STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075362	A. Building B. Wing	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evergreen Woods	88 Notch Hill Road North Branford, CT 06471

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 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 observations, review of facility policy, and interviews, the facility failed to prepare and serve food in a sanitary manner due to the lack of a hair restraint. The findings include: Observation in the kitchen on 8/29/25 at 9:30 AM with the Executive Chef, identified Dietary Aide #1 preparing cold sandwiches for lunch service later that day without the benefit of wearing a beard restraint. Interview with Dietary Aide #1 on 8/29/25 at 9:30 AM identified he was unsure if the facility had beard restraints for staff with facial hair but was pretty sure they didn't. Additionally, Dietary Aide #1 was unaware of the requirement to wear a beard restraint during food preparation and service.Interview with the Executive Chef on 8/29/25 at 9:40 AM identified she was unaware of the staff's requirement to wear beard nets for food preparation and service. The Executive Chef indicated that she believed she did have beard restraints available for staff, but if not, she would order them immediately. Review of the facility's Food Preparation and Service policy of Food Service/Distribution identified that Food and nutrition services staff shall wear hair restraints (hair net, hat, beard restraint, etc.) so that hair does not contact food.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, review of clinical records, facility documentation, and facility policy for 1 of 2 sampled residents, (Resident #51) reviewed for abuse, the facility staff failed to ensure treatment in a dignified manner. The findings include:Resident #51's diagnoses included acute systolic (congestive) heart failure, impingement syndrome and pain of the right shoulder, and venous stasis dermatitis with blistering.The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #51 had a Brief Interview of Mental Status (BIMS) score of 15 indicating no cognitive impairment, required partial/moderate assistance for toileting hygiene, and supervision or touching assistance for transfers.The Resident Care Plan (RCP) dated 8/28/2025 identified Activities of Daily Living (ADL) self-care deficits related to impaired mobility. Interventions included providing encouragement/supervision and allow adequate time to complete tasks.Interview with Resident #51 on 8/29/2025 at 11:03 AM identified that sometime between 11:00 PM on 8/28/2025 and 1:00 AM on 8/29/2025 he/she rang the call bell to ask for assistance with toileting. The resident indicated that the bathroom floor may have been wet making him/her afraid of falling, so he/she requested Nurse Aid (NA) #1 check the floor prior to going. NA #1 responded with I am not maintenance; it is not my job. NA #1 further stated, your aide is on break, (NA #3) they will be back in an hour, smiled, and left the room. Resident #51 indicated this agitated and upset him/her. Resident #51 identified that NA #3 came and assisted him/her 10 minutes later. Resident #51 indicated it had been his/her intention to notify the Director of Nursing (DNS), but this was the first time he/she was reporting the incident to anyone. Review of Resident #51's NA care card (how to provide care) identified he/she required the assistance of 1 staff for mobility and ADLs. Interview with NA #1 on 9/3/2025 at 6:24 AM identified she worked on 8/28/2025 from 11:00 PM to 8/29/2025 at 7:00 AM and although Resident #51 was not on her assignment, she answered the resident's call light, as NA #3 was on break. NA #1 identified that Resident #51 asked to go to the bathroom and asked if she could see if the floor was clean. NA #1 stated the bathroom appeared clean, but she told the resident that if he/she thought it wasn't clean then he/she should call maintenance. NA #1 stated that Resident #51 was aggravated with her for saying that, so she left the room without providing any assistance to allow the resident to calm down. After informing Resident #51's assigned aide, NA #3, they both went to assist the resident. On arrival Resident #51 told NA #1 to get out of the room. NA #1 stated she went back to the room about 30 minutes later to apologize and stated that I didn't mean to treat someone like that. NA #1 appeared to become upset during the surveyor interview, left the interview, and the facility. Interview on 9/3/2025 at 7:07 AM with Licensed Practical Nurse (LPN) #1 identified she, was made aware by NA #2 on 8/29/25 of an incident that occurred on the night shift the previous night which began on 8/28/25 (see