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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility policy and interviews for 1 of 24 sampled residents (Resident #41) reviewed for advanced directives, the facility failed to ensure advanced directives were consistent throughout the clinical record. The findings include:Resident #41's was admitted to the facility on [DATE] with diagnoses that included rhabdomyolysis (a rare muscle injury where your muscles break down), epilepsy (seizure disorder) and major depressive disorder. A facility Advanced Directive Consent/Acknowledgement and Release Form signed by Resident #41 and LPN #9 on [DATE] identified Resident #41 did not want Cardiopulmonary Resuscitation (CPR), Artificial Respiration and Artificial Nutrition administered. The signed form was retained in Resident #41's medical record.An admission physician's order dated [DATE] at 5:38 AM and [DATE] at 10:45 PM directed to provide CPR for Resident #41 (a discrepancy with the Advanced Directive Consent form signed by Resident #41 and Licensed Practical Nurse (LPN) #9 on [DATE]). An admission progress note written by Advanced Practice Registered Nurse (APRN) #1 and dated [DATE] at 8:15 AM indicated the code status was reviewed with Resident #41 and he/she requested to be do not resuscitate (DNR)/do not intubate (DNI). The progress not indicated measures concerning DNR/DNI were discussed with the resident with all questions and concerns addressed and documentation was updated with the resident's request.APRN #1's progress note dated [DATE] at 9:30 AM identified Resident #41's Code Status as RN (registered nurse) May Pronounce/Do Not Intubate/Cardio Pulmonary Resuscitation/Do Not Attempt Resuscitation/DNR.APRN #1's progress note dated [DATE] at 8:30 AM identified Resident #41's Code Status as Cardio Pulmonary Resuscitation (a discrepancy with the Advanced Directive Consent form signed by Resident #41 on [DATE] and APRN #1's progress note of [DATE]).The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #41 had intact cognition and required partial/moderate assistance with toileting, bed mobility and transfers. The Resident Care Plan (RCP) dated [DATE] identified Resident #41's Advanced Directive Guidelines were Code Status: Full Code/CPR/DNI/RNP (a discrepancy with the Advanced Directive Consent form signed by Resident #41 on [DATE] and APRN #1's progress note of [DATE]). Interventions included to honor advanced directives as directed by the resident and to review advanced directives with the resident on admission and at least quarterly. Interview and review of the clinical record with LPN #3 on [DATE] at 10:08 AM identified if Resident #41 was to be found unresponsive, CPR would be administered Resident #41 based on what was listed in the computer and on the resident's face sheet (while the advanced directive form in the resident's medical record directed Resident #41 was a DNR/DNI). LPN #3 indicated the physician's order in the computer and on the face sheet was incorrect and she was unable to indicate the reason the physician's order was not written to reflect Resident #41's wishes to be a DNR/DNI. LPN #3 identified she would immediately address Resident #41's advanced directives with the physician and make the necessary corrections. Subsequent to surveyor inquiry, a physician's order dated [DATE] directed Do Not Resuscitate, no artificial respiration, and no artificial nutrition and the RCP was updated on [DATE] to reflect a Code Status of DNR/DNI/no artificial respiration/no artificial nutrition for (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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #41.Interview and review of the clinical record with the DNS on [DATE] at 8:51 AM identified when Resident #41 signed the Advanced Directive form to be a DNR/DNI on [DATE], LPN #9 should have contacted the physician and obtained a new order to change the residents code status from CPR to DNR/DNI. The DNS was unable to indicate the reason LPN #9 did not follow through on obtaining a physician's order and she was unable to identify why APRN #1's progress notes were inconsistent regarding Resident #41's code status. Interview and review of the clinical record with APRN #1 identified when she reviewed code status with Resident #41 on [DATE] and the resident indicated he/she wanted to be a DNR/DNI, she did not review the resident's orders and was not aware Resident #41's order reflected he/she was to be provided CPR. APRN #1 indicated when Resident #41 signed the Advanced Directive form to be a DNR/DNI on [DATE], LPN #9 should have contacted the physician and obtained a new order to change the residents code status from CPR to DNR/DNI. APRN #1 identified she had failed to ensure the resident's choice to be a DNR/DNI was reflected in the physician's orders and was consistently documented in her progress notes in Resident #41's clinical record. Interview with LPN #9 on [DATE] at 10:58 AM identified she had signed the Advanced Directive form with Resident #41 on [DATE] which reflected the resident choice to be a DNR/DNI. LPN #9 indicated after signing the form with Resident #41 she gave the admission packet to the nursing supervisor and assumed the nursing supervisor would have contacted the physician for a new order. LPN #9 indicated she was not aware Resident #41 was to be administered CPR based on what was listed in the computer and on the resident's face sheet. LPN #9 identified the nursing supervisor would review and obtain any necessary orders and she was unsure why that was not done. Review of facility policy, Advanced Care Planning Code Status, dated 2/25, directed upon admission the option of choosing to resuscitate or not to resuscitate will be offered and reviewed with the resident and a physician's order must be written accordingly. The healthcare provider who is provided with consent for an order not to resuscitate must promptly issue an order not to resuscitate. When the consent of the resident has been obtained and the DNR decision has been made, the directive shall be written as a formal order by the healthcare provider in the medical record.

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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 observation, resident/staff interviews, and facility policy, the facility failed to ensure that food items were maintained at a palatable and appetizing temperature at time of serving. The findings include: Food Committee Meeting Minutes from 1/13/25, 2/24/25, 4/21/25, 5/19/25, 6/16/25, and 7/23/25 identified resident complaints of cold food.On 1/2/25 at 12:20 PM a test/temperature tray was conducted with the Director of Dietary and the following was identified:At 12:26 PM the test tray was prepared and plated in the kitchen located on the basement floor. The test meal was plated on a heated dish, placed in a plastic base, covered with a plastic dome, and put onto a meal tray. The meal tray was then placed in a closed meal delivery truck with other resident trays. The meal delivery truck left the kitchen at 12:27 PM for its destination to the second-floor unit.At 12:29 PM (2 minutes after leaving the dietary department), the meal delivery cart arrived at the second-floor (hallway 1), where multiple staff members were observed distributing trays to residents.At 12:39 PM (12 minutes after leaving the dietary department) the food cart proceeded to the second-floor, hallway 2, and staff members were observed passing trays to residents in that area.At 12:48 PM (22 minutes after leaving the dietary department) the last resident tray was passed, and temperatures of the test tray were taken by surveyor with a calibrated thermometer in the presence of the Dietary Manager (who did not bring a thermometer) identifying the following:Battered Fried Fish internal temperature was 118.9 degrees FahrenheitRoasted Tomatoes internal temperature was 106.9 degrees FahrenheitOven [NAME] Potatoes internal temperature was 104.5 degrees FahrenheitAn interview with the Dietary Manager conducted on 1/5/25 at 10:21 AM confirmed indicated that hot food should be served at a minimum temperature of 120 F to ensure palatability (which is a discrepancy with facility policy related to food temperature).The facility's Culinary Services: Food Temperature Measurement policy, revised March 2022, indicates that food held between 41 F and 135 F is considered within the ?Danger Zone.' The policy defines proper food temperature as both safe and appetizing to the resident. It further specifies that food temperature measurements may be conducted during receiving, storing, cooking, holding, serving, cooling, and reheating.