STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075241	A. Building B. Wing	08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Glen Health Care Center	162 South Britain Rd Southbury, CT 06488

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. (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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation(s), review of the clinical record, facility policy and interviews for 1 of 4 residents (Resident #118) reviewed for respiratory care, the facility failed to properly store medication and obtain a physician order with completion of a self administration assessment for a resident with chronic obstructive pulmonary disease (COPD). The findings include:Resident #118's diagnoses included COPD, chronic respiratory failure with hypoxia, emphysema, and pneumonia. A physician's order dated 7/16/25 directed Ventolin HFA (a bronchodilator used to treat asthma) aerosol solution 108mcg/act (Albuterol Sulfate HFA) 2 puffs inhaled orally every 4 hours as needed for shortness of breath.The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #118 was cognitively intact and required partial/moderate assistance with bed mobility, transfers, and toileting. The MDS indicated Resident #118 was on continuous oxygen therapy. The Resident Care Plan (RCP) dated 7/29/25 identified Resident #118 had a risk for respiratory impairment related to COPD and an infection of the respiratory tract (pneumonia). Interventions included to administer medications and treatments per the physician's order and to monitor lung sounds and changes in respiratory rate and effort.The Medication Administration Record (MAR) for August 2025 identified Resident #118 had a physician's order for Ventolin HFA Aerosol Solution 108 mcg/act (Albuterol Sulfate HFA) 2 puffs inhaled orally every 4 hours as needed for shortness of breath. The MAR failed to indicate documentation of any dates or times of administration of Ventolin to Resident #118 from 8/1/25 through 8/14/25.A physician's progress note dated 8/4/25 at 11:24 AM identified Resident #118 had a chest x-ray ordered for acute worsening of a cough with congestion and was declining nebulizer treatments and preferred to use a metered dose inhaler.A respiratory treatment progress note dated 8/4/25 at 11:54 AM identified Resident #118 had an increased cough and congestion with coarse rhonchi and an expiratory wheeze throughout his/her lung fields. The progress note recommended to continue maintenance inhalers.A physician's progress note dated 8/7/25 at 11:16 AM identified Resident #118 had developed congestion and a cough with some wheezing. The progress note indicated Ventolin as a current medication.A physician's progress note dated 8/11/25 at 6:21 PM identified Resident #118's cough and shortness of breath had improved, and the resident didn't feel the nebulizer was helpful and preferred to use a metered dose inhaler.Observation and interview with Resident #118 on 8/14/25 at 9:50 AM identified he/she had an Albuterol Inhaler on the nightstand next to his/her bed and that it was given to him/her by the facility. Resident #118 indicated he/she kept the inhaler next to his/her and would self-administer the inhaler as needed 3-4 times per day. Resident #118 stated the nurses were aware he/she had the inhaler at the bedside, and he/she was not asked by and did not inform the nurses when he/she self-administered the inhaler or what its effectiveness was.An interview and observation with Nurse Aide (NA) #3 on 8/14/25 at 9:55 AM identified Resident #118 was in bed and an Albuterol inhaler was unsecured/not locked up on the nightstand next to the bed. NA #3 indicated the inhaler was always there and she had observed Resident #118 using the inhaler on a few occasions. NA #3 identified although medications should not be left at a resident's bedside, she failed to inform the nurse the inhaler was there and should have. An interview, observation, and review of the clinical record on 8/14/25 at 10:00 AM with Licensed Practical Nurse (LPN) #3 identified Resident #118 was in bed and an Albuterol inhaler was resting on the nightstand next to the bed. LPN #3 indicated although it was not brought to her attention by other staff, she had observed the Albuterol inhaler on the resident's nightstand and was aware the resident was using it. LPN #3 identified the inhaler was from the facility and contained a pharmacy label on its side which indicated the resident's name and the name of the medication. Review of the clinical record with LPN #3 failed to identify Resident #118 had a physician's order to self-administer or a self-administration assessment completed for the use of the Albuterol inhaler. LPN #3 further indicated the Albuterol inhaler should have been locked in the