STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075386	A. Building B. Wing	06/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shady Knoll Center for Health & Rehabilitation	41 Skokorat Street Seymour, CT 06483

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for 1 of 3 residents (Resident #33) reviewed for mistreatment, the facility failed to ensure an allegation of rushed and rough care which potentially caused a left hand bruise was thoroughly investigated. The findings include:Resident #33's diagnoses included atrial fibrillation, anxiety, and chronic idiopathic constipation.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #33 was moderately cognitively impaired, had no physical/verbal symptoms directed toward others, and had no behavior of rejection of care. The MDS assessment also identified Resident #33 was dependent for toileting hygiene and required substantial/maximal assistance with lower body dressing and bed mobility.The Resident Care Plan (RCP) dated 6/5/25 identified Resident #33 had the potential for verbal aggression related to mental/emotional illness, poor impulse control, and was inclined to yell and scream at the staff. Interventions included to give Resident #33 as many choices as possible about care and activities and when Resident #33 was noted to be aggressive, staff were to leave/redirect and reapproach at a later time. The RCP further identified Resident #33 had the potential for verbal expressions of distress and/or persistent anger with self or others. Interventions included conversing with the resident during care, use a calm, gentle approach, and if Resident #33 refuses/resists care, honor requests and attempt at a later time.A facility Reportable Event form dated 6/16/25 for the 3:00 PM to 11:00 PM shift identified Resident #33 was noted with a bruise to the left hand and Resident #33 stated he/she hit the Nurse Aide (NA) during care. The Reportable Event form further identified Resident #33 was not sure if he/she hit the NA or the siderail when he/she obtained the bruise, further indicating the NA was laughing at him/her and rough.A Facility Summary Report dated 6/18/25 identified upon facility investigation, Resident #33 was interviewed by the DNS and Administrator. The Summary Report identified Resident #33 reported that the NAs came into the room to do care, and he/she was hitting the staff with his/her hands back and forth in the air. The report identified Resident #33 was unsure if he/she got bruised by hitting the staff or the side rail and further indicated the NA was laughing at him/her and rough. The report identified there were 2 staff members (NA #6 and NA #7) present in the room for care and both staff were interviewed. Both NAs stated Resident #33 was hitting and cursing at them, and both NAs reported they stopped care and explained to Resident #33 that he/she was soiled. The report identified Resident #33 stopped hitting the NAs, care resumed and the NAs stated they had sped up care to avoid further agitation of Resident #33. The report identified both NAs denied making fun of Resident #33 or being rough with care and the facility was unable to substantiate any mistreatment towards Resident #33. Interview with the DNS on 6/30/25 at 1:25 PM identified she had completed the investigation for the allegation of abuse for Resident #33 and her process for investigation of an allegation of abuse was after determining the cause of the allegation she interviewed all staff working the shift when the event occurred, spoke with the resident involved, the family, the APRN, and the roommate if the resident resided in a double room. The DNS further identified Resident #33 was able to recall and provide the names of the 2 NAs that he/she indicated had mistreated him/her, that she interviewed Resident #33, and had interviewed Resident #20 (Resident #33's roommate) who had told her the same story as Resident #33 so she didn't include Resident #20's interview in her investigation.Review of the facility accident and incident investigation documentation identified signed statements by NA #6, NA #7, and the DNS.Review of the facility investigation documentation failed to identify a resident witness interview (roommate/Resident #20) dated, documented, and signed by the nursing supervisor or designee.Review of the facility investigation documentation failed to identify interviews with relevant staff on that unit with written statements that were dated and signed. NA #4, NA #5, Licensed Practical Nurse (LPN) #4, and LPN #5 were working on that unit on the 3:00 PM to 11:00 PM shift on 6/15/25 and their statements were not within the investigation documentation.Review of the facility investigation documentation failed to identify documentation of statement from NA #3 who was informed by Resident #20 and Resident #33 of the incident the morning of 6/16/25 and who observed the bruise to Resident #33's left hand and reported it. Review of the Abuse Policy & Procedure directed, in part, mistreatment would include not following the assignment resulting in potential or actual harm to the resident. The policy directed staff training should include appropriate interventions to deal with aggressive reactions of residents. The policy directed that any suspicion of resident abuse was to be thoroughly investigated and reported and the facility investigation would be completed within 5 days of the

