STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075321	A. Building B. Wing	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saint Josephs Living Center, Inc.	14 Club Rd Windham, CT 06280

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 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and facility policy review, the facility failed to recognize, assess, and manage acute pain for two of three sampled residents reviewed for accidents (Residents #1 and #5), resulting in actual harm when both residents experienced prolonged unrelieved pain after emergent injuries. Resident #1 sustained a secondˆdegree burn on 3/4/26 with documented discomfort. Yet, staff did not complete a comprehensive pain assessment or administer available PRN analgesia. The ordered burn dressing was no applied until the next shift, leaving the resident to report throbbing pain for many hours without followˆup from nursing. Similarly, on 3/15/26, Resident #5 experienced a witnessed fall with visible leftˆarm deformity and severe pain, but staff failed to administer any PRN pain medication before the resident was transported to the emergency department approximately 35 minutes later, despite active orders for both acetaminophen and morphine; the resident did not receive pain relief until more than two hours after the fall. These failures to promptly assess and treat acute pain following injuries resulted in avoidable, significant suffering for both residents and occurred despite facility policies requiring immediate pain assessment and timely intervention upon onset of new pain. The findings include:1. Resident #1?s diagnoses included dementia without behavioral disturbances, type II diabetes mellitus, muscular dystrophy (progressive muscle weakness and degeneration), lymphedema (chronic swelling of the body's tissues caused by lymphatic fluid buildup) and anxiety disorder.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had intact cognition (Brief Interview for Mental Status (BIMS) score of 15), and was independent for eating, bed mobility, transfers and ambulation.The Resident Care Plan (RCP) dated 1/6/26 identified Resident #1 had an alteration in comfort related to the aging process and lymphedema. Interventions included interviewing the resident and observing for pain characteristics including quality, severity, location, precipitating and relieving factors, monitoring for nonverbal signs and symptoms of pain, administering medications as ordered and monitoring for effects of and side effects of the medications.An accident/incident note by RN #1 dated 3/4/26 at 2:30 PM identified while participating in a recreational activity, Resident #1 was served a cup of hot tea with a lid which he/she removed and spilled on his/her left leg. The note reported the area to the left upper inner thigh was slightly pink, with what appeared to be a popped blister and measured approximately five (5) centimeters (cm) by four (4) cm. A cool compress was applied to the area with some improvement in the discomfort, Resident #1's responsible party and the APRN were notified, and a new order was obtained to apply Xeroform gauze to the area followed by a dry protective dressing.A status post incident-accident note by RN #2 dated 3/4/26 at 10:00 PM identified the Xeroform gauze and dressing were applied to Resident #1's left inner thigh over the burn area and that discomfort was noted.Review of the clinical record failed to identify a comprehensive pain assessment was completed following a significant change in condition or when there was an onset of new pain per the facility policy.Review of the March 2026 Medication Administration Record (MAR) identified an order dated 1/23/26 directing to administer acetaminophen 325 milligrams (mg), give two (2) tablets (650 mg) by mouth every six (6) hours as needed for mild pain, but failed to identify that it had been administered on 3/4/26 for the resident's discomfort following the burn incident.A provider note by (continued on next page)

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

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F 0697 Level of Harm - Actual harm Residents Affected - Few	APRN #1 dated 3/5/26 at 9:45 AM identified she saw Resident #1 following the 3/4/26 incident where Resident #1 spilled a cup of hot tea on his/her left inner thigh. The note reported the left inner thigh had an erythematous superficial burn (skin injury characterized by redness, pain and dryness) exhibiting desquamation (shedding dead skin cells) and epidermal sloughing (the peeling, shedding or separation of the top layer of skin). The surrounding tissue was observed with mild inflammatory edema (swelling) consistent with a second-degree burn and Resident #1 reported discomfort at the burn site to the left inner thigh.A physician's order dated 3/5/26 and entered by APRN #1 directed