F600). NA #2 had not worked on 8/28/25 but was told by Resident #51 on 8/29/25 about an incident with NA #1 during which he/she had requested NA #1 check the bathroom floor for wetness and take him/her to the bathroom. NA #2 indicated Resident #51 went on to state NA #1 replied it was not her job to check the floor, she could not help him/her out of bed due to his/her size, she would call NA #3 to assist and then turned and left the room. Following notification, both she and the Nurse Supervisor, Registered Nurse (RN) #2 immediately went to speak to the resident. Resident #51 stated he/she informed NA #1 of the need to use the bathroom, requested the floor be checked, and that she responded it was not her job to check the floor, she could not help him/her out of bed due to his/her size, she would call NA #3 to assist, and then turned and left the room. Resident #51 indicated he/she felt embarrassed and hurt by what NA #1 had said. LPN #1 stated that if she had been aware of the incident when it happened the previous night she worked (8/28/2025), she would have immediately reported the incident to the nurse supervisor. Interview with NA #2 on 9/3/2025 at 7:53 AM identified Resident #51 described an incident that had occurred on the night shift the (continued on next page)

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	previous night which began on 8/28/25 into 8/29/25 when he/she had asked NA #1 for help going to the bathroom and how NA #1 had told him/her that he/she was too heavy, looked out the door and said look, there goes your aide and nurse on break. They can't help you and walked away with a smile on her face. NA #2 identified that after leaving the Resident #51's room, she immediately notified LPN #1 and RN #2 about Resident #51's bathroom encounter with NA #1, and both nurses went to speak with the resident.Interview with DNS on 9/3/2025 at 9:43 AM identified RN #3 made him aware, on 9/1/25, of NA #1's statements regarding toileting that occurred on the night shift beginning on 8/28/2025 into 8/29/25 the morning of 9/1/2025. Interview with RN #3 on 9/3/2025 at 10:00 AM identified she worked during the day shift on 8/29/25. When she went to provide care, Resident #51 made her aware of his/her request for assistance with help to the bathroom. Resident #51 stated NA #1 did not want to help him, his/her assigned aide was on break, and he/she didn't want to get anyone in trouble. RN #3 reported the incident to the DNS on 8/29/2025 during the day (not on 9/1/25 as described by the DNS) but was unsure of the time, and although she knew she should have, she failed to document the incident in the clinical record. Interview with the DNS on 9/3/2025 at 9:43 AM identified he was made aware of Resident #51's treatment of requesting the bathroom on 9/1/25. Interview with the Administrator on 9/3/2025 at 10:24 AM identified that she was never made aware the bathroom incident until interviewed by the surveyor. Interview with NA #3 on 9/3/2025 at 2:10 PM identified that she worked during the night shift on 8/28/2025 from 11:00 PM to 8/29/25 at 7:00 AM. NA #3 identified that she was on break when Resident #51 had an incident with NA #1. NA #3 stated NA #1 had come to the staff break room, sometime towards the end of her break between 3:00 AM to 4:00 AM and told her that she had residents waiting for her help. NA #3 stated that she immediately went to assist Resident #51 and that was when the resident informed her that he/she requested NA #1 was asked to check and take him/her to the bathroom. Resident #51 stated to her that NA #1 refused to check the bathroom and replied to him/her I'm not maintenance. You will have to wait for your aide, and that will be in the next hour or so NA #1 then stopped in the doorway and she smirked at me. NA #3 indicated by the time she arrived at Resident #51's room, the resident indicated he/she had taken a chance and used the bathroom alone because he/she did not want to risk having NA #1 back in the room. Review of the Resident Rights policy dated 2021, in part, identified that the resident has the right to a dignified existence and to be treated with respect, kindness, and dignity.