medication cart between uses and not left on Resident #118's nightstand. LPN #3 proceeded to remove the Albuterol inhaler from Resident #118's room and locked the inhaler in the medication cart.Interview and review of the clinical record on 8/14/25 at 10:10 AM with the RN Supervisor (RN # 2) identified the Albuterol inhaler should not have been at Resident #118's bedside and review of the clinical record failed to indicate a physician's order for self-administration, or a self-administration of medication assessment had been completed for the resident. RN #2 indicated it was the responsibility of the nurse who verified the physician's order to clarify with the physician and assess the resident for self-administration. RN #2 identified that even with the physician's order for self-administration and an

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F 0578 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility policy and interviews for the 1 of 32 sampled residents (Resident #2) reviewed for advanced directives, the facility failed to ensure advanced directives were consistent. The findings include:Resident #2's was admitted to the facility on [DATE] with diagnoses that included Parkinson's disease, acute respiratory failure with hypercapnia (retention of carbon dioxide) and chronic kidney disease. A State of Connecticut Department of Public Health transfer of Do Not Resuscitate (DNR) order form signed by the physician on [DATE] indicated Resident #2 had a valid DNR order which was written on [DATE] and was retained in the resident's medical record. A hospital discharge summary for Resident #2 dated [DATE] at 11:59 PM identified the discharge code status as do not resuscitate/do not intubate (DNR/DNI). An admission physician's order dated [DATE] indicated Resident #2 was a DNR. An Advanced Practice Registered Nurse (APRN) order written by APRN #2 dated [DATE] directed Resident #2 was a Full Code (meaning in the event of his/her heart stopping, cardiopulmonary resuscitation would be performed). An APRN #2 progress note dated [DATE] at 9:45 AM identified Resident #2 had a code status of Full Code/CPR (despite the physician signed State of Connecticut Department of Public Health transfer of DNR order form dated [DATE] and physician order indicating DNR). The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 was cognitively intact and required partial/moderate assistance with bed mobility, toileting, and transfers. A Resident Care Plan (RCP) dated [DATE] identified Resident #2 had an advance directive for a full code (perform CPR). Interventions included to honor and to re-evaluate advance directives as needed. (despite the physician signed State of Connecticut Department of Public Health transfer of DNR order form dated [DATE] and physician order indicating DNR). Review of Resident #2's clinical record on [DATE] at 11:06 AM identified Resident #2 had both a DNR and Full Code order in place. Interview and review of the clinical record with the Registered Nurse supervisor (RN #2) on [DATE] at 10:16 AM identified Resident #2 was a full code based on what was listed on the resident's face sheet. Review of the active physician's orders for Resident #2 with RN #2 indicated the resident had both DNR and Full Code orders in place. RN #2 identified the [DATE] admission DNR order was signed by the physician on [DATE] and a [DATE] Full Code order from APRN #2 was also signed on [DATE]. RN #2 indicated Resident #2's advanced directive orders were confusing, and the resident should not have had two different advanced directive orders in place at the same time. RN #2 indicated she was unsure what Resident #2's current code status was, and she was unable to indicate why a new order was written by APRN #2 on [DATE] for Resident #2 to be a Full Code. RN #2 indicated she would immediately address the residents advanced directives with the resident and the physician and make the necessary corrections. Subsequent to surveyor inquiry, Resident #2's DNR/DNI order (dated [DATE]) was discontinued on [DATE] and Resident #2 was made a Full Code. Attempts to interview APRN #2 were unsuccessful. Review of facility policy, Advanced Directives, dated [DATE], directed a resident has the right to formulate an advanced directive and advanced directives are honored in accordance with state law and facility policy. The policy further directed that if the resident has executed an advanced directive, copies of the documents are obtained and maintained in the same section of the resident's medical record and are readily retrievable by any facility staff. The resident's wishes are communicated to the resident's physician and direct care staff by placing the advance directive documents in a prominent accessible location in the medical record.

