STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075382	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodlake at Tolland	26 Shenipsit Lake Road Tolland, CT 06084

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **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 one of two sampled residents (Resident #94) reviewed for skin condition (skin tears), the facility failed to ensure Geri-sleeves were implemented to prevent recurrence of skin tears and for one sampled resident (Residents #54) with wandering and exit seeking behaviors, the facility failed to ensure the care plan addressed the resident's exit seeking and wandering behaviors. The findings include: Resident #94 had diagnoses that included dementia and anemia. The annual MDS assessment dated [DATE] identified Resident #94 had severe cognitive impairment and required total assistance with personal hygiene and dressing. The assessment further identified Resident #94 did not have the presence of skin tears. The accident and incident report dated 10/7/25 at 8:00 AM identified Resident #94 was noted with a skin tear to the left hand that measured 0.6 centimeters (cm) in length by 0.8 cm in width with no active bleeding. The note further noted Resident #94 self-propelled in the wheelchair, was combative at times, and had fragile and thin skin. Additionally, the APRN and family were notified, and Geri-sleeves were added to the resident's plan of care to protect the resident's skin. The Resident Care Plan (RCP) dated 10/7/25 identified Resident #94 sustained a skin tear on 10/7/25. Care plan interventions included assess resident for pain and/or discomfort, obtain treatment, monitor for signs and symptoms of infection, and re-approach resident when combative during care. Although, the accident and incident report noted the intervention of Geri-sleeves, the care plan was not updated to reflect the use of Geri-sleeves. The nurse's note dated 10/25/25 at 11:38 AM identified Resident #94 became combative during morning care, started swinging his arms and hit his/her right hand on the side rail resulting in a skin tear that measured 1.5 cm in length and 0.5 cm in width with a scant amount of serosanguineous drainage. The nurse's note dated 1/8/26 at 8:41AM identified Resident #94 became combative during care and hit his/her left forearm on the side rail that resulted in a skin tear that measured 1.8 cm in length. The care plan for skin tears dated 1/8/26 identified that the intervention for the application of Geri-sleeves to the bilateral upper extremities was not added to the care plan until 1/8/26 after the resident sustained a third skin tear. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations on 2/4/26 at 11:00 AM and 2/10/26 at 9:55 AM identified Resident #94 lying in bed, wearing a hospital gown without the Geri-sleeves in place and not found in the bed. Interview with NA #3 on 2/10/26 at 11:25 AM identified Resident #94 required assistance for dressing and personal hygiene. She identified Resident #94 can become combative when he/she is not ready to get up in the morning. She further identified Resident #94 is supposed to have Geri-sleeves applied to the upper extremities at all time that can be removed for care. After surveyor inquiry NA #3 found one Geri-sleeve in the bedside drawer. She further identified that Resident #94 was on her assignment, but she had not provided morning care because they had extra help and another nursing aide provided the morning care. Interview with the DNS on 2/11/26 at 9:50 AM identified that the charge nurses are responsible for updating the resident care plan after an incident of skin tears. He identified that Resident #94 had a skin tear on 10/7/25 and the nursing intervention was to wear Geri-sleeves at all time to prevent further skin tears. He identified that Resident #94 should be wearing the Geri-sleeves to the bilateral upper extremities at all times and only removed for care. He could not provide a reason why the care plan was not implemented on 10/7/25 when the accident and incident report indicated that Geri-sleeves were added to the resident care plan. The Care Plans policy identified that the interdisciplinary care plan would be developed to maintain resident optimal status to each resident. The RCP would identify for the care and services required and the date of the expected achievement of the goals. Resident #54 was admitted to the facility in August of 2025 with diagnoses that included anemia, chronic kidney disease and dementia. The quarterly MDS assessment dated [DATE] identified Resident #54 had moderately impaired cognition, required maximal assistance with toileting hygiene, personal hygiene, could self-propel in the wheelchair, required moderate assistance with transfers and bed mobility. The assessment further identified Resident #54 was ambulatory with supervision. Review of the Psychiatry evaluation and progress note dated 1/5/26 identified Resident #54 was seen by the provider for a follow-up for increased behaviors. The note further identified staff reports that Resident #54 had increased periods of confusion, yelling, exit seeking, refusing care, and was not always redirectable. The note further identified Resident#54 had an order for Trazodone (anti-depressant medication) as needed and to continue with current medication and monitoring. Review of the Psychiatry evaluation and progress note dated 1/26/26 identified Resident #54 was seen by the provider for a follow-up for increased behaviors. The note further identified staff reported that Resident #54 had increased periods of confusion, yelling, exit seeking and refusing care, and was not always redirectable. The note further identified that Trazadone (medication) was effective and the order for Trazadone was renewed. Review of the Psychiatry evaluation and progress note dated 1/29/26 identified Resident #54 was seen by the provider for a follow-up on increased behaviors. The note identified staff reported that Resident #54 had increased periods of confusion, yelling, exit seeking and refusing care, and were not always redirectable. The staff also reports resident is up during the night with increased behaviors (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and the provider will increase the Trazadone dosing at bedtime to 50 milligrams (mg). The nurse's progress note dated 1/29/26 at 11:40 PM identified Resident #54 was confused and wandered into other residents' room and was redirected several times. The nurse's progress note dated 2/1/26 at 12:06 AM identified resident wandered on the unit and was assisted to bed at around 10:00 PM. The nurse worked on 1/31/26 but charted at midnight, hence this occurred on 1/31/26. The nurse's progress note dated 2/1/26 at 10:00 PM written by RN #5 identified Resident was agitated for most of the shift, going from room to room and was found in the kitchen on the unit by dietary. The note further identified Resident #54 attempted to open the door to the stairs and was redirected several times. The resident then managed to pull the fire alarm at 8:15 PM and the fire department responded. Resident #54 was assisted to bed and provided with 9:00 PM medications. The note further indicated that the resident's responsible party was notified regarding the incident. Review of the Psychiatric evaluation and progress note dated 2/2/26 identified Resident #54 was alert, oriented and somewhat irritable and staff reports that Resident #54 had increased periods of confusion, yelling, exit seeking and refusing care, and were not always redirectable. The note further identified Resident #54 has a physician's order to administer Trazadone medication as needed and the medication was used for 2 months and reports to be effective, and the at bedtime dose was recently increase. The notes further dictate to continue to monitor Resident #54. Review of the clinical record from November 2025 to February 2, 2026, failed to reflect that an elopement risk assessment was completed nor any interventions implemented for the resident's wandering and exit seeking behavior as identified in the nurse's progress notes and the psychiatry evaluation and progress notes. Review of Resident #54's care plan dated 1/26/26 identified Resident #54 exhibits and is at risk for exhibiting non-compliance with the treatment plan as evidenced by refusing care, non-compliant with transfer status with interventions that included reapproach resident, monitor behaviors and determine the underlining cause and divert attention. However, the care plan failed to reflect a risk for elopement/wandering and exit seeking behaviors with the appropriate interventions that were individualized to the resident such as elopement risk assessment and the placement of a wander guard device. Interview with the Care Plan Coordinator (LPN #4) on 2/11/26 at 12:30 PM identified he was responsible for updating and revising the residents who reside on the long-term care unit plan of care. He identified that he was aware of the resident's exit seeking behavior, wandering and pulling of the fire alarm, however he did not update the resident's care plan and implement the appropriate interventions. He identified at the time of the incident when the resident exhibited the wandering behaviors and exit seeking the supervisor on the 3-11 PM shift should have updated the care plan so that it would be reviewed by the ADNS and himself and then discussed in the morning meeting. Interview with the DNS on 2/11/26 at 10:25 AM identified at the time of the incident involving the pulling of the fire alarm, wandering on the unit and exit seeking the resident's care plan should have been updated with the appropriate interventions implemented. Review of the Care Plans policy identifies the interdisciplinary care plan would be developed to (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	maintain resident's optimal status to each resident. The RCP would identify for the care and services required and the date of the expected achievement of the goals. The policy further identifies the care plan can also be revised as needed at any time on an interim basis and will address the residents' needs on an individualized basis.