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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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observations, facility documentation, facility policy and interviews for 1 of 5 sampled residents (Resident #44) reviewed for Preadmission Screening and Resident Review (PASRR), the facility failed to ensure a PASRR Level II assessment was completed following an exempted short term approval for a resident with a suspected serious mental illness. The findings include: Resident #44 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease and bipolar disorder.A Notice of PASRR Level I screen outcome dated 3/5/25 identified Resident #44 had a suspected or had been diagnosed with a serious mental illness and received a 7 day emergency short term post hospital discharge approval for Level I. Recommendations included a re-screen for Level I screen and, as necessary, a Level II evaluation on or before the 7th day if the individual was to remain in the nursing facility.The discharge Minimum Data Set (MDS) assessment dated [DATE] identified Resident #44 was discharged to an acute care hospital with an anticipated return.The PASRR episode tracker dated 3/14/25 identified Resident #44 was referred for a Level II evaluation and was subsequently cancelled by the screening authority on 3/17/2.A review of the facility census identified Resident #44 was re-hospitalized [DATE], readmitted back to the facility on 4/3/25 then subsequently discharged back to the hospital from [DATE] to 4/12/25.The PASRR episode tracker dated 3/17/25 to 6/23/25 failed to identify a Level II PASSRR was completed following readmission to the facility on 4/12/25.An interview with Social Worker (SW) #1 on 6/24/25 at 3:03 PM identified she was responsible for tracking and ensuring the completion of Level I and Level II PASRR evaluations for newly admitted residents and changes thereafter. SW #1 identified that a PASRR Level II was requested for Resident #44 for 3/14/25. However, Resident #44 was discharged to the hospital on 3/13/25 resulting in the cancellation of the assessment on 3/17/25. SW #1 indicated she did not follow up on referring Resident #44 for a Level II evaluation upon readmission to the facility from the hospital as an oversight.An interview with the DNS on 6/30/25 at 2:44 PM identified she would expect PASRR referrals to be completed as recommended.Although requested, a policy related to PASRR referrals was not provided.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation, facility policy, and interviews for 1 of 5 residents (Resident # 44) reviewed for unnecessary medications, the facility failed to ensure that a comprehensive care plan was developed for a resident with a recent history of smoking/vaping and issues with smoking contraband. The findings include: Resident # 44 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD), diabetes, and failure to thrive.A Hospital Discharge summary dated [DATE] identified Resident #44 was transferred to the facility on 3/1/25 following hospitalization, had a prior history of vape use, and recent tobacco use which included smoking a 1/2 pack of cigarettes (10 or more cigarettes) per day.The nursing admission assessment dated [DATE] at 9:47 PM identified that Resident #44 had an unknown history of smoking or tobacco use.A nursing note dated 3/1/25 at 10:00 PM identified Resident #44 was found to have 2 vape devices in his/her possession upon admission to the facility. The note identified that Resident #44 had one pink, and one green vape device which he/she stated belonged to his/her late spouse. The nursing note further identified that the vape devices were removed from the resident and stored in a safe place. Review of the clinical record failed to identify any documentation related to smoking assessments on or after 3/1/25 and subsequent to the vape devices being found.Review of Resident #44's care plans from 3/1/25 to current failed to identify a care plan had been developed for Resident #44's history of vaping or interventions related to Resident #44's prior history of vape use, recent tobacco use, or vape devices observed on admission by facility staff on 3/1/25The 5-day Minimum Data Set (MDS) dated [DATE] identified Resident # 44 had intact cognition, was always incontinent of bowel, frequently incontinent of bladder, and was dependent on staff for assistance with bathing, dressing, and toileting. Review of the clinical record identified Resident #44 was hospitalized from [DATE] related to atrial flutter and returned to the facility on 4/3/25. A nursing note dated 4/3/25 at 2:39 PM identified Resident #44 reported difficulty breathing, had an oxygen saturation of 76%, was subsequently transferred back to the hospital and admitted to the hospital from [DATE] to 4/12/25 for acute hypoxic respiratory failure. Review of the hospital discharge documentation dated 4/12/25 identified Resident #44 as a smoker who had smoked 3 packs of cigarettes per day since his/her teenage years. Review of Resident #44's care plan failed to identify the care plan was comprehensive to include Resident #44's history of vaping and tobacco use following readmission to the facility on 4/12/25 and therefore no interventions were in place.An APRN progress note dated 4/17/25 and written by APRN #1 identified Resident #44 was observed at the nurse's station with 'another' vape in his/her hand. APRN #1 identified that the vape device was given to a nursing supervisor, and that the importance of not smoking or vaping had been consistently discussed with Resident #44. Upon entrance to the facility on 6/23/25 as part of an annual recertification survey, the facility identified that it was a non-smoking facility following a change of ownership on 10/10/24 and identified that residents in the facility who were smokers at the time of the change had been grandfathered in and provided list of identified residents. Review of the facility list of residents grandfathered into smoke failed to identify Resident #44. Interview with the DNS on 6/26/25 at 4:00 PM identified that Resident #44's care plan should have included a previous history of smoking/vaping.The facility policy on Baseline/Comprehensive Person-centered Care plan directed that the interdisciplinary team would utilize the comprehensive person-centered care planning process to address the residents strengths, needs, and or problems as identified on the admission and discharge summary, as well as other professional assessments and orders from the health care provider, dietary team, therapy, social services and PASARR and MDS. The person-centered care plan was developed to include information necessary to properly care for the resident and would address the resident's preferences, goals, desired outcomes and plan for discharge.