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of the clinical record, facility documentation, facility policy and interviews for 1 of 3 residents (Resident #13) reviewed for pressure ulcers and for 1 of 1 resident (Resident #15) reviewed for a tracheostomy, the facility failed to wear Personal Protective Equipment (PPE) during wound and tracheostomy care. Additionally, for 1 of 2 residents (Resident #29) reviewed for skin conditions, and for 1 of 1 residents (Resident #60) reviewed for dialysis, the facility failed to implement enhanced barrier precautions (EBP). The findings include: 1.Resident #13 was admitted to the facility in December 2023 with diagnoses that included dementia, spectrum beta lactamase (ESBL) bacteria in urine (highly antibiotic-resistant bacteria in urine) which is a multidrug resistant organism (MDRO) and stage 3 pressure ulcer. The reentry Minimum Data Set assessment dated [DATE] identified Resident #13 was unable to participate in a Brief Interview for Mental Status due to severe cognitive impairment, was dependent on staff for all activities of daily living, required maximum assistance with bed mobility and had a Stage 3 (full thickness skin loss with or with dead tissue) pressure ulcer. Physician's orders dated 12/16/25 directed Enhance Barrier Precautions (EBP) for chronic urinary catheter, history ESBL in the urine and a Stage 3 pressure ulcer to the sacrum. The treatment to the sacrum wound was to pack the wound using Dakin's solution (antimicrobial solution) and gauzed once a day and as needed. The Resident Care Plan dated 12/21/25 identified Resident #13 was on EBP for urinary catheter, Stage 3 pressure ulcer, and history of ESBL in the urine. Interventions included EBP for the duration of stay related to a history of ESBL in the urine and chronic urinary catheter, and to don (put on) a gown and gloves when performing high contact care activities. Observation on 12/30/25 at 10:00 AM noted Resident #13 had signage outside of his/her room regarding the need for EBP, a set up for personal protective equipment (PPE) was by the entrance to the room and a bin for soiled PPE was on the inside of the room before exiting the room. Observation on 12/31/25 at 12:30 PM noted RN #3 (Wound Care Nurse) assisting with Resident #13's dressing change. RN #3 had only gloves on for PPE and was not wearing a gown. However, all other 3 nursing staff in Resident #13's room had on full PPE (gown, gloves and facemask). Initially, RN #3 was to take photographs of Resident #13's sacrum wound but then proceeded to assist nursing staff with repositioning Resident #13 on his/her side two times during the dressing change. RN #3 then proceeded to take photographs of Resident # 13's sacral wound. RN #3 did not wash her hands or change gloves during this process. Resident #13's EBP were in place not only for his/her Stage 3 pressure ulcer but for a urinary catheter and a history of ESBL in the urine. Interview with RN #3 on 12/31/25 indicated that she should have put on full PPE as she provided hands-on assistance to Resident #13 during the dressing change. In addition, Resident #13 was on EBP for a urinary catheter and history of ESBL. Review of the facility policy, Precautions to Prevent Infection, dated 6/2024, directed residents with wounds and at risk for increased MDRO transmission should be placed on EBP. Examples of wounds included chronic wounds and diabetic ulcers. In addition, signage regarding the particular type of (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	precaution was to be utilized. Review of the memorandum, Centers for Medicare and Medicaid Services (CMS) Guidance on Enhanced Barrier Precautions in Nursing Homes, dated 3/20/24, directed that EBP expands the use of personal protective equipment to donning of gown and gloves during high-contact resident care activities for residents with chronic wounds. 2.Resident #15's diagnoses included chronic respiratory failure, history of stroke, and diabetes. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #15 had a feeding tube, required tracheostomy care, required suctioning, and was dependent with personal hygiene, bed mobility and transfers. The MDS assessment failed to identify Resident #15's cognitive patterns/mental status. The Resident Care Plan (RCP) dated 12/30/25 identified Resident #15 had increased susceptibility for infection related to presence of a tracheotomy. Interventions included EBP as ordered, notify the Medical Doctor (MD) if Resident #15 developed signs and symptoms of infection. The RCP identified Resident #15 required EBP due to an indwelling medical device, feeding tube, and trach. Interventions included to bundle high contact activities whenever possible, and don a gown and gloves when performing high contact care activities including care or use of the indwelling medical device (trach). Observation of Resident #15's room on 12/30/25 at 11:30 AM noted Resident #15 had a trach with oxygen via a trach mask and EBP signage was posted on the left side of the doorway prior to the entrance of the room. Observation of Licensed Practical Nurse (LPN) #6 on 1/2/26 at 7:35 AM identified she was providing tracheostomy care which included suctioning of Resident #15's trach and changing the gauze around the area without the benefit of wearing a gown. Interview with LPN #6 at that time identified Resident #15 was on EBP, she should have been wearing a gown and could not convey the reason she did not wear a gown while performing trach care. LPN #6 further identified the gowns were located on the linen cart in the hallway and observation of the linen cart confirmed gowns were available for use. Interview with the Director of Nursing Services (DNS) on 1/2/26 at 9:05 AM identified residents who were on EBP were identified by signage on the doorway. The DNS identified a gown and gloves should have been worn by LPN #6 when she provided trach care and suctioned Resident #15. Review of the clinical record failed to identify a physician order for EBP. Review of the Enhanced Barrier Precautions policy directed, in part, EBP are indicated for residents with indwelling medical devices (trach). The policy directed PPE for EBP included gown and gloves worn during high contact resident care activities that included device care. The policy directed that residents on EBP were identified by signage on the doorway and designation in the Kardex within the electronic medical record. Review of the facility policy, Precautions to Prevent Infection, dated 6/2024, directed residents with wounds and at risk for increased MDRO transmission should be placed on EBP. Examples of wounds included chronic wounds and diabetic ulcers. In addition, signage regarding the particular type of precaution was to be utilized. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Resident #29's diagnoses included type 2 diabetes mellitus with foot ulcer, chronic ulcer of the left ankle, and methicillin resistant staphylococcus aureus (MRSA) infection. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #29 was cognitively intact and had a lower extremity impairment on one side. The MDS indicated Resident #29 required substantial/maximal assistance with bed mobility, toileting and transfers and had a diabetic foot ulcer requiring application of a dressing. The Resident Care Plan dated 10/29/25 identified Resident #29 had a non-pressure ulcer related to diabetes and a multi drug resistant organism (MDRO) with infection/colonization of Methicillin-Resistant Staphylococcus Aureus (MRSA) in the left ankle wound. Interventions included to apply the wound treatment as ordered and conduct weekly wound evaluations with wound clinic follow-up as indicated. Further interventions included the use of a disposable gown and gloves during physical contact with the resident. The RCP failed to indicate and include Enhanced Barrier Precautions (EBP) for Resident #29. Review of the facility skin and wound evaluation documentation dated 12/3/25 identified Resident #29 had a diabetic wound to the left lateral ankle that was acquired at the facility on 10/4/24. The evaluation indicated the wound had moderate serosanguinous exudate (thin, watery, pinkish, or light red wound drainage) and was slow to heal. A physician's order dated 12/15/25 directed to cleanse the left lateral ankle with Saline, dry and apply skin prep to the peri wound (surrounding the wound) area then apply Collagen to the wound and cover with a dry protective dressing (gauze pad and gauze wrap) three times per week and as needed if the dressing became soiled or dislodged. Observations on 12/29/25 at 10:20 AM and 12/30/25 at 10:30 AM identified that although Resident #29 was receiving wound care for a chronic diabetic ulcer of the left lateral ankle, the outside of Resident #29's room failed to indicate posted signage for Enhanced Barrier Precautions (EBP). Wound care observation, interview, and review of the clinical record on 12/31/25 at 10:50 AM with the wound care nurse (RN #3) and the nursing supervisor (RN #4) identified Resident #29 failed to have a physician's order and signage outside of his/her room indicating the need for EBP. RN #3 and RN #4 identified although Resident #29 had