| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 075416 | A. Building<br>B. Wing | 03/31/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Candlewood Valley Health & Rehabilitation Center | 30 Park Lane East<br>New Milford, CT 06776 |

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 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observations, clinical record review, and review of facility policy for the only sampled resident reviewed for respiratory care (Resident #76), the facility failed to ensure a safe environment related to a resident self-administering a petroleum-based jelly while receiving continuous oxygen, creating a fire risk relating to oxygen speeding up combustion in the presence of oil based materials. Additionally, the use of petroleum-based products while receiving oxygen creates a risk of medical danger for aspiration pneumonia due to the potential for small particles being inhaled into the lungs from the petroleum product which over time can accumulate in the lungs causing inflammation of the lung tissue, chronic coughing and irreversible lung scarring. These failures resulted in the finding of immediate jeopardy, and for 1 of 4 residents (Resident #9) reviewed for accidents, the facility failed to provide adequate supervision during toileting for a cognitively impaired resident who was dependent on staff for toileting resulting in a fall. The findings include: 1.Resident #76's diagnoses included chronic obstructive pulmonary disease (COPD), chronic respiratory failure with hypoxia, obstructive sleep apnea, and senile degeneration of brain.Physician orders dated 7/3/2025 and currently in effect directed to utilize Oxygen at 0-4 liters/minute continuously every shift via nasal cannula to maintain oxygen saturation level above 90%.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #76 had severely impaired cognition and required substantial assistance with personal hygiene, dependent with transfers, and moderate assistance with bed mobility. The MDS further indicated Resident #76 had a diagnosis of COPD and was receiving oxygen therapy.The Resident Care Plan (RCP) dated 2/23/26 identified Resident #76 was at risk for respiratory distress related to COPD, dyspnea on exertion and when lying flat, and resident removed oxygen on 7/7/25. Interventions directed oxygen therapy as ordered, reapply oxygen as needed and raise HOB when lowered by resident to prevent SOB, obtain oxygen saturation as ordered and update MD/APRN/PA with abnormal results, observe for signs and symptoms of acute respiratory insufficiency such as but not limited to anxiety, restlessness, confusion, cyanosis, chest pain, increase difficulty breathing, somnolence and shortness of breath at rest.Observation during the initial tour of the facility on 3/23/26 at 8:48 AM identified Resident #76 was lying in his/her bed, utilizing oxygen as ordered at 2 liters/minute via nasal cannula with 1 opened (13 ounce) tub of Vaseline petroleum-based jelly which was 1/4 empty located on the bedside table not within reach.Interview with Resident #76 on 3/23/26 at 8:49 AM identified his/her family member had brought in the tub of Vaseline petroleum-based jelly and the resident had been self-administering the Vaseline petroleum-based jelly when his/her lips felt dry (with the oxygen running). Resident #76 identified he/she also dabbed the Vaseline petroleum-based jelly on his/her nose when it felt dry.A second observation on 3/23/26 at 9:53 AM identified Resident #76 was seated in his/her recliner chair utilizing the oxygen as ordered at 2 liters/minute via nasal cannula with 1 (13 ounce) tub of Vaseline petroleum-based jelly which was 1/4 empty located on the overbed table in front of him/her on the side of other personal items products such as a hair comb and a white washcloth. Observation and interview with Registered Nurse (RN) #1 on 3/23/26 at 11:05 AM identified Resident#76 was in<br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| Candlewood Valley Health & Rehabilitation Center | 30 Park Lane East<br>New Milford, CT 06776 |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | his/her recliner chair at the bedside, utilizing oxygen as ordered at 2 liters/minute via nasal cannula with 1 (13 ounce) tub of Vaseline petroleum-based jelly which was 1/4 empty located on the overbed table in front of him/her. RN #1 identified Resident #76 utilized oxygen at 2 liters/minute via nasal cannula for comfort. RN #1 identified Resident #76 did not have a physician order to use Vaseline petroleum-based jelly and she did not know who provided it. RN #1 indicated she had not noticed the Vaseline petroleum-based jelly on the overbed table until surveyor's inquiry.Interview with Nurse aide (NA) #1 on 3/23/26 at 11:09 AM identified she was aware Resident #76 had 1 tub (13 ounce) of Vaseline petroleum-based jelly on the overbed table. NA #1 identified she was aware that the resident was self-administering the Vaseline petroleum-based jelly to his/her lips while on continuous oxygen.Interview with the Director of Nurses (DNS) on 3/23/26 at 11:15 AM identified he was not aware Resident #76 applied Vaseline petroleum-based jelly to his/her lips throughout the day wearing oxygen continuously at 2 liters. The DNS identified Resident #76 should not be using Vaseline petroleum-based jelly while utilizing oxygen. Subsequent to surveyor inquiry an observation on 3/23/26 at 11:23 PM identified the Vaseline (13 ounce) of petroleum-based jelly had been removed from Resident #76's room by the DNS. Interview with the DNS on 3/23/26 at 11:29 AM identified Resident #76 did not have a physician order to use Vaseline petroleum-based jelly. The DNS indicated he did not know how long Resident #76 was using Vaseline petroleum-based jelly while utilizing oxygen. The DNS indicated it was possible Resident #76's family brought in the item. Interview with the Operations Manager of the oxygen company on 3/24/26 at 2:30 PM identified Vaseline was a petroleum-based material which should not come into direct contact with the flow of oxygen. The Operations Manager indicated oxygen and friction from Resident #76 applying Vaseline to his/her nose and lips while receiving oxygen via nasal cannula would be a risk for combustion resulting in a potential fire. The Operations Manager identified use of petroleum-based products should not be used around oxygen and it would be unsafe to be in a resident's room while oxygen was running. Although requested, a facility Oxygen Therapy policy was not provided.The above deficiency resulted in the finding of Immediate Jeopardy (IJ). After observations and interviews were made on 3/23/26, the facility Administrator and Director of Nurses were provided with the IJ template on 3/23/26 at 1:22 PM and submitted a removal plan which was approved by the State Agency on 3/23/26.The removal plan noted in part, the following: the DNS immediately removed the Vaseline from Resident #76's room. Immediate in-service education was conducted with all staff, including nursing, housekeeping, physical therapy, and all ancillary departments, regarding the prohibition of oil-based and petroleum-based products within the facility. Additionally, the removal plan identified a facility-wide audit was completed on 3/23/26 (after initial observations were made of Vaseline on Resident #76's bedside table within his/her reach) ensuring that no resident on oxygen was utilizing any petroleum-based products. Facility-wide postings have been placed to notify all staff, residents, and visitors that oil-based and petroleum-based products are strictly prohibited. In addition, written notification has been prepared and distributed to residents' [NAME] of Attorney (POA) and/or responsible parties to inform them of these restrictions. The facility will continue to conduct intermittent audits to ensure ongoing compliance. Additional postings have also been placed in all resident rooms where oxygen therapy is in use to reinforce adherence to safety requirements. Observation and review of facility documentation on 3/23/26 identified that the facility implemented the removal plan and the IJ was removed. 2. Resident #9 had diagnoses that included Parkinson's disease, generalized muscle weakness, uncoordinated gait, and dementia.The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #9 had severely impaired cognition, was frequently incontinent of bowel, and dependent on staff for transfers, toileting, and mobility in the wheelchair. The MDS further identified Resident #9 had a history of falls.The Resident Care Plan (RCP) dated 2/6/26 identified Resident #9 was at risk for falls related to potential blood pressure changes with position changes, a neurological movement disorder, significant lower body mobility impairment, a history of falls, and antidepressant use. Interventions included providing physical<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | therapy and other rehabilitation services as ordered, placing commonly used items within reach including the call bell, and encouraging the resident to use the call bell.The physician's order dated 3/4/26 directed to provide extensive assistance with toileting, provide neuromuscular reeducation, occupational therapy, physical therapy, and gait training.A nursing note dated 3/13/26 at 1:46 PM identified Resident #9 experienced an unwitnessed fall in the shower room while seated on the toilet, with a family member initially present. The note indicated the family member briefly left the room to ask the nurse a question. Staff subsequently found the resident sitting on the floor with no obvious injuries. The nurse then instructed staff to remain with the resident in the bathroom at all times, even when a family member is present.Review of the facility Reportable Event dated 3/13/26 at 1:30 PM identified Resident #9 sustained an unwitnessed fall with no injuries identified. Resident #9 required extensive assistance with toileting both prior to and following the fall. APRN #2 was notified, and new orders were obtained to monitor the resident's vital signs every shift for three days and to complete neurological checks in accordance with facility policy.Review of the facility Event Interview Form dated 3/13/26 identified NA #3 stated she assisted Resident #9 to the toilet and left Resident #9 with his/her spouse in the bathroom with the door open, while she collected trays on the unit. NA #3 further stated Resident #9's spouse left the bathroom to ask the nurse a question. Upon returning to check on Resident #9, NA #3 found the resident on the floor.Review of the facility Investigation for Skin Tears/Bruises Report dated 3/13/26 identified Resident #9 was dependent on staff for care at the time of the fall, and staff were directed to remain with the resident while in the bathroom.Review of the facility Rehabilitation Fall Report dated 3/17/26, completed by Physical Therapist #2, identified Resident #9 should not be left unattended on the toilet.Interview with RN #2 (Nursing Supervisor) on 3/26/26 at 2:15 PM identified Resident #9 should not have been left alone in the bathroom and a family member's presence did not negate the need for staff supervision. RN #2 identified after the fall staff were educated not to leave Resident #9 unattended in the bathroom, including when a family member is present.Interview with the Assistant Director of Nurses (ADNS) on 3/26/26 at 3:30 PM identified Resident #9, who is dependent on staff for toileting, should not have been left alone in the bathroom. The ADNS indicated family members and visitors may assist residents with activities of daily living and other care tasks. The ADNS identified the facility remains responsible for ensuring resident safety and well-being. Although requested, a toileting policy was not provided. |