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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. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, facility documentation, facility policy and interviews for 1 of 2 residents (Resident #103) reviewed for choices, the facility failed to support a resident's choice related to assistance with oral care. The findings include:Resident #103 had diagnoses that included hemiplegia (paralysis)and hemiparesis (muscle weakness) following a stroke affecting the left side, Moyamoya disease, and cognitive communication deficit.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #103 was moderately cognitively impaired and the behavior of rejection of care was not exhibited. The MDS assessment also identified Resident #103 required setup or clean-up assistance with oral hygiene, was dependent with personal hygiene, and required substantial/maximal assistance with bed mobility.The Resident Care Plan (RCP) dated 5/27/25 identified Resident #103 required assistance with activities of daily living (ADL) care and mobility related to a significant stroke resulting in left side hemiplegia. Interventions included oral care 2 times a day as needed, treatment for dry mouth per physician order, and assistance with bed mobility.Interview with Person #1 on 6/23/25 at 1:32 PM and 6/24/25 at 12:04 PM identified Resident #103 wanted to brush his/her teeth (oral care) 2 times a day and required setup to complete this task but staff were not assisting with setup of the necessary supplies 2 times a day. Person #1 identified that Resident #103 often reported to him/her that nursing staff had not assisted him/her with setup of the toothbrush and supplies. Person #1 identified that a concern related to Resident #103 receiving assistance with oral care had been brought up with the facility administrator and nursing staff on multiple occasions, but the assistance was still not consistently being provided 2 times a day. Person #1 identified he/she had placed a sign on the wall in Resident #103's room with instructions on how Resident #103 preferred to be setup for oral care but stated that the sign didn't help. Person #1 identified Resident #103 required 3 cups of water and his/her toothbrush with a small amount of toothpaste applied to the bristles. Person #1 identified that if the proper supplies were provided, Resident #103 could brush his/her teeth, rinse his/her mouth, and rinse his/her toothbrush without additional staff assistance until he/she required clean-up of the supplies. Person #1 further identified the nursing staff were not providing setup of these supplies 2 times a day as Resident #103 preferred.Interview with Resident #103 on 6/25/25 at 12:00 PM identified he/she had not been assisted with brushing his/her teeth yet today. Interview with Nurse Aide (NA) #1 on 6/25/25 at 12:05 PM identified that she had assisted Resident #103 with brushing his/her teeth by setting Resident #103 up with an emesis basin, toothbrush, and a couple cups of water.Interview with NA #1 on 6/25/25 in Resident #103's room with Resident #103 at 12:10 PM identified the toothbrush she stated she had provided Resident #103 that morning was not the toothbrush that Resident #103 uses. NA #1 identified she had not known Resident #103's toothbrush was in the bathroom. NA #1 identified she assisted Resident #103 with brushing his/her teeth when she worked on the 7:00 AM to 3:00 PM shift and could not identify if she was aware of Resident #103's preference for brushing his/her teeth and the supplies preferred for this task, and acknowledged that she was aware of the sign on Resident #103's wall, but that she did not pay attention to the sign. NA #1 could not identify if the instructions were on the NA care card, was unable to locate the NA care card, and was unable to identify where to find the NA care card if it was not hanging within Resident #103's closet.Review of the NA care card dated 6/25/25 identified nursing staff were directed to provide Resident #103 oral care 2 times a day as needed, treatment for dry mouth per order. The NA care card failed to identify Resident #103's preference for assistance with oral care to be automatically provided 2 times a day without him/her having to request assistance, and the care card failed to identify directions of the oral care supplies Resident #103 prefers so he/she can perform oral care.Interview with Registered Nurse (RN) #1 6/25/25 at 3:00 PM identified she was not aware of who was responsible for ensuring the NA care cards were up to date with accurate information. RN #1 identified the information on the NA care cards was automatically generated from the physician orders and that she did not review them. RN #1 identified the NA care cards were located within through electronic medical record (EMR) platform, NAs could access them using their tablets, and it had been a long time since they were inside the resident closets. RN #1 identified she was not aware of signs in Resident #103's room placed by a family member to explain how and when Resident #103 would like assistance with oral care. RN #1 identified she was unaware how to enter resident specific care requests into the EMR so that it would be reflected on the NA care cards. RN #1 further identified Resident #103's oral care preferences should be included in his/her NA care card so that the

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for 1 of 5 residents (Resident #35) reviewed for unnecessary medications, the facility failed to ensure that weekly weight monitoring was completed timely. Additionally, for 1 of 5, (Resident #44) reviewed for activities of daily living (ADL), the facility failed to re-evaluate the continued use of mobility equipment and plan of care for its continued use following the removal of a motorized chair. The findings include:1.Resident # 35 was admitted to the facility on [DATE] with diagnoses that included acute and chronic respiratory failure, chronic obstructive pulmonary disease (COPD), and heart failure.A hospital Inter-Agency Referral (W-10) document dated 4/2/25 identified Resident #35 was hospitalized from [DATE] to 4/2/25 for acute and chronic respiratory failure. The hospital documentation identified that Resident #35 was discharged to the long-term care facility on 4/2/25 with medication orders to continue Furosemide (a diuretic medication used for fluid buildup in heart failure) 40 milligrams (mg) daily, and a new medication order for Acetazolamide 250 mg (a medication used for fluid buildup) twice weekly.A physician's order dated 4/4/25 directed Furosemide 40 mg daily for heart failure and Acetazolamide 250 mg twice weekly on Monday and Friday to reduce fluid buildup.