STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075420	A. Building B. Wing	04/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summit at Plantsville Center for Health & Rehabili	261 Summit Street Plantsville, CT 06479

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** Based on review of clinical records, interviews, facility documentation and facility policies for one (1) of three (3) sampled residents (Resident #1) reviewed for abuse, the facility failed to revise and implement resident-specific care plan and care card interventions following repeated resident-to-resident physical altercations to ensure cognitively impaired residents residing on a secured unit were supervised and maintained at a safe distance from one another. The facility failed to update Resident #1's care plan and care card with specific behavioral triggers, de-escalation approaches, and direction to keep Resident #1 and Resident #2 separated following physical altercations on 3/22/26 and 3/28/26, which resulted in another physical altercation on 4/10/26 when assigned staff were unaware of the residents' history and required interventions to prevent further resident-to-resident aggression.The findings include:Based on review of clinical records, interviews, facility documentation and facility policies for one (1) of three (3) sampled residents (Resident #1) reviewed for abuse, the facility failed to revise and implement resident-specific care plan and care card interventions following repeated resident-to-resident physical altercations to ensure cognitively impaired residents residing on a secured unit were supervised and maintained at a safe distance from one another. The facility failed to update Resident #1's care plan and care card with specific behavioral triggers, de-escalation approaches, and direction to keep Resident #1 and Resident #2 separated following physical altercations on 3/22/26 and 3/28/26, which resulted in another physical altercation on 4/10/26 when assigned staff were unaware of the residents' history and required interventions to prevent further resident-to-resident aggression.1. Resident #1 was admitted to the facility April 2025 and had diagnoses of dementia, anxiety disorder, and violent behavior.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 as severely cognitively impaired (Brief Interview for Mental Status (BIMS) score of 5), required partial assistance with bathing and personal hygiene, and was able to ambulate fifty (50) feet with supervision/touch assistance. The Resident Care Plan (RCP) dated 3/25/26 identified Resident #1 had the potential to be physically aggressive related to progressive cognitive impairment. Interventions identified Resident #1 expressed fear that others may steal his/her personal belongings, particularly his/her remote control, his/her behavior tended to escalate when he/she noticed unfamiliar individuals in the environment, to reduce anxiety, staff was to proactively introduce new staff and residents and provide frequent reassurance regarding who was present, and to monitor, document, and report signs/symptoms of posing a danger to self and others.Review of the Resident Care Card (RCC) dated 3/21/26 identified the following resident care interventions: assist resident with hand hygiene and monitor/record for target behavior symptoms, agitation, and restlessness.2. Resident #2 was admitted to the facility March 2026 and had diagnoses which included dementia, cognitive communication deficit, and post-traumatic stress disorder, unspecified.The comprehensive Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 as severely cognitively impaired (Brief Interview for Mental Status (BIMS) score of 6), required maximal assistance with lower body dressing and personal hygiene, and had wandering behavior. The Resident Care Plan (RCP) dated (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	3/26/26 identified Resident #2 had a diagnosis of dementia with wandering occurring and roommate incompatibility with recent room transfer. Interventions directed to assist the resident in orienting to a new setting, routine and caregivers, to introduce to compatible peers, and to encourage the resident to verbally express his/her daily needs and feelings of loss/worry.A nurse's note dated 3/20/26 at 2:33 PM identified Resident #2 was admitted to room [ROOM NUMBER] at 12:00 PM.A nurse's note by LPN #2 on 3/21/26 at 6:00 PM identified Resident #2 got into an argument with Resident #1, they were separated several times, and the supervisor was called. Resident #1 and Resident #2 were redirected with an activity without further issue. A Reportable Event (RE) form dated 3/22/26 at 8:05 AM identified a witnessed, verbal altercation turned physical when Resident #1 struck Resident #2 on the left cheek, causing bruising/swelling and a small 0.5-centimeter laceration to the left cheek. Interventions included a one-to-one assignment for Resident #1 until hospital transfer for a psychiatric evaluation (which cleared Resident #1 of harm to self and others); Resident #2's neurological status was evaluated and room changed per family request.A written statement by NA #2 on 3/22/26 identified he/she was two doors down when he/she overheard Resident #1 yelling at Resident #2. NA #2 indicated he/she observed Resident #2 pushing his bedside table forward (not into Resident #1) and Resident #1 punching Resident #2 on the left side of his face. NA #2 immediately separated the residents and called for assistance from staff. Review of the RCP for Resident #1 identified the following interventions were added following the 3/22/26 incident: a one-to-one monitor for safety, a psychiatric/psychogeriatric consult as indicated, and fear that others may steal his/her personal belongings, particularly his/her remote control, his/her behavior tended to escalate when he/she noticed unfamiliar individuals in