STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075395	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurel Ridge Center for Health & Rehabilitation	642 Danbury Road Ridgefield, CT 06877

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48950 Based on review of clinical records, facility documentation, facility policy and interviews for four sampled residents (Resident #59, Resident #81, Resident #90 and Resident #100) reviewed for mistreatment, the facility failed to prevent resident to resident altercations between Resident #59 and Resident #81, and between Resident #90 and Resident #100. Additionally, for four of eight residents (Residents #27, #40, #62 and #99) reviewed for abuse, the facility failed to ensure the residents were free from neglect and that care was provided in a timely manner on 3/8/2025 during the 7 AM to 3 PM shift. The findings include: 1a. Resident #59 was admitted to the facility in September of 2022 with diagnoses that included dementia, anxiety, and dysphagia. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #59 was severely cognitively impaired, had verbal behavioral symptoms directed towards others, had the behavior of wandering, and was independent with eating, bed mobility and transfers. The Resident Care Plan (RCP) dated 4/29/24 identified Resident #59 had a history of anxiety and depression. Interventions included observing for periods of anxiety, provide a calm, quiet environment and encourage Resident #59 to verbalize thoughts and feelings related to anxiety. A nursing note written by the Nursing Supervisor (the current Director of Nursing (DNS)) dated 5/13/24 at 12:45 PM identified she assessed Resident #59 who had been punched in the face by another resident (Resident #81). The nursing note identified Resident #59 was seated in the dining room with other residents when Resident #81 approached Resident #59 and asked some questions, Resident #59 responded saying, I don't understand you., and Resident #81 then punched Resident #59 in the face. The nursing note identified Resident #59 was taken to his/her room for further assessment and neuro checks, Resident #59 denied pain, and had intact skin with no redness or scratches to the face. The nursing note further identified the responsible party and attending APRN had been notified, and the attending APRN came to the facility to evaluate Resident #59. The progress note failed to identify Resident #59 had been punched in the face the previous evening on 5/12/24 (when the actual event occurred). (continued on next page)

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

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nursing note written by Licensed Practical Nurse (LPN) #2 on 5/13/24 at 5:45 PM (1 day after the resident to resident altercation occurred) identified Resident #59 was in the dining room waiting for dinner when another resident (Resident #81) approached him/her asking questions and Resident #59 responded, I don't understand you, after which Resident #81 punched Resident #59 in the face. The nursing note identified that LPN #2 assessed Resident #59, performed neuros, and did not identify bleeding, pain or discomfort. The nursing note further identified LPN #2 redirected Resident #81 to his/her room, and the APRN and responsible party were notified. b. Resident #81 was admitted to the facility in June of 2023 with diagnoses that included Alzheimer's disease, anxiety disorder, and delusional disorders. The Resident Care Plan (RCP) dated 2/27/24 identified Resident #81 had potential for agitation manifested by hitting other residents and Resident #81 was physical and combative at times as evidenced by hitting and aggression on 10/20/23 and aggression/altercation on 4/29/24. Interventions included offering fluids and snacks and have Resident #81 stay next to the nursing station sitting on the bench, ensure Resident #81 was the first resident to get ready for bed after dinner, and provide one on one with Resident #81 to manage agitation. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #81 was severely cognitively impaired, had several days mood symptoms of being short-tempered and easily annoyed, had verbal behavioral symptoms directed towards others, had the behavior of wandering, required supervision or touching assistance with eating, and was independent with transfers and walking. A nursing note by LPN #2 dated 5/12/24 at 10:18 PM identified Resident #81 was anxious, crying and aggressive with another resident (Resident #59), and Resident #81 was redirected to his/her room, was offered crackers and apple juice without positive results, and was given Lorazepam (an antianxiety medication) 0.25 milligrams (mg) with positive results. A facility Reportable Event form dated 5/13/24 identified on 5/12/24 at 4:30 PM Resident #81 walked up to Resident #59 and punched Resident #59 in the face. The event was witnessed by a visitor who reported it to Licensed Practical Nurse (LPN) #2. A nursing progress note written by the Nursing Supervisor (the current Director of Nursing (DNS)) dated 5/13/24 at 7:44 PM identified Resident #81 had been evaluated by the APRN who issued a Physician's Emergency Certificate (PEC) (authorization for temporary involuntary psychiatric treatment) sending Resident #81 to the Emergency Department (ED) for crisis intervention. Interview with LPN #2 on 4/8/25 at 11:00 AM identified she had been outside the dining room when she heard yelling and she went into the dining room to see what was happening. Upon entering the dining room LPN #2 identified she had observed Resident #81 standing next to Resident #59 and a visitor sitting near them told her Resident #81 had hit Resident #59. LPN #2 identified she had removed Resident #81 from the dining room and brought him/her to his/her room to sit with a Nurse Aide. LPN #2 identified she had evaluated Resident #81 but that she cannot recall what she had done after that. Review of the Clinical Services Abuse Policy and Procedure directed, in part, the facility will provide individualized care plans that identify risk factors of residents as well as plans for protecting their rights and when any allegations of abuse or mistreatment are observed by any employee the facility will immediately protect the resident from alleged abuse. