STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075379	A. Building B. Wing	08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sharon Center for Health & Rehabilitation	27 Hospital Hill Road Sharon, CT 06069

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation, facility policy and staff interviews for 1 of 5 residents (Resident #1) reviewed for unnecessary medications, the facility failed to review and respond to pharmacy recommendations in a timely manner. The findings include: Resident #1 was admitted to the facility on [DATE] with diagnoses that included dementia, diabetes, and hypertension.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 was severely cognitively impaired, dependent on bathing, and personal hygiene. Also, identified Resident #1 required maximal assistance for toileting, dressing and partial moderate assistance for transfers. Further, identifying Resident #1 required set-up assistance for eating.A physician order dated 11/13/24 directed to administer Rexulti (an antipsychotic medication used to treat agitation associated with dementia) 0.5 milligram (mg) tablet every evening.A pharmacy medication review dated 12/6/24 recommended since Resident #1 was started on Rexulti and to add an order for orthostatic blood pressures once weekly for 4 weeks lying and standing or lying and sitting if unable to stand. Also, identifying the need for lab test of a HbA1c to be completed.The Resident Care Plan (RCP) dated 12/29/24 identified Resident #1 had psychotropic medication used with interventions that included to give medication as ordered and monitor and record for target behavior symptoms such as physical aggressiveness, resistive to care, and labs as ordered. A pharmacy medication review dated 1/26/25 noted a second request identifying Resident #1's need for lab work of a HbA1c to be completed.A pharmacy medication review dated 2/7/25 noted a third request identifying Resident #1's need for lab work of a HbA1c to be completed.Review of the clinical record identified a lab test for HbA1c was obtained on 2/21/25 (more than 2 months after the pharmacist's initial recommendation) but failed to identify orthostatic blood pressures were ever initiated.An interview on 8/29/25 at 11:55 AM with the Director of Nursing Services (DNS) identified once a pharmacist makes a recommendation, the facility should act upon it in a timely manner which would be within 30 days. Also, identifying nurse management was responsible for ensuring pharmacy recommendations were completed. Further, identifying the HbA1c was completed after 3 requests were made and the ortho static blood pressures not being completed was an oversight, updating the order on 8/29/25 in the presence of the surveyor.Review of the Pharmacy Medication Review Policy dated April 2023 identified the consultant pharmacist reviews the medication regimen of each resident at least monthly. Findings and recommendations are communicated to those with responsibility to implement the recommendations, and to answer in a timely fashion. Also, identifying the consultant pharmacist will submit their monthly recommendations reports to the DNS and follow up on the recommendation to verify that appropriate action has been taken and or responded to within a reasonable time frame.