a chronic diabetic ulcer, he/she was not on EBP because only residents with draining wounds and an MDRO needed to be on EBP. RN #3 was observed to provide wound care and although she was wearing gloves for wound care, she failed to wear a gown during the dressing change. After the wound care observation revealed wound drainage and review of the clinical record indicated Resident #29 had an MDRO, RN #3 and RN #4 indicated they were unsure why Resident #29 had not been placed on EBP and they would need to check with the Infection Preventionist (IP) nurse. Subsequent to surveyor inquiry, an observation on 1/2/26 at 7:53 AM identified EBP signage had been posted outside of Resident #29's room. Interview and review of the clinical record with the Director of Nursing Services (DNS) on 1/2/26 at 8:53 AM identified Resident #29 should have been on EBP for his/her wound and that posted EBP signage was not required outside of the resident's room because the nursing staff wound know the resident was on EBP per the resident's care plan and kardex. The DNS indicated it would have been the responsibility of the charge nurse or IP nurse to make sure the resident was put on EBP. The DNS (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Nurse Aide (NA) care card/kardex identified Resident #60 was on EBP for a left arterio-venous shunt and a MDRO/ESBL in the urine. The kardex further directed staff to don a gown and gloves when performing high contact care activities including bathing, dressing, assisting with toileting/changing brief and transferring the resident. Observation, interview, and review of the clinical record with NA #4 on 12/31/25 at 9:35 AM identified NA #4 was providing personal care for Resident #60 and was not wearing appropriate Personal Protective Equipment (PPE) (no isolation gown). NA #4 indicated she had provided Resident #60 with incontinent care, a bed bath, dressed Resident #60 and transferred him/her into the wheelchair without the benefit of an isolation gown. NA #4 identified she was not aware Resident #60 was on EBP and did not check her assignment before providing care. NA #4 indicated she had made an error and although she saw the posted EBP signage outside of the room she thought it was for the other resident in the room and not Resident #60. Observation and interview with Licensed Practical Nurse (LPN) #3 on 12/31/25 at 10:05 AM identified EBP signage was posted outside of Resident #60's room. LPN #3 indicated although she did not tell NA #4 that Resident #60 was on EBP, NA #4 should have checked her assignment on the computer before providing care for Resident #60. LPN #3 identified NA #4 should have worn an isolation gown when she provided personal care to Resident #60. Interview and review of the clinical record with the Director of Nursing Services (DNS) on 1/2/26 at 8:53 AM identified for resident's on EBP, nursing staff should don an isolation gown and gloves when providing personal care. The DNS indicated NA #4 should have known what PPE was required and should have donned an isolation gown when providing personal care for Resident #60. The DNS identified she was unsure why the NA did not wear the appropriate PPE and she would need to provide further education to NA #4. Interview with the Infection Preventionist (LPN #4) on 1/2/26 at 10:30 AM identified for resident's on EBP, nursing staff should don an isolation gown and gloves when providing personal care. Th IP nurse indicated NA #4 should have known what PPE was required and should have donned an isolation gown when providing personal care for Resident #60. The IP nurse identified she would need to provide further education to the nursing staff. Review of the facility policy, Infection Prevention and Control Policy, dated 6/2024, directed EBP requires gown and glove use for residents with an MDRO and indwelling medical devices (including hemodialysis catheters) during high risk resident care activities (identified as dressing, bathing, transferring, providing hygiene and changing briefs/assisting with toileting). Review of the facility policy, Enhanced Barrier Precautions, undated, directed EBP precautions were indicated for residents with an MDRO and indwelling medical devices. An isolation gown and gloves should be donned when performing high contact care activities such as bathing, dressing, providing hygiene, changing briefs/assisting with toileting and transferring of residents. Review of the memorandum, Centers for Medicare and Medicaid Services (CMS) Guidance on Enhanced Barrier Precautions in Nursing Homes, dated 3/20/24, directed that EBP expands the use of personal protective equipment to donning of gown and gloves during high-contact resident care activities for residents with indwelling medical devices and MDRO's.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interviews for 1 of 5 (Resident #42) reviewed for dining, the facility failed to ensure a dignified dining experience. The findings included: Resident #42 was admitted to the facility in July 2022 with diagnoses that included dementia, anxiety, and dysphagia (difficulty swallowing).The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #42 was severely cognitively impaired and required set up assistance for meals and moderate assistance with activities of daily living.The Resident Care Plan dated 11/5/25 identified Resident #42 had swallowing difficulty with interventions that included to provide adequate time to consume meals, assist as needed, no rice, honor food preferences, monitor for any signs of difficulty swallowing, monitor for malnutrition, and document amount eaten.Physician's orders dated 11/24/25 directed to provide easy to chew food textures (mechanical soft) with regular liquids. Observation of the 2nd floor main dining room on 12/29/25 at 12:35 PM identified there were 13 residents seated there for lunch. Resident #42 was seated at a table in the back of the dining room with another resident (Resident #41). Resident #41 received his/her meal tray at 12:35 PM but Resident #42 did not receive his/her meal tray until 1:05PM (waiting 30 minutes while Resident #41 was eating. Nurse Aide (NA) #10 identified that Resident #42's tray was not on the dining room cart. At 12:47 PM, NA #10 called the kitchen to notify that Resident #42 did not have a meal tray and needed a lunch meal. Resident #42 continued to sit at the table with only beverages and no offers of a snack from staff while waiting for his/her lunch. At 1:05 PM a lunch tray of chopped ham, mashed potatoes and vegetables arrived from dietary staff for Resident #42. At the same time, NA #10 brought Resident #42's meal tray that was located on another cart from Brookview unit. Observation on 12/29/25 at 1:05 PM noted Resident #42 immediately started to consume his/her meal, a half hour after the other residents were served their lunch. All residents in the dining room except for 2 residents had finished their lunch and were eating dessert. All other residents had started to exit the dining room when Resident #42's lunch meal was provided.Interview with NA #10 on 12/29/25 at 1:08 PM identified that she located Resident #42's tray on the cart when she finished providing the residents on the unit their meal. NA #10 stated that Resident #42's meal tray was not usually on the unit cart but on the dining room cart and was unsure why his/her tray was placed on the wrong cart. However, she stated that sometimes a tray was missing or put on the wrong cart from the kitchen. Interview with the Director of Food Services on 12/31/25 at 1:20 PM identified that the Dietary Aide prints out the meal tickets for residents that eat in their rooms and residents that eat in the dining room. The tickets are then sorted and placed on the appropriate meal cart. She stated that Resident #42's meal ticket inadvertently got placed on the wrong cart and was unsure how it happened as she assisted with the meal line on 12/29/25. Furthermore, the Director of Food Services stated that when dietary receives a call for a meal when serving, the turnaround time is usually 15 minutes. She also indicated that there are food items in the cabinet and in the refrigerator in the dining room and the nursing assistants can provide a snack for a resident if waiting for a meal. She indicated that Resident #42 should have not waited 1/2 hour for his/her meal while all the other residents in the dining room were eating and that he/she should have been offered a snack by the nursing assistants.A review of the Resident Preferences Dining Policy dated 1/22 directed, in part, Residents have the right to choose their schedules for dining, with whom they prefer to eat and where they prefer to sit. A method will be in place to assist staff in identifying residents such as meal tickets, a dining roster or other community specific processes. The information will be kept in a location that is easily accessible to staff and not in the public view.