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| F 0572<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Give residents a notice of rights, rules, services and charges.<br><br>Based on review of facility documentation, resident council meeting minutes, facility policy, and interviews reviewed for Resident Council, the facility failed to ensure residents were informed of their rights, of all the rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. The findings include: On 03/24/2026 at 1:32 PM, a Resident Council meeting was held with Residents #65, #75, #102, #103, #127, and #147 in attendance. The residents identified that facility staff had not reviewed or discussed Resident Rights with them. The residents further indicated they had not received education regarding facility rules or policies governing resident conduct and responsibilities. Residents #65 and #147 stated that although Resident Rights are posted, they are not accessible because the posting is positioned too high for individuals using wheelchairs, and too small to read. Residents #75, #102, #103, and #127 agreed with these concerns.Review of Resident Council meeting minutes from 1/29/2025 through 2/24/2026 failed to provide documentation that residents were informed of their rights or educated on the rules and regulations governing residents conduct and responsibilities during their stay in the facility.Interview with Administrator on 3/30/26 at 12:43 PM identified he was aware that Resident Rights were not being reviewed during Resident Council meetings. The Administrator stated the facility management waits to be invited by the Resident Council to attend meetings. The Administrator identified that he had not taken the initiative to attend the Resident Council meetings to review Resident Rights and the facility rules and regulations but should have done so. Review of the facility Resident [NAME] of Rights Policy, directed in part, residents have the right to be fully informed, orally or in writing, in a language the resident understands, of your rights and the facility's rules governing your conduct and responsibilities, and of changes in the resident rights and in the facility's rules. This [NAME] of Rights tells you about your rights as a nursing home resident. |

