

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075378	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/23/2026
NAME OF PROVIDER OR SUPPLIER Livewell Connecticut		STREET ADDRESS, CITY, STATE, ZIP CODE 1261 South Main Street Plantsville, CT 06479	

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)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, facility documentation, facility policy, and interviews for one of three residents (Resident #1) reviewed for abuse, the facility failed to ensure the staff provided care in accordance with the plan of care and failed to ensure staff to reapproached the resident when resisted care. The findings include: Resident #1's diagnoses included dementia with behaviors, delusions, and major depression. The quarterly Minimum Data Set (MDS) dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of zero out of fifteen, indicative of severe cognitive impairment, was dependent with ADLS, and independent with transfers and ambulation. The Resident Care Plan (RCP) dated 3/24/2026 identified a cognitive loss due to dementia, alteration in communication, and alteration in ADL function. Interventions directed to assist to make needs known, use Resident #1's personal life story to make connections, ask yes/no questions, assess ability to communicate related to confusion/mood state with each interaction, assist with ADLs, and if not interested in care to come back at a later time and try again. Facility Reportable Event dated 3/31/2026 at 6:30 PM identified NA #1 reported that she was in a room and Resident #1 and Resident #2 were both laying on the bed. NA #1 indicated she observed NA #2 enter the room and approach Resident #1. NA #2 told Resident #1, I'm not doing this s. tonight. NA #1 then stated she observed NA #2 reach out with one hand and grab Resident #1 by the ponytail close to his/her scalp and squeezed with a closed hand and stated to Resident #1, get the f. up and pulled Resident #1 from a position of laying on his/her side to a sitting position. Resident #1 began to resist physically and was mumbling incoherently. NA #2 continued to pull Resident #1 by the ponytail causing Resident #1 to get into a squat-like position next to the bed. Resident #1 then got up and NA #2 let go of Resident #1 and followed Resident #1 out of the room. Assessment identified no injury and no distress, and NA #2 was suspended pending an investigation. Nursing note dated 3/31/2026 at 7:42 PM identified Resident #1 was in bed resting quietly with no apparent discomfort, hair was in a ponytail with no loose hair strands or any redness/irritation noted at the hairline. Will continue to monitor. Nursing note dated 3/31/2026 at 8:15 PM identified an RN assessment was completed with no acute physical or emotional distress. Review of facility RE summary dated 4/2/2026 identified the facility investigation did not substantiate abuse occurred as Resident #1 had no physical harm, mental anguish or deprivation. Further there were two (2) additional staff that were outside the room when the event occurred that did not provide conclusive or corroborating evidence. Interview, review of NA #1 written statement, and facility documentation review on 4/23/2026 at 10:41 AM with NA #1 identified on 3/31/2026 she was standing in a resident's room, on side of the bed near the window and observed Resident #1 and Resident #2 were both lying on another resident's bed and the roommate was sleeping in the second bed in the room. Residents #1 and 2 were both lying on their sides, with Resident #1 closer to the headboard. NA #1 was facing the door when NA #2 walked into the room and said, I'm not doing this s-t tonight. NA #1 indicated NA #2 immediately approached Resident #1, held her arm out and grabbed Resident #1 by the ponytail, close to scalp end with a clenched fist, pulled Resident #1 up from laying position to a seated position on the bed. When (continued on next page)</p>

