STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075367	A. Building B. Wing	12/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Civita Care Meadowbrook	350 Salmon Brook Street Granby, CT 06035

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, review of facility policy and interviews for one of twenty-three sampled residents (Resident #4) reviewed for advance directives, the facility failed to ensure the physician's order matched the wishes of the resident/responsible party. The findings include: Resident #4's diagnoses included atrial flutter, Type 1 diabetes mellitus with hyperglycemia, and mild intellectual disability. The quarterly MDS assessment dated [DATE] identified Resident #4 had intact cognition, required moderate assistance with personal hygiene, was independent with bed mobility and utilized a walker for mobility. Resident #4's clinical record (physical) identified a folded Advanced Directives Declaration Code Status form that identified Resident #4 had elected a code status of Do Not Resituate (DNR) which means if the resident stops breathing or if the resident's heart stops beating, cardiopulmonary resuscitation will not be provided. It also identified that the election of Do Not intubate (DNI) which indicates the resident does not want a breathing tube) had also been designated. The form was signed by the resident's Power of Attorney (POA) and dated [DATE]. The form was not signed by the physician.The Care Plan dated [DATE] identified Resident #4 had an advance directive that established the resident elected the code status of full code indicating the resident's wish to receive cardiopulmonary resuscitation if the resident stops breathing or the heart stops beating.Review of the physician's orders for the period of [DATE] to [DATE], directed a code status of Full Code/Cardiopulmonary Resuscitation (CPR). Interview with Resident #4's Power of Attorney (Person #2) on [DATE] at 1:00 PM identified that a code status of DNR had been elected because that was Resident #4's wishes. Person #2 identified that she had discussed DNR status with the facility. Interview and clinical record review with the charge nurse (LPN #5) on [DATE] at 1:34 PM identified that if Resident #4 had a life-threatening emergency where the decision to administer CPR or withhold CPR needed to be made, she would check the resident's code status. LPN #5 identified the code status is found in the computer on the banner section of the computer screen in the resident's electronic medical record, in the resident's clinical record (physical) under the advance directive tab and the physician's order. After reviewing the flagged folded Advanced Directives Declaration Code Status consent form, the physician's orders and the electronic medical record with LPN #5, she noted that the physician's order and the electronic medical record banner indicated full code while the Advanced Directive Declaration Code Status consent form indicated DNR which was signed on [DATE]. In addition, LPN #5 identified that the physician's order should match the newest signed Advanced Directive Declaration Code Status consent form. LPN #5 identified that the code status is obtained on admission and physician's orders are obtained by 2 nurses if the provider is not in the building, if consent is obtained over the phone, then the form is flagged in the chart for the physician to sign, which is usually within 24 hours. Interview with the Nursing Supervisor (RN #3) on [DATE] at 1:57 PM identified code status is obtained on admission, readmission, and change in condition and a telephone physician order with 2 nurses present to obtain consent and for orders. RN #3 identified she was unable to state why the consent was not reviewed by the provider and an order not in place reflecting the most recent advance directives consent form.Interview with the ADNS on [DATE] at (continued on next page)

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

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2:45 PM identified that when the advance directive consent is signed by the resident/resident representative, then a telephone order is obtained until the provider comes in the facility to sign the actual consent form. The Advanced Directive policy and procedure identified that at the time of admission the facility reviews the Advance Directive form with the competent resident or responsible party/conservator. After reviewing, the appropriate party will check the appropriate box on the forms and sign the form. Based on the CPR/DNR consent form the nurse is then responsible for obtaining an order from the physician. The resident or responsible party/conservator has the right to change the code status at any time, and the physician is to be notified, and a new code status order obtained. The policy further identified that for the Department of Developmental Services (DDS) client all contemplated DNR orders are communicated to the case manager and the regional health coordinator by social service. Social services then obtain a signed Release of Medical Information from the client guardian, responsible party or family member prior to this notification. The facility will provide all medical information necessary to facilitate DDS's review for appropriateness of the contemplated DNR order.