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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 observations, review of clinical record, review of facility documentation, review of facility policy/procedures and interviews for one sampled resident (Resident #116) observed with medication at the bedside, the facility failed to ensure that medications were not left at the resident's bedside for a resident who is without an order or assessment for self-administration of medication and the nursing supervisor (RN #3) observed sleeping on shift in view of the resident unit. The findings include:. The findings include: Observation on 2/10/26 at 4:55 AM identified RN #3 (Nursing Supervisor) in the supervisor's office on the 1st floor seated in a chair with his head bent down to his chest with his eyes closed. The office has two walls that are windows, and a door with windows, so that people outside of the office can see into the office. The lights were off and the door was slightly ajar. The laundry staff person (Laundry #1) pushed the door open and entered the room. Laundry Staff #1 called RN #3's name twice and announced the state was there. At that time, RN #3 opened his eyes and lifted his head to look at the Surveyor. Laundry Staff #1 left the office and RN #3 stood up and rubbed his eyes at which time the Surveyor requested a staffing schedule for the night shift and asked if he had a busy night and his reply was inaudibly mumbled and then he indicated he was resting his eyes. Interview with RN #10 on 2/10/26 at 5:10 AM identified she was responsible for the rehabilitation unit on the overnight shift and indicated RN #3 was the RN supervisor. Interview with Laundry Staff #1 on 2/10/26 at 6:04 AM identified RN #3 was asleep when we entered the supervisor's office and indicated that sometimes the staff sleep on shift when they are on a lunch break. Interview with the ADM on 2/10/26 at 12:05 PM identified that if staff have their assignments covered, they sometimes sleep on their lunch break. The payroll automatically deducts a half hour for lunch but staff do not punch out for the lunches. The ADM indicated the facility had a staff break room and staff should not be asleep in view of the residents. The ADM identified she would have to get the employee handbook and facility policy for guidance on this situation. Review of RN #3 employee timecard report identified RN #3 punched in for work on 2/9/26 at 11:19 PM and punched out on 2/10/26 at 8:06 AM. The facility employee handbook, page 11, identified that all hourly employees will receive a 30-minute unpaid meal break for shifts consisting of over six hours. The policy indicated that if an employee was unable to take a meal break, they should fill out the appropriate form and submit it to HR/payroll coordinator. The facility employee handbook further outlines standards of conduct and corrective action. Page 36 identified the expectation of all employees to use good judgement and maintain the highest standards of professionalism at all time and identified conduct for which discipline may be imposed included sleeping on duty. Facility RN shift supervisor job description identified the nursing supervisor oversees the facility in the absence of higher-ranking management officials, demonstrates measures to promote a safe environment for residents and others. The purpose of the RN shift supervisor position includes to (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	coordinate or manage nursing care, nursing services in accordance with current federal, state, local standards, HIPPA regulations, guidelines and regulations that govern our facility to ensure that the highest degree of quality care is always maintained. The RN supervisor works under the Director of Nursing and/or the Administrator. Resident #116's diagnoses included acute kidney failure, bacteremia, and nontraumatic subdural hemorrhage. The admission MDS assessment dated [DATE] identified Resident #116 had intact cognition, required maximal assistance with toileting hygiene, lower body dressing, transfers and ambulation. Observation on 2/5/26 at 10:19 AM identified Resident #116 was lying in his/her bed with the overbed table positioned on the right side of the bed. Further observation identified on the top of the over bed table a clear plastic bag containing an opened bottle of Latanoprost ophthalmic solution 0.005 % dispensed by an outside pharmacy with approximately a quarter of the solution remained, which the resident indicated he/she uses this medication nightly for his/her recent diagnosis of glaucoma. Resident #116 identified the eye drops were brought in from home, and he/she instill one drop into each eye at bedtime. Resident #116 further identified the staff should be aware that he/she has eye drops in the room as he/she keeps them in plain sight on the over-bed table and he/she needs to have this medication. The monthly physician's order for February 2026 directed Latanoprost ophthalmic solution 0.005 percent (%) to instill one drop into both eyes at bedtime. However, the orders failed to reflect a physician order for self-administration or storage of medication at the resident's bedside. Observation and interview with the Charge Nurse (LPN #8) and the Unit Manager (RN #8) on 2/5/26 at 10:26 AM identified Resident #116 was lying in his/her bed and on the top of the over bed table located on the right side of the bed, a plastic bag containing an opened Latanoprost solution 0.005% eye drop. LPN #8 identified she did not see this medication when she administered the resident his/her medication this morning and RN #8 identified she did not see the medication on the overbed table. LPN #8 removed the medication from the room and placed it in the medication cart. Observation of the medication cart with LPN #8 on 2/5/26 at 10:32 AM failed to identify a facility supply of Latanoprost ophthalmic solution 0.005 % eye drops for Resident #116. Observation of the medication storage room located on the unit with RN #8 on 2/5/26 at 10:33 AM identified in the fridge an unopened bottle Latanoprost ophthalmic solution 0.005 % eye drops for Resident #116 with a pharmacy dispense date of 2/1/26. Interview with RN #8 on 2/5/26 at 10:33 AM identified Resident #116 had signed a self-administration of medication consent form indicating that he/she voluntarily chose not to self-administer medication and does not wish to be assessed by the interdisciplinary team, hence the resident should not be administering any medication to him/herself. RN #8 further identified that the medication should not be kept in the resident's room on the overbed table unless there is a physician's or order directing the storage of medication in the resident's room within the lock box. RN #8 identified the resident can change his/her mind regarding self-administration and if this occurs a self-administration assessment and consent form would need to be completed and the medication to be stored appropriately. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the electronic Medication Administration Record (MAR) with the Charge Nurse LPN #9 on 2/10/26 at 3:45 PM identified Latanoprost solution 0.005 % eye drops are scheduled for 8:00 PM and were signed off as administered from 2/2/26 through 2/8/26 by LPN #9. Interview with the Charge Nurse LPN #9 on 2/10/26 at 3:45 PM identified whenever a resident brings in medication from home it is reported to the supervisor and the medication is removed. LPN #9 further identified the facility at times will use the medication supply brought in by the resident until the facility pharmacy sends the resident's supply and the supervisor will keep the resident's supply until returned to the resident. LPN #9 identified he was aware that Resident #116 had eye drops at his/her bedside which he uses to administer to the resident but stores the eye drops in the medication cart. LPN #9 further identified he did not inform the supervisor that he had found the eye drops in the resident's room nor did he bring the eye drops to the supervisor. LPN #9 identified he found a Latanoprost solution 0.005 % eye drops in the fridge that was not opened and it skipped his mind on using the dispensed medication from the facility pharmacy and continued to use the resident's supply. A review of the medication cart with LPN #9 identified the Latanoprost solution 0.005 % eye drops dispended on 2/1/26 by the facility pharmacy was opened on 2/9/26 and the supply brought in by the resident was discarded on 2/8/26 by LPN #8. Interview with the DNS on 2/11/26 at 10:25AM identified medications cannot be left at the bedside unless there is a care plan, a self-administration assessment and a physician order in place. The DNS further identified staff can use medication brought in from home after it is checked for expiration date, notifying the provider but the facility would store the medication in the cart. Review of the Medications Self Administration policy identified patient who request to self -administer medications will be assessed for capability and if it is determined that the patient is able to self-administer: a physician/mid-level provider order is required, self-administration must be care planned, patients must be provided with a secure, locked area to maintain medications, patients must be instructed in a self-administration and periodic evaluation of capability must be performed. Review of the Medication Administration policy identifies a resident may be allowed to self-administer medication only when specifically ordered to do so by an attending physician.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of clinical records, review of facility policy, review of facility documentation, and interviews for one of three sampled residents (Resident #116), reviewed for activities of daily living (ADL), the facility failed to ensure a resident who requested assistance with ADL care received the care in a timely manner. The findings include: Resident #116 was admitted to facility in January of 2026 with diagnoses that included acute kidney failure, bacteremia, and nontraumatic subdural hemorrhage.The admission MDS assessment dated [DATE] identified Resident #116 had intact cognition, required maximal assistance with toileting hygiene, bathing, taking off footwear, lower body dressing, transfers and ambulation. The assessment further identified Resident #116 was frequently incontinent of bladder and always incontinent of bowel.The care plan dated 1/31/26 identified Resident #116 had potential for alteration in skin integrity relate to decrease mobility, activity in tolerance with interventions that included protect skin with incontinent care and toileting assistance on toileting schedule or routine.Resident #116 care card dated 1/31/26 identified the resident required assistance of one staff member with dressing, personal hygiene, toileting, transfers, provide incontinent care every two hours, and out of bed daily to tolerated wheelchair.Observation on 2/5/26 at 10:19 AM identified Resident #116 was still lying in bed, wearing a Johnny (hospital gown). Resident #116 identified he/she had called for assistance using the call light early in the morning and was told the nurse aide is with another resident and nobody yet to come to provide him/her with assistance to get dressed and washed for the day. During an observation and interview with the Charge Nurse (LPN #8) and the Unit Manager (RN #8) on 2/5/26 at 10:26 AM for medication found at the bedside Resident #116 was still lying in bed, wearing a Johnny (hospital gown). Resident #116 then expressed that he/she had called earlier to get washed up and out of bed and nobody had come to provide him/her with assistance.Interview with RN #8 on 2/5/26 at 10:30 AM identified she did not answer Resident #116's call light and they are down one aide currently as the aide is coming in late. RN #8 identified they were getting residents up who had appointments, therapy and any residents who requested to get out of bed. On leaving the room NA #9 was assisting the roommate of Resident #116 and NA#14 was outside of the room when they were asked if the resident had rung in which they replied no and that they did not answer a call light from the resident.Interview with the LPN #8 on 2/5/26 at 10:45 AM identified Resident #116 rang his/her call light before breakfast, which breakfast comes at 8:30 AM, when she answered Resident #116 call light and he/she requested to get washed and out of bed. LPN #8 identified she was doing her medication pass and told the resident that the nurse aide is with another resident and she when across the hallway to NA #9 and told her the resident needed to wash up for the day.Interview with Resident #116 on 2/5/26 at 2:35 PM identified he/she was last provided with incontinent care sometime after 5:00AM by the 11:00PM to 7:00 AM shift. Resident #116 identified he/she had rung the call light before breakfast and NA #9 indicated she was with another resident. Resident #116 further identified he/she was incontinent with bladder. The resident indicated he/she then received care after the surveyor intervened.Therefore, Resident #116 was last provided with personal hygiene care after 5:00AM and then care was provided again minutes after 11:00 AM, hence resident did not receive assistance with ADL's for over 5 hours. The unit had a census of 21 residents and staff with 3 licensed staff and 2 nurse aides with another nurse aide scheduled to arrive at 8:00AM.Interview with NA #10 on 2/5/26 at 2:11PM identified she is usually scheduled for 8:00 AM but she usually comes in at 8:30 AM or 9:00 AM. NA #10 identified she had overslept this morning and called the facility to let them know she was coming late. She then arrived at the unit after 10:00 AM and immediately went to NA #14 in the hallway to ask her which resident she should see first, when they told her NA #9 would complete care on Resident #116, so she went to another resident. NA #10 further identified her assignment had included Resident #116Interview with NA #9 on 2/5/26 at 2:46 PM identified her interaction with Resident #116 prior to breakfast was to (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ask him/her what he/she would like for breakfast and what drink she needs and at that time the resident did not let her know he/she needed to get washed up and out of bed. NA #9 identified she did not hear Resident #116 rang his/her call light nor did she answer the resident's call light. NA #9 identified RN #8 informed her that NA #10 was here yet, so she then started to work on her assignment went she started with Resident #116 roommate first, then she provided care to Resident #116 minutes after 11:00 AM. NA #9 further identified LPN #8 did not inform her during their interaction that Resident #116 requested to be washed up. NA #9 identified usually all the residents on her assignment would be provided with personal hygiene care before 10:00 AM. Interview with NA #14 on 2/9/26 at 1:35 PM identified she knew one of the nurse aides would be late, however when 8:00 AM came and the nurse aide did not arrive they called the scheduler who indicated she was going to check. NA #14 cannot recall what time the scheduler got back to them, but when they heard NA #10 was coming later than schedule, they started working on her assignment. NA #14 identified she did not hear Resident #116 rang his/her call light nor did she answer the resident's call light. NA #14 identified when NA #10 arrived, she asked who was left to provide care on her assignment and she informed her about the residents she provided care.Interview with the DNS on 2/9/26 at 3:16 PM identified a call light when rang and answered, the request of the resident should be addressed as soon as possible, within a few minutes. The DNS identified that the facility does not have a system to track when a call light was rung, however if the resident call light was answered prior to 8:30 AM the request should not be answered until 10:45 AM, that was unacceptable. The DNS identified they were aware that the nurse aide was coming late, and the unit manager indicated she would work as the nurse aide until the nurse came in, hence the unit manager did come to the morning meeting. The DNS further identified that if a nurse is in the middle of their medication pass and a resident rang their call light and request to be provided with AM care that the nurse delegate the task but should complete simply task when requested by the resident during medication pass.Review of the Call Light policy and procedure identifies each resident is provided with a working call light. The procedure identifies to answer the call light as quickly as possible and if you cannot give the resident the item or service asked for to do the following: explain to the resident you will ask someone else, get assistance from the charge nurse and return to the resident quickly with a reply.Review of the Activities of Daily Living policy identified appropriate care and services will be provided for residents who are unable to carry out ADL's independently, with the consent of the resident and in accordance with the plan of care including support and assistance with hygiene, mobility, elimination, dining, and communication.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of the clinical record, review of facility policy and procedures and interviews for one sampled resident (Resident #29) reviewed for limited range of motion, the facility failed to ensure splints were applied according to the wearing schedule as ordered by the physician. The findings include: Resident #29 was admitted to the facility in 2019 with diagnoses that included unspecified dementia, unspecified severity, with agitation, non-pressure chronic ulcer of other part of left foot limited to breakdown of skin, hydrocephalus and poly-osteoarthritis. The Quarterly Minimum Data Set (MDS) dated [DATE] identified Resident #29 had severely impaired cognition, exhibited bilateral upper extremity impairment, no impairment of the lower extremities, was dependent with all self-care and mobility and was not receiving therapy services. Physician's orders dated 1/27/26 directed the following splinting devices:Bilateral upper extremity palm guards to maintain skin integrity and contracture management, Bilateral elbow extension splints ON during AM care; OFF during PM care with directions to store device in the bedside drawer between uses and direction to document changes in skin condition or concerns, notify therapy via screen as necessary every day shift to check splint cleanliness/condition, check skin integrity pre/post application, perform range of motion as needed, fasten straps, if applicable and monitor device during use as needed.Bilateral knee splints ON in the evening and OFF in the AM with directions to store device in the closet between uses, document changes in skin condition or concerns and notify therapy via screen as necessary. The care plan dated 1/15/26 directs the care card that includes directions for splint to include:Bilateral elbow extension splints on during am care; off during PM care, remove splints prior to transfers via mechanical lift. Apply splints again once transfer completed and stored in the bedside drawer. Document changes in skin condition or concerns. check splint cleanliness/condition, check skin integrity pre/post application, perform ROM as needed, fasten straps, if applicable, monitor device during use as needed notify nursing/rehab/MD with any unusual findingsResident to have bilateral upper extremity palm guard to maintain skin integrity and contracture management.Bilateral knee extension splints On in evening; off in am. Between uses store device in the closet and document changes in skin condition or concerns. Notify therapy via screen as necessary. check splint cleanliness/condition, check skin integrity pre/post application, perform ROM as needed, fasten straps, if applicable, monitor device during use as needed notify nursing/rehab/MD with any unusual findingsThe care plan indicated the NA, LPN and RN were responsible for the splint care. Occupational therapy note dated 1/23/26 identified a therapy goal of caregivers will demonstrate competence in performing passive range of motion to the patient's bilateral upper extremities, including the hand, and will safely don and doff the prescribed palm guard to reduce the risk of contracture. The treatment administration record dated January and February 2026 identified that splint donning (putting on) and doffing (taking off) was completed daily for the bilateral elbow splints, bilateral knee splints, and every shift, every day for the bilateral palm guard monitoring. Occupational Therapy note dated 2/3/26 identified caregivers were able to follow the plan of care for an orthotic device on bilateral hands but did not identify who the caregivers were. Occupational Therapy note dated 2/4/26 identified caregiver education was provided on donning/doffing an orthotic device for the hands to prevent a risk for contractures and that care givers were provided hands on training but does not identify who the care givers were. Observation of Resident #29 on 2/4/2026 at 11:41 AM identified several splints on the dresser in the resident room. Resident #29 was lying in bed with no upper extremity splints in place. There were no palm guards or elbow splints in place. Resident #29 was covered by a blanket, and the lower extremity is not visible. Resident #29's upper extremities are very bent at the elbows and appear contracted. Resident #29's hands are contracted with fingers bent in and not extended at all with fingertips/nails that look like they are pushing into the resident's palm (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075382	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodlake at Tolland	26 Shenipsit Lake Road Tolland, CT 06084

