

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075393	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/20/2026
NAME OF PROVIDER OR SUPPLIER Bel-Air Manor Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 256 New Britain Avenue Newington, CT 06111	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0760 Level of Harm - Actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, camera footage, and interviews for one (1) of three (3) sampled residents (Resident #2) reviewed for pain management, the facility failed to ensure the resident remained free of significant medication errors. This included failure to administer and replace fentanyl patches every 72 hours as ordered, maintain accountability of fentanyl patches as controlled substances, accurately transcribe and implement physician's medication orders, administer oxycodone every four (4) hours as ordered, recognize and correct medication administration errors, and adequately assess and manage Resident #2's pain. These failures resulted in repeated missed, delayed, inaccurately documented, and unaccounted-for opioid doses resulting in uncontrolled pain and restlessness. The findings include:Resident #2's diagnoses included malignant neoplasm of the bronchus/lung, secondary malignant neoplasm of the intrathoracic lymph nodes, chronic pain syndrome, and palliative care.The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had intact cognition (Brief Interview for Mental Status (BIMS) score of 15), required supervision with bed mobility, required partial assistance with transfers, received scheduled and as-needed pain medications, experienced frequent moderate pain, and received hospice services.The Resident Care Plan (RCP) dated 3/22/26 identified Resident #2 required assistance with activities of daily living (ADLs) and had altered comfort related to small cell lung cancer with metastasis to the intrathoracic lymph nodes, restless leg syndrome, degenerative disc disease, lumbar spinal stenosis, chronic bilateral low back pain with sciatica (pain caused by irritation or compression of the sciatic nerve), and claudication (pain or cramping caused by decreased blood flow). Interventions included providing one-person assistance with bathing, dressing, toileting, hygiene, and transfers using a rolling walker, monitoring for pain, administering medications as ordered, documenting the effectiveness of pain medications, and monitoring and documenting verbal and nonverbal signs and symptoms of pain.A. Delay in fentanyl patch administrationA physician's order dated 5/13/26 at 6:08 AM directed a fentanyl transdermal patch 12 micrograms (mcg) per hour, apply one (1) patch every three (3) days for pain, rotate application sites, and remove the patch according to the schedule.The May 2026 Medication Administration Record (MAR) identified RN #4 applied the 12 mcg fentanyl patch at 8:30 AM on 5/13/26. The order was discontinued later that day at 6:07 PM.A physician's order dated 5/13/26 at 6:05 PM, entered by Advanced Practice Registered Nurse (APRN) #2, directed a fentanyl transdermal patch 12 mcg per hour, apply one (1) patch every three (3) days for pain, rotate application sites, and remove the patch according to schedule.The May 2026 MAR identified the replacement order scheduled the next fentanyl patch application for 8:30 AM on 5/14/26, although the initial patch had already been applied on 5/13/26. RN #4 documented the 5/14/26 dose as not administered because the previously applied patch remained in place. The next documented fentanyl patch change did not occur until 5/17/26. Although (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 075393 If continuation sheet Page 1 of 27

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F 0760 Level of Harm - Actual harm Residents Affected - Some	the physician's order directed the patch be changed every 72 hours, the patch remained in place for approximately 96 hours. The Controlled Substance Disposition Record identified ten (10) fentanyl 12 mcg patches were received. One (1) patch was removed from inventory on 5/13/26, leaving nine (9) patches remaining. The next patch was not removed from inventory until 5/17/26, leaving eight (8) patches remaining, consistent with the delayed replacement documented in the MAR. Interview with the Director of Nursing (DON) on 7/16/26 at 10:05 AM identified she was unaware of the medication error until surveyor notification. The DON identified the order re-entered by APRN #2 was transcribed incorrectly, causing the administration schedule to populate inaccurately. The DON identified APRN #2 should have verified when the initial fentanyl patch had been administered before re-entering the order, and RN #4 should have questioned why the order repopulated the following day rather than document the medication as not administered. Interview with APRN #2 on 7/16/26 at 10:56 AM identified she did not recall why the original order was discontinued but believed it was related to pharmacy processing requirements for controlled substances. APRN #2 identified she re-entered the order without verifying the generated administration schedule and was unaware of the electronic medical record scheduled the next application for 5/14/26 instead of 5/16/26. APRN #2 identified she should have adjusted the order time to reflect the initial application on 5/13/26 so the subsequent 72-hour administration schedule populated correctly. Interview with RN #4 on 7/16/26 at 11:22 AM identified he applied the fentanyl patch on 5/13/26. When prompted to administer another patch on 5/14/26, he observed the previous patch remained intact and documented the medication as not administered because he believed the electronic medical record generated the order in error. RN #4 identified he did not review the physician's order to determine why the medication repopulated and acknowledged he should have. On 5/17/26, he removed the patch dated 5/13/26 and applied a new patch but did not recognize the original patch had remained in place longer than the ordered 72-hour interval. B. Missing fentanyl patches on 5/18/26 A Nurse's note by RN #2 dated 5/18/26 at 3:18 PM identified she notified the provider after both fentanyl patches were removed by Resident #2. RN #2 searched Resident #2's room but was unable to locate either fentanyl patch. The MAR was updated with a new order to reapply the fentanyl patches. RN #2 documented she educated Resident #2 and a family member regarding the importance of leaving the fentanyl patches in place. The May 2026 MAR identified a physician's order dated 5/12/26 directing one (1) fentanyl transdermal patch 25 micrograms (mcg) per hour every three (3) days for pain. The MAR identified the last documented application occurred on 5/16/26 at 8:30 AM. A physician's order dated 5/13/26 directed staff to administer one (1) fentanyl transdermal patch 12 mcg per hour every three (3) days. The last documented application occurred on 5/17/26 at 8:30 AM. The MAR further identified licensed nurses documented both fentanyl patches were present during every shift check on 5/17/26, including RN #4 during the 7:00 AM to 3:00 PM shift, LPN #5 during the 3:00 PM to 11:00 PM shift, and LPN #3 during the 11:00 PM to 7:00 AM shift. Both fentanyl patches were documented as reapplied on 5/18/26 at 12:30 PM by LPN #4. Interview with LPN #4 on 7/16/26 at 11:36 AM identified he was assigned to Resident #2 during the 7:00 AM to 3:00 PM shift on 5/18/26. During the scheduled fentanyl patch check, he was unable to locate either the 12 mcg or 25 mcg fentanyl patch. Resident #2 was unable to identify what happened to the patches. Interview with RN #2 on 7/16/26 at 12:00 PM identified LPN #4 notified her both fentanyl patches were missing. RN #2 completed a body check, searched Resident #2's bed linens, trash receptacles, and room, but was unable to locate either fentanyl patch. RN #2 identified Resident #2 reported attempting to remove the nicotine patch because he/she wanted to smoke; however, the nicotine patch remained intact. RN #2 notified the DON, who instructed her to notify the provider for replacement orders. Although the fentanyl patches could not be located, RN #2 (continued on next page)		

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F 0760 Level of Harm - Actual harm Residents Affected - Some	did not obtain statements from staff members who had contact with Resident #2. Interview with the DON on 7/16/26 at 12:12 PM identified RN #2 did not report the missing fentanyl patches on 5/18/26. The DON identified when she later reviewed documentation she determined placement of both fentanyl patches had been verified by LPN #3 during the overnight shift before they were discovered missing. Although RN #2 documented Resident #2 reported removing the patches, the missing fentanyl patches represented unaccounted-for controlled substances. The DON identified the incident should have been reported to the State Agency, staff and visitor statements should have been obtained, and an investigation should have been initiated immediately. Interview with LPN #3 on 7/20/26 at 11:11 AM identified if she documented verifying placement of the fentanyl patches during the 11:00 PM to 7:00 AM shift, the fentanyl patches were present. LPN #3 identified if either fentanyl patch had been missing, she would have notified the nursing supervisor immediately. LPN #3 further identified she was never contacted by the facility to provide a statement after the incident. Although attempted, an interview with LPN #5 was not obtained. C. Missing fentanyl patches on 5/24/26 The Reportable Event (RE) form dated 5/24/26 identified RN #4 was unable to locate Resident #2's fentanyl patches during the scheduled morning placement check. The provider, hospice agency, and police department were notified. Resident #2 was monitored for changes in pain, and an investigation was initiated regarding the missing fentanyl patches and individuals who had visited Resident #2 after the patches were last documented as present. A Nurse's note by RN #4 dated 5/24/26 at 10:48 AM identified he was unable to locate the fentanyl patches applied on 5/23/26 at 12:30 PM. RN #4 completed a body check, searched Resident #2's room, bed linens, and trash receptacles, but was unable to locate either fentanyl patch. Resident #2 denied removing the patches. The May 2026 MAR identified licensed nurses documented both fentanyl patches were present on 5/23/26 during the 7:00 AM to 3:00 PM, 3:00 PM to 11:00 PM, and 11:00 PM to 7:00 AM shifts before they were later discovered missing. A Nurse's note by RN #5 dated 5/24/26 at 4:51 PM identified RN #4 notified her the fentanyl patches applied to Resident #2's right posterior scapular area could not be located. RN #5 initially checked the application site but delayed completing a full body check until Resident #2 finished breakfast. During the subsequent body check, completed with RN #4 and NA #1, Resident #2 reported a family member had placed one (1) fentanyl patch on his/her leg. No fentanyl patches were identified until NA #1 observed a fentanyl patch dated 5/17/26 on Resident #2's left upper inner arm while providing personal care. The DON, hospice agency, and provider were notified. Hospice requested the fentanyl patches be discontinued, and the provider ordered scheduled oral oxycodone in place of the fentanyl patches. D. Oxycodone order transcribed incorrectly resulting in missed overnight doses Facility documentation dated 6/17/26 identified the administration times for Resident #2's oxycodone did not match the physician's orders from 5/24/26 through 6/17/26. Physician's orders dated 5/24/26, 5/29/26, 6/4/26, and 6/15/26 directed staff to administer oxycodone 10 milligrams (mg) by mouth every four (4) hours for terminal pain. The May 2026 Medication Administration Record (MAR) identified the 5/24/26 and 5/29/26 oxycodone orders contained administration times of 6:00 AM, 10:00 AM, 2:00 PM, 6:00 PM, and 10:00 PM, but failed to include the required 2:00 AM administration, resulting in one missed scheduled dose every day. The June 2026 MAR identified the 6/4/26 and 6/15/26 oxycodone orders continued to omit the required overnight administration. The administration schedule was not corrected until 6/17/26, when the MAR was revised to include every four (4) hour administration times of 12:00 AM, 4:00 AM, 8:00 AM, 12:00 PM, 4:00 PM, and 8:00 PM. The Order Audit Report identified RN #5 entered the original oxycodone order on 5/24/26 and RN #2 confirmed the order as accurate. Interview with Person #2 on 7/17/26 at 9:05 AM identified Resident #2 frequently complained of not receiving pain medication during the overnight shift and repeatedly reported (continued on next page)		