the environment, to reduce anxiety, staff was to proactively introduce new staff and residents and provide frequent reassurance regarding who was present.Review of the RCC for Resident #1 dated 3/22/26 through 3/27/26 identified the following resident care interventions: assist resident with hand hygiene and monitor/record for target behavior symptoms, agitation, and restlessness.An RE dated 3/28/26 at 6:25 PM identified LPN #1 heard yelling in the hallway and witnessed Resident #2 getting pushed by Resident #1, falling, and striking his/her head on the floor, which resulted in a small laceration to the crown of Resident #2's head. Interventions involved assigning a one-to-one monitor to Resident #1 and administering a cool compress to his/her tongue due to an injury sustained during the incident. Resident #2 was transferred to the hospital for further evaluation with no injury identified. A written statement by LPN #1 on 3/28/26 identified he/she heard yelling while at the nurse's station and observed Resident #1 and Resident #2 standing in close proximity, yelling at each other. While running down the hallway, calling out to the residents, LPN #1 witnessed Resident #1 strike Resident #2, Resident #2 strike Resident #1, and Resident #1 return to strike while pushing Resident #2. LPN #1 further indicated Resident #2 lost his/her balance, fell to the floor and struck his/her head with Resident #1 partially landing on Resident #2. Resident #1 was able to get up and ambulate away from the area, LPN #1 called for assistance, and applied direct pressure to Resident #2's head due to active bleeding. Review of the RCP for Resident #1 identified a one-to-one monitor was assigned on 3/28/26, however failed to identify additional interventions to deter/prevent further altercations between Resident #1 and other residents.A provider's note by APRN #1 on 3/29/26 at 8:42 AM identified the one-to-one monitor was discontinued for Resident #1.Review of clinical documentation identified the implementation of fifteen (15) minute checks for Resident #1 starting 3/29/26 through 4/7/26 and restarting on 4/9/26 through 4/10/26.Review of the RCC for Resident #1 dated 3/28/26 through 4/9/26 identified the following resident care interventions: assist resident with hand hygiene and monitor/record for target behavior symptoms, agitation, and restlessness (no changes were made to the RCC since 3/21/26). An RE dated 4/10/26 at 3:40 PM identified Resident #2 entered Resident #1's room, Resident #1 yelled at and punched Resident #2, and Resident #2 hit Resident #1 back. Interventions involved assigning a one-to-one monitor to Resident #1, psychiatric evaluation, Physician's Emergency Certificate for medical/behavioral evaluation, and hospital transfer. Resident (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#2 was administered Tylenol and ice to his/her cheek.Interview with NA #1, assigned to Resident #1 on 4/10/26 during the 3:00 PM to 11:00 PM shift, on 4/24/26 at 11:12 AM identified he/she had only worked with Resident #1 twice prior to the 4/10/26 incident and was unfamiliar with Resident #2. NA #1 identified he/she was in the hallway near Resident #1's room when he/she observed Resident #2 walk by. NA #1 indicated he/she asked Resident #2 where his/her walker was because he/she had an unsteady gait. Resident #2 responded he did not know and entered Resident #1's room. NA #1 identified he/she followed Resident #2 into Resident #1's room, informed Resident #2 it was not his/her room and tried to guide him/her out to locate the walker. However, Resident #1 yelled at Resident #2 to get the f**k out of his/her room, and as NA #1 attempted to guide Resident #2 out of the room, Resident #2 touched Resident #1's walker and was punched in the face by Resident #1. Resident #2 punched back, and the two residents continued to exchange punches until NA #3 entered the room and was able to redirect Resident #2 out of the room. NA #1 further identified he/she received report regarding the residents at the start of the shift, however, did not receive specific instructions regarding Resident #1 and Resident #2 needing to be kept at a safe distance from each other or how to manage them if in close proximity, and was unaware of previous altercations between them.Interview with the Director of Nursing Services (DNS) on 4/24/26 at 9:15 AM identified he/she implemented and relied on staff huddles at the beginning and end of each shift to communicate issues, concerns or incidents between Resident #1 and Resident #2. The DNS further indicated that new staff (who had never worked on the secured unit before) would get direct report from the charge nurse with specific instructions on how to manage Resident #1 and Resident #2 when in close proximity of one other and strategies for how to maintain ample distance between them. The DNS identified the RCP and RCC for Resident #1 was not updated with specific interventions as he/she implemented what was thought to be appropriate at the time while investigating the cause of Resident #1's aggression and was utilizing huddles to manage and communicate issues/concerns amongst floor staff. The DNS further indicated Resident #1's medications were adjusted at that time and felt that would have been sufficient to satisfy/modify his/her behaviors.Review of the Abuse Policy and Procedure identified each resident has the right to be free from abuse, neglect, and misappropriation of resident property and exploitation and it was the policy of all National Health Care Associates facilities to encourage an environment that recognizes the special qualities of its residents and provide them with a safe environment.PAST NON-COMPLIANCE:The facility presented a corrective action plan dated 3/31/26 which included:Immediate Interventions: Separating residents, initiating 1:1 observation, updating care plans to include triggers, early warning signs, specific deescalation strategies, adding behavior specific interventions.Trends and Concerns: Care plans lack specific target behavior/deescalation strategies with root cause of failure to proactively identify and manage behavioral triggers.Implementation of the following corrective actions: Care Plan Optimization, Mandatory Staff Education, and Clinical Review/IDT reviewStaff education/training: Deescalating aggressive behavior, Dementia Communication, Programming and ObservationOn-going steps/follow up audits to ensure corrective actions remain in place and the facility is in substantial compliance: Resident Engagement; Process Review, Care plan drives care, Care Observations, Abuse reporting, HCW Interviews and Observations.Date of Substantial Compliance: 4/11/26