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #35 had intact cognition, was always incontinent of bowel and bladder and was dependent on staff to assist with toileting, bathing, and dressing. The Resident Care Plan dated 4/4/25 identified Resident #35 had a history of heart failure that required prescribed diuretic medication with interventions that included to monitor weights as ordered.A review of the clinical record identified that on 5/12/25, Resident #35 weighed 356.5 lbs. Further review of the clinical record identified that on 6/2/25, Resident #35 weighed 365.3 lbs. (a weight gain of 8.8 lbs. or 2.46% over 3 weeks).An APRN order dated 6/2/25 written by APRN #1 directed to obtain weekly weights for 4 weeks beginning on 6/11/25.Review of the June 2025 Medication Administration Record (MAR) and weight record failed to identify any weekly weight documentation until 6/19/25 (8 days after the APRN order for weekly weights).A review of the clinical record identified that on 6/19/25, Resident #35 weighed 399.1 lbs. (a weight gain of 33.8 lbs. or 9.25% since 6/2/25 (17 days)). Further review of the clinical record identified APRN #1 was notified of the weight gain on that date.Interview with the DNS on 6/26/25 at 4:00 PM identified that Resident #35 routinely refused weight monitoring, and that nursing staff may have forgotten to document a refusal in the clinical record.Interview with APRN #1 on 7/1/25 at 9:35 AM identified that Resident #35 had a history of heart failure, respiratory failure, and fluid retention and she was aware of Resident #35's recent weight gain. APRN #1 identified she would expect the facility nursing staff would follow the provider's orders related to weight monitoring.Review of the clinical record failed to identify any documentation related to Resident #35's refusals of weight monitoring.Review of the clinical record failed to identify any care plans or interventions related to Resident #35's refusals of weight monitoring.The facility policy on weight directed that weights would be obtained and recorded. The policy further directed that residents experiencing significant weight changes may require weekly weights.The facility policy on weight policy and procedures directed that residents with significant unintended weight changes would be added to weekly weights for 4 weeks or until weight stabilizes as determined by the IDT. The policy further directed that significant weight changes would have verification of weight measurement for accuracy and documentation purposes, and that significant weight changes included 5 % in 30 days, 7.5% in 90 days, or 10% in 180 days.2a. Resident #44 diagnoses included deep vein thrombosis of the left lower extremity and recent history of pneumonia.The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #44 was cognitively intact, required one person assist with bed mobility/transfers and mobilized with the use of a manual wheelchair and assist of one.The Resident Care Plan (RCP) dated 5/3/25 identified Resident #44 had a deficit in functional mobility and was non ambulatory. Interventions included ambulation with rehabilitation staff only and assist of two with transfers.An Occupational Therapy note dated 5/3/25 identified Resident #44's personal power chair was brought to the building where Resident #44 was assessed for safety with operation. Resident #44 was provided education in maintaining the slowest speed while in the building due to frequent obstacles and other residents. Further assessment and training were required to clear Resident #44 for independent use of the power chair. An Occupational Therapy note dated 5/5/25 identified Resident #44's personal power chair was assessed for safety. Resident #44 was able to drive from his/her room to the nurse's station, to the elevator and gym and back with intermittent cues for safety. Resident #44 was cleared for use of the power chair on

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, staff interviews, facility documentation, and facility policy for 1 of 3 residents (Resident #31) reviewed for pressure ulcers, the facility failed to follow physician orders timely and initiate treatment orders for a newly identified wound. The findings include:Resident #31's diagnoses included unspecified dementia, chronic kidney disease, and essential hypertension.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #31 was severely cognitively impaired and dependent on staff for shower/bathing, lower body dressing, and putting on/taking off footwear.Review of a skin condition binder located on the 3rd floor identified on 4/28/25 a new skin issue/concern for Resident #31 was identified on the 3:00 PM to 11:00 PM shift as a right heel open area and that the on-call Advanced Practice Registered Nurse (APRN) and supervisor were notified.An on-call APRN progress note dated 4/28/25 at 6:17 PM identified Resident #31 had a chief complaint of a pressure wound. The summary identified a right heel open area measuring 2.0 centimeters (cm) by 2.0 cm, that a scab fell off and follow-up with wound care in the morning. Additionally, the note failed to recommend any type of treatment to the right heel.An on-call APRN order dated 4/28/25 at 6:17 PM directed follow up with wound care in the morning and notify a clinician of any changes in condition. Additionally, the order failed to recommend any type of treatment to the right heel.A nursing note dated 4/28/25 at 7:32 PM identified Resident #31 had an open wound to the right heel measuring 2.0 cm by 2.0 cm, the on-call APRN was made aware, resident to be seen by the wound care team the next day, the resident's family member was made aware with a request for a follow up call from the wound care team, but no treatment was ordered.A Resident Care Plan meeting note dated 4/29/25 at 4:15 PM identified Resident #31 had a wound on right heel and was to be seen by the wound care team. The Resident Care Plan dated 5/1/25 identified Resident #31 had the potential for skin breakdown due to decreased mobility and incontinence. Interventions included offloading heels when in bed as tolerated by the resident, pressure redistribution cushion, pressure redistribution mattress, skin checks with care, turn and reposition every two to three hours as tolerated by resident, and weekly skin evaluations.A wound care specialist progress noted dated 6/6/25 (39 days after the physician order dated 4/28/25 to follow up with wound care in the morning) at 9:40 PM identified Resident #31 was seen as a consultation for evaluation of a right heel ulcer. The wound assessment identified a Stage two pressure ulcer to the right heel with a size of 0. 