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F 0760 Level of Harm - Actual harm Residents Affected - Some	uncontrolled pain. Interview with Resident #2 on 7/17/26 at 10:42 AM identified he/she experienced chronic pain requiring scheduled pain medication but was unable to recall specific dates doses were missed. Interview with RN #2 on 7/20/26 at 1:07 PM identified she confirmed the 5/24/26 oxycodone order without recognizing the administration schedule omitted the overnight dose. RN #2 identified she should have thoroughly reviewed the administration times before confirming the order and acknowledged the medication error could have been identified sooner. Interview with RN #5 on 7/20/26 at 1:18 PM identified she entered the original oxycodone order and mistakenly selected prepopulated administration times that excluded the overnight dose. RN #5 identified she should have fully reviewed the physician's order before completing the transcription. Interview with APRN #2 on 7/20/26 at 2:07 PM identified licensed nurses were responsible for ensuring physician's orders were accurately entered and followed. APRN #2 identified staff should compare physician's orders with the Medication Administration Record (MAR), medication card, and Controlled Substance Disposition Record to identify transcription errors. APRN #2 further identified Resident #2's chronic pain could have worsened overnight when the scheduled oxycodone doses were omitted. The May and June 2026 MARs identified the only as-needed (PRN) pain medication available after the scheduled oxycodone order was acetaminophen 325 mg, two (2) tablets by mouth every six (6) hours as needed for discomfort or a temperature greater than 101 degrees. The MAR failed to identify administration of the PRN acetaminophen from 5/24/26 through 6/17/26. Interview with the Director of Nursing (DON) on 7/20/26 at 3:46 PM identified RN #5 should have accurately transcribed the oxycodone order and RN #2 should have thoroughly reviewed the order before confirming it. The DON identified comparison of the MAR, medication card, and Controlled Substance Disposition Record should have identified the error sooner and prevented the continued omission of scheduled overnight oxycodone doses. E. Failure to administer oxycodone every four hours as ordered on 6/13/26 into 6/14/26A physician's order dated 6/4/26 directed staff to administer oxycodone 10 mg by mouth every four (4) hours for terminal pain. Continuous camera footage dated 6/13/26 identified LPN #5 administered medications at approximately 9:15 PM and informed Resident #2 pain medication was being administered. Nursing staff did not re-enter the room until 12:09 AM, when RN #9 administered Ativan. At 3:29 AM Resident #2 was observed thrashing about in bed and grimacing. At 3:51 AM Resident #2 appeared restless and attempted to place both legs over the side of the bed. At 3:52 AM RN #9 entered the room, briefly assessed Resident #2, identified Resident #2 was incontinent, turned off the call bell, and exited without administering pain medication. At 4:00 AM an NA changed Resident #2's brief and exited the room. At 4:23 AM Resident #2 was observed thrashing about in bed and restless. Resident #2 continued to appear restless until 5:37 AM, when RN #9 returned and administered oxycodone, more than eight (8) hours after the previous scheduled dose. The Controlled Substance Disposition Record identified oxycodone 10 mg was administered on 6/13/26 at 10:00 PM and was not administered again until 5:30 AM on 6/14/26, approximately seven and one-half (7.5) hours later. The June 2026 Medication Administration Record (MAR) identified the only PRN pain medication available remained acetaminophen 325 mg. The MAR failed to identify administration of PRN acetaminophen during the overnight shift. RN #9 documented Resident #2's pain level as zero (0) despite the camera footage capturing restlessness, grimacing, thrashing about in bed, and attempting to get out of bed. Interview with RN #9 on 7/20/26 at 2:24 PM identified Resident #2 routinely complained of pain. RN #9 identified she documented pain assessments based on her observations and believed Resident #2 was not exhibiting signs of pain. RN #9 acknowledged if Resident #2 had reported pain or demonstrated signs of discomfort she should have administered pain medication. F. Failure to administer oxycodone every four (4) hours as ordered on 6/22/26 into 6/23/26 Continuous camera footage dated 6/22/26 (continued on next page)		

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F 0760 Level of Harm - Actual harm Residents Affected - Some	identified LPN #6 administered medications to Resident #2 in applesauce at approximately 9:17 PM but did not identify what the medications administered were. No licensed nurse entered Resident #2's room again until 3:03 AM on 6/23/26. At 3:01 AM, Resident #2 was observed thrashing about in bed and repeatedly kicking his/her legs over the side of the bed, appearing uncomfortable. At 3:03 AM, RN #9 entered the room and administered pain medication in applesauce more than three (3) hours after the scheduled administration time, although the Medication Administration Record (MAR) documented the oxycodone 10 milligrams (mg) dose as administered at 12:00 AM with a pain level of zero (0). At 5:07 AM, RN #9 returned and administered another oxycodone dose approximately two (2) hours after the previous administration. At 7:50 AM, LPN #9 asked Resident #2 if he/she was in pain. Resident #2 reported a little bit of pain, and LPN #9 administered haloperidol (Haldol), morphine, oxycodone, and gabapentin. The camera footage identified Resident #2 received three (3) oxycodone doses within four (4) hours and forty-seven (47) minutes. The Controlled Substance Disposition Record identified Resident #2 received oxycodone 10 mg on 6/22/26 at 9:00 PM, the next dose was not administered until 2:40 AM on 6/23/26, five (5) hours and forty (40) minutes later, followed by another dose at 5:15 AM and again at 8:00 AM, approximately every two (2) to three (3) hours rather than every four (4) hours as ordered. Interview with RN #9 on 7/20/26 at 2:24 PM identified she could not recall the events of 6/22/26 into 6/23/26. RN #9 identified physician's orders should be followed, medications should be administered within one (1) hour of the scheduled administration time, and documentation should occur at the time medications were administered. RN #9 acknowledged she should not have administered the scheduled oxycodone dose more than three (3) hours late, followed by another scheduled dose approximately two (2) hours later. RN #9 further identified she should have notified the provider and communicated the late medication administration to the oncoming shift. Interview with LPN #9 on 7/20/26 at 2:59 PM identified RN #9 did not notify her the previous scheduled oxycodone dose had been administered late. LPN #9 identified had she known, she would have adjusted the next administration time to comply with the physician's order. G. Failure to administer oxycodone every four (4) hours as ordered on 6/26/26 into 6/27/26 Continuous camera footage dated 6/26/26 identified LPN #7 administered medications to Resident #2 at approximately 7:58 PM. Camera footage identified Resident #2 was awake throughout the night and appeared distressed. No licensed nurse entered Resident #2's room again until 5:29 AM on 6/27/26, when RN #8 informed Resident #2 she was administering clonazepam (Klonopin) and pain medication. Although RN #8 was not observed entering Resident #2's room until 5:29 AM, the MAR documented oxycodone administrations at 12:00 AM and 4:00 AM with pain assessments of zero (0). At 6:03 AM, two (2) Nursing Assistants (NA #2 and NA #3) provided personal care, during which Resident #2 reported not feeling well and requested the hospice nurse. The Progress Notes dated 6/27/26 failed to identify missed or late pain medication administration, Resident #2's request for the hospice nurse, or notification of the provider regarding the change in condition. The Controlled Substance Disposition Record identified oxycodone 10 mg was removed from inventory for the documented 12:00 AM and 4:00 AM administrations; however, the camera footage did not identify RN #8 entering Resident #2's room until 5:29 AM. Interview with Person #2 on 7/17/26 at 9:05 AM identified he/she reviewed the camera footage and notified RN #6 on 6/27/26 that Resident #2 had not received pain medication for approximately ten (10) hours even though the medications had been documented as administered. Person #2 further identified Resident #2 repeatedly reported not feeling well and requested hospice be contacted. Interview with the Director of Nursing (DON) on 7/20/26 at 3:30 PM identified licensed nurses were responsible for assessing Resident #2 for pain each shift, implementing interventions when pain was identified, administering medications according to physician's orders, and notifying the (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0760 Level of Harm - Actual harm Residents Affected - Some	provider whenever medications could not be administered within the required timeframe. Although attempted, interviews with RN #6, RN #8, NA #2, and NA #3 were not obtained. The Medication Errors policy dated 11/2025 directed, in part, medications were to be administered according to physician's orders and accepted standards of professional practice. The policy further directed licensed nurses to verify the right resident, medication, dose, route, time, and administration to prevent medication errors and ensure residents remained free from significant medication errors. The Pain Management policy dated 10/16/25 directed, in part, the facility would utilize a systematic approach to recognizing, assessing, treating, monitoring, and reassessing pain. The policy directed staff to identify verbal and nonverbal indicators of pain, administer pain management interventions consistent with the resident's assessment and physician's orders, evaluate the effectiveness of interventions, reassess pain, revise interventions when pain was not adequately controlled, and notify the practitioner when pain management was ineffective. The Medication Orders policy (undated) directed, in part, medication orders were to be documented promptly and accurately, entered correctly into the electronic health record, transcribed onto the Medication Administration Record (MAR), clarified when necessary, and verified to ensure safe implementation. Staff were responsible for ensuring medication orders accurately reflected the physician's directions before implementation.		