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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observations, facility documentation, facility policy and interviews, the facility failed to ensure that the correct portion of chicken was served, and corn bread or a similar substitute was provided per facility menu. The findings include: Observation of the lunch menu for 8/25/25 identified 4 oz of chicken and cornbread was to be served.a. Observations in the [NAME] Unit dining room on 8/25/25 at 12:15 PM noted that Resident #13 did not have any protein with his/her lunch meal. Resident #13 was asked if he/she wanted any chicken with lunch by the surveyor. Resident #13 responded that he/she would like chicken. Dietary Aid (DA) #1 responded, we don't have any more chicken. DA #1 did not offer an alternative and/or provide Resident #13 with any protein with his/her meal. Further observation on 8/25/25 at 12:30 PM in the [NAME] Wing dining room noted that 7 small chicken legs were served to residents out of the 11 residents in the [NAME] Wing dining room. Two residents were served an alternative (sandwich) and 2 residents had puree consistency meal. Resident #19 who was in the dining room commented, hey, look at this little chicken leg. Resident #19 indicated that he/she should have another chicken leg as it was not enough chicken. DA #1 indicated that there was no more chicken to serve residents. NA#1 on 8/25/25 at 12:45 PM asked Resident #19 if he/she did not get enough chicken to eat after the steam table left the dining room area. Resident #19 responded that he/she did not want any more food, just a second glass of iced tea which NA#1 provided to Resident #19. An interview with the Dietary Manager on 8/26/25 at 9:15 AM indicated that not enough chicken was thawed out to serve lunch. Therefore, she had to thaw out more chicken which were 2 oz (ounce) size chicken legs and prepare the chicken legs during the lunch meal. The chicken legs were not finished cooking until halfway through the lunch meal and brought up to the dining room by the Dietary Manager. The Dietary Manager indicated that she had instructed the dietary aides to provide the residents with 2 pieces of chicken legs. Furthermore, the Dietary Manager indicated that it was her responsibility to ensure the correct portion size of protein was provided to the residents and substitutions/alternatives were provided to residents. An interview with DA #1 on 8/26/25 at 10:16 AM indicated that she was instructed by the Dietary Manager to serve 2 pieces of chicken legs. DA #1 indicated that she did not serve 2 pieces of chicken legs because she was afraid, she would run out of chicken again. DA #1 stated that she did not express this concern to the Dietary Manager and she did not offer Resident #13 an alternative because Resident #13 was a very picky eater and sometimes did not want any meat other than chicken. Furthermore, Resident #13 will say he/she was a vegetarian at times but will eat meat. b. Observations in the [NAME] Wing dining room on 8/25/25 at 12:15 PM noted that no corn bread was provided to residents per facility lunch menu on 8/25/25 and there was no alternative/substitute for the lack of corn bread provided to the residents. An interview with the Dietary Manager on 8/25/25 at 9:15 AM indicated that she was aware that corn bread was not served for lunch as per the menu. She further indicated that although the menu had corn bread listed, it was not on the individual meal tickets for the residents. The Dietary Manager could not explain why the corn bread or an alternative was not provided but stated that she had been extremely busy in the kitchen as she had been cooking due to a staffing issue in the kitchen. An interview with DA #1 on 8/25/25 at 10:16 AM indicated that she was not sure why corn bread was not served or why an alternative was not offered. DA #1 indicated that no residents received corn bread as it was not prepared and that it was busy in the kitchen the last few days and maybe it was not ordered. An interview with the Dietitian on 8/26/25 at 12:30 PM indicated that she was made aware by the Dietary Manager of the chicken portions and no corn bread being available on 8/25/25. The Dietitian indicated that 2 pieces of chicken legs should have been provided to equal the 4 oz indicated on the menu and if the chicken was not available another protein should have been offered. Furthermore, if corn bread was unavailable a substitute should have been provided such as rolls or sliced bread.A review of the Nutritional and Culinary Policy dated 7/1/2025 directed, in part, planned (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	menus are developed and used to provide each resident with a nourishing palatable well-balanced diet that meets daily nutritional and special dietary needs of the residents.Reasonable alternative food items that (reasonably) accommodate individual resident needs, allergies, intolerances, and preferences are available and offered to residents at each meal if the primary menu or immediate selections for a particular meal are not to the residents' liking, alternative options are appealing and of similar nutritive value.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, review of the clinical record, and facility policy for 3 of 5 residents (Resident #1, Resident #34 and Resident #54) reviewed for infection control, the facility failed to maintain proper infection control techniques regarding social distancing (Resident #1 and Resident #34) and Enhanced Barrier Precautions (EBP) when entering a room of a resident on droplet precautions (Resident #54). The findings include: 1.Resident #1 had diagnoses that included COVID-19, dementia, and diabetes. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 was severely cognitively impaired, used a walker, required setup or clean-up assistance with eating, was independent with bed/chair transfers, and required supervision or touching assistance with walking. The Resident Care Plan (RCP) dated 8/23/25 identified Resident #1 was confirmed to have COVID-19 virus. Interventions included to assist Resident #1 with application of face mask as needed and place Resident #1 on contact/droplet transmission based precautions. The RCP further identified Resident #1 had potential to become physically aggressive related to dementia and poor impulse control. Interventions included to provide visual and verbal cues to alleviate anxiety and give the resident as many choices as possible about care. A physician order dated 8/23/25 directed contact/droplet isolation precautions to be maintained at all times every shift for 10 days related to diagnosis of COVID-19 positive. 2. Resident #34 had diagnoses that included dementia, diabetes, and atrial fibrillation. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #34 was cognitively intact, required setup or clean-up assistance with eating, and was independent with bed/chair transfers and walking. The Resident Care Plan (RCP) dated 6/17/25 identified Resident #34 had potential COVID-19 exposure. Interventions included daily and as needed COVID-19 screening, assist Resident #34 with application of face mask as needed, and assist Resident #34 with hand hygiene as needed. Observation on 8/26/25 at 11:57 AM in the Park area (central common area near nursing station) identified Resident #34 was sitting in a chair with his/her eyes closed, not wearing a face mask while Resident #1, a COVID positive (+) resident, sat in a recliner eating lunch with his/her face mask pulled under his/her chin while he/she ate. There were 2 floor tiles of space (each tile measured 18 inches by 18 inches) noted on the floor between Resident #34's chair and Resident #1's recliner. Observation on 8/26/25 at 12:04 PM identified while waiting for Registered Nurse (RN) #1 to come to the Park area, Resident #34 opened his/her eyes, stood up, walked into his/her room, and laid down on top of his/her bed. Interview and observation with Registered Nurse (RN) #1 on 8/26/25 at 12:07 PM identified Resident #1 sitting in a recliner 2 floor tiles away from the chair that Resident #34 had just vacated. RN #1 observed the space between the chair and agreed it was approximately 3 feet. RN #1 identified it was difficult to maintain social distancing of 6 feet with dementia residents who did not realize the need for social distancing. RN #1 stated it was difficult when a resident wanted to sit down in a chair and a (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	COVID + resident was sitting nearby eating without a mask on. RN #1 identified a staff member should have redirected Resident #34 to sit in a location further away from Resident #1. RN #1 identified social distancing should be used with COVID-19 positive residents and Resident #34 should not have been sitting in that chair while Resident #1 was not wearing his/her mask over his/her nose and mouth. Observation on 8/26/25 at 12:10 PM identified, subsequent to surveyor inquiry, nursing staff approached Resident #1 and asked if he/she wanted to go back to his/her room to finish eating. Resident #1 declined and the nursing staff let him/her stay in the recliner eating. Observation on 8/26/25 at 12:47 PM identified, subsequent to surveyor inquiry, Resident #34 was observed sitting in the Park area, not wearing a mask, in the same chair as he/she previously sat in, the chair was noted to have been moved to a different location away from the recliner that Resident #1 sat in. There was greater than 6 feet of distance between Resident #34 and Resident #1 as they both sat in their chair/recliners. Review of Inservice Education titled: COVID-19 positive wanderers dated 8/27/25-8/29/25 identified subsequent to surveyor inquiry education was initiated for nursing staff that directed to ensure if a COVID-19 positive resident is a wanderer who does not adhere to the droplet/contact precautions, to redirect the resident to stay in their room as much as possible. The inservice directed if the resident will not stay in their room to encourage them to wear a mask. The inservice further directed to ensure residents are all socially distanced from other residents and to remove residents out of the area as able and encourage residents to wear a mask. 58 staff signatures (from all departments) were identified on the inservice sheet. Review of the Clinical Guide for Operations During COVID-19 Health Emergency policy directed, in part, face covering or mask (covering mouth and nose) should be worn in accordance with CDC guidance. The policy directed source control (use of mask to cover mouth and nose) was recommended for individuals with suspected or confirmed COVID-19 infection. The policy directed communal activities and dining may occur while adhering to the core principles (wearing a mask to cover mouth and nose when confirmed with COVID-19 infection). The policy directed staff members should be designated on all shifts to audit staff compliance with appropriate donning and doffing of personal protective equipment and social distancing during breaks and mealtimes. The policy further identified to take measures to limit crowding in communal spaces. Review of the Quick Reference Guide policy (used by facility staff to guide on key points of main policy) directed, in part, for dining follow outbreak measures, continue to allow those residents on unaffected units that are not symptomatic to attend, physically distance, and wear a face mask. 3.Resident #54's diagnoses included positive for covid-19, extended spectrum beta lactamase (ESBL) resistance, and dementia. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified that Resident #54 was cognitively intact and was dependent for bed mobility, transfers, bathing, personal hygiene and toilet use. Also, identifying Resident #54 was a set up assistant for eating. A nursing note dated 8/25/25 at 4:54 AM identified Resident #54 was placed on Covid isolation precautions. (continued on next page)

