STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075352	A. Building B. Wing	03/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Connecticut Baptist Homes, Inc	292 Thorpe Avenue Meriden, CT 06450

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 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, facility policies, and staff interviews, the facility failed to timely identify and respond to significant weight loss for 2 of 6 residents (Residents #3 and #26). The facility did not complete physician^ordered weekly weights, did not obtain required reweights after weight loss of 5 pounds or greater per policy, failed to notify providers and the dietitian of documented significant weight loss, and did not implement or provide ordered nutritional supplements. These failures resulted in delays in assessment and intervention, allowing both residents to experience continued, preventable weight loss over multiple weeks. The findings include: 1.Resident #3's diagnosis included cerebrovascular disease, anxiety, and dementia. A Resident Care Plan dated 10/8/25 identified Resident #3 was at risk for malnutrition with interventions that included to provide gentle encouragement at mealtime, honor food preferences, and diet as ordered. A quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #3 was moderately, cognitively impaired and required set up assistance with oral hygiene, upper/lower body dressing and personal hygiene. Additionally, the MDS identified Resident #3 was independent with eating, was not on a mechanically altered or therapeutic diet, did not have a significant weight loss, and Resident #3 weighed 134 pounds (lbs.). a. A physician order dated 12/4/25 directed weekly weights for 4 weeks and then monthly. Review of the Vital Sign record on 3/26/26 at 11:47 AM with Registered Nurse (RN) #1 failed to identify weekly weights were completed on 12/11/25, 12/19/25 and 12/26/25. Interview with RN #1 on 3/26/26 at 11:47AM identified nurses were responsible for ensuring weights were completed as ordered and she was responsible for oversight. RN #1 further noted all weights were to be documented in the Electronic Medical Record (EMR) once obtained and if the weight loss was greater than 5 pounds (lbs) a reweight should be obtained and the family, physician and dietician were to be notified if the weight loss was greater than 5lbs. b. On 3/26/26 at 11:47 AM, review of the Weight and Vital Summary identified on 12/8/25, Resident #3 weighed 136.2 pounds (lbs.), on 1/1/26 weighed 125 lbs. (a weight loss of 11.2 lbs./8.2% in 24 days), on 1/9/26 weighed 123 lbs. (a 13.2 lb./9.6% loss in 31 days). Additionally, on 2/3/26, Resident #3 weighed 117.8 lbs. (a loss of 19.2 lbs./14% in 57 days).A physician order dated 2/9/26 directed to weigh Resident #3 weekly for 4 weeks related to weight loss (39 days after a 11.2 lb./8.2% weight loss was documented).A physician order dated 2/11/26 directed to provide Med pass 2.0, (a nutritional supplement) 4 ounces by mouth twice a day due to weight loss and suboptimal by mouth intake (41 days after a 11.2 lb./8.2% weight loss was documented).On 2/20/26, Resident #3 weighed 113.6lbs., on 2/24/26 Resident #3 weighed 115.6lbs, and Resident #3 weighed 114.4 on 3/3/26. Physician orders dated 3/16/26 directed to administer Remeron (an appetite Stimulant) 15 milligrams give 1/2 tab to equal 7.6 milligrams by mouth at hours of sleep. On 3/26/26 at 10:05 AM interview with the Dietician identified Resident #3 had lost 11.2 lbs./8.2% pounds from 12/8/25 to 1/8/26. The Dietician noted that on 1/3/26 she sent Registered Nurse (RN) #1 an e-mail requesting weekly weights be completed and to start a nutritional supplement (however she did not identify a specific nutritional supplement). Additionally, the Dietician noted when weekly weights and a nutritional supplement had not been ordered, she sent another e-mail on 2/9/26 to RN#1 requesting weekly weights and a nutritional supplement be ordered. The (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0692 Level of Harm - Actual harm Residents Affected - Few	Dietician further noted that Resident #3 would not have continued to lose as much weight from 1/8/26 to 2/9/26 had a supplement been added when she requested on 1/3/26. An interview on 3/26/26 at 11:47 AM with RN #1 identified she did receive an email from the Dietician on 1/3/26 but failed to act upon the request made by the Dietician identifying it was an oversight on her part. On 3/30/26 at 11:09 AM interview with Advance Practice Registered Nurse (APRN) #1 identified she was notified of Resident #3's weight loss on 2/9/26 (39 days after Resident #3 had a 11.2 lbs/8.2% lb. loss). APRN #1 further noted if she was informed of the weight loss from 1/1/26 she would expect the nursing staff to obtain a reweight on the resident and would have started Resident #3 on Remeron (an appetite stimulant) sooner. Further, identifying the resident should have been reweighed on 1/2/26 because the resident had a weight loss of 5 lbs. or greater per the facility policy and the provider/family should have been notified of the weight loss. (please refer to F 580) 2. Resident #26's diagnoses included Type 2 diabetes mellitus, gastro-esophageal reflux disease and unspecified protein-calorie malnutrition.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #26 was cognitively intact and required partial/moderate assistance with bed mobility and transfers. Additionally, the MDS identified Resident #26 required substantial/maximal assistance with toileting, had significant weight loss, was not on a physician prescribed weight loss regimen and had a diagnosis of malnutrition. The MDS further noted Resident #26 was on a mechanically altered and therapeutic diet. A Nutritional Care Recommendation form completed by Dietician #1 on 11/12/25 identified Resident #26 had a significant weight change of 14 pounds (lbs.) from October 2025 and to weigh the Resident #26 weekly.A physician order dated 11/12/25 directed Resident #26 was to be weighed weekly for 4 weeks.The Resident Weight and Vital Sign summary section located in the electronic health record (EHR) identified on 10/5/25 Resident #26 weighed 140.8 lbs., on 11/7/25 weighed 127.4 lbs. (which was documented by RN #3) (a 13.4 lb./9.5% loss in 33 days). A Nutritional quarterly review note written by Dietician #1 and dated 11/13/25 identified Resident #26 had a 14 lb. weight loss in the past month despite medication changes and interventions and further noted the physician and family would be notified.A physician order dated 11/17/25 directed Resident #26 was to receive a mechanical soft diet with thin liquids, add pudding to lunch and add ice cream to supper.The Resident Care Plan (RCP) dated 11/17/25 identified