STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075368	A. Building B. Wing	04/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gardner Heights Health Care Center, Inc	172 Rocky Rest Road Shelton, CT 06484

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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 review of the clinical record, review of facility documentation, review of facility policy/procedures and interviews for one of five sampled residents (Resident #15) reviewed a resident-to-resident altercation, the facility failed to ensure the resident was free from abuse. The findings include: Resident #15's diagnoses included bipolar disorder, anxiety disorder, and dementia. The annual MDS assessment dated [DATE] identified Resident #15 was moderately cognitively impaired, required supervision with transfers and was ambulatory. The care plan dated 10/11/24 identified Resident #15 was involved in a resident-to-resident altercation with interventions that directed to notify MD/APRN, offer psychiatric support services, and social work follow up and support. Resident #104's diagnoses included dementia, unspecified psychosis, and mood disorder.The annual MDS assessment dated [DATE] identified Resident #104 was moderately cognitively impaired, required partial/moderate assistance with bed mobility, transfers, dressing, and substantial/maximal assistance with personal hygiene. The assessment further identified that the resident utilized a walker and wheelchair for mobility. The care plan dated 10/11/24 identified Resident #104 was involved in a resident-to-resident altercation with interventions that directed to notify MD/APRN, offer psychiatric support service, and social work follow up and support. The nurse's note dated 10/10/24 at 6:49PM identified the charge nurse reported that Resident #104 slapped Resident #15 on the left side of the face in the theater room. Resident #15 complained of severe pain in the jaw, ear, and left side of the neck and reported it felt like his/her jaw was broken. The APRN's progress note dated 10/10/24 at 11:26PM identified Resident #15 was evaluated for a contusion to the left jaw following being slapped by another resident. Resident #15 complained of pain being a level 10 on a scale of 1 to 10 with 10 being the most severe and was worried his/her jaw was broken. The note further identified the resident was sent to the hospital emergency department for evaluation. Review of the Reportable Event report dated 10/10/24 at 4:30PM identified LPN #7 witnessed Resident #104 place a chair in front of Resident #15 blocking his/her path to exit the dining room. Resident #15 attempted to grab the handles of Resident #104's wheelchair and asked why Resident #104 was blocking the path. Resident #104 slapped Resident #15 on the left side of the face. Resident #15 described the slap as hard as hell and noted that it made him/her see stars and lose his/her balance briefly. Resident #15 identified his/her pain level was a 10 out of 10. The nursing supervisor was informed and police were called. Resident #15 was sent to the hospital for evaluation. The report further identified that Resident #104 had no prior incidents of this type of behavior. Review of the hospital emergency department report dated 10/10/24 identified Resident #15's complained that he/she was assaulted and had jaw pain. Resident #15 was treated for a closed head injury and ordered Tylenol as needed for pain control. The nursing note dated 10/10/24 identified Resident #104 was sent to the hospital emergency department for a psychiatric evaluation following the altercation with another resident and was cleared to return to the facility. Review of Social Work notes dated 10/11/24, 10/14/24, and 10/15/24 identified Resident #15 felt a little sore and had no signs or symptoms of emotional distress and no concerns voiced. Interview on 4/27/26 at 1:00 PM with the DNS identified she was the ADNS (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at the time of the incident and did not specifically recall the incident however she was aware of it. The DNS further identified that all residents should be free from abuse in the facility. Review of the Abuse Policy directed all residents are treated with kindness, compassion, and dignity, and that any allegations of abuse are thoroughly investigated and addressed in accordance with all applicable laws and regulations. Defining abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain, or mental anguish.