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation, facility policies, interviews, and observations, for one (1) of three (3) sampled residents (Resident #2) reviewed for pain management, the facility failed to ensure pain medications were administered according to physician's orders. This included failure to administer and replace fentanyl patches every 72 hours as ordered, maintain accountability of fentanyl patches as controlled substances, accurately transcribe and implement physician's medication orders, administer oxycodone every four (4) hours as ordered, recognize and correct medication administration errors, and adequately assess and manage Resident #2's pain. These failures resulted in missed and delayed doses of prescribed pain medication, prolonged intervals between medication administrations, unaccounted-for controlled substances and unmanaged pain. The findings include: Resident #2's diagnoses included malignant neoplasm of the bronchus/lung, secondary malignant neoplasm of the intrathoracic lymph nodes, chronic pain syndrome, and palliative care. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had intact cognition (Brief Interview for Mental Status (BIMS) score of 15), required supervision with bed mobility, required partial assistance with transfers, received scheduled and as-needed pain medications, experienced frequent moderate pain, and received hospice services. The Resident Care Plan (RCP) dated 3/22/26 identified Resident #2 required assistance with activities of daily living (ADLs) and had altered comfort related to small cell lung cancer with metastasis to the intrathoracic lymph nodes, restless leg syndrome, degenerative disc disease, lumbar spinal stenosis, chronic bilateral low back pain with sciatica (pain caused by irritation or compression of the sciatic nerve), and claudication (pain or cramping caused by decreased blood flow). Interventions included providing one-person assistance with bathing, dressing, toileting, hygiene, and transfers using a rolling walker, monitoring for pain, administering medications as ordered, documenting the effectiveness of pain medications, and monitoring and documenting verbal and nonverbal signs and symptoms of pain. A. Delay in fentanyl patch administration A physician's order dated 5/13/26 at 6:08 AM directed a fentanyl transdermal patch 12 micrograms (mcg) per hour, apply one (1) patch every three (3) days for pain, rotate application sites, and remove the patch according to the schedule. The May 2026 Medication Administration Record (MAR) identified RN #4 applied the 12 mcg fentanyl patch at 8:30 AM on 5/13/26. The order was discontinued later that day at 6:07 PM. A physician's order dated 5/13/26 at 6:05 PM, entered by Advanced Practice Registered Nurse (APRN) #2, directed a fentanyl transdermal patch 12 mcg per hour, apply one (1) patch every three (3) days for pain, rotate application sites, and remove the patch according to schedule. The May 2026 MAR identified the replacement order scheduled the next fentanyl patch application for 8:30 AM on 5/14/26, although the initial patch had already been applied on 5/13/26. RN #4 documented the 5/14/26 dose as not administered because the previously applied patch remained in place. The next documented fentanyl patch change did not occur until 5/17/26. Although the physician's order directed the patch be changed every 72 hours, the patch remained in place for approximately 96 hours. The Controlled Substance Disposition Record identified ten (10) fentanyl 12 mcg patches were received. One (1) patch was removed from inventory on 5/13/26, leaving nine (9) patches remaining. The next patch was not removed from inventory until 5/17/26, leaving eight (8) patches remaining, consistent with the delayed replacement documented in the MAR. Interview with the Director of Nursing (DON) on 7/16/26 at 10:05 AM identified she was unaware of the medication error until surveyor notification. The DON identified the order re-entered by APRN #2 was transcribed incorrectly, causing the (continued on next page)		

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F 0697 Level of Harm - Actual harm Residents Affected - Few	administration schedule to populate inaccurately. The DON identified APRN #2 should have verified when the initial fentanyl patch had been administered before re-entering the order, and RN #4 should have questioned why the order repopulated the following day rather than document the medication as not administered. Interview with APRN #2 on 7/16/26 at 10:56 AM identified she did not recall why the original order was discontinued but believed it was related to pharmacy processing requirements for controlled substances. APRN #2 identified she re-entered the order without verifying the generated administration schedule and was unaware the electronic medical record scheduled the next application for 5/14/26 instead of 5/16/26. APRN #2 identified she should have adjusted the order time to reflect the initial application on 5/13/26 so the subsequent 72-hour administration schedule populated correctly. Interview with RN #4 on 7/16/26 at 11:22 AM identified he applied the fentanyl patch on 5/13/26. When prompted to administer another patch on 5/14/26, he observed the previous patch remained intact and documented the medication as not administered because he believed the electronic medical record generated the order in error. RN #4 identified he did not review the physician's order to determine why the medication repopulated and acknowledged he should have done so. On 5/17/26, he removed the patch dated 5/13/26 and applied a new patch but did not recognize the original patch had remained in place longer than the ordered 72-hour interval. B. Missing fentanyl patches on 5/18/26 A Nurse's note by RN #2 dated 5/18/26 at 3:18 PM identified she notified the provider after both fentanyl patches were removed by Resident #2. RN #2 searched Resident #2's room but was unable to locate either fentanyl patch. The MAR was updated with a new order to reapply the fentanyl patches. RN #2 documented she educated Resident #2 and a family member regarding the importance of leaving the fentanyl patches in place. The May 2026 MAR identified a physician's order dated 5/12/26 directing one (1) fentanyl transdermal patch 25 micrograms (mcg) per hour every three (3) days for pain. The MAR identified the last documented application occurred on 5/16/26 at 8:30 AM. A physician's order dated 5/13/26 directed staff to administer one (1) fentanyl transdermal patch 12 mcg per hour every three (3) days. The last documented application occurred on 5/17/26 at 8:30 AM. The MAR further identified licensed nurses documented both fentanyl patches were present during every shift check on 5/17/26, including RN #4 during the 7:00 AM to 3:00 PM shift, LPN #5 during the 3:00 PM to 11:00 PM shift, and LPN #3 during the 11:00 PM to 7:00 AM shift. Both fentanyl patches were documented as reapplied on 5/18/26 at 12:30 PM by LPN #4. Interview with LPN #4 on 7/16/26 at 11:36 AM identified he was assigned to Resident #2 during the 7:00 AM to 3:00 PM shift on 5/18/26. During the scheduled fentanyl patch check, he was unable to locate either the 12 mcg or 25 mcg fentanyl patch. Resident #2 was unable to identify what happened to the patches. Interview with RN #2 on 7/16/26 at 12:00 PM identified LPN #4 notified her both fentanyl patches were missing. RN #2 completed a body check, searched Resident #2's bed linens, trash receptacles, and room, but was unable to locate either fentanyl patch. RN #2 identified Resident #2 reported attempting to remove the nicotine patch because he/she wanted to smoke; however, the nicotine patch remained intact. RN #2 notified the DON, who instructed her to notify the provider for replacement orders. Although the fentanyl patches could not be located, RN #2 did not obtain statements from staff members who had contact with Resident #2. Interview with the DON on 7/16/26 at 12:12 PM identified RN #2 did not report the missing fentanyl patches on 5/18/26. The DON identified when she later reviewed documentation she determined placement of both fentanyl patches had been verified by LPN #3 during the overnight shift before they were discovered missing. Although RN #2 documented Resident #2 reported removing the patches, the missing fentanyl patches represented unaccounted-for controlled substances. The DON identified the incident should have been reported to the State Agency, staff and visitor statements should have been obtained, and an (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Bel-Air Manor Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 256 New Britain Avenue Newington, CT 06111	
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F 0697 Level of Harm - Actual harm Residents Affected - Few	investigation should have been initiated immediately. Interview with LPN #3 on 7/20/26 at 11:11 AM identified if she documented verifying placement of the fentanyl patches during the 11:00 PM to 7:00 AM shift, the fentanyl patches were present. LPN #3 identified if either fentanyl patch had been missing, she would have notified the nursing supervisor immediately. LPN #3 further identified she was never contacted by the facility to provide a statement after the incident. Although attempted, an interview with LPN #5 was not obtained. C. Missing fentanyl patches on 5/24/26 The Reportable Event (RE) form dated 5/24/26 identified RN #4 was unable to locate Resident #2's fentanyl patches during the scheduled morning placement check. The provider, hospice agency, and police department were notified. Resident #2 was monitored for changes in pain, and an investigation was initiated regarding the missing fentanyl patches and individuals who had visited Resident #2 after the patches were last documented as present. A Nurse's note by RN #4 dated 5/24/26 at 10:48 AM identified he was unable to locate the fentanyl patches applied on 5/23/26 at 12:30 PM. RN #4 completed a body check, searched Resident #2's room, bed linens, and trash receptacles, but was unable to locate either fentanyl patch. Resident #2 denied removing the patches. The May 2026 MAR identified licensed nurses documented both fentanyl patches were present on 5/23/26 during the 7:00 AM to 3:00 PM, 3:00 PM to 11:00 PM, and 11:00 PM to 7:00 AM shifts before they were later discovered missing. A Nurse's note by RN #5 dated 5/24/26 at 4:51 PM identified RN #4 notified her the fentanyl patches applied to Resident #2's right posterior scapular area could not be located. RN #5 initially checked the application site but delayed completing a full body check until Resident #2 finished breakfast. During the subsequent body check, completed with RN #4 and NA #1, Resident #2 reported a family member had placed one (1) fentanyl patch on his/her leg. No fentanyl patches were identified until NA #1 observed a fentanyl patch dated 5/17/26 on Resident #2's left upper inner arm while providing personal care. The DON, hospice agency, and provider were notified. Hospice requested the fentanyl patches be discontinued, and the provider ordered scheduled oral oxycodone in place of the fentanyl patches. D. Oxycodone order transcribed incorrectly resulting in missed overnight doses Facility documentation dated 6/17/26 identified the administration times for Resident #2's oxycodone did not match the physician's orders from 5/24/26 through 6/17/26. Physician's orders dated 5/24/26, 5/29/26, 6/4/26, and 6/15/26 directed staff to administer oxycodone 10 milligrams (mg) by mouth every four (4) hours for terminal pain. The May 2026 Medication Administration Record (MAR) identified the 5/24/26 and 5/29/26 oxycodone orders contained administration times of 6:00 AM, 10:00 AM, 2:00 PM, 6:00 PM, and 10:00 PM, but failed to include the required 2:00 AM administration, resulting in one missed scheduled dose every day. The June 2026 MAR identified the 6/4/26 and 6/15/26 oxycodone orders continued to omit the required overnight administration. The administration schedule was not corrected until 6/17/26, when the MAR was revised to include every four (4) hour administration times of 12:00 AM, 4:00 AM, 8:00 AM, 12:00 PM, 4:00 PM, and 8:00 PM. The Order Audit Report identified RN #5 entered the original oxycodone order on 5/24/26 and RN #2 confirmed the order as accurate. Interview with Person #2 on 7/17/26 at 9:05 AM identified Resident #2 frequently complained of not receiving pain medication during the overnight shift and repeatedly reported uncontrolled pain. Interview with Resident #2 on 7/17/26 at 10:42 AM identified he/she experienced chronic pain requiring scheduled pain medication but was unable to recall specific dates doses were missed. Interview with RN #2 on 7/20/26 at 1:07 PM identified she confirmed the 5/24/26 oxycodone order without recognizing the administration schedule omitted the overnight dose. RN #2 identified she should have thoroughly reviewed the administration times before confirming the order and acknowledged the medication error could have been identified much sooner. Interview with RN #5 on 7/20/26 at 1:18 PM identified she entered the original oxycodone order and mistakenly selected (continued on next page)		