9 cm by 0.3 cm by 0.2 cm and calculated area of 0.27 square cm. Additionally, the note identified the wound status as new. A treatment order was started directing staff to cleanse right heel with normal saline and apply collagen and kerlix every day on evening shift and as needed (39 days after the development of the right heel wound). Although weekly skin assessments had been completed, review of skin and wound total body skin assessments dated 4/3/25, 4/10/25, 4/17/25, 4/24/25, 5/1/25, 5/18/25, 5/22/25, 5/29/25, and 6/5/25 identified no new wounds (despite Resident #31 developing a pressure ulcer to the right heel on 4/28/25). Interview and record review with Infection Prevention Registered Nurse (RN) #2 on 6/26/25 at 10:32 AM identified that for a new wound, the APRN, resident family member, and wound care team would be contacted and that any nurse can make contact. The wound care specialist was at the facility weekly and was responsible for weekly tracking/assessments. Additionally, review of the clinical record with RN #2 identified that Resident #31 was not seen by the wound care team until 6/6/25 (39 days after the APRN order) and that was the reason weekly tracking/assessments and wound care orders were not initiated on 4/28/25. Additionally, RN #2 identified that she was responsible for monitoring wounds in the facility but was not made aware of Resident #31's heel wound until 6/6/25 (39 days after the development). RN #2 indicated that if they were made aware then she would have tracked the wound in coordination with the wound care team. Interview with RN #4 on 6/26/25 at 10:55 AM identified that while performing care for Resident #31, an open area to the right heel was identified on 4/28/25. RN #4 indicated that she made the on-call APRN aware and entered a progress note with her findings. Additionally, RN #4 indicated that the finding was provided during report to the oncoming shift and that the finding was entered into the skin assessment binder which she understood to be an additional reporting tool to the wound care team when they come to the facility.Interview and record review with the DNS and Administrator on 6/26/25 at 3:15 PM identified that the facility policy for transcription of orders was that when an order was given, whether over the phone, verbal or paper, the nurse or supervisor can input those orders into the electronic health record. The DNS and Administrator indicated that the skin observation binder was no longer in use as a communication tool and

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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 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. (continued on next page)

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation, facility policy, and interviews for 1 of 5 residents (Resident # 44) reviewed for unnecessary medications, the facility failed to ensure that a resident with recent history of tobacco use was assessed for smoking upon admission and re-admission to the facility; and failed to ensure that the resident was free of smoking materials within the facility; and failed to ensure interventions were in place following the identification of smoking/vaping materials within the facility. The findings include:Resident # 44 was admitted to the facility on [DATE] with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD), diabetes, and failure to thrive. A hospital Discharge summary dated [DATE] identified Resident #44 was transferred to the long term care facility on 3/1/25 following hospitalization. The hospital discharge summary further identified Resident #44 had a prior history of vape use, and recent tobacco use which included smoking a 1/2 pack of cigarettes (10 or more cigarettes) per day.The nursing admission assessment dated [DATE] at 9:47 PM identified that Resident #44 had an unknown history of smoking or tobacco use.A nursing note dated 3/1/25 at 10:00 PM identified Resident #44 was found to have 2 vape devices in his/her possession upon admission to the facility. The nursing note identified that Resident #44 had one pink, and one green vape device which he/she stated belonged to his/her late spouse. The nursing note further identified that the vape devices were removed from the resident and stored in a safe place. Review of the clinical record failed to identify any documentation related to smoking assessments initiated or completed for Resident #44 on or after 3/1/25.Review of the Resident Care Plans failed to identify any care plans or interventions related to Resident #44's prior history of vape use, recent tobacco use, or vape devices observed on admission by facility staff.The 5-day Minimum Data Set (MDS) dated [DATE] identified Resident # 44 had intact cognition, was always incontinent of bowel, frequently incontinent of bladder, and was dependent on staff for assistance with bathing, dressing, and toileting.Review of the clinical record identified Resident #44 was hospitalized on [DATE] for anemia and atrial flutter and returned to the facility on 4/3/25. A nursing note dated 4/3/25 at 2:39 PM identified Resident #44 reported difficulty breathing, had an oxygen saturation of 76%, and was subsequently transferred back to the hospital. Review of the clinical record identified Resident #44 was subsequently re-hospitalized from [DATE] through 4/12/25 for acute hypoxic respiratory failure. Review of the hospital Discharge summary dated [DATE] identified Resident #44 as a smoker who had smoked 3 packs of cigarettes per day since his/her teenage years. Review of the clinical record failed to identify any documentation related to smoking assessments initiated or completed on or after 4/12/25.Review of the Resident Care Plans failed to identify any revisions or interventions related to Resident #44's history of vaping and tobacco use following readmission to the facility on 4/12/25.An APRN note dated 4/17/25 written by APRN #1 identified Resident #44 was observed at the nurse's station and that she observed Resident #44 with 'another' vape in his/her hand. APRN #1 identified that the vape device was given to a nursing supervisor, and that the importance of not smoking or vaping had been consistently discussed with Resident #44. Review of the clinical record failed to identify any additional documentation related to counseling or education provided to Resident #44 related to smoking or vaping.Review of the clinical record failed to identify any documentation related to smoking assessments initiated or completed on or after 4/17/25.Upon entrance to the facility on 6/23/25 as part of an annual