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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 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 clinical record reviews, review of facility documentation, and review of facility policy for one of three sampled residents (Resident #40) reviewed for medication reconciliation, the facility failed to ensure the medications from the hospital discharge instructions were accurately transcribed to the facility electronic physician's orders to prevent medication error and for one sampled resident (Resident #88) reviewed for bowel function, the facility failed to ensure the bowel regimen was followed as per physician order and facility policy. The findings include:1. Resident #40's was admitted to the facility on [DATE] with diagnoses that included multiple fractures of the ribs, wedge compression fracture of 4th lumbar vertebrae, delirium, glaucoma, Gastro-Esophageal Reflux Disease (GERD), depression and dementia. Review of Resident #40's hospital Discharge summary dated [DATE] identified the following medication instructions: continue taking cyanocobalamin 100 microgram (mcg) (vitamin) by mouth once a day, donepezil 10 milligram (mg) (dementia) by mouth once a day, memantine 10 mg (dementia) by mouth twice a day, pantoprazole 40 mg (GERD) by mouth once a day, sertraline 50 mg (anti-depressant) give 2 tablets by mouth once a day, Xalatan ophthalmic solution 0.005% (glaucoma) give 1 drop to both eyes at evening, oxycodone 5 mg (opioid analgesic) give one half tablet every 6 hours for mild to moderate pain, and oxycodone 5 mg give 1 tablet every 6 hours for severe pain. Review of the medications transcribed in the facility's electronic physician's orders dated 11/4/25 directed to administered cyanocobalamin 100 mcg by mouth once a day, donepezil 10 mg by mouth once a day, memantine 10 mg by mouth twice a day, pantoprazole 40 mg by mouth once a day, sertraline 50 mg give 2 tablets by mouth once a day, Xalatan ophthalmic solution 0.005% (glaucoma) give 1 drop to both eyes at bedtime, oxycodone 5 mg give one half tablet every 6 hours for mild to moderate pain, and oxycodone 5 mg give 1 tablet every 6 hours for severe pain. Further review of the physician's orders identified the following medications were also transcribed: administer gabapentin 300 mg (anti-convulsant) by mouth four times per day for neuropathy and senna-s (laxative) give 2 tablets by mouth at bedtime. The gabapentin 300 mg and senna-s medications were not part of Resident #40's medication instructions from the hospital. The Resident Care Plan (RCP) dated 11/4/25 identified Resident #40 had a fracture rib and wedge compression fracture. Care plan interventions directed to administer medication per physician's order to promote comfort, assist resident with position changes as needed for optimal comfort, physical and occupational therapy evaluation and treatment as physician orders. Review of the Medication Administration Record (MAR) from 11/4/25 to 11/6/25 identified Resident #40 had received the gabapentin 300 mg by mouth on 11/5/25 at 5:00 PM and 9:00PM and senna-s 2 tablets by mouth (laxative) on 11/5/25 at 8:00 PM. The facility accident and incident report dated 11/6/25 at 12:40 AM identified Resident #40 had incorrect medications entered in the physician's orders. There were 2 doses of gabapentin 300 mg were given on 12/5/25 at 5:00 PM and 9:00 PM and 1 dose of senna-s 2 tablets was given on 11/5/25 at 8:00 PM. The nurse's note dated 11/6/25 at 2:15 PM identified that the ADNS was notified regarding a medication error that had occurred. Resident #40 received 2 doses of gabapentin 300 mg and one dose (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	senna-s which were not prescribed to the resident. The physician was notified of the medication error who ordered the following laboratory tests; a Basic Metabolic Panel (BMP) and a Complete Blood Count (CBC). The orders also instructed to monitor Resident #40's neurological signs every 4 hours for 48 hours. Resident #40 denied pain or discomfort. The family was also notified with the medication error. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #40 had severe cognitive impairment and required extensive assistance with personal hygiene, dressing, toileting, and transfer. Interview with the ADNS on 11/26/25 at 10:25 AM identified she was notified that there was a medication error that had occurred with Resident #40's medication reconciliation. She identified that the gabapentin 300 mg and senna-s medication were incorrectly added to Resident #40's physician orders and he/she had received 2 doses of gabapentin 300 mg and 1 dose of senna-s medications. She identified that the process of medication reconciliation was the admitting nurse would enter all the medications in the physician order queue, and another nurse verifies that all physician orders are accurately transcribed from the hospital discharge record and activates the physician orders when it is verified that all medication in the physician order were accurately transcribed. She identified that the admitting nurse incorrectly transcribed the medication in the physician orders and second nurse activated the physician orders. She further identified that there were multiple admissions on 11/4/25 and the nurse accidentally added a medication in the physician's orders that did not belong to Resident #40 medication listing. Interview with LPN #2 on 11/26/25 at 2:10 PM identified that the facility asked her if she could help with the admission on [DATE] because there were five admissions expected. In addition, she identified that the charge nurse was not feeling well so the nursing supervisor worked on the nursing unit. She identified that she transcribed the medications in the physician's order queue, but she accidentally transcribed the gabapentin 300 mg and senna-s that did not belong for Resident #40. She also identified that the second nurse is supposed to verify the medications transcribed in the physician's order queue before activating the physician's orders to ensure that they were correct. She identified that although she had accidentally transcribed the wrong medication the second nurse who activated the physician's orders should have verified all medications matched what was in the discharge summary medication list. An attempt to interview LPN #6 was made (who activated the physician's order) but she was not available for interview during the survey period. A review of the Medication Reconciliation policy identified that the process of verifying the resident's current medication list matches the physician's orders for the purpose of providing the correct medications to the residents. The policy also identified to compare the physician's orders to the hospital record and obtain clarification as needed; the facility nurse would transcribe the physician's order in accordance with the procedures for admission orders and the second nurse would review the transcribed physician's orders for accuracy and co-sign the physician's order to indicate the review. 2. Resident #88 was admitted to the facility on [DATE] with diagnoses that included fusion of the cervical spine, cognitive communication deficit, and weakness. A nursing admission assessment dated [DATE] identified Resident #88's abdomen was soft, non-tender, and had normal bowel sounds. The assessment also indicated that Resident #88's last (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bowel movement was on 8/28/2025. A nursing note dated 8/29/2025 at 12:21 PM identified Resident #88 arrived at the facility alert and forgetful from the hospital. The physician's orders dated 8/29/25 directed to administer oxycodone extended release (a narcotic pain medication) 10 milligrams (mg) by mouth every morning and at bedtime for pain control and directed to implement bowel routine as per policy. A review of the medication administration record (MAR) identified Resident #88 received the scheduled oxycodone medication once on 8/29/2025, twice on 8/30/2025, and twice on 8/31/2025. A nursing note dated 8/31/2025 at 2:24 PM indicated Resident #88 had a syncopal episode while in the bathroom attempting to have a bowel movement and noted Resident#88's abdomen was firm, distended, and had decreased bowel sounds. The note further indicated that the on-call medical provider was notified, and a bowel regimen was started. A review of physician's orders identified that on 8/31/2025 at 2:28 PM the following orders were placed: 1) Give 30 milliliters (ml) of Milk of Magnesia Suspension 400 mg/ 5 ml for constipation, use first; 2) Insert one suppository of Bisacodyl Suppository 10 mg as needed for constipation if Milk of Magnesia was ineffective; 3) Administer Fleet Enema 7-19 grams (gm)/118 ml as needed for constipation if Bisacodyl ineffective. A review of the MAR for 8/31/2025 did not identify that bowel regimen medications were administered. On 9/1/2025 at 7:29 PM, Resident #88 was given 30 ml of Milk of Magnesia suspension 400mg/5ml; (17 hours after the bowel regimen was ordered). Additionally, the MAR identified that the medication was ineffective. On 9/2/2025 at 1:11 PM, an abdominal x-ray was taken. At 1:43 PM, Resident #88 was administered a