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F 0697 Level of Harm - Actual harm Residents Affected - Few	prepopulated administration times that excluded the overnight dose. RN #5 identified she should have fully reviewed the physician's order before completing the transcription. Interview with APRN #2 on 7/20/26 at 2:07 PM identified licensed nurses were responsible for ensuring physician's orders were accurately entered and followed. APRN #2 identified staff should compare physician's orders with the Medication Administration Record (MAR), medication card, and Controlled Substance Disposition Record to identify transcription errors. APRN #2 further identified Resident #2's chronic pain could have worsened overnight when the scheduled oxycodone doses were omitted. The May and June 2026 MARs identified the only as-needed (PRN) pain medication available after the scheduled oxycodone order was acetaminophen 325 mg, two (2) tablets by mouth every six (6) hours as needed for discomfort or a temperature greater than 101 degrees. The MAR failed to identify administration of the PRN acetaminophen from 5/24/26 through 6/17/26. Interview with the Director of Nursing (DON) on 7/20/26 at 3:46 PM identified RN #5 should have accurately transcribed the oxycodone order and RN #2 should have thoroughly reviewed the order before confirming it. The DON identified comparison of the MAR, medication card, and Controlled Substance Disposition Record should have identified the error sooner and prevented the continued omission of scheduled overnight oxycodone doses. E. Failure to administer oxycodone every four hours as ordered on 6/13/26 into 6/14/26 A physician's order dated 6/4/26 directed staff to administer oxycodone 10 mg by mouth every four (4) hours for terminal pain. Continuous camera footage dated 6/13/26 identified LPN #5 administered medications at approximately 9:15 PM and informed Resident #2 pain medication was being administered. Nursing staff did not re-enter the room until 12:09 AM, when RN #9 administered Ativan. At 3:29 AM Resident #2 was observed thrashing about in bed and grimacing. At 3:51 AM Resident #2 appeared restless and attempted to place both legs over the side of the bed. At 3:52 AM RN #9 entered the room, briefly assessed Resident #2, identified Resident #2 was incontinent, turned off the call bell, and exited without administering pain medication. At 4:00 AM an NA changed Resident #2's brief and exited the room. At 4:23 AM Resident #2 was observed thrashing about in bed and restless. Resident #2 continued to appear restless until 5:37 AM, when RN #9 returned and administered oxycodone, more than eight (8) hours after the previous scheduled dose. The Controlled Substance Disposition Record identified oxycodone 10 mg was administered on 6/13/26 at 10:00 PM and was not administered again until 5:30 AM on 6/14/26, approximately seven and one-half (7.5) hours later. The June 2026 Medication Administration Record (MAR) identified the only PRN pain medication available remained acetaminophen 325 mg. The MAR failed to identify administration of PRN acetaminophen during the overnight shift. RN #9 documented Resident #2's pain level as zero (0) despite the camera footage capturing restlessness, grimacing, thrashing about in bed, and attempting to get out of bed. Interview with RN #9 on 7/20/26 at 2:24 PM identified Resident #2 routinely complained of pain. RN #9 identified she documented pain assessments based on her observations and believed Resident #2 was not exhibiting signs of pain. RN #9 acknowledged if Resident #2 had reported pain or demonstrated signs of discomfort she should have administered pain medication. F. Failure to administer oxycodone every four (4) hours as ordered on 6/22/26 into 6/23/26 Continuous camera footage dated 6/22/26 identified LPN #6 administered medications to Resident #2 in applesauce at approximately 9:17 PM but did not identify what the medications administered were. No licensed nurse entered Resident #2's room again until 3:03 AM on 6/23/26. At 3:01 AM, Resident #2 was observed thrashing about in bed and repeatedly kicking his/her legs over the side of the bed, appearing uncomfortable. At 3:03 AM, RN #9 entered the room and administered pain medication in applesauce more than three (3) hours after the scheduled administration time, although the Medication Administration Record (MAR) documented the oxycodone 10 milligrams (mg) dose as administered at 12:00 AM with a pain level of zero (0). At (continued on next page)		

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F 0697 Level of Harm - Actual harm Residents Affected - Few	5:07 AM, RN #9 returned and administered another oxycodone dose approximately two (2) hours after the previous administration. At 7:50 AM, LPN #9 asked Resident #2 if he/she was in pain. Resident #2 reported a little bit of pain, and LPN #9 administered haloperidol (Haldol), morphine, oxycodone, and gabapentin. The camera footage identified Resident #2 received three (3) oxycodone doses within four (4) hours and forty-seven (47) minutes. The Controlled Substance Disposition Record identified Resident #2 received oxycodone 10 mg on 6/22/26 at 9:00 PM, the next dose was not administered until 2:40 AM on 6/23/26, five (5) hours and forty (40) minutes later, followed by another dose at 5:15 AM and again at 8:00 AM, approximately every two (2) to three (3) hours rather than every four (4) hours as ordered. Interview with RN #9 on 7/20/26 at 2:24 PM identified she could not recall the events of 6/22/26 into 6/23/26. RN #9 identified physician's orders should be followed, medications should be administered within one (1) hour of the scheduled administration time, and documentation should occur at the time medications were administered. RN #9 acknowledged she should not have administered the scheduled oxycodone dose more than three (3) hours late, followed by another scheduled dose approximately two (2) hours later. RN #9 further identified she should have notified the provider and communicated the late medication administration to the oncoming shift. Interview with LPN #9 on 7/20/26 at 2:59 PM identified RN #9 did not notify her the previous scheduled oxycodone dose had been administered late. LPN #9 identified had she known, she would have adjusted the next administration time to comply with the physician's order. G. Failure to administer oxycodone every four (4) hours as ordered on 6/26/26 into 6/27/26 Continuous camera footage dated 6/26/26 identified LPN #7 administered medications to Resident #2 at approximately 7:58 PM. Camera footage identified Resident #2 was awake throughout the night and appeared distressed. No licensed nurse entered Resident #2's room again until 5:29 AM on 6/27/26, when RN #8 informed Resident #2 she was administering clonazepam (Klonopin) and pain medication. Although RN #8 was not observed entering Resident #2's room until 5:29 AM, the MAR documented oxycodone administrations at 12:00 AM and 4:00 AM with pain assessments of zero (0). At 6:03 AM, two (2) Nursing Assistants (NA #2 and NA #3) provided personal care, during which Resident #2 reported not feeling well and requested the hospice nurse. The Progress Notes dated 6/27/26 failed to identify missed or late pain medication administration, Resident #2's request for the hospice nurse, or notification of the provider regarding the change in condition. The Controlled Substance Disposition Record identified oxycodone 10 mg was removed from inventory for the documented 12:00 AM and 4:00 AM administrations; however, the camera footage did not identify RN #8 entering Resident #2's room until 5:29 AM. Interview with Person #2 on 7/17/26 at 9:05 AM identified he/she reviewed the camera footage and notified RN #6 on 6/27/26 that Resident #2 had not received pain medication for approximately ten (10) hours even though the medications had been documented as administered. Person #2 further identified Resident #2 repeatedly reported not feeling well and requested hospice be contacted. Interview with the Director of Nursing (DON) on 7/20/26 at 3:30 PM identified licensed nurses were responsible for assessing Resident #2 for pain each shift, implementing interventions when pain was identified, administering medications according to physician's orders, and notifying the provider whenever medications could not be administered within the required timeframe. Although attempted, interviews with RN #6, RN #8, NA #2, and NA #3 were not obtained. The Pain Management policy dated 10/16/25 directed, in part, the facility would utilize a systematic approach to recognizing, assessing, treating, monitoring, and reassessing pain. The policy directed staff to identify verbal and nonverbal indicators of pain, administer pain management interventions consistent with the resident's assessment and physician's orders, evaluate the effectiveness of interventions, reassess pain, revise interventions when pain was not adequately controlled, and notify the (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0697 Level of Harm - Actual harm Residents Affected - Few	practitioner when pain management was ineffective. The Medication Orders policy (undated) directed, in part, medication orders were to be documented promptly and accurately, entered correctly into the electronic health record, transcribed onto the Medication Administration Record (MAR), clarified when necessary, and verified to ensure safe implementation. Staff were responsible for ensuring medication orders accurately reflected the physician's directions before implementation. The Medication Errors policy dated 11/2025 directed, in part, medications were to be administered according to physician's orders and accepted standards of professional practice. The policy further directed licensed nurses to verify the right resident, medication, dose, route, time, and administration to prevent medication errors and ensure residents remained free from significant medication errors.		