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2a. Resident #90's diagnoses included Alzheimer's disease, delusional disorder, and psychosis. The Resident Care Plan (RCP) dated 2/28/25 identified Resident #90 had the potential for negative behaviors with interventions to approach and speak to Resident #90 in a calm manner. Also, for the staff to anticipate/meet Resident #90's needs, and to explain all procedures to the resident before starting care. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #90 was severely cognitively impaired, required substantial/maximal assistance for toileting, showering, dressing and personal hygiene. Also, identified that Resident #90 was independent with ambulation/transfers, and required set up for eating. b. Resident #100's diagnoses included dementia, anorexia, and chronic heart disease. The quarterly MDS assessment dated [DATE] identified Resident #100 was severely cognitively impaired, requiring substantial assistance for dressing, and personal hygiene. Also, identified Resident #100 required assistance for eating, and oral hygiene, was totally dependent on showering, and toileting. Further, identified that Resident #100 required supervision assistance with transfers, and ambulation. The Resident Care Plan dated 1/27/25 identified Resident #100 had a deficit in functional mobility with interventions to encourage Resident #100 to engage in physical activities such as walking along with supervise/touching assist for transfers. Resident #100 was also at risk for falls with interventions for Resident #100 to ask for assistance prior to transfers or ambulation as needed, and to orient Resident #100 to his/her surroundings. A facility Reportable Event form dated 3/26/25 identified at 10:26 AM Nurse Aide (NA) #6 was trying to provide morning care to Resident #90 but he/she was visibly agitated even though an attempt was made by NA #6 to redirect Resident #90. Resident #90 pushed NA #6 away and then proceeded to push Resident #100 who fell to the ground. The Psychiatric Evaluation and Consultation dated 3/26/25 noted Resident #90 was evaluated after increased behavioral disturbances. Resident #90 was identified with becoming more impulsive/combatively recently and has been more difficult to redirect. Resident #90 was anxious and pacing throughout the interview. Resident #90 had become combative with care with increased impulsive behavior and tended to be intrusive and wander throughout the facility. An interview on 4/3/25 at 12:05 PM with Licensed Practical Nurse (LPN) #2 identified that Resident #90 was resistive to care on 3/26/25 while NA #6 was with him/her. Further, identifying that Resident #100 was walking the hallway by Resident #90's room that morning when the incident occurred but her vision was obstructed, and she did not see the pushing. An interview on 4/7/25 at 10:16 AM with NA #6 identified that she was attempting to provide morning care for Resident #90, but the resident was agitated, angry and pacing in his/her room. NA #6 further identified that she attempted to redirect Resident #90 to go in the opposite direction in the hallway. Further, identifying Resident #90 then tried to push her and then as Resident #100 was walking by, Resident #90 pushed Resident #100 onto the floor. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Resident Abuse policy dated 1/23 identified that each resident has the right to be free from abuse, neglect, and misappropriation of resident's property and exploitation. Also, identified was the facility to encourage an environment that recognizes the special qualities of the residents and provides them with a safe environment. Further, identified was Resident to Resident altercation is defined as physical or verbal act between two residents with or without resulting an injury. 3a. Resident #27 had a diagnosis of obstructive and reflux uropathy (impaired urine flow). The admission MDS dated [DATE] identified Resident #27 had a BIMS of 14 indicating an intact cognition and was always incontinent of bladder and bowel. The RCP dated 1/6/2025 identified a self-care deficit, and incontinent of bladder and bowel. Interventions directed to assist with ADLs and provide incontinent care. b. Resident #40 had a diagnosis of hemiplegia/ hemiparesis (weakness/paralysis) of the right dominant side, and aphasia. The annual MDS dated [DATE] identified severely impaired cognitive skills, required assistance with ADLs, and was always incontinent of bladder and bowel. The Resident Care Plan (RCP) dated 2/3/2025 identified alteration in ADLs, and incontinence. Interviews directed to assist with ADLs and provide incontinent care. c. Resident #62 had a diagnosis of cerebral infarction (stroke) with hemiplegia affecting the left side, and a cognitive communication deficit. The annual MDS dated [DATE] identified Resident #1 had a BIMS of 14 indicating intact cognition and was frequently incontinent of bladder, and always incontinent of bowel. The RCP dated 2/3/2025 identified incontinent of bowel and bladder, and a self-care deficit. Interventions directed to assist with ADLs and to provide incontinent care approximately every 2 hours and as needed. d. Resident #99 had a diagnosis of dementia. The quarterly MDS assessment dated [DATE] identified Resident #99 had a Brief Interview of Mental Status (BIMS) score of 8 indicating moderately impaired cognition, was dependent for ADLs, and was always incontinent of bladder and bowel. The RCP dated 1/23/2025 identified an ADL deficit and incontinent of bowel and bladder. Interventions directed to assist with ADLs, and to provide incontinent care every two (2) hours and as needed. A facility incident report dated 3/10/2025 at 12 noon identified on 3/8/2025 at approximately 1:30 PM, LPN #1 identified when LPN #1 was providing treatments he identified Resident #40 was in need of incontinent care. LPN #1 and a NA provided the care. Further, LPN #1 identified Residents #27, #62 and #99 were in need of incontinent care, and care was provided. Facility summary dated 3/14/2025 identified although morning care was provided for Residents #27, #40, #62 (Resident #99 refused morning care), incontinent care was not provided until 2 PM for Residents #27, 40, #62 and #90 when it was provided by LPN #1. Record review