STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075335	A. Building B. Wing	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beechwood Health & Rehabilitation Center	31 Vauxhall Street New London, CT 06320

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 clinical record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident # 1) reviewed for abuse, the facility failed to ensure staff treated the resident with dignity and respect when the resident did not respond to redirection. The findings include:Resident #1 was admitted to the facility with diagnoses that included dementia, restlessness and agitation, generalized muscle weakness, frequent falls and anxiety. A 5-day Minimum Data Set (MDS) assessment dated [DATE] identified Resident # 1 had a Brief Interview for Mental Status (BIMS) score of 0, (severely impaired cognition), had wandering behavior one (1) to three (3) days in the prior seven (7) days, and required assistance for personal hygiene. The Resident Care Plan (RCP) dated 5/22/2025 identified Resident #1 had impaired cognition and wandering behaviors. Interventions that directed to face Resident #1 when speaking, and if restless or agitated, reapproach later, and redirect as needed. A facility reportable event (RE) form dated 8/2/2025 at 5:30 PM identified Resident #1 was lying on another resident's bed (while that resident was sitting in his/her wheelchair) and saying the other resident was his/her baby. Resident #1 was trying to get up to go to the other resident, and became agitated and RN #1 used a stern voice to try to redirect Resident #1. The facility RE report summary dated 8/4/2025 identified an allegation of staff-to-resident abuse without injury on 8/2/2025. The RE indicated Resident #1 was observed lying on top of another resident's bed (the other resident was sitting in his/her wheelchair and was removed from the room by staff). Resident #1 was getting out of bed and approaching the roommate in the room (Resident #4) in the room who was in his/her bed. Resident #1 was speaking uncomprehensible words and tapping Resident 4 on the top of his/her head. RN #1 stood between the two (2) residents and attempted to redirected Resident #1 away from Resident #4, and Resident #1 became agitated and thought Resident 4 was his/her baby. RN #1 was alleged to use a stern voice to redirect Resident #1. The residents were separated, and Resident #1 was placed on one-to-one (1:1) supervision. Interview with RN #2, nursing supervisor working on 8/2/2025, on 9/18/2025 at 10:00 AM identified on 8/2/2025 she responded to the unit about 5:30 PM and observed RN #1 to be positioned between Resident #1 who was sitting on the bed by the window and Resident #4. RN #1 was attempting to direct Resident #1 out of the room, RN #1 had both her hands raised, flexed at the elbow at shoulder height and was saying Oh no, no, no, no don't touch my friend. RN #2 stated RN #1's voice was stern and loud, and she appeared very frustrated. RN #2 entered the room and told RN #1 do not react like that, you'll make the resident more agitated and directed her to be calm, and then RN #2 directed her attention to Resident #1. RN #1 left the room, RN #2 went to Resident #1 gently held Resident #1's hand, and Resident #1 began to calm down, a NA came into the room to stay with Resident #1, and a visitor arrived for Resident #1 and he/she then left the room. RN #2 stated staff had reported to her that they heard RN #1 yelling toward Resident #1, and RN #1 should have been calm when interacting with Resident #1, and RN #1's reaction may have increased Resident #1's agitation. Interview and facility documentation review with NA #2 on 9/18/2025 at 12:21 PM identified she was the NA assigned to Resident #1 on 8/20/2025 during the 3 to 11 PM shift, and about 5 PM she observed Resident #1 (continued on next page)

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	sleeping in a bed in Resident #4's room (the roommate was in his/her wheelchair in the room). NA #2 attempted to redirect Resident #1 back to his/her room. Resident #1 did not respond, NA #2 asked NA #1 for assistance, and they were not able to redirect Resident #1 and they notified RN #1 and they left the room with the resident that was in the wheelchair. About 5:15 PM, NA #2 was in the hallway when she heard RN #1 in Resident #4's room, call out that she was changing tactics to be stern and was going to start to yell. As RN #1 told Resident #1 to go back to his/her room, RN #1's voice became louder and louder and sterner each time, and stated she was not going to allow Resident #1 to hurt anyone. RN #1 directed NA #1 to call 911, and NA #1 called the supervisor (RN #2) who then responded to the unit. NA #2 then went into the room and saw RN #1 standing near Resident #1 who was trying to get up from the bed and appeared to be swatting at RN #1. RN #1 was yelling that Resident #1 could not hurt her friend and Resident #1 was saying something that was not understandable. RN #2 arrived, and RN #1 left the room, and then Resident #1 became calm and sat in a chair. Interview with NA #1 on 9/22/2025 at 