Resident #26 had impaired cognitive function with cognitive decline, Type 2 diabetes mellitus and was at risk for malnutrition with weight loss over the past 6 months. Interventions included providing diet and supplements as ordered, weigh the resident per the physician's order and to keep the physician and family notified with a dietary consult for a nutritional regimen and ongoing monitoring.The Weights and Vitals summary section located in the electronic health record (EHR) identified that on 12/3/25 weighed 128.2 lbs., on 1/10/26 weighed 116.8 lbs. (which was documented by RN #3) (an 11.4 lb./8.89% loss in 38 days), and on 1/23/26 weighed 116.4 lbs. (a 25.2 lb./17.33% loss in 110 days from 10/5/25 to 1/23/26).A Social Service Note/Care Plan Meeting Note dated 2/10/26 identified Resident #26 attended his/her care plan meeting, and Person #1 was in attendance by phone. The note indicated Resident #26 had lost 11.8 lbs. since December.A Nutritional Care Recommendation form, undated and completed by Dietician #1 directed to add 1 scoop of Prosource to vehicle of choice two times a day for skin healing and to discontinue if refused.A physician's order dated 2/26/26 directed Prosource 1 scoop twice daily in vehicle of choice (drink) at 8:30 AM and 8:30 PM.a. An observation of dining on 3/23/26 at 12:15 PM noted Resident #26 awake, seated in his/her wheelchair, hunched forward over the table in the dining room. A plate of liver and onions of chopped consistency was in front of him/her at the dining room table and Resident #26 was not eating. Resident #26 was not served pudding with his/her lunch (as per physician order dated 11/17/25) and pudding was not indicated on the resident's meal ticket. Resident #26 did not eat the chopped liver and onions that was served, was not prompted/cued or assisted by staff to eat during the meal and was not offered an alternative meal. On 3/26/26 at 12:47 PM, interview and review of Resident #26's lunch meal ticket dated 3/23/26 with the Food Service Director (FSD) identified the meal ticket failed to indicate (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	a pudding was to be served to Resident #26 at lunch. The FSD stated pudding should have been listed on all the resident's meal tickets for lunch and was unsure why it was not on the ticket. The FSD identified he would correct the error and ensure the pudding with lunch and ice cream with dinner was listed on all of the resident's meal tickets. The FSD was unable to indicate if Resident #26 was eating the pudding with lunch and ice cream with dinner as their consumption was not being tracked. Additionally, the FSD identified it was his responsibility to include pudding/ice cream on the meal ticket so that dietary could serve pudding with Resident #26's lunch tray. Additionally, the FSD identified pudding was likely only missed on 3/23/26 but couldn't be sure.A second meal observation on 3/26/26 at 12:05 PM noted Resident #26 seated in his/her wheelchair, hunched forward over the table in the dining room. A plate of chicken pot pie of chopped consistency with a biscuit on top and a plastic handled mug of coffee was in front of Resident #26 at the dining room table. Resident #26 was moving his/her hands but not eating. At 12:09 PM, RN #2 prompted Resident #26 to eat while your food is hot, Resident #26 sat up, began to use the spoon, and take small bites of the biscuit. At 12:11 PM, Resident #26 requested ginger ale which was provided by RN #2. At 12:13 PM dietary staff placed a sealed cup of vanilla pudding in front of Resident #26, but it remained unopened by staff. At 12:15 PM Resident #26 requested cranberry sauce which was provided by the FSD and Resident #26 continued to take small bites of the ground chicken pot pie and biscuit with the cranberry sauce. Resident #26's meal ticket for 3/26/26 indicated a 4 oz. vanilla pudding for dessert. Interview and review of the clinical record with the Dietician on 3/26/26 at 1:45 PM identified she was aware that Resident #26 had a significant weight loss of more than 25 lbs. in the last several months. The Dietician indicated after the resident's weight loss was identified in November 2025, she ordered weekly weights and for the resident to have pudding with lunch and ice cream with dinner (which would have provided an additional 300 calories.b. A physician order dated 11/12/25 directed weekly weights for 1 month.Review of the Treatment Administration Record (TAR) with the Dietician indicated the weekly weights ordered on 11/12/25 had not been documented on the TAR for 11/15/25, 11/22/25 and 11/29/25. The Dietician indicated it would have been the responsibility of the nursing staff to ensure Resident #26's weights were obtained weekly and documented in the TAR.Further review of Resident #26's weight record with the Dietician indicated Resident #26 had an additional 11.4 lb. weight loss from 12/3/25 to 1/10/26 when she was away for a few weeks in January 2026 and was not notified of the weight loss until she returned to the facility on 1/20/26 (10 days later). The Dietician indicated the nursing staff should have notified the Regional Dietician of the resident's weight loss in her absence. The Dietician stated the nursing staff would usually communicate a resident's weight loss in person, via email or put a note in the communication book, however review of her email and the communication book failed to indicate she was notified of Resident #26's continued weight loss. (please refer to F 580).Additionally, the Dietician stated her only intervention on 1/20/26 was for Resident #26 to be re-weighed (which was not obtained until 1/23/26 for a weight of 116.4 lbs.) and she should have ordered the resident to be weighed weekly for 4 weeks but had failed to do so. The Dietician further indicated that although Resident #26 was ordered to have pudding with lunch and ice cream with supper, she was unsure of the resident's intake of the pudding and ice cream because the intake was not being tracked and she had not asked the nursing staff about Resident #26's consumption of pudding/ice cream. Interview and review of the clinical record with RN #3 on 3/26/26 at 3:15 PM identified she obtained and documented Resident #26's weight of 116.8 lbs. on 1/10/26 but failed to notice Resident #26's continued weight loss of 11.4 lbs. from 12/3/25. RN #3 indicated she did not compare the resident's prior weights and assumed RN #1 (who was the nursing supervisor) would have noticed the weight loss trend because RN #1 reviews weights, looks for trends and notifies everyone including the physician, Dietician and responsible party on the morning shift. RN #3 further indicated although Resident #26 was not an ice cream eater and would complain the ice cream was