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, policy, and interviews for 1 of 2 sampled residents, (Resident #51) reviewed for abuse, the facility failed to report an allegation of abuse to the State Agency (SA) within the required time frame. The findings include:Resident #51's diagnoses included acute systolic (congestive) heart failure, impingement syndrome of the right shoulder, pain in the right shoulder, and venous stasis dermatitis with blistering.The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #51 had a Brief Interview of Mental Status (BIMS) score of 15 indicating no cognitive impairment, required partial/moderate assistance for toileting hygiene, and supervision or touching assistance for transfers.The Resident Care Plan (RCP) dated 8/28/2025 identified Resident #51 was at risk for pain related to impaired mobility. Interventions included to manage or reduce side effects associated with pharmacological therapy, such as promoting adequate bowel and bladder function. Additionally, the RCP identified Activities of Daily Living (ADL) self-care deficits related to impaired mobility. Interventions included provide encouragement/supervision and allow adequate time to complete tasks.Interview with NA #2 on 9/3/2025 at 7:53 AM identified an incident with NA #1 occurring on 8/29/2025 into 8/30/2025 at approximately 11:45 PM. Resident #51 was sitting on the side of the bed, legs dangling, and she and NA #1 were assisting him/her to lie down. Resident #51 had open wounds on his/her lower legs covered by bandages. NA #1 grabbed the resident's bandaged legs and pulled upward in a rough/forceful manner. Resident #51 began screaming that NA #1 was hurting him/her and for her to stop. She indicated that NA #1 replied that you are a pretty big guy and make my back hurt. Resident #51 responded I can't help that; I need the help. NA #2 stated that NA #1 did not stop moving Resident #51's legs or remove her hands, despite being screamed at, until Resident #51's legs were fully placed on the mattress. Wanting to get Resident #51 centered on the bed, she asked NA #1 to help boost the resident up with her, but NA #1 grabbed Resident #51 by both upper arms/shoulders and pushed him/her to the middle of the bed. Resident #51 again began screaming stating please don't touch me, what is wrong with you, you are hurting me again. NA #2 stated that she told NA #1 to let go of the resident, due to his/her response and that Resident #51 told NA #1 not to touch him/her anymore. NA #1 then left the room. Resident #51 told NA #2 that he/she didn't want NA #1 to care for him/her anymore because she was rough with care. Resident #51 stated that NA #1 was always complaining about his/her weight and consistently spoke rudely. In addition, NA #2 identified that after leaving Resident #51's room, she immediately notified LPN #1 and RN #2 and both LPN #1 and RN #2 left to speak with Resident #51.An interview with LPN #1 on 9/3/25 at 8:12 AM indicated NA #2 made her aware on 8/29/25 into 8/30/25, that she witnessed Resident #51 receive rough treatment by NA #1 as well as another incident that occurred on the previous night 8/28/25 into 8/29/25 (see F550). Additionally, LPN #1 indicated NA #2 reported to her in the presence of Registered Nurse (RN) #2 that Resident #51 was screaming from pain due to the rough care he/she received by NA #1 during a transfer. NA #2 stated that NA #1 had grabbed the resident by his/her legs and shoulders in a rough manner. On interviewing Resident #51 LPN#1 identified that Resident #51 stated he/she was uncomfortable with NA #1 performing care. LPN #1 identified that she and RN #2 determined NA #1 would not provide care to Resident #51 going forward and that the DNS would be notified of the mistreatment. Additionally, LPN #1 identified that she failed to document the incident in Resident #51 electronic health record.Interview with RN #2 (nurse supervisor) on 9/3/2025 at 9:19 AM identified she was made aware of the 8/29/2025 incident by NA #2 during the night shift on 8/29/25 to 8/30/25. NA #2 indicated that NA #1 had grabbed Resident #51's legs and shoulders causing him/her to scream in pain. RN #2 identified that she did not start an incident report, did not notify the oncoming shift, and did not report the incident to the DNS but should have. RN #2 indicated that she (continued on next page)

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	075362	A. Building B. Wing	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evergreen Woods	88 Notch Hill Road North Branford, CT 06471