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

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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 observations, review of the clinical record, facility documentation, facility policy and interviews for 1 of 3 residents (Resident #29) reviewed for accidents the facility failed to follow the plan of care for a resident with a history of falls. The findings include: Resident #29's diagnoses included a displaced fracture of the left lower leg, repeated falls, and a history of falls.A fall evaluation dated 2/15/25 identified Resident #29 was a high fall risk, was unsteady and had unsafe behaviors. The fall evaluation indicated Resident #29 had intermittent confusion and disorientation and a visual impairment.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #29 was cognitively intact and required substantial/maximal assistance with bed mobility, toileting, and transfers. The MDS also indicated Resident #29 had a lower extremity impairment on one side.The Resident Care Plan (RCP) dated 10/29/25 identified Resident #29 had impaired mobility and muscle weakness and was at risk for falls related to an impaired sense of balance, an unsteady gait, and being legally blind. Interventions included to provide a low bed and floor mats and to ensure the bed was left at an acceptable height.The Nurse Aide (NA) care card/kardex identified Resident #29 was a high fall risk and required a low bed and floor mats.Observations on 12/29/25 at 10:20 AM and 1/2/26 at 7:32 AM noted Resident #29 in bed and without the benefit of a low bed and floor mats. Resident #29's bed was not in a low position and the resident had his/her eyes closed.Observation, interview, and review of the clinical record with NA #8 on 1/5/26 at 8:30 AM identified Resident #29 was in bed and without the benefit of a low bed and floor mats. Resident #29's bed was not in a low position and the resident was awake. Review of the NA care card/kardex with NA #8 indicated Resident #29 was a high fall risk and was to be in a low bed with fall mats on the floor. NA #8 proceeded to search the resident's room for the floor mats but was unable to locate them. NA #8 identified she was aware Resident #29 needed floor mats and she saw them in the resident's room before, was unsure what happened to them and would need to ask the nurse. Observation and interview with LPN #8 on 1/5/26 at 8:37 AM identified Resident #29 was in bed and without the benefit of a low bed and floor mats. Resident #29's bed was not in a low position and the resident was awake. LPN #8 indicated she was aware Resident #29 was a high fall risk, was to be in a low bed with fall mats on the floor and she was unsure why the bed was not in a low position and the fall mats were not in the room. LPN #8 identified the mats may have been removed for cleaning and she would need to call maintenance. Interview and review of the clinical record with the DNS on 1/5/26 at 10:13 AM identified Resident #29 was a high fall risk and per the plan of care should have had a low bed and fall mats in place. The DNS indicated she was unsure why the resident was in a regular bed (which was not in a low position) and did not have fall mats in place. The DNS identified it would have been the responsibility of the NA or charge nurse to ensure, while the resident was in bed, the bed was in a low position and the fall mats were on both sides of the bed.Review of facility policy, Fall Prevention Program, dated 3/2023, directed residents at risk for falls would be identified on the CNA kardex/assignment and for residents at high risk for falls, the care plan would have interventions initiated to prevent falls. Interventions and fall prevention measures would be developed and incorporated into the resident care plan and CNA kardex/assignment.

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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 interviews, review of the clinical record, and review of facility policy for 1 of 1 sampled resident (Resident #109) reviewed for issues with care, the facility failed to revise the resident's care plan following a staff-related grievance that resulted in a change to how care was delivered. The findings include:Resident #109's diagnoses included chronic obstructive pulmonary disease, type two Diabetes Mellitus, generalized anxiety disorder, and major depressive disorder. A quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #109 was cognitively intact, independent with eating, required set-up assistance for oral hygiene, and was dependent for toileting, bathing, dressing, and transfers. A Resident Care Plan (RCP) dated 10/8/25 identified Resident #109 experienced anxiety with interventions that included to provide reassurance and implement supportive psychiatric and social services. Additionally, the RCP identified Resident #109 exhibited accusatory behavior with interventions to provide redirection, 2 staff for care and provide a supportive approach with trigger monitoring. On 12/5/25, Resident #109 filed a grievance stating that three named Nurse Aides (NAs) were at times unkind and made him/her uncomfortable. The grievance documented that the NAs were educated, removed from Resident #109's assignment and restricted from entering the resident's room. The grievance further indicated that Resident #109 verbally agreed to the plan on 12/9/25 which resulted in a change to the resident's assigned staff and how daily care was provided.A social work progress note, dated 12/10/25 at 10:44 AM, completed as a routine assessment of mood, assessed that Resident #109 demonstrated good insight into his/her emotional state, effectively utilized available support systems, and presented as cooperative with an anxious mood and congruent affect.Review of the RCP failed to reflect the RCP had been revised to include Resident #109's complaint of NAs being unkind and interventions to prohibit 3 NAs from providing care to him/her as noted on a grievance form (which was not part of the clinical record and kept in a Grievance Log binder).Interview on 1/5/26 at 12:45 PM with the DNS indicated that staff assignments were adjusted at Resident #109's request and that she did not expect a revision to the resident's care plan following the 12/5/25 incident. She further stated that the facility did not add individual incidents, with dates, to resident care plans. This practice was inconsistent with prior care plan updates for Resident #109 related to other incidents on 6/14/24, 10/8/24, and 12/21/25. The DNS also stated that removal of staff from a resident's care team was not documented in the care plan but tracked on the nursing supervisor's schedule and communicated to involved staff, and that she did not expect behavioral intervention updates to reflect care team changes related to the 12/5/25 incident because the resident's anxiety behaviors continued.The Baseline/Comprehensive Person-Centered Care Plan (CPCCP) Policy, last revised in March 2023, required the CPCCP to be reviewed and revised upon changes in the plan of care or resident status and when new problems, goals, or interventions were identified. The facility failed to revise Resident #109's care plan to reflect the care team intervention implemented on 12/9/25, resulting in noncompliance with facility policy.

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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 review of the clinical record, facility documentation, facility policy and interviews for 1 of 5 residents (Resident #41) reviewed for unnecessary medications, the facility failed to ensure administration of the correct medication according to professional standards of practice. The findings includeResident #41 had diagnoses that included rhabdomyolysis (muscle injury where the muscles break down), pain in left hip, and anxiety.An admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #41 was cognitively intact and was dependent on staff for oral/personal hygiene, toilet use and bathing. The MDS further identified Resident #41 was not taking opioid medication.The Resident Care Plan identified Resident #41 had the potential for pain related to rhabdomyolysis, pain in the left ankle, joints of the left foot, the left hip and left shoulder. Interventions included to administer medication per orders, evaluate the effectiveness of pain interventions and monitor/document the side effects of pain medication. Additionally, the RCP identified Resident #41 was administered pain medications (Tramadol) without a physician order on 12/1/25.A Reportable Event (RE) Form dated 12/1/25 at 9:00 PM identified Resident #41 was administered Tramadol (an opioid analgesic used to treat moderate to severe pain) 50 milligrams (mg) by Licensed Practical Nurse (LPN) #10 without a physician's order. The RE further identified there was no injury or distress to Resident #41, the Advanced Practice Registered Nurse (APRN) was notified, the responsible party was notified, and actions taken were to monitor Resident #41 for any change in condition.An APRN progress note dated 12/1/25 at 11:38 PM identified she saw Resident #41 via video observation for a medication error. The note identified Resident #41 was given Tramadol 50 mg at 9:00 PM but he/she did not have an order for that medication. The note identified the medication error was not noted for a couple hours until the nurses were checking the narcotic count. The note identified Resident #41 had been asleep most of the night without complaints but was easily awakened for the APRN visit. The note identified Resident #41 was at baseline physical and cognitive status with stable vital signs.A nursing note dated 12/2/25 at 12:42 PM identified Resident #41's responsible party was notified of the medication error and Resident # 41 was alert with no distress noted.Review of the Medication Administration Record (MAR) from 12/1/25 through 12/31/25 failed to identify documentation that Resident #41 was administered Tramadol 50 mg on 12/1/25. An Investigation Statement obtained by the facility, written by LPN #10 and dated 12/1/25 identified Resident #41 had requested pain medication with his/her nighttime medications. The statement identified LPN #10 had added Tramadol 50 mg to Resident #41's other medications due to a name mix up. The statement identified the nursing supervisor was notified.Review of a Controlled Substance Disposition Record that was included with the investigation of the medication error identified the Tramadol 50 mg administered to Resident #41 on 12/1/25 was prescribed for a different resident. The disposition record identified LPN #10 signed out a dose of Tramadol 50 mg at 8:00 PM on 12/1/25, but it was not Resident #41's name on the disposition record.Review of an Inservice Attendance Sheet signed by LPN #10 included with the investigation of the medication error identified LPN #10 was educated on the 5 rights of a medication pass. The education directed to be sure to utilize the 5 rights of a medication pass to avoid potential errors, and a medication should be checked on the MAR prior to administration to ensure there is an existing order. The education failed to identify what the 5 rights of medication administration were.Interview with the Director of Nursing Services (DNS) and the Assistant DNS (ADNS) on 1/3/26 at 1:40 PM identified LPN #10 should not have administered Tramadol to Resident #41 without a physician order for that medication. The ADNS identified Resident #41 requested pain medication and LPN #10 had seen the Tramadol medication in her medication cart and thought it was Resident #41's medication. The ADNS identified the medication error had been identified when the nurses were completing the narcotic count at the end of the 3:00 PM to 11:00 PM shift and that was when LPN #10 had realized the medication given to Resident #41 was not ordered and was a different resident's medication. The (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ADNS identified there were no ill effects to Resident #41 as a result of this medication error and that the pharmacy had not been notified of the medication error. The ADNS further identified that as a result of LPN #10 giving Tramadol 50 mg to Resident #41 that was ordered for a different resident, she had provided education to LPN #10 on the 5 rights of medication administration.Review of the Medication Pass Policy directed, in part, administration of medications must be documented at the time of the medication pass. The policy directed when PRN medications are administered documentation is to include: date and time of administration, dose and route of administration, symptoms or pain scale for which medication was given, and signature of person administering the medication. The policy directed that the 6 rights of medication administration were: right resident, right drug, right dose, right dosage form, right route, right time.