recertification survey, the facility identified that it was a non-smoking facility following a change of ownership on 10/10/24 and identified that residents in the facility who were smokers at the time of the change had been grandfathered in and provided list of identified residents. Review of the facility list of residents grandfathered into smoke failed to identify Resident #44.Interview with the DNS on 6/26/25 at 4:00 PM identified that Resident #44 had not had any recent smoking or vape use in the facility and that Resident #44 had only been found to have a single vape device which the facility had confiscated on initial admission to the facility on 3/1/25. The DNS identified that Resident #44 had a visitor at the facility who initially provided the vape device on 3/1/25 and the visitor had been instructed that the device was not allowed in the facility. The DNS then identified that the visitor had brought the device in and out of the facility on multiple occasions. The DNS identified that APRN #1 had contacted her regarding the vape device on 4/17/25 and that facility nursing staff reached out to Resident #44's visitor to remove the device from the facility. The DNS identified the vape device observed by APRN #1 on 4/17/25 was the same device that was observed on 3/1/25. The DNS identified that Resident #44 had no recent history of smoking, had not been observed using the vape devices, and therefore she did not

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation, facility policy and staff interviews for 1 of 5 residents (Resident #93) reviewed for unnecessary medications, the facility failed to review and respond to pharmacy recommendations in a timely manner. The findings include:Resident #93 was admitted to the facility on [DATE] with diagnoses of dementia, anxiety, and hypertension.A physician's order dated 12/10/24 directed to administer Citalopram Hydrobromide (Celexa) (an antidepressant medication) 40 milligrams(mg) 1 tablet by mouth once a day.The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #93 was severely cognitively impaired, dependent on bathing, dressing, and toileting. Also identifying Resident #93 required maximal assistance for personal and oral hygiene and was receiving an antidepressant medication. The Pharmacy medication review dated 12/12/24 identified Resident #93 was receiving Citalopram (Celexa) 40 mg per day and noted Celexa was no longer recommended to be used at doses greater than 20 mg per day in those of [AGE] years of age because it can cause dose-dependent QT interval prolongation (a heart rhythm-disorder that can cause fast, chaotic heartbeats).The Medication Administration Record dated from 12/11/24 through 4/28/25 identified Resident #93 was receiving Celexa 40 mg every day, then discontinued on 4/28/25 due to Resident #93 being on medical leave. Also identifying Resident #93 was restarted on Celexa 10 mg to take 2 tablets to equal 20 mg every day on 5/25/25.The Resident Care Plan (RCP) dated 12/26/24 identified Resident #93 had psychotropic medication used with interventions that included to give medication as ordered, and monitor, document and report as needed any adverse reactions of the psychotropic medications such as falls, weight loss, vomiting and hallucinations. The Pharmacy medication review dated 2/12/25 noted a second request identifying Resident #93 was still receiving Celexa 40 mg every day and the Pharmacist recommended to evaluate and consider tapering Celexa to 20 mg daily and monitor the effect.The Pharmacy medication review dated 4/8/25 noted a second request (even though it was the third request) identifying Resident #93 was still receiving Celexa 40 mg every day and the Pharmacist recommended to evaluate and consider tapering Celexa to 20 mg daily and monitor the effect. The Pharmacy medication review dated 5/9/25 identified a fourth request regarding Celexa 40 mg for evaluation and tapering to 20 mg every day and monitor the effect. A Pharmacist note dated 5/9/25 at 10:44 AM identified the medication regimen was reviewed and recommendations have been made for nursing to review. The physician order dated 5/27/25 directed for Celexa 10 mg 1 tablet to be given every day (physician responded after 4 pharmacy reviews with recommendations). Interview with the Director of Nursing (DNS) on 6/30/25 at 12:37 PM identified that the Pharmacist recommendations for Celexa were to decrease the dosage, the same recommendation was made again 2/12/25 and these recommendations had not been addressed by the physician. Also identifying that once a recommendation was made by the Pharmacist, the Advanced Practice Registered Nurse (APRN) was to review the recommendations and either change the order or chart a reason for not changing the order and no record could be identified regarding decreasing the Celexa. Further identifying that she reviews the Pharmacist recommendations monthly and it was an oversight that Celexa had not been decreased since 12/12/24 and it should have been addressed within the first month of the recommendation.An interview with APRN #2 on 6/30/25 at 1:02 PM identified she had stopped working at the facility in January 2025 and at the time some residents had transferred from another facility causing confusion on which provider covered the new transferred residents.An interview with the Pharmacist on 6/30/25 at 1:04 PM identified that she does not usually write consecutive recommendations which was the reason the decrease in dosage of Celexa was not addressed by pharmacy in January 2025 and March 2025. Also, identifying that when a recommendation was not addressed, she would let the DNS know but there was no documentation for this until 5/9/25. Further identifying that the recommendation for the dose reduction of Celexa was made 4 times over 5 months. Review of the facility policy for Pharmacy medication review identified that the Consultant Pharmacist reviews the medication regime of each resident at least monthly. The findings and recommendations are communicated to those with responsibility to implement the recommendation, and to answer in a timely fashion. The Consultant Pharmacist will submit their monthly recommendation reports to the DNS and follow the recommendations to verify that appropriate action has been taken or responded to within a reasonable time frame. Physicians may accept and act on the recommendations or reject the recommendation and provide an explanation for disagreement. If there was a potential for serious harm and the attending