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	075379	A. Building B. Wing	08/29/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physician's order dated 8/25/25 directed to maintain droplet/contact precautions for Covid-19 positive every shift for 10 days. The Resident Care Plan (RCP) dated 8/25/25 identified that Resident #54 was confirmed Covid-19 positive with interventions that included to assist Resident #54 with the application of applying a face mask as indicated or needed, to maintain contact/droplet precautions, and perform vital signs as needed. On 8/25/25 at 9:30 AM, observation made outside of Resident #54's room identified that Nurse Aid (NA) #2 was in Resident #54's room, wearing only a blue surgical mask, and was observed emptying the garbage. Registered Nurse (RN) #1 was also in Resident #54's room, wearing only a blue surgical mask, and was assisting Resident #54's roomate with respiratory equipment. Transmission based precaution signage was posted outside the door of Resident #54's room which directed that isolation droplet/contact precautions were in place and that staff must wear gloves, a gown, N-95 mask (not a blue surgical mask), and eye protection upon entering the room. A cart containing isolation gowns and other personal protective equipment (PPE) was observed already in place outside of Resident's 54's room. An interview on 8/25/25 at 9:35 AM with RN #1 identified she was performing morning rounds and stated she was assisting the resident by the window and not Resident #54 by the door. Also, identifying Resident #54 was on Contact/Droplet Barrier Precautions and she should be wearing full PPE which includes a N-95 mask, gown, gloves, and googles. An interview with NA #2 identified she went into Resident #54's room without full PPE, googles, gown, gloves, and N-95 should have been worn. Also, identifying she knows the policy to gown up before going in and she just followed RN #1 into the room. Review of the Viral Respiratory Pathogen Guidance Policy dated January 2025 identified the policy provides guidance on preventing, detecting, and managing the spread of respiratory viruses such as Covid. The goal was to protect both residents and healthcare providers by implementing a comprehensive approach involving vaccination, testing, treatment, and effective infection prevention and control measures. Also, identified enforce standard precautions, including appropriate use of PPE, hand hygiene, respiratory hygiene/cough etiquette principles and environmental cleaning protocols. Review of the signage provided by the facility directs staff to wear a gown, N-95, gloves, and googles. 4. Interview with the Infection Preventionist (RN #1) on 8/25/25 at 9:50 AM identified the facility's current COVID-19 outbreak began with a Nurse Aide (NA) that worked on 8/15/25 who developed COVID-19 signs and symptoms that same day and then tested for COVID-19 positive on 8/16/25. RN #1 stated the NA did not notify the facility of his positive COVID-19 test until 8/19/25, but had not worked since 8/16/25. RN #1 identified once she was aware of the NA COVID-19 positive test they began outbreak testing. RN #1 identified there were currently 4 COVID-19 positive residents on the lower level units. Interview with RN #1 on 8/29/25 at 11:10 AM identified she did not have a mechanism for tracking COVID-19 testing of residents. RN #1 identified per policy, testing for residents was completed on days 1, 3, and 5 following identification of a COVID-19 positive staff member or resident and declaration of an outbreak. RN #1 identified she did not have a spreadsheet or written documentation which tracked testing of residents and included at minimum, the name of the resident, location of (continued on next page)

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	075379	A. Building B. Wing	08/29/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident, date of test, and results of test. RN #1 stated that the orders for COVID-19 testing were in the computer and we know who's getting tested. RN #1 identified after the initial testing of residents on days 1, 3, and 5, the facility does testing of the residents on the affected unit every 3-5 days until there are 14 days with no new positive COVID-19 results. RN #1 stated there was not a physician order for as needed (PRN) testing for those tests done every 3-5 days, because the policy only directed for testing on days 1, 3, and 5, and so she was unable to put in orders to test beyond those 3 days. RN #1 identified that the tests were completed by the charge nurses on the units and wrote the test results next to the resident name on a census report sheet. RN #1 identified this information was only located on those sheets and was not placed into a formal spreadsheet or document for use in tracking of the tested residents. RN #1 identified once the initial testing on days 1, 3, and 5 was completed, the facility did not go back to days 1, 3, and 5 testing for subsequent positive COVID-19 test results, she stated that they would just continue to test every 3-5 days until 14 days of no new positives. RN #1 identified there were currently 4 positive residents and there were a total of 9 positive staff members with one recovered and back to work. RN #1 identified 5 out of the 9 positive staff members had worked on both floors but the facility did not continue to test residents on the upper floor after the initial days 1, 3, and 5 testing because that floor had not had residents that tested positive on days 1, 3, and 5 so they were not going to be tested again unless there was a cluster of residents with signs and symptoms of COVID-19. Review of a Detailed Census Report dated 8/28/29 identified 80 resident names listed. There were 48 resident names crossed off including 1 name that was out on a medical leave of absence (MLOA). There were 33 residents with documentation next to their name that indicated neg for the result of their COVID-19 test. There was 1 resident who's name was crossed off but there was documentation saying neg next to his/her name. There were 40 residents listed from the lower level but only 32 were tested, 4 were COVID-19 positive, and 1 was on a MLOA. This leaves 3 residents on the lower level that did not receive a COVID-19 test. Review of the Clinical Guide for Operations During COVID-19 Health Emergency policy directed, in part, facilities are required to test residents and staff based on nationally accepted standards, such as CDC recommendations. The policy directed testing of staff and residents during an outbreak investigation was initiated upon identification of a single new case of COVID-19 infection in any staff or residents. The policy directed upon identification of a new COVID-19 case in the facility, document the date the case was identified, the date that other residents and staff are tested, the dates that staff and residents who tested negative are retested, and the results of all tests. The policy directed facilities may document the conducting of tests in a variety of ways, such as a log of community risk factors, schedules of completed testing, and/or staff and resident records. The policy further directed for residents the facility must documents testing results in the medical record.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and facility policy for 1 of 2 sampled residents observed with medication at the bedside (Resident #50), the facility failed to ensure Resident #50 was assessed and had a physician order to self-administer medication. The findings include: Resident #50's diagnoses included chronic obstructive pulmonary disease (COPD).A physician's order dated 3/25/24 and currently in effect directed ProAir HFA (a bronchodilator used to treat asthma) aerosol solution 108 micrograms (mcg)/act 2 puffs inhaled orally every 6 hours for shortness of breath.The Resident Care Plan (RCP) dated 1/9/25 identified that Resident #50 had an altered respiratory status/difficulty breathing related to COPD. Interventions included administering medications per the physician's order and monitoring for effectiveness/side effects.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified that Resident #50 was cognitively intact and independent with bed mobility, transfers, and toileting.On 8/26/25 at 8:50 AM, observation of Resident #50's room, identified a ProAir inhaler was located on top Resident #50's nightstand, and not secured. Resident #50 was in the room and also had an ambulatory roommate. Resident #50 noted he/she kept the inhaler on the nightstand for his/her self-administration.An interview and record review (both electronic and paper versions) with Licensed Practical Nurse (LPN) #2 on 8/26/25 at 10:26 AM indicated that he/she was aware that Resident #50 kept his/her inhaler at the bedside. LPN #2 indicated that Resident #50's physician's order for his/her inhaler did not indicate self-administration or directions to keep the inhaler at his/her bedside. Further review failed to identify that Resident #50 was assessed to self-administer the inhaler. On 8/26/25 at 10:34 AM, subsequent to the surveyor's inquiry, Resident #50 was assessed for medication self-administration safely to keep his/her inhaler at the bedside. An interview with the Director of Nursing Services (DNS) on 8/26/25 at 10:40 AM indicated that she was made aware of Resident #50 having his/her inhaler at the bedside without the presence of a self-administration assessment or a physician order. The DNS indicated that the process for a resident to self-administer medications included a resident evaluation, a physician's order, the addition of self-administration to the resident's care plan, and the provision of a lockbox for the resident to store the medication at the bedside safely. The DNS indicated that for Resident #50, the process would be completed that day.Subsequent to the surveyor's inquiry on 8/26/25, a physician's order was obtained, which directed ProAir HFA Inhalation Aerosol Solution 108 mcg/act, 2 puffs inhaled orally every 6 hours for shortness of breath related to emphysema, and that Resident # 50 may keep at the bedside and self-administer.A physician order, dated 08/26/2025 at 4:00 PM, directed that for Resident #50, his/her ProAir HFA Inhalation Aerosol Solution 108 mcg/act, 2 puffs inhaled orally every 6 hours for shortness of breath related to emphysema, and that the Resident may keep at the bedside and self-administer. Review of the National Healthcare Associates, Clinical Services Self-Administration Policy, last revised October 2024, directed that to maintain the residents' right to maintain a high level of independence, residents who request to self-administer medications are permitted to do so if the center's self-evaluation had determined that the practice would be safe for the Resident and that there was a health care provider's order to self-administer medication(s)/treatments. The procedure listed, within this policy, included the need for a Self-Administration Evaluation completed by a licensed nurse to evaluate the Resident's safety and understanding of their medications, obtainment of an order from the Healthcare Provider for self-administration for the specific medication, instruction to the Resident in the process of storing medications safely including a locked box, and periodic review of the residents' ability to continue to self-administer over time.