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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 observations, review of the clinical record, facility documentation, facility policy and interviews for 2 of 2 residents (Resident #13 and Resident #41) reviewed for activities of daily living (ADL's), the facility failed to provide nail care for residents who required assistance with personal care. The findings include: 1. Resident #13 was admitted to the facility in December 2023 with diagnoses that included dementia, cerebral infarction (stroke) with left side weakness, and malnutrition. The re-entry Minimum Data Set (MDS) assessment dated [DATE] identified Resident #13 had a short/long term memory problem and was dependent on staff for all activities of daily living. The Resident Care Plan dated 12/18/25 identified a deficit in ADLs/self-care related to weakness, left hemiparesis, and the need for assistance with personal care. Interventions included to provide assistance with feeding, assistance with all personal hygiene, physical and occupational therapy as needed. Physician orders dated 12/20/25 directed out of bed to a tilt and space wheelchair, splint to left hand, on in the morning (AM) and off in afternoon (PM) as tolerated, physical therapy and occupational therapy as needed. Observation on 12/30/25 at 9:38 AM noted Resident #13 was out of bed in a wheelchair in the recreation area with a splint in place to the left hand. Resident #13's fingernails on both hands were noted to be jagged, lengthy and in need to be trimmed. Observation on 12/31/25 at 12:00 PM noted Resident #13 to be out of bed in a wheelchair in the dining area with nails still jagged, lengthy and in need to be trimmed. Observation and interview with Nurse Aide (NA) #9 on 1/2/26 at 9:41AM (after Resident #13 received AM care by NA #9) noted Resident #13's nails were still lengthy and needed to be trimmed. NA #9 stated that Resident #13 should have nails trimmed on his/her shower day and that the nurse aides were responsible for trimming fingernails. NA #9 was unsure why Resident #13's nails were lengthy and needed to be trimmed. NA #9 indicated that indeed Resident #13's nails were long and in need of trimming. NA # 9 indicated that she did not attempt to trim Resident #13's fingernails when she provided AM care on 1/2/26. After surveyor inquiry, NA #9 trimmed Resident #13's fingernails. Interview with the DNS on 1/2/26 at 12:30 PM identified that the facility had conducted an audit of residents' fingernails to identify any residents that needed fingernails to be trimmed. A review of the list with the DNS on 1/2/26 at 12:30 PM identified that Resident #13's name was not on the list. The DNS indicated that maybe Resident #13 was care planned for refusals related to care and that is why he/she may not have been on the list. The DNS indicated that the assigned NA was responsible to ensure a resident's fingernails were trimmed on shower days or as needed and refusals were reported and documented. 2.Resident #41 was admitted to the facility on [DATE] with diagnoses that included rhabdomyolysis (a rare muscle injury where your muscles break down), muscle weakness and need for assistance with personal care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The quarterly Minimum Data Set (MDS) assessment dated [DATE], identified Resident #41 was cognitively intact and required partial/moderate assistance with toileting, bed mobility and transfers. The Resident Care Plan (RCP) dated 12/29/25 identified Resident #41 required assistance with personal care due to muscle weakness and chronic musculoskeletal pain. Interventions included to provide the resident with substantial/maximal assistance with personal hygiene. Observation and interview with Resident #41 on 10/29/25 at 11:03 AM identified his/her fingernails on both hands were untrimmed and very lengthy. Resident #41 indicated he/she did not like to keep his/her fingernails that length, and he/she was unable to trim them by him/herself. Resident #41 identified he/she had not had his/her fingernails trimmed since admission to the facility and when he/she had asked staff to trim his/her fingernails, he/she was told by staff they did not have the time. Resident #41 further indicated although his/her shower was supposed to be every Thursday, he/she did not get showered weekly and therefore fingernails were never trimmed. An additional observation and interview with Resident #41 on 12/30/25 at 10:00 AM identified Resident #41's fingernails on both hands were untrimmed and very lengthy. Resident #41 indicated again that he/she did not have his/her fingernails trimmed since he/she came to the facility. Interview and observation with Nurse Aide (NA) #3 on 12/30/25 at 2:54 PM identified she was responsible to trim Resident #41's nails and did not trim them because after providing morning care she ran out of time. NA #3 indicated Resident #41 did not refuse care, was always on her assignment and she was aware the resident's fingernails were very lengthy due to his/her nails not being trimmed since admission. NA #3 identified Resident #41's weekly shower was scheduled for Thursdays on the 7:00 AM to 3:00 PM shift. She further indicated when she provided Resident #41 a shower, the resident asked to have his/her fingernails trimmed but the facility did not have nail clippers available, so she was unable to trim the resident's fingernails. NA #3 further indicated she would forget to trim Resident #41's fingernails during personal care but would trim them now. Subsequent to surveyor inquiry, an observation and interview with Resident #41 on 12/30/25 at 3:00 PM identified the resident's fingernails on both hands were trimmed, short and was happy NA #3 had trimmed his/her fingernails. Interview and review of the clinical record with the DNS on 1/2/26 at 8:45 AM identified resident's fingernails should be trimmed when needed and should be checked and trimmed with weekly showers. The DNS indicated it was the responsibility of the assigned NA to provide nail care and nail clippers were provided on the units in the supply room. Review of the RCP with the DNS identified Resident #41 required assistance with personal care and failed to identify the resident refused care. The DNS indicated she would need to determine why Resident #41 never had his/her fingernails trimmed and would review nail care and showers with the NA's. Review of facility policy, CNA Standard of Care/Information Sheet, dated 3/23, directed routine care was to be provided by the nursing assistants and daily morning care included nail care daily as needed.