too cold, the resident was still served ice cream with supper but did not eat it. RN #3 identified she had not informed anyone that Resident #26 was not (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	consuming ice cream at supper but should have.Interview and review of the clinical record with the RN Supervisor covering for the Director of Nursing Services (RN #1) on 3/26/26 at 3:45 PM identified she was aware that Resident #26 had a significant weight loss of more than 25 lbs. in the last several months. RN #1 indicated after the resident's weight loss in November 2025 the Dietician ordered weekly weights for 4 weeks and ordered pudding with lunch and ice cream with dinner.Additionally, RN #1 identified weekly weights were documented on the Treatment Administration Record. Review of the Treatment Administration Record (TAR) with RN #1 indicated the weekly weights ordered to be completed in November 2025 had not been documented on the TAR for 11/15/25, 11/22/25 and 11/29/25. RN #1 indicated it would have been the responsibility of the nursing staff to ensure Resident #26's weights were obtained weekly and documented in the TAR. RN #1 further identified Resident #26 should have been re-weighed the following day after the continued weight loss was identified on 1/10/26 (loss of 11.4 lbs.) and indicated a re-weight should be completed with a 5 lb. or more weight loss to confirm the weight loss and then the physician, Dietician and responsible party should have been notified. RN #1 identified it was the responsibility of RN # 3 (who obtained and documented Resident #26's weight on 1/10/26) who should have re-weighed the resident, made the necessary notifications, documented in the nursing progress notes, and passed on the information during shift report. Additionally, RN #1 indicated Resident #26's pudding with lunch and ice cream with dinner was not tracked for consumption so the Dietician would not know if the resident was not consuming it and she was unsure if the nursing staff would notice if Resident #26 had received and eaten the pudding or ice cream during his/her meals. Facility policy related to Weights, dated 11/24, directed each resident will have their weight monitored, which will ensure that each resident maintains an optimum body weight. All residents will be weighed at least monthly unless the physician orders otherwise. If a resident's weight is a gain or loss of 5 pounds or more a reweight will take place the next day. If the resident's repeat weight is a gain or loss of 5 pounds the weight will be reported to the physician and the dietician for appropriate interventions. The responsible party will be notified of the weight change and recommended interventions. Weekly and/or more frequently weights will be done per the physician orders and reported according to the parameters given.Facility policy related to Nutrition, dated 2022, directed the Dietician will develop a plan of nutritional care using clinical observation of nutrition and nutritional intake and the resident's intake and weight will be reviewed. Nursing personnel are to ensure each resident receives the correct diet and significant weight fluctuations are reported to the physician.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and review of facility policy for 2 of 2 medication rooms, the facility failed to ensure expired supplies were discarded and failed to ensure the medication cart was secured when staff were not in attendance. The findings include: 1. Interview and observation of the 2nd floor medication room with the Nursing Supervisor (RN #1) on [DATE] at 8:02 AM identified the following expired supplies a. 14 Covid19 AG Binox now tests ([NAME]), expired [DATE] b. Two (2) 10 milliliter (ml) syringe 22-gauge (g) x one (1) inch (in), expired [DATE] c. Six (6) three (3) ml syringe 23g x 1in, expired 8/20 d. 67 three (3) ml syringe 25g x 5/8 in, expired [DATE] e. 12 Hydrocortisone Acetate suppositories 25mg, expired [DATE]. 2. Interview and observation of the 3rd floor medication room with the Nursing Supervisor (RN #1) on [DATE] at 8:05 AM identified the following: a.One (1) 10 ml syringe 22g x one (1) in, expired [DATE] b. One (1) three (3) ml syringe 23g x 1in, expired [DATE] c. 21 three (3) ml syringe 25g x 5/8 in, expired 2/20 d. 30 Linzess 145 microgram capsules, expired 12/25 e. One (1) filter straw, expired [DATE] - located in emergency medication box f. One (1) filter straw, expired [DATE] - located in emergency medication box g. One (1) filter straw, expired [DATE] - located in emergency medication box h. Two (2) safety glide 25g x one (1) in needles, expired [DATE] - located in emergency medication box i. One (1) Atropine Sulfate one (1) ml vial, expired 2/26 j. Two (2) Clarithromycin 500 milligram tablets, expired 1/26RN #1 identified that the expired items should have been discarded and that it was the responsibility of the nursing staff on the 11:00 PM to 7:00 AM shift to check for expiration dates. RN #1 identified that the 11:00 PM to 7:00 AM checklist was signed off that staff checked for expiration dates.Attempts to contact staff on the 11:00 PM to 7:00 AM shift were unsuccessful.Review of facilities Storage and Expiration Dating of Medications and Biologicals policy, dated [DATE], directed in part that facility should destroy or return all discontinued, outdated/expired, or deteriorated medications or biologicals. Facility staff should inspect nursing station storage areas for proper storage compliance on a regular basis. 3. Observation of medication administration on [DATE] at 9:36 AM with Registered Nurse (RN) #2 identified RN #2 prepared medication for Resident #23, turned his back to the medication cart, entered Resident #23's room to administer medication, but left the medication cart unlocked with the top drawer (which contained various bottles of over the counter medications) open in the hallway.Interview with RN #2 on [DATE] at 9:41 AM identified that the policy for medication carts was that it should always be locked when a staff member was not present and that it was his responsibility to ensure that it was. RN #2 indicated that he forgot to lock the medication cart when he left it and that he should have locked it.Interview with the Nursing Supervisor (RN #1) on [DATE] at 10:00 AM identified that medication carts should be locked during medication administration when the assigned nurse was not present and that it was the responsibility of the nurse to ensure that it was secured.Review of facilities Storage and Expiration Dating of Medications and Biologicals policy, dated [DATE], identified that the facility should ensure all medications and biologicals, including treatment options, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors.