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was working a double shift (16 hours) and was exhausted, but it was her responsibility per the facility practice, to start an incident report, and make the appropriate notifications.Interview with DNS on 9/3/2025 at 9:43 AM identified when allegations of abuse occur, the incident should be reported immediately, a report should be sent to the State Agency, suspension initiated for the alleged staff member until the investigation was complete, and that the DNS and Administrator were responsible. The DNS identified he was not made aware of Resident #51's allegation of rough treatment by NA #1 until being interviewed by the surveyor.Interview with the Administrator on 9/3/2025 at 10:24 AM identified that she was never made aware of the incident until interviewed by the surveyor. The facility has a no tolerance policy for abuse and staff were to report allegations immediately, including to the State Agency, Department of Social Services (DSS), and the staff member accused of abuse was to be suspended during the investigation. The Administrator indicated that it was the responsibility of the DNS or Administrator to report abuse, and she should have been notified. Additionally, the Administrator stated she would report the allegation to the State Agency and suspend NA #1 until the investigation was complete.Subsequent to surveyor inquiry, on 9/3/25 at 2:00 PM, the facility Report the incidents to the State Agency.Review of the facility's Abuse, Neglect, Exploitation or Misappropriation Reporting and Investigating policy dated 9/2022 directed, in part, that if resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and other officials. The administrator or the individual making the allegation immediately reports their findings to the following persons or agencies: the state licensing/certification agency responsible for surveying/licensing the facility, the local/state ombudsman, the resident's representative, adult protective services, law enforcement officials, the resident's attending physician and the facility medical director. Immediately is defined as: within two hours of an allegation involving abuse or result in serious bodily injury; or within 24 hours of an allegation that does not involve abuse or result in serious bodily injury

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, review of clinical records, review of documentation and facility policy for 1 of 2 residents, (Resident #51) reviewed for abuse, the facility failed to thoroughly investigate allegations of staff to resident abuse. The findings include: Number of residents sampled: 2Number of residents cited: 1Resident #51's diagnoses included acute systolic (congestive) heart failure, impingement syndrome of the right shoulder, pain in the right shoulder, and venous stasis dermatitis with blistering.The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #51 had a Brief Interview of Mental Status (BIMS) score of 15 indicating no cognitive impairment, required partial/moderate assistance for toileting hygiene, and supervision or touching assistance for transfers.The Resident Care Plan (RCP) dated 8/28/2025 identified Resident #51 was at risk for pain related to impaired mobility. Interventions included to manage or reduce side effects associated with pharmacological therapy, such as promoting adequate bowel and bladder function. Additionally, the RCP identified Activities of Daily Living (ADL) self-care deficits related to impaired mobility. Interventions included provide encouragement/supervision and allow adequate time to complete tasks.An Interview with NA #2 on 9/3/2025 at 7:53 AM identified an incident with NA #1 occurring on 8/29/2025 into 8/30/2025 at approximately 11:45 PM. Resident #51 was sitting on the side of the bed, legs dangling, and she and NA #1 were assisting him/her to lie down. Resident #51 had open wounds on his/her lower legs covered by bandages. NA #1 grabbed the resident's bandaged legs and pulled upward in a rough/forceful manner. Resident #51 began screaming that NA #1 was hurting him/her and for her to stop. She indicated that NA #1 replied that you are a pretty big guy and make my back hurt. Resident #51 responded I can't help that; I need the help. NA #2 stated that NA #1 did not stop moving Resident #51's legs or remove her hands, despite being screamed at, until Resident #51's legs were fully placed on the mattress. Wanting to get Resident #51 centered on the bed, she asked NA #1 to help boost the resident up with her, but NA #1 grabbed Resident #51 by both upper arms/shoulders and pushed him/her to the middle of the bed. Resident #51 again began screaming stating please don't touch me, what is wrong with you, you are hurting me again. NA #2 stated that she told NA #1 to let go of the resident, due to his/her response and that Resident #51 told NA #1 not to touch him/her anymore. NA #1 then left the room. Resident #51 told NA #2 that he/she didn't want NA #1 to care for him/her anymore because she was rough with care. Resident #51 stated that NA #1 was always complaining about his/her weight and consistently spoke rudely. In addition, NA #2 identified that after leaving Resident #51's room, she immediately notified LPN #1 and RN #2 and both LPN #1 and RN #2 left to speak with Resident #51.An interview with LPN #1 on 9/3/25 at 8:12 AM indicated NA #2 made her aware on 8/29/25 into 8/30/25, that