to administer acetaminophen 325 mg, give 2 tablets (650 mg) by mouth two times a day for left inner thigh pain.Review of the March 2026 MAR identified Resident #1 was not administered acetaminophen or a pain relieving medication until 3/5/26 at 5:30 PM following the burn incident on 3/4/26 at 2:30 PM (more than 24-hours later) although documentation identified Resident #1 was in discomfort on 3/4/26 and 3/5/26.Interview with Resident #1 on 4/1/26 at 10:47 AM identified following the 3/4/26 burn incident, nursing applied a cool compress to the area which slightly relieved the pain but no one returned to check on him/her for several hours. Resident #1 reported nursing did not administer or offer medications for pain relief at the time of the incident or later that night and the left thigh area throbbed in pain. Additionally, Resident #1 reported the area was left open to air which was uncomfortable, and the Xeroform dressing was not applied until around 5:30 PM which was painful when applied.Review of physician's orders and the March 2026 MAR failed to identify an order for Xeroform gauze to be applied to the left inner thigh and failed to identify the treatment was administered on 3/4/26 following the burn incident until 3/5/26, when the order was entered by APRN #1.Interview with RN #1 on 4/1/26 at 12:37 PM identified following the burn to Resident #1's left inner thigh, LPN #1 and herself applied several cool compresses to the left inner thigh but Resident #1 was still in discomfort. RN #1 reported that LPN #1 should have administered acetaminophen following the incident or at least offered the acetaminophen for pain relief. RN #1 identified she obtained the Xeroform gauze dressing order verbally from APRN #1 but was unable to explain why she had not entered the order. RN #1 reported she did not apply the dressing to Resident #1 following the incident, she requested that RN #2 do so.Interview with LPN #1 on 4/1/26 at 12:54 PM identified she applied a cool compress to Resident #1's left inner thigh following the burn. She identified she should have offered acetaminophen for pain relief but Resident #1 appeared shocked and was not talking so she assumed Resident #1 was fine, left for her shift and did not offer or administer acetaminophen to Resident #1. Additionally, she identified she should have written a nurse's note regarding the care she provided and was unsure why she didn't.Interview with RN #2 on 4/1/26 at 11:22 AM identified she did not know what time it was when she applied the Xeroform gauze to Resident #1's left inner thigh burn on 3/4/26, the area was undressed and open to air and Resident #1 was in visible discomfort. RN #2 reported once she applied the dressing to the area Resident #1 appeared more comfortable but she did not offer acetaminophen for pain relief prior to or following the dressing application and was unable to explain why. She reported although she verified the dressing order for Resident #1 with RN #1, she was unaware there was no order entered for the dressing on 3/4/26 or that she did not sign it off, and she was unable to identify when she applied the dressing.Interview with APRN #1 on 4/1/26 at 1:11 PM identified any resident with acute pain or discomfort should be evaluated for pain and offered pain relief medication timely if indicated. Additionally, she identified when she saw Resident #1 on 3/5/26 following the burn incident, Resident #1 was in discomfort, so she ordered acetaminophen scheduled twice daily for three (3) days. She identified she gave RN #1 a verbal order for the Xeroform gauze treatment on 3/4/26 which was not transcribed to the clinical record so she entered the order on 3/5/26.Interview with the DON on 4/1/26 at 1:19 PM and 2:48 PM identified a pain assessment should be completed following a significant change in condition and with any identification of new acute pain. She reported if staff are documenting that a resident is in pain or discomfort, they should also be documenting follow-up and what interventions were put into place to decrease or eliminate pain. She identified that nursing staff should have offered Resident #1 pain (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	relief medication when it was identified he/she was in pain or discomfort. She reported RN #1 should have immediately transcribed the verbal order she received from APRN #1 for the Xeroform gauze dressing so that nursing could document the application timely and accurately. Further, she identified LPN #1 should have documented her role in the incident and the care she provided as the charge nurse, and that nursing staff should ensure documentation is complete and accurate prior to leaving the shift.2. Resident #5?s diagnoses included Alzheimer's disease, low back pain, encounter for palliative care, type II diabetes mellitus and anxiety disorder.