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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 interviews, observations in the Dietary department and facility policy, the facility failed to ensure various food items were labeled with the date opened/expiration date, failed to ensure items were not stacked when wet, failed to identify plates coming from the dishwasher were clean, and failed to take freezer temperatures in 2 of 2 nourishment rooms. The findings include: On 3/23/26 at 10:24 AM, tour of the Dietary department with the Director of Dining identified the following: a. an 18 quart (qt) clear plastic bin (1/16 full) containing loose flour, an 18 qt clear plastic bin (4 qts full) containing loose breadcrumbs, and a 22 qt clear bin (12 qt full) containing loose oatmeal failed to identify the date the items were transferred into the bins from the original packaging and lacked an expiration date. The blue lid to the plastic bins of flour and breadcrumbs had an accumulation of white powdery debris and were dusty. b. a 46-ounce (oz) (almost full) plastic coated box type container of cranberry juice located in the beverage cooler was uncapped (no cap was located in the cooler), exposing the juice to the air. c. Observation of the clean side of the dishwashing room on 3/23/26 at 10:40 AM with the Director of Dining noted Dietary Aide (DA) #1 removed clean dishes and lid covers from the dishwasher and stacked them on a metal cart in the clean side of the dishwashing room. The metal cart contained 28 dome plastic entree lid covers stacked upside down, in 3 piles on top of the metal cart. The inside of the lid covers were wet with water, Additionally, there were stacked plates on the metal cart that clean dishes from the dishwasher were stacked on. The top plate was noted to have yellow, dried on debris and a lid cover was noted to have brown sticky debris along the rim. Interview with DA #1 at that time, identified the plates and lid covers just came out of the dishwasher, were clean and ready to be put into circulation. She identified that she does check the items for cleanliness as they come out of the dishwasher, did not notice the soiled plate and lid cover and must have missed it. Subsequent to surveyor inquiry, the Director of Dining removed the soiled lid cover and plate from the metal cart for re-washing. Interview with the Director of Dining on 3/23/26 at 10:42 AM identified the lid covers were stacked when they came out of the dishwasher because the kitchen does not have drying racks. He further identified that he didn't consider the lid covers to be stacked wet because they were going to be transported to the tray line (which was approximately 12 feet away). Observation of 5 stacked piles of lid covers noted on the tray line (on the counter to the steam table that were going to be used for lunch service/plating) noted the underside of the lid covers were also wet with droplets of water. d. On 3/25/26 at 12:18 PM, observation of the 2nd floor nourishment room (snack room) with the Director of Dining identified a refrigerator temperature of 38 degrees ( ) Fahrenheit (F). The freezer failed to have a thermometer present, but the inside of the refrigerator had 2 metal, round, portable thermometers. The freezer contained 46 (4 ounce) individual containers of majic cup and fat free sherbert, a 28-ounce (oz) tub (1/4 full) of Lactose free ice cream and a full 16-oz container of ice cream. e. On 3/25/26 at 12:20 PM, observation of the 3rd floor nourishment room identified there was no thermometer present for the freezer section, and the refrigerator's temperature was 34 F noted by a metal, round, portable thermometer. The contents of the freezer included 50 (4 oz) individual containers of ice cream and majic cups, a 1 qt tub of Lactose free ice cream (3/4 full) and a 28 oz tub (1/4 full) of Coffee ice cream. The Director of Dietary identified nursing was responsible for checking temperatures of the refrigerator/freezer and therefore did not know where the temperature logs were kept. On 3/25/26 at 12:20 PM, interview with Registered Nurse (RN) #1 identified that Dietary was responsible for checking refrigerator/freezer temperatures and therefore did not know where the temperature logs were kept. On 3/25/26 at 2:00 PM, the Director of Dining provided a temperature log that identified temperatures completed for the 2nd and 3rd floor refrigerators only and noted that temperatures were not taken for the freezer compartments. Additionally, the Director of Dining noted that he originally stated that nursing was responsible for taking temperatures of the refrigerators/freezers in the nourishment room in error. Facility policy for (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	refrigerator temperatures identified temperatures would be monitored with appropriate documentation every 24 hours and a log will be maintained by the department or service manager. The policy failed to identify the frequency of taking freezer temperatures/logging the temperatures from the nourishment room freezers. Facility policy for dating and labeling food identified non-Time/Temperature Control for Safety (TCS) foods that have been removed from their original packaging shall be labeled with the item name, open date, original manufacturer's expiration date, and associate initials.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, review of facility policy and observations of resident bathrooms on 2 of 2 nursing units, the facility failed to ensure personal care items were properly labeled, covered, and stored according to facility policy and in a manner to provide a clean environment. The findings included: Observation on 3/25/26 at 11:33 AM and on 3/25/26 at 1:00 PM observation with Registered Nurse (RN) #1 identified the following: a. room [ROOM NUMBER]'s shared bathroom contained 2 wash basins located on the floor and 1 urinal on the back of the toilet; all items were unlabeled (as to whom they belonged to) and not covered.b. room [ROOM NUMBER]'s shared bathroom contained 1 bedpan located on the handrail near the toilet, uncovered and unlabeled (as to whom it belonged to).c. room [ROOM NUMBER]'s bathroom contained 1 wash basin, which was labeled but located on the floor of the bathroom. c. room [ROOM NUMBER]'s shared bathroom contained 1 wash basin which was uncovered, labeled but stored on the floor and 1 bedpan hanging from the handrail near the toilet which was unlabeled (as to whom it belonged to) /uncovered.d. room [ROOM NUMBER]'s shared bathroom contained 1 unlabeled (as to whom it belonged to) and uncovered wash basin located on the back of the toilet. e. room [ROOM NUMBER]'s shared bathroom contained 1 wash basin located on the floor which was unlabeled (as to whom it belonged to) and uncovered.f. room [ROOM NUMBER]'s shared bathroom contained 1 wash basin located on the floor which was unlabeled (as to whom it belonged to) and uncovered.g. room [ROOM NUMBER]'s shared bathroom contained 1 wash basin located on the floor which was unlabeled (as to whom it belonged to) and uncovered. h. room [ROOM NUMBER]'s shared bathroom contained 1 wash basin located on the floor, unlabeled (as to whom it belonged to) and uncovered.i. room [ROOM NUMBER]'s shared bathroom contained 1 wash basin located on the floor and unlabeled (as to whom it belonged to).j. room [ROOM NUMBER]'s shared bathroom contained 1 wash basin located on the floor and unlabeled (as to whom it belonged to).k. room [ROOM NUMBER]'s shared bathroom contained 1 bedpan and 1 wash basin located on the floor; both were unlabeled (as to whom they belonged to).l. Room#314's shared bathroom contained 1 wash basin located on the floor and unlabeled (as to whom it belonged to). Interview with RN #1 on 3/25/26 at 1:20 PM identified resident personal hygiene items such as basins, bedpans, and urinals were to be stored in a cabinet and not on the floor and all items were to be labeled with the resident's name. RN #1 further identified the Nurse Aides were responsible for ensuring items were properly stored, labeled and the nurses were responsible for oversight.Interview with Licensed Practice Nurse (LPN) #1 (who was the Infections Preventionist) on 3/25/26 at 2:24 PM identified she last completed environmental rounds in December 2025 that included observations of rooms/ bathrooms and when she made observations to the resident's room during rounds, she had observed unlabeled and not properly stored personal hygiene items which required her to dispose of the items.Subsequent to surveyor inquiry, all unlabeled personal hygiene items were disposed of by RN#1 on 3/25/26 at 1:30PM.Review of the facility policy, Personal Care Items dated 2024, directed personal care items are handled in a manner to prevent the spread of infection through personal equipment. Personal care items are for single resident use only. To be marked with the Resident's name and discarded after discharge. Store bedpans and urinals in the resident's bedside cabinet or drawer after placing in a bag. If a resident uses the bedpan and urinal at will, do not allow placement on the floor or on a bedside table that was used for eating or drinking.