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and appearing stiff. Resident #29 is in a hospital johnny, eyes were closed with crusted residue, and it does not appear that morning care had been completed. Observation of Resident #29 on 2/9/2026 at 10:07 AM identified Resident #29 in bed with upper extremity splints, elbow splints, nor palm guards, in place on the resident. Signage on the door identified Resident #29's room is droplet/contact precautions. Observation of Resident #29 on 2/10/2026 at 6:45 AM identified upper extremity splints, elbows and palm guards, were not in place on the resident but present on the resident dresser. Resident#29 was observed still sleeping under the covers with the right knee splint outline visible under the blanket. Occupational Therapy note dated 2/11/26 identified caregiver education was provided for how to measure orthotic device for proper fitting. Observation of Resident #29 on 2/11/2026 at 1:45 PM identified Resident #29 in bed without bilateral upper elbow or palm guard splints not in place on resident. One elbow splint observed on the resident dresser and one elbow splint observed on the chair in the corner of the resident room. Resident #29 is sleeping and covered with blankets so lower extremity splints are not observed. Observation of Resident #29 on 2/13/2026 at 9:40 AM identified Resident #29 in bed asleep without bilateral upper elbow or palm guard splints in place. Resident #29 was covered in blankets and knee splints were not visible. Interview with NA#5 on 2/13/2026 at 9:48 AM identified she was going to perform morning care with Resident #29. Observation of Resident #29 care performed by NA#5 and an orientee and interview with NA#5 on 2/13/26 at 9:55 AM identified a right knee brace in place on Resident #29. NA#5 indicated that Resident #29 only had the right knee brace and had never seen one on the left leg. Observation of Resident #29's room failed to locate a second knee brace. When morning care was completed, NA#5 put the knee brace back in place on the right knee. NA#5 placed the palms guard with the grey pillow splint on the right hand and the velcro palm guard splint on the left hand with the thumb hole on the pinky side. NA#5 did not put on the bilateral elbow splints are not placed back on Resident #29. NA#5 identified that she does not put them on until Resident #29 is moved via Hoyer lift into the wheelchair. When NA#5 was asked how the splinting was ordered, NA #5 then points to a sign on the wall that says please remove elbow splints prior to moving in the Hoyer lift. NA#5 indicated that Resident #29 does not wear the elbow splints when in bed and that Resident #29 is always moved to the wheelchair before 11:00 AM. NA#5 identified that nursing ensures Resident #29 is out of bed early but NA#5 could not identify what happens if NA#5 is not assigned to the resident and NA#5 indicated she could not identify when she was last assigned to Resident #29. Interview with the Rehab Director, who is the Occupational Therapist on 2/13/2026 at 10:28 AM identified the bilateral hand splints were placed incorrectly and were placed on the wrong hands. The Rehab Director indicated therapy is responsible for educating the nurse aides and other staff on splint placement. The Therapy Director identified Resident #29 should have the bilateral leg splints off during the day and the elbow splints should be on when the residentis getting up for the day. The Therapy Director indicated she needed to review the orders but identified if the resident stays in bed during the day, the splints might be uncomfortable but if they are ordered then they should be on. Additionally, the Therapy Director indicated she would have to double check on the second knee splint as she was not aware of what was ordered and that Physical therapy (PT) was responsible for managing the knee splints. Interview with the Therapy Director on 2/13/2026 at 11:23 AM identified Resident #29 is supposed to have bilateral knee splints, bilateral elbow splints and bilateral hand splints currently. The bilateral hand splints were most recently ordered 1/23/26 after a quarterly assessment which found worsening contracture. The Therapy Director indicated that OT short term goals for the start of care indicated that new caregivers need education for the orthotic device related to the elbow splints and palm guards. The Therapy Director could not identify if staff or which staff had received education on donning and doffing the splints. Interview with NA#5 on 2/13/2026 at 10:40 AM identified that although she is familiar with Resident #29 and has the resident often, she had never been trained to place splints and had not placed them prior to today. Interview with the Therapy Director on 2/13/2026 at 12:44 PM identified palm guards are supposed to be on all the time, elbow splints should (continued on next page)