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	075379	A. Building B. Wing	08/29/2025

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of clinical records, facility policy and interviews for 1 of 3 sampled residents reviewed for wounds, the facility failed to ensure Resident #46 was placed on the correct precautions to prevent Resident #46 from being confined to his/her room. The findings include: Resident #46's diagnoses included non-pressure chronic ulcer of right foot with unspecified severity and Type 2 diabetes. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #46 was cognitively intact and required moderate assistance of 1 staff member with activities of daily living.The Resident Care Plan (RCP) dated 7/22/25 identified Resident #46 was on Enhanced Barrier Precautions (EBP) for wounds and indwelling medical devices (intravenous catheter). Interventions included applying personal protective equipment (PPE) when providing high contact care activities.A physician's order dated 8/12/25 directed to apply Mupriocin external ointment (a topical antibiotic used to treat bacterial infections of the skin) to the right foot every shift and as needed to diabetic ulcers followed by collagen then border foam topical dressing, maintain EBP, non-weight bearing to lower extremities and light physical therapy (PT) on recumbent bike with limited pressure to forefoot or heel region. May transfer once a day with an ortho wedge shoe. A nursing note dated 8/13/25 written by the Infection Control Nurse (ICN) at 11:35 AM identified Resident #46 had a right foot wound culture report from 8/9/25 ruling out Carbapenem-resistant Enterobacterales (CRE) (an infection difficult to treat with antibiotics). Resident #46 was placed on isolation precautions pending findings by the ICN. Resident #46's RCP was updated on 8/15/25 regarding resistant bacterium but failed to reflect any updates regarding isolation precautions.In an interview with Resident #46 on 8/27/25 at 10:00 AM in his/her bedroom, Resident #46 stated he/she had just recently been removed from precautions that confined him/her to his/her bedroom. Resident #46 stated that he/she was informed that the culture to the foot did not show the infection and stated that he/she was made aware by nursing staff that the confinement to his/her room was not necessary anymore. Resident #46 also stated that he/she probably would have come out of the room during the time he/she was on isolation if he/she had been permitted to do so, and that he/she had not been able to go to the rehab gym for therapy. An interview with the ICN on 8/27/25 at 11:45 AM indicated that she placed Resident #46 on transmission based/isolation precautions for suspected CRE on 8/13/25. She indicated that the regional corporate nurse was on vacation and when she returned, she instructed her to change Resident #46 to EBP. The ICN indicated that Resident #46's drainage to the foot had always been contained with a dressing and stated that she had placed Resident #46 on isolation precautions, confinement to his/her room in error and removed the isolation precautions on 8/25/25 to EBP (12 days after initiating the isolation precautions).A review of an ICN note on 8/27/25 at 2:14 PM indicated that the right foot drainage specimen obtained from Resident #46's right foot on 8/6/25 was negative for CRE and the APRN, resident, and responsible party had been updated. An interview Physical Therapist (PT) #1 on 8/28/25 at 9:35 AM noted that Resident #46 was not permitted to have therapy in the gym from 8/13/25 through 8/25/25 and stated that Resident #46 had received therapy in his/her room. PT #1 indicated that Resident #46 was limited to his/her physical therapy due to non-weight bearing status to his/her feet and that most of his/her therapy was able to be performed in the bedroom even though Resident #46 had a physician's order for the use of the recumbent bike in the rehab gym with some limitations. An interview with the Medical Director on 8/28/25 at 10:00 AM revealed that Resident #46 was previously on isolation precautions and they were recently discontinued. He indicated that the facility follows their policy for infection precautions, and he was unsure why they had placed Resident #46 on isolation precautions for the suspected CRE if it did not follow the facility policy. An interview with the Regional Corporate Nurse and the DNS on 8/28/25 at 12:30 PM identified that it was not necessary for Resident #46 to be on isolation precautions. The (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075379	A. Building B. Wing	08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sharon Center for Health & Rehabilitation	27 Hospital Hill Road Sharon, CT 06069

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regional Corporate Nurse stated that the wound was contained so contact precautions would have been sufficient. The DNS indicated it was the responsibility of the ICN to ensure the correct precautions are put in place for residents and was unsure why she had put Resident #46 on isolation.A review of the Precautions to Prevent Infections policy dated June 2024 directed, in part, EBP which falls between Standard and Contact Precautions, and require the use of gown and gloves for certain residents during specific high contact resident care. Gown and gloves would be required for resident care activities for pan-resistant organisms and Carbapenemasse-producing Enterobacteriaceae. Residents are not restricted to their rooms or limited from participation in group activities. In general, isolated activities that are not otherwise bundled with other high contact care activities would not necessitate use of gown and gloves.

