRN, and Administrator were notified, and no new orders were received. Facility reportable event form dated 4/1/26 at 1:00 PM, identified, Resident #8 reported on 4/1/26 at approximately 2:00 AM, while being toileted by NA #6, NA #6 was sharp with him/her and usually had a bad attitude. Resident #8 stated he/she was afraid to use the call button afterward due to NA #6's attitude. Investigation was initiated and NA #6 was placed on administrative leave pending the outcome of the investigation. Review of RN #6's written statement dated 4/2/26 at 10:29 PM identified Resident #8 was alert and oriented x's 4 and able to verbalize all needs. RN #6 identified he had concerns regarding NA #6's interactions with residents. RN #6 further identified that he had previously reported two additional allegations involving NA #6 to the nursing team. RN #6 indicated he had educated NA #6 on multiple occasions regarding the importance of choosing appropriate words and refraining from expressing frustration while in residents' rooms.Facility reportable event summary dated 4/2/26 identified Resident #8, who is alert and oriented reported, a staff member woke him/her up during the overnight hours to provide toileting care and subsequently Resident #8 felt hesitant to request assistance due to the staff member's perceived attitude. Resident #8 did not provide specific statements or language indicative of verbal abuse but expressed general concerns regarding the staff member's demeanor. NA #6 was placed on administrative leave pending investigation. NA #6 denied the allegation of abuse. Following a thorough investigation, the allegation of abuse was unsubstantiated. Education was provided to staff regarding resident rights, including the right to request assistance without hesitation or fear of reprisal.Interview on 5/20/26 at 9:35 AM with Resident #8 identified a month or so ago when NA #6 (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	went into his/her room in the middle of the night to assist him/her with the bed pan, NA #6 was not happy to help, NA #6 seemed annoyed, and NA #6 had a bad attitude. Resident #8 indicated NA #6 was not the nicest girl, but after the incident he/she was nervous to use the call bell again. Resident #8 identified he/she never felt that way before, so he/she reported what happened to the Director of Nursing (DNS) and never seen NA #6 again. Resident #8 could not recall exactly when it happened or when he/she reported it to the DNS. Interview with the DNS on 5/20/26 at 11:00 AM identified on 4/1/26 at 1:00 PM, Resident #8 reported at approximately 2:00 AM when NA #6 entered the room to assist him/her with toileting, NA #6 made him/her feel hesitant to call for assistance again due to NA #6's attitude. The DNS indicated he asked Resident #8 what NA #6 said to him/her and Resident #8 did not provide any specifics on language used towards him/her, but felt NA #6's attitude towards him/her was not positive. The DNS indicated the allegation of staff to resident abuse was unsubstantiated. The DNS identified NA #6 had prior customer service complaints made against her that were addressed. The DNS further identified NA #6 did not provide Resident #8 with good customer service, therefore, NA #6 was terminated. Although attempted, interviews with RN #6 and NA #6 were not obtained. Review of the facility Resident Rights policy dated February 2001, directed in part, employees shall treat all residents with kindness, respect, and dignity. These rights include the resident's right to be treated with respect, kindness, and dignity Review of the facility Hospitality Services Standard policy dated 2/2022, directed in part, to anticipate the needs of each resident and respond positively and promptly to their requests, respond timely with empathy and concern.