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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 observations, review of the clinical record, review of facility documentation, review of facility policy and interviews for one sampled resident (Resident #56) with an alteration in skin integrity, the facility failed to ensure the wound was assessed per the standard of practice, and failed to ensure a physician's order was in place to address the alteration in skin integrity and failed to ensure weekly monitoring of the alteration in skin integrity. The findings include:Resident #56 was admitted to the facility in August of 2024 with diagnoses that included cerebral infarction, type 2 diabetes mellitus, cognitive communication deficit and muscle weakness.The quarterly MDS assessment dated [DATE] identified Resident #56 had severely impaired cognition, was dependent on staff for dressing, personal hygiene, putting on and/taking off footwear, transfers, bed mobility and was non-ambulatory.The care plan dated 2/2/26 identified Resident #56 had diabetes with interventions that directed to watch for increased pain and/or numbness and vascular changes in extremities and report to MD/APRN. The care plan further identified Resident #56 was at risk for skin breakdown due to decreased mobility, and incontinence. Care plan interventions directed to inspect skin when providing care for signs/symptoms of breakdown. The nurse's note dated 4/1/26 at 12:54 PM written by the ADNS identified Resident #56 was noted to have a darkened area with a small open area measuring 0.3 by 0.1 by 0.1 centimeters (cm) to the right great toe. The APRN was notified with new orders to cleanse with normal saline followed by bacitracin ointment and dry protective dressing daily and to follow-up with podiatryThe physician order dated 4/1/26 directed to cleanse right great toe with normal saline followed by bacitracin ointment and dry clean dressing, and to change every day and as needed for 10 days.Review of the clinical record failed to identify that the darkened area on the right great toe was measured, only the small open area was measured when first identified on 4/1/26.Observation and interview on 4/22/26 at 9:47AM with LPN #2 and RN #1 identified Resident #56 was seated in the wheelchair and LPN #2 let the resident know what she was going to do prior to removing the resident's socks, once the socks were removed, a discolored area to the side of the right great toe with a scabbed area towards the center of the discolored area. Both LPN #2 and RN #1 identified this was a new area, and noted the resident had a skin impairment on the left 2nd toe that resolved on 4/21/26.Interview on 4/24/26 at 11:53 AM with the ADNS in the presence of LPN #2 (Wound Nurse), the DNS, and RN #1 identified she was notified by the charge nurse to assess the area to the right toe. The ADNS further identified that at the time of her initial assessment she had not classified the wound, she left the classification to the APRN to determine. Review of the clinical record failed to identify that the Wound Care APRN or the wound nurse evaluated the area identified on 4/1/26 on the right great toe and failed to identify that the area had been assessed since the initial documentation. Observation and interview with the ADNS, LPN #2 (wound nurse) and RN #1 on 4/24/26 at 2:05 PM identified Resident #56 lying in bed. LPN #2 removed the resident's socks and noted the area to the right side of the great toe which measured 2.0 cm in length by 1.0 cm in width by 0.0 depth, within the discolored area towards the top noted some areas appeared darker measuring 0.5cm in length by 1.0cm with width; in the middle of the discolored areas noted a peeled back scab measuring 0.3 length by 0.3 cm in width; on the lower area of the discoloration measured 1.2 cm in length by 1.1 cm in width. The ADNS identified the area seen currently as what she had identified on 4/1/26, which now appeared lighter and improved from her first observation of the area, wherein the area was much darker. The ADNS further identified she should have measured the open area and the darkened area that was identified. The Wound Care APRN (APRN #1) initial evaluation progress note dated 4/7/26 at 7:13 AM identified Resident #56 was seen for an evaluation and management of a wound on the left second toe, a diabetic foot ulcer, partial thickness. The note failed to identify that an evaluation of the right great toe was completed.Interview on 4/24/26 at 11:53 AM with LPN #2 (Wound Nurse), the DNS, the ADNS and RN #1 identified that they run a 24-hour nurse's progress (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	report to review and discuss concerns at morning report. LPN #2 further identified that any wound issues that were identified would be discussed in the meeting as well. LPN #2 further identified Resident #56 had an area to the left 2nd toe and was unaware of the area to the right great toe. LPN #2 further