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| F 0577<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Allow residents to easily view the nursing home's survey results and communicate with advocate agencies.<br><br>Based on observations, facility documentation review, facility policy review, and interviews reviewed for Resident Council, the facility failed to ensure the most recent surveys of the facility conducted by Federal or State surveyors were posted in a place readily accessible to residents, family members, and legal representatives of residents and failed to post notice of the availability of such reports in areas of the facility that are prominent and accessible. The findings include: A Resident Council meeting was held on 3/24/26 at 1:32 PM with Residents #65, #75, #102, #103, #127, and #147 in attendance. The residents identified that they were not aware they could examine the results of the most recent surveys of the facility conducted by Federal or State surveyors or where the surveys were located.Review of Resident Council meeting minutes from 1/29/2025 through 2/24/2026 failed to provide documentation that residents were informed of their right to examine the most recent survey of the facility or where the reports were located.Observation in the main lobby on 3/24/2026 at 2:30 PM, identified several signs were on a windowsill behind a credenza (table); however, no signage identifying the location of the State Inspection Report book was visible. The posted materials were not accessible at wheelchair level due to their placement behind the credenza.Interview with the Receptionist #1 on 3/24/26 at 2:31 PM identified she believed the State Inspection Report book was in one of the drawers on the table in front of the lobby window. Receptionist #1 indicated there had previously been a sign on the table identifying the location of the State Inspection Report book.Observation on 3/24/26 at 2:32 PM of the main lobby identified the credenza located in the bay window identified a table with two small drawers (one on the right side and one on the left side) and no visible signed indicating the location of the State Inspection Report book. The right-side drawer was obstructed by a free-standing hand sanitizer on a metal pole with a base. After removing the obstruction, the right-side drawer opened and the State Inspection Report book was inside bent in half within the drawer.Interview and observation on 3/24/2026 at 2:35 PM with the Administrator identified the State Inspection Report book should be kept on top of the credenza. During the interview, the Administrator reached over the credenza to the windowsill, moved a sign, and revealed a sign behind it that read, Survey Results in Desk. The Administrator stated he was unaware of why the sign had been moved or how long it had been in that position. The Administrator indicated he did not know how long the State Inspection Report book had been stored in the drawer, that was blocked by the free-standing hand sanitizer dispenser. was obstructed by a free-standing hand sanitizer dispenser.Review of the facility Resident [NAME] of Rights Policy, directed in part, residents have the right to know where to find, and to see, the results of current federal, state and local inspection reports and plan of corrections. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on a tour of the Dietary Department, observation, review of facility policy, and interview, the facility failed to ensure staff wore a beard guard (hair restraint) when assembling and serving food. The findings include:Observation of the meal service on 3/23/26 at 7:15 AM with the Dietary Director, identified:Dietary Aide #1 was observed at the steam table plating scrambled eggs, oatmeal, and toast onto residents' plates for meal delivery. Dietary Aide #1 had visible facial hair extending below the chin and was not wearing a beard restraint.Interview with the Dietary Director on 3/23/26 at 7:20 AM identified dietary staff are required to wear appropriate hair coverings, including beard restraints, when working in the kitchen and handling food. The Dietary Director stated beard covers are always available to staff and Dietary Aide #1 should have been wearing a beard guard.Subsequent to the surveyor's inquiry, the Dietary Director directed Dietary Aide #1 to apply a beard guard.Review of the facility Hair Restraint policy, dated 1/20/17, directed that kitchen staff, anyone inside the kitchen, or anyone handling food must wear hair restraints, including a beard guard if applicable. The policy defined a beard as anything beyond stubble, scruff, or two days' growth. |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, review of the clinical records, facility documentation, and facility policy for 3 of 6 residents (Resident #1, Resident #5, and Resident #94) reviewed for Advanced Directives, the facility failed to ensure Advanced Directives forms were signed by the resident representatives and failed to ensure the Advanced Directive form identified the resident's expressed wishes. The findings include:1.Resident #1 had diagnoses that included dementia with behaviors, stroke, anxiety, and depression.<br><br>A physician's order dated 12/31/25 directed Do not Resuscitate (DNR).<br><br>The Advanced Directive /Medical Treatment Decision Form dated 12/31/25 indicated verbal telephone consent was obtained from Resident #1's responsible party. The form identified Resident #1 was a DNR. The Advanced Directive/Medical Treatment Decision Form was not signed by Resident #1's representative since admission (85 days later).<br><br>The nurse's note dated 12/31/25 at 8:04 PM identified Resident #1 arrived at the facility from the hospital by ambulance and Resident #1's code status was changed to a DNR.<br><br>The admission Minimum Data Set (MDS) dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of three (3) out of fifteen (15) indicative of severely impaired cognition.<br><br>A care plan meeting note dated 1/14/26 identified Resident #1 nor Resident #1's representative was present. The note further identified Resident #1's code status was a DNR.<br><br>Review of the Advanced Directive/Medical Treatment Decision Form on 3/26/26 identified it had not been signed by Resident #1's representative since admission (85 days later).<br><br>2. Resident #5 had a diagnosis that included dementia.<br><br>The Advanced Directive /Medical Treatment Decision Form dated 11/12/24 indicated verbal telephone consent was obtained from Resident #5's responsible party. The form identified Resident #5 was a full code (all life saving measures). The Advanced Directive/Medical Treatment Form dated 11/12/24 was not signed by Resident #5's representative since admission (500 days later).<br><br>A physician's order dated 11/12/24 directed Full code (all life saving measures).<br><br>The admission MDS dated [DATE] identified Resident #5 had a BIMS score nine (9) of fifteen (15) indicative of moderately impaired cognition.<br><br>A care plan team review note dated 11/26/24 identified Resident #5 was a Full code.<br><br>The Resident Care Plan dated 11/26/24 identified Resident #5 was a Full code and had Advanced Directives. Interventions directed to respect the resident representatives and resident's request regarding their choice for Advanced Directives.<br>(continued on next page) |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview with the Director of Nursing (DNS) on 3/26/2026 at 8:18 AM identified upon admission the resident's code status and Advanced Directives form should be addressed with the resident, or, if the resident is confused with the resident's representative if present. The DNS identified if the resident's representative is not present, two nurses must call obtain verbal consent for the code status and inform the representative they will need to sign the form as soon as possible. The DNS stated the Advanced Directives form for Resident #1 and Resident #5's Advanced Directives should have been signed by the resident's representatives.<br><br>Review of the facility Advanced Directive policy dated 4/25/2013, directed in part, all residents, or their primary decision maker have the right to formulate an advanced directive. The purpose is to ensure that the residents' wishes are incorporated into treatment, care, and services. Advanced directives are discussed with the resident/representative by a licensed nurse at the time of admission. The resident/representative will be asked to sign the appropriate Advanced Directive Form according to his/her wishes, which will be maintained in the clinical record and signed by the physician.<br><br>3. Resident #94 had diagnoses that included high blood pressure, difficulty swallowing, and malnutrition.<br><br>The Advanced Directive /Medical Treatment Decision Form dated 2/5/25 identified Do not Hospitalize box was the only boxed checked off on the form, but no other boxes were checked off to identify what Resident #94's Advanced Directive wishes were.<br><br>The admission MDS assessment dated [DATE] identified Resident #94 had intact cognition.<br><br>The physician's order dated 2/5/25 directed a Do Not Resuscitate (DNR), RN may pronounce, and death is anticipated due to illness, infirmity, and/or disease.<br><br>Review of the care plan team review notes dated 2/26/25, 3/27/25, 6/26/25, 10/2/25, and 12/30/25 identified Resident #94 was a DNR.<br><br>Interview and clinical record review on 3/25/26 at 12:52 PM with LPN #3 identified on 2/5/25 Resident #94 had not elected a DNR on his/her Advanced Directive/Medical Treatment Decision form (despite a physician's order dated 2/5/25 for a DNR).<br><br>Interview and clinical record review with the DNS on 3/25/26 at 1:40 PM identified the Advanced Directive /Medical Treatment Form should identify the resident's code status wishes and match the physician order. The DNS identified Resident #94's Advanced Directive/Medical Treatment form was not filled out correctly despite the physician's order that directed Resident #94 was a DNR.<br><br>Review of the facility Advanced Directive policy dated 4/25/13, directed in part, all residents, or their primary decision maker have the right to formulate an advanced directive. The purpose is to ensure that the residents' wishes are incorporated into treatment, care, and services. Advanced directives are discussed with the resident/representative by a licensed nurse at the time of admission. The resident/representative will be asked to sign the appropriate Advanced Directive Form according to his/her wishes, which will be maintained in the clinical record and signed by the physician. |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, facility documentation, facility policy, and interviews for 1 of 3 residents (Resident #14) reviewed for abuse, the facility failed to report an injury of unknown origin to the State Agency in a timely manner. The findings include:Resident #14 had diagnoses that included dementia with behavioral disturbances.The quarterly Minimum Data Set (MDS) dated [DATE] identified Resident #14 had severely impaired cognition, was always incontinent of bowel and bladder, was totally dependent on staff for personal hygiene, dressing, and transfers. The MDS further identified Resident #14 had behaviors 1 to 3 days a week directed towards others such as hitting screaming or disruptive sounds.The Resident Care Plan (RCP) dated 2/4/26 identified Resident #14 had dementia with behavioral symptoms of sundowning and agitation. Interventions included redirect resident as needed, remove from public area when residents' behavior is unacceptable, psychiatric evaluation as needed, and give medications as ordered.The physician's orders dated 2/14/26 directed to administer Remeron (medication used to treat depression) 15 milligrams (mg) once daily at bedtime, Melatonin (sleep aid) 5 mg once daily at bedtime, and Trazodone (antidepressant used to treat depression) solution 10 mg/milliliter (mL) give 37.5 mg /3.75 ml twice a day.The Advanced Practice Registered Nurse (APRN) note dated 3/23/26 at 4:22 PM identified Resident #14 was evaluated via an audio-video visit for a new acute problem of right-hand swelling. Resident #14 presented with swelling and discoloration of the right hand of unclear origin, with no known history of trauma.The facility Accident and Incident report dated 3/23/26 at 4:45 PM identified Resident #14 was at the nurse's station and noted with a bruise to the right hand measuring 8.5 centimeters (cm) by 3.7 cm with mild swelling. There were no witnesses. Resident #14 is alert but confused and requires a mechanical lift for transfers. The APRN and family were notified. Registered Nurse (RN) #5's written investigation dated 3/23/26 identified Resident #14 is confused, Nurse Aide (NA) #3 used mechanical lift during the 7:00 AM to 3:00 PM shift. RN #5 identified Resident #14 has behaviors that include hitting and grabbing at staff.NA #4's written statement dated 3/23/2026 identified that during the last two times she cared for Resident #14, she did not observe a bruise on Resident #14's hand.NA #5's written statement dated 3/23/2026 identified she did not observe a bruise on Resident #14's hand.NA #6's written statement dated 3/23/26 identified he did not observe a bruise on Resident #14's hand.NA #7's written statement dated 3/23/2026 identified she was not assigned to care for Resident #14 and did not observe any bruise on the resident's hand.The nurse's note written by RN #4 dated 3/23/2026 at 6:30 PM identified that Resident #14's right hand had light bruising and mild swelling.The nurse's note written by RN #5 dated 3/23/2026 at 6:44 PM identified Resident #14 was received sitting in a wheelchair in the dining room with a recreation staff person present. RN #5 identified Person #2 observed a bruise on Resident #14's right hand. RN #5 identified Resident #14's bruise measured 8.5 cm by 3.7 cm and mild swelling was noted.Interview with Person #2 on 3/24/26 at 10:07 AM identified on 3/23/26 at 4:00 PM he/she visited Resident #14 and observed a large bruise covering the right pointer finger that extended up the back of the hand and the wrist. Person #2 indicated no one from the facility notified him/her about Resident #14's bruise or the circumstances surrounding it. Person #2 identified Resident #14 can be difficult during care and questioned whether staff may have become frustrated and bent Resident #14's finger back. Person #2 indicated on 3/22/26 at 4:00 PM, he/she visited Resident #14 and the bruise and swelling to the right hand and finger were not there.Observation on 3/24/26 at 11:00 AM identified Resident #14 was in his/her wheelchair and noted with swelling to his/her right hand and wrist with light black discoloration to his/her right hand and wrist, right pointer finger, and the top of the right posterior thumb. The nurse's note dated 3/24/2026 at 9:44 PM identified Resident #14 was status post bruising to the right index finger and the knuckle of digit #1. Person #2 into visit Resident #14 and requested<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 075416 | A. Building<br>B. Wing | 03/31/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Candlewood Valley Health & Rehabilitation Center | 30 Park Lane East<br>New Milford, CT 06776 |