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #5 had intact cognition (Brief Interview for Mental Status (BIMS) score of 14), was independent for bed mobility and required partial assistance for transfers and supervision assistance for ambulation.The Resident Care Plan (RCP) dated 3/13/26 identified Resident #5 was admitted to hospice services as of 8/19/25, was at risk for falls due to decreased safety awareness, unsteady gait, cognitive deficits, psychotropic and narcotic drug use and was at risk for pain, complications and decline due to uterine lesion/tumor, left breast lump and breast cancer. Interventions included anticipating the resident's needs, monitoring for any signs and symptoms of pain, administering medications as ordered by the physician and monitoring their effect.An Accident/Incident note by RN #3 dated 3/15/26 at 11:24 PM identified Resident #5 tripped over his/her own feet while walking to the closet, bumped into the closet door, fell onto his/her bottom and hit both upper extremities on the floor. The incident was witnessed by the charge nurse (LPN #2) and Resident #5 did not hit his/her head but was complaining of pain to the left arm, was holding the left arm and RN #3 reported the left arm looked deformed. The note identified an assessment was completed, Resident #5 had severe pain to the left arm, Resident #5's family was notified and requested Resident #5 be sent to the ED for evaluation. Hospice services were notified at 5:00 PM, Emergency Services was called at 5:20 PM and Resident #5 was transferred to the ED.Review of the facility Reportable Event (RE) identified Resident #5's fall occurred at 4:45 PM (35 minutes prior to transfer to the ED).Review of the March 2026 MAR identified active orders dated 6/4/22 directing to administer acetaminophen 325 mg, give 2 tablets (650 mg) by mouth every four (4) hours as needed for pain or general discomfort, as well as an order dated 8/15/25 directing to administer morphine sulfate oral solution 100 mg per 5 milliliters (mL), give 0.25 mL by mouth every 4 hours as needed for pain or shortness of breath. Although as needed pain-relieving medications were in place, the MAR failed to identify Resident #5 had been administered medications for the severe pain on 3/15/26 following the fall with left arm deformity within the 35-minute timeframe from when the fall occurred until Resident #5 was transferred to the ED.The hospital documentation dated 3/15/26 identified there was suspicion for a non-displaced fracture (a bone break where the bone is cracked but remains properly aligned) of the posterior aspect of the humerus (the backside of the upper arm bone), was provided with a sling and Resident #5 would be referred to orthopedic surgery. Additionally, the documentation identified Resident #5 was administered acetaminophen 975 mg at 6:51 PM (more than two hours after the fall occurred).Interview with the DON on 4/1/26 at 1:19 PM and 2:48 PM identified that nursing staff should have offered Resident #5 pain relief medication when it was identified he/she was in pain or discomfort following the fall. Additionally, she identified that LPN #2 should have documented her role in the resident fall incident and the care she provided to Resident #5 as the charge nurse prior to leaving for her shift that night.Interview with LPN #2 on 4/1/26 at 2:24 PM identified although Resident #5 was in severe pain and was holding his/her left arm following the fall on 3/15/26, she did not administer pain relief medication to Resident #5 prior to the resident being transferred to the ED. She assumed Resident #5 would medicated in the ED and did not consider the ambulance ride to the ED. LPN #2 reported that she should have administered pain relief medication to Resident #5 before he/she was transferred to the ED. Additionally, she identified she should have written a nurse's note regarding witnessing the fall and the care she provided to Resident #5 but was unable to explain why she did not. Although attempted, an interview with RN #3 was not obtained.Review of the Pain Assessment and Management policy (undated) directed, in part, (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	the pain management program is based on a facility-wide commitment to resident comfort. Pain management is defined as the process of alleviating the resident's pain to a level that is acceptable to the resident and is based on his of her clinical condition and established treatment goals. Pain management is a multidisciplinary care process that includes assessing the potential for pain, effectively recognizing the presence of pain, addressing the underlying causes of the pain and monitoring for the effectiveness of interventions. Conduct a comprehensive pain assessment upon admission to the facility, at the quarterly review, whenever there is a significant change in condition, and