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	075379	A. Building B. Wing	08/29/2025

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and facility policy for 1 of 2 sampled residents (Resident #48) observed with medication at the bedside, the facility failed to ensure licensed staff followed standards of practice for medication administration and remained with the resident until medication was consumed. The findings include: Resident #48 was admitted to the facility on [DATE] with diagnoses that included congestive heart failure, hypertension, and atrial fibrillation. A physician's order date 8/14/25 directed to administer Metoprolol Tartrate 12.5 mg (milligrams) two times a day for blood pressure, Spironolactone 25 mg once a day for heart failure, Isosorbide Mononitrate ER (extended release) 30 mg one a day for blood pressure, Lorestan Potassium 25 mg two times a day for blood pressure and Aspirin 81 mg in the morning for surgical aftercare.A Resident Care Plan dated 8/17/25 did not reflect that Resident #48 may self-administer medication and/or had been assessed for self-administration of medications.The 5-day admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #48 was cognitively intact, required set-up/supervision for activities of daily living and was able to eat independently. Observation on 8/26/25 at 8:30 AM identified Resident #48 had pills in a medication cup located on his/her beside table without the presence of the nurse. Resident #48 stated he/she took the medications without the nurse present all the time and indicated that he/she was able to do so independently. An interview with Licensed Practical Nurse (LPN) #1 on 8/26/25 at 8:50 AM indicated that she had left the medications with Resident #48 and was aware that she should not have left the medications with the resident. LPN #1 stated that she had worked on the unit before and was aware that Resident #48 liked to take his/her medications independently. An interview with the DNS on 8/26/25 at 9:15 AM indicated that LPN #1 had spoken to her after the incident and was aware that medications were left with Resident #48. In addition, the DNS stated that the medications should not been left at the bedside, and it was the charge nurse's responsibility not to leave the medications with the resident. According to the 2025 Joint Commission, medication management, when giving medication to patients, it is crucial to stay with the patient to ensure safe administration. Leaving pills at the bedside or not being present during medication administration can lead to potential hazards such as choking, hoarding or other adverse outcomes.

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	075379	A. Building B. Wing	08/29/2025

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility policy and interviews for 1 of 3 residents (Resident #10) reviewed for pressure ulcer/injury, the facility failed to obtain a timely nutritional evaluation for a resident with a new and worsening wound. The findings include: Resident #10 had diagnoses that included epilepsy (seizure disorder), dementia, and leukoencephalopathy (brain disease that damages the white matter which is responsible for communication between different brain regions).The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #10 was moderately cognitively impaired, at risk for developing pressure ulcer/injury, and was dependent for eating, bed mobility, and transfers.A physician order dated 4/1/25 directed to provide Thrive ice cream (protein rich ice cream) 2 times a day with lunch and dinner for weight loss related to variable oral intake.A Nutritional Evaluation written by Dietician #1 on 4/1/25 at 1:40 PM identified Resident #10 met 51 percent (%) to75% of his/her estimated dietary intake needs with his/her average amount of oral intake between 25-100%. The evaluation identified Resident #10 had a 7%/12 pounds (lbs.) significant weight loss in 30 days (weight 228.4 pounds (lbs.) on 3/1/25 and weight 216.4 lbs. on 4/1/25). The evaluation identified Resident #10 was at risk for malnutrition related to a non-pressure wound, mechanically altered diet, dementia, and cholecystectomy. The evaluation further identified Resident #10 was started on the Thrive ice cream at lunch and dinner related to his/her significant weight loss and oral intake.The Resident Care Plan (RCP) dated 4/8/25 identified Resident #10 was at risk for impaired nutrition. Interventions included to provide diet per physician orders with Thrive ice cream with lunch and dinner and provide feeding/dining assistance as needed. The RCP identified Resident #10 had potential for skin breakdown due to decreased mobility and history of adult failure to thrive. Interventions included to obtain a dietician evaluation and interventions as needed and provide supplements and/or vitamins as ordered. The RCP further identified Resident #10 had an actual alteration in skin integrity related to surgical incisions from a cholecystectomy. Interventions included to updated the physician with changes as needed and obtain weekly wound evaluations until healed.A Skin & Wound Evaluation by Licensed Practical Nurse (LPN) #3 on 4/19/25 at 7:41 PM identified Resident #10 had a facility acquired wound to the medial, middle, inferior, sacrum that measured 2.8 centimeters (cm) length by 1.1 cm width by not applicable (NA) depth. The evaluation failed to identify the practitioner, responsible party, or dietician had been notified.A Skin & Wound Evaluation by Registered Nurse (RN) #1 on 4/25/25 at 8:31 AM identified Resident #10 had a facility acquired Stage 2 pressure ulcer to the medial, middle, inferior, sacrum first observed on 4/19/25 that measured 2.8 cm X 1.3 cm X 0.1 cm). The evaluation identified the practitioner was notified and indicated the Medical Doctor (MD) #1 and Resident #10's representative was notified. The evaluation identified the dietician was notified.A wound progress note written by Advanced Practice Registered Nurse (APRN) #1 on 4/25/25 (6 days after the pressure ulcer was identified) at 8:52 AM identified she had seen Resident #10 for consultation for management of a new Stage 2 pressure injury to the sacrum. The note identified the wound measured 2.8 centimeters (cm) long by 1.3 cm wide by 0.1 cm deep and had 100% epithelial tissue to the wound base. The note identified the treatment for the pressure injury was to cleanse the wound followed by apply calcium alginate (highly absorbent topical wound dressing) to the base of the wound followed by cover with a dry clean dressing and change daily and/or as needed. The note further identified wound recommendations to optimize nutrition with a registered dietician consultation.A wound progress note written by APRN #1 on 5/2/25 at 8:02 AM identified she had seen Resident #10 for consultation for management of Resident #10's pressure injury to the sacrum. The note identified the pressure injury had worsened and was a Stage 3 pressure injury that measured 4.1 cm X 1.6 cm X 0.3 cm and the wound base was 75% granulated tissue and 25 % slough (dead tissue). The note further identified wound recommendations to optimize nutrition with a registered dietician consultation.Review of nursing notes and nutritional/dietary (continued on next page)

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	075379	A. Building B. Wing	08/29/2025