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	075352	A. Building B. Wing	03/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Connecticut Baptist Homes, Inc	292 Thorpe Avenue Meriden, CT 06450

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility policy and interviews for 2 of 6 residents (Resident #3 and Resident #26) reviewed for nutrition, the facility failed to ensure timely notification of a significant weight loss to either the physician, Dietician or responsible party. The findings include: 1. Resident #3's diagnosis included cerebrovascular disease, anxiety, and dementia. A Resident Care Plan (RCP) dated 10/8/25 identified Resident #3 was at risk for malnutrition with interventions that included gentle encouragement at mealtimes, honor food preferences, and diet as ordered. A quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #3 was moderately, cognitively impaired and required set up assistance with oral hygiene, upper/lower body dressing and personal hygiene. Additionally, the MDS identified Resident #3 was independent with eating, was not on a mechanically altered or therapeutic diet and weighed 134 pounds (lbs.). The Weight and Vital Summary located in the electronic health record (EHR) identified Resident #3 weighed 136.2 pounds (lbs.) on 12/8/25, weighed 125 lbs. on 1/1/26 (a weight loss of 11.2 lbs./8.2% in 24 days), weighed 123 lbs. on 1/9/26 (a 13.2 lb./9.6% loss in 31 days). Additionally, on 2/3/26, Resident #3 weighed 117.8 lbs. (a loss of 19.2 lbs./14% in 57 days), on 2/20/26 weighed 113.6 lbs. and weighed 115.6 lbs. on 2/24/26. Interview with Registered Nurse (RN) #1 on 3/26/26 at 11:47AM identified the nurses were responsible for ensuring weights were completed as ordered and she was responsible for oversight. Also, identifying all weights were to be documented to the Electronic Medical Record (EMR) once obtained and if the weight loss was greater than 5 pounds(lbs.) a reweight should have been obtained. Further, identifying the family and physician were to be notified if the weight loss was greater than 5 lbs and the family had not been notified of Resident #3's significant weight loss from 12/8/25 through 1/1/26 until the Resident Care Plan meeting on 1/26/26. 2. Resident #26's diagnoses included Type 2 diabetes mellitus, gastro-esophageal reflux disease and unspecified protein-calorie malnutrition. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #26 was cognitively intact and required partial/moderate assistance with bed mobility and transfers. The MDS further identified Resident #26 required substantial/maximal assistance with toileting, had weight loss, was not on a physician prescribed weight loss regimen and had a diagnosis of malnutrition. The MDS further noted Resident #26 was on a mechanically altered and therapeutic diet. The Resident Care Plan (RCP) dated 11/17/25 identified Resident #26 had impaired cognitive function with cognitive decline, Type 2 diabetes mellitus and was at risk for malnutrition with weight loss over the past 6 months. Interventions included providing diet and supplements as ordered, weigh the resident per the physician's order and to keep the physician and family notified with a dietary consult for a nutritional regimen and ongoing monitoring. Review of the Weights and Vitals summary located in the electronic health record (HER) identified (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that on 10/5/25 Resident #26 weighed 140.8 pounds (lbs.), on 11/7/25 weighed 127.4 lbs. (which was documented by RN #3) (a 13.4 lb/9.52% loss in 33 days), on 11/11/25 weighed 125.8 lbs., on 12/3/25 weighed 128.2 lbs., on 1/10/26 weighed 116.8 lbs. (which was documented by RN #3) (an 11.4 lb./8.89% loss in 38 days), and on 1/23/26 weighed 116.4 lbs. (a 25.2 lb./17.33% loss in 110 days from 10/5/25 to 1/23/26). A Social Service Note/Care Plan Meeting Note dated 2/10/26 identified Resident #26 attended his/her care plan meeting, and the residents responsible party (Person #1) was in attendance by phone. The note indicated Resident #26 had lost 11.8 lbs. since December 2025. Interview and review of the clinical record with the Dietician on 3/26/26 at 1:45 PM identified she was aware that Resident #26 had a significant weight loss of more than 25 lbs. in the last several months. Review of the resident's weight record with the Dietician indicated Resident #26 had an additional 11.4 lb. weight loss identified on 1/10/26 (weight of 116.8 lbs.) and she was not notified of the weight loss until she returned to the facility on 1/20/26. The Dietician indicated the nursing staff should have notified the regional dietician of the resident's weight loss in her absence and she was unsure why that was not done on 1/10/26. The Dietician stated the nursing staff would usually tell her in person, email her or put a note in the communication book to notify her of a resident's weight loss, however review of her email and the communication book failed to indicate she was notified of Resident #26's continued weight loss. Additional review of Resident #26's physician/APRN and nursing progress notes with the Dietician noted the physician/APRN and resident representative had not been notified of Resident #26's additional weight loss in 1/10/26 and the nursing staff was responsible to make those notifications. Interview and review of the clinical record with RN #3 on 3/26/26 at 3:15 PM identified she obtained and documented Resident #26's weight on 1/10/26 and failed to notice the residents continued weight loss of 11.4 lbs. (from prior weight on 12/3/25). RN #3 indicated she did not look at the resident's prior weights and assumed RN #1 would have seen the weight loss trend and would have notified the physician, dietician, and responsible party on the morning shift if necessary. RN #3 further identified she always worked the 3:00 PM to 11:00 PM shift, and since Resident #26's weight loss would have triggered in the system, RN #1 should have picked it up the next day. Interview with Person #1 on 3/26/26 at 3:35 PM identified he/she was not notified of Resident #26's weight loss from 12/3/25 to 1/10/26 (loss of 11.4 lb.) until he/she attended the resident's care plan meeting by phone on 2/10/26. Person #1 indicated although he/she had received timely phone calls about the residents falls, she was not notified of the continued weight loss until the care plan meeting and during his/her subsequent visit to the facility to see Resident #26 in February 2026. Interview and review of the clinical record with the RN Supervisor covering for the Director of Nursing Services (RN #1) on 3/26/26 at 3:45 PM identified she was aware that Resident #26 had a significant weight loss of more than 25 lbs. in the last several months. RN #1 indicated after the residents continued weight loss was identified on 1/10/26 (loss of 11.4 lbs.) RN #3 should have notified the physician, dietician, and responsible party on the same day. RN #1 identified it would have been the responsibility of RN # 3 (who obtained and documented Resident #26's weight on 1/10/26) who should have made the necessary notifications and documented in the nursing progress notes and she was unsure why that was not done. RN #1 indicated she was going to need to