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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 review of the clinical record, facility policy, camera footage and interviews for one (1) of three (3) sampled residents (Resident #2) reviewed for personal care, the facility failed to ensure Resident #2 was treated with dignity and respect during the provision of care. Specifically, review of continuous camera footage revealed multiple instances in which staff failed to communicate appropriately, did not address the resident by name, did not obtain permission before providing care, and did not maintain the resident's dignity. The findings include: Resident #2's diagnoses included malignant neoplasm of the bronchus/lung, secondary malignant neoplasm of the intrathoracic lymph nodes, chronic pain syndrome and palliative care. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had intact cognition (Brief Interview for Mental Status (BIMS) score of 15), and required supervision with bed mobility and partial assistance with transfers. Additionally, it identified Resident #1 received scheduled pain medication and as needed pain medication, had frequent moderate pain and was on hospice services. The Resident Care Plan (RCP) dated 3/22/26 identified Resident #2 required assistance with Activities of Daily Living (ADLs) and had an alteration in comfort/pain related to small cell lung cancer metastasized to intrathoracic lymph nodes, restless leg syndrome, degenerative disc disease/spinal stenosis of the lumbar region, chronic bilateral low back pain with sciatica (nerve pain caused by compression or irritation of the sciatic nerve) and claudication (muscle pain, cramping or weakness of the legs or buttocks). Interventions included providing an assist of one (1) for bathing, dressing, toileting, hygiene and transfers with a rolling walker as ordered, monitoring for pain, administering medications as ordered, documenting the effects of pain medication and monitoring for verbal/nonverbal signs and symptoms of pain and documenting the pain. A. Review of continuous camera footage dated 6/17/26 at 10:07 PM identified NA #4 and NA #6 entered Resident #2's room. NA #6 approached the left side of the bed, pulled the sheet off of Resident #2 and opened Resident #2's brief without speaking to Resident #2. NA #4 was talking to NA #6 in a language which Resident #2 did not speak or understand and stopped care multiple times to talk to NA #6. NA #4 wiped Resident #2's front side with a towel and started to turn Resident #2 to the side when Resident #2 appeared to wake up. At 10:10 PM NA #6 spoke to Resident #2 for the first time stating, We're going to turn you. NA #6 cannot be heard talking throughout the footage due to her back facing the camera. B. Review of continuous camera footage dated 6/19/26 at 8:24 PM identified NA #4 walked into Resident #2's room and stated, They are going to complain. NA #5 was on the right side of Resident #2's bed, Resident #2 had eyes closed and NA #5 removed the oxygen nasal cannula without speaking to Resident #2. Resident #2 woke up, appeared frightened and started to grab NA #5. NA #4 placed her hand between Resident #2's legs to touch the brief and stated, he/she's not wet, we'll leave him/her alone. NA #5 covered Resident #2 and at 8:25 PM NA #4 was heard saying, I'm not going to jail. They exit the room at 8:26 PM with Resident #2 visibly awake. Interview with the DON on 7/20/26 at 3:30 PM identified she was not aware of the video footage but reported Resident #2 should have been treated with dignity and respect. The DON identified staff should always knock before entering a resident's room and explain what they will be doing prior to touching a resident or performing care. Staff should not speak in a language which the resident cannot understand or make inappropriate comments in a resident's room. Interview with NA #5 on 7/20/26 at 4:02 PM identified she was aware there was a camera recording in Resident #2's room and she should have addressed Resident #2 by name, woken him/her up and explained what they were going to do prior to taking off (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the oxygen. NA #5 identified Resident #2 should have been treated with dignity and respect. Although attempted, an interview with NA #4 was not obtained. Review of the Quality of Life- Dignity policy dated 11/10/25 directed, in part, residents must always be treated with dignity and respect. Treated with dignity means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth. Staff will knock and request permission before entering residents' rooms. Staff shall speak respectfully to residents at all times, including addressing the resident by his or her name of choice and not labeling or referring to the resident by his or her room number, diagnosis or care needs. Staff shall keep the resident informed and oriented to their environment. Procedures shall be explained before they are performed and residents will be told in advance if they are going to be taken out of their usual or familiar surroundings. Demeaning practices and standards of care that compromise dignity are prohibited. Staff shall promote dignity and assist residents as needed.		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation, facility policy, camera footage, and interviews, for one (1) of three (3) sampled residents (Resident #2) reviewed for medication administration, the facility failed to ensure an incident involving missing fentanyl patches and an allegation of neglect related to medication administration were reported to the State Agency within the required timeframe (within 2 hours). The findings include: Resident #2's diagnoses included malignant neoplasm of the bronchus/lung, secondary malignant neoplasm of the intrathoracic lymph nodes, chronic pain syndrome, and palliative care. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had intact cognition (Brief Interview for Mental Status (BIMS) score of 15), required supervision with bed mobility and partial assistance with transfers, received scheduled and as-needed pain medication, had frequent moderate pain, and was receiving hospice services. The Resident Care Plan (RCP) dated 3/22/26 identified Resident #2 required assistance with activities of daily living (ADLs) and had an alteration in comfort/pain related to small cell lung cancer metastasized to intrathoracic lymph nodes, restless leg syndrome, degenerative disc disease/spinal stenosis of the lumbar region, chronic bilateral low back pain with sciatica (nerve pain caused by compression or irritation of the sciatic nerve), and claudication (muscle pain, cramping or weakness of the legs or buttocks). Interventions included providing an assist of one (1) for bathing, dressing, toileting, hygiene, and transfers with a rolling walker as ordered; monitoring for pain; administering medications as ordered; documenting the effects of pain medication; and monitoring and documenting verbal and nonverbal signs and symptoms of pain. A. The May 2026 Medication Administration Record (MAR) identified an order dated 5/12/26 directing administration of fentanyl transdermal patch 25 micrograms (mcg) per hour, one (1) patch transdermally every three (3) days for pain. The last administration was documented on 5/16/26 at 8:30 AM. An order dated 5/13/26 directed administration of fentanyl transdermal patch 12 mcg per hour, one (1) patch transdermally every three (3) days. The last administration was documented on 5/17/26 at 8:30 AM. The MAR also directed staff to check placement of the fentanyl patches every shift. Placement was documented as verified on 5/17/26 by RN #4 on the 7:00 AM to 3:00 PM shift, LPN #5 on the 3:00 PM to 11:00 PM shift, and LPN #3 on the 11:00 PM to 7:00 AM shift. Both fentanyl patches were documented as reapplied on 5/18/26 at 12:30 PM by LPN #4. A Nurse's note by RN #2 dated 5/18/26 at 3:18 PM identified she notified the APRN that both fentanyl patches had been removed by Resident #2. RN #2 searched Resident #2's room but was unable to locate the patches. RN #2 documented educating Resident #2 and a family member regarding the importance of the patches and instructing Resident #2 to give any removed patches to nursing staff. Interview with LPN #4 on 7/16/26 at 11:36 AM identified he was the charge nurse assigned to Resident #2 on the 7:00 AM to 3:00 PM shift on 5/18/26. When he checked Resident #2 to verify the fentanyl patches were intact, he was unable to locate either the 12 mcg or 25 mcg fentanyl patch, and Resident #2 was unable to identify their whereabouts. LPN #4 immediately notified RN #2. LPN #4 identified consistent staff had been working with Resident #2, with the exception of LPN #3, an agency nurse who worked the 11:00 PM to 7:00 AM shift from 5/17/26 into 5/18/26. Interview with RN #2 on 7/16/26 at 12:00 PM identified LPN #4 notified her on 5/18/26 that Resident #2's fentanyl patches could not be located. RN #2 performed a body check for Resident #2 and checked Resident #2's sheets and garbage but was unable to locate the patches. RN #2 reported Resident #2 indicated he/she attempted to remove the nicotine patch because he/she wanted to (continued on next page)		

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	smoke; however, the nicotine patch remained intact. RN #2 reported she assumed Resident #2 had removed the fentanyl patches, notified the Director of Nursing (DON), and was directed to notify the provider for new orders. RN #2 acknowledged she did not recognize the missing fentanyl patches as an incident of medication misappropriation, did not report the incident to the State Agency, did not initiate an investigation, and did not obtain statements from staff who had contact with Resident #2. Interview with the DON on 7/16/26 at 12:12 PM identified RN #2 did not report the missing fentanyl patches to her on 5/18/26. The DON identified she routinely reviewed nurses' notes for the off hours but did not recall seeing RN #2's note dated 5/18/26. The DON identified she was notified of the incident on 5/24/26 and subsequently reviewed the documentation. The DON identified LPN #3 had documented verification of the fentanyl patches during the 11:00 PM to 7:00 AM shift prior to the patches being unable to be located. The DON further identified that when fentanyl patches could not be located, the incident should have been reported to the State Agency, statements should have been obtained from staff and visitors who had contact with Resident #2, and an investigation should have been initiated. B. Camera footage dated 6/26/26 through 6/27/26 identified Resident #2 received medications from LPN #7 at 7:58 PM on 6/26/26. No nursing staff were observed entering Resident #2's room to administer medications again until RN #8 entered at 5:29 AM on 6/27/26. At 5:29 AM, RN #8 was heard identifying she was administering Klonopin and pain medication. However, RN #8 had documented administration of oxycodone 10 mg at 12:00 AM and 4:00 AM on 6/27/26, with pain levels of zero (0). The Controlled Substance Disposition Record (CSDR) for Resident #2's oxycodone 10 mg every four (4) hours identified a dose administered on 6/26/26 at 9:00 PM. The 12:00 AM and 4:00 AM doses on 6/27/26 were documented as removed from stock; however, camera footage did not identify RN #8 entering Resident #2's room until 5:29 AM. Camera footage dated 6/27/26 at 6:03 AM identified NA #2 and NA #3 were observed in Resident #2's room providing personal care. Resident #2 reported not feeling well and requested the hospice nurse. Review of the 6/27/26 progress notes failed to identify documentation of missed or late medications or notification that Resident #2 reported not feeling well or requested the hospice nurse. Interview with Person #2 on 7/17/26 at 9:05 AM identified Person #2 reviewed camera footage from 6/26/26 into 6/27/26 and notified RN #6 on 6/27/26 that Resident #2 had not received pain medication in approximately ten (10) hours and the medications were being documented as administered. Person #2 further identified Resident #2 subsequently reported not feeling well and requested that hospice be contacted. Interview with the DON on 7/20/26 at 3:30 PM identified she was not shown the camera footage related to the overnight medication administration concerns. The DON identified Person #2 also notified her that Resident #2 had not received medications during the overnight shift from 6/26/26 into 6/27/26. The DON reviewed the MAR and CSDR, identified the medications were documented as administered, and determined the allegation was unsubstantiated. The DON did not report the allegation to the State Agency within the required timeframe and did not initiate a further investigation, including obtaining statements from staff assigned to the overnight shift from 6/26/26 into 6/27/26. Although attempted, an interview with RN #6 was not obtained. The Compliance with Reporting Allegations of Abuse/Neglect/Exploitation policy (undated) directed all allegations or suspicions of abuse, neglect, exploitation, mistreatment, injuries of unknown source, and misappropriation of resident property be reported immediately to the Administrator and appropriate State and Federal agencies within required timeframes. The policy further directed the facility to investigate allegations, protect residents during the investigation, document actions taken, and report investigation results and corrective actions as required. The Abuse, Neglect and Exploitation policy (undated) identified misappropriation of resident property as the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	belongings or money without the resident's consent. The policy directed the facility to immediately investigate allegations of misappropriation, protect residents during and after investigations, and implement corrective actions when indicated.		