11:10 AM identified that on 8/2/2025, NA #2 had asked her to assist with Resident #1 who was in another resident's bed. NA #2 stated sometimes Resident #1 would recognize one of regular NAs and will then respond to that NA's redirection, but NA #2 was unable to redirect Resident #1 back to his/her room. Resident #1 indicated he/she believed Resident #4 was his/her baby and they called RN #1 to come to the room. NA #1 was in the hall serving meal trays when she overheard RN #1 yelling out that she was changing tactics, to go back to his/her room, and that Resident #1 could not hurt the other residents. RN #1 yelled to call 911 and NA #2 thought she was calling for help so she called RN #2 who came to the unit immediately. Interview and facility documentation review with RN #1 on 9/18/2025 at 11:04 AM identified during the 3 to 11 PM shift on 8/2/2025 she observed Resident #1 wandering in/out of rooms as per his/her usual behavior. About 5:15 PM, staff observed Resident #1 in another resident's bed in Resident #4's room, and the NAs were unable to redirect Resident #1. Resident #1 stated Resident #4 was his/her baby and began to reach for Resident #4. RN #1 notified RN #2/supervisor, who directed to administer PRN (as needed) behavior medications. RN #1 informed RN #2 that Resident #1 had refused his/her scheduled 4 PM medications and may not take a PRN. A message was left requesting the family to call as that had helped Resident #1 to calm down in the past. RN #1 stated she returned to the room and observed the NAs had not been successful redirecting Resident #1 from the room and she attempted to redirect Resident #1. RN #1 stated she was gentle at first but when Resident #1 began to approach Resident #4 she positioned herself between the residents and told Resident #1 not to touch the other resident. Resident #1 began to push RN #1, and RN #1 announced out loud for the staff to hear that she was going to change tactics as she knew that when she began to tell Resident #1 sternly and loudly that Resident #1 could not hurt Resident #4, that staff may get upset. RN #1 stated she had been trained while working in the hospital on how to deal with physically agitated patients. RN #2 arrived and was subsequently able to calm Resident #1. RN #1 stated she believed it was appropriate to raise her voice to Resident #1, and stated she was aware the facility staff would be upset. Interview and facility document review with the DON on 9/18/2025 at 10:54 and 9/22/2025 at 9:53 AM identified that RN #1 raised her voice as a last resort and that RN #1 acknowledged her escalation in tone. The DON stated stern and screaming at a resident was disrespectful and she would have expected RN #1 to have asked for help and disengage with Resident #1 when she was unable to redirect Resident #1 and became frustrated. The DON continued that RN #1 reacted in a moment of panic, and although there was no physical contact, RN #1 was concerned the situation could have led to a physical altercation between Resident #1 and Resident #4. The facility Residents' Rights Policy dated 10/26/2022, directed in part, that employees shall treat all residents with kindness, respect and dignity and to assure all residents are treated that way.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on clinical record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #2) reviewed for abuse, the facility failed to prevent further potential abuse while the investigation was in progress and failed to suspend the alleged staff member during the investigation in accordance with facility policy. The findings include: Resident #2 was admitted to the facility with diagnoses that included mild neurocognitive disorder with behavioral disturbance, and anxiety disorder. A quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 6/12/2025 identified Resident #2 had a Brief Interview for Mental Status (BIMS) score of 15 (indicated was alert and oriented) and required staff assistance for personal care. The Resident Care Plan (RCP) dated 7/28/2025 identified Resident #2 had impaired coping and pain. The RCP directed to evaluate the cause of anxiety or fear, provide care in a calm and reassuring manner, and provide medications as ordered. A facility reportable event (RE) form dated 8/31/2025 at 4:40 PM identified an allegation of staff-to-resident abuse without injury. Resident #2 reported that LPN #1 did not provide his/her medications timely, was ignoring Resident #2, and was rough when taking his/her blood pressure (BP). The facility RE report summary dated 9/10/2025 identified Resident #2 made an allegation on 8/31/2025 that LPN #1 had applied the blood pressure cuff roughly and medications were given late, and LPN #1 was suspended pending the outcome of the investigation. The Summary identified LPN #1 was behind with her medication pass when approached by Resident #2. LPN #1 offered to go to Resident #2's room, and Resident #2 was frustrated and refused. LPN #1 obtained Resident #2's BP and the supervisor administered the medications. Staff reported LPN #1 was frustrated with the interaction with Resident #2 and spoke sternly to the resident. A review of the medical record identified Resident #2 received his/her medications later than scheduled. Further, the Summary identified the investigation indicated abuse was not substantiated. Interview and review of LPN #1's time sheet with the DON on 9/22/2025 at 9:53 AM identified the allegation of mistreatment was made on 8/31/2025 at 4:40 PM. Facility documentation review identified LPN #1 worked in the facility on 9/2/2025 (two days after the allegation was made and eight days prior to the reportable event summary) from 7:00 AM to 11:30 AM. The DON identified that when she saw LPN #1 on the unit on 9/2/2025 she immediately sent her home as the investigation had not yet been completed. The DON stated she did not know how LPN #1 was scheduled to work on 9/2/2025, and why she worked when she was suspended. The DON stated LPN #1 should not have been working until the investigation was completed. The facility policy Abuse Prohibition & Quality Assurance/Reporting dated 4/12/2025 directed in part, that as protection for residents, the identified alleged staff member will be suspended pending investigation pending the outcome of the investigation ensuring prohibition and prevention of retaliation.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on clinical record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #2) reviewed for abuse or neglect, the facility failed to provide physician order medications as scheduled. The findings include:Resident #2 was admitted to the facility with diagnoses that included congestive heart failure, mild neurocognitive disorder with behavioral disturbance, and anxiety disorder. A quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 6/12/2025 identified Resident # 2 had a Brief Interview for Mental Status (BIMS) score of 15 and was alert and oriented, and required assistance with personal care. The Resident Care Plan (RCP) dated 7/28/2025 identified impaired coping and pain. Interventions directed to administer medications as ordered. Physician orders dated 8/12/2025, directed to administer the following medications: Bumetanide 1 milligram (mg), 2 tablets once a day for pedal edema (swelling of the feet/lower legs). Celexa 20 mg once a day for depression Oxybutynin Chloride Extended release (ER) 24 hours one (1) tablet daily for urinary retention. Prednisone eye drops and Systane gel, one (1) drop each eye, for Sjogren syndrome (disease that causes dry eyes and mouth). Iron supplement tablet 240 mg twice daily for chronic kidney disease. Omeprazole ER 20 mg 2 tablets 2 times daily for gastro reflux. Tylenol extra strength 500 mg tablet, give 2 tablets three times a day Cevimeline HCL 30 mg, give 1 capsule three times a day for Sjogren syndrome B-complex Oral Tablets one (1) tablet by mouth Calcitonin Solution 200 units per milliliter(ml) Vitamin D3 1000 units (u) give 2 tablets Cranberry tablets 450 mg give one (1) tablet daily. Vitamin B12 one (1) tablet by mouth Multivitamins with minerals one (1) tablet daily. Record review identified the above medications were scheduled to be administered on 8/31/2025 at 9 AM. A facility reportable event (RE) form dated 8/31/2025 at 4:40 PM LPN #1 did not provide Resident #2's medications timely. The facility RE report summary dated 9/10/2025 identified medications were administered late, and to educate staff regarding Resident #2's needs. Interview with LPN #1 on 9/22/2025 at 9:15 AM identified that she was an agency nurse and was no familiar with the unit, and on 8/31/2025 she had fallen behind on her morning medication pass. LPN #1 was aware Resident #2's medications were scheduled for 9 AM and by 1 PM she had not yet administered the scheduled medications, and stated she had notified the supervisor/RN #3 that she was behind with her medication pass. Interview with RN #3 on 9/22/2025 at 9:04 AM identified on 8/31/2025 she was notified that LPN #1 was very far behind in her medication pass. RN #3 stated she was notified at some time in the afternoon that LPN #1 was late with her medication pass. The DON stated Resident #2 did not have any adverse effect from the late medication administration. RN #3 was unable to explain what support was provided or what interventions were implemented to ensure the medications were administered timely. A review of facility documents and interview with the DON on 9/22/2025 at 9:53 AM identified although many of the scheduled medications scheduled on 8/31/2025 at 9 AM were daily medications, the medications were administered at 1 PM (4 hours after the scheduled time). The DON stated she would have expected LPN #1 to notify the supervisor when she was late with the 9 AM medication pass before 1 PM, so the supervisor could have helped with the medication pass to ensure residents received their medications timely in accordance with physician orders. The DON stated medications are to be administered within one (1) hour before or after the scheduled time. The facility policy Medication Administration dated 9/13/2024 directed in part, that medications shall be administered in a safe and timely manner.