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 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | an X-ray. The nurse noted that the right index finger remained bruised and swollen at the knuckle. The APRN was updated, and a new order was obtained to perform an X-ray of Resident #14's right hand tomorrow.The APRN note dated 3/25/26 identified Resident #14 was seen today for ecchymosis of the right dorsal hand, first noted on 3/23/26, with no known injuries or trauma reported. An X-ray done on 3/25/26 showed soft tissue swelling, with intact joints, no fracture or dislocation. The APRN indicated Resident #14's right-hand contusion could be related to Resident #14's underlying combative behaviors.Interview with the Director of Nursing Services (DNS) on 3/30/26 at 10:15 AM identified he was not notified and was not aware of Resident #14's right-hand bruising. The DNS identified bruises of unknown origin must be reported to the State agency. The DNS further identified had he been notified, he would have reported Resident #14's injury of unknown origin.Although attempted, interviews with NA #3, #4, #6, and #7 were not obtained.Review of the facility Abuse Prevention and Prohibition Program policy identified to ensure the facility establishes, operationalizes, and maintains an Abuse Prevention and Prohibition Program designed to screen and train employees, protect resident's, and ensure a standardized methodology for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, misappropriation of property, and crime in accordance with feral and state requirements. Each resident has the right to be free from mistreatment, neglect, abuse, involuntary seclusion, and misappropriation of property. The facility has zero tolerance. This policy also identifies Special Considerations regarding the investigation of injuries of unknown origin. Identification of physical abuse would include welts, bruises, abrasions, lacerations, and black eyes. The facility promptly and thoroughly investigates reports of resident abuse, mistreatment, and injuries of unknown sources. If the Administrator receives a report of abuse or injury of unknown origin the Administrator or designee may appoint a member to investigate the alleged incident. The investigator may take some or all of the following steps. Review all relevant documents, review the residents medical record, interview(s) the person who fills out the incident report, anyone who witnessed the alleged incident, facility staff may have had contact with the resident during the period of the incident, residents visitors or family member, reviews all events leading up to the incident, and communicates with the Administrator on a daily basis of findings. The investigator prepares an investigation report documenting findings of the investigation. Witness statements must be given in writing signed and dated. The investigator gives a copy of the completed investigation to the Administrator within 5 working days of the initial report for unexplained injuries. An employee who knowingly makes a false statement report may be subject to disciplinary action, up to and including termination. Injuries of unknown origin (unexplained injuries are promptly and thoroughly investigated by the DNS to ensure the resident safety is not compromised and action is taken whenever possible, to avoid future occurrences. If a resident is observed with unexplained injuries the nurse on duty will complete the Reportable Event Form and record information in the resident's medical record. Documentation must include information relevant to risk factors and conditions that cause or predispose someone to similar signs and symptoms. Documentation must be objective and should not be speculative about causes. The facility will report allegations of abuse, neglect, exploitation, mistreatment, injuries of unknown source immediately but no later than 2 hours, reporting is based on real clock time not business hours. The administrator will provide state survey agency, law enforcement and the ombudsman with a copy of the investigation report within 5 business days of the incident. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 075416 | A. Building<br>B. Wing | 03/31/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Candlewood Valley Health & Rehabilitation Center | 30 Park Lane East<br>New Milford, CT 06776 |

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 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, facility documentation, facility policy, and interviews for 1 of 3 residents (Resident #14) reviewed for abuse, the facility failed to conduct a complete and thorough investigation for a resident with an injury of unknown origin. The findings include:Resident #14 had diagnoses that included dementia with behavioral disturbances.The quarterly Minimum Data Set (MDS) dated [DATE] identified Resident #14 had severely impaired cognition, was always incontinent of bowel and bladder, was totally dependent on staff for personal hygiene, dressing, and transfers. The MDS further identified Resident #14 had behaviors 1 to 3 days a week directed towards others such as hitting screaming or disruptive sounds.The Resident Care Plan (RCP) dated 2/4/26 identified Resident #14 had dementia with behavioral symptoms of sundowning and agitation. Interventions included to redirect resident as needed, remove from public area when residents' behavior is unacceptable, psychiatric evaluation as needed, and give medications as ordered.The physician's orders dated 2/14/26 directed to administer Remeron (medication used to treat depression) 15 milligrams (mg) once daily at bedtime, Melatonin (sleep aid) 5 mg once daily at bedtime, and Trazodone (antidepressant used to treat depression) solution 10 mg/milliliter (mL) give 37.5 mg /3.75 ml twice a day.The Advanced Practice Registered Nurse (APRN) note dated 3/23/26 at 4:22 PM identified Resident #14 was evaluated via an audio-video visit for a new acute problem of right-hand swelling. Resident #14 presented with swelling and discoloration of the right hand of unclear origin, with no known history of trauma. The facility Accident and Incident report dated 3/23/26 at 4:45 PM identified Resident #14 was at the nurse's station and noted with a bruise to the right hand measuring 8.5 centimeters (cm) by 3.7 cm with mild swelling. There were no witnesses. Resident #14 is alert but confused and requires a mechanical lift for transfers. The Advanced Practice Registered Nurse (APRN) and family were notified. Registered Nurse (RN) #5's written investigation dated 3/23/26 identified Resident #14 is confused, Nurse Aide (NA) #3 used mechanical lift during the 7:00 AM to 3:00 PM shift. RN #5 identified Resident #14 has behaviors that include hitting and grabbing at staff. The nurse's note written by RN #5 dated 3/23/2026 at 6:44 PM identified Resident #14 was received sitting in a wheelchair in the dining room with a recreation staff person present. RN #5 identified Person #2 observed a bruise on Resident #14's right hand. RN #5 identified Resident #14's bruise measured 8.5 cm by 3.7 cm and mild swelling was noted.NA #4's written statement dated 3/23/2026 identified that during the last two times she cared for Resident #14, she did not observe a bruise on Resident #14's hand.NA #5's written statement dated 3/23/2026 identified she did not observe a bruise on Resident #14's hand.NA #6's written statement dated 3/23/26 identified he did not observe a bruise on Resident #14's hand. NA #7's written statement dated 3/23/2026 identified she was not assigned to care for Resident #14 and did not observe any bruise on the resident's hand.Interview with Person #2 on 3/24/26 at 10:07 AM identified on 3/23/26 at 4:00 PM he/she visited Resident #14 and observed a large bruise covering the right pointer finger that extended up the back of the hand and the wrist. Person #2 indicated no one from the facility notified him/her about Resident #14's bruise or the circumstances surrounding it. Person #2 identified Resident #14 can be difficult during care and questioned whether staff may have become frustrated and bent Resident #14's finger back. Person #2 indicated on 3/22/26 at 4:00 PM, he/she visited Resident #14 and the bruise and swelling to the right hand and finger were not there. Observation on 3/24/26 at 11:00 AM identified Resident #14 was in his/her wheelchair and noted with swelling to his/her right hand and wrist with light black discoloration to his/her right hand and wrist, right pointer finger, and the top of the right posterior thumb. The nurse's note dated 3/24/2026 at 9:44 PM identified Resident #14 was status post bruising to the right index finger and the knuckle of digit #1. Person #2 into visit Resident #14 and requested an X-ray. The nurse noted that the right index finger remained bruised and swollen at the knuckle. The APRN was updated, and a new order was obtained to perform an X-ray of<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 075416 | A. Building<br>B. Wing | 03/31/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Candlewood Valley Health & Rehabilitation Center | 30 Park Lane East<br>New Milford, CT 06776 |