identified that when APRN #1 came on 4/7/26 for the initial assessment of the wound, she showed the APRN the left foot 2nd toe which had discoloration because that is where she thought the resident had the wound, therefore the right foot was not seen by the APRN. Interview with the ADNS, LPN #2 and RN #1 on 4/24/26 at 2:05 PM identified that the ADNS co-signs LPN #2's notes indicating she agrees with LPN #2's documentation. The ADNS was then asked when she reviewed LPN #2's note why she didn't see it was the left foot instead of the right, when she responded that it did not dawn on her at the time.Review of the weekly wound report documentation failed to identify Resident #56's right great toe was thoroughly assessed/monitored and documented on weekly from the date it was discovered, 4/1/26 through 4/22/26.Interview on 4/24/26 at 11:53 AM with LPN #2 in the presence of the DNS, the ADNS and RN #1 identified wounds including skin discoloration are seen weekly by the wound care APRN and the wound nurse and is documented on until the area is resolved. LPN #2 identified she was unaware of the area to the right great toe so there was no weekly documentation or monitoring completed.Review of the Wound and Skin Care Protocol policy identified skin areas will have weekly documentation until healed, and wounds will be reviewed at the weekly at risk meeting utilizing the skin and pressure ulcer tracking sheet.Review of the physician order for the period of April 7, 2026, through April 22, 2026, failed to identify a treatment directing care of the wound to the right great toe.Interview on 4/24/26 at 11:53 AM with LPN #2 in the presence of the DNS, the ADNS and RN #1 identified she had deleted the current treatment for the right great toe on 4/7/26 when the resident was first seen by APRN #1 and the new order for the left second toe was entered into the electronic medical record. LPN #2 identified she had made a mistake as the order had stated right great toe when she discontinued the order. Review of the Wound and Skin Care Protocol policy identified residents are assessed by the nurse for risk of skin breakdown. Weekly body audits will be completed on bath/shower day by a licensed nurse. The policy further identified skin areas will have weekly documentation until healed.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record reviews, review of facility documentation, review of facility policy and interviews for two of six sampled residents (Resident #3 and Resident #56) reviewed for foot care, the facility failed to ensure the resident received podiatry services for trimming of toenails. The findings include: Resident #3 was admitted to the facility on [DATE] with diagnoses that included type II diabetes, polyneuropathy, and atrophic disorder of the skin. The admission MDS assessment dated [DATE] identified Resident #3 was cognitively intact, had no behaviors, required substantial/maximal assistance with bed mobility, and personal hygiene, and independent for dressing. The assessment further identified that the resident did not ambulate and utilized a wheelchair for mobility. The care plan dated 1/13/26 identified Resident #3 needed staff assistance related to ADL's with interventions that included full mechanical lift assist x2 to standard wheelchair, ambulate only with therapy, may use a wheelchair for positioning/transport, keep commonly used articles within reach. Hospital discharge paperwork dated 1/9/26 identified a referral placed to ensure follow up with primary care physician, podiatrist and wound care center. Under follow up appointment the paperwork directed to follow up with the primary care physician within 1-2 weeks, podiatry specialist within 1-2 weeks of discharge, and follow up with wound care center. Physician's order dated 1/9/26 placed by the admitting nurse signed by the medical director directed wound, vision, dental, podiatry, audiology and psychiatric services as needed. This order was discontinued on 3/5/26. Physician's order dated 3/5/25 directed to obtain a routine vision, dental, podiatry, and audiology consult. This order was discontinued on 3/7/26.