of NA care card on 3/8/2025 identified Resident #27 received or provided incontinent care at 4:08 AM and did not receive incontinent care again until 2:31 PM (10 hours and 23 minutes after last received). Record review of NA care card on 3/8/2025 identified Resident #40 received incontinent care at 6:47 AM on 3/8/2025 and did not receive incontinent care again until 1:44 PM on 3/8/2025 (6 hours and 57 minutes after last received). (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of NA care card on 3/8/2025 identified Resident #62 received incontinent care at 3:49 AM and did not receive incontinent care again until 2:34 PM (10 hours and 45 minutes after last received). Record review of NA care card on 3/8/2025 identified Resident #99 received incontinent care at 4:40 AM and did not receive incontinent care again until 11:53 AM (7 hours and 13 minutes after last received). Facility written statement from LPN #1 on 3/9/2025 identified he took a NA with him to perform resident treatments and when performing treatments on Resident #40, LPN #1 identified the resident's brief was fully soiled with a bowel movement and urine. The statement further identified that all the residents he provided treatments for, required incontinent care. RN #1 (day shift supervisor) was notified the residents had not received care. Facility undated written statement from RN #1 identified on 3/8/2025 LPN #1 notified her that NA #1 did not change the residents she was assigned to during the afternoon. RN #1 questioned NA #1 about her assigned residents that were not changed and indicated all assigned residents need to be toileted and changed in the afternoon after lunch. Although attempted, interviews with LPN #1 and RN #1 were not obtained during the survey. Interview with NA #1 on 3/28/2025 at 1:26 PM identified NA #1 gave incontinent care to Resident #27 at 8:30 AM and then did not check on Resident #27 again until 1:30 PM (5 hours later), and she gave no additional incontinent care after 8:30 AM because Resident #27 said he/she did not need it. NA #1 stated Resident #40 required assist of two (2) staff, and on 3/8/2025 about 9:30 AM she tried asking other NAs to wash and change Resident #40, but they never came to help her. NA #1 stated she tried to change Resident #40 but he/she said no, and then when she checked, Resident #40 was not incontinent. The next care provided was about 2:30 PM by LPN #1 and another NA; NA #1 stated she gave no care to Resident #40 during the shift because she did not have a second staff to assist. For Resident #62, NA #1 stated she saw Resident #62 at 9:30 AM and washed only his/her upper body. NA #1 did not change Resident #62's brief or wash the lower body, and stated Resident #62 was not incontinent at 9:30 AM. NA #1 indicated she wanted to change Resident #62 but no other staff would help her. NA #1 stated she then checked on Resident #62 at 2:30 PM (5 hours later) and another NA saw Resident #62 was incontinent and she said she was going to report NA #1. NA #1 stated she told the other NA that she had asked for help during the shift, but the other NA did not help her. NA #1 stated she washed Resident #99's upper body at 9:30 AM and Resident #99 was not incontinent at that time. NA #1 gave no care to the lower body because Resident #99 required two (2) staff for care and no other staff would help her. NA #1 did not check on Resident #99 again until 2:30 PM (5 hours later) and then provided care to the resident at that time. NA #1 stated she only must check on residents two (2) times a shift - once in the morning and then again right before her shift ends. NA #1 further stated that she did not ask the charge nurse or RN supervisor for help but stated that she should have asked them and she should have checked on her residents more often. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and record review with the DNS on 3/28/2025 at 9:32 AM identified the 4 residents that did not receive care on 3/8/2025 were Resident #27, #40, #62 and #99. The DNS stated she did not know why the residents did not receive care. The DNS indicated NA #1 had asked other staff for assistance, but did not notify LPN #1/charge nurse or RN #1/supervisor that she required assistance. The DNS stated the facility investigation identified the last time incontinent care was provided was a follows: Resident #27 at 8:30 AM, next provided at 1:30 PM (care was next provided 5 hours later). Resident #40 at 4:16 AM, next provided at 2:30 PM (care was next provided 10 hours and 14 minutes without care). Resident #62 at 3:49 AM and then next provided at 2:36 PM (care was next provided 10 hours and 47 minutes without care). Resident #99 at 4:41 AM and then next received care at 2:30 PM (care was next provided 9 hours and 49 minutes without care). The DNS stated residents are supposed to be checked every two (2) hours to see if they need incontinent care and as needed. The DNS stated based on her investigation, NA #1 failed to check on her residents every two (2) hours to see if care needed to be provided. The DNS concluded based upon the investigation that was conducted the allegation of neglect was substantiated. Review of facility Abuse Policy dated 12/2023 directed in part, neglect means the failure of the facility/employees to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. 50094 51183