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 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Resident #14's right hand tomorrow. The APRN note dated 3/25/26 identified Resident #14 was seen today for ecchymosis of the right dorsal hand, first noted on 3/23/26, with no known injuries or trauma reported. An X-ray done on 3/25/26 showed soft tissue swelling, with intact joints, no fracture or dislocation. The APRN indicated Resident #14's right-hand contusion could be related to Resident #14's underlying combative behaviors. Interview with the Director of Nursing Services (DNS) on 3/30/26 at 10:15 AM identified he was not aware on 3/23/26, Person #2 reported to RN #5 that Resident #14's right hand was bruised and swollen. The DNS stated that RN #5 should have notified him, and had he been notified, he would have investigated. The DNS identified his expectation for any injury of unknown origin is that the investigation is complete and through, including a 72-hour look back, interviews with all staff who cared for the resident, and written statements. Interview with RN #5 on 3/30/26 at 10:52 AM identified she doesn't know how Resident #14 obtained the bruise. RN #5 identified on 3/23/26 Person #2 was the first to notify her of the bruise. RN #5 indicated that Resident #14 was previously in the dining room sitting with a recreation staff person, but she could not recall who. RN #5 stated she asked staff on duty to write statements regarding the bruise. RN #5 stated based on the staff statements she obtained she was unable to determine how Resident #14 sustained a bruise. RN #5 stated she assumed Resident #14 may have hit his/her hand, but no staff witnessed it from 3:00 PM to 4:45 PM. RN #5 identified that she did not notify the DNS of the bruise of unknown origin and instead left the reportable event form and staff statements for the DNS to review the next day.Interview with RN #4 on 3/30/26 at 11:22 AM identified on 3/23/26 the charge nurse informed her of the bruise on Resident #14's right hand, and she did the assessment. RN #4 identified Resident #14's posterior right hand and index finger were slightly swollen and discolored. RN #4 indicated that she left the forms for the staff to write statements but did not ask whether staff had put Resident #14 back in bed between 3:00 PM to 4:45 PM to provide incontinent care or if they had used the mechanical lift. Review of the facility Abuse Prevention and Prohibition Program policy identified this is to ensure the facility establishes, operationalizes, and maintains an Abuse Prevention and Prohibition Program. This policy also identifies Special Considerations regarding the investigation of injuries of unknown origin. Injuries of unknown origin (unexplained injuries) are promptly and thoroughly investigated by the DNS to ensure the resident safety is not compromised and action is taken whenever possible, to avoid future occurrences. If a resident is observed with unexplained injuries the charge nurse on duty will complete the Reportable Event Form and record information in the resident's medical record. Documentation must include information relevant to risk factors and conditions that cause or predispose someone to similar signs and symptoms. Documentation must be objective and should not be speculative about causes. The facility will report allegations of abuse, neglect, exploitation, mistreatment, injuries of unknown source immediately but no later than 2 hours, Reporting is based on real clock time not business hours. The administrator will provide state survey agency, law enforcement and the ombudsman with a copy of the investigation report within 5 business days of the incident. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 075416 | A. Building<br>B. Wing | 03/31/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Candlewood Valley Health & Rehabilitation Center | 30 Park Lane East<br>New Milford, CT 06776 |

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 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 2 (Resident #142) residents reviewed for hospitalization, the facility failed to ensure the resident and/or resident representative were provided with written information regarding the bed hold policy at the time the resident was sent to the hospital. The findings include: Resident #142 had diagnoses that included Alzheimer's disease, chronic systolic (congestive) heart failure, chronic atrial fibrillation, chronic kidney disease, and restlessness and agitationThe quarterly Minimum Data Set (MDS) dated [DATE] identified Resident #142 had intact cognition. A nurse's note dated 3/4/2026 at 12:41 PM written by Registered Nurse (RN) #2 identified Resident #142 was being treated for diverticulitis and presented with altered mental status, hypoxia, hypotension, and bradycardia. RN #2 identified the Physician Assistant (PA) #1 was notified, new orders obtained to transfer Resident #142 to the hospital, and the resident was transported from the facility via EMS to the hospital. A social worker note dated 3/5/26 at 10:41 AM written by Social Worker (SW) #1 identified Resident #142 was admitted to the hospital on [DATE]. Review of the clinical record failed to reflect that written notice, which specifies the duration of the bed-hold policy, had been provided to the Resident #142 or his/her resident representative when the resident was transferred to the hospital on 3/4/26. Interview with RN #2 on 3/26/26 at 12:10 PM identified on she was the supervisor on duty on 3/4/26 when Resident #142 was transferred to the hospital. RN #2 indicated she was unsure who is responsible for providing a bed hold policy when a resident is transferred to the hospital. RN #2 stated that she did not provide a bed hold notice or policy to Resident #142 when he/she was transferred to the hospital on 3/4/26. Interviews with SW #1 and SW #2 on 3/26/26 at 12:12 PM identified that they were not responsible for providing bed hold notice when a resident is transferred to the hospital. SW #1 and SW #2 indicated they believed the Admissions department was responsible for bed hold notices. Interview with the Administrator on 3/26/26 at 12:20 PM identified a bed hold notice was not provided to Resident #142 when he/she was transferred to the hospital on 3/4/26. The Administrator further identified bed hold notices were not being consistently provided. The Administrator stated that the social workers should be responsible for ensuring bed hold notices are issued when a resident is transferred to the hospital and a bed hold notice should have been provided to Resident #142 on 3/4/26. Interview with the Director of Nurses (DNS) on 3/26/26 at 12:40 PM identified a copy of the bed hold notice should be provided to the resident at time of transfer to the hospital and a copy should remain in the chart and mailed to the resident representative. The DNS indicated it is the responsibility of the nursing supervisor to provide the bed hold notice at the time of transfer. The DNS stated the bed hold notice was not provided to Resident #142 at the time of the hospital transfer on 3/4/26 because it was not completed. Review of facility Bed-Holds and Return policy dated March 2017, directed in part, prior to transfers residents or resident representatives will be informed in writing of the bed-hold and return policy. Prior to transfer, written information will be given to the resident and the resident representative that explains in detail the rights and limitations of the resident regarding bed-holds. |

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| | 075416 | A. Building<br>B. Wing | 03/31/2026 |

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| Candlewood Valley Health & Rehabilitation Center | 30 Park Lane East<br>New Milford, CT 06776 |

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| F 0644<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical records, facility documentation, facility policy, and interviews for 2 of 5 residents (Resident #1 and Resident #5) reviewed for Preadmission Screening and Resident Review (PASRR), the facility failed to submit a request for a Level II screen subsequent to Resident #1 and Resident #5's new psychiatric diagnoses. The findings include:1.Resident #1 was admitted to the facility in March 2025 with diagnoses that included dementia with behaviors, stroke, anxiety, and depression. The admission Minimum Data Set (MDS) dated [DATE] identified Resident # 1 had intact cognition and had no verbal or physical behaviors. The Resident Care Plan dated 4/9/25 identified Resident #1 was at risk for behaviors due to dementia with interventions that included to redirect the resident as needed.A PASSR screening dated 4/30/25 identified the screening was being submitted because the Level 1 PASSR was expiring. The screening identified Resident #1 had diagnoses of dementia, stroke, and anxiety. The outcome from the assessment identified Resident #1 required an onsite face to face Level 2 PASRR evaluation. A PASSR Level 1 screen dated 5/7/25 identified Resident #1 had diagnoses of anxiety, dementia, and depression. Resident #1 had typical symptoms that included low mood, worrying, irritability, and agitation. Resident #1 when frustrated throws pillows and yells. Resident #1 made comments about wanting to harm self when he/she had a conflict with his/her. Resident #1 had no psychiatric stays. Resident #1 is prescribed Xanax 1 mg three times a day for anxiety. The outcome from the assessment identified Resident #1 was excluded from a PASRR Level 2 due to no appropriate diagnosis. The PASRR Level I screen further identified Resident #1's approval remained valid and that no additional screening was required unless Resident #1 was diagnosed with a PASRR condition or if his/her symptoms worsened. The significant change MDS dated [DATE] identified Resident #1 had moderately impaired cognition, exhibited verbal and physical behavioral 4 to 6 days a week but not daily. The MDS further identified Resident #1 had received antianxiety and antidepressant medications over the last 7 days.The psychiatric Advanced Practice Registered Nurse (APRN) note dated 7/21/25 identified Resident #1 had a new diagnosis of psychotic disorder not due to substance or known psychological condition. Resident #1 appeared paranoid and verbalized persecutory delusions. Resident #1 has ongoing symptoms of mood dysregulation, paranoia, and agitation the plan is to start Zyprexa (antipsychotic) 5 mg daily at bedtime.Review of Resident #1's diagnoses identified a new diagnosis of psychotic disorder not due to a substance or known physiological condition was added on 7/21/25. The nurse's note dated 7/28/25 at 1:43 PM identified a physician emergency certificate (PEC) was completed for Resident #1, pending insurance approval, Resident #1 will be transferred to a behavioral health facility. The social worker note dated 7/28/25 at 4:02 PM identified Resident #1's PEC was completed. Resident #1 will be transferred to a behavioral health unit for evaluation awaiting transportation. The nurses note dated 7/28/25 at 5:25 PM identified Resident #1 was transferred by to an inpatient psychiatric facility. The nurses note dated 8/12/25 at 2:26 PM identified Resident #1 was readmitted to the facility. Review of Resident #1's diagnoses identified a new diagnosis of post-traumatic stress disorder (PTSD) was added in December 2025.Review of the clinical record failed to identify the PASSR contracted agency was notified of the new psychiatric diagnoses of psychotic disorder from 7/21/25 through 3/25/26 in order to conduct a Level 2 screen.Interview with the Social Worker (SW) #1 the Director of Social Services on 3/25/26 at 12:35 PM identified she and SW #2 were responsible for updating the PASRR contracted agency when there was a new psychiatric diagnosis. SW #1 indicated the nurses are responsible for updating the social workers if a resident receives a new diagnosis. SW #1 indicated she indicated Resident #1 was on SW #2's caseload.Interview with SW #2 on 3/25/26 at 12:47 PM identified Resident #1 was on her caseload. SW #2 indicated that when a resident has a change in condition or a new mental health diagnosis she may or may not update the PASRR contracted agency.<br>(continued on next page) |