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	evaluations from 4/25/25 through 5/22/25 failed to identify Resident #10 was evaluated by a Dietician per APRN's recommendation on 4/25/25.A Nutritional Evaluation by Dietician #1 on 5/23/25 (30 days after the APRN's recommendation) at 2:01 PM identified Resident #10 had a significant change. The evaluation identified Resident #10 had a food intervention of Thrive ice cream 2 times a day with lunch and dinner. The evaluation identified Resident #10 met 51-75% of his/her estimated dietary intake needs with his/her average amount of oral intake at 74% of meals in the past 2 weeks. The evaluation identified Resident #10 was at risk for malnutrition related to a pressure injury, mechanically altered diet, dementia, and a cholecystectomy. The evaluation identified Resident #10 had a new pressure injury, significant weight loss and tolerated the Thrive ice cream 2 times a day with lunch and dinner with mostly 100% intake of the ice cream. The evaluation further identified Dietician #1 added to provide Ensure Plus inside Resident #10's honey thick liquids daily at breakfast, and to administer liquid protein supplement once daily.A physician order dated 5/23/25 directed to administer Ensure Plus once daily with breakfast and liquid protein supplement once daily inside honey thick liquids.A wound progress note written by APRN #1 on 5/25/25 at 9:45 PM identified she had seen Resident #10 for consultation for management of Resident #10's pressure injury to the sacrum. The note identified the pressure injury had worsened and was unstageable and measured 3.9 cm X 3.0 cm X 0.1 cm and the wound base was 100% slough.An interview with Dietician #1 on 8/28/25 at 1:54 PM identified she followed up weekly for residents with weight loss and attended the weekly risk meetings which reviewed residents with weight loss and pressure injuries. Dietician #1 identified RN #1 sent her a wound report every week via email, would review the report and adjust residents supplements as needed. Dietician #1 identified when she worked she put in wound notes weekly for new or worsening wounds, but she did not put weekly notes in for stable wounds. Dietician #1 identified she had been on vacation and also was ill from the beginning of April 2025 through the end of May 2025 and she had not been working at the time Resident #10's pressure injury was first identified. Dietician #1 identified she did not know who covered for her while she was away but identified upon her return to work at the end of May 2025 had evaluated Resident #10 on 5/23/25 and had added the Ensure and liquid protein supplements for added nutritional supplements due to Resident #10's pressure injury. Dietician #1 further identified the nursing staff could have initiated supplements for Resident #10 to address his/her new pressure injury and the nursing staff did not have to wait for her to put in dietary/supplement orders.An interview with APRN #1 on 8/29/25 at 10:51 AM identified she had seen Resident #10 on 4/25/25 for a new stage 2 pressure injury to the sacrum. APRN #1 identified she had seen Resident #10 on 5/2/25 and the pressure injury to the sacrum had worsened to a Stage 3 pressure injury. APRN #1 identified she had seen Resident #10 again on 5/23/25 and the sacral wound was unstageable and had worsened. APRN #1 identified immobility, nutrition, and resident refusals of care contributed to worsening of a wound. APRN #1 identified she recommended to optimize nutrition in her wound notes. APRN #1 further identified protein was good for wound healing and if a resident was not eating well and was nutritionally challenged he/she should be referred by the nursing staff to the dietician for a nutritional evaluation.An interview with Director of Nursing Services (DNS) on 8/29/25 at 12:10 PM identified per policy the dietician was notified of pressure ulcers which typically occurred at the weekly risk meetings. The DNS identified when Dietician #1 was on vacation or ill for an extended period she would have someone cover for her remotely. The DNS identified the covering dietician should be notified of new or worsening pressure ulcers. The DNS identified Resident #10 should have had a nutritional evaluation after identification of his/her pressure injury on 4/19/25 and before Dietician #1's evaluation on 5/23/25. The DNS was unaware who covered for Dietician #1 while she away the beginning April 2025 through the end of May 2025.Although requested the name of the covering dietician for April 2025 through May 2025 during the time of absence of Dietician #1 was not provided.Review of the Pressure Injury Nutritional Protocols policy directed, in part, a nutritional assessment was required for residents with pressure injuries. The policy directed if the resident was (continued on next page)

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	075379	A. Building B. Wing	08/29/2025

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	unable to consume adequate calorie and/or protein needs via meals/snacks, consider the addition of high-calorie, high-protein fortified foods and/or nutritional supplements. The policy further directed for stage 2 or greater pressure injuries to provide high-calorie, high-protein, arginine, zinc, and antioxidant oral nutritional supplements.

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	075379	A. Building B. Wing	08/29/2025

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Top of FormBased on observations, clinical record review, review of facility documentation, review of facility policy and interviews for the only sampled resident reviewed for respiratory care (Resident #85), the facility failed to follow a physician's order for oxygen administration and failed to ensure oxygen was administered to a resident on continuous oxygen with a diagnoses of chronic obstructive pulmonary disease (COPD). The findings include: Top of FormResident #85's diagnoses included COPD, dependence on supplemental oxygen (O2), and shortness of breath (SOB). The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #85 was cognitively intact and required substantial/maximal assistance with bed mobility and full assistance with toileting and transfers. The MDS also indicated Resident #85 had a diagnosis of COPD and was dependent on supplemental O2. A Resident Care Plan (RCP) dated 6/27/25 identified Resident #85 had the potential for alteration in respiratory status related to shortness of breath and COPD. Interventions included to provide O2 via nasal cannula at 1 liter and to monitor the resident for increased coughing, wheezing and SOB. Physician's orders dated 7/17/25 directed O2 at 1 liter (L) per minute every shift for SOB related to COPD and to call the physician (MD) if oxygen saturation (O2 sat) was below 90%. A physician's progress note dated 7/31/25 at 2:57 PM identified Resident #85 had an episode of hypoxia with an O2 saturation (sat) of 88 percent (%), the resident's condition was guarded. Nursing progress notes dated 8/2/25 at 3:55 PM and 8/7/25 at 2:02 PM noted Resident #65 had a suspected respiratory infection and was being administered O2 at 2 L (despite physician orders dated 7/17/25 directing O2 at 1 L per minute). An observation on 8/25/25 at 11:57 AM noted Resident #85 in bed with an oxygen concentrator at the bedside set at 2 L (despite physician orders dated 7/17/25 directing O2 at 1 L per minute). The oxygen nasal cannula was sitting to the side of the resident's nares (nasal openings) and he/she was able to put the nasal cannula back in place when asked to. Review of the Nurse Aid care card in Resident #85's room on 8/27/25 directed Oxygen Settings: O2 via nasal cannula at 1 L. Review of Resident #85's Treatment Administration Record for August 2025 on 8/27/25 directed O2 at 1 L every shift and to contact the MD if the O2 sat was below 90 %. Observation on 8/27/25 at 12:55 PM noted Resident #85 in bed without the benefit of O2 via nasal cannula in place. The O2 tubing was found disconnected from the oxygen concentrator and coiled up and sitting on top of the O2 concentrator, which was out of reach of the resident. The oxygen concentrator was operating, was set at 2 L (despite physician orders dated 7/17/25 directing O2 at 1 L per minute), was to the far right of the resident and placed against the wall behind the resident. Resident #85 was unable to indicate how oxygen ended up off of him/her and out of reach or for how long it had been that way. Observation and interview with Registered Nurse (RN) #3 on 8/27/25 at 12:57 PM identified she was not aware Resident #85 did not have O2 on/in place or that it was out of reach of the resident. RN #3 indicated she was last in the resident's room around 10:00 AM during medication pass. RN #3 proceeded to reconnect the O2 tubing to the oxygen concentrator and placed the O2 on the resident via nasal cannula at 2 L. An O2 saturation reading taken on room air was 82% and it increased to 94% after the O2 was placed back on the resident. RN #3 identified she was unsure how the oxygen tubing had ended up behind and out of reach of the resident and indicated the resident required continuous oxygen. RN #3 further identified although Resident #85 sometimes removed the nasal cannula from his/her nares, the resident would not have been able to physically place the O2 tubing how it was found (disconnected, out of reach, and behind the resident) because he/she was unable to move around a lot. Interview and observation with Nurse Aide (NA) #3 on 8/27/25 at 12:57 PM identified she was assigned to Resident #85 and was last in the resident's room around 11:15 AM when she provided incontinent care to the resident. NA #3 was unsure how the oxygen tubing ended up behind and out of reach of the resident but indicated the resident required continuous oxygen. NA #3 further identified that although Resident #85 sometimes removed the nasal cannula from his/her (continued on next page)