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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. **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.ˆ 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 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 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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, (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#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 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. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical record, interviews, facility documentation and facility policy for 1 of 3 (Resident #13) residents reviewed for pressure ulcers, the facility failed to ensure that an alternating air pressure mattress was implemented timely per facility policy. The findings include:Resident #13 was admitted to the facility in December 2023 with diagnoses that included dementia, cerebral infarction (stroke) with left side weakness, and malnutrition.The readmission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #13 was severely cognitively impaired, required maximum assistance with bed mobility and was at risk for developing a pressure ulcer. A Braden Scale (tool to assess the risk for development pressure injury) was used to determine Resident #13's risk for developing a pressure ulcer dated 9/14/25 and 10/14/25 identified Resident #13 was at mild risk developing a pressure ulcer. There were no further Braden Scale assessments completed since 10/14/25.Physician's orders dated 9/15/25 directed a wound care consultant as needed, skin prep to the bilateral heels daily, weekly skin checks, and magic cup (high calorie ice cream) twice a day.The Resident Care Plan dated 9/26/25 identified a problem with being at risk for skin breakdown. Interventions included to apply skin prep to bilateral heels, assist with changing position every 2 hours, assist and provide incontinent care every 2 hours and as needed, dietitian evaluations as needed, nutritional supplements as order and weekly skin checks. A revision to the RCP dated 10/3/25 (after the development of pressure ulcers) included a Stage 3 (full-thickness skin loss/ with or without dead tissue) pressure ulcer to sacrum related to compromised nutritional status, edema, immobility, and sensory impairment. Interventions included assistance with changing position every 1 hour, (may use wedge) when in bed, tilt and space wheelchair and change position every 2 hours using tilt mechanism, report signs and symptoms of infection, provide frequent incontinent care, treatment as ordered, and wound evaluations until resolved. The wound consultant's initial wound evaluation dated 10/8/25 identified Resident #13 had a Stage 3 pressure ulcer to left buttock and sacrum. The left buttock measured 1.3 cubic centimeters (cm) length by 1.6 cm width with no depth. The Stage 3 sacrum wound measured 3.6 cm length by 2.5cm width by 0.1cm depth with moderate amount of serosanguinous (thin, watery bloody) fluid. Additionally the wound bed had 30% granulation (healthy, red tissue), 70% slough (yellowish, soft material from dead or dying tissue) and was in need of debridement (removal of damaged tissue).The wound consultant note dated 10/29/25 identified Resident #13's left buttock opening had healed on 10/15/25 and required only barrier cream (cream that restores and strengthens the skin). However, the sacrum wound was deteriorating, debridement was performed and it was discussed with nursing to offload the area as much as possible. Interview with Registered Nurse (RN) #3 (wound nurse) on 12/31/25 at 12:30 PM identified Resident #13 did not have a low air loss mattress (mattress composed of multiple inflatable air tubes that alternately inflate and deflate, mimicking the movement of shifting in bed) placed on his/her bed until 11/625 (35 days after the pressure ulcers were identified). She indicated that Resident #13's position was being changed every hour by nursing staff when in bed. RN #3 indicated that she was responsible for initiating the low air loss mattress and that in retrospect, she should have had low air loss mattress placed on the bed before 11/6/25 and it should have been placed on the bed when the pressure ulcers were identified.A review of the Pressure Injury Prevention Policy dated 3/23, directed, in part, the prevention and treatment of pressure injuries begins with identification of the resident's risk of developing a pressure injury based on a comprehensive evaluation of the resident's skin integrity and any existing predisposing factors upon admission and thereafter. Evaluate the resident's specific factors and changes in the resident's condition that may impact the development and healing of a pressure injury. Implement and monitor, and modify interventions to attempt to stabilize, reduce or remove underlying risk factors; and if a pressure injury is present, provide treatment and services to heal, prevent infection and the development of additional pressure ulcers. To promote prevention (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	injury and promote healing of existing wounds by implementing appropriate support services. One stage 3 pressure ulcer indicates the use of alternating pressure mattress. A review of the Admission/re-admission Policy dated 3/23 directed, in part, licensed nurses will complete a Braden/[NAME] evaluation for all residents upon admission/re-admission and initiate preventive measures based on identified risk factors. Risk factors may also be identified through MDS 3.0 assessment process, hospital discharge summary, physician orders, rehab notes consult reports and/or lab studies. The Braden/[NAME] Evaluation will be completed weekly for 4 weeks post admission/readmission.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, interviews and facility policy for the only sampled resident (Resident #13) reviewed for bowel and bladder incontinence/catheter, the facility failed to ensure Urologist orders were implemented for changing a urinary catheter. The findings included:Resident #13 was admitted in December 2023 with diagnoses that included obstructive and reflux uropathy (blockage in urinary system), urinary retention, and history of extended spectrum beta lactamase (ESBL) bacteria in urine (highly antibiotic-resistant bacteria in urine).The discharge Minimum Data Set, dated [DATE] identified that Resident #13 was unable to participate in a Brief Interview of Mental Status due to severe cognitive impairment, required moderate assistance with activities of daily living, and had an indwelling urinary catheter.Physician's orders dated 4/8/25 directed to replace indwelling urinary catheter size 16 French with 10 cubic centimeters (cc) [NAME] if removed/leaking or plugged as needed, change catheter drainage bag from straight drainage to leg bag when out of bed, and may irrigate catheter with 60 cc of sterile saline if leaking or plugged as neededThe Care Plan dated 4/8/25 identified that Resident #13 had an indwelling foley catheter/stents secondary to obstructive uropathy with urinary catheter replacement in hospital on 4/9/25. Intervention included follow up with urology as ordered, keep catheter bag and tubing positioned lower than the level of the bladder and away from the entrance doorway, monitor for signs and symptoms of urinary tract infection and notify physician, keep urinary collection bag off the floor, privacy cover over collection bag, and enhanced barrier precautions. The Care Plan failed to reflect how often the urinary indwelling catheter needed to be changed and size of the catheter. The Advanced Practitioner Registered Nurse (APRN) #1 progress note on 4/8/25 at 9:45AM identified Resident #13 had a fever of 103 Fahrenheit, with body shivering, concentrated urine and decreased urine output. Resident #13 had dislodged urinary stents which his/her urologist was aware of stent concern. APRN #1 ordered intravenous (IV) antibiotic (Ceftriazone 1-gram intermuscular dose on 4/8/25 then continue via IV for 4 days). APRN #1 indicated that Resident #13 was at high risk for urinary infection related to stents and needed closed monitoring. APRN #1 indicated that Resident #13 was already scheduled to visit urologist on 4/9/25. A nurse's note dated 4/9/25 at 8:09PM identified that Resident #13 continued with elevated temperature, chills, and had nausea and vomiting. An order was obtained to send Resident #13 to the hospital for an evaluation.APRN #4 progress note dated 4/17/25 at 9:30AM identified that Resident #13 was readmitted from the hospital on 4/16/25 after being treated for a urinary tract infection and stent removal. A call was placed to urology office by APRN #4 regarding urinary catheter management. Urology office directed to have urinary catheter remain in place and urologist will evaluate on 4/28/25 when Resident #13 had scheduled follow-up visit.Resident #13's office visit notes by APRN #2 (Urology APRN) dated 4/28/25 identified that Resident #13's urinary catheter must be changed every 4 weeks at the facility. APRN #2 indicated that Resident #13 should have a follow-up visit in 12 months for a renal ultrasound.APRN #1's follow up progress note related to urology recommendations dated 5/1/25 at 10:30AM identified that Resident #13 continued with chronic urinary foley catheter and that catheter was to be changed every 4 