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| F 0644<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | SW #2 indicated she does not update the PASRR contracted agency when a resident is diagnosed with a new psychiatric illness because the state agency case may or may not want to change Level 1 to Level 2. SW #2 identified based on her experience she decides when she believes she should update the PASRR contracted agency. SW #2 identified she was aware on 7/21/25 and 12/15/25 that Resident #1 had new psychiatric diagnoses and she did not update the PASRR contracted agency. 2. Resident #5 was admitted to the facility in November 2024 with diagnoses that included depression and dementia.A PASRR Level 1 screen dated 11/11/24 identified Resident #5 had diagnoses of Alzheimer's dementia, mild or situational depression, type 2 diabetes, hypertension, and hyperlipidemia. The outcome from the assessment identified a Level 2 was not required because there was no evidence of serious behavioral conditions unless Resident #5 was suspected of having a serious mental illness, had changes, or new information then a new screen must be completed. The Resident Care Plan (RCP) dated 11/12/24 identified Resident #5 was at risk for behavioral symptoms. Interventions included redirect resident as needed, remove from public area when resident behavior is unacceptable, medications as ordered, and a psychiatric consultation as needed. The admission MDS dated [DATE] identified Resident #5 had moderately impaired cognition.The psychiatric APRN note dated 4/2/25 identified Resident #5 did not have a diagnosis psychotic disorder and had no recent behavioral concerns.The psychiatric APRN note dated 4/8/25 identified Resident #5 was newly diagnosed with a psychotic disorder not due to substance or known physiological condition.Review of Resident #5's diagnoses identified a new diagnosis of a psychotic disorder was added on 4/8/25. Review of the clinical record failed to identify the PASSR contracted agency was notified of Resident #5's new psychiatric diagnosis of psychotic disorder from 4/8/25 through 3/26/25 in order to conduct a Level 2 screen.Interview with the Administrator on 3/25/26 at 11:00 AM identified social workers are responsible for updating the PASRR contracted agency if needed due to any changes. Interview with SW #2 on 3/26/26 at 10:37 AM identified she and SW #1 were responsible for updating the PASRR contracted agency when there was a new psychiatric diagnosis. SW #2 indicated on 11/11/24 Resident #5 had a PASRR Level 1 screen and a Level 2 was not required. SW #2 identified she was aware in April 2025; Resident #5 was diagnosed with a new psychiatric disorder. SW #2 indicated at that time she did not feel she needed to update the PASSR contracted agency. Although requested, a facility PASRR policy was not provided. |

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| Candlewood Valley Health & Rehabilitation Center | 30 Park Lane East<br>New Milford, CT 06776 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0694<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide for the safe, appropriate administration of IV fluids for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy review, and interviews, the facility failed to follow professional standards of care for intravenous medication administration for the only sampled resident (Resident #101) reviewed for intravenous therapy. The findings include:Resident #101 had diagnoses that included cerebral infarction, hypertension, and gastroesophageal reflux disease.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #101 had a Brief Interview of Mental Status (BIMS) score of fourteen (14) indicative of intact cognition and was dependent on staff for dressing, toileting, and transfers.The Resident Care Plan (RCP) dated 3/24/26 identified Resident #101 required intravenous therapy (IV) related to an elevated white blood count. Interventions included administration of IV therapy per physician's order and IV-line management per facility protocol.A physician's order dated 3/24/26 directed to administer Ceftriaxone (an antibiotic used to treat infections) 1 gram via intravenous infusion once a day at 5:30 PM for 3 days and flush the peripheral IV catheter using the Saline, Antibiotic, Saline (SAS) technique, every 12 hours at 8:30 AM and 8:30 PM with 10 milliliters (ml) of normal saline. Interview and clinical record review on 3/26/26 at 12:21 PM with Licensed Practical Nurse (LPN) #1 (Infection Preventionist) identified the facility policy requires intravenous catheters to be flushed before and after intermittent medication administration .Review of Resident #101's clinical record with LPN #1 identified a physician's order for Ceftriaxone 1 gram once daily at 5:30 PM for 3 days, as well as an additional order to flush the peripheral catheter using the SAS technique every 12 hours at 8:30 AM and 8:30 PM.LPN #1 could not identify the meaning of SAS or determine whether the flushing order was appropriate for intermittent intravenous administration.Interview and clinical record review on 3/26/26 at 12:43 PM with the Assistant Director of Nursing (ADNS) on 03/26/26 at 12:43 PM identified the facility policy required nurses to flush intravenous catheters before and after intermittent medication administration. Review of Resident #101's clinical record with the ADNS identified a physician's order for Ceftriaxone 1 gram once daily at 5:30 PM for 3 days, along with a separate flushing order instructing SAS (identified by the ADNS to stand for saline, antibiotic, saline) every 12 hours at 8:30 AM and 8:30 PM. Review of Resident #101's Medication Administration Record with the ADNS identified the SAS flushing order was signed off as completed on 3/24/26 at 8:30 AM and 8:30 PM; 3/25/26 at 8:30 AM and 8:30 PM; and on 3/26/26 at 8:30 AM . The Ceftriaxone (antibiotic) was signed off as administered on 3/24/26 at 5:30 PM and 3/25/26 at 5:30 PM. The ADNS stated although the documented flushing times did not align with the antibiotic administration time, staff just know to flush with saline, administer the antibiotic, and then flush again with saline when administering intermittent medications. The ADNS identified the times of administration should have aligned. The ADNS could not explain why orders to flush the IV line were scheduled at times that did not correspond with the Ceftriaxone administration times. Review of the facility Short Peripheral Catheter Flushing Policy dated 11/2021 directed in part to flush before and after administration of medication. |

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| | 075416 | A. Building<br>B. Wing | 03/31/2026 |

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| Candlewood Valley Health & Rehabilitation Center | 30 Park Lane East<br>New Milford, CT 06776 |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of the clinical record, facility policy, and interviews for one sampled resident (Resident #76) reviewed for respiratory care, the facility failed to ensure cautionary and safety signage was posted outside the room of a resident receiving oxygen therapy. The findings include: Resident #76's diagnoses included Chronic Obstructive Pulmonary Disease (COPD), dementia, and hypertension.The physician's order dated 7/3/2025 directed Resident #76 to receive oxygen at a rate of zero to four liters(L) per minute (min) to maintain SpO2 (peripheral capillary oxygen saturation) above 90%.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #76 had a Brief Interview of Mental Status (BIMS) score of 5 indicative of severely impaired cognition, required moderate assistance for rolling left and right, and required maximum assistance for personal hygiene. Additionally, the MDS identified Resident #76 was receiving oxygen therapy.The Resident Care Plan (RCP) dated 3/11/2026 identified Resident #76 was at risk for respiratory distress due to COPD. Interventions included oxygen administration as ordered by the physician, maintaining oxygen saturation as ordered, and monitoring for signs and symptoms of respiratory deficiency.Observation on 3/23/2026 at 8:48 AM identified Resident #76 in bed receiving continuous oxygen at 2 L/min via nasal cannula connected to an oxygen concentrator. There was no posted oxygen cautionary and safety signage at the doorway to identify that oxygen was in use.Observation on 3/23/2026 at 9:53 AM identified Resident #76 was seated in a recliner chair receiving continuous oxygen as ordered at 2 L/min via nasal cannula connected to an oxygen concentrator. There was no posted oxygen cautionary and safety signage at the doorway to identify that oxygen was in use.Interview on 3/25/2026 at 11:31 AM with Licensed Practical Nurse (LPN) #6 identified nursing was responsible for placing oxygen signage on the doorways of residents utilizing oxygen. LPN #6 identified that she did not place signage on Resident #76's doorway because she could not locate any cautionary oxygen safety signage.Interview on 3/25/2026 at 11:41 AM, Registered Nurse (RN) #2 stated she was unaware that Resident #76's doorway lacked cautionary oxygen signage. RN #2 identified she had recognized the need to order additional cautionary and safety oxygen signs a few weeks earlier while switching out concentrators.Interview on 3/25/2026 at 1:33 PM with the Director of Nursing Services (DNS) identified all staff are responsible for ensuring oxygen cautionary and safety signage is posted on resident doors when oxygen is in use. The DNS indicated that staff conduct audits and rounds to ensure signage is posted but he could not provide the dates the audits were conducted because the audit sheets did not include any dates.The facility Oxygen Concentrator policy dated 7/14/2010 identified in part that residents utilizing an oxygen concentrator will have an oxygen in use sign posted on the resident's door. |