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 50094 Based on record review, facility documentation, and staff interviews for 1 of 1 residents (Resident #9) reviewed for an injury of unknown origin, for 2 of 4 residents involved in resident to resident altercations (Resident #59 and Resident #81), and for four of eight residents (Resident #27, #40, #62 and #99) reviewed for abuse, the facility failed to report the injury of unknown origin (Resident #9) and the resident to resident altercations to the Stage Agency. Additionally, for Resident #27, #40, #62 and #99, the facility failed to ensure staff reported an allegation of abuse immediately. The findings include: 1. Resident #9 was admitted to the facility in October of 2024 with diagnoses that included hemiplegia (one sided muscle paralysis) affecting the right dominant side, hypertension, and diabetes. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #9 was cognitively intact, was dependent on staff for toileting and required maximum assistance for personal hygiene and bed mobility and transfers. The MDS further identified Resident #9 had an impairment on one side of his/her upper extremity and lower extremities and used a walker and wheelchair for ambulation. The Resident Care Plan (RCP) dated 10/24/24, identified Resident #9 required extensive assistance of 1 staff member for self-care tasks due to weakness, impaired sitting balance and strength. Interventions included assisting Resident #9 with self-care tasks and referral to occupational therapy when applicable. A facility Reportable Event (RE) form dated 11/29/24 at 12:00 PM written by LPN #3 identified Resident #9 with a discoloration to the left eye with no complaints of pain or discomfort. The RE further identified Resident #9 was alert and oriented, the responsible party was notified of the injury on 11/29/24 at 3:00 PM and APRN #2 was notified of the left eye discoloration on 11/29/24 at 3:05 PM. A nursing note dated 11/29/24 at 3:17 PM written by LPN #3 identified that she was notified by NA #7 of Resident #9's discoloration to the left eye. LPN #3 notified APRN #2 who directed a complete blood count with differential test (group of blood cells that measure the number and size of the different cells in blood), cold compresses every 15 to 20 minutes for 24 hours and neuro assessments according to the facility's protocol. The nursing note further directed staff to notify the APRN with worsening symptoms such as swelling to the left eye, blurred or double vision, headache, nausea or vomiting. LPN #3 indicated that Resident #9's responsible party was also notified. Interview with LPN #3 on 4/3/24 at 2:40 PM identified that she was notified of Resident #9's discoloration to left eye on 11/29/24 by NA #7. LPN #3 identified that she assessed Resident #9 and noted a bluish color/discoloration around the entire left eye. LPN #3 further identified that she notified the Nursing Supervisor (RN#2) and the provider APRN #2 of the injury through a phone call. LPN #3 identified that APRN #2 directed a blood test and cold compress to the left eye. LPN #3 identified that the RN Supervisor was responsible for assessing and ensuring that accidents and incidents were reported to the appropriate state agencies according to the facility's policy. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview and record review with RN #2 on 4/3/25 at 3:00 PM, identified that she was the Nursing Supervisor for the 7:00 AM to 3:00 PM shift on 11/29/24 when Resident #9's injury was identified. RN #2 identified that notification of Resident#9's injury to the state agency was not done since she did not complete an assessment of Resident #9's left eye. RN #2 identified that such an injury would be classified as an injury of unknown origin and should have been reported to the overseeing state agency after the injury was identified. (Please cross reference F 658) Interview with the DNS on 4/5/25 at 12:00 PM identified that Resident #9's injury was not reported to the overseeing state agency. The DNS identified that an injury of unknown origin should have been investigated and reported to the overseeing state agency. Subsequent to document request, the facility provided a statement completed by LPN #3 dated 4/11/24 that identified that the discoloration to Resident#9's left eye was approximately pea size even though she had identified in an interview with the surveyor that she noted a bluish color/discoloration around Resident #9's entire left eye. Review of facility policy titled, Accident/Incident Reporting Policies and Procedures, identified in part, that all incident all occurrences are reported and thoroughly investigated as per state and federal regulations. 2a. Resident #59 was admitted to the facility in September of 2022 with diagnoses that included dementia, anxiety, and dysphagia. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #59 was severely cognitively impaired, had verbal behavioral symptoms directed towards others, had the behavior of wandering, and was independent with eating, bed mobility and transfers. The Resident Care Plan (RCP) dated 4/29/24 identified Resident #59 had a history of anxiety and depression. Interventions included observing periods of anxiety, provide a calm, quiet environment and encourage Resident #59 to verbalize thoughts and feelings related to anxiety. A nursing note written by Licensed Practical Nurse (LPN) #2 on 5/13/24 at 5:45 PM (referring to an event that occurred on 5/12/24 per the facility Reportable Event form) identified Resident #59 was in the dining room waiting for dinner when another resident (Resident #81) approached him/her asking questions and Resident #59 responded, I don't understand you., after which Resident #81 punched Resident #59 in the face. The nursing note identified that LPN #2 assessed Resident #59, performed neuros, and did not identify bleeding, pain or discomfort. The nursing note further identified LPN #2 redirected Resident #81 to his/her room, and the APRN and responsible party were notified. b. Resident #81 was admitted to the facility in June of 2023 with diagnoses that included Alzheimer's disease, anxiety disorder, and delusional disorders. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Resident Care Plan (RCP) dated 2/27/24 identified Resident #81 had potential for agitation manifested by hitting other residents and Resident #81 was physical and combative at times as evidenced by hitting and aggression on 10/20/23 and aggression/altercation on 4/29/24. Interventions included offering fluids/snacks and have Resident #81 stay next to the nursing station sitting on the bench, ensure Resident #81 was the first resident to get ready for bed after dinner, and provide one on one with Resident #81 to manage agitation. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #81 was severely cognitively impaired, had several days of the mood symptom of being short-tempered and easily annoyed, had verbal behavioral symptoms directed towards others, had the behavior of wandering, required supervision or touching assistance with eating, and was independent with transfers and walking. A nursing note written by LPN #2 dated 5/12/24 at 10:18 PM identified Resident #81 was anxious, crying and aggressive with another resident (Resident #59), and Resident #81 was redirected to his/her room, was offered crackers and apple juice without positive results, and was given Lorazepam (antianxiety medication) 0.25 milligrams (mg) with positive results. A facility Reportable Event form dated 5/13/24 identified on 5/12/24 at 4:30 PM Resident #81 walked up to Resident #59 and punched Resident #59 in the face. The event was witnessed by a visitor who reported it to Licensed Practical Nurse (LPN) #2. Review of the State Agency reportable event website identified the facility didn't report the resident to resident altercation until 5/13/24 at 10:00 AM (17 hours and 30 minutes after the event). Interview with Director of Nursing Services (DNS) on 4/8/2025 at 9:50 AM identified she had not reported the resident to resident altercation to the State Agency timely due to she was not aware of the incident until the following day. On 5/13/25 when she became aware of the incident she immediately reported it to the State Agency. Review of the Clinical Services Abuse Policy and Procedure directed, in part, when any allegations of abuse or mistreatment are observed by any employee the following steps will be implemented: immediately protect the resident from alleged abuse; immediately notify the nursing supervisor; the nursing supervisor/charge nurse will immediately report abuse allegations to the Administrator and DNS; and the facility will notify the Department of Public Health immediately but no later than 2 hours after the allegation is made if the event involves abuse. 3a. Resident #27 had a diagnosis of obstructive and reflux uropathy (impaired urine flow). The admission MDS dated [DATE] identified Resident #27 had a BIMS of 14 indicating an intact cognition and was always incontinent of bladder and bowel. The RCP dated 1/6/2025 identified a self-care deficit, and incontinent of bladder and bowel. Interventions directed to assist with ADLs and provide incontinent care. b. Resident #40 had a diagnosis of hemiplegia/ hemiparesis (weakness/paralysis) of the right dominant side, and aphasia. The annual MDS dated [DATE] identified severely impaired cognitive skills, required assistance with ADLs, and was always incontinent of bladder and bowel. The Resident Care Plan (RCP) dated 2/3/2025 identified alteration in ADLs, and incontinence. Interviews directed to assist with ADLs and provide incontinent care. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075395	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurel Ridge Center for Health & Rehabilitation	642 Danbury Road Ridgefield, CT 06877

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. Resident #62 had a diagnosis of cerebral infarction (stroke) with hemiplegia affecting the left side, and a cognitive communication deficit. The annual MDS dated [DATE] identified Resident #1 had a BIMS of 14 indicating intact cognition and was frequently incontinent of bladder, and always incontinent of bowel. The RCP dated 2/3/2025 identified incontinent of bowel and bladder, and a self-care deficit. Interventions directed to assist with ADLs and to provide incontinent care approximately every 2 hours and as needed. d. Resident #99 had a diagnosis of dementia. The quarterly MDS assessment dated [DATE] identified Resident #99 had a Brief Interview of Mental Status (BIMS) score of 8 indicating moderately impaired cognition, was dependent for ADLs, and was always incontinent of bladder and bowel. The RCP dated 1/23/2025 identified an ADL deficit and incontinent of bowel and bladder. Interventions directed to assist with ADLs, and to provide incontinent care every two (2) hours and as needed. A facility incident report dated 3/10/2025 at 12 noon identified on 3/8/2025 at approximately 1:30 PM, LPN #1 identified when LPN #1 was providing treatments he identified Resident #40 was in need of incontinent care. LPN #1 and a NA provided the care. Further, LPN #1 identified Residents #27, #62 and #99 were in need of incontinent care, and care was provided. Facility summary dated 3/14/2025 identified although morning care was provided for Residents #27, # 40, #62 (Resident #99 refused morning care), incontinent care was not provided until 2 PM for Residents #27, 40, #62 and #90 when it was provided by LPN #1. Please cross reference F 600. Review of the State Agency reportable event website identified the State Agency was notified of the allegation of neglect on 3/10/2025 at 12 PM. Review of the reportable event identified the incident occurred on 3/8/2025 at 1:30 PM; the State Agency was notified (1 day, 22 hours and 30 minutes after the facility was aware). Facility undated written statement from RN #1 identified on 3/8/2025 LPN #1 notified her that NA #1 did not change the residents she was assigned to during the afternoon. Although attempted, an interview with RN #1 was not obtained during the survey. Interview and record review with the DNS on 3/28/2025 at 9:32 AM identified Residents #27, 40, 62 and 99 did not receive care on 3/8/2025. The DNS stated although RN #1 (supervisor working 7 AM to 3 PM) was aware of the allegation, RN #1 did not notify her until the end of RN #1's shift (shift ended at 3 PM). The DNS stated RN #1 should have notified her immediately when the neglect was identified, and the State Agency should have been notified within two (2) hours. Interview failed to identify why the State Agency was not notified until 3/10/2025. Review of facility Abuse Policy directed in part, abuse allegations require immediate action, report immediately to the supervisor and a two (2) hour requirement to report to the State Agency. Facility documentation review identified staff education was initiated on 2/28/2025 and included directing staff to report allegations immediately, and allegations are required to be reported to the State Agency within two (2) hours. A QAPI meeting was held on 3/10/2025, and audits were initiated on 3/14/2025. Based on review of facility documentation, past non-compliance was identified. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	50250 51183