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview and the Resident Assessment Instrument (RAI) manual policy for the only resident reviewed for communication/sensory (Resident #8), for 1 of 3 reviewed for pressure ulcers (Resident #15), for the only sampled resident reviewed for position/mobility (Resident #90) and for 1 of 3 reviewed for accidents (Resident #117), the facility failed to ensure that the Minimum Data Set (MDS) assessment was coded correctly for the use of hearing aids (Resident #8), limited range of motion (Resident #15), position/mobility (Resident #90) and falls (Resident #117). The findings include: 1.Resident #8 diagnoses included failure to thrive, heart failure, and osteoarthritis. The Resident Care Plan (RCP) dated 5/22/25 identified Resident #8 was hard of hearing with interventions that included to attempt to minimize noise, refer to audiology as needed and when talking to Resident #8, use simple sentences, maintain eye contact and use gestures. The RCP lacked documentation that Resident #8 utilized hearing aids until 8/14/25 indicating an appointment was scheduled with a hearing aide company. A 6/7/25 Nursing readmission Evaluation identified that Resident #8 had hearing aids for both ears and hearing was adequate with the use of hearing aids. The 5-day Medicare Minimum Data Set (MDS) assessment dated [DATE] identified Resident #8 was cognitively intact, required supervisor/set up for activities of daily living and did not utilize hearing aids (despite the 6/7/25 Nursing readmission Evaluation identifying Resident #8 utilized hearing aids in both ears). An interview with Resident #8 on 8/11/25 at 12:35 PM identified that his/her right hearing aid was not working. When the interview started, Resident #8 turned his/her head to the right and pointed to his/her right ear. Resident #8 stated speak loudly so I can hear you. Resident #8 had the left hearing aid in his/her ear. Resident #8 indicated she made staff aware a few weeks ago that the right hearing aid was not working but was not sure who he/she told. Resident #8 indicated that he/she had hearing aids for a very long time and got them from a hearing aid company prior to coming to the facility. Resident #8 stated he/she always wears the hearing aids until recently when the right hearing aid stopped working a few weeks ago. Resident #8 indicated that he/she takes care of the hearing aids independently and that he/she puts them in his/her ears every morning and removes them and places them in the recharger case every night (the recharger case was stored in the top drawer of Resident #8's nightstand). Resident #8 demonstrated his/her routine with hearing aids while describing the process. A facility contracted audiology consult form dated 9/17/24 identified that Resident #8 had a right and left hearing aid from a hearing aid company. The aids were cleaned for wax and debris and were functioning at that time. Resident #8 declined to receive new hearing aids at that time and no follow up audiology consults were in the clinical record. Observations of Resident #8 on 8/14/25 and 8/15/25 at 9:00 AM noted Resident #8 had his/her hearing aid in the left ear only. (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Interview with Nurse Aide (NA) #2 on 8/14/25 at 9:20 AM identified that she was Resident #8's primary aide on 7-3 shift. She indicated that she was aware that Resident #8 was hard of hearing and wears hearing aids. Interview with RN #1 on 8/14/25 at 10:05 AM indicated that she completed the MDS for Resident #8 and that Resident #8 did not have hearing aids. When informed that Resident #8 had hearing aids, RN #1 stated then Resident #8 must not wear them. RN #1 indicated that she coded section B on the MDS as Resident #8 not having hearing aids because Resident #8 must not have had them in. RN #1 was informed that Resident #8 indicated that he/she always wore the hearing aids up until a few weeks ago when Resident #8 stopped wearing the right hearing aid as it was not functioning. RN #1 stated she was not aware. 2. Resident #15 had diagnoses that included dementia, anemia, and hypertension. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #15 was severely cognitively impaired, had no signs/symptoms of a possible swallowing disorder, had no functional limitation in range of motion to his/her upper extremities, had impairment in functional range of motion to both lower extremities, and required substantial/maximal assistance with eating, bed mobility, and chair/bed transfers. The Resident Care Plan (RCP) dated 6/28/25 identified Resident #15 had a self care deficit related to impaired mobility, cognition, and failure to thrive. Interventions included to assist at meals, assist to bathe as needed, and to assist with activities of daily living. The RCP failed to identify Resident #15 had contractures or stiff extremities that caused difficulty with positioning due to limited range of motion. A nutritional follow-up note written by the Dietician on 6/30/25 at 2:53 PM identified Resident #15 exhibited delayed swallowing with an occasional cough, had been seen by speech therapy and his/her liquid portion of diet was changed to mildly thick liquids. The note identified Resident #15 was dependent for eating. A nursing note written by Licensed Practical Nurse (LPN) #1 on 7/3/25 at 11:49 AM identified Resident #15 was seen by the wound Advanced Practice Registered Nurse (APRN) that morning, had been very hard to turn in bed and Resident #15 was noted to be very contracted. A Physical Therapy Evaluation and Plan of Treatment note written by Physical Therapist (PT) #2 and dated 7/11/25 at 3:13 PM identified Resident #15 had been seen for a PT evaluation due to positioning difficulties. The note identified Resident #15 had severe rigidity with loss of functional mobility of his/her bilateral lower extremities, bilateral upper extremities, and trunk (torso). The note identified Resident #15 had extensor tone (tension in the muscle groups responsible for extending the arms and legs) that was severe when lying on his/her back in bed and when sitting in the wheelchair. The note identified Resident #15's mobility function score (ranges from 0-12 with 12 being the highest function) was 0 and identified Resident #15 was dependent for bed mobility and bed/chair transfers. (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #15 was severely cognitively impaired, had no signs/symptoms of a possible swallowing disorder, had no functional limitation in range of motion to his/her upper or lower extremities, and required substantial/maximal assistance with eating, bed mobility, and chair/bed transfers. The MDS assessment failed to identify Resident #15 had functional limitation in range of motion to both upper and both lower extremities, and was dependent for all functional mobility areas (eating, oral hygiene, toileting hygiene, shower/bathing, upper and lower body dressing, putting on/taking off footwear, personal hygiene, bed mobility, sit to lying, lying to sitting, and transfers). Interview and clinical record review with the MDS Coordinator (RN #7) on 8/15/25 at 11:40 AM identified the quarterly MDS assessment dated [DATE] showed he/she had a functional limitation in range of motion to both side of the lower extremities, but the quarterly MDS assessment dated [DATE] showed Resident #15 had no functional limitation in range of motion to his/her upper or lower extremities. RN #7 identified the documentation of no functional limitation in range of motion in the 7/11/25 quarterly MDS assessment was incorrect. Interview and clinical record review with MDS Coordinator (RN #1) on 8/15/25 at 12:00 PM identified she was aware Resident #15 was dependent for eating, bed mobility, chair/bed transfers, but had coded Resident #15's section GG of the quarterly MDS' dated 6/19/25 and 7/11/25 as substantial/maximal assistance for eating, bed mobility, and chair/bed transfers. RN #1 identified that she was unable to code the MDS assessments as dependent for Resident #15's functional mobility areas even though there was physician documentation, rehabilitative therapy documentation, and nursing documentation that said he/she was dependent for functional mobility. RN #1 identified that all documentation must match 100% for her to code the MDS Section GG as dependent for Resident #15, and that if even 1 nurse aide (NA) documented that Resident #15 required only substantial/maximal assistance then she would have to code that functional area as substantial/maximal assistance. RN #1 further identified that the NA documentation for Resident #15's functional mobility areas consistently showed documentation of at least 1 NA inaccurately coding Resident #15's functional mobility as substantial/maximal assistance even though the NA care card directed Resident #15 was dependent. RN #1 identified that she had sent emails to the staff education and administration about the inaccurate NA documentation resulting in her having to code the GG section of MDS as substantial/maximal instead of dependent. Although requested a copy of an email sent to staff development and/or administration by RN #1 to notify them of the inaccurate documentation of NAs for the functional mobility of residents with orders that directed that they were dependent for care was not provided. 3. Resident #90 had diagnoses that included dementia, diabetes, and chronic pulmonary edema. A physician order dated 5/6/25 directed to place a right hand palm guard on at bedtime and off in the morning every day and evening shift. (The physician order failed to identify the correct hand for placement of the palm guard). The Resident Care Plan (RCP) dated 6/12/25 identified Resident #90 had a self-care deficit for activities of daily living (ADL) related to physical limitations. Interventions included Resident #90 required assist of 1 staff member for ADL's, obtain occupational therapy evaluation and treatment per physician orders, and use assistive/adaptive equipment such as rolling walker and wheelchair. (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #90 was moderately cognitively impaired, had no functional limitation in range of motion to upper or lower extremities, used a wheelchair, required setup or clean-up assistance with eating, and required substantial/maximal assistance with personal hygiene, bed mobility and chair/bed transfers. The MDS assessment failed to identify Resident #90 had a limitation in range of motion to one side of his/her upper extremities. Review of the Medication Administration Record (MAR) dated 6/1/25 through 6/30/25 identified documentation