weeks per facility protocol.A nursing note by LPN #3 dated 5/12/25 indicated that a call was placed to urology office to determine if the urinary catheter foley was changed on 4/28/25 when Resident #13 had an office visit. An order was obtained by LPN #3 to change foley catheter every 4 weeks from urology office. However, a physician's order was obtained on 5/21/25 to discontinue urinary catheter change every 4 weeks and to change urinary catheter if it is removed, dislodged or plugged. Interview and review of the clinical record with LPN #3 on 1/2/26 at 1:15PM indicated that she was not aware of urology orders to change urinary catheter every 4 weeks. She indicated that she was unsure if the urinary catheter was getting changed at the facility or at the urology office. LPN #3 reviewed current (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physician's orders and indicated that urinary catheter was only to be changed if became dislodged/plugged or leaked. LPN #3 indicated that she was not aware of the facility's policy on changing urinary catheters, but it was nursing responsibility to change urinary catheters.A reinterview with LPN #3 on 1/2/26 at 1:25PM indicated that she did not recall calling the urology office or obtaining an order for the urinary catheter changes. An interview with DNS on 1/2/26 at 1:35PM indicated that it was facility policy not to change urinary catheters on a regular scheduled basis and that they are only to be changed as needed. The DNS indicated the facility is trying to move away from regular scheduled changes of urinary catheters. The DNS indicated that Resident #13's current order was to change the urinary catheter as needed.An interview with APRN #2 on 1/2/26 at 1:41PM via telephone indicated that she was not aware that the facility was not changing Resident #13's urinary catheter every 4 weeks. APRN #2 stated that due to Resident #13's history and risk factors for infection that the urinary catheter must be changed every 4 weeks. In addition, APRN #2 indicated that she wrote on consult sheet when Resident #13 had a follow up visit that urinary catheter must be changed every 4 weeks and that the facility had contacted the office on 5/12/25 and had spoken to LPN #3 giving an order to change urinary catheter every 4 weeks. Furthermore, APRN #2 indicated that she would expect that the facility would have contacted the office prior to changing the order as she would not have approved an order to change the urinary catheter as needed. Interview with APRN #1 on 1/5/26 at 12:30PM indicated that she follows Resident #13 and works closely to prevent hospitalizations for Resident #13. APRN #1 indicated that she was aware that Resident #13's catheter orders were to change on an as needed basis and that urology's recommendation was for every 4 weeks. She indicated that although she was aware of the order change, it was nursing's responsibility to have notified the urology office/practitioner when the order was changed to as needed. Interview with RN #4 on 1/5/26 at 12:45PM indicated that it was nursing's responsibility to notify the urology's office when the order for the urinary catheter was changed from every 4 weeks to as needed. RN #4 indicated that she is not sure why it was not done but she was not the supervisor on the floor during that timeframe. RN #4 indicated that it was her practice to notify consulting practitioners when their recommendations are not followed by the facility. A review of the Urinary Catheterization Policy dated 4/24 directed, in part, the interval between catheter changes should be determined by the individual patient's needs. Indications for changes may include mechanical dysfunction or blockage of the urinary catheter system, and contamination of the closed system. Indwelling catheters should not be changed at arbitrary fixed intervals. Although requested, a policy on consulting practitioners was not provided.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation, facility policy and staff interviews for 1 of 1 resident (Resident #14) reviewed for hospice, the facility failed to review and respond to pharmacy recommendations in a timely manner. The findings include:Resident #14's diagnoses included schizoaffective disorder, bipolar, and post-traumatic stress disorder.A physician order dated 5/14/24 and currently in effect directed Lurasidone HCL (an antipsychotic medication used to treat schizophrenia and bipolar disorder) 40 milligrams (mg) once a day.A quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #14 was cognitively intact and was dependent on staff for all activities of daily living. Additionally, the MDS identified Resident #14 was administered antipsychotic medication, antianxiety and antidepressant medication.A Resident Care Plan (RCP) dated 2/26/25 identified Resident #14 had the potential for behavior problems related to schizoaffective disorder, bipolar and post traumatic stress syndrome. Interventions included to complete a comprehensive psychiatric evaluation yearly at minimum, anticipate and meet the resident's needs, and mental health counseling.The Pharmacy medication regimen review dated 3/4/25 (first request) identified Resident #14's last Abnormal Involuntary Movement Scale (AIMS) and the recommendation was to be completed every 6 months. Also, identified APRN #3 disagreed as she cannot reevaluate Resident #14 because Resident #14 was receiving hospice services.The Pharmacy medication regimen review dated 4/1/25 (second request) identified Resident #14's last AIMS was completed on 9/6/24 and the recommendation was to be completed every 6 months. Also, identifying hospice residents were not exempt as AIMS needed to be completed to monitor for adverse effects of antipsychotic drugs, please consider ordering or performing. The response to pharmacy recommendations by APRN #3 was that she couldn't see the resident because Resident #14 was receiving hospice services.The Pharmacy medication regimen review dated 5/1/25 (third request) identified Resident #14's last AIMS was completed on 9/6/24 and the recommendation was to be completed every 6 months. Also, identifying hospice residents were not exempt as AIMS needed to be completed to monitor for adverse effects of antipsychotic drugs, please consider ordering or performing. The response to pharmacy recommendations by APRN #3 was that she couldn't see the resident because Resident #14 was receiving hospice services.The Pharmacy medication regimen review dated 7/1/25 (fourth request) identified Resident #14's last AIMS was completed on 9/6/24 and the recommendation was to be completed every 6 months. Also, identifying hospice residents were not exempt as AIMS needed to be completed to monitor for adverse effects of antipsychotic drugs, any provider or Registered Nurse may perform. Please consider ordering or performing. The response to pharmacy recommendations by APRN #3 was that she couldn't see a resident because Resident #14 was receiving hospice services.Review of 7 Pharmacy medication regimen review forms dated 9/5/24 through 7/1/25 recommended completing an AIMS with the response to pharmacy recommendations by APRN #3 was that she couldn't see a resident because Resident #14 was receiving hospice services.Interview with the DNS on 1/2/26 at 9:29 AM identified she was unsure of how often an AIMS evaluation should be completed or if a resident on hospice could have an AIMS evaluation. Also, identifying the oversight of the Pharmacy recommendation was to be completed by the Assistant Director of Nursing Services (ADNS).Interview with APRN #3 on 1/2/26 at 11:20 AM identified a resident with a certain hospice provider cannot have an AIMS completed, she was told this by the hospice provider but could not identify the staff member's name.Interview with the Senior Care Administrator from the hospice agency on 1/2/26 at 11:45 PM identified the hospice provider would not go against the facility policy and an AIMS test should have been completed.Interview with the DNS on 1/2/26 at11:50 AM identified a nurse can complete an AIMS evaluation.Interview with the Assistant Directive of Nursing (ADNS) on 1/2/26 at 1:22 PM identified hospice was responsible for (continued on next page)

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	completing an AIMS and that an AIMS was completed 8/20/25 (after 7 pharmacy recommendations for completion of an AIMS). Also, identifying she herself was trained to complete an AIMS evaluation and the expectation was that APRN #3 would communicate that she could not complete an AIMS due to Resident #14 being on hospice. The ADNS could not recall having a conversation with APRN #3. The facility did not have a policy on AIMS evaluations but identified she was responsible for reviewing the Pharmacy medication review recommendations and an AIMS evaluation should have been completed in March 2025 (it was completed on 8/20/25).Review of the policy for Pharmacy Medication Review dated 4/2023 identified the medication regime of each resident should be reviewed monthly, findings, recommendation are communicated to those with responsibility to implement the recommendations and to answer in a timely fashion. Also, identifying the consultant pharmacist will submit their monthly recommendations reports to the DNS and follow up on the recommendations to verify that appropriate action has been taken and or responded to within a reasonable time frame.