\ Interview with Resident #3 on 4/20/26 at 10:00AM identified he/she had been requesting from the facility to be seen by podiatry as he/she needed his/her nails trimmed and was diabetic. Resident #3 identified he/she was offered the service when admitted and was told that the facility would set it up for him/her. Review of the clinical chart identified no podiatry visits had been scheduled, canceled, refused, or completed. No notes regarding podiatry care were in the clinical chart nor were there any podiatry consents received or services declined. Interview with the ADNS on 4/22/26 at 12:00PM identified when a patient is admitted from the hospital the admitting nurse reviews the paperwork and gives the information to the supervisor or ADNS regarding any upcoming appointments. The ADNS is responsible for making the follow up appointments and either scheduling with the podiatric provider routine services or would make an appointment with an outside provider if needed. The ADNS identified that no appointment was made for Resident #3 following admission and there should have been one made for him/her. The ADNS further identified that Resident #3 was never signed onto Health drive services during his/her time in the facility as well, no was there evidence of decline of services. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and measurement of the resident's toenails with the DNS and Infection Preventionist (wound nurse) on 4/23/26 at 1:30PM identified on the left foot the great toenail measured 0cm, 2nd toenail measured 4cm, 3rd toenail measured 2cm, 4th toenail measured 3cm, and 5th toenail measured 1cm. On the right foot the great toenail measured 1cm, the 2nd toenail measured 2cm, the 3rd toenail measured 1cm, the 4th toenail measured 2cm, and the 5th toenail measured 0cm. Interview with the DNS on 4/23/26 at 1:45PM identified Resident #3 should have been seen by podiatry and would be followed approximately every 60 days by the podiatrist for toenail care due to the diabetic status. Therefore, the resident should have been on the second visit from podiatry from admission. Review of the Ancillary Services policy directed ancillary services include, but are not limited to podiatry, dentistry, optometry, audiology, and other specialized care as required by resident's condition. Resident's ancillary needs will be determined during admission and as part of ongoing assessments by the interdisciplinary team. Ancillary services will be provided by the facility or through coordination with qualified external providers. Residents and or their legal representatives will be informed of available services and assisted in scheduled appointments as needed. Resident #56 was admitted to the facility in August of 2024 and had diagnoses that included cerebral infarction, type 2 diabetes mellitus, cognitive communication deficit and muscle weakness. The quarterly MDS assessment dated [DATE] identified Resident #56 had severely impaired cognition, dependent on staff for dressing, personal hygiene, putting on and/taking off footwear, transfers, bed mobility and was non-ambulatory. The care plan dated 2/2/26 identified Resident #56 had diabetes with interventions that directed to watch for increased pain and/or numbness and vascular changes in extremities and report to MD/APRN. The care plan further identified Resident #56 was at risk for skin breakdown due to decreased mobility, incontinence with interventions that directed to inspect skin when providing care for sign/symptom of breakdown. The monthly physician's order directed consults with vision, dental, podiatry, audiology and psychiatric services as needed and body audit on admission and weekly by the licensed nurse on Tuesday on shower days with an origination order date 8/24/24. The physician's order for February/2025 through April/2026 directed weekly body audit on every Tuesday on the evening shift on shower day. Observation and interview on 4/21/26 at 1:58 PM with NA #1 identified Resident #56 lying in bed when NA #1 asked the resident permission prior to removing his/her socks and noted the resident's toenails on feet needed to be trimmed. NA #1 identified that she had noted the resident's toenail length and reported it to the nurse about a month ago, which the nurse told her then, the resident would be placed on the podiatry list. NA #1 indicated that she was unable to recall the name of the nurse who she told about the resident's toenails. Review of Resident #56 clinical records failed to identify the resident had been seen by the podiatrist since his/her admission. Review of the Nursing admission assessment dated [DATE] failed to identify Resident #56 had toenails that need trimming nor did it reflect any concerns or issues with his/her toenails. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Treatment Administration Record (TAR) for the period of August/2025, and from November 2025 through April 21, 2026, identified weekly body audits were completed on Resident #56 assigned shower day. Further, review of the clinical records for the period of January/2025 through April 21, 2026, failed to identify a note reflecting any issues or concerns with Resident #56's toenails nor did the records identified Resident #56 and/or his/her conservator had refused/offered podiatry services. Interview with the ADNS on 4/21/26 at 2:30 PM identified an email was sent to the company that provides podiatry services to the facility on 3/13/26 to add Resident #56 to the podiatry list and the resident was then scheduled to be seen on May 11, 2026. She further identified Resident #56's conservator did not want to sign the consent form even though he/she wanted the resident to receive podiatry services. The ADNS identified Resident #56 needed to be seen by podiatry and the conservator was hesitant in signing the consent, so they completed a physician order form provided by the company on 4/1/26 for the resident to be seen. The ADNS further identified for a resident to be seen by the podiatrist or received other services from the contracted provider, she would need to send over the resident's demographic sheet (face sheet) and consent form them to be enrolled in the various services offered. The DNS then joined the interview when they were asked why the resident wasn't placed on the podiatry list sooner and the DNS responded that she was not aware that the resident needed podiatry services prior. Observation on 4/22/26 at 9:47AM with LPN #2 and RN #1 identified Resident #56 was seated in the wheelchair and LPN #2 let the resident know what she was about to do prior to removing the resident socks and the following was noted: on the left foot: the great toenail extending over the tip of the toe measuring 2.0 centimeters (cm) with a nail thickness of 1.0 cm; the 2nd toenail extending over the tip of the toe measuring 2.0 cm with a nail thickness of 0.5cm; the 3rd toenail extending over the tip of the toe towards under the 2nd toenail measuring 1.5 cm; the 4th toenail curved and extending over the tip of the toe measuring 1.8 cm and the 5th toenail curved towards the sole of feet with a dark line midway across the nail which extended over the of the toe measuring 2.8 cm. On the right foot noted: the great toenail extending over the tip of the toe measuring 3.5 cm with a nail thickness of 1.0 cm curving towards the 2nd toenail, and dark discoloration to the right side of the great toe; the 2nd toenail extending over the tip of the toe measuring 2.4 cm; the 3rd toenail extending over the tip of the toe measuring 2.0 cm which is curved under the 2nd toenail; the 4th toenail extending over the tip of the toe measuring 2.8 cm; and the 5th toenail extending over the tip of the toe measuring 2.7cm which curved towards the 4th toenail. According to the article title Nails in Older Adults by Albucker SJ, Conway J, [NAME] SR. identified on average toenails grow 1.0 mm/month and fingernails grow 3.0mm/month. A review of the Podiatrist's service dates at the facility for the period of October 1, 2025, through April 24, 2026, identified that the Podiatrist visited the facility a total of 6 times to provide podiatry services. Interview with LPN #1 in the presence of the DNS and RN #1 on 4/22/26 at 12:06 PM identified Resident #56's conservator had mentioned the need for podiatry services at least once in the last 6 months and each time it was mentioned she would report it to the front office which is the DNS and ADNS. Interview with the ADNS and DNS in the presence of RN #1 on 4/22/26 at 12:05 PM identified the resident had not received podiatry services since admission. The ADNS identified she became aware (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of the toenails when the resident's conservator had removed the resident's sock, and she came in to assess the area. The DNS and the ADNS identified that they would expect the toenails to have been identified sooner than 3/13/26, given that skin checks are completed weekly and care is provided to the resident daily. Interview on 4/22/26 at 2:30 PM with NA #2 identified she had seen the toenails and thought the resident was on the podiatry list. She further identified the toenails has been like that for more than a month and did not notify the nurse as the podiatrist does come to the facility. She further indicated that she should have let the nurse know when she had noticed the length of the toenails. Interview with APRN #1 (Wound care Specialist) on 4/22/26 at 2:46PM identified a resident with diabetes should automatically have an order for daily diabetic foot checks. When asked what are the complications that could occur if toenails are not trimmed and she responded it could lead to skin break down, infections and ingrown nails. Interview with the Charge Nurse LPN #5 on 4/23/26 at 3:20 PM identified she completes weekly skin check on the resident's shower days which includes checking the resident's nails, and when an issue is identified with the skin, she would then write a progress note. She further identified that they knew about Resident #56's toenail. LPN #5 further identified she could