when there is onset of new pain or worsening of existing pain. Observe the resident for during rest and movement for physiological and non-verbal signs of pain to include verbal expressions, facial expressions and guarding, rubbing or favoring a particular part of the body. Ask the resident if he/she is experiencing pain and be aware the resident may avoid the term pain and use other descriptors such as throbbing, aching, hurting, numbness or tingling. Review the resident's clinical record to identify conditions or situations that may predispose the resident to pain including musculoskeletal conditions, skin and wound conditions and end of life/hospice care. Review the resident's treatment record or recent nurse's notes to identify any situations or interventions where an increase in the resident's pain may be anticipated such as treatments for wound care or dressing changes. Pain management interventions shall reflect the sources, types and severity of pain and shall address the underlying causes of the resident's pain. Monitor the resident by performing a basic assessment with enough detail and, as needed, with standardized assessment tools and relevant criteria for measuring pain management. Document the resident's reported level of pain with adequate detail (enough information to gauge the status of pain and the effectiveness of interventions for pain) as necessary and in accordance with the pain management program. Upon completion of the pain assessment, the person conducting the assessment shall record the information obtained from the assessment in the resident's medical record.Review of the Medication and Treatment Orders policy (undated) directed, in part, verbal or telephone orders must be recorded immediately in the resident's chart by the person receiving the order and must include prescriber's last name, credentials and the time and date of the order.Review of the Charting and Documentation policy (undated) directed, in part, all services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for two (2) of three (3) sampled residents (Residents #1 and #5) reviewed for accidents, the facility failed to maintain complete and accurate clinical records by failing to ensure physician orders obtained following an incident were transcribed into the medical record and failing to ensure all licensed nurses involved in the incidents documented the care and services provided. The findings include:1. Resident #1?s diagnoses included dementia without behavioral disturbances, type II diabetes mellitus, muscular dystrophy (progressive muscle weakness and degeneration), lymphedema (chronic swelling of the body's tissues caused by lymphatic fluid buildup) and anxiety disorder.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had intact cognition (Brief Interview for Mental Status (BIMS) score of 15), and was independent for eating, bed mobility, transfers and ambulation.The Resident Care Plan (RCP) dated 1/6/26 identified Resident #1 had an alteration in comfort related to the aging process and lymphedema. Interventions included interviewing the resident and observing for pain characteristics including quality, severity, location, precipitating and relieving factors, monitoring for nonverbal signs and symptoms of pain, administering medications as ordered and monitoring for effects of and side effects of the medications.An accident/incident note by RN #1 dated 3/4/26 at 2:30 PM identified while participating in a recreational activity, Resident #1 was served a cup of hot tea with a lid which he/she removed and spilled on his/her left leg. The note reported the area to the left upper inner thigh was slightly pink, with what appeared to be a popped blister and measured approximately five (5) centimeters (cm) by four (4) cm. A cool compress was applied to the area with some improvement in the discomfort, Resident #1's responsible party and the APRN were notified, and a new order was obtained to apply Xeroform gauze to the area followed by a dry protective dressing.Review of the facility schedule dated 3/4/26 identified LPN #1 was the charge nurse assigned to Resident #1.Review of nurse's notes dated 3/4/26 failed to identify documentation regarding the burn incident from LPN #1.A status post incident-accident note by RN #2 dated 3/4/26 at 10:00 PM identified the Xeroform gauze and dressing were applied to Resident #1's left inner thigh over the burn area and that discomfort was noted.Interview with Resident #1 on 4/1/26 at 10:47 AM identified following the 3/4/26 burn incident, nursing applied a cool compress to the area which slightly relieved the pain but no one returned to check on him/her for several hours. Resident #1 reported the area was left open to air which was uncomfortable, and the Xeroform dressing was not applied until around 5:30 PM which was painful when applied. Review of physician's