meet with the nursing staff to provide further education on notifications and documentation. Interview and review of the clinical record with APRN #1 on 3/30/26 at 11:00 AM identified although (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she was aware of Resident #26's weight loss in November 2025, she was not notified of Resident #26's continued weight loss in January 2026. APRN #1 indicated the nursing staff would have been responsible to notify her in person or by phone of the weight loss and review of APRN #1's communication book and progress notes failed to indicate notification documentation. APRN #1 identified she would have expected to be notified of the residents 11.4 lb. weight loss on the same day (1/10/26) and had she been notified she would have written a progress note, asked for the resident to be re-weighed and requested the dietician to see the resident. Additionally, APRN #1 indicated she would have assessed Resident #26, re-evaluated the resident's supplements and Remeron dosage (a medication used for appetite stimulation), and ordered blood work. APRN #1 stated in addition to herself, the nursing staff should have notified the Dietician, and Resident #26's responsible party of the continued weight loss timely. APRN #1 further indicated that if the regular Dietician was away the nursing staff should have notified the covering/regional dietician of Resident #26's weight loss and not waited for the regular Dietician to return to the facility on 1/20/26. Review of the Weight Policy dated 11/24 directed, in part each resident will have their weight monitored, which will ensure that each resident maintains an optimum body weight. All residents will be weighed at least monthly unless the physician orders otherwise. If a resident's weight is a gain or loss of 5 pounds or more a reweight will take place the next day. If the resident's repeat weight is a gain or loss of 5 pounds the weight will be reported to the physician and the dietician for appropriate interventions. The responsible party will be notified of the weight change and recommended interventions. Weekly and/or more frequently weights will be done per the physician orders and reported according to the parameters given.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interviews, and facility policy for 1 of 3 sampled residents (Resident #9) reviewed for accidents, the facility failed to complete neurological assessments after multiple unwitnessed falls, per facility policy. The findings include: Resident #9 was admitted to the facility in February 2025 with diagnoses that included unspecified dementia, displaced fracture of the left femur and osteoporosis with a current pathological fracture.A quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #9 was severely cognitively impaired and required supervision or touching assistance for transfers and bed mobility and partial/moderate assistance for toileting.The Resident Care Plan (RCP) dated 11/14/25 identified Resident #9 was at risk for falls due to multiple risk factors with interventions to toilet Resident #9 before and after meals, encourage Resident #9 to wear proper footwear and keep the resident's environment safe.a. A facility Reportable Event (RE) form dated 9/20/25 at 8:00 PM identified Resident #9 had an unwitnessed fall. The RE identified Resident #9 was observed sitting on the floor next to his/her recliner. The resident denied any pain or discomfort and no apparent injury was noted.A nursing note dated 9/20/25 at 11:33 PM identified Resident #9 was sitting on the floor next to his/her recliner and the resident was alert with baseline confusion. No apparent injury was identified. The nursing note failed to indicate neurological assessments were initiated or completed.b. A facility RE form dated 11/10/25 at 6:30 PM identified Resident #9 had an unwitnessed fall. Resident #9 was observed on the floor in front of his/her recliner. Additionally, the RE identified Resident #9 had no complaints of pain or discomfort. A nursing note dated 11/11/25 at 12:00 AM identified Resident #9 was found on the floor in front of his/her recliner. There was no apparent injury noted and the resident had no complaints of pain or discomfort. The nursing note failed to indicate neurological assessments were initiated or completed.c. A facility RE form dated 11/12/25 at 5:10 PM identified Resident #9 had an unwitnessed fall. The RE identified Resident #9 was observed sitting on the floor next to his/her recliner. The resident indicated he/she was going to the bathroom and no apparent injury was noted.A nursing note dated 11/12/25 at 11:54 PM identified Resident #9 was noted sitting on the floor next to his/her recliner. The resident was observed with loose stool on his/her pants and no apparent injuries were identified. The nursing note failed to indicate neurological assessments were initiated or completed.d. A facility RE form dated 11/14/25 at 6:20 PM identified Resident #9 had an unwitnessed fall. The RE identified Resident #9 was sitting on the floor next to his/her recliner. The resident was alert with baseline confusion and had no complaints of pain.A nursing note dated 11/14/25 at 11:03 PM identified Resident #9 was found sitting on the floor next to his/her recline. The resident had no complaints of pain or discomfort and was assisted off the floor. The nursing note failed to indicate neurological assessments were initiated or completed. e. A facility RE form dated 11/27/25 at 10:40 AM identified Resident #9 had an unwitnessed fall. The RE indicated Resident #9 slid out of her recliner chair and onto the floor and had no injuries.A nursing note dated 11/27/25 at 12:54 PM identified Resident #9 slid to the floor from his/her recliner and had a negative head strike. The resident was unable to give a clear answer as to what had occurred due to his/her baseline confusion. The nursing note failed to indicate neurological assessments were initiated or completed. On 3/30/26 at 11:30 AM, interview and review of the clinical record with the RN Supervisor covering for the DNS (RN #1) failed to identify neurological assessments were completed for Resident #9's unwitnessed falls on 9/20/25, 11/10/25, 11/12/25 and 11/14/25. Additionally, although a Neurological Assessment form was initiated for Resident #9 fall on 11/27/25, there was no documentation for 14 out of 22 assessments which should have been completed for the unwitnessed fall on 11/27/25.An interview with the RN Supervisor covering for the DNS (RN #1) on 3/30/26 at 11:30 AM identified neurological assessments should have been completed for Resident #9's unwitnessed falls, especially because the resident was confused and unable to reliably indicate if he/she had a head strike. RN #1 stated it would have been the (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	responsibility of the charge nurse to ensure neurological assessments were initiated, completed and documented on the Neuro Assessment form after the resident's unwitnessed fall.Review of facility policy, Fall Management, dated 10/21, directed neurological assessments will be completed according to policy with all falls unless it is witnessed and the resident did not hit their head and/or the resident is alert, oriented without a diagnosis of dementia/confusion and reports they did not hit their head.