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation, facility policy, camera footage, and interviews, for one (1) of three (3) sampled residents (Resident #2) reviewed for medication administration, the facility failed to thoroughly investigate an allegation of medication misappropriation and an allegation of neglect related to medication administration. The findings include: Resident #2's diagnoses included malignant neoplasm of the bronchus/lung, secondary malignant neoplasm of the intrathoracic lymph nodes, chronic pain syndrome, and palliative care. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had intact cognition (Brief Interview for Mental Status (BIMS) score of 15), required supervision with bed mobility and partial assistance with transfers, received scheduled and as-needed pain medication, had frequent moderate pain, and was receiving hospice services. The Resident Care Plan (RCP) dated 3/22/26 identified Resident #2 required assistance with activities of daily living (ADLs) and had an alteration in comfort/pain related to small cell lung cancer metastasized to intrathoracic lymph nodes, restless leg syndrome, degenerative disc disease/spinal stenosis of the lumbar region, chronic bilateral low back pain with sciatica (nerve pain caused by compression or irritation of the sciatic nerve), and claudication (muscle pain, cramping or weakness of the legs or buttocks). Interventions included providing an assist of one (1) for bathing, dressing, toileting, hygiene, and transfers with a rolling walker as ordered; monitoring for pain; administering medications as ordered; documenting the effects of pain medication; and monitoring and documenting verbal and nonverbal signs and symptoms of pain. A. A Nurse's note by RN #2 dated 5/18/26 at 3:18 PM identified she notified the APRN that both fentanyl patches had been removed by Resident #2. RN #2 searched Resident #2's room but was unable to locate the patches. RN #2 documented educating Resident #2 and a family member regarding the importance of the patches and instructing Resident #2 to give any removed patches to nursing staff. The May 2026 Medication Administration Record (MAR) identified an order dated 5/12/26 directing administration of fentanyl transdermal patch 25 micrograms (mcg) per hour, one (1) patch transdermally every three (3) days for pain. The last administration was documented on 5/16/26 at 8:30 AM. An order dated 5/13/26 directed administration of fentanyl transdermal patch 12 mcg per hour, one (1) patch transdermally every three (3) days. The last administration was documented on 5/17/26 at 8:30 AM. The MAR also directed staff to check placement of the fentanyl patches every shift. Placement was documented as verified on 5/17/26 by RN #4 on the 7:00 AM to 3:00 PM shift, LPN #5 on the 3:00 PM to 11:00 PM shift, and LPN #3 on the 11:00 PM to 7:00 AM shift. Both fentanyl patches were documented as reapplied on 5/18/26 at 12:30 PM by LPN #4. Interview with LPN #4 on 7/16/26 at 11:36 AM identified he was the charge nurse assigned to Resident #2 on the 7:00 AM to 3:00 PM shift on 5/18/26. When he checked Resident #2 to verify the fentanyl patches were intact, he was unable to locate either the 12 mcg or 25 mcg fentanyl patch, and Resident #2 was unable to identify their whereabouts. LPN #4 immediately notified RN #2. LPN #4 identified consistent staff had been working with Resident #2, with the exception of LPN #3, an agency nurse who worked the 11:00 PM to 7:00 AM shift from 5/17/26 into 5/18/26. Interview with RN #2 on 7/16/26 at 12:00 PM identified LPN #4 notified her on 5/18/26 that Resident #2's fentanyl patches could not be located. RN #2 performed a body check for Resident #2 and checked Resident #2's sheets and garbage but was unable to locate the patches. RN #2 reported Resident #2 indicated he/she attempted to remove the nicotine patch because he/she wanted to smoke; however, the nicotine patch remained intact. RN #2 reported she assumed Resident #2 removed the fentanyl patches and notified the DON, who (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	directed her to notify the provider for new orders. RN #2 acknowledged she did not initiate an investigation or obtain statements from staff who had contact with Resident #2 and was unable to explain why. Interview with the DON on 7/16/26 at 12:12 PM identified RN #2 did not report the missing fentanyl patches to her on 5/18/26. The DON identified she routinely reviewed nurses' notes for the off hours but did not recall seeing RN #2's note dated 5/18/26. The DON identified she was notified of the incident on 5/24/26 and subsequently reviewed the documentation. The DON identified LPN #3 had documented verification of the fentanyl patches during the 11:00 PM to 7:00 AM shift prior to the patches being unable to be located. The DON further identified that when fentanyl patches could not be located, staff and visitor statements should have been obtained and an investigation should have been initiated. B. Camera footage dated 6/26/26 through 6/27/26 identified Resident #2 received medications from LPN #7 at 7:58 PM on 6/26/26. No nursing staff were observed entering Resident #2's room to administer medications again until RN #8 entered at 5:29 AM on 6/27/26. At 5:29 AM, RN #8 was heard identifying she was administering Klonopin and pain medication. However, RN #8 had documented administration of oxycodone 10 mg at 12:00 AM and 4:00 AM on 6/27/26, with pain levels of zero (0). The Controlled Substance Disposition Record (CSDR) for Resident #2's oxycodone 10 mg every four (4) hours identified a dose administered on 6/26/26 at 9:00 PM. The 12:00 AM and 4:00 AM doses on 6/27/26 were documented as removed from stock; however, camera footage did not identify RN #8 entering Resident #2's room until 5:29 AM. Camera footage dated 6/27/26 at 6:03 AM, identified NA #2 and NA #3 were observed in Resident #2's room providing personal care. Resident #2 reported not feeling well and requested the hospice nurse. The 6/27/26 progress notes failed to identify documentation of missed or late medications or notification that Resident #2 reported not feeling well or requested the hospice nurse. Interview with Person #2 on 7/17/26 at 9:05 AM identified Person #2 reviewed camera footage from 6/26/26 into 6/27/26 and notified RN #6 on 6/27/26 that Resident #2 had not received pain medication in approximately ten (10) hours and the medications were being documented as administered. Person #2 further identified Resident #2 subsequently reported not feeling well and requested that hospice be contacted. Interview with the DON on 7/20/26 at 3:30 PM identified she was not shown the camera footage related to the overnight medication administration concerns. The DON identified Person #2 also notified her that Resident #2 had not received medications during the overnight shift from 6/26/26 into 6/27/26. The DON reviewed the MAR and CSDR, identified the medications were documented as administered, and determined the allegation was unsubstantiated. The DON did not initiate a further investigation, including obtaining statements from staff assigned to the overnight shift from 6/26/26 into 6/27/26. Although attempted, an interview with RN #6 was not obtained. The Compliance with Reporting Allegations of Abuse/Neglect/Exploitation policy (undated) directed, in part, that allegations or suspicions of abuse, neglect, exploitation, mistreatment, injuries of unknown source, and misappropriation of resident property be investigated, residents be protected during the investigation, actions taken be documented, and investigation results and corrective actions be reported as required. The Abuse, Neglect and Exploitation policy (undated) identified misappropriation of resident property as the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings or money without the resident's consent. The policy directed the facility to immediately investigate allegations of misappropriation, protect residents during and after investigations, and implement corrective actions when indicated.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, camera footage, facility documentation/policy, and interviews, for one (1) of three (3) sampled residents (Resident #2) reviewed for medication administration and care, the facility failed to ensure staff followed the individualized plan of care. Specifically, across multiple shifts and involving multiple staff members, the facility failed to ensure two (2) staff members were present for all care, including medication administration, as directed by the Resident Care Plan (RCP) and physician's order. The findings include: Resident #2's diagnoses included malignant neoplasm of the bronchus/lung, secondary malignant neoplasm of the intrathoracic lymph nodes, chronic pain syndrome, and palliative care. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had intact cognition (Brief Interview for Mental Status (BIMS) score of 15) and required supervision with bed mobility and partial assistance with transfers. The RCP dated 3/19/26 identified Resident #2 was at risk for falls and serious injuries related to a history of falls. Interventions included providing Resident #2 with verbal reminders of individual limitations and observing for alterations in gait. The RCPs dated 3/22/26 identified Resident #2 required assistance with activities of daily living (ADLs) and had an alteration in comfort/pain related to small cell lung cancer metastasized to intrathoracic lymph nodes, restless leg syndrome, degenerative disc disease/spinal stenosis of the lumbar region, chronic bilateral low back pain with sciatica (nerve pain caused by compression or irritation of the sciatic nerve), and claudication (muscle pain, cramping or weakness of the legs or buttocks). Interventions included providing an assist of one (1) for bathing, dressing, toileting, hygiene, and transfers with a rolling walker as ordered; monitoring for pain; administering medications as ordered; providing two (2) staff members for care; documenting the effects of pain medication; and monitoring and documenting verbal and nonverbal signs and symptoms of pain. A physician's order dated 5/27/26 directed staff to provide two (2) staff for all care, including medication administration, and observation every shift for behaviors and allegations. A. Continuous camera footage dated 6/13/26 identified Resident #2 was administered medications in applesauce by LPN #5 at 9:15 PM, and LPN #5 was heard identifying she was administering pain medication. A second staff member was not present during the medication administration. Continuous camera footage dated 6/14/26 at 12:09 AM identified RN #9 entered Resident #2's room and was heard identifying she was administering Ativan before administering a syringe to Resident #2. A second staff member was not present during the medication administration. Continuous camera footage dated 6/14/26 at 