not recall seeing the length of his/her toenail, nor could she recall if any of the nurse aide told her about the resident's toenail. She indicated that if she was told about a resident toenail needing to be trimmed, she would report it to the nursing supervisor and could not recall if she did. Interview with Person #1 (Senior Account Manager for the contracted service provider that is used by the facility for ancillary services) on 4/23/26 at 11:29 AM identified for a resident to be enrolled in podiatry services the facility would only need to send over the resident's face sheet and the completed physician order form provided by their company by indicating the services in which the resident need. After these documents are received the resident will automatically be added to the list to be seen by the provider on their next visit to the facility. She further identified Resident #56 was enrolled in podiatry on 3/13/26 and was not added to the list of residents to be seen on 3/18/26 as the podiatrist list was full at the time, hence the resident was placed on the May 11, 2026, list. She further identified if a resident had a greater need to be seen by the podiatrist the facility would need to let the podiatrist know before the visit or at the time of the visit, so they could be seen. Interview with the ADNS, LPN #2, in the presence of the DNS and RN #1 on 4/24/26 at 11:53 AM identified Resident #56 toenails would be a priority to be seen by the podiatrist immediately. However, they failed to identify that the podiatrist was made aware of the resident urgent need on 3/13/26, and at the time of the podiatrist visit on 3/18/26 and after. The ADNS identified she contacted the contracted company again on 4/1/25 when the resident was noted to have a darkened area with a small opening to the side of the right great toe and sent over the company's physician order form. Review of the Ancillary Services policy identified ancillary services include, but are not limited to, podiatry, dentistry, optometry, audiology, and other specialized care as required by the resident's condition. The policy further identifies the resident's ancillary service needs will be evaluated during admission and as part of ongoing assessments by the interdisciplinary care team and primary physician.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility staffing, review of facility documentation and staff interviews for 4 of 4 days reviewed, the facility failed to ensure that staffing met the State of Connecticut, Public Health Code minimum staffing requirements of 3.0 Per Patient Day (PPD) hours and failed to meet ratios as outlined in the facility assessment. The findings include:The facility triggered for low weekend staffing Oct through [DATE] and triggered for one star staffing.Facility staffing on Saturday, 11/15/25, identified a census of 112 residents.The facility schedule dated 11/15/25 (Saturday) identified that for Nurse Aide (NA) staff, there were 174 PPD hours worked during the 7:00 AM to 9:00 PM time frame. The facility schedule dated 11/15/25 (Saturday) identified that for Licensed staff, there were 64 PPD hours worked during the 7:00 AM to 9:00 PM time frame. The combination of the Nurse Aide and Licensed staff PPD hours was 238 PPD hours. According to the Public Health Code 3.0 Staffing Grid, the facility was required to have 243.04 PPD hours of combined Licensed and NA staff (a shortage of 5.04 hours) for a census of 112 residents.Review of the facility accident and incident tracking form dated November 2025, there were 10 unwitnessed falls or injuries during the month of November. There was one unwitnessed fall that occurred on 11/15/25 on the 3 PM to 11 PM shift on the secured unit.Review of the facility assessment dated [DATE] identified 1 RN supervisor each shift and staffing ratios of Licensed nurses to residents as 1:30-35 on days and evenings and 1:40 on nights. The assessment identified ratio of direct care staff (NA) to residents 1:8-10 on days, 1:10-15 on evenings and 1:20-25 on nights.Review of the facility staffing compliance guidelines dated 4/26/26 identified that for an actual census of 110-114 the facility required 5 RN/LPN and 14 NAs on the 7 AM - 3 PM shift (a shortage of 2 NAs) and 5 RN/LPNs and 11 NAs on the 3 PM - 11 PM shift (a shortage of 1 RN/LPN) b. Facility staffing on Sunday, 1/4/26, identified a census of 112 residents.The facility schedule dated 1/4/26 (Sunday) identified that for Nurse Aide (NA) staff, there were 170 PPD hours worked during the 7:00 AM to 9:00 PM time frame. The facility schedule dated 1/4/26 (Sunday) identified that for Licensed staff, there were 62 PPD hours worked during the 7:00 AM to 9:00 PM time frame. The combination of the Nurse Aide and