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	075379	A. Building B. Wing	08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nares, the resident would not have been able to physically place the O2 tubing how it was found (disconnected, out of reach, and behind the resident) because he/she was unable to move around a lot. An additional interview and review of the clinical record with RN #3 on 8/27/25 at 1:38 PM identified she had reviewed Resident #85's oxygen orders and noted the resident was supposed to be placed on O2 at 1 L (not 2 L) and she had made a mistake. RN #3 indicated Resident #85's medical doctor (MD) was very particular and did not want the resident's O2 to go above 1 L. She was unsure why the O2 concentrator had been set at 2 L or for how long it was like that. RN #3 identified Resident #85's MD was called to notify him of the resident's hypoxia (low O2 sat) due to a lack of oxygen administration and the incorrect setting of the oxygen concentrator and she was awaiting a call back. RN #3 further indicated although Resident #85 was often cyanotic (lacking oxygen) with his/her lips appearing bluish at times, he/she was receiving O2 at 1 L with an oxygen saturation of 91% at this time. A nursing progress note dated 8/27/25 at 2:03 PM identified Resident #85 was observed without O2 in place via NC and the oxygen tubing was found on top of the oxygen concentrator machine. The progress note indicated Resident #85's O2 sat was 82% on room air and O2 at 2 L was administered via NC with an increase in the O2 sat to 91-93% noted. The progress note further identified the residents O2 was lowered to 1 L with an O2 sat of 92% and a call was placed to the MD. A nursing progress note dated 8/27/25 at 2:31 PM identified RN # 3 had received a call back from the physician and he was notified of the resident's hypoxia due to a lack of oxygen administration and the incorrect setting of the resident's oxygen concentrator. Subsequent to surveyor inquiry, a physician's order was obtained on 8/27/25 which directed DO NOT increase O2 via NC (nasal cannula) past 1L (liter) under any circumstance. Interview with the DNS on 8/28/25 at 12:45 PM identified Resident #85 should have had his oxygen in place and the nursing staff should have been checking the resident regularly and on rounds. The DNS indicated Resident #85's oxygen tubing should not have been disconnected from the concentrator and out of reach of the resident because the resident would become hypoxic if he/she did not have continuous oxygen on. The DNS identified that although Resident #85 would sometimes remove the oxygen tubing from his/her nares, the resident would not have been able to place it out of reach or disconnect it from the concentrator and it was up to the nursing staff to monitor and check on the resident more frequently. The DNS further indicated Resident #85 should have been on the correct O2 setting of 1L and not 2L before and after oxygen need to be put back on the resident and RN #3 should have reviewed the oxygen order first. Review of the facility policy, Oxygen Therapy, undated, directed to verify the physicians order to determine liter flow and type of O2 delivery device, adjust the O2 flow meter to the prescribed flow and to [NAME] the flow of O2 at the patient end of the delivery device. The policy further directed for COPD patients, that every patient needed to be assessed individually to determine their own oxygen requirement.

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	075379	A. Building B. Wing	08/29/2025

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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 personnel files and staff interviews for 3 of 3 employee files reviewed (Nurse Aide (NA) #4, NA #5, and NA #6), the facility failed to ensure the required annual performance evaluations were completed. The findings include:: 1. NA #4's date of hire was 8/27/13. The last performance evaluation identified in the employee's personnel file was dated 10/20/20. Although requested, the facility could not provide an updated annual evaluation for NA #4 for 2021 and 2022. Additional review with human resources identified that no additional evaluations were available. Upon review of NA #4's record with the DNS, she identified that this NA was now a Licensed Practical Nurse (LPN) as of 2022. Additionally, there were no employee yearly evaluations for 2023, 2024, and 2025. Review of the facility time clock documentation for August 2025 for NA #4/LPN identified she currently works in the facility (on 8/6/25, 8/7/25, 8/9/25, 8/10/25, 8/13/25, 8/14/25, 8/15/25, 8/20/25, 8/21/25, 8/23/25, 8/24/25, 8/27/25, and 8/28/25). 2. NA #5's date of hire was 11/30/09. The last yearly performance evaluation in the employee's personnel file was dated 5/5/23. Although requested, the facility could not provide any additional annual evaluations for NA #5 for 2024 or 2025. Review of the facility time punch documentation for August 2025 for NA #5 identified that she currently works in the facility (on 8/3/25, 8/4/25, 8/5/25, 8/11/25, 8/18/25, 8/19/25, 8/25/25, 8/26/25, and was scheduled for 8/30/25). 3. NA #6's date of hire was 6/22/23. There were no yearly performance evaluations available in the personnel file for NA #6. Although requested, the facility could not provide any annual evaluations for NA #6. Review of the facility time punch documentation for August 2025 for NA #5 identified she currently works in the facility (on 8/6/25, 8/7/25, 8/8/25, 8/6/25, 8/11/25, 8/12/25, 8/14/25, 8/15/25, 8/16/25, 8/17/25, 8/19/25, 8/20/25, 8/21/25, 8/22/25, 8/23/25, 8/24/25, 8/25/25, 8/26/25, 8/28/25, and 8/29/25). An interview and review of facility documentation with the Director of Human Resources on 8/29/25 at 12:27 PM identified that performance evaluations should be in the employee's personnel file, and that she was aware that evaluations had fallen behind under the prior facility owner, that a new form was implemented for evaluations under the new facility owner, and that evaluations were being caught up currently, but were still not up to date for all employees. Additional interviews with the Facility Administrator on 8/29/25 at 12:58 PM identified that performance evaluations would be in the employee's personnel file and that he was aware that the evaluations had not been completed for all employees since the change in ownership. The Administrator further identified that evaluations were triggered for department head completion by HR, that he would expect completion annually, and that these were potentially missed during the transition of ownership. An interview with the DNS on 8/29/25 at 13:00 PM indicated that human resources (HR) would have tracked and informed her when the performance evaluations were due, and it would have been her responsibility to get them completed, either by herself or a designee, for NA#4, NA #5, and NA #6. She further identified that she would expect that evaluations were completed annually for all staff. Although requested, a facility policy on performance evaluations was not available.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075379	A. Building B. Wing	08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sharon Center for Health & Rehabilitation	27 Hospital Hill Road Sharon, CT 06069