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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, facility documentation, and interviews for 1 of 2 (Resident #116) reviewed for positioning/mobility, the facility failed to provide rehabilitation services as recommended by the orthopedic physician. The findings included:Resident #116 was admitted to the facility in September 2024 with diagnoses that included pain to lower back, right shoulder, and left thigh, effusion of left knee (swollen joint), and spondylosis cervical region (fracture of vertebrae). The annual Minimum Data Set assessment dated [DATE] identified Resident #116 had intact cognition and was independent with all activities of daily living.The Resident Care Plan dated 9/16/25 identified Resident #116 had actual/potential for pain related to chronic pain syndrome, right shoulder bursitis, left knee effusion, lumbar spinal stenosis, and cervical spondylosis. Interventions included to administer medications as ordered for pain, identify and treat resident' existing conditions, monitor and document probable causes of each pain episode and remove and limit causes whenever possible, splint and brace to left knee, and physical/occupational referrals as ordered.Physician orders dated 10/27/25 directed an orthopedic consult for left knee pain.The clinical record indicated that Resident #116 was referred to an orthopedic on 10/27/25 based on results of a Magnetic Resonance Imaging (MRI) of the left knee performed on 9/23/25. Resident #116's MRI results indicated a complex tear of the meniscus (torn cartilage), sprain of lateral ligament, and small bone marrow contusion involving the lateral proximal tibia. Resident #116's orthopedic physician responded to the referral request with a recommendation on 11/4/25 to have Resident #116 start with physical therapy and if no positive outcome, then refer to orthopedic. The clinical record lacked documentation that a referral for physical therapy was initiated for the left knee in November 2025.Interview with Resident #116 on 12/30/25 at 11:15 AM indicated that he/she was having significant pain to his/her left knee and that he/she had not received any therapy for his/her left knee recently. Resident #116 indicated that he/she thought that MRI revealed some type of tear to the left knee and that he/she was supposed to receive physical therapy.Interview with the DNS on 1/5/26 at 9:10 AM identified that she was not aware of the orthopedics' recommendation for physical therapy and that the standard process was that nursing would complete a communication sheet to therapy indicating an order for physical therapy. The DNS indicated that she could not locate any communication to therapy regarding the recommendation for physical therapy from the orthopedic office. The DNS indicated that it was nursing's responsibility to notify physical therapy if there was a recommendation for services and she was unsure of why it was not completed.Interview with Occupational Therapist (OT) #1 on 1/5/26 at 9:20 AM identified that Resident #116 had not received any physical therapy in November 2025 or December of 2025 for his/her left knee. OT #1 could not locate a referral or a nursing to therapy communication sheet for November 2025 regarding Resident #116's left knee. OT #1 indicated that the last referral received was on 10/9/25 for recent Resident #116's weight loss. OT #1 indicated that nursing would either provide therapy with a communication sheet requesting a resident to be seen or a copy of the actual referral/order for physical therapy. OT #1 indicated that at a minimum, therapy would have conducted an evaluation of Resident #116 related to the orthopedics recommendation for physical therapy had they been notified. Interview with Advanced Practice Registered Nurse (APRN) #1 on 1/5/26 at 12:30 PM indicated that she was not aware that Resident #116 did not receive physical therapy for the left knee. She indicated that although she initialed and dated the orthopedic fax sheet recommendation for physical therapy on 11/4/25 it was her expectation that nursing would follow up on the recommendation to ensure the referral was made to physical therapy.Although requested a policy on physical therapy and nursing to therapy communication was not provided.

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **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 sampled resident (Resident #107) reviewed for falls, the facility failed to provide the required notification of the transfer/discharge to the state Ombudsman's office. The findings include: Resident #107's diagnoses included chronic obstructive pulmonary disease, dementia, and spinal stenosis.The Resident Care Plan (RCP) dated 7/5/25 identified Resident #107 had the potential to fall with interventions that included to assist Resident #107 with transfers and ambulation as ordered, and to wear appropriate footwear when ambulating or when the resident was in the mobilized wheelchair. Additionally, the RCP identified Resident #107 had a deficit of functional mobility due to weakness with ambulation. Interventions included to provide and use a mechanical lift with transfers with 2 staff and provide positioning while out of bed.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #107 had a severe cognitive impairment, was dependent with bed mobility, transfers, dressing, toileting, eating, and personal hygiene.A nursing note dated 10/12/25 at 10:09 PM identified Resident #107 fell on [DATE] at 3:10 PM and sustained a laceration above the right eyebrow and was sent to the hospital at 3:30 PM.A nursing note dated 10/12/25 at 10:48 PM identified Resident #107 was admitted to the hospital.A nursing note dated 10/14/25 at 7:45 PM identified Resident #107 returned to the facility (2 days after being transferred to the hospital) with a laceration to the left side of his/her forehead with 5 sutures in place.On 12/31/25 at 12:55 PM an interview with Social Worker (SW) #1 identified that she started working at the facility on 11/24/25 and notification to the Ombudsman was not sent for Resident #107 because SW#1 did not have access to the electronic portal for submitting. SW #1 identified the social workers were responsible for notifying the Ombudsman's office of all transfers/discharges and that she has full access to the portal now.On 12/31/25 at 1:05 PM an interview with the DNS identified that the social workers were responsible for notifying the Ombudsman of all transfer/discharges. Subsequent to surveyor inquiry, the facility updated the Ombudsman's office through the electronic portal on 1/1/26 regarding Resident #107's transfer/discharge to the hospital on [DATE].On 1/05/2026 at 9:09 AM an interview with SW #1 identified that she submitted the notification of the transfer/discharge of Resident #107 to the Ombudsman on 1/1/26 because she did not have access to the portal at the end of November. Also, identifying SW#1 did notify the Administrator on 11/26/25 that she did not have access to the portal but couldn't remember when she gained access to the portal.Review of the facility's Admission, discharge policy dated 6/2025 identified the facility was to provide each resident with a safe transition of care that meets the resident's established goals. Also, identifying the Ombudsman's office was to be notified of discharges per state and federal regulations.

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F 0646 Level of Harm - Potential for minimal harm Residents Affected - Some	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview for 1 of 6 sampled residents (Resident #2) review for Pre-admission Screening Resident Review (PASRR), the facility failed to notify the PASRR agency to complete a Level 2 screen for a resident with a psychiatric diagnosis. Resident #2 was admitted to the facility on [DATE] from another long-term care facility with diagnoses that included psychotic disorder with hallucinations related to physiological conditions, Parkinsons disease and hypertension.A Level 1 PASRR screen dated 2/1/19 (transferred with Resident #2 from the previous long term care facility) identified Resident #2 had no psychiatric history and therefore a Level 2 evaluation was not required.Psychiatric progress notes written by an Advanced Practice Registered Nurse (APRN) dated 10/20/25 identified Resident #2 had a psychotic disorder, stable on current psychiatric medications, resident denies psychiatric history, despite previous psychiatric diagnoses.On 1/5/26 at 10:18 AM, interview and clinical record review with the Social Worker (SW) failed to identify the PASRR agency had been notified of a need to complete a Level 2 assessment for Resident #2's psychiatric diagnosis. SW further identified the psychiatric group notifies her verbally when residents develop a new psychiatric diagnosis. The SW further identified that she would be responsible for notifying the PASRR agency, but she was not employed at the facility during that time frame.Subsequent to surveyor inquiry, the facility notified the PASSR agency on 1/6/26, a Level 1 screen was completed, resident was approved for long term and indicated a Level 2 was not indicated. Facility policy regarding Pre admission Screening and Resident Review dated April 2023 indicated routine clinical record reviews and facility communication assists the facility to identify residents with newly evident or possibly serious mental disorder or a related condition after admission to the facility.