bisacodyl suppository, 18 hours after the administration of Milk of Magnesia. On 9/2/2025 at 8:00 PM, Resident #88 was given two tablets of scheduled sennosides (a medication for constipation) 8.6 mg. At 11:00 PM, and 15 ml of lactulose solution (a medication for constipation) 10mg/15ml. A nursing note dated 9/3/2025 identified Resident #88 had a bowel movement; three days after Resident #88 was noted to have a firm and distended abdomen, and six days after the last documented bowel movement. On 12/1/2025 at 1:45 PM, an interview with LPN#4 identified that she did not recall whether she had administered bowel regimen medication to Resident #88 on 8/31/2025, but indicated that if she had administered anything, it would have been documented. Additionally, LPN#4 indicated that any shift can start the bowel regimen protocol and if the medication given is ineffective, then it would be reported to the next shift, so the resident can be administered the next step in the bowel regimen protocol. LPN#4 further indicated that the time between the different steps in the bowel regimen protocol is one shift or 8 hours. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/1/2025 at 3:11 PM, an interview with APRN#1 identified that on 9/2/2025, she evaluated Resident #88 and noted that the resident did not have a bowel movement after the bowel regimen was ordered. APRN#1 identified that she then ordered an abdominal x-ray, and when the x-ray results returned in the evening, she ordered a dose of lactulose. APRN#1 indicated that although she was not the provider on-call on 8/31/2025, she indicated that Resident#88's syncopal episode was most likely a vasovagal reaction while trying to have a bowel movement. APRN#1 indicated that if the bowel regimen was ordered on 8/31/2025 after the resident was noted to be constipated, then the bowel regimen medications should have been started that day. On 12/2/2025 at 9:59 AM, an interview with RN#5 identified that she did not recall whether she had administered a bowel regimen medication for Resident #88 on 8/31/2025. The Bowel Evacuation Protocol identified that the bowel protocol should start with Milk of Magnesia in the 3 PM to 11 PM shift. If the Milk of Magnesia were not effective, then the 11 PM to 7 AM shift would administer a bisacodyl suppository. If the bisacodyl suppository were ineffective, then the 7 AM to 3 PM shift would administer a Fleets enema. The protocol also indicated that if the bowel protocol was ineffective, notify the medical provider.

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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 0692 Level of Harm - Minimal harm or potential for 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 review of the clinical record, review of facility policy and interviews for one sampled resident reviewed for hydration (Resident #88), the facility failed to ensure a resident's hydration needs were assessed and did not ensure that intake and output were consistently documented as per facility policy. The findings include: A hospital discharge summary report dated 8/28/2025 identified Resident #88 may have been dry with a creatinine that had increased from 1.2 to 1.5 on 8/24/2025 and that there were no concerns that would necessitate hospitalization. Resident #88 was then admitted to the facility on [DATE] with diagnoses that included fusion of the cervical spine, cognitive communication deficit, and weakness. A nursing admission assessment dated [DATE] at 9:30 AM identified Resident #88 was alert and oriented to person, place, and time. The resident's abdomen was soft, non-tender, and had normal bowel sounds, and the last bowel movement was on 8/28/2025. The admission assessment also indicated Resident #88 was independent with eating and oral hygiene, and dependent for bed mobility. A medical provider's note dated 8/29/2025 identified Resident #88 had moist mucus membranes. The note identified that Resident #88's most recent laboratory data was from 8/20/2025. The note did not identify any fluid intake goals. A physician's order dated 8/29/2025 directed to monitor I & O (intake and output) every shift for 72 hours upon admission/readmission and to document on the I&O paper flowsheet. A review of the I&O flowsheet identified that no I&O documentation for 8/29/2025, although Resident #88 had been readmitted to the facility on [DATE] at 9:30 AM. The I&O flowsheet for 8/30/2025 failed to identify if Resident #88 drank or had fluids offered from 12:00 AM to 3:00 PM. Additionally, two instances of intake of 240mL each were recorded for a total of 480mL of total fluid for the 3:00 PM