he/she witnessed Resident #51 receive rough treatment by NA #1 as well as another incident that occurred on the previous night 8/28/25 into 8/29/25 (see F550). Additionally, LPN #1 indicated NA #2 reported to her in the presence of Registered Nurse (RN) #2 that Resident #51 was screaming from pain due to the rough care he/she received by NA #1 during a transfer. NA #2 stated that NA #1 had grabbed the resident by his/her legs and shoulders in a rough manner. On interviewing Resident #51 LPN#1 identified that Resident #51 stated he/she was uncomfortable with NA #1 performing care. LPN #1 identified that she and RN #2 determined NA #1 would not provide care to Resident #51 going forward and that the DNS would be notified of the mistreatment. Additionally, LPN #1 identified that she failed to document the incident in Resident #51 electronic health record.Interview with RN #2 (nurse supervisor) on 9/3/2025 at 9:19 AM identified she was made aware of the 8/29/2025 incident by NA #2 during the night shift on 8/29/25 to 8/30/25. NA #2 indicated that NA #1 had grabbed Resident #51's legs and shoulders causing him/her to scream in pain. RN #2 identified that she did not start an incident report, did not notify the oncoming shift, did not start an investigation, and did not report the incident to the DNS but should have. RN #2 indicated that she was working a double shift (16 hours) and was (continued on next page)

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	075362	A. Building B. Wing	09/04/2025

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	exhausted, but it was her responsibility per the facility practice, start an investigation and notify the appropriate staff. Interview with DNS on 9/3/2025 at 9:43 AM identified that when allegations of abuse occur, the incident should be reported immediately, an investigation should commence, and a suspension initiated for the alleged staff member until the investigation was complete. The DNS identified he was not made aware of Resident #51's allegation of rough treatment by NA #1 until being interviewed by the surveyor.Interview with the Administrator on 9/3/2025 at 10:24 AM identified that she was never made aware of the incident until interviewed by the surveyor. The facility has a no tolerance policy for abuse and staff were to report allegations immediately, begin an investigation and the staff member accused of abuse was to be suspended during the investigation. The Administrator indicated she should have been notified of the allegation. Additionally, the Administrator stated she would initiate an investigation and suspend NA #1 until the investigation was complete.Subsequent to surveyor inquiry, on 9/3/25 at 2:00 PM, the facility began an investigation. Review of the facility's Abuse, Neglect, Exploitation or Misappropriation Reporting and Investigating policy dated 9/2022 directed, in part, that if resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and other officials. The administrator or the individual making the allegation immediately reports their findings to the following persons or agencies: the state licensing/certification agency responsible for surveying/licensing the facility, the local/state ombudsman, the resident's representative, adult protective services, law enforcement officials, the resident's attending physician and the facility medical director. Immediately is defined as: within two hours of an allegation involving abuse or result in serious bodily injury; or within 24 hours of an allegation that does not involve abuse or result in serious bodily injury

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of clinical records, facility documentation, facility policy, and interviews for 1 of 3 sampled residents (Resident #29) reviewed for pressure ulcers, the facility failed to ensure signage was posted for a resident on Enhanced Barrier Precautions (EBP) and failed to perform hand washing/hand sanitization during wound care. Based on observations, interviews, clinical record and policy reviews, and facility documentation for 2 of 3 sampled residents, (Resident #13 and #29) reviewed for pressure ulcers and for the only sampled resident (Resident #20) reviewed for intravenous administration, the facility failed to ensure standards of infection control were maintained. The findings included: 1. Resident #13's diagnoses included an unstageable pressure ulcer of the sacral region, muscle weakness, and abnormalities of gait and mobility. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #13 had a Brief Interview of Mental Status (BIMS) score of 2 indicating severe cognitive impairment and was dependent on staff for personal hygiene, and dressing. The Resident Care Plan dated 6/18/25 identified Resident #13 had an unstageable pressure ulcer on the coccyx. Interventions included providing wound care per the physician order and notifying the physician if the current wound treatment was not effective. A physician's order dated 8/24/25 directed to cleanse the wound with Dakin's solution 0.25%, apply skin prep to the peri-wound, apply Xeroform (wound dressing that keeps the wound moist) over the exposed bone in the wound bed, lightly pack wound with Aquacel Ag (wound dressing that helps prevent infections) and cover with a dry clean dressing daily or as needed due to soiling, saturation, or accidental removal. Observation of Resident #13's wound care with Registered Nurse (RN) Supervisor #1 and Licensed Practical Nurse (LPN) #1 on 9/2/25 at 10:07 AM identified RN #1 performed hand hygiene, applied new gloves and cleaned the wound with normal saline soaked gauze. After cleaning the wound, without the benefit of changing her gloves or sanitizing her hands, RN #1 dried the area with gauze and proceeded to pack the clean wound with Xeroform. Again, without the benefit of changing her gloves or hand sanitizing she packed the wound with Aquacel Ag. RN #1 applied skin prep to Resident #13's peri wound and applied a dry clean dressing over the wound with the same gloves used to originally cleanse the wound. Interview with RN #1 on 9/2/25 at 1:47 PM identified it was facility policy to change gloves after cleaning a wound, identifying she should have performed hand hygiene and changed her gloves, but could not identify why she did not. Interview with the Infection Prevention RN on 9/2/25 at 2:01 PM identified it was facility policy to change gloves when going from dirty to clean during wound care, which included changing gloves after cleaning a wound and prior to packing the wound and placing a clean dressing. A review of the Procedure for Clean Dressing Technique directed to cleanse the wound as ordered, observe the wound for size, color, drainage, appearance then remove gloves, then wash/sanitize hands and apply clean gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #20's diagnoses included osteomyelitis, cellulitis, and hypertension. A physician's order dated 8/21/25 directed Enhanced Barrier Precautions (EBP) every shift. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #20 had a Brief Interview of Mental Status (BIMS) score of 14 indicating cognition was intact. Additionally, the MDS identified Resident #20 required set-up/cleaning assistance from staff for eating, and substantial/maximal assistance for transfers and toileting. The Resident Care plan dated 8/27/25 identified Resident #20 was at risk for complications of infection related to a diagnosis of a right foot wound infection. Interventions included maintaining universal precautions and additional precautions as indicated. A review of the facility's Enhanced Barrier Precautions list identified Resident #20 was on precautions due to his/her wound and intravenous therapy. Observation of Resident #20's room on 9/2/25 at 1:00 PM identified EBP signage posted outside the room. Observation of Licensed Practical Nurse (LPN) #2 on 9/2/25 at 1:00 PM identified she performed hand hygiene, applied gloves, entered Resident #20's room and administered intravenous (IV) medication via a peripherally inserted central catheter/midline located in the right arm without the benefit of placing a gown. Interview with LPN #2 on 9/2/25 at 1:06 PM identified Resident #20 was on EBP due to his/her wound and when the wound was accessed was the only time Personal Protective Equipment (PPE) would have to be placed. Although she could not identify if PPE had to be worn when hanging/administering an IV medication, a review of the EBP signage posted outside Resident #20's room directed providers, and staff must wear gloves and a gown when performing high contact activities such as device care or use: central lines. LPN # 2 identified Resident #20's peripherally inserted central catheter/midline was a central line and she should have worn a gown and gloves when hanging/administering the IV medication, but she did not realize this was necessary because she only worked at the facility 2 days per week. Interview with Registered Nurse (RN) Supervisor #1 on 9/2/25 1:47 PM identified the facility policy on EBP was to wear a gown and gloves with any high contact activities for residents with wounds, urinary catheters, gastrostomy tubes, and IVs. Further a gown and gloves should have been worn by LPN #2 when she was hanging/administering an IV medication to Resident #20. Interview with Infection Prevention RN on 9/2/25 at 2:01 PM identified the facility policy on EBP was to don gloves and a gown anytime staff was to touch a resident, which included hanging/administering an IV medication. 3. Resident #29's diagnoses included fracture around internal prosthetic right hip muscle weakness, and cognitive communication deficit. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #29 had a Brief Interview of Mental Status (BIMS) score of 3 indicating severe cognitive impairment, was dependent for personal hygiene, rolling left and right, and chair/bed-to-chair transfers, and had a (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075362	A. Building B. Wing	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evergreen Woods	88 Notch Hill Road North Branford, CT 06471

