STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075390	A. Building B. Wing	01/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beacon Brook Center for Health & Rehabilitation	89 Weid Drive Naugatuck, CT 06770

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, facility documentation, facility policy and interviews for 1of 1 resident reviewed for positioning/mobility, the facility failed to follow physician orders regarding skin protection (Resident #14) and for 1 of 5 residents, (Resident #125) reviewed for dining, the facility failed to ensure meal supervision and feeding by staff was provided in accordance with physician order and the plan of care, resulting in a choking incident. The findings include: 1.Resident #14's diagnosis included hemiplegia and hemiparesis following a cerebral infarction affecting left side, dysphagia, and diabetes. The quarterly Minimum Data Set (MD) dated 11/21/25 identified Resident #14 was cognitively intact and was dependent on staff for eating, showering, toileting, dressing, and transfers: The MDS further identified Resident #14 was at risk for developing a pressure ulcer requiring a pressure reducing device for the bed and chair. A physician's order dated 12/2/25 directed to apply a bed cradle to bottom of the bed at all times. A physician's order dated 12/2/25 directed to place offloading boots to bilateral feet at all times and to check skin integrity every shift. The Resident Care Plan (RCP) dated 12/2/25 identified Resident #14 had the potential for skin breakdown.? Interventions included placing a bed cradle when the resident was in bed, offload heels with bilateral heel boots at all times and checking skin integrity every shift. Observation on 12/30/25 at 10:21 AM identified Resident #14 was in bed with one heel protector on the left leg, there was not a bed cradle in place, his/her bilateral lower extremities were elevated on a pillow while in bed, and the sheets were on top of the resident's toes. Observation on 12/30/25 at 2:45 PM identified Resident #14 was in bed with no bed cradle in place on the bed. The bed cradle was noted to be on the floor of the room by the dresser, only one heel protector was in place to Resident #14's left leg and the sheets were hitting the resident's toes. Observation on 12/31/25 at 9:12 AM identified Resident #14 was in bed, the bed cradle was not in place, the bed cradle was noted to be on the floor of the room by the dresser, the right heel protector was not in place, and the bed sheets were hitting the resident's toes. Interview with Nurse Aid (NA) #5 on 12/31/25 at 2:30 PM identified Resident #14 was to wear 1 heel (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075390	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/05/2026
NAME OF PROVIDER OR SUPPLIER: Beacon Brook Center for Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 89 Weid Drive Naugatuck, CT 06770	

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	protector, and the other foot was to be elevated on a pillow. NA #5 further identified that the bed cradle was on the floor but was unsure of how to place the cradle on the bed and had never asked how the cradle was to be placed on the bed. Additionally, NA #14 identified she had cared for Resident #14 for a while and had never seen a second heel protector in Resident #14's room. On 12/31/25 at 2:35 PM, interview and review of the NA care card with NA #5 identified Resident #14 was to have offloading boots to the bilateral feet at all times, to check skin integrity every shift, and the bed cradle was to be placed at the bottom of the bed at all times. Interview with Licensed Practical Nurse (LPN) #5 on 12/31/25 at 2:38 PM identified the physician order for Resident #14 was for a bed cradle to be placed at the bottom of the bed and offloading boots to bilateral feet at all times. She was responsible for following physician's orders and to provide oversight. Although she was aware she was responsible she could not identify the reason it was not done. LPN #5 also identified Resident #14 has had a past history of skin breakdown, and the orders of a bed cradle and offloading boots were for protection and prevention of skin breakdown. Interview with the DNS on 1/1/26 at 9:37 AM identified Resident #14 had a physician order to have offloading boots to bilateral feet at all times, and the bed cradle was to be placed at the bottom of the bed at all times. The DNS identified the nurse on the unit was responsible for oversight. Although a policy was requested for heel protectors and the bed cradle the DNS identified the facility did not have one. 2.Resident #125's diagnoses included dementia, chronic obstructive pulmonary disease (COPD), and seizure disorder. The Resident Care Plan dated 9/17/2025 identified Resident #125 had a potential for aspiration and weight loss due to missing teeth, and unintentional weight loss. Interventions directed to encourage to eat in the dining room, provide a full feed to promote food intake, attention to meal task providing verbal encouragement, eat when upright and 30 minutes after meals, eat at a slow rate, small bites and chew thoroughly. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #125 had a Brief Interview for Mental Status (BIMS) score of 9 indicating Resident #1 was mildly cognitively impaired, required substantial assistance when eating, and did not display signs and symptoms of a possible swallowing disorder. A physician order dated 11/20/2025 directed a consistent carbohydrate regular diet, regular texture, thin consistency (liquids) for risk of malnutrition. Physician order dated 12/6/2025 directed to assist with all meals and Speech Therapy consult difficulties swallowing for weight loss, and consistent carbohydrate regular diet, regular texture, thin consistency (liquids) for risk of malnutrition. Speech therapy (ST) note dated 10/2/2025 identified mastication (chewing) mildly extended, good oral clearance noted without signs of aspiration, required max verbal cues to encourage oral intake; frequently distracted/benefitting from supervision to improve oral intake. Discussed concerns with nursing staff on duty regarding weight loss and need for increased supervision and encouragement with meals. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Speech therapy note dated 11/12/2025 identified adequate textural breakdown, mastication, and oral clearance with no signs of aspiration. ST note dated 11/13/2025 identified staff educated regarding strategies to promote oral intake, and staff verbalized good understanding and signed inservice sheet. discharge date [DATE]. The Facility Reportable Event (RE) form dated 12/6/2025 at 1:20 PM identified on 12/6/25 staff observed Resident #125 exhibiting sudden drooling of fluid and seizure like activity while seated in wheelchair in room. Staff noted a piece of chicken fell from Resident #125's mouth and immediately assessed the resident's airway. Resident #125 was actively breathing with some coughing noted, back blows and abdominal thrust were initiated per facility policy. Resident #125 continued to maintain spontaneous respirations throughout, although was unresponsive. Emergency services were called, and Resident #125 was transferred to the hospital. Meal ticket and food checked on tray was consistent with current diet orders. A nursing note written by RN #1 dated 12/6/2025 at 2:14 PM identified Resident #125 was cyanotic (bluish coloration to skin), had reduced responsiveness with weak hand grasps, oxygen saturation was 82 percent (%) (COPD diagnosis normal greater than 90 percent) and oxygen was applied via a non-rebreather mask at 15 liters per minute. Back and abdominal thrusts were performed without any visible food being dislodged, and Resident #125 was transferred to the hospital at 1:20 PM Emergency Medical Services (EMS) run sheet dated 12/6/2025 identified EMS was notified at 12:58 PM and arrived at the facility at 1:02 PM. The report identified Resident #125 was breathing, not responsive, and responded to painful stimuli. Staff reported they believed Resident #125 was choking and had a syncopl episode, but when placed on the floor he/she pinked up and started breathing normally. The report further identified the pulse was 88 with an initial rhythm and Resident #125 was not a cardiac arrest, patient is breathing. Started to develop a slow heart rate, and was a cardiac arrest, CPR was initiated and continued until arrival to hospital. Hospital note dated 12/6/2025 identified Resident #125 presented after witnessed choking episode and lost pulses en route with EMS. Initial laryngoscopy attempted patient was noted to have large food bolus within the glottic opening (main airway valve to the lungs; space between the vocal cords in the larynx). Foreign body was removed with [NAME] forceps, and the patient was intubated. Three (3) rounds of epinephrine were administered with compressions via [NAME] device, and defibrillation as indicated and was admitted to the ICU. The hospital Discharge summary dated [DATE] at 11:32 AM identified Resident #125 was admitted on [DATE] after choking on meat, subsequently suffered cardiac arrest in the ambulance in route to the hospital ED and a cardiac rhythm was re-established after approximately fifteen (15 minutes). Intubation (placement of a tube through the mouth and into the airway) was completed in the Emergency Department (ED) but brain injury due to lack of oxygen was suspected. Resident #125 continued to be unstable for the next few days and despite aggressive intervention. Resident #125 suffered a cardiac arrest and expired on 12/8/2025 at 10:40 AM. The Facility RE summary dated 12/8/2025 identified Resident #125 required to be fed meals to promote oral intake and attention to meal task. Due to a respirator outbreak in the facility, communal dining was on hold. NA #1 brought the lunch tray to Resident #125 and placed it off to the side until resident was able to have assistance with feeding. The summary identified Resident #125 was currently hospitalized and the facility identified the meal tray should not have been left with Resident #125 until staff were ready to assist with feeding. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and record review with Speech Language Pathologist (SLP – therapist) #1 on 12/29/2025 at 11:51 AM identified she saw Resident #125 for therapy related to decreased intake and weight loss. SPT #1 stated Resident #125 did not display evidence of dysphagia (swallowing difficulty) although chewing was mildly extended likely due to missing teeth. Resident #125 had good oral clearance and required maximum verbal cues to encourage food intake due to easily distracted. SLP #1 recommended supervision with meals to improve Resident #125's food intake and stated Resident #125 did not exhibit impulsive behaviors regarding food or eating too quickly; her recommendations were to enhance food consumption and to cue Resident #125 to stay on task. SLP #1 stated staff had not reported any further concerns regarding Resident #125's eating habits to her. Interview and record review with NA #2 on 12/29/2025 at 12:45 PM identified on 12/6/2025 about 1:00 PM she was exiting the room next to Resident #125's room when she observed Resident #125 sitting up in the wheelchair with his/her arms straight out to either side of his/her body moving with jerking motions. NA #2 stated she thought Resident #125 was having a seizure and she called out for help, and LPN #1 and LPN #2 responded to the room. NA #2 observed Resident #125's bedside table to the right side of the chair with the lunch tray on top. NA #2 stated when she moved the bedside table, she observed the cover for the meal plate had been removed from the dish, and she saw small cut-up pieces of chicken on the plate. Interview and record review with LPN # 2 on 12/29/2025 at 12:10 PM identified she was the Charge Nurse on the unit when she responded to NA #2's call for help on 12/6/2025. She observed Resident #125 slumped forward in the wheelchair and she immediately repositioned Resident #125 back to a seated position. LPN #2 stated she observed Resident #125 drooling from his/her mouth that appeared to contain small food particles. Resident #125 was unresponsive but appeared to be trying to cough or breath. LPN #2 began to perform abdominal thrusts, and an oral finger sweep produced more drool and no food particles. RN #1 and LPN #1 came into the room and assisted to place Resident #125 on the floor. LPN #2 stated she did not need to move the bedside table to provide care for Resident #125 during the incident. Interview and record review with LPN #1 on 12/29/2025 at 11:46 AM identified she responded to the room and observed LPN #2 attempting to move Resident #125. RN #1 (nursing supervisor) arrived, and they both assisted LPN #2 to lower Resident #125 to the floor. LPN #1 stated Resident #125's color was dusky and improved when Resident #125 was placed on the floor. Resident #125 appeared to be breathing, had a weak rapid pulse with an oxygen saturation by pulse oximetry of 82 % (normal 90% or above). LPN #1 completed a finger sweep after turning Resident #125 on his/her side without any food noted. LPN #1 directed staff to call 911, and she and RN #1 applied oxygen via a non-rebreather mask at 15 liters per minute and obtained vital signs. Resident #125's color improved; blood pressure was 148/82, pulse was 86 and blood sugar was 258. Interview, record review and review of the investigation summary dated 12/8/2025 with the DNS and RN #2 (regional nurse), on 12/29/2025 at 2:00 PM identified Resident #125 required to have meals supervised or full feed (staff member to stay with Resident to assist feeding) due to poor oral intake at meals and inability to stay on task. NA #1 was expected to be with Resident #125 when eating, to assist and cue as per ST recommendations and consistent with Resident #125's care needs. The facility investigation included a follow up interview with NA #1 that identified she did not review the care card prior to her shift on 12/6/2025. NA #1 had dropped off Resident #125's tray, leaving it on Resident #125's bedside table to the side of Resident #125 who was sitting up in the wheelchair. NA #1 had identified that she had cut up the chicken, replacing the lid on the plate and left the room to feed another resident because communal dining was suspended at the time. The DNS stated the tray (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	should not have been distributed to the room by NA #1 until NA #1 was able to assist the resident with the meal. The DNS stated NA #1 was aware that Resident #1 was a supervised or full feed that required supervision for meals; review of education dated 11/12/2025 (prior to the incident) identified NA #1 signed inservice attendance that addressed Resident #125's care need of being a full feed with meals to promote oral intake for cuing and attention to meal task with small bites. Although attempted, NA #1 and RN #1 were unavailable for interview during the survey. Facility documentation review identified staff education was initiated on 12/7/2025 and included to check the resident Kardex to ensure to follow the resident's plan of care for eating strategies, and not to pass trays to residents until a staff member was ready to assist with the meal. Audits were initiated on 12/8/2025 and a QAPI meeting was held on 12/8/2025, to review the quality initiative. Based on review of facility documentation and interview with the DNS, past non-compliance was identified.