to 11:00 PM shift. No 24-hour estimated fluid needs were recorded in the designated area of the I&O flowsheet. A nursing note dated 8/31/2025 at 2:24 PM indicated Resident #88 had a syncopal episode while in the bathroom attempting to have a bowel movement. The note identified that Resident#88's abdomen was firm and distended, with bowel sounds present but decreased. The note also indicated that the on-call medical provider was notified, and the facility's bowel regimen was started. The I&O flowsheet for 8/31/2025 identified a total intake of 1,320 ml the flowsheet for 9/1/2025 identified a total intake of 1,620 ml, and the flowsheet for 9/2/2025 identified a total intake of 1,500 ml. No 24-hour estimated fluid needs were recorded in the designated area of the I&O flowsheet. The I&O flowsheet for 9/3/2025 identified a total intake of 1,440 ml. A 24-hour estimated fluid needs of 3,431 mL was recorded in the designated area of the I&O flowsheet. A further review of the medical record failed to identify a nursing hydration assessment or a nutritional assessment after the resident was admitted on [DATE] or after the resident was found to be constipated on 8/31/2025. On 12/01/2025 at 3:11 PM, an interview with APRN #1 identified that all residents are placed on I&O monitoring for three days and that if residents are not meeting their fluid intake needs, then staff would notify the medical provider. APRN#1 indicated that the Dietitian calculates the fluid needs and puts it in their assessment, and that nursing staff could also calculate the fluid needs from a chart. APRN#1 also indicated that she would try to look at lab values from the hospital when a resident gets admitted to the facility but could not recall if she looked at Resident#88's lab values recorded in the hospital discharge summary; APRN #1 indicated that the lab values in her note were from 8/20/2025 and that those must have been the lab values she looked at when admitting Resident #88 to the facility. A record review with APRN#1 identified that the Resident's BUN and creatinine (lab tests used to evaluate kidney function) had increased from 8/20/2025 to 8/24/2025. The BUN had gone from 29 milligrams (mg)/deciliter (dL) to 39 mg/dL (normal range is 9 to 20 mg/dL), and the creatinine had gone from 1.0 mg/dL to 1.5 mg/dL (normal range is 0.7 mg/dL to 1.3 mg/dL). APRN#1 indicated that it could indicate a hydration need, but that other information would need to be gathered, such as medications the resident may have been on; APRN#1 further indicated that a hydration evaluation would have been helpful in managing care. On (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/2/2025 at 12:01 PM, an interview with ADNS indicated that a hydration assessment should be done on each admission and readmission if a resident had been on medical leave for over 24 hours. On 12/02/2025 at 12:33 PM, an interview with the Dietitian identified that she sees all admissions and readmissions to the facility and calculates hydration needs. The Dietitian indicated that she looks at general intake, laboratory values, and a clinical assessment when determining if someone is dehydrated or to evaluate their hydration needs. The Dietitian indicated that she may not have seen Resident #88 because she works two days a week at the facility, and the resident may have been at the hospital. The Dietitian indicated that had she seen the resident, she would have looked at lab values taken at the hospital, including the resident's BUN and creatinine. The Dietitian indicated that nursing staff can also estimate a resident's fluid needs, but that an estimated fluid need of 3,431 ml, as was written in the I&O sheet for 9/3/2025, would not be accurate. Attempts to contact RN#2 were not successful. A review of the facilities' Hydration policy identified that at-risk residents would be reviewed and provided with interventions to promote hydration. The policy also indicated that a Registered Dietitian, MD, or licensed nurse would determine the minimum fluid needs range. If the resident consumed less than their estimated needs for three consecutive days, a dehydration evaluation would be completed. The facilities policy for I&O identified that I&O monitoring would be done for 72 hours after a resident is admitted or readmitted and that I&O should be documented for each shift.