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stage 2 pressure ulcer. The Resident Care Plan (RCP) in effect on 9/2/25 identified Resident #29 had a stage 2 pressure ulcer. Interventions included use of a pressure reducing mattress, and to turn/reposition the resident. The RCP failed to include the use of Enhanced Barrier Precautions (EBP). A. Observations on 9/2/2025 at 10:30 AM and on 9/3/2025 at 9:20 AM failed to identify EBP signage posted or any Protective Personal Equipment (PPE) (gowns/gloves) outside of Resident #29's room. Interview on 9/3/2025 at 9:28 AM with the Assistant Director of Nursing Services (ADNS) (the Infection Prevention Nurse) identified that the facility policy was to place residents who had a stage 2 pressure ulcer on EBP. The ADNS indicated that he was responsible to place residents on EBP, but he had mistakenly been placing residents on EBP based on the size of their wound. The ADNS indicated that both a sign and PPE should have been located outside of Resident #29's room. Interview with the Director of Nursing Services (DNS) on 9/4/2025 at 10:06 AM identified that the ADNS was responsible for placing residents on EBP and that an EBP sign should have been located outside of Resident #29's room per the facility policy. The DNS further indicated that Resident #29 should have immediately been placed on EBP on 8/21/2025 when a stage 2 pressure ulcer was noted to be present. B. Observation and interview with Licensed Practical Nurse (LPN) #1 on 9/2/2025 at 10:30 AM during the provision of Resident #29's wound care identified, that despite having EBP signage and available PPE outside of the resident's room, LPN #1 failed to place a gown prior to performing wound care. Additionally, LPN #1 failed to perform hand hygiene prior to wound care and during wound care when gloves were changed. She stated she should have but the hand sanitizer was located on the opposite side of Resident #29's room not near the gloves and she had forgotten. Interview on 9/2/2025 at 11:54 AM with the ADNS (the Infection Prevention nurse) identified that before glove placement, upon glove changes, after wound care LPN #1 should have sanitized her hands. Further he identified that staff were last in-serviced (educated) on hand hygiene in November 2024 and LPN #1 was aware that hand hygiene should have been performed with Resident #29 wound care. Interview on 9/2/2025 at 12:01 PM with the DNS identified that LPN #1 failed to follow the facility policy during Resident #29's wound care when she did not perform hand hygiene before placing gloves prior to wound care, when changing gloves, and that she should have had hand sanitizer near her during wound care. The DNS was unable to explain why LPN #1 did not follow facility policy and use proper hand hygiene during the wound care of Resident #29. Review of the Enhanced Barrier Precautions Policy directed in part that EBP precautions apply when a resident is not known to be infected or colonized with any MDRO, has a wound or indwelling medical device and does not have excretions or secretions that cannot be covered. Signage should be posted on the door or wall outside a resident's room indicating the type of precautions and personal protection equipment (PPE) to use. Examples of high contact resident care activities requiring the use of gown and gloves for EBP's include dressing, bathing/showering, providing hygiene or grooming, changing briefs/toileting, transferring, providing bed mobility, changing linens, prolonged high contact with items in the resident's room, with resident equipment, or with resident's clothing or skin, device care or use (central line, urinary catheter, feeding tube, tracheostomy, etc.), and wound care. (continued on next page)

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	075362	A. Building B. Wing	09/04/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Handwashing/Hand Hygiene Policy identified, in part, that hand hygiene should be performed before performing an aseptic task and immediately after glove removal.