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observations, facility documentation, facility policy and interviews for 1 of 3 sampled residents (Resident #67) reviewed for choices, the facility failed to ensure a meal was provided according to preference and served in a timely manner. The findings include:Resident #67 had diagnoses that included chronic kidney disease and calculus of the gallbladder.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #67 was cognitively intact and independent with eating.The Resident Care Plan dated 5/19/25 identified Resident #67 with a nutritional diagnosis of obesity with limited mobility. Interventions included providing the diet as ordered and honoring the resident's food/beverage preferences. Physician orders dated 5/30/25 directed a 2 gram (GM) Sodium (2 GM Na+) diet, regular texture with thin (no thickening agent required) consistency fluids.An interview with Resident #67 on 6/23/25 at 11:04 AM identified he/she cannot have salt or milk as it caused gastrointestinal symptoms and the concern was discussed with dietary staff. However, Resident #67 continued to receive food items with milk or that were salty.The facility menu dated 6/24/25 identified a main lunch meal of garlic herb pork loin/marinated chicken, garlic mashed potatoes and steam vegetables with a white dinner roll with butter.A lunch meal ticket dated 6/24/25 for identified Resident #67 ordered 1 serving of scrambled eggs, 1/2 cup penne pasta and 1 dinner roll with butter.A subsequent observation on 6/24/25 at 12:43 PM identified Resident #67 received garlic herb pork loin, garlic mashed potatoes and steam vegetables for lunch (not the scrambled eggs, penne pasta and dinner roll with butter as Resident #67 requested).An interview with Resident #67 on 6/24/25 at 12:43 PM identified Resident #67 was not served any eggs with the lunch meal and instead, NA #8 served pork with mashed potatoes. Resident #67 refused the meal and requested NA #8 to prepare a personal soup kit, but she never returned.An interview and photographic image review of the meal with NA #8 on 6/24/25 at 2:40 PM and 6/30/25 at 10:59 AM identified she would contact the kitchen to request any food items for residents who report not receiving what was ordered. NA #8 identified meal ticket selections were to be verified before serving resident meal trays. NA #8 served Resident #67 the lunch meal tray on 6/24/25 but only verified the name and room number without also verifying the meal choice. NA #8 indicated Resident #67 reported to her that he/she did not receive eggs as ordered, however, NA #8 did not contact the kitchen to obtain an alternate meal according to resident preference as Resident #67 requested she prepare a personal soup kit instead. NA #8 further identified she had not yet prepared and served the soup to Resident #67, (approximately two hours after the request) as she was toileting other residents.An interview with the Food Service Director (FSD) on 6/30/25 at 8:21 AM identified meal tickets were to be verified at the time they were plated in the kitchen and when dietary staff bring to the units.An interview with the Administrator on 6/30/25 at 8:23 AM and 6/30/25 at 8:23 AM identified once the meal trays were on the units, nurse aide staff were expected to verify meal tickets before serving to the residents. The Administrator indicated meals should be provided according to preference and served in a timely manner.Although requested, a policy for the provision of meal according to preference was not provided.Although requested, a policy for verifying resident meal choices was not provided.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on a temperature meal tray sample taken with the Dietary Director and staff/resident interviews, the facility failed to ensure meals was served at appropriate temperatures.During the Resident Council meeting on 6/24/25 at 1:34 PM, residents complained of ongoing issues with food being served cold. On 6/25/25 at 12:35 PM, a test tray was conducted. The following was identified:The lunch meal was plated and left the Dietary Department on a variety of serving carts which were two tiered and open to air starting at 11:45 AM which were filled with 7 to 8 meals on each serving cart, plated and covered with a clear plastic lid with a hole in the center. Dietary Aides transferred meal trays to the third floor first, returning after the serving carts were emptied to refill with meals plated in the kitchen, then returned to the units to finish serving. The food temperature log was reviewed with all foods identified at appropriate temperatures for each item on the steam table. The test temperature tray was plated at 12:35 PM and brought up to the second-floor unit at 12:40 PM. One Nurses Aid was on the unit passing trays even though other Nurses Aids were seen down the hall of the second floor. The last tray was served to a resident at 12:50 PM and temperatures were obtained of the temperature test tray at 12:50 PM with the Dietary Director identifying the following:a. The chicken cutlet entrees' internal temperature was 128 degrees with both the Dietary Director and surveyor's thermometer. b. The baked potato's internal temperature was 128 degrees with both the Dietary Director and surveyor's thermometer. c. The cooked spinach's internal temperature was 129 degrees with both the Dietary Director and surveyor's thermometer.d. The mashed potato's internal temperature was 129 degrees with the surveyor's thermometer and 130 degrees with the Dietary Director's thermometer.An interview with the Dietary Director on 6/25/25 at 12:55 PM identified that all the Nurse's Aides were responsible for passing the trays. Also, the Dietary Director provided a copy of the Test Tray form with the acceptable temperature for all hot items being served at 135 degrees. Further identifying that all the food that was temperature tested was cold and that the food was not served in a timely manner. The Dietary Director identified there was a portable steam table that the dietary staff was using but it was too difficult to transport to the unit, and it did not have enough areas to hold all the food item options during meals, which was the reason it was no longer being utilized. Also, identifying that all staff should be serving trays during mealtimes which included department heads, and Nurses Aids. On 6/26/25 at approximately 9:30 AM the DNS and Administrator identified that they assisted with passing breakfast trays on the second-floor unit that morning which took about 15 minutes and when they performed a temperature check of the meal being served it was all cold. Also identifying that they contacted corporate regarding food temperature and the plan was to have closed carts ordered to keep the food warm.