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation, review of facility policy/procedures and interviews for 1 of 2 medication carts reviewed for medication storage (unit 3), the facility failed to ensure control drugs were secured under double lock. The findings include:Observation on 12/1/25 at 11:10AM with LPN#3 identified the unit 3 medication cart identified LPN #3 used a key to unlock the medication cart and once opened she was able to lift the door to the compartment that contained the controlled medications (the controlled medications were not double locked).Interview on 12/1/25 at 11:15 AM with LPN#3 identified that sometimes due to the cards in the drawer the drawer does not click shut. However, the drawer closed and locked when LPN#3 attempted to secure the lock and identified the lock does work and is not broken. Interview on 12/2/25 at 1:30 PM with the DNS identified that control drugs should be secured under double lock in the medication cart. The nurse should have had the lock box inside the cart secured. She had not heard of any issue with the medication cart having any difficulty locking. Review of the Control Substance Handling policy directed all controlled drugs shall be stored in a 2 door double locked cabinet with 2 separate keys designed for that purpose, separate from all other drugs.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 ensure expired food items stored in the first-floor nourishment room, were removed. The findings include:Observation on 11/25/25 at 1:08 PM identified the first-floor nourishment room refrigerator contained; 14-(4) ounce individual containers of orange juice with an expiration date of 11/7/25, 3-(4) ounce individual containers of orange juice with an expiration date of 11/19/25, and a container of yogurt with an expiration date of 11/15/25.Interview on 11/25/25 at 1:30 PM with the Food Service Director (FSD), identified the prep cook is responsible for checking the refrigerators daily and removing any expired items and restocking the refrigerators. The orange juice and yogurt should have been removed. All expired orange juice and yogurt were removed by the FSD and discarded. An attempt to interview the Prep [NAME] on 11/26/25 at 11:42 AM was unsuccessful. The Personal Food Policy directed that the dietary aides were responsible for checking nourishment refrigerator's daily. Food Brought in From Visitors policy identified the dietary staff are to adhere to food safety standards to prevent foodborne illness and meet local, state and federal regulations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075367	A. Building B. Wing	12/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Civita Care Meadowbrook	350 Salmon Brook Street Granby, CT 06035

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 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, review of facility documentation, review of facility policy, and interviews for two sampled residents (Resident #86 and #88) reviewed for hospitalization and discharge to the community, the facility failed to ensure the Ombudsman's office was provided with the required notification of the transfer and the discharge. The findings include: 1. Resident #86's diagnoses included malignant neoplasm of brain and unspecified part of bronchus or lung, hypertensive heart disease with heart failure, and aphasia. The admission MDS assessment dated [DATE] identified Resident #86 had moderate cognitive impairment. RN #2's progress note dated 9/3/25 at 9:00 PM identified that on 9/2/25 Resident #86 was observed in respiratory distress had oxygen saturation rates in the 70's, was placed on a non-rebreather oxygen mask at 6 liters and was sent to the acute care hospital. The Director of Social Service's (SW #1) progress note dated 9/3/25 at 9:58 AM identified Resident #86 was transferred out to the hospital on 9/2/25 with no anticipated return date. On 12/1/25 at 9:30 AM, the Director of Social Service (SW #1) was asked to provide the last four months of the monthly report of transfers and discharges sent to the ombudsman's office. The report was not provided. A review of the facility's Action Summary Report for the last five months identified the following: In June 2025, thirty-two residents were discharged and/or transferred from the facility. In July 2025, twenty-six residents were discharged and/or transferred from the facility. In August 2025 forty-three residents were discharged and/or transferred from the facility. In September 2025 thirty residents were discharged and/or transferred from the facility. In October 2025 thirty-six residents were discharged and/or transferred from the facility. Interview with SW #1 at 12:20 PM identified she was responsible for sending the routine transfer and discharges to the Ombudsman offices monthly. SW #1 identified she had not submitted the routine transfer and discharge reports to the Ombudsman office for the months requested. She further indicated that she fell behind and the last report was sent in June for the May 2025 discharges. Interview with the Administrator on 12/1/25 at 3:30 PM identified that the Social Worker is responsible for sending the reports of the transfers and discharges to the Ombudsman's office monthly via the portal. The Administrator identified that she was unaware that the Ombudsman's notifications were not being sent, however she was aware that the Director of Social Services was behind. On 12/1/25 (after surveyor inquiry) the facility updated the Ombudsman's office of all discharges and (continued on next page)