3:51 AM identified Resident #2 was observed with his/her legs over the side of the bed and appeared to be attempting to get out of bed. At 3:52 AM, RN #9 entered Resident #2's room, checked Resident #2, identified Resident #2 was wet, turned off the call bell, and exited the room. At 4:00 AM, NA #7 entered Resident #2's room, provided personal care, and exited without a second staff member present. At 5:37 AM, RN #9 entered Resident #2's room and was heard identifying she was administering oxycodone to Resident #2. A second staff member was not present during the medication administration. The June 2026 Treatment Administration Record (TAR) identified LPN #5 and RN #9 signed off on 6/13/26 that two staff members were present for all care, including medication administration. Although attempted, interviews with LPN #5 and NA #7 were not obtained. B. Continuous camera footage dated 6/16/26 identified NA #5 entered Resident #2's room at 8:57 PM and provided personal care. NA #5 completed care and exited the room at 9:03 PM. A second staff member was not present during the care. Interview with NA #5 on 7/20/26 at 4:02 PM identified (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she was aware Resident #2 required two (2) staff for care. NA #5 was unable to explain why a second staff member was not present and could not recall specific details of 6/16/26.C. Continuous camera footage dated 6/17/26 at 9:35 AM identified NA #1 informed Resident #2 she was going to transfer Resident #2 to the shower chair for a shower. NA #1 assisted Resident #2 to sit on the left side of the bed. Without applying a gait belt or using a rolling walker as ordered, NA #1 instructed Resident #2 to give her a big hug and performed a bear-hug transfer. At 9:50 AM, following the shower, NA #1 again instructed Resident #2 to sit up and give her a big hug and performed another bear-hug transfer. NA #1 was the only staff member present during both transfers to and from the shower chair. Interview with NA #1 on 7/20/26 at 1:28 PM identified that before preparing to shower Resident #2, other staff informed her Resident #2 required an assist of one (1) for care and transfers. NA #1 identified she did not review Resident #2's care card (a quick-reference summary sheet that outlines essential daily care needs), although she should have. NA #1 identified she transferred Resident #2 to and from the shower chair alone without a second staff member present.D. Continuous camera footage dated 6/22/26 identified Resident #2 was administered medications in applesauce by LPN #6 at 9:17 PM. A second staff member was not present during the medication administration. Continuous camera footage dated 6/23/26 at 3:03 AM identified RN #9 entered Resident #2's room and was heard identifying she was administering pain medication in applesauce. A second staff member was not present during the medication administration. At 5:07 AM, RN #9 entered Resident #2's room and was heard identifying she was administering oxycodone. A second staff member was not present during the medication administration. At 7:50 AM, LPN #9 entered Resident #2's room and was heard identifying she was administering Haldol, morphine, oxycodone, and gabapentin and administered the medications in applesauce. A second staff member was not present during the medication administration. The June 2026 TAR identified LPN #6 and RN #9 signed off on 6/22/26 and LPN #9 signed off on 6/23/26, that two staff members were present for all care, including medication administration. Interview with RN #9 on 7/20/26 at 2:24 PM identified that although she signed the TAR indicating a second staff member was present when she administered medications to Resident #2 during her 11:00 PM to 7:00 AM shift from 6/13/26 into 6/14/26 and from 6/22/26 into 6/23/26, she was unaware Resident #2 required two (2) staff for care. RN #9 identified that if she signed the TAR indicating two staff members were present, she should have ensured the documentation was accurate. Interview with LPN #9 on 7/20/26 at 2:59 PM identified she was unable to recall whether a second staff member was present when she administered medications to Resident #2 on 6/23/26 but identified that if she signed the TAR indicating a second staff member was present, she should have ensured the documentation was accurate. Interview with LPN #6 on 7/20/26 at 3:22 PM identified he was unable to recall whether a second staff member was present when he administered medications to Resident #2 on 6/22/26 but identified that if he signed the TAR indicating a second staff member was present, he should have ensured the documentation was accurate.E. Continuous camera footage dated 6/26/26 identified Resident #2 was administered medications in applesauce by LPN #7 at 7:58 PM. A second staff member was not present during the medication administration. On 6/27/26 at 5:29 AM, RN #8 entered Resident #2's room and was heard identifying she was administering Klonopin and pain medication. A second staff member was not present during the medication administration. The June 2026 TAR identified LPN #7 and RN #8 signed off on 6/26/26 that two staff members were present for all care, including medication administration. Interview with the DON on 7/20/26 at 3:30 PM identified staff were responsible for reviewing each resident's plan of care through the RCP and/or care card every shift before providing care. The DON identified staff should have followed Resident #2's plan of care at all times and ensured two (2) staff members were present for all care, (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	including medication administration. The DON identified the two-staff requirement was implemented following an alleged medication misappropriation on 5/24/26 and was intended to protect both Resident #2 and staff. The DON identified she was unaware of the camera footage concerning the medication administration and reported Resident #2's family had only shown her the footage of the shower provided by NA #1 on 6/17/26. The DON further identified licensed staff should not have signed the TAR indicating two staff members were present when they were not and that documentation should have been accurate. Although attempted, interviews with LPN #7 and RN #8 were not obtained. The Care Planning policy dated 11/2025 directed, in part, that a comprehensive and individualized plan of care be developed for each resident and guide caregivers in assisting residents to achieve or maintain their highest practical level of well-being. The policy further directed Resident Care Cards be updated as needed to reflect changes made to the resident's plan of care. Although requested, policies regarding following physician's orders and NA care cards were not available.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation, camera footage, facility policy, and interviews, for one (1) of three (3) sampled residents (Resident #2) reviewed for safe transfers, the facility failed to ensure Resident #2 was transferred in accordance with the physician's order and individualized plan of care. Specifically, staff failed to use the required gait belt and rolling walker and performed transfers using an unsafe, unapproved bear hug technique despite Resident #2 exhibiting anxiety, grabbing the shower chair, and verbally indicating an inability to assist. The findings include: Resident #2's diagnoses included malignant neoplasm of the bronchus/lung, secondary malignant neoplasm of the intrathoracic lymph nodes, chronic pain syndrome, palliative care, and a history of falling. A physician's order dated 3/10/26 directed staff to provide an assist of one (1) for transfers with a rolling walker. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had intact cognition (Brief Interview for Mental Status (BIMS) score of 15) and required supervision with bed mobility and partial assistance with transfers. The Resident Care Plan (RCP) dated 3/19/26 identified Resident #2 was at risk for falls and serious injuries related to a history of falls. Interventions included providing Resident #2 with verbal reminders of individual limitations and observing for alterations in gait. The RCP dated 3/22/26 identified Resident #2 required assistance with activities of daily living (ADLs) and had an alteration in comfort/pain related to small cell lung cancer metastasized to intrathoracic lymph nodes, restless leg syndrome, degenerative disc disease/spinal stenosis of the lumbar region, chronic bilateral low back pain with sciatica (nerve pain caused by compression or irritation of the sciatic nerve), and claudication (muscle pain, cramping or weakness of the legs or buttocks). Interventions included providing an assist of one (1) for bathing, dressing, toileting, hygiene, and transfers with a rolling walker as ordered, monitoring for pain, administering medications as ordered, providing two (2) staff members for care, documenting the effects of pain medication, and monitoring and documenting verbal and nonverbal signs and symptoms of pain. A physician's order dated 5/27/26 directed staff to provide two (2) staff for all care, including medication administration, and observation every shift for behaviors and allegations. Continuous camera footage dated 6/17/26 at 9:35 AM showed NA #1 informing Resident #2 she was going to transfer Resident #2 to the shower chair for a shower. NA #1 assisted Resident #2 to sit on the left side of the bed. Without applying a gait belt or using the ordered rolling walker, NA #1 instructed Resident #2 to give her a big hug and performed a bear-hug transfer. Resident #2 repeatedly grabbed the shower-chair arm and appeared anxious. NA #1 told Resident #2 to Let go twice, removed Resident #2's hand, and pivoted Resident #2 into the shower chair positioned at the left side of the bed. At 9:50 AM, following the shower, NA #1 again directed Resident #2 to sit up and give her a big hug and performed another bear-hug transfer. Resident #2 stated, I can't, and made grunting noises; however, NA #1 continued the transfer and pivoted Resident #2 back to bed. NA #1 was the only staff member present during both transfers. Interview with the Rehab Director on 7/20/26 at 12:42 PM identified NA #1 should have used a gait belt and rolling walker for Resident #2's transfers in accordance with the established plan of care. The Rehab Director identified the bear-hug transfer performed by NA #1 was not an approved transfer technique and placed Resident #2 at risk for injury. The Rehab Director further identified that when Resident #2 appeared anxious and grabbed the shower chair, NA #1 should have stopped the transfer and requested assistance. When Resident #2 indicated an inability to assist as directed, NA #1 should not have continued the transfer and instead (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	should have stopped to ensure Resident #2's safety. Interview with NA #1 on 7/20/26 at 1:28 PM identified that before preparing to shower Resident #2, other staff informed her Resident #2 was an assist of one (1) for care and transfers. NA #1 acknowledged she did not review Resident #2's care card (a quick-reference summary sheet that outlines essential daily care needs), although she should have. NA #1 identified she transferred Resident #2 to and from the shower chair alone, without using the rolling walker or gait belt. NA #1 further identified that when Resident #2 became anxious and grabbed the shower chair, she should have stopped and requested assistance but instead performed the bear-hug transfer. NA #1 acknowledged that after the shower she should have requested staff assistance to safely transfer Resident #2 back to bed and should have stopped when Resident #2 stated, I can't, rather than continue the transfer. Interview with the DON on 7/20/26 at 1:49 PM identified NA #1 did not follow Resident #2's established transfer and care instructions on 6/17/26. The DON identified NA #1 should have reviewed Resident #2's care card before assisting with the shower and should not have attempted the transfers without the required gait belt and rolling walker. The DON identified the bear-hug transfer was unsafe, was not an approved technique, and placed Resident #2 at risk for injury. The DON further identified that when Resident #2 became anxious, grabbed the shower chair, or stated, I can't, NA #1 should have stopped the transfer, reassessed the situation, and requested additional staff assistance. Review of the Safe Resident Handling/Transfers policy (undated) directed, in part, that all residents require safe handling when transferred to prevent or minimize the risk of injury to residents and employees. The policy directed that the interdisciplinary team or designee evaluate each resident's individual mobility needs and identified handling aids may include gait belts, transfer boards, or other devices. The policy further directed that resident lifting and transferring be performed according to the resident's individual plan of care. Although requested, a policy regarding gait belts was not provided.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075393	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/20/2026