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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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #1 attempted to lay back down, NA #2 pulled the ponytail again and pulled Resident #2 to a seated position again. NA #1 believed the force of NA #2 pulling Resident #1's hair caused Resident #1 to come off the bed into a low squatting position. Resident #1 yelled, mumbled and moved his/her arms while NA #2 held the ponytail. NA #2 stated, get the f-k up to Resident #1, who stood up and NA #2 released the ponytail. Resident #1 then left the room independently. NA #2 remained in room, and NA #1 stayed in room to assist Resident #2 out of bed, and reported the incident to the charge nurse, the supervisor and another nurse. NA #1 further indicated no one else could see into the room when the incident occurred. NA #1 stated she did not intervene or call for help due to shock at what happened. NA #1 stated it was her first time witnessing abuse and the first time working with NA #2. NA #1 stated when she exited the room she observed there were no staff in the immediate area (room or common area/hallway), and she had received abuse reporting education when she was hired recently, and she reported the incident as soon as possible. Interview and review of facility documentation on 4/23/2026 at 11:27 AM with NA #2 identified that Resident #1 and Resident #2 were found sleeping in another resident's bed and she wanted to get that resident into bed, she tried to get Resident #1 up and Resident #1 said, leave me alone, don't touch me, I want to sleep and stated she was pulling resident up by his/her back, trying to get resident into a sitting position so he/she could stand up. NA #2 stated she said, let's go, go with me, we got to go to your room and Resident #1 was trying to lay back down, the other aide was not helping, was just standing there and helping Resident #2. Resident #1 would not get up and NA #2 stated she was trying to get Resident #1 into a sitting position, once Resident #1 was up she walked Resident #1 to his/her room. NA #2 stated Resident #1 wears a ponytail at middle of his/her head, and the hair end touches residents' neck and indicated she touched hair only when she held Resident #1's neck. NA #2 further stated she had no issues with NA #1, who was new, and it was their first time working together. NA #2 stated Resident #1 often falls asleep in other resident's rooms, and at times gets up on own and other times needs to be taken back to his/her room. NA #2 denied the allegation of the verbal comments and indicated she did not tell Resident #1 to get the f-k up or we're not doing this s-t tonight. NA #2 indicated she did not consider reapproaching Resident #1 when he/she would not get out of the bed, as it was time for the resident whose bed it was to go to bed, and she did not ask NA #1 to help her with Resident #1 as NA #1 was busy with Resident #2. Interview and facility documentation review on 4/27/2026 at 9:33 AM with RN #1 identified he was the supervisor on 3/31/2026 when the alleged incident occurred. RN #1 stated NA #1 may not have been comfortable confronting a more experienced aide (NA #2), and stated that during interviews neither NA appeared to have ill will toward the other. RN #1 described NA #2 as having a direct demeanor that can seem cold and had worked with NA #2 for an extended period. RN #1 stated any action such as grabbing a resident by the ponytail or pulling a resident to force movement, and the alleged verbal comments would be inappropriate. Interview and record review with RN #2 (Director of Clinical Advancement) and the Administrator on 4/23/2026 at 1:39 PM, identified the allegation of abuse was made on 3/31/2026 at approximately 6:30 PM. NA #1 reported potential abuse by NA #2 to the charge nurse, and RN #1/supervisor was notified. NA #1 and #2 both provided different accounts of the incident, and both residents had dementia. Resident #1 and Resident #2 were found in another resident's bed, and the other resident was due to return to bed. Facility review of hall security video monitoring identified no sounds were heard (from the room/incident) before NA #1 was witnessed on the video to exit the room and speak with the charge nurse to report the allegation, approximately 10 minutes after the alleged incident occurred. The facility did not confirm Resident #1 was pulled by the hair or NA #2 made the statements alleged. NA #1 and NA #2 had never worked together previously and had no personal history. Interview identified NA #1 could have used a call bell to call for help, or could have used the staff-issued communication system that staff wear. Although the facility did not substantiate the allegation, NA #1's employment was terminated for not reporting the incident immediately, and NA #2's employment was terminated related to the incident. The DNS was not available for interview during the survey. Review of Nursing Home Resident's (continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>[NAME] of Rights Policy directed in part that residents have the right to be treated with consideration, respect and full recognition of their dignity and individuality in an environment that promotes maintenance or enhancement of quality of life and privacy. Further, residents have the right to be free from verbal, sexual, physical or mental abuse, neglect, exploitation. Review of Certified Nursing Assistant Position (job) Description directed in part; focus on the well-being of all residents. Further the Position Description directed to respect the dignity of residents by respecting their right to refuse care (i.e. leaves and return later - does not insist on care being given.) and to respond with patience when the resident may be slow to respond. Review of the facility Compliance and Ethics - Code of Conduct directed in part, to provide an empathic approach to dementia care.</p>		