Licensed staff PPD hours was 232 PPD hours. According to the Public Health Code 3.0 Staffing Grid, the facility was required to have 63.84 PPD hours of Licensed staff (a shortage of 1.84 hours) and 243.04 PPD hours of combined Licensed and NA staff (a shortage of 11.04 hours) for a census of 112 residents.Review of the facility accident and incident tracking form dated January 2026 identified 20 unwitnessed accident/injuries during the month of January 2026. The tracking indicated 3 unwitnessed incidents on 1/4/26 before 9 PM. This unwitnessed incident occurred on the secured unit.Review of the facility staffing compliance guidelines dated 4/26/26 identified that for an actual census of 110-114 the facility required 5 RN/LPN and 14 NAs on the 7 AM - 3 PM shift (a shortage of 1 RN/LPN and 1 NA) and 5 RN/LPNs and 11 NAs on the 3 PM - 11 PM shift. There was not a shortage based on facility staffing grid. c. Facility staffing on Monday, 4/13/26, identified a census of 108 residents.The facility schedule dated 4/13/26 (Monday) identified that for Nurse Aide (NA) staff, there were 160 PPD hours worked during the 7:00 AM to 9:00 PM time frame. The facility schedule dated 4/13/26 (Monday) identified that for Licensed staff, there were 56 PPD hours worked during the 7:00 AM to 9:00 PM time frame. The combination of the Nurse Aide and Licensed staff PPD hours was 216 PPD hours. According to the Public Health Code 3.0 staffing Grid, the facility was required to have 61.56 PPD hours of Licensed staff (a shortage of 5.56 hours) and 234.36 PPD hours of combined Licensed and NA staff (a shortage of 18.36 hours) for a census of 108 residents.Review of the facility accident/incident tracking form dated April 2026 identified 14 unwitnessed incidents for the month of April 2026 with 1 unwitnessed incident on 4/13/26.Review of the facility staffing compliance guidelines dated 4/26/23 identified that for an actual census of 100-104 residents, the facility required 5 RN/LPN and 14 NAs on the 7 AM (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075368	A. Building B. Wing	04/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gardner Heights Health Care Center, Inc	172 Rocky Rest Road Shelton, CT 06484

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-3 PM shift (a shortage of 1 RN/LPN and 1 NA) and 5 RN/LPN and 11 NAs on the 3 PM - 11PM shift (a shortage of 1 RN/LPN and 1 NA)Observation of the facility secured unit all dates of the survey 4/20, 4/21, 4/22, 4/23, 4/24 and 4/27/26 identified a secured unit, requiring a numeric code to enter and exit at the two entrances inside of the facility and three doors that exited the facility to outside space. Resident capacity on this unit was 35 with a daily census of 34 and 3 NAs assigned to the unit. A census of 34 would indicate the need for 4 NAs according to the facility assessment, indicating a shortage of 1 NA on the secured unit.Review of the facility assessment dated [DATE] identified staffing was based on census and acuity and identified ratios of Licensed nurses to residents 1:30-25 on days and evenings and 1:40 on nights and ratio of direct care staff (NAs) of 1:8-10 on days, 1:10-15 on evenings and 1:20-25 on nights.Review of the facility schedule dated 4/13/26 (Monday) identified that the ADNS and the DNS were pulled from their positions to staff units in the facility. However, review of the DNS time sheet for the week identified hours worked on 4/13/26 (Monday) indicated the time worked 7:30 AM to 5:00 PM was identified as DNS hours and not RN supervisor hours.Interview with the DNS on 4/27/26 at 12:32 PM identified that she denotes on her time card what position she held for the designated day of work. The DNS indicated that if she worked something other than as the DNS, it would be written in on the time sheet. The DNS could not recall her main duties on 4/13/26. Interview with the Human Resources Dir (HR) and the Administrator on 4/24/26 at 10:58 AM identified HR was responsible for submitting the PBJ staffing (which indicated the facility had low weekend staffing October through December 2025. HR indicated she had a staffing form that she used to confirm adequate staffing. The Administrator identified the form as an old form and left the office to get an updated form. HR put the form away and did not provide a copy for me.Interview with the scheduler on 4/24/26 at 11:10 AM identified she fills the schedule according to direction from the administrator. The scheduler indicated she did not figure out staffing based on hourly requirements according to census but followed direction from the Administrator. The scheduler was not aware of how many hours per resident were needed to staff Licensed staff nor NA staff. Interview with the