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| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident must receive and the facility must provide necessary behavioral health care and services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, observations, and interviews for the only sampled resident (Resident #14) reviewed for behaviors, the facility failed to ensure recommendations from a community psychiatrist were obtained to address a resident's behavioral health care needs in a timely manner. The findings include: Resident #14 had diagnoses that included dementia with behaviors, anxiety, and agitation. The quarterly Minimum Data Set (MDS) dated [DATE] identified Resident #14 had severely impaired cognition, was always incontinent of bowel and bladder, was dependent on staff for personal hygiene, dressing, and transfers. The MDS further identified Resident #14 exhibited behaviors 1 to 3 days a week directed towards others such as hitting, screaming, or making disruptive sounds.The Resident Care Plan (RCP) dated 2/4/26 identified Resident #14 had dementia with behavioral symptoms of sundowning and agitation. Interventions directed to redirect resident as needed, remove from public areas when the resident's behaviors are unacceptable, obtain a psychiatric evaluation as needed, and administer medications as ordered.The APRN note dated 2/4/26 identified Resident #14 who has dementia, was recently hospitalized , and had multiple medication changes. A neurology consultant recommended follow-up with the community psychiatrist for medication management and consideration of reducing Trazodone (medication used to treat depression). The APRN note identified that staff reported Resident #14 continues to exhibit intermittent behaviors that include yelling out and striking at staff. The APRN identified she deferred medication changes pending psychiatric follow up. The APRN note identified Resident #14 will continue Remeron (medication used to treat depression) 15 milligrams (mg) nightly, Trazodone (medication used to treat depression) 37.5 mg three times a day, and Risperidone (antipsychotic medication used to treat mood disorders) 0.25 mg twice a day.The physician's orders dated 2/14/26 directed to administer Remeron 15 mg once daily at bedtime, Melatonin (sleep aid) 5 mg once daily at bedtime, and Trazodone solution 10 mg/milliliter (mL) give 37.5 mg /3.75 ml twice a day.The APRN note dated 2/25/26 identified Resident #14 was evaluated for continued use of Seroquel (antipsychotic medication used to treat mood disorders and irritability) as needed. Resident #14 has a history of yelling and combative behaviors and followed by a community psychiatrist. The community psychiatrist recommended starting Seroquel 12.5 mg twice daily for 14 days, which has now been completed. The physician's order dated 2/25/26 directed to administer Seroquel 12.5 mg twice a day as needed for 14 days for yelling, combative behavior, and agitation with a stop date of 3/11/26. The nurse's note written by RN #2 (day supervisor) dated 3/10/26 identified Resident #14 was seen by his/her community psychiatrist, and the community psychiatrist had not provided any new orders. RN #2 indicated she informed Resident #14's community psychiatrist that recommendations must be faxed to the facility for approval by the in-house provider. RN #2 identified the DNS had spoken with the psychiatrist yesterday who was supposed to send new orders, but no fax was received. RN #2 indicated she spoke with Person #2 (Resident #14's representative) and asked him/her to follow up with the community psychiatrist. The nurse's note dated 3/18/26 at 10:07 PM identified during incontinent care Resident #14 grabbed and bit a nurse aide on the hand.The nurse's note dated 3/22/26 at 11:23 PM identified Resident #14 was yelling out during the shift. Observation on 3/23/26 at 8:19 AM identified Resident #14 was lying in bed and yelling help.Observation on 3/24/26 at 10:55 AM identified Resident #14 was seated in his/her wheelchair yelling stop.Interview with Person #2 on 3/24/26 at 10:45 AM identified Resident #14 sees a psychiatrist in the community. Person #2 identified on 3/5/26 Resident #14 was seen by his/her psychiatrist who recommended discontinuing Trazodone and starting Seroquel twice daily. Person #2 identified the changes have not been implemented since 3/5/26. Person #2 indicated she asks the nurse in charge almost daily and was told the facility had not received a fax from the psychiatrist. Person #2 indicated he/she met with the<br>(continued on next page) |