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of the clinical record, facility policy and interviews for 1 of 3 residents observed utilizing an air mattress (Resident #31), the facility failed to ensure the air mattress was set according to physician orders. Additionally, for 1 of 2 sampled residents (Resident #45) reviewed for edema, the facility failed to complete weekly weights after readmission to the facility, per the physician order. The findings include: 1.Resident #31's diagnoses included dementia, chronic respiratory failure, and anxiety. A physician order dated 2/25/25 and currently in effect directed an air mattress for the bed, to set according to the resident's weight, and check for inflation/function every shift. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #31 was moderately cognitively impaired, dependent on staff for dressing toileting, showering and transfers. The MDS further identified Resident #31 required set up assistance for eating, was at risk for a pressure ulcer, had a pressure reducing device for his/her bed and weighed 152 pounds (lbs.). The Resident Care Plan (RCP) dated 1/7/26 identified Resident #31 had a potential for pressure ulcer development related to impaired mobility and incontinence. Interventions included pressure reducing mattress to bed, keeping skin clean/dry and notifying the charge nurse of any skin issues. Observation on 3/24/26 at 9:45 AM, 3/25/26 at 9:19 AM noted Resident #31 lying in bed on an air mattress that was set at 250 lbs. with a sticker on the setting directing to set according to weight (Resident #31 weighed 152 lbs.). Observation on 3/26/26 at 6:17 AM noted Resident #31 lying in bed on an air mattress that was set at 225 lbs. Interview on 3/26/26 at 6:17 AM with Licensed Practical Nurse (LPN) #2 identified the air mattress was in place to prevent Resident #31 from developing a pressure ulcer and was set incorrectly at 225 lbs. LPN #2 further identified nursing staff were responsible for overseeing that the air mattress was set correctly according to the resident's weight. LPN #2 also indicated Resident #31 had skin issues in the past and was incontinent. Interview on 3/26/26 at 6:28 AM with Registered Nurse (RN) #1 identified the Resident Care Plan directed for the use of an air mattress to be set according to the resident's weight which was 141 lbs. on 3/26/26. RN #1 further noted the air mattress should be set at 150 lbs. Further, identifying all nurses were responsible for ensuring the air mattress was set correctly and nursing was to check every shift that it was set according to the resident's weight per the facility policy. Review of the Use of Support Surfaces Policy dated 2026 directed, in part support surface will be used in accordance with evidence-based practice for residents with or at risk for pressure injuries. Support surfaces refer to a specialized mattress, mattress overlay, or chair cushion designed to manage pressure, shear, microclimate, or friction forces on tissue. Support surfaces will be utilized in accordance with the physician orders. 2. Resident #45's diagnoses included metabolic encephalopathy, Type 2 diabetes mellitus, and essential hypertension. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #45 had intact cognition, required substantial/moderate assistance for toileting hygiene and showering/bathing self, lying to sitting on side of bed, and sitting to standing. The Resident Care Plan (RCP) dated 10/21/25 identified Resident #45 had impaired circulation related to deep vein thrombosis and lymphedema of the right lower extremity. Interventions included elevating legs when resting and inspecting foot/ankle/calf skin for redness, edema, puffiness, tenderness, and areas with no sensation. Resident #45 was readmitted to the facility on [DATE] from the acute care hospital. A readmission physician's order dated 12/26/25 directed to weigh Resident #45 every week for 4 weeks and then monthly. A Nursing Admission/readmission Assessment on 12/26/25 identified a weight of 185 pounds (lbs.). The Medication Administration Record from 12/26/25 to 1/16/26 identified weights were documented as completed by initials on 1/2/26 and 1/16/26 with no weight number entered. A Weights and Vitals summary located in the electronic health record (EHR) from 12/26/25 to 1/16/26 identified a weight of 180.4 lbs. was documented on 1/2/26, but failed to include weekly weights from 1/9/26, 1/16/26 and 1/23/26. Interview and facility document review with Nurse Aide (NA) #3 on 3/26/26 at 8:47 AM identified that residents were usually weighed monthly on their shower day and that it was the responsibility of the NA to complete them. NA #3 indicated that they know which residents need to be weighed on their shift when given the NA worksheet which was filled out by the unit nurse. Additionally, NA #3 identified that weights were documented on the NA worksheet and given to the unit nurse once all resident weights/vitals were completed for that shift. NA #3 could not identify the reason Resident #45 was not weighed on 1/9/26, 1/16/26 and 1/23/26 although Resident #45 was listed on the NA worksheet to have weights completed weekly. Interview and clinical record review with Registered Nurse (RN) #2 on 3/26/26 at 9:03 AM identified that residents were weighed monthly on their shower day and that it was the responsibility of the NA to complete them. RN #2 indicated that residents were assigned the shower day and it typically stays the same. RN #2 indicated that to see if a resident's orders for weights have changed, they would be informed during report, by the dietician, by the provider, or they would review the resident orders for changes at the beginning of the shift. RN #2 indicated that NAs would document resident weights/vitals on the NA worksheet. After completion the NAs would give the worksheet to the unit nurse to document in the resident's EHR. RN #2 indicated that if weights were not completed, it should be documented by the NA on the NA worksheet and in the EHR by the unit nurse. RN #2 could not identify the reason Resident #45 was not weighed on 1/9/26, 1/16/26 and 1/23/26 and that the NA should have documented why it was not completed. Interview and clinical record review with the Registered Nurse Supervisor (RN #1) on 3/26/26 at 9:08 AM identified that residents were weighed weekly for four (4) weeks upon admission/readmission to the facility and then monthly unless provider orders indicated otherwise. RN #1 indicated it was the responsibility of the NA to complete the weights on the scheduled days, but that it was the overall responsibility of the unit nurse to ensure they were completed and documented in the resident's EHR. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RN #1 identified that Resident #45 had physician orders for weekly weights upon readmission into the facility on [DATE]. Review of the facilities weights policy dated 11/24 directed in part that weights will be obtained within 24 hours of admission and then weekly for 1 month. Weights will be recorded in the electronic medical record. Weekly/more frequent weight checks will be done per physician order.