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, interviews, and review of facility documentation and policies for one (1) of three (3) residents (Resident #1) reviewed for care planning, the facility failed to update Resident #1's plan of care with specific care instructions following the 3/28/26 physical altercation to ensure a cognitively impaired resident (Resident #2) on a secured unit was kept safe from harm. The findings included: Resident #1 was admitted to the facility April 2025 and had diagnoses of dementia, anxiety disorder, and violent behavior.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 as severely cognitively impaired (Brief Interview for Mental Status (BIMS) score of 5), required partial assistance with bathing and personal hygiene, and was able to ambulate fifty (50) feet with supervision/touch assistance. The Resident Care Plan (RCP) dated 3/25/26 identified Resident #1 had the potential to be physically aggressive related to progressive cognitive impairment. Interventions identified Resident #1 expressed fear that others may steal his/her personal belongings, particularly his/her remote control, his/her behavior tended to escalate when he/she noticed unfamiliar individuals in the environment, to reduce anxiety, staff was to proactively introduce new staff and residents and provide frequent reassurance regarding who was present, and to monitor, document, and report signs/symptoms of posing a danger to self and others.Review of the Resident Care Card (RCC) for Resident #1 dated 3/22/26 through 3/27/26 identified the following resident care interventions: assist resident with hand hygiene and monitor/record for target behavior symptoms, agitation, and restlessness.A Reportable Event (RE) Form 3/28/26 at 6:25 PM identified LPN #1 heard yelling in the hallway and witnessed Resident #2 getting pushed by Resident #1, falling, and striking his/her head on the floor, which resulted in a small laceration to the crown of Resident #2's head. Interventions involved assigning a one-to-one monitor to Resident #1 and administering a cool compress to his/her tongue due to an injury sustained during the incident. Resident #2 was transferred to the hospital for further evaluation with no injury identified. Review of the RCP for Resident #1 identified a one-to-one monitor was assigned on 3/28/26, however failed to identify additional interventions to deter/prevent further altercations between Resident #1 and other residents.A provider's note by APRN #1 on 3/29/26 at 8:42 AM identified the one-to-one monitor was discontinued for Resident #1.Review of the RCC for Resident #1 dated 3/28/26 through 4/9/26 identified the following resident care interventions: assist resident with hand hygiene and monitor/record for target behavior symptoms, agitation, and restlessness (no changes were made to the RCC since 3/21/26). An RE dated 4/10/26 at 3:40 PM identified Resident #2 entered Resident #1's room, Resident #1 yelled at and punched Resident #2, and Resident #2 hit Resident #1 back. Interventions involved assigning a one-to-one monitor to Resident #1, psychiatric evaluation, Physician's Emergency Certificate for medical/behavioral evaluation, and hospital transfer. Resident #2 was administered Tylenol and ice to his/her cheek.Interview with NA #1, assigned to Resident #1 on 4/10/26 during the 3:00 PM to 11:00 PM shift, on 4/24/26 at 11:12 AM identified he/she had only worked with Resident #1 twice prior to the 4/10/26 incident and was unfamiliar with Resident #2. NA #1 further identified he/she received report regarding the residents at the start of the shift, however, did not receive specific instructions regarding Resident #1 and Resident #2 needing to be kept at a safe distance from each other or how to manage them if in close proximity, and was unaware of previous altercations between them.Interview with the Director of Nursing Services (DNS) on 4/24/26 at 9:15 AM identified he/she implemented and relied on staff huddles at the beginning and end of each shift to communicate issues, concerns or incidents between Resident #1 and Resident #2. The DNS further indicated that new staff (who had never worked on the secured unit before) would get direct report from the charge nurse with specific instructions on how to manage Resident #1 and Resident #2 when in close proximity of one other and strategies for how to maintain ample distance between (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	them. The DNS identified the RCP and RCC for Resident #1 was not updated with specific interventions as he/she implemented what was thought to be appropriate at the time while investigating the cause of Resident #1's aggression and was utilizing huddles to manage and communicate issues/concerns amongst floor staff.The Baseline/Comprehensive Person-Centered Care Plan policy directed the Comprehensive Person-Centered Care Plan would be kept current by all disciplines on an outgoing basis and disciplines would be responsible for updating the care plan when there was a new problem that required that discipline to intervene.