that Resident #90 had a right palm guard placed on at bedtime on the 3:00 PM to 11:00 PM shift and removed in the morning on the 7:00 AM to 3:00 PM shift. Observation on 8/11/25 at 1:24 PM and 8/12/25 at 10:46 AM identified Resident #90 located in his/her room wearing a blue palm guard splint on his/her left hand. Interview with OT #2 on 8/13/25 at 2:30 PM identified Resident #90 had a physician order for a palm guard because he/she had a contracture with hand tightness of the 3rd, 4th, and 5th fingers on his/her left hand. OT #2 identified Resident #90 had limited range of motion in his/her left hand and that it was a progressive contracture that was getting worse so the palm guards were being used to help decrease/slow down the progression of the left hand's contracture. OT #2 identified Resident #90 had 2 different palm guards. One with finger separators that was worn at night and one without finger separators that was worn in the day time. Interview and review of the clinical record with MDS Coordinator Registered Nurse (RN) #1 on 8/14/25 at 1:50 PM identified when completing the MDS assessments she collected the information she needed from Nurse Aide (NA) documentation, nursing notes/documentation and rehabilitation/therapy notes/documentation. RN #1 identified she must have missed the physician order for Resident #90's palm guard. 4. Resident #117's diagnosis included pneumonia, heart failure, and chronic kidney disease. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #117 was moderately cognitively impaired and required set-up assist with eating. Also, Identified Resident#117 required partial moderate assistance for toileting, personal hygiene, and transfers. Further, identified Resident #117 required substantial moderate assistance for bathing and had falls prior to admission within the last 2 to 6 months. The Resident Care Plan (RCC) dated 7/10/25 identified Resident #117 was a risk for falls due mobility, ambulation, weakness, cognition, and recent falls at home, intervention to maintain bed in a low position, staff to reinforce the need to call for assistance, and have commonly used articles within easy reach. A facility Accident and Incident report dated 7/25/25 at 1:15 PM identified Resident #117 had an unwitnessed fall and sustained a large, raised area to left posterior side his/her head(hematoma). Also, identified Resident #117 was trying to get up and reach his/her wheelchair and fell to the floor hitting his/her head on the tray table. Nursing notes dated 7/25/25 at 2:42 PM identified Resident #117 had an unwitnessed fall and had pain to the left side of his/her posterior head. (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	The Resident Care Plan (RCC) dated 7/25/25 identified Resident #117 was at risk for falls due to mobility, ambulation, weakness, cognition, recent fall at home, Chronic Foley Catheter, interventions to keep the resident's wheelchair locked at the bedside, provide assistance to transfer and ambulate as needed. The Reentry Minimum Data Set (MDS) dated for7/28/25 identified Resident #117 as cognitively intact, and requiring moderate assistance for toileting, and maximal assistance for bathing, and transfers. Further, identifying Resident #117 had a fall without an injury (which did not identify the fall of 7/25/25 where Resident #117 sustained a hematoma to the head). An interview on 8/14/25 at 1:51 PM with Registered Nurse (RN) #7 identified the MDS dated [DATE] coded the fall incorrectly and should have been coded for fall with a minor injury. Further, identifying it was an oversight, and falls were reviewed during the daily morning report meeting. The Resident Assessment Instrument (RAI) manual identified that when a resident has a fall with a minor injury, the MDS should be coded to reflect the fall with a minor injury. Also, identifying a minor injury as skin tears, abrasions, lacerations, superficial bruises, hematomas, sprains and any other injury that causes the residents to complain of pain. Review of the MDS 3.0 Resident Assessment Instrument (RAI) Manual which contained instructions the facility must follow when submitting MDS assessments directed, in part a resident's functional status can be impacted by the environment or situations encountered at the facility. Observing the resident's interactions with others in different locations and circumstances is important for a comprehensive understanding of the resident's functional status. If the resident's functional status varies, record the resident's usual ability to perform each activity. Do not record the resident's best performance and do not record the resident's worst performance, but rather record the resident's usual performance. The manual directed when coding the resident's usual performance, use the six-point scale (Code 06-independent, Code 05-setup or clean-up assistance, Code 04-supervision or touching assistance, Code 03-partial/moderate assistance, Code 02-substantial/maximal assistance, and Code 01-dependent). The manual directed to use Code 02-substantial/maximal assistance if the helper does more than half the effort to complete the activity. The manual further directed to use Code 01-dependent if the helper does all of the effort and the resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete the activity.