orders and the March 2026 MAR failed to identify an order for Xeroform gauze to be applied to the left inner thigh and failed to identify the treatment was administered on 3/4/26 following the burn incident until 3/5/26, when the order was entered by APRN #1. Interview with RN #1 on 4/1/26 at 12:37 PM identified following the burn to Resident #1's left inner thigh, LPN #1 and herself applied several cool compresses to the left inner thigh but Resident #1 was still in discomfort. RN #1 identified she obtained the Xeroform gauze dressing order verbally from APRN #1 but was unable to explain why she had not entered the order. RN #1 reported she did not apply the dressing to Resident #1 following the incident, she requested that RN #2 do so.Interview with LPN #1 on 4/1/26 at 12:54 PM identified she applied a cool compress to Resident #1's left inner thigh following the burn. She identified she should have written a nurse's note regarding the care she provided and was unsure why she did not.Interview with RN #2 on 4/1/26 at 11:22 AM identified she did not know what time it was when she applied the Xeroform gauze to Resident #1's left inner thigh burn on 3/4/26, the area was undressed and open to air and Resident #1 was in visible discomfort. RN #2 reported once she applied the dressing to the area Resident #1 appeared more comfortable, and although she verified the dressing order for Resident #1 with RN #1, she was unaware there was no order entered for the dressing on 3/4/26 or (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that she did not sign it off, and she was unable to identify when she applied the dressing.Interview with APRN #1 on 4/1/26 at 1:11 PM identified when she saw Resident #1 on 3/5/26 following the burn incident, she gave RN #1 a verbal order for the Xeroform gauze treatment on 3/4/26 which was not transcribed to the clinical record so she entered the order on 3/5/26.Interview with the DON on 4/1/26 at 1:19 PM and 2:48 PM identified RN #1 should have immediately transcribed the verbal order she received from APRN #1 for the Xeroform gauze dressing following the burn incident so that nursing could document the application timely and accurately and LPN #1 should have documented her role and the care provided to Residents #1 as the charge nurse. She identified nursing staff should ensure documentation is complete and accurate prior to leaving for their shift.2. Resident #5?s diagnoses included Alzheimer's disease, low back pain, encounter for palliative care, type II diabetes mellitus and anxiety disorder.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #5 had intact cognition (Brief Interview for Mental Status (BIMS) score of 14), was independent for bed mobility and required partial assistance for transfers and supervision assistance for ambulation.The Resident Care Plan (RCP) dated 3/13/26 identified Resident #5 was admitted to hospice services as of 8/19/25, was at risk for falls due to decreased safety awareness, unsteady gait, cognitive deficits, psychotropic and narcotic drug use and was at risk for pain, complications and decline due to uterine lesion/tumor, left breast lump and breast cancer. Interventions included anticipating the resident's needs, monitoring for any signs and symptoms of pain, administering medications as ordered by the physician and monitoring their effect.An Accident/Incident note by RN #3 dated 3/15/26 at 11:24 PM identified Resident #5 tripped over his/her own feet while walking to the closet, bumped into the closet door, fell onto his/her bottom and hit both upper extremities on the floor. The incident was witnessed by the charge nurse (LPN #2) and Resident #5 did not hit his/her head but was complaining of pain to the left arm, was holding the left arm and RN #3 reported the left arm looked deformed. The note identified an assessment was completed, Resident #5 had severe pain to the left arm, Resident #5's family was notified and requested Resident #5 be sent to the ED for evaluation. Hospice services were notified at 5:00 PM, Emergency Services was called at 5:20 PM and Resident #5 was transferred to the ED.Review of nurse's notes dated 3/15/26 failed to identify documentation from LPN #2 related to Resident #2's fall or the care she provided to Resident #2.Interview with the DON on 4/1/26 at 1:19 PM and 2:48 PM identified that LPN #2 should have documented her role in the fall incident and the care she provided to Resident #5 as the charge nurse prior to leaving for her shift.Interview with LPN #2 on 4/1/26 at 2:24 PM identified she should have written a nurse's note regarding witnessing Resident #5's fall and the care she provided to Resident #5 but was unable to explain why she didn't. Review of the Charting and Documentation policy (undated) directed, in part, all services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record.