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	075382	A. Building B. Wing	02/13/2026

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	be applied as the order states, with AM care. The Therapy Director indicated that even if Resident #29 did not get out of bed, the elbow splints should be put in place with AM care. The Therapy Director identified that subsequent to surveyor inquiry, new knee and elbow assessments were being completed due to not knowing if the resident splinting was consistently completed appropriately and staff education would be completed regarding wearing schedule and proper placement of the splints. Interview with APRN #1 on 2/13/2026 at 1:52 PM identified splinting orders are dependent on therapy assessment and recommendations and the expectation is that splinting is completed as ordered. Interview with PT #1 on 2/13/2026 at 2:18 PM identified Resident #29 was supposed to have bilateral knee splints in place with PM care and removed with AM care. PT #1 indicated that a second knee splint had been located and implemented in Resident #29's care and that the assessment showed improvement to the bilateral lower extremity contractures. PT#1 identified Resident #29 would be picked up for care and staff would be educated on the donning and doffing of the splints and could not identify when both splints were last used. After surveyor inquiry, physical therapy note dated 2/13/26 identified Resident #29 was being picked up for therapy services with goal that caregiver will be able to don bilateral knee brace without assistance of therapy when patient is back to bed at night and off early in the morning as per order.Facility policy for adaptive devices to include orthotics, prosthetics, wheelchairs and positioning devices identified that a picture of the patient wearing the device should be taken and kept where the facility designates for staff reference. The policy indicated that in-service sessions for the patient's primary nurse and CNA to ensure they understand how to don and doff the splint and are familiar with the recommended wearing schedule. The policy identified this training should be documented using the paper in-service form and that training could be documented in the daily treatment note. The policy indicated that therapy issued devices required auditing every six months to assess the need for modifications.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of clinical records, review of facility documentation, review of facility policy and procedure, and interviews, for two of eight sampled residents (Residents #54 and Resident #110) reviewed for accidents, the facility failed to ensure an elopement risk assessment was completed per facility policy and facility failed to ensure a resident wearing a wander guard device was functioning and transmitting to alert staff when triggered and for one of three sample residents (Resident #11) reviewed for accidents, the facility failed to ensure the staff follow the resident care plan to prevent a fall. The findings include:Resident #54 was admitted to the facility in August of 2025 with diagnoses that included anemia, chronic kidney disease and dementia. The quarterly MDS assessment dated [DATE] identified Resident #54 had moderately impaired cognition, had behaviors, required maximal assistance with toileting hygiene, personal hygiene, wheeling of the manual wheelchair 50 feet and make two turns and at 150 feet in the corridor and moderate assistance with transfers and bed mobility. The assessment further identified Resident #54 ambulates 10 feet and 50 feet with supervision or touch assistance. The care plan initiated on [DATE] identified Resident #54 at risk for exhibiting non-compliance with the treatment plan as evidenced by refusing care, non-complaint with transfer status with interventions that included reapproach resident, monitor behaviors and determine the underlining cause and divert the resident's attention. The physician's order dated [DATE] directed to offer seating near the nurse's station with stimulating activity when the resident is awake during the late-night shift. Review of the clinical records identified Resident #54 had an elopement risk assessment completed on [DATE] given the resident a score of zero which indicates low risk/not applicable for risk of wandering. Review of the Psychiatry evaluation and progress note dated [DATE] identified Resident #54 was seen by the provider for a follow-up on increased behaviors. The note further identified staff reports that Resident #54 had increased periods of confusion, yelling, exit seeking and refusing care, and were not always redirectable. The note identified resident has an order for Trazodone (anti-depressant medication) as needed and to continue with current medication and monitoring. Review of the Psychiatry evaluation and progress note dated [DATE] identified Resident #54 was seen by the provider for a follow-up on increased behaviors. The notes further identified staff report that Resident #54 had increased periods of confusion, yelling, exit seeking and refusing care, and were not always redirectable. The note further identified that Trazadone (medication) was effective and the order for Trazadone use was renewed, with a schedule Trazadone order for bedtime which was agreed by the resident's Power of Attorney (POA). Review of the Psychiatry evaluation and progress note dated [DATE] identified Resident #54 was seen by the provider for a follow-up on increased behaviors. The note identified staff reports that Resident #54 had increased periods of confusion, yelling, exit seeking and refusing care, and were not always redirectable. The staff also reports resident is up during the night with increased behaviors and the provider will increase the Trazadone dosing at bedtime to 50 milligrams (mg). (continued on next page)

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	075382	A. Building B. Wing	02/13/2026