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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 observations, review of the clinical record, facility policy and interviews for the only sampled resident (Resident #6) reviewed for positioning and mobility, the facility failed to apply a left upper extremity splint per the physician's order for a resident with a hand contracture. The findings include: Resident #6's diagnoses included unspecified dementia with agitation, spondylolysis (stress fracture or crack in bone of vertebrae of spine), and age-related osteoporosis. An Occupational Therapy (OT) evaluation dated 1/29/25 identified Resident #6 had worsening hand tremors, worsening tone and increased left hand tightness. The OT evaluation further noted Resident #6 was at risk for development of a hand contracture and skin breakdown. The quarterly Minimum Data Set (MDS) assessment dated [DATE], identified Resident #6 was severely cognitively impaired and dependent with toileting, bed mobility and transfers. The MDS indicated Resident #3 had an upper extremity impairment on one side but failed to indicate the use of orthotics. The Resident Care Plan (RCP) dated 1/15/26 identified Resident #6 wore a splint to his/her left hand to inhibit contractures and skin breakdown. Interventions included to check the resident's skin when putting the splint on and off, to put the splint on the left hand when Resident #6 was out of bed and take the splint off when the resident was in bed. Additional interventions included for rehab to check the splint and nursing to monitor skin integrity. A physician's order dated 2/2/26 directed application of a left-hand splint when out of bed and to monitor skin integrity pre and post application of the splint. The Nurse Aide (NA) Assignment Card identified the resident was to have a left-hand splint applied when out of bed and removed when in bed. Observations on 3/23/26 at 12:30 PM and 3/24/26 at 12:28 PM noted Resident #6 out of bed in a customized wheelchair, seated in the dining room without the benefit of a left upper extremity splint.An additional observation on 3/25/26 at 1:17 PM noted Resident #6 out of bed in a customized wheelchair seated in his/her room without the benefit of a left upper extremity splint. Observation and interview on 3/25/26 at 1:33 PM with NA #2 identified Resident #6 was seated in a custom wheelchair in his/her room and without the benefit of a left upper extremity splint on. NA #2 indicated she had been unable to locate Resident #6's splint, but had not informed the charge nurse. NA #2 proceeded to search Resident #6's dresser drawers for the splint but was unable to locate the splint. NA #2 then informed RN #2 that the splint was not available. Observation, interview and review of the clinical record with RN #2 on 3/25/26 at 1:35 PM identified although he had already initialed the Treatment Administration Record indicating Resident #6's left upper extremity splint had been applied, he was unsure why the resident did not have the hand splint applied and he was unaware the splint was unable to be located. RN #2 indicated Resident #6 should have had the left upper extremity splint applied while out of bed and NA #2 should have notified him if she was unable to find the splint. Additionally, RN #2 indicated he would continue to look for the splint and notify the rehab department if he was unable to locate it. Interview with the RN Supervisor covering for the Director of Nursing (RN #1) on 3/25/26 at 2:45 PM identified Resident #6 should have had the left upper extremity splint applied per the physician's order and she was unsure why staff were unable to locate the splint. RN #1 indicated the NA should have notified the charge nurse when she could not find or apply the splint. Subsequent to surveyor inquiry, an observation of Resident #6 on 3/26/26 at 9:48 AM noted Resident #6 out of bed in a customized wheelchair seated in his/her room with a left upper extremity splint applied. An additional interview with RN #2 on 3/26/26 at 10:00 AM indicated Resident #6's left upper extremity splint was located in the afternoon on 3/25/26 at the nurses station. RN #2 indicated he was unsure why the splint was there and not on the resident and he or the NA should have ensured it was applied. Observation, interview and review of the clinical record with the Rehab Director (PT #1) on 3/26/26 at 10:15 AM noted Resident #6 out of bed in a customized wheelchair with the left upper extremity splint applied. PT #1 indicated the splint was to maintain range of motion and to prevent the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075352	A. Building B. Wing	03/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Connecticut Baptist Homes, Inc	292 Thorpe Avenue Meriden, CT 06450

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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	residents hand contracture from getting worse. PT #1 identified if Resident #6 was not wearing the splint as ordered it could also worsen Resident #6's left upper extremity muscle tone and put the skin integrity of the resident's hand at risk. PT #1 further indicated it would have been the responsibility of the nursing staff to ensure the left upper extremity splint was applied as ordered and if the splint was unable to be located the charge nurse should have notified the rehab department. Review of the facility policy, Splinting Policy, undated, directed nursing staff must apply and remove splints per the ordered schedules, document compliance and observations and report concerns promptly to therapy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075352	A. Building B. Wing	03/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Connecticut Baptist Homes, Inc	292 Thorpe Avenue Meriden, CT 06450

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, facility policy and interviews for the only sampled resident (Resident #6) reviewed for positioning and mobility, the facility failed to complete a mechanical lift transfer with 2 staff members. The findings include: Resident #6's diagnoses included unspecified dementia with agitation, spondylolysis (stress fracture or crack in bone of vertebrae of spine), and age-related osteoporosis.The quarterly Minimum Data Set (MDS) assessment dated [DATE], identified Resident #6 was severely cognitively impaired and dependent with toileting, bed mobility and transfers. The MDS indicated Resident #3 had an upper extremity impairment on one side and a lower extremity impairment on both sides. The Resident Care Plan (RCP) dated 1/15/26 identified Resident #6 had impaired mobility, was non- ambulatory and was at risk for falls. Interventions included Resident #6 required total assistance with transfers with a mechanical lift with the assist of 2 staff and had total dependence on staff for repositioning and turning in bed. A physician's order dated 2/2/26 directed transfer Resident #6 with assist of 2 staff using a mechanical lift and the resident was non-ambulatory.The Nurse Aide (NA) Assignment Card identified Resident #6 was non-ambulatory and required assistance of 2 staff for transfers via a mechanical lift. Observation and interview with NA #1 on 3/25/26 at 1:28 PM noted NA #1 was transferring Resident #6 from the wheelchair to the bed with the mechanical lift and without the benefit of another staff person present to assist. NA #1 indicated she was performing the transfer alone in the room with Resident #6 and she should not have been. The resident was observed connected to the mechanical lift and was being moved over the bed while being suspended by the mechanical lift. NA #1 proceeded to lower the mechanical lift and place Resident #6 onto the mattress of the bed. RN #2 then entered the room and indicated NA #1 should have asked for his or the other NA's assistance with the transfer and should not have transferred Resident #6 with the mechanical lift without another staff present and assisting her. RN #2 was unable to identify the reason NA #1 would transfer the resident by herself as he and NA #3 were both on the unit.Interview with the Administrator and the Nursing Supervisor covering for the Director of Nursing Services (RN #1) on 3/25/26 at 1:37 PM identified NA #1 should have had a second staff person in the room when using the mechanical lift to transfer Resident #6 from the wheelchair to the bed. RN #1 indicated all nursing staff were trained on the proper use of the mechanical lift and NA #1 would have been responsible to safely transfer the resident with 2 staff persons.Review of the facility policy, Safe Resident Handling, dated 6/2016, directed to promote a safe, secure, and comfortable experience for residents who require full transfer assistance, staff members are trained on and required to maintain compliance with policies and procedures related to safe resident handling. Failure of staff to maintain compliance would lead to disciplinary action up to and including termination of employment. Safe resident handling and moving required staff use all mechanical handling devices in accordance with policy, instruction, and training.