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| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | DNS last week, who confirmed the community psychiatrist had not sent any new orders. Person #2 identified he/she is upset and could not understand why no one had called to obtain the new orders since 3/5/26. Person #2 stated he/she was hopeful the medication changes would help address Resident #14's behaviors. Review of the nurse's notes dated 3/11/26 through 3/30/26 was unable to reflect staff contacted the community psychiatrist to obtain the new orders or new recommendations.Interview and clinical record review with the DNS on 3/30/26 at 9:08 AM identified the supervisors are responsible for following up with consultation recommendations the same day and must notify the APRN so orders can be implemented. The DNS identified if the consultation form does not return with the resident or is illegible, the nurse must call the consulting physician's office. The DNS further identified if the physician provides verbal orders the nurse must contact the APRN to implement the orders. The DNS confirmed he had not seen Resident #14's psychiatrist consultation form and that the physician order for Seroquel was ending today. The DNS stated on 3/9/26 he spoke with Resident #14's community psychiatrist, who requested a blank physician order sheet so she could document the medication changes and new recommendations. The DNS indicated he faxed the blank physician order sheet as requested but has not received it back. The DNS identified he had not contacted the psychiatrist since, and that no fax was not received. The DNS identified from 3/10/26 through 3/30/26, none of the nurses followed up on the psychiatrist's recommendations from the 3/5/25 visit. Interview with RN #2 on 3/30/26 at 9:19 AM identified she could not recall the date Resident #14 was seen by his/her community psychiatrist. RN #2 identified on 3/10/26 the psychiatrist called and reported several new orders for Resident #14. RN #2 stated she informed the psychiatrist that the new orders needed to be faxed to the facility but did not ask for the specific orders. RN #2 identified she did not receive a fax with the new orders and had not attempted to call the psychiatrist to request the orders. Subsequent to surveyor inquiry, on 3/30/26 (25 days after Resident #14 was seen by the psychiatrist) at 1:42 PM the facility obtained a fax from Resident #14's community psychiatrist dated 3/9/26 with the new recommendations and new orders. Although requested, a Community Consultation policy was not provided. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of the clinical record, facility policy, and interviews for the only sampled resident (Resident #50) reviewed for tube feeding, the facility failed to wear appropriate Personal Protective Equipment (PPE) during care, and for 1 of 3 residents (Resident #88) reviewed for pressure ulcer, the facility failed to maintain proper infection control and practice hand washing between glove changes during wound care. The findings include:1. Resident #50's had diagnoses that included cancer of the upper throat, difficulty swallowing, and malnutrition.<br><br>The Resident Care Plan (RCP) dated 3/11/26 identified that Resident #50 received tube feedings related to difficulty swallowing and malnutrition, with interventions that included administering tube feedings as ordered.<br><br>The physician's order dated 3/11/26 directed to administer continuous tube feeding, change tubeˆfeeding supplies such as the nutrient bag, tubing, and irrigation set daily, and to maintain Enhanced Barrier Precautions (EBP) related to the resident's feeding tube.<br><br>The admission Minimum Data Set (MDS) dated [DATE] identified that Resident #50 had intact cognition, required supervision for eating, reported difficulty or pain with swallowing, used a feeding tube, and received a mechanically altered diet.<br><br>Observation of Resident #50's room on 3/26/26 at 9:42 AM identified an Enhanced Barrier Precautions (EBP) sign posted outside of Resident #50's room that directed all individuals entering and exiting the room to clean their hands. A Personal Protective Equipment (PPE) cart that contained equipment such as gowns, was outside of the room. The signage further instructed staff to wear gloves and a gown for highˆcontact resident care activities, such as dressing, bathing, providing hygiene, wound care, and care or use of indwelling devices including central lines, urinary catheters, and feeding tubes.<br><br>Observation and interview on 3/26/26 at 9:44 AM identified with Licensed Practical Nurse (LPN) #4 identified she performed hand hygiene, donned a pair of gloves before entering Resident #50's room. LPN #4 was changing Resident #50's tube feeding set up without the appropriate PPE, only wearing gloves (without the benefit of wearing a gown), she removed the used tube feeding set-up, discarded the supplies, and placed the new labeled and dated tube feeding set up. LPN #4 identified she was aware Resident #50 was on EBP for tube feedings. LPN #4 identified during high-contact care activities like changing the tube feeding set-up a gown was required. LPN #4 identified she should have worn a gown but didn't because she forgot.<br><br>Interview with LPN # 1 (Infection Prevention Nurse) on 3/26/26 at 3:30 PM identified a resident with any indwelling device, such as a tube feeding, are placed on EBP. LPN #1 identified during high-contact care activities staff are required to don gloves and a gown as part of EBP requirements.<br><br>Review of the facility Enhanced Barrier Precautions policy, dated 3/3/26, directed that enhanced barrier precautions will be initiated for residents with chronic wounds or indwelling medical devices, even if the resident was not colonized with a multidrugˆresistant organism. The policy further defined indwelling medical devices as central lines, urinary catheters, and feeding tubes. The policy identified the required PPE for enhanced barrier precautions as a gown and gloves when providing highˆrisk activities such as care related to activities of daily living, wound care, and device care, including tube feeding.<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 2. Resident #88 had diagnoses that included dementia and osteoarthritis.<br><br>The significant change MDS dated [DATE] identified Resident # 88 had severely impaired cognition, was always incontinent of bowel and bladder, required maximum assistance with toileting, bathing, upper and lower dressing, and personal hygiene and dependent on staff for transfers.<br><br>The RCP dated 3/15/26 identified Resident #88 had impaired skin integrity related to blisters on the left and right medial thighs and a rash. Interventions directed to ensure that briefs fit properly, monitor skin for signs of infection, and provide treatment as ordered.<br><br>The physician's order dated 3/15/26 directed to cleanse the Moisture associated skin damage (MASD) to bilateral groins with soap and water, then apply bacitracin ointment to affected areas twice a day for 7 days, cleanse bilateral wounds with soap and water, pat dry, and apply a small amount of Nystatin powder to affected areas twice a day, and apply skin prep to intact blisters to the right and left thighs twice a day.<br><br>The Wound Assessment Report dated 3/16/26 completed by APRN #1 (wound) identified Resident #88's right medial thigh had a cluster of 2 intact serous filled blisters measuring 5.0 centimeters (cm) by 5.0 cm with no depth and the left inner medical thigh had a cluster of 2 serous filled intact blisters measuring 5.0 cm by 4.0 cm with no depth.<br><br>The nurse's note dated 3/17/26 at 3:34 PM identified Resident #88 had an open blister to inner thigh, APRN #1 was notified, and new orders were obtained.<br><br>The physician's orders dated 3/17/26 directed to cleanse open areas on the inner thigh with normal saline, pat dry, apply calcium alginate, followed by a dry clean dressing.<br><br>Observation of Resident #88's wound care on 3/23/2026 at 8:04 AM with APRN #1 (wound nurse) and LPN #7 identified Resident #88 was seated in a high back wheelchair. LPN #7 assisted Resident #88 to a standing position so APRN #1 could assess the resident's wounds. APRN #1 proceeded with the assessment by pulling Resident #88's pants down so she could obtain a partial view of the wounds. APRN #1 left the room and returned with a treatment cart. APRN #1 collected the necessary supplies and placed them on Resident #88's bed without placing a barrier on the surface. APRN #1 performed hand hygiene, donned a new pair of gloves, with one hand removed the soiled dressing on Resident #88's right inner thigh, discarded the soiled dressing on to the bed, then without changing her gloves she removed the soiled dressing on the left inner thigh and discarded the soiled dressing on to the bed. APRN #1 without changing her gloves, picked up a pile of 4 x4 gauze pads dampened with wound cleanser, and cleansed the right inner thigh wound in a circular motion, and discarded the soiled 4x4 gauze pads on to the bed. APRN #1 without changing her gloves used one hand to pick up a pile of 4x4 gauze pads dampened with wound cleanser, used her other hand and forearm to hold Resident #88's pants up and away from the wound while she cleansed the left inner thigh wound in a circular motion, and then discarded the soiled gauze pads on to the bed. APRN #1 picked up the soiled dressings, soiled gauze pads, and discarded them in the bathroom trash can. APRN #1 removed her soiled gloves, performed hand hygiene, and donned a new pair of gloves. APRN #1 measured the left upper medial thigh wound, using the same tape measure measured the right upper medial thigh, then proceeded to apply Xeroform (non-adherent gauze impregnated with a mixture of petroleum jelly and an antimicrobial agent) dressing to the left thigh wound then the right thigh wound, followed by bordered gauze dressings without the benefit of changing her gloves or performing hand hygiene. APRN #1 picked up the remaining dressing supplies from the bed, discarded her gloves, performed hand<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | hygiene, and left the resident's room.<br><br>Interview with APRN #1 on 3/23/26 at 8:30 AM identified she should treat every wound separately. APRN #1 stated she should have changed her gloves and performed hand hygiene when moving from one wound to another. APRN #1 identified when she administered Resident #88's wound treatments she should have changed her gloves and performed hand hygiene between cleaning, measuring, removing, and applying the dressing on each wound. APRN #1 indicated she did not know why she did not change her gloves and perform hand hygiene. APRN #1 stated that she placed the soiled dressings and soiled supplies on the bed because no other surface was available.<br><br>Review of the facility Dry Clean Dressing Policy identified the purpose of this procedure is to provide guidelines for the application of a dry clean dressing. Verify the physicians order and assemble equipment and supplies needed. Clean bedside stand and establish a clean field. Place the clean equipment on the clean field. Tape a biohazard bag or plastic bag on the bedside stand or use a waste basket below clean field. Position resident and adjust clothing to provide access to affected area. Wash and dry your hands thoroughly. Put on gloves loosen tape and remove soiled dressing. Pull glove over dressing and discard into plastic bag. Wash and dry your hands thoroughly. Open dry, clean dressing by pulling corners of the exterior wrapping outward, touching only the exterior surface. Label tape or dressing with date, time, and initials. Place on clean field. Using clean technique, open other products such as prescribed dressing or dry clean gauze. Wash hands and dry thoroughly. Put on clean gloves. Assess the wound and surrounding skin for edema, redness, drainage, tissue healing progress and wound stage. Cleanse the wound with ordered cleanser, if using gauze, use clean gauze for each cleaning stroke. Clean from the least contaminated area to the most contaminated area(usually from the center of the wound outward). Use dry gauze to pat dry the wound. Apply the ordered dressing and secure with tape or bordered dressing per order. Label with date and initials to the top of the dressing. Discard disposable items into the garbage. Remove gloves and wash hands thoroughly. Reposition the bed cover and make resident comfortable. Clean the bedside table and wash your hands.<br><br>Review of the facility Hand Hygiene Policy identified it is the policy to ensure that all individuals use appropriate hand hygiene while at the facility. The facility considers hand hygiene the primary means to prevent the spread of infection. Facility staff follow hand hygiene procedures to help prevent the spread of infections to other staff, residents, and visitors. Staff must perform hand hygiene procedures in the following circumstances. Wash hands with soap and water before eating, after using the bathroom, between glove changes, Hand hygiene is always the final step after removing and disposing of personal protective equipment. The use of gloves does not replace hand hygiene procedures. |