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nurse's progress note dated [DATE] at 11:40 PM identified Resident #54 was confused and wandered in the unit going into other residents' room and was redirected several times. The nurse's progress note dated [DATE] at 12:06 AM identified resident wandered on the unit and was assisted to bed at around 10:00 PM. The nurse worked on [DATE] but charted at midnight, hence this occurred on [DATE]. The nurse's progress note dated [DATE] at 10:00 PM written by RN #5 identified Resident was agitated for most of the shift, going from room to room and was found in the kitchen on the unit by dietary. The note further identified Resident #54 attempted to open the door to the stairs and was redirected several times. The resident then managed to pull the fire alarm at 8:15 PM and the fire department responded. Resident #54 was assisted to bed and provided with 9:00 PM medications. The note further indicated the resident responsible party was notified regarding the incident. Review of the Psychiatric evaluation and progress note dated [DATE] identified Resident #54 was alert, oriented and somewhat irritable. The note identified staff reports that Resident #54 had increased periods of confusion, yelling, exit seeking and refusing care, and were not always redirectable. The note further identified Resident #54 has a physician's order to administer Trazadone medication as needed and the medication was used for 2 months and reports to be effective, and the at bedtime dose was recently increase. The notes further dictate to continue to monitor Resident #54. Review of the clinical records from [DATE] to February 2, 2026, failed to reflect that an elopement risk assessment was completed nor any interventions implemented for the resident's wandering and exit seeking behavior as identified in the nurse's progress notes and the Psychiatry evaluation and progress notes. Interview with the DNS on [DATE] at 3:00 PM identified he was aware of the incident that occurred on [DATE] with Resident #54 regarding the pulling of the fire alarm and wandering behavior. He further identified the incident was discussed at morning meeting and the interdisciplinary team decided the resident was not at risk for elopement as the resident was just anxious. The DNS identified the staff offered as needed medication for the behavior, offered the resident snack, psychiatric follow-up and social service follow-up for support were completed. The DNS identified an elopement risk assessment is completed on admission, quarterly and after any incident of elopement. The DNS then reviewed the resident's clinical records and identified the resident should have had an elopement risk assessment completed in November of 2025 at the time of the quarterly MDS assessment. The DNS further identified after looking back at the incident which occurred on [DATE], that another elopement risk assessment should have been complete then to determine if the resident was at risk for elopement and wandering. Interview with Nursing Supervisor (RN #5) on [DATE] at 1:58 PM identified her notes dated on [DATE] was her documentation of what the staff had reported to her. RN #5 was asked after the incident with the resident pulling the fire alarm, opening exit doors what interventions were put in place when she responded that the resident was checked on frequently as the nurse's aides know to do that as it is common sense and there were 5 staff schedule on the unit so they were able to manage the resident. RN #5 further identified she was not sure if the physician was updated but the maintenance staff came in when the fire alarm was pulled. Interview with the Charge Nurse (LPN #7) on [DATE] at 8:33 AM identified at the beginning of the shift, Resident #54 displayed behaviors such as opening doors, trying to open exit doors and was (continued on next page)

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	075382	A. Building B. Wing	02/13/2026

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	redirected several times. LPN #7 identified Resident #54 wanted to leave the facility and wanted to call the police because other residents were taking his/her stuff. LPN #7 identified while she was doing her medication pass, she heard the fire alarm went off and it was Resident #54 who had pulled the fire alarm as he wanted to leave. LPN #7 identified she had reported the incident to the supervisor (RN #5) and could not recall the supervisor telling her to do anything, the staff did frequent checks on the resident, and the supervisor had written a note and notified the family. LPN #7 identified that looking back at the incident an elopement risk assessment should have been completed as the resident wanted to leave. Interview with the Unit Manager (RN #8) on [DATE] at 1:13 PM identified she was unaware that it was her responsibility to complete the quarterly assessment that was due in November of 2025 which included the elopement risk assessment. RN #8 identified she was just made aware yesterday that she was responsible for completing the assessments for the residents residing on the rehabilitation unit. Subsequent to surveyor's inquiry Resident #54 had an elopement risk assessment on [DATE] which indicated a score of 9 (medium risk to wander) and a wander guard device was placed on the resident's right ankle. Review of the Wandering Risk Assessment policy identifies a wandering risk assessment will be utilized and complete on all residents to determine their risk level. The assessment will be done upon admission and quarterly. Review of the Elopement Prevention policy identifies the facility shall complete a wandering/elopement risk assessment on every resident upon admission, quarterly and after elopement incidents. The policy further identifies the quarterly assessment will be conducted while the quarterly MDS's are completed. Resident #110's diagnoses included type 1 diabetes mellitus, anxiety, and metabolic encephalopathy. The admission MDS assessment dated [DATE] identified Resident #110 had severely impaired cognition, required maximal assistance with personal hygiene, dressing, bed mobility, wheeling of the manual wheelchair 50 feet and make two turns and at 150 feet in the corridor and dependent with transfers. The care plan dated [DATE] identified Resident #110 was at risk for elopement related to confusion with interventions that included the resident is triggered for wandering/eloping and the behavior will be deescalated. The physician's order dated [DATE] directed for a wander guard bracelet to the right ankle and to check for placement of the bracelet on each shift and to check wander guard for function every night on the 11:00PM to 7:00AM shift. Observation on [DATE] at 11:34 AM with NA #8 identified Resident #110 is located on the second floor of the building. Resident #110 was in his/her room seated in his/her wheelchair and a wander guard bracelet was noted on the resident's right ankle. The nurse aide then wheeled the resident to the exit door of the unit, and the alarm did not sound. The nurse aide proceeded to take the resident on the elevator to the first floor and after leaving the elevator and upon entering the first-floor entry doorway the alarm sounded. NA #8 identified that the wander guard alarm should have been alarmed (continued on next page)

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	075382	A. Building B. Wing	02/13/2026

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	lumbar vertebra, right knee osteoarthritis, and morbid obesity. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #11 had intact cognition, required total assistance for personal hygiene, dressing, bed mobility, transfers, and was non-ambulatory. The physician's order dated [DATE] with origination date of [DATE] directed to provide toileting at bed level with assistance of 2 people, dressing at bed level with assistance of 2 people, and use a mechanical lift with 2 people. The morse fall scale (used to predict risk for fall) dated [DATE] identified Resident #11 score 55 which indicates a high risk for fall. The Resident Care Plan (RCP) dated [DATE] identified interventions that directed bed mobility with assistance of 2 people, dressing at bed level with assist of 2 people, and personal hygiene with assistance of 2 people. The accident and incident report dated [DATE] at 1:50 PM identified Resident #11 was transferred back to bed to provide incontinent care, and he/she was asked to turn to the side, and he/she rolled out of bed onto the floor. The nurse's note dated [DATE] at 4:26 PM identified Resident #11 was observed between 2 beds with his/her knees facing the wall and he/she was noted hanging onto the bed rails. NA #2 was providing his/her care alone. Resident #11 was turned onto his/her right side, and he/she rolled off the bed. Resident #11 was assessed for injuries and/or pain, and he/she was transferred back to the bed using a mechanical lift. Resident #11 was observed with pink area measured 6.5 centimeters (cm) by 4.5 cm to the left knee and 5 cm by 6cm redness with bruising to the right knee. Resident #11 complained of 8 out of 10 on the pain scale. The physician was notified of the fall and new physician's order was obtained to administer oxycodone 5 milligrams (mg) for one dose, apply ice pack three times daily for 3 days and obtain 3 views of right knee x-ray. Family was also notified of the fall. The right knee x-ray report dated [DATE] identified Resident #11 did not have an acute fracture and/or dislocation. The nurse's note dated [DATE] at 4:53 AM identified Resident #11 was alert, verbal, and status post fall. Resident #11 had slight redness to the bilateral knee and no complaint of pain and discomfort. Interview with OTR #1 (rehab director) on [DATE] at 9:50 AM identified Resident #11 was receiving Physical Therapy (PT) services when the resident had an accident. She identified Resident #11 had a trunk weakness and required 2 people assist at bed level for personal hygiene, toileting, and dressing when he/she rolled out of the bed. She further identified that the staff were re-educated to follow the resident care plan when providing care. Interview with NA #2 on [DATE] at 10:20 AM identified she asked Resident #11 to turn to the right side to provide an incontinent care when he/she rolled off out of bed. She identified that she was alone at that time providing incontinent care and she was not aware that he/she required 2 people for bed mobility. She identified that she was a new employee at that time of the accident and she just went off the orientation when Resident #11 had an accident. She identified that she did not check the resident care plan because nobody knew where to find the resident care card. She identified that she (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	did not ask the nurse whether Resident #11 required 2 people to provide for incontinent care. She further identified that she was educated to ask for another person to provide incontinent after the accident. Interview with the Director of Nursing Services (DNS) on [DATE] at 10:35 AM identified that Resident #11 was in his/her bed and rolled off from the bed when NA # 2 was providing incontinent care. He identified that NA #2 was alone providing incontinent for Resident #11 when he/she rolled out of bed. He identified that Resident #11 care plan was updated to have 2 people assist at bed level and staffs were educated after the accident happened. The Fall Prevention Program policy identified that all resident falls would have a focus review by interdisciplinary team for causes, risk factors and to provide preventive measures and interventions. The facility would develop an individualized care plan to meet the residents' needs and implement the plan to prevent a fall.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075382	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodlake at Tolland	26 Shenipsit Lake Road Tolland, CT 06084