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on the tour of the Dietary Department, staff interviews, and review of facility policies, the facility failed to ensure opened items were labeled and dated when opened, and expired food was discarded. The findings include:Tour of the Dietary Department on 6/23/25 at 9:55 AM during the initial walk through with the Dietary Director identified the following:a. A large bag of Ciabatta Garlic bread sticks opened, not dated, located in the walk-in freezer.b. 4 (gallon sized) opened freezer bags of frozen chicken wings observed in the walk-in-freezer were not dated when opened.c. 1 (1 pound) bag of coconut half full, not dated and open to air located in the dry storage room.d. 1 (24-ounce) package of powdered gravy mixed which was opened and dated 1/21/25 in the dry storage room which was not sealed closed.e. 11 individual 0.98-ounce packages of oatmeal not in the original box (which identified the expiration date) with no expiration date noted.An interview with the Dietary Director on 6/23/25 at 10:00 AM identified that all food that was opened should be labeled with a date when opened and any expired food should be discarded. Also identifying that the cooks were responsible for labeling and dating the items. Further identifying that she would not use the dry gravy mix.An observation of the tray line with the Dietary Director on 6/25/25 at 11:45 AM identified the following:a. 1 (46-ounce) container of orange juice which was 1/4 full with an open date of 12/17/24 and an expiration date of 6/4/25 (21 days passed the expiration date) which was on the beverage cart during tray line, but it was not utilized.An interview with the Dietary Director on 6/25/25 at 11:50 AM identifying the orange juice should have been thrown away and not used after the expiration date. Also identifying that all dietary staff were responsible for discarding expired items.Review of the facility policy for Storage of food and supplies food, by dates. Also identified was food removed from its original container must be labeled with the common name of the food. Further identifying that refrigerator time/temperature safety, ready-to-eat food that was opened but not completely used and was held for longer than 24 hours should be labeled with the common names and use by day, with day 1 counted as the day the item was opened. Rotate food product (dry, refrigerated, or frozen) to ensure the oldest inventory was used first. Discard food that exceeds their used by date or expiration date, was damaged, spoiled, has the time/temperature danger zone requirements, or was incorrectly stored such that it was unsafe, or its safety was uncertain.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, staff interviews, and facility policy for 1 of 4 residents (Resident #102) reviewed for activities of daily living (ADL), the facility failed to refer resident to physical therapy (PT) and occupational therapy (OT) after identifying a decline in ADLs. The findings include:Resident #102's diagnoses included unspecified Alzheimer's disease, functional quadriplegia, and weakness.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #102 was severely cognitively impaired and required setup or clean-up assistance with eating, supervision or touching assistance with oral hygiene, and partial to moderate assistance with personal hygiene.The quarterly MDS assessment dated [DATE] identified Resident #102 was severely cognitively impaired and dependent on staff for eating, oral hygiene, and personal hygiene (a decline from the 1/29/25 quarterly MDS).The Resident Care Plan dated 5/19/25 identified Resident #102 had a deficit in self-care related to cognitive loss and decreased mobility. Interventions included resident was dependent on eating/feeding with 1 facility staff helping complete the activity and resident was dependent on personal hygiene/oral care with 2 facility staff helping complete the activity.Physican orders for the month of May 2025 failed to identify orders for physical therapy/occupational therapy (PT/OT) to assess/address Resident #102's decline in status.Interview and record review with the MDS Coordinator Registered Nurse (RN) #5 on 6/30/25 at 9:41 AM identified that Resident #102 had a decline in ADL's assessed at the quarterly MDS on 5/1/25. RN #5 indicated that if a resident had a decline in ADL's, orders should be input for referral to PT and OT. RN #5 identified that it was the responsibility of the MDS Coordinator to ensure referrals for PT/OT were input after a decline was identified and could not provide a reason a PT/OT referral was not completed.Interview with the Director of Rehabilitation on 6/30/25 at 10:07 AM identified that they would expect to receive a referral and assess a resident who was identified as having a decline in ADLs. The interview identified that they receive notice of resident decline and referrals through paper reports, orders in the electronic health record, and morning report. Additionally, the interview identified the last time Resident #102 was seen by PT or OT was in January 2025 and that with the decline documented in the quarterly MDS dated [DATE], Resident #102 should have been referred to PT and OT. Review of the therapy admissions policy dated 1/2018 identified admissions to rehabilitation services will be made by appropriately credentialed therapists according to the patient's needs. Additionally, it stated patients are identified through the screening process or can be evaluated without the screening process if the interdisciplinary team identifies a significant change in medical and/or functional condition.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shady Knoll Center for Health & Rehabilitation	41 Skokorat Street Seymour, CT 06483

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 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on review of facility documentation and staff interview, the facility failed to ensure the 1st quarter Payroll Based Journal (PBJ) report was submitted. The findings include:Review of the [NAME] 1st Quarter (10/1/24 through 12/31/24) PBJ Staffing Data Report identified there were no submittals for Registered Nurse hours and for licensed nursing coverage 24 hrs./day for 10/1/24 through 10/10/24.An interview with the Administrator on 6/30/25 at 9:43 AM and 6/30/25 at 2:30 PM identified the former owners of the facility were responsible for nursing staff PBJ submissions and failed to complete transmissions 10/1/24 through 10/10/24 as an oversight before the change of ownership which was effective 10/10/24.Although a policy for PBJ submission was requested, none was provided.