Administrator on 11/19/24 at 1:48 PM identified he is aware of the 3.0 staffing requirements. He indicated that the high staffing turnover in the facility was the cause of the facility not being able to meet the staffing requirements. The Administrator further identified that the facility's policy was the 3.0 staffing requirements were provided by corporate but could not identify if the corporate guidance reflected requirements, and indicated staffing assignments were based on acuity.Interview with the Administrator on 4/27/26 at 12:44 PM identified that both SW#1 and SW#2 had BS in Human Services. The Administrator indicated she was aware of the 3.0 staffing and was looking for the direction for staffing received from corporate and was not familiar with the hours per resident required for staffing. Interview with HR on 4/27/26 at 12:35 PM identified she was responsible for submitting the PBJ staffing but could not identify if the facility was short on staffing. The HR indicated if they are short, the ADM might get an email.Interview with NA#3, NA#4, NA#5 and NA#6 on 4/27/26 between 2:07 PM and 2:20 PM identified that, at times, NA assignments included more than 10 residents per NA. All of the NA's identified that the assignments kept them busy throughout the day, they could use additional NAs, they identified good teamwork and the ability to manage the resident load.Interview with ADM on 4/27/26 at 2:25 PM identified she did not know what the facility staffing compliance grid was based on and indicated that was what the facility followed for staffing and was directed from corporate and would need to be reviewed.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of facility documentation and staff interviews, the facility failed to ensure the secured unit was addressed in the facility assessment. The findings include:Observations on all days of the survey 4/20, 4/21, 4/22, 4/23, 4/24 and 4/27/26 identified a secured unit located on the right side of the building after entering through the front door. The unit consisted of two entrance doors accessible from the inside of the facility that required a numeric code to be entered to enter or exit the unit. Inside the unit, there were four additional doors to exit the unit. One door required a numeric code to exit and exited into an internal courtyard. One door required a numeric code to exit and exited outside the rear of the building. Two doors, which were one door into a vestibule containing another door, required a numeric code to exit or enter. To come back into the building the interior door had an entrance button, not a numeric code to come back in. The exterior doors were confirmed to have a delayed, alarmed egress in the event of an emergency. The unit consisted of three hallways with cameras that fed to a monitor at the secured unit nurses' station. The unit capacity was 35 residents.Observations on all days of the survey 4/20, 4/21, 4/22, 4/23, 4/24 and 4/27/26 identified sensors on the walls in the hallways and near exit doors throughout the entire building identified as sensors to support the wanderguard system for wandering residents. The system was confirmed to be working.Review of facility documentation identified criteria for admission to a secured dementia unit that included a diagnosis of dementia and behaviors, elopement or wandering, that required closer supervision for safety.Review of the facility assessment dated [DATE] identified the number of licensed beds was 130 and served residents with common diagnoses that included Alzheimer's disease, non-Alzheimer's dementia, impaired cognition and other behaviors that require intervention. The assessment indicated that acuity of residents with behavioral symptoms and cognitive performance had an average number of residents identified as 36 and indicated special treatments for behavioral health needs an average number of 36. Section 2 of the assessment identified resident support/care needs that included care of someone with cognitive impairment and indicated all staff on hire and annually receive competency training on caring for people with dementia, Alzheimer's and cognitive impairments. The physical environment and building/plant needs failed to identify a wander guard system and failed to identify the facility had a secure unit.Interview with the Administrator on 4/22/26 at 10:39 AM identified a secured unit policy that was implemented [DATE] and indicated the unit was called the secured dementia unit. Further interview with the Administrator on 4/22/26 at 11:16 AM indicated that she was unable to locate the secured unit in the facility assessment and that it must have been an oversight. Additionally, the Administrator confirmed capacity of the facility was 120 beds.