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50094 Based on record review, facility documentation, facility policy and staff interviews for 1 of 8 residents (Resident #9) reviewed for accidents, for 1 of 4 residents reviewed for resident to resident altercations (Resident #59 and Resident #81) and for four of eight residents (Residents #27, #40, #62 and #99) reviewed for abuse, the facility failed to ensure Registered Nurse (RN) assessments were completed timely. The findings include: 1. Resident #9 was admitted to the facility in October of 2024 with diagnoses that included hemiplegia (one sided muscle paralysis) affecting the right dominant side, hypertension, and diabetes. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #9 was cognitively intact, was dependent on staff for toileting and required maximum assistance for personal hygiene and bed mobility and transfers. The MDS further identified Resident #9 with an impairment on one side of his/her upper extremity and lower extremities and used a walker and wheelchair for ambulation. The Resident Care Plan (RCP) dated 10/24/24, identified Resident #9 required extensive assistance of 1 staff member for self-care tasks due to weakness, impaired sitting balance and strength. Interventions included assisting Resident#9 with self-care tasks and referral to occupational therapy when applicable. A facility Reportable Event (RE) form dated 11/29/24 at 12:00 PM written by LPN #3 identified Resident #9 with a discoloration to the left eye with no complaints of pain or discomfort. The RE further identified that Resident #9 was alert/oriented, the responsible party was notified of the injury on 10/29/24 at 3: 00 PM and APRN #2 was notified on 10/29/24 at 3:05 PM. A nursing note dated 11/29/24 at 3:17 PM by LPN #3 identified that she was notified by NA #7 of Resident #9's discoloration to the left eye. LPN #3 notified APRN #2 who directed a complete blood count with differential test (group of blood cells that measure the number and size of the different cells in blood), cold compresses every 15 to 20 minutes for 24 hours and neuro assessments according to the facility's protocol. The note further directed staff to notify the APRN with worsening symptoms such as swelling to the left eye, blurred or double vision, headache, nausea or vomiting. LPN #3 indicated that Resident #9's responsible party was also notified. Interview with LPN #3 on 4/3/24 at 2:40 PM identified that she was notified by NA #7 of the discoloration to Resident #9's left eye on 11/29/24. LPN #3 identified that she assessed Resident #9 and noted a bluish color/discoloration around the entire eye. LPN #3 further identified that she notified the Nursing Supervisor (RN#2) and APRN #2 of the injury through a phone call. LPN #3 identified that APRN #2 directed a blood test and cold compress to the left eye. LPN #3 was unable to identify whether Resident #9 was assessed by RN #2 but indicated that the RN Supervisor should have assessed Resident #9 and documented the assessment findings including measurements and description of the bruise. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and record review with RN #2 on 4/3/25 at 3:00 PM, identified that she was the Nursing Supervisor for the 7:00 AM to 3:00 PM shift on 11/29/24 when Resident #9's left eye discoloration was identified. RN #2 was unable to identify an RN assessment and documentation related to Resident #9's left eye discoloration on 11/29/24. RN #2 identified that an injury of unknown origin should have been assessed by an RN and investigation into the incident initiated to identify the cause of the injury. RN #2 could not recall if she was notified by LPN #3 but indicated that she was responsible for having completed the RN assessment and documentation of the injury. Interview with the DNS on 4/5/25 at 12:00 PM identified that RN #2 was responsible for completing and documenting an assessment of Resident #9's bruising to the eye. The DNS was unable to identify the reason RN#2 did not assess and/or document her assessment findings in Resident#9's clinical record. Subsequent to document request, the facility provided a statement completed by LPN #3 dated 4/11/24 that identified that the discoloration to Resident#9's left eye was approximately pea size even though she had identified in an interview with the surveyor that she noted a bluish color/discoloration around Resident #9's entire left eye. Review of facility policy titled, Accident/Incident Reporting Policies and Procedures, identified in part, that staff will notify the nursing supervisor/licensed nurse when an incident occurs. The licensed nurse or the nursing supervisor will complete an evaluation of residents' condition. The evaluation is to include, but not limited to vital signs and neuro signs, if applicable, type of injury with location on the body, include measurements if the injury's a skin tear or a bruise. 2a. Resident #59 was admitted to the facility in September of 2022 with diagnoses that included dementia, anxiety, and dysphagia. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #59 was severely cognitively impaired, had verbal behavioral symptoms directed towards others, had the behavior of wandering, and was independent with eating, bed mobility and transfers. The Resident Care Plan (RCP) dated 4/29/24 identified Resident #59 had a history of anxiety and depression. Interventions included to observe for periods of anxiety, provide a calm, quiet environment and encourage Resident #59 to verbalize thoughts and feelings related to anxiety. A facility Reportable Event form dated 5/13/24 identified on 5/12/24 at 4:30 PM another resident (Resident #81) walked up to Resident #59 and punched Resident #59 in the face. The event was witnessed by a visitor who reported it to Licensed Practical Nurse (LPN) #2. A nursing note written by Licensed Practical Nurse (LPN) #2 on 5/13/24 at 5:45 PM (1 day after the actual resident to resident altercation occurred per the facility Reportable Event form) identified Resident #59 was in the dining room waiting for dinner when another resident (Resident #81) approached him/her asking questions and Resident #59 responded, I don't understand you, after which Resident #81 punched Resident #59 in the face. The nursing note identified that LPN #2 assessed Resident #59, performed neuros, and did not identify bleeding, pain or discomfort. The nursing note further identified LPN #2 redirected Resident #81 to his/her room, and the APRN and responsible party were notified. The nursing note failed to identify the nursing supervisor had been notified of the event. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the clinical record failed to identify a nursing note or assessment by a Registered Nurse (RN) for Resident #59 on 5/12/24 following a resident to resident altercation on 5/12/24 at 4:30 PM. Interview with Director of Nursing Services (DNS) on 4/8/25 at 9:50 AM identified LPN #2 should have told the Nursing Supervisor immediately when the resident to resident altercation occurred so that the Supervisor could have done an assessment and provided additional directions. b. Resident #81 was admitted to the facility in June of 2023 with diagnoses that included Alzheimer's disease, anxiety disorder, and delusional disorders. The Resident Care Plan (RCP) dated 2/27/24 identified Resident #81 had potential for agitation manifested by hitting other residents and Resident #81 was physical and combative at times as evidenced by hitting and aggression on 10/20/23 and aggression/altercation on 4/29/24. Interventions included offering fluids/snacks and have Resident #81 stay next to the nursing station sitting on the bench, ensure Resident #81 was the first resident to get ready for bed after dinner, and one on one with Resident #81 to manage agitation. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #81 was severely cognitively impaired, had several days of the mood symptom of being short-tempered and easily annoyed, had verbal behavioral symptoms directed towards others, had the behavior of wandering, required supervision or touching assistance with eating, and was independent with transfers and walking. A nursing note written by LPN #2 dated 5/12/24 at 10:18 PM identified Resident #81 was anxious, crying and aggressive with another resident (Resident #59), and Resident #81 was redirected to his/her room, was offered crackers and apple juice without positive results, and was given Lorazepam (an antianxiety medication) 0.25 milligrams (mg) with positive results. The nursing note failed to identify the Nursing Supervisor had been notified of the event. A facility Reportable Event form dated 5/13/24 identified on 5/12/24 at 4:30 PM Resident #81 walked up to Resident #59 and punched Resident #59 in the face. The event was witnessed by a visitor who reported it to Licensed Practical Nurse (LPN) #2. Review of the clinical record failed to identify a nursing note or assessment by a Registered Nurse for Resident #81 on 5/12/24 following a resident to resident altercation on 5/12/24 at 4:30 PM. Interview with Director of Nursing Services (DNS) on 4/8/25 at 9:50 AM identified LPN #2 should have told the Nursing Supervisor immediately when the resident to resident altercation occurred on 5/12/24 so that the Supervisor could have completed an assessment and provided additional directions. Review of the Clinical Services Abuse Policy and Procedure directed, in part, any observation of resident abuse is to be thoroughly investigated and reported. When any allegations of abuse or mistreatment are observed by any employee the nursing supervisor is notified immediately and the nursing supervisor/charge nurse will immediately report abuse allegations to the Administrator and DNS, and notify the provider to conduct a physical and/or mental assessment. Additionally, the facility investigation will be completed within 5 days of the incident and documentation will include all necessary evaluations (skin/body checks, pain evaluation). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075395	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/08/2025

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3a. Resident #27 had a diagnosis of obstructive and reflux uropathy (impaired urine flow). The admission MDS dated [DATE] identified Resident #27 had a BIMS of 14 indicating an intact cognition and was always incontinent of bladder and bowel. The RCP dated 1/6/2025 identified a self-care deficit, and incontinent of bladder and bowel. Interventions directed to assist with ADLs and provide incontinent care. b. Resident #40 had a diagnosis of hemiplegia/ hemiparesis (weakness/paralysis) of the right dominant side, and aphasia. The annual MDS dated [DATE] identified severely impaired cognitive skills, required assistance with ADLs, and was always incontinent of bladder and bowel. The Resident Care Plan (RCP) dated 2/3/2025 identified alteration in ADLs, and incontinence. Interviews directed to assist with ADLs and provide incontinent care. c. Resident #62 had a diagnosis of cerebral infarction (stroke) with hemiplegia affecting the left side, and a cognitive communication deficit. The annual MDS dated [DATE] identified Resident #1 had a BIMS of 14 indicating intact cognition and was frequently incontinent of bladder, and always incontinent of bowel. The RCP dated 2/3/2025 identified incontinent of bowel and bladder, and a self-care deficit. Interventions directed to assist with ADLs and to provide incontinent care approximately every 2 hours and as needed. d. Resident #99 had a diagnosis of dementia. The quarterly MDS assessment dated [DATE] identified Resident #99 had a Brief Interview of Mental Status (BIMS) score of 8 indicating moderately impaired cognition, was dependent for ADLs, and was always incontinent of bladder and bowel. The RCP dated 1/23/2025 identified an ADL deficit and incontinent of bowel and bladder. Interventions directed to assist with ADLs, and to provide incontinent care every two (2) hours and as needed. A facility incident report dated 3/10/2025 at 12 noon identified on 3/8/2025 at approximately 1:30 PM, LPN #1 identified when LPN #1 was providing treatments he identified Resident #40 was in need of incontinent care. LPN #1 and a NA provided the care. Further, LPN #1 identified Residents #27, #62 and #99 were in need of incontinent care, and care was provided. Facility summary dated 3/14/2025 identified although morning care was provided for Residents #27, #40, #62 (Resident #99 refused morning care), incontinent care was not provided until 2 PM for Residents #27, 40, #62 and #90 when it was provided by LPN #1. Record review of NA care card on 3/8/2025 identified Resident #27 received or provided incontinent care at 4:08 AM and did not receive incontinent care again until 2:31 PM (10 hours and 23 minutes after last received). Record review of NA care card on 3/8/2025 identified Resident #40 received incontinent care at 6:47 AM on 3/8/2025 and did not receive incontinent care again until 1:44 PM on 3/8/2025. Record review of NA care card on 3/8/2025 identified Resident #62 received incontinent care at 3:49 AM and did not receive incontinent care again until 2:34 PM. Record review of NA care card on 3/8/2025 identified Resident #99 received incontinent care at 4:40 AM and did not receive incontinent care again until 11:53 AM. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility written statement from LPN #1 on 3/9/2025 identified he was performing resident treatments, he identified Residents #28, #40, #62 and #99 did not receive care timely and he notified RN #1. Please cross reference F 600. Facility undated written statement from RN #1 identified on 3/8/2025 LPN #1 notified her that NA #1 did not change the residents she was assigned to during the afternoon. RN #1 questioned NA #1 about her assigned residents that were not changed and indicated all assigned residents needed to be toileted and changed in the afternoon after lunch. Although attempted, interviews with LPN #1 and RN #1 were not obtained during the survey. Record review failed to identify RN assessments were completed for Residents #27, #40, #62, and #99 on 3/8/2025. Subsequent to surveyor inquiry, the facility provided nursing notes for Residents #27, #40, and #62 that were dated 3/27/2025 as late entries for 3/10/2025. The nursing notes were written by LPN #3 and LPN#8, and although the notes indicated resident evaluations were completed on 3/10/2025, no RN assessments were completed. Further, subsequent to surveyor inquiry, the facility provided an APRN late entry note, dated 3/27/2025 at 11:58 AM. The note indicated the APRN saw Resident #40 on 3/10/2025 at 8 AM to evaluation Resident #40's skin on his/her buttocks that was identified as bleeding during routine care. Although the APRN note identified she saw Resident #40 on 3/8/2025, the visit occurred at 8 AM, and the omitted care occurred at 1:30 PM (5 1/2 hours after the APRN visit occurred). Although attempted an interview was not obtained with RN #1 during the survey. Interview and record review with the DNS on 3/28/2025 at 9:32 AM identified Residents #27, #40, #62 and #99 did not receive care on 3/8/2025. The DNS stated the investigation identified the last time incontinent care was provided was a follows: Resident #27 at 8:30 AM, next provided at 1:30 PM (5 hours after last provided). Resident #40 at 4:16 AM, next provided at 2:30 PM (10 hours and 14 minutes without care). Resident #62 at 3:49 AM and then next provided at 2:36 PM (10 hours and 47 minutes without care). Resident #99 at 4:41 AM and then next received care at 2:30 PM (9 hours and 49 minutes without care). The DNS further stated RN #1 and the 3 PM to 11 PM shift RN supervisor did not complete RN assessments/skin assessments for the residents after it was identified they had not received timely care. The DNS stated RN assessments should have been completed immediately following the incident and the DNS did not know why RN #1 did not complete assessments. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility Procedure for Abuse Investigation dated 12/2023 directed in part, to conduct a physical assessment as appropriate. 50250 51183

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50094 Based on record review, facility documentation, and staff interviews for one of six residents (Resident #40) reviewed for abuse, the facility failed to ensure the medical record was complete and accurate to include timely documentation of an APRN visit. The findings include: Resident #40 had a diagnosis of hemiplegia/ hemiparesis (weakness/paralysis) of the right dominant side, and aphasia. The annual MDS dated [DATE] identified severely impaired cognitive skills, required assistance with ADLs, and was always incontinent of bladder and bowel. The Resident Care Plan (RCP) dated 2/3/2025 identified alteration in ADLs, and incontinence. Interviews directed to assist with ADLs and provide incontinent care. A facility incident report dated 3/10/2025 at 12 noon identified on 3/8/2025 at approximately 1:30 PM, LPN #1 identified when LPN #1 was providing treatments when he identified Resident #40 had not received timely incontinent care. Interview and record review with the DNS on 3/28/2025 at 9:32 AM identified care was not provided timely during the shift, and the DNS indicated an RN assessment was not completed after the delay in care was identified; from 1:30 PM through 11 PM no assessment was performed. Subsequent to surveyor inquiry, the facility provided an APRN late entry note, dated 3/27/2025 at 11:58 AM. The note indicated that the APRN saw Resident #40 on 3/10/2025 (1 day, 18 hours and 30 minutes after the omitted care was identified) at 8 AM to evaluate Resident #40's skin on his/her buttocks that was identified as bleeding during routine care. Although the APRN note identified she saw Resident #40 on 3/10/2025 at 8 AM, and the omitted care occurred on 3/8/2025 at 1:30 PM (1 day, 18 hours and 30 minutes before the APRN visit occurred). Record review failed to identify the APRN note was entered in the clinical record timely. The late entry note was written 17 days after the APRN visit occurred. Interview and record review with APRN #1 on 3/28/2025 at 11:07 AM identified she saw Resident #40 on 3/10/2025 when she was asked to see the resident, but she did not write a note until 3/27/2025 (17 days later) because she forgot to write the note on 3/10/2025. APRN #1 stated she should have written the note on 3/10/2025 after she saw the resident. Interview and record review with the DNS on 3/28/2025 at 9:32 AM identified the APRN note should have been written on 3/10/2025 when Resident #40 was seen, and the DNS did not know why it was not entered until 3/27/2025 (17 days after the visit occurred). Review of facility charting and documentation policy dated 1/2025 directed in part, to complete documentation at the time of service, but no later than the shift in which the assessment, observation, or care service occurred.