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, review of facility policy/procedures and interviews for 1 of 8 sampled residents (Resident #95) reviewed for nutrition, the facility failed to ensure quarterly nutrition assessments were completed. The findings included: Resident #95's diagnoses included Type II diabetes, Gastro-esophageal reflux disease (GERD) with esophagitis, Barretts esophagus without dysplasia. The care plan dated 4/10/25 identified Resident #95 was at risk for a nutrition problem related to Type 2 Diabetes, GERD, intestinal malabsorption, prostate cancer, hypertension, coronary artery disease, Barretts esophagus with interventions that included diet consult as needed, honor food preferences as they arise, monitor weights monthly, registered dietician to evaluate and make diet changes and recommendations as needed. The quarterly MDS assessment dated [DATE] identified Resident #95 was moderately cognitively impaired, was independent for bed mobility, transfers, dressing, eating and personal hygiene. Physician order review for May 2025 identified an order directing Monthly weights. Review of the monthly weight for June 2025 identified a monthly weight of 136.8lbs on 6/5/25. Review of the monthly weight for July 2025 identified a monthly weight of 130.4lbs on 7/4/25. Review of the quarterly nutritional assessments identified a quarterly assessment was done by the Dietician on 3/28/25. The next quarterly assessment was not completed until 11/26/25. Interview on 2/10/26 at 1:14PM with the Dietician identified that if a resident has a greater than 5lb weight loss or gain during a monthly weight there should be a re-weight completed. When Resident #95 was weighed on 7/4/25 there should have been a re-weight completed as the weight loss was greater than 5lbs. The Dietician identified that although she reviews the monthly weights completed, she does not always notice the weight loss unless it triggers significant weight loss in her computer. When she does notice the weight losses, she makes a list a give them to the units of who need a re-weight. However, the dietician identified she did not notice the weight loss or request a reweight that she could recall. Furthermore, the Dietician identified that she is responsible for completing quarterly nutritional assessments on residents and each resident should have an evaluation every quarter. These evaluations are synonymous with MDS date. The process she follows would be to go into the computer and see who is triggering for an MDS to be completed that month. However, she had now learned that more people can be added to the MDS list as the month goes on so she has had to do several more checks to ensure someone is not missed. The Dietician identified she did in fact miss completing Resident #95's quarterly nutrition assessment that should have been completed for the MDS in August of 2025. Interview on 2/11/26 at 11:44AM with the DNS identified he would expect the quarterly nutrition assessments to be completed by the dietician, and the weights to be identified by the nurse or dietician when a re-weight needs to be completed. Review of the Weight Measurement Policy directed residents with a weight variance of 5lbs more or less than the previous month will be re-weighed. The dietician will review the resident weight and make recommendations accordingly. Review of the Nutrition Documentation Policy directed nutrition documentation should include nutrition assessments- initial, annual, or significant change. Quarterly assessments or progress notes- identifying dietary changes as they occur and monitoring if interventions are working and goals are being met.

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	075382	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observations, review of facility documentation, review of facility policy/procedures and interviews for the facility reviewed for medication storage the facility failed to ensure there was a system of receipt and disposition to accurately ensure reconciliation of controlled substances received into the facility. The findings included:Interview with the nursing supervisor, RN #3 on 2/10/26 at 5:26 AM identified that when controlled substances come into the facility they are inventoried by the receiving nurse, verified and signed by a second nurse, and the controlled substance disposition record (CSDR) gets photocopied and the copy goes to the ADNS and the original goes with the medication on the medication cart.Interview with the ADNS on 2/11/26 at 10:37 AM identified she had been the ADNS for a year at this facility. The ADNS indicated that when the copies of the CSDR comes into her office they are placed in a binder. The ADNS identified that once a medication is zeroed out the original sign off CSDR is brought to the ADNS office and placed in the binder and the copy is thrown away. The ADNS identified that there was a binder that she kept all the outstanding CSDR copies in. The ADNS indicated that when she completes the bi-weekly audits she does not take the binder with her and the audits consist of counting the controlled substances with the nurse responsible for the med cart. The ADNS identified that she does keep the delivery slips but does not review them.Observation of the ADNS office on 2/11/26 at 10:40 AM identified two large binders with completed CSDR signature sheets, one binder with copies of CSDR sheets, and several piles around the office of CSDR originals and copies. Additionally, the ADNS produced a file with complete CSDRs and identified that those were medications that had been destroyed. When asked to produce all the CSDR copies that had not been reconciled, the ADNS indicated they were in the binder and there were several around her office and asked for time to get them together.Interview with the ADNS on 2/11/26 at 1:13 PM identified she had not been trained on a process for audit and reconciliation and had dismantled the binder with all of the copies of the CSDRs and indicated that she went around the facility to identify controlled substances in use in the facility so that she could make a binder with all of the controlled substances in use in the facility. The ADNS identified that she took out all the CSDR copies that were not in use in the facility and not yet reconciled and placed them into a different binder to be reconciled at a later time.Review of all of the outstanding CSDR copies on 2/11/26 at 1:20 PM, those in use in the facility and the non-reconciled not in use in the facility, identified two hundred fifty three (253) CSDR copies that were not reconciled, meaning the medication was not in use in the facility and it was unknown if the medication had been destroyed, returned, completed, discontinued or sent home with a discharged resident. 66 of these CSDR copies were flagged for the facility to reconcile.Interview with the DNS and ADM on 2/11/26 at 3:00 PM identified they were not aware that the ADNS did not have a reconciliation process for the controlled substances. The DNS indicated that he did oversee the ADNS, designated the DNS responsible for the audits and reconciliation, but identified although the ADNS was not trained on how to complete the process, he thought she was familiar with the process of audit and reconciliation.Interview with the ADM on 2/13/26 at 8:40 AM identified the facility had completed a full audit of the outstanding CSDRs and streamlined the process and indicated that the destruction and reconciliation process was being revamped. The ADM provided proof that the 66 flagged CSDRs were able to be reconciled and indicated that all controlled substances were able to be located.The facility policy for Medication distribution and control identified the DNS is responsible for all control drugs in the facility and she/he will maintain complete accounting of the distribution of all control drugs in the facility.Although requested, a pharmacy contract, nor a policy for controlled substance audit and reconciliation, was not provided by the facility.

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	075382	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, facility policy and interviews for 2 of 3 sampled medication rooms and observation of medication administration, the facility failed to store medications appropriately. The findings include: Observation on [DATE] at 9:18AM identified a bottle of Fluticasone 50mcg nasal spray approximately 1/3 full for Resident #39 and a Tresiba Flex Touch Insulin degludec injection with 100 units remaining on top of a medication cart with 12 units dialed into the pen for Resident #31 in the Rehab unit. No nurse was attending the cart at the time and later it was identified the nurse was down the hall in a resident's room without eyes on the medication. This medication was observed to be unattended for approximately 4 minutes before the nurse returned to the cart. Interview on [DATE] at 9:10AM with LPN#5 identified she was nurse assigned to this medication cart and she was down in a resident's room and had left these two medications out on top of the cart because they were the last two medications to be given in her medication pass. LPN#5 identified the medications should not have left them on top of the cart due to the fact a resident could have picked it up and it would be dangerous. Interview on [DATE] at 11:44AM with the DNS identified medication should be locked and not left out on top of a medication cart. A nurse should not leave medication unattended. Observation on [DATE] at 2:29PM of the second-floor medication room identified 5 IV dressing change trays expired on [DATE] and 12 IV start kits expired [DATE]. Interview on [DATE] at 2:30PM with RN#7 identified there is a company that starts IV's and the kits would only be utilized by the company that starts IV's as they do not start IV's in the facility. They make complete dressing changes however they should not be utilizing expired trays and that there was not anyone currently on an IV on the second floor, expired items should be thrown out. The facility also utilized a stock person. Interview on [DATE] at 2:47PM with Stock Person #1 identified she did not order or receive IV supplied and that expired supplies should be thrown out. Review of the medication storage policy directed medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is only accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Drugs dispensed in the manufacturer's original container will be labeled with the manufacturer's expiration date.