NAME OF PROVIDER OR SUPPLIER Bel-Air Manor Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 256 New Britain Avenue Newington, CT 06111	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for one (1) of three (3) sampled residents (Resident #2) reviewed for medication order transcription and controlled substances, the facility failed to ensure physician orders were accurately entered and transcribed into the electronic medical record and failed to ensure proper accountability and disposition of controlled substances. Resident #2's diagnoses included malignant neoplasm of the bronchus/lung, secondary malignant neoplasm of the intrathoracic lymph nodes, chronic pain syndrome, and palliative care. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had intact cognition (Brief Interview for Mental Status (BIMS) score of 15) and required supervision or limited assistance with activities of daily living. The Resident Care Plan (RCP) dated 3/22/26 identified Resident #2 had altered comfort related to small cell lung cancer with metastasis and chronic pain. Interventions included monitoring for pain, administering medications as ordered, and documenting the effectiveness of pain medications. A. Incorrect transcription of fentanyl patch orders A physician's order dated 5/13/26 directed staff to apply one (1) fentanyl transdermal patch 12 micrograms (mcg) per hour every three (3) days and rotate application sites. The order was discontinued and re-entered later that day by Advanced Practice Registered Nurse (APRN) #2. The May 2026 Medication Administration Record (MAR) identified the electronic medical record scheduled the next fentanyl patch application for 5/14/26, despite the patch being applied on 5/13/26. The Controlled Substance Disposition Record identified ten (10) fentanyl patches were received and only one (1) patch was removed from inventory on 5/13/26, with the next patch removed on 5/17/26. This reflected a delay in patch replacement consistent with an incorrectly generated administration schedule. Interview with the DON on 7/16/26 at 10:05 AM identified the order re-entered by APRN #2 was transcribed incorrectly, causing the administration schedule to populate inaccurately. The DON identified APRN #2 should have verified the initial administration time when re-entering the order so the correct 72-hour schedule would populate. Interview with APRN #2 on 7/16/26 at 10:56 AM identified she re-entered the fentanyl order without reviewing the automatically generated administration times and acknowledged she should have adjusted the order to reflect the patch applied on 5/13/26. B. Failure to maintain accountability for controlled substances (missing fentanyl patches on 5/18/26) A nurse's note by RN #2 dated 5/18/26 at 3:18 PM identified she notified the provider after both fentanyl patches were removed by Resident #2. RN #2 searched Resident #2's room but was unable to locate either fentanyl patch. The MAR was updated with a new order to reapply the fentanyl patches. The May 2026 MAR identified a physician's order dated 5/12/26 directing one (1) fentanyl transdermal patch 25 micrograms (mcg) per hour every three (3) days for pain. The MAR identified the last documented application occurred on 5/16/26 at 8:30 AM. A physician's order dated 5/13/26 directed staff to administer one (1) fentanyl transdermal patch 12 mcg per hour every three (3) days. The last documented application occurred on 5/17/26 at 8:30 AM. The MAR further identified licensed nurses documented both fentanyl patches were present during every shift check on 5/17/26, including RN #4 during the 7:00 AM to 3:00 PM shift, LPN #5 during the 3:00 PM to 11:00 PM shift, and LPN #3 during the 11:00 PM to 7:00 AM shift. Both fentanyl patches were documented as reapplied on 5/18/26 at 12:30 PM by LPN #4. Interview with LPN #4 on 7/16/26 at 11:36 AM identified he was assigned to Resident #2 during the 7:00 AM to 3:00 PM shift on 5/18/26 and was unable to locate either fentanyl patch during the scheduled patch check. Interview with RN #2 (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Bel-Air Manor Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 256 New Britain Avenue Newington, CT 06111	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on 7/16/26 at 12:00 PM identified she conducted a search of Resident #2's room and belongings, but the patches were not located. RN #2 identified she did not obtain statements from staff or visitors who had contact with Resident #2. Interview with the DON on 7/16/26 at 12:12 PM identified the missing fentanyl patches represented unaccounted for controlled substances. The DON identified the incident should have been immediately reported to the State Agency, staff and visitor statements should have been obtained, and an investigation should have been initiated. The DON further identified staff were not interviewed regarding the missing patches. Although attempted, an interview with LPN #5 was not obtained. C. Failure to maintain accountability for controlled substances (missing fentanyl patches on 5/24/26) A Reportable Event (RE) form dated 5/24/26 identified RN #4 was unable to locate Resident #2's fentanyl patches during the scheduled morning placement check. The provider, hospice agency, and police department were notified. An investigation was initiated regarding individuals who had visited Resident #2 after the patches were last documented as present. A nurse's note by RN #4 dated 5/24/26 at 10:48 AM identified he completed a body check and searched Resident #2's room and belongings but was unable to locate either fentanyl patch applied on 5/23/26. The May 2026 MAR identified licensed nurses documented both fentanyl patches were present on 5/23/26 during the 7:00 AM to 3:00 PM, 3:00 PM to 11:00 PM, and 11:00 PM to 7:00 AM shifts before they were later discovered missing. A nurse's note by RN #5 dated 5/24/26 at 4:51 PM identified she initially checked the application site and later completed a full body assessment with RN #4 and NA #1. NA #1 identified an old fentanyl patch dated 5/17/26 on Resident #2's left upper inner arm. The DON, hospice agency, and provider were notified. The hospice agency requested discontinuation of fentanyl patches, and the provider ordered scheduled oral oxycodone in place of the fentanyl patches. D. Incorrect transcription of oxycodone orders resulting in omitted overnight dosing Facility documentation dated 6/17/26 identified the administration times for Resident #2's oxycodone did not match the physician's orders from 5/24/26 through 6/17/26. Physician's orders dated 5/24/26, 5/29/26, 6/4/26, and 6/15/26 directed staff to administer oxycodone 10 milligrams (mg) by mouth every four (4) hours for terminal pain. The May 2026 MAR identified the 5/24/26 and 5/29/26 oxycodone orders populated administration times of 6:00 AM, 10:00 AM, 2:00 PM, 6:00 PM, and 10:00 PM, but did not include the required overnight dose scheduled every four hours. The June 2026 MAR identified the 6/4/26 and 6/15/26 orders continued to omit the overnight dosing until the MAR was corrected on 6/17/26. The Order Audit Report identified RN #5 entered the original oxycodone order on 5/24/26 and RN #2 confirmed the order as accurate. Interview with RN #2 on 7/20/26 at 1:07 PM identified she confirmed the oxycodone order without recognizing the administration schedule omitted the overnight dose. RN #2 identified she should have thoroughly reviewed the generated schedule before confirming the order. Interview with RN #5 on 7/20/26 at 1:18 PM identified she mistakenly selected prepopulated administration times that excluded the overnight dose and acknowledged she should have fully reviewed the physician's order before completing the transcription. Interview with APRN #2 on 7/20/26 at 2:07 PM identified licensed nurses were responsible for ensuring physician's orders were accurately entered, transcribed, and followed. APRN #2 identified staff should compare orders with the MAR and medication card to identify transcription errors. Interview with the DON on 7/20/26 at 3:46 PM identified RN #5 should have accurately transcribed the oxycodone order and RN #2 should have thoroughly reviewed it before confirming. The DON identified comparison of the MAR, medication card, and Controlled Substance Disposition Record should have identified the error sooner. Review of the facility's Medication Orders policy (undated) directed, in part, medication orders were to be entered accurately into the electronic health record, transcribed correctly onto the MAR, clarified when necessary, and verified before implementation.		

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NAME OF PROVIDER OR SUPPLIER Bel-Air Manor Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 256 New Britain Avenue Newington, CT 06111	
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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observations, camera footage, facility policy and interviews for one (1) of three (3) sampled residents (Resident #2) who were reviewed for incontinence care, the facility failed to ensure infection control practices were implemented during incontinence care, specifically failing to ensure that soiled incontinence briefs and soiled linens were not placed on the floor or on clean surfaces. The findings include:Resident #2's diagnoses included malignant neoplasm of the bronchus/lung, secondary malignant neoplasm of the intrathoracic lymph nodes, chronic pain syndrome and palliative care.The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had intact cognition (Brief Interview for Mental Status (BIMS) score of 15), required supervision with bed mobility and partial assistance with transfers. The MDS identified Resident #2 was frequently incontinent of urine and occasionally incontinent of bowel.The Resident Care Plan (RCP) dated 3/22/26 identified Resident #2 required assistance with ADLs. Interventions included providing an assist of one (1) for bathing, dressing, toileting, hygiene and transfers with a rolling walker as ordered.A. Review of continuous camera footage dated 6/15/26 at 8:02 PM identified NA #4 and NA #5 entered Resident #2's room to provide incontinence care. At 8:03 PM, NA #4 threw a soiled brief directly onto the bedside floor mat to the right side of the bed. The soiled linens that were used to wash Resident #2 were placed directly on the bed sheets and the sheets were not changed prior to NA #4 and NA #5 leaving the room.Although attempted, an interview with NA #4 was not obtained.B. Review of continuous camera footage dated 6/16/26 at 8:57 PM identified NA #5 entered Resident #2's room to provide incontinence care. At 8:58 PM, NA #5 threw a soiled brief directly onto the bedside floor mat to the right side of the bed. The soiled linens that were used to wash Resident #2 were placed directly on the bed sheets and the sheets were not changed prior to NA #5 leaving the room.Interview with the DON on 7/20/26 at 3:30 PM identified infection control is a standard of care and staff should never place dirty linens or incontinent briefs on clean linens or floor surfaces, rather, they should be bagged separately and discarded.Interview with NA #5 on 7/20/26 at 4:02 PM identified dirty briefs and linens should be placed in separate bags and not placed directly on clean linens or the floor. She was unable to explain why the surfaces were not cleaned, and the sheets were not changed prior to leaving Resident #2's room.Although requested, a policy on infection control practices related to disposing of soiled linens and incontinence supplies was not obtained.		