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	transfers that occurred during the period of June/2025 through November/2025. The discharge planning policy and procedure for notice to the ombudsman identified that the Ombudsman will be provided with copies of notices and/or a monthly listing of individuals transferred to the hospital on an emergency basis. 2. Resident #88 was admitted on [DATE] with diagnoses that included fusion of the cervical spine, cognitive communication deficit, and weakness. A 5-day MDS assessment identified Resident #88 had moderately impaired cognition and required substantial/maximal assistance with bed mobility and bed/chair transfers. A nursing note dated 9/6/2025 indicated Resident #88 was discharged from the facility against medical advice. Interview with the Social Worker on 12/2/2025 at 12:20 PM identified that all discharges and transfers are supposed to be sent to the state ombudsman every month. She noted that notifications had not been made since May 2025 because she had fallen behind with her workload and had not been submitting the discharges and transfers to the state ombudsman's office monthly. A review of the facility policy for Discharge Planning identified that the state ombudsman is provided with copies of notices or a monthly listing of individuals transferred to the hospital but did not include residents that were discharged . However, the policy indicated that social services would ensure systems are implemented to provide written notification to the resident/responsible party in accordance with federal guidelines.

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F 0730 Level of Harm - Potential for minimal harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on review of facility documentation, review of facility policy/procedures and interviews for 2 of 3 Nurse Aides (NA #1 and NA #2) reviewed for annual performance evaluations, the facility failed to ensure they were completed and available for review. The findings include:Based on review of facility documentation, review of facility policy/procedures and interviews for 2 of 3 Nurse Aides reviewed for annual performance evaluations, the facility failed to ensure they were completed and available for review. The findings included: Review of personnel records for Nurse Aide performance reviewed identified NA#1 had an evaluation 11/20/24 and was due to have one completed 11/2025. No evaluation was available to review in the personnel record or could be located for NA#1. NA#2 had an evaluation completed 10/9/25 and no 2024 evaluation was available in the personnel record or could be located to review.Interview on 11/26/25 at 9:30AM with Human Resources identified he started in May of 2025 and was unable to locate the missing reviews. It was his understanding that the DNS completed the annual performance reviews for nursing and had recently done some before going out on leave, however NA#1 from 2025 and NA#2 from 2024 could not be found. Interview on 12/2/25 at 9:27AM with the DNS identified that she does complete all of the nursing reviews and usually she gets a list at the beginning of the year as it comes around and completes them a couple of months in advance. Corporate will also send out a list of evaluations to get completed. The DNS identified that she used to leave the evaluation with the supervisor and then they would not get done. When she is done giving the evaluation which is sometimes done over the phone she asked the employee to come into HR to sign the evaluation and gives the evaluations to HR. Once she had given the reviews to HR she is unsure why they would not be placed into the employee file. Review of the Performance evaluation appraisals policy directed department heads and supervisors will complete performance appraisals prior to the anniversary date of employment. Once complete the employee and supervisor will sign and date the review and the evaluation will be placed in the employee's file.