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	075382	A. Building B. Wing	02/13/2026

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record reviews, facility policy review, and interviews for two of six sampled residents (Resident #8 & #90) reviewed for nutrition, the facility failed to ensure the adaptive equipment (two handled cup) was implemented in accordance with the physician's orders. The findings include: Resident #90's with diagnoses that included dementia, multiple sclerosis, and primary generalized osteoarthritis. The occupational therapy evaluation and plan of treatment from 3/14/25 to 6/11/25 identified Resident #90 was evaluated for difficulties with the regular cup related to fine motor deficit. The resident goal identified Resident #90 would be able to utilize a two handled mug for all liquid to increase performance and independence with self-feeding and increase fluid intake. The physician's order dated 3/21/25 identified Resident #90 directed to use two handled mug with straw during all meals. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #90 had severe cognitive impairment and independent with eating, total assist for toileting, personal hygiene, dressing, and transfer. Further review of the resident assessment identified Resident #90 was on mechanically altered diet. The Resident Care Plan (RCP) dated 1/16/25 identified Resident #90 care card. Care plan interventions directed to provide diet per physician's order, use scoop dish at all meal, and use two handled mug with straw during all meals. Observation on 2/4/26 at 12:30 PM identified Resident #90 sitting in bed eating his/her lunch and noted with scoop dish plate and one plastic container cup of cranberry juice and one plastic container cup of orange juice on the bedside table. The meal ticket on the resident tray identified a scoop dish for adaptive equipment but the 2 handled mug was not listed in the adaptive equipment. Observation on 2/10/26 at 12:10 PM identified Resident #90 sitting in bed eating his/her lunch and noted with scoop dish plate and one plastic container cup of cranberry juice and one plastic container cup of orange juice on the bedside table. The meal ticket on the resident tray identified a scoop dish for adaptive equipment but the 2 handled mug was not listed in the adaptive equipment. Interview with the Food Service Director (FSD) on 2/10/26 at 12:45 PM identified that all residents that need adaptive equipment would be coming from therapy and/or nursing. He identified that the nursing and/or the therapy would send out a notification ticket to the dietary department, and the adaptive equipment would be added to the resident ticket to identify the adaptive equipment needed for the resident. He identified that Resident #90 used a scoop dish plate for all meals, but he was not aware of the two handled mug for all liquid. He further identified that he might not receive the notification that Resident #90 need to use the two handled mug that why it was not listed in the resident meal ticket. Interview with OTR #1 (rehab director) on 2/10/26 at 1:35 PM identified that the rehab department would evaluate a resident whether an adaptive equipment is needed for meal. She identified that either her rehab department and/or nursing would notify the dietary when there is an order to use (continued on next page)

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	075382	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	adaptive equipment. She identified that she received a concern from the nursing department regarding Resident #90 fluid intake. She identified that Resident #90 had a fine motor deficit to his/her hands and was evaluated to use a two handled mug for all liquid to increase and/or promote the resident fluid intake. She could not identify why the two handled mug was not reflected in the resident meal ticket. The Resident Adaptive Feeding Equipment Changes policy identified that the facility would ensure all residents have appropriate and updated feeding equipment per physician's orders. The resident adaptive feeding equipment would be found in the facility electronic medical record system, and all feeding equipment changes must be the result of an evaluation by therapy, nursing, and physician. Resident #8 was admitted to the facility February 2025 with diagnoses that included Adult failure to thrive, cancer, arthritis, cataracts, muscle weakness and other lack of coordination. Occupational Therapy assessment dated [DATE] identified Resident #8 was referred for assessment after spilling hot liquids with a goal that indicated Resident #8 would safely perform self-feeding tasks with independence with use of 2 handled mug for proper positioning during meals and for grasp/release of items in order to increase independence in self-feeding and increase nutritional intake. Resident #8 was discharged from OT services 6/16/25. The Quarterly Minimum Data Set (MDS) dated [DATE] identified Resident #8 had intact cognition, required set up or clean up assistance with eating, required supervision or touching assistance with oral hygiene, received a therapeutic diet and parenteral/IV feeding, receiving 500 cc/day or leg of fluid intake by IV, while a resident at the facility. The care plan dated 12/29/26 identified Resident #8 required a right-hand orthotic to prevent contracture and OT adaptive equipment provided a 2 handled mug for liquids with all meals and feeding set up. Treatment Administration Record (TAR) dated February 2026 documented on days and evenings identified total fluid intake: 2/1/26 total 1160 ml 2/2/26 total 1240 ml 2/3/26 total 1100 ml 2/4/26 total 720 ml 2/5/26 total 1480ml 2/6/26 total 1580 ml 2/7/26 total 960 ml 2/8/26 total 1200 ml (continued on next page)

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	075382	A. Building B. Wing	02/13/2026

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2/9/26 total 840 ml 2/10/26 total 1000 ml 2/11/26 total 580 ml 2/12/26 total 1220 ml Physician's orders dated 2/2/26 directed to encourage oral hydration for 24 hours, increase PO fluids every day and evening shift for increased creatinine, OT adaptive equipment PT to provide 2 handled mug for all liquids (originated 5/12/25) with a duplicate order added 2/13/26 after surveyor inquiry. Observation of Resident #8's overbed tray table on 2/4/26 at 2:34 PM identified 4 clear plastic cups with straws, one containing a tan colored liquid half full, one half full of clear liquid, one half full with a whitish colored liquid and one half full with an orange color liquid. There was not a cup with any handle in the room. Interview with Resident #8 on 2/4/26 at 2:34 PM identified Resident #8 was experiencing side effects from either medications or chemotherapy and indicated Resident #8 experienced loose stools and abdominal pain which limited Resident #8's desire for food or fluid intake. Resident #8 identified that this day was a chemotherapy day and indicated that he/she did not feel well and had not and would not be consuming the items on the overbed tray. Interview with Person #1, Resident #8's son, on 2/5/26 at 2:15 PM identified Resident #8 as a picky eater who sometimes doesn't eat and indicated this was a side effect of chemotherapy. Review of the clinical chart on 2/5/26 at 2:34 PM identified Resident #8 had and 18.67% weight loss since 11/13/25. Observation of Resident #8 on 2/9/26 at 10:16 AM identified Resident #8 seated in the wheelchair and 4 plastic cups on the overbed tray table, one half full of clear liquid, one half full of orange colored liquid, one half full of red liquid and one half full of oatmeal. Resident #8 indicated that he/she could not recall eating breakfast and identified he/she was not feeling well but was not able to elaborate and identified he/she would not be consuming the items on the overbed tray table. There was not a cup with a handle in the room. Resident #8's hands were in the resident's lap and the fingers appeared knobby with pronounced knuckles, as fingers with arthritis would appear Interview with RN#7 on 2/9/26 at 10:27 AM identified Resident #8 has refusals of intake after chemo treatments but has fluids provided in the room. RN #7 indicated that Resident #8 likes applesauce, pudding, ginger ale and cookies and was able to eat and drink independently and did not need any assistive devices. Observation of Resident #8 on 2/10/26 at 7:12 AM identified the overbed tray table had a plastic cup with reddish colored liquid with a straw but was not within reach of the resident. There is not a cup with a handle in the room. The meal ticket identified Resident #8 had a special diet with notes to cut up all foods but did not list any adaptive equipment. Interview with Person#1, Resident #8's son, on 2/13/26 at 10:40 AM identified that staff had left a container of applesauce not opened and without a spoon on the bedside table and indicated he was (continued on next page)

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	075382	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodlake at Tolland	26 Shenipsit Lake Road Tolland, CT 06084