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 0755 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observations, interviews, review of controlled substance (narcotic) records, and facility policy, the facility failed to ensure the completion of the controlled medication count by licensed staff. The findings include: An interview and review of the 1st floor narcotic logbook located on the medication cart with the Nursing Supervisor/Registered Nurse (RN) #2 on 8/27/25 at 9:30 AM, noted 8 out of 78 missing signatures on the Narcotic Change of Shift Audit for August 2025. RN #2 identified signatures should have been completed by two nurses at each shift change for confirmation and reconciliation of the count of narcotics available in the medication cart.An interview and review of the 2nd floor narcotic logbook, located on the medication cart, with the Director of Nursing Services (DNS) on 8/28/25 at 12:20 PM, identified that the narcotic logbook was missing 7 out of 82 expected signatures on the Narcotic Change of Shift Audit for August 2025. The DNS indicated these signatures should be completed by two nurses at each shift change for confirmation and reconciliation of the count of narcotics available.An 8/28/25 review of the Clinical Services: Bi-Monthly Narcotic Drug Audit Forms with the DNS at 12:30 PM indicated that numerous audits identified under the item reviewed 'All change of shift narcotic count sheets are signed (no empty spaces)' that this item was not met month-over-month and documented as not met as far back as January 2025.An 8/28/25 review of the Clinical Services: Bi-Monthly Narcotic Drug Audit Forms for the prior six months, identified that in 2025: 9 of 9 audits conducted in March 2025, 2 of 11 audits conducted in April 2025, 8 of 10 audits conducted in May 2025, and 4 of 4 conducted in August 2025 indicated that there were empty spaces on the Narcotic Change of Shift Audit sheets, where a nursing signature should have been.On 8/29/25 at 11:32 AM, a review and interview with the DNS of the Narcotic Change of Shift Audit logs from March 2025 through August 2025 identified that: in March 2025, the upper level South Narcotic Change of Shift Audit log was missing no signatures, the upper level [NAME] Narcotic Change of Shift Audit log was missing 5 of 93 signatures, the lower level South Narcotic Change of Shift Audit log was missing 7 of 93 signatures, and the lower level [NAME] Narcotic Change of Shift Audit log was missing 8 of 93 signatures; in April 2025, the upper level South Narcotic Change of Shift Audit log was missing 1 of 90 signatures, the upper level [NAME] Narcotic Change of Shift Audit log was missing 4 of 90 signatures, lower level [NAME] Narcotic Change of Shift Audit log was missing 3 of 90 signatures, and the lower level South Narcotic Change of Shift Audit log was missing 13 of 90 signatures; in May 2025, the upper level South Narcotic Change of Shift Audit log was missing 3 of 93 signatures, the upper level [NAME] Narcotic Change of Shift Audit log was missing 6 of 93 signatures, lower level [NAME] Narcotic Change of Shift Audit log was missing 14 of 93 signatures, and the lower level South Narcotic Change of Shift Audit log was missing 13 of 93 signatures; in June 2025, lower level [NAME] Narcotic Change of Shift Audit log was missing 11 of 93 signatures and the lower level South Narcotic Change of Shift Audit log was missing 12 of 93 signatures; in July 2025, the upper level South Narcotic Change of Shift Audit log was missing 8 of 93 signatures, the upper level [NAME] Narcotic Change of Shift Audit log was missing 15 of 93 signatures, lower level [NAME] Narcotic Change of Shift Audit log was missing 6 of 93 signatures, and the lower level South Narcotic Change of Shift Audit log was missing 15 of 93 signatures; in August 2025, the upper level South Narcotic Change of Shift Audit log was missing 8 of 83 signatures and the lower level South Narcotic Change of Shift Audit log was missing 8 of 83 signatures.An interview on 8/29/25 at 11:32 AM with the DNS and the Regional Director of Clinical Operations (RN #4) revealed that clinical staff received orientation about the proper completion of Narcotic Change of Shift Audit logs during their clinical orientation, and that the expectation was that staff provide peer-to-peer review of this practice at each shift change, as needed. Additionally, the DNS and RN #4 identified that two nurses, the nurse coming onto the shift and the nurse leaving from the prior shift, were responsible for completing their signatures on the Narcotic Change of Shift Audit form documenting a dual count of (continued on next page)

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F 0755 Level of Harm - Potential for minimal harm Residents Affected - Some	the narcotics available at each medication cart; that a review of these documents for completion was the responsibility of the DNS, however this was delegated to any registered nurse as needed and that these reviews were completed no less than twice per month. The DNS and RN #4 indicated that when a gap in documentation completion was identified, the nurse responsible would be contacted to complete the task in real-time, whenever possible, or at home if they were not present at the time of identification. The DNS and RN #4 indicated that when the same nurse was not completing the required signatures, the pattern would be discussed during Quality Assurance and Performance Improvement Committee (QAPI) meetings to identify and correct the root cause, up to and including re-education of the individual, monitoring of completion efforts, and progressive discipline when necessary.Although requested, a facility policy on documentation of narcotic counts at change of shift on the Narcotic Change of Shift Audit was not available. RN #4 indicated that this process is part of nurses' clinical orientation training.