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	going to feed Resident #8. Person #1 identified that Resident #8 had arthritis in the hands which made it difficult to grasp at times. Observation at this time identified Resident #8 had 1 liter of normal saline that had finished infusing into an IV placed in the left arm of Resident #8. Interview with RN#2, RN currently caring for Resident #8 on 2/13/26 at 10:49 AM identified Resident #8 fell on 2/9/26 and was found to be dehydrated and had received 2 liters of IV fluid since 2/9/26. Interview with the dietician on 2/13/26 at 11:52 AM identified Resident #8 was followed by the APRN but misses and/or refuses meals due to chemotherapy treatments and indicated Resident #8 was able to use utensils per the dietician's observations, identified Resident #8 was ordered a two handled cup for liquids, but could not confirm if the cup was being used. Observation of Resident #8 on 2/13/26 at 12:10 PM identified Resident #8 consumed less than 25% of the lunch meal and identified on the overbed tray table 2 plastic cups, one containing a pink colored liquid and another with a chocolate nutritional shake in the cup without a straw. There was not a two handled cup present. Interview with the dietician on 2/13/26 at 12:17 PM identified Resident #8 had a fluid goal of 1900 to 2300 ml/daily but indicated there was no order to monitor fluid intake. The dietician identified that she does not review the fluid intake unless the resident was on a fluid restriction and indicated that Resident #8 was not receiving enough fluid orally according to the documentation and identified it should be reviewed more consistently. Interview with NA#5 on 2/13/26 at 1:20 PM identified she was not sure if Resident #8 had a special cup as she had not seen the resident with one. Additionally, NA#5 was collecting lunch dishes from the rooms and there was not a handled cup on the dishware cart. NA #5 indicated that Resident #8 holds cups independently and drinks well and identified Resident #8 would not need a handled cup. Interview with RN#7 on 2/13/26 at 1:25 PM identified Resident #8 was receiving IV fluids for dehydration and indicated she had never seen Resident #8 with a handled cup. Interview with APRN#1 on 2/13/26 at 1:47 PM identified that intake and output should be monitored for all residents and should be in the resident chart notes. APRN#1 indicated that Resident #8 had received IV fluids in the past related to dehydration and that Resident #8 was not great with PO intake but could not identify if Resident #8 required any assistive devices but indicated that if it had been ordered by therapy, she would expect it to be implemented. Interview with the Therapy Director (Occupational Therapist) on 2/13/26 at 2:43 PM identified Resident #8 was assessed and ordered a dual handled cup for spilling a hot beverage. The therapy director indicated the process was that after the assessment, therapy was responsible for putting the order for the assistive device into the electronic health record (EHR) and identified the kitchen and nursing are notified when an assistive device is ordered. The therapy director indicated that she was not certain the communication was relayed to the kitchen, but identified the assistive device is located in Resident #8's care plan. Interview with the Food Service Director (FSD) and the Dietician on 2/13/26 at 2:55 PM identified the kitchen had no knowledge of the dual handled cup prior to this day. The FSD indicated the assistive device was added to the meal ticket and would be implemented on the resident floor and produced the meal ticket which identified Resident #8 had adaptive equipment of a 2 handled mug with lid. (continued on next page)

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	075382	A. Building B. Wing	02/13/2026

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DNS on 2/13/26 at 3:02 PM identified Resident #8 was being followed by the APRN and the dietician and that the expectation for facility monitoring of a resident included complying with ordered adaptive equipment and collaboration between departments. All observations only showed drinks present in Resident #8's room. There were no observations of Resident #8 drinking anything provided and when asked, Resident #8 refused to drink. Resident #8 was never observed with a 2 handled cup nor an orthotic device. Resident #8 had multiple issues including chemotherapy (side effect of diarrhea), 2 diuretics, 2 stool softeners, history of dehydration, minimal fluid and food intake, assistive device ordered and not implemented, and intake refusals. Resident #8 was monitored by each discipline (Therapy, dietician, APRN) although the assessments were being done, the interventions were more reactive than proactive, and it did not appear that the individual disciplines were collaborating. Definitively, the assistive device that was ordered was never implemented and could have contributed to the dehydration was could not be solely responsible for the dehydration. Facility policy for hydration identified dehydration risk factors to include history of refusing fluids and use of diuretics and indicated if the resident had consumed less than their estimated fluid goal for 3 consecutive days, evaluate the resident for signs and symptoms of dehydration. Facility policy for nutritional intake identified the purpose of the policy was to ensure all residents receive the appropriate diet, are provided with assistance and adaptive equipment as indicated, and have food and fluid intake observed and recorded. Additionally, the policy indicated that adaptive self-help devices are provided to assist the residents' independence in eating and that nursing personnel will observe the food and fluid intake of residents and report any situations of concern to the physician.

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	075382	A. Building B. Wing	02/13/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record, review of facility documentation, review of facility policy, and interviews for 3 sample residents (Resident #90, Resident #92, and Resident #94) reviewed for infection surveillance, the facility failed to maintain a system to track a Multi-Drug Resistant Organism (MDRO) infection to the other healthcare provider upon transfer. The findings include: Review of facility MDRO line listing tracking form identified Resident #90 had a history of Methicillin Resistant Staphylococcus Aureus (MRSA) to a wound that was identified on 12/10/21. Resident #90's diagnoses included multiple sclerosis, dementia, and anxiety. The resident medical diagnoses failed to identify the MRSA to a wound. The quarterly MDS assessment dated [DATE] identified Resident #94 identified severe cognitive impairment and required extensive assist with toileting, personal hygiene, dressing, and transfer. Review of facility MDRO line listing tracking form identified Resident #92 had a history of Extended Spectrum Beta-Lactamase (ESBL) in the urine that was identified on 12/17/25. Resident #92 diagnoses included Chronic Obstructive Pulmonary Disease (COPD), osteoarthritis, anxiety, and depression. The resident medical diagnoses failed to identify the ESBL in the urine. The quarterly MDS assessment dated [DATE] identified Resident #92 identified intact cognition and required extensive assist with toileting, personal hygiene, dressing, and transfer. Review of facility MDRO line listing tracking form identified Resident #94 had a history of ESBL in the urine that was identified on 10/11/24. Resident #94 diagnoses included COPD, dementia, and anemia. The resident medical diagnoses failed to identify the ESBL in the urine. The quarterly MDS assessment dated [DATE] identified Resident #92 identified severe cognitive impairment and required extensive assist with toileting, personal hygiene, dressing, and transfer. Interview with RN #2 (infection control nurse) on 2/9/26 at 2:00 PM identified that all residents with history of MDRO would be included in the resident medical diagnoses so other provider would be aware of the residents history of MDRO. She identified that the MDS person is the responsible for adding the MDRO diagnosis in the resident clinical record. She identified that she would add any resident with history of MDRO to her tracking form and remove the resident from the tracking form when discharge from the facility. She also identified that the MDRO tracking form was only available in her office and the nursing unit did have a copy of the MDRO tracking form. Review of Resident # 90, Resident #92, and Resident #94 with RN#2 the history of MDRO were not added to the medical diagnosis. She further identified that she could not recall whether she communicated to the MDS coordinator that Resident #90, Resident #92, and Resident #94 had history of MDRO. Interview with LPN #3 (MDS Coordinator nurse) on 2/11/26 at 12:15 PM identified that she was responsible for adding the medical diagnoses in the clinical record. She identified that she would add the MDRO to the resident's medical diagnosis when she was made aware. She could not recalled whether she was aware of the history of MDRO for Resident #90, Resident #92, and Resident #94. Review of the Multidrug-Resistant Organisms policy identified that the appropriate precautions will be taken when caring for residents with known or suspected to have a MDRO. The policy further identified that when single rooms are not available, cohort residents with the same MDRO in the same room, and if not possible cohort with a resident who was at low risk for acquisition of MDRO's and are likely to have a short length of stay.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075382	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodlake at Tolland	26 Shenipsit Lake Road Tolland, CT 06084

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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on review of facility documentation, facility policy/procedure, and interviews for 2 of 3 nurse aides (NA #12 and #13), the facility failed to complete the required annual in-service training. Review of NA#12's personnel file identified that she was hired on 2/9/09 and failed to identify documentation that Abuse Neglect and Exploitation, Resident Rights, Dementia Care, and Infection Control training was completed for 2024. The two trainings able to view for 2024 were Communication and Behavioral Health. Review of NA#13's personnel file identified that she was hired on 11/7/24 and failed to identify documentation that Dementia Care, Behavioral Health, and Communication training was completed for 2025. The training completed for 2025 was Abuse Neglect and Exploitation, Resident Rights, and Infection control. Review of the training schedule identified each month there are scheduled training that should be completed for the facility. Interview on 2/13/26 at 3:52PM with the Staff Development Nurse (RN #11) identified she was recently hired as the staff development nurse at the facility. She identifies it is the responsibility of the staff development nurse to ensure staff receives the mandatory annual education training and track when the training was completed. The staff development nurse identified that there is mandatory education scheduled throughout the year and a skill fair is done annually. Interview on 2/13/26 at 3:55PM with the Administrator identified that the staff development nurse and other department heads would host a skill fair event which included majority of the required mandatory education and training, where staff would be able to complete the required education/training. The Administrator further identified that there had been a great deal of turnover in the staff development nurse role and that she was unable to locate the training materials requested. Although a facility policy was requested one was not received.