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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 observations, review of the clinical record, interviews and facility policy for the only resident reviewed for communication/sensory (Resident #8), for 1 of 3 sampled resident (Resident #32) reviewed for pressure ulcers, for the only sampled resident reviewed for positioning (Resident #90), the facility failed to ensure a comprehensive care plan was in place for hearing (Resident #8), for refusals of care (Resident #32) and for functional limitation in range of motion (Resident #90). The findings include: 1.Resident #8 diagnoses included failure to thrive, heart failure, and osteoarthritis. A facility contracted audiology consult form dated 9/17/24 identified that Resident #8 had a right and left hearing aid from another company. The aids were cleaned for wax and debris and were functioning. Resident #8 declined to receive new hearing aids at that time. No follow up audiology consults were in the clinical record. The Resident Care Plan (RCP) dated of 5/22/25 identified Resident #8 was hard of hearing with interventions that included to attempt to minimize noise, refer to audiology as needed and when talking to Resident #8 use simple sentences, maintain eye contact and use gestures. The RCP failed to include that Resident #8 utilized hearing aids until 8/14/2025 indicating an appointment was scheduled with Miracle Ear. A Nursing re-admission Evaluation dated 6/7/25 identified that Resident #8 had hearing aids for both ears and hearing was adequate with the use of hearing aids. The 5-day Medicare Minimum Data Set (MDS) assessment dated [DATE] identified Resident #8 was cognitively intact and required supervision/set up for activities of daily living and did not utilize hearing aids. An interview with Resident #8 on 8/11/25 at 12:35 PM noted that his/her right hearing aid was not working. When the interview started, Resident #8 turned his/her head to the right and pointed to his/her right ear. Resident #8 stated speak loudly so can I hear you. Resident #8 had the left hearing aid in his/her ear and indicated he/she made staff aware a few weeks ago that the right hearing aid was not working but was not sure who he/she told. Resident #8 indicated that he/she has had hearing aids for a very long time and got them from a hearing aid company prior to coming to the facility. Resident #8 stated he/she always wore the hearing aids but stopped wearing the right hearing aid a few weeks ago when it stopped working. Resident #8 indicated that he/she takes care of the hearing aids independently. Resident #8 stated that he/she puts them in his/her ears every morning and removes them and places them in the recharger case every night. The recharger case was stored in the top drawer of Resident #8's nightstand Observations of Resident #8 on 8/14/25 and 8/15/25 at 9:00 AM noted Resident #8 had his/her hearing aid in the left ear. Interview with Nurse Aide (NA) #2 on 8/14/25 at 9:20 AM identified that she was Resident #8's primary aide on 7:00 AM to 3:00 PM shift and was aware that Resident #8 was hard of hearing and wore hearing aids. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Glen Health Care Center	162 South Britain Rd Southbury, CT 06488

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with RN #1 on 8/14/25 at 10:05 AM indicated that she completed the MDS and care plan for Resident #8 she was not aware Resident #8 wore hearing aids and that nurses update the care plan most of the time Subsequent to surveyor inquiry, the interim DNS indicated that the Care Plan Coordinator was responsible for ensuring the care plan was accurate when conference meetings were conducted. 2.Resident #32's was admitted to the facility on [DATE] with diagnosis that included heart failure, diabetes and chronic kidney disease. A nursing note dated 5/15/25 identified Resident #32 was admitted to the facility on [DATE] and consultation was requested for evaluation of the resident's right buttock. Also, identifying Resident #32 refused to have her right heel evaluated. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #32 was cognitively intact, required maximal assistance for bathing and toileting. Also, identified Resident #32 required moderate assistance for transfers and set up assistance for eating. A nursing note dated 5/21/25 identified Resident #32 refused to be weighed and stated, I am not doing my weights every day. A nursing note dated 5/22/25 identified Resident #32 refused to have an evaluation of his/her right heel. A nursing note dated 5/28/25 identified Resident #32 refused a shower. The Resident Care Plan (RCP) dated 6/19/25 identified Resident #32 had actual skin breakdown to the right heel and a reopened stage 2 ulcer. Interventions included to administer treatment per physician orders, flex boot while the resident was in bed, and wound consultation as needed. A wound care specialist note dated 6/19/25 at 8:10 PM identified Resident #32 refused to allow the dressing to the right heel be removed for an assessment. Also, identifying education was provided to Resident #32 about the risk of the area worsening. The quarterly Minimum Data Set (MDS) dated [DATE] identified Resident #32 as cognitively intact and required moderate assistance for dressing. Also, identified Resident #32 required maximal assistance with showering, toileting and transfers. Further, refusal of care was not identified. A nursing note dated 8/14/25 identified Resident #32 refused to wear flex boots at night. An interview on 8/13/25 at 1:59 PM with Registered Nurse (RN) #6 Identified Resident #32 often refused care. An interview on 8/14/25 at 11:26 AM with the Advanced Practice Registered Nurse (APRN) identified Resident #32 refused a wound care and assessments at times. Also, identifying Resident #32 refused to have his/her heel evaluated until 6/19/25 although several attempts were made to assess the wound to the right heel from Resident #32's admission of 5/10/25. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 8/14/25 at 11:30 AM with Licensed Practical Nurse (LPN)#1 identified Resident #32 refused care often. An interview on 8/14/25 at 11:32 AM with LPN #5 identified Resident #32 refused his/her boots and wound care to the right heel numerous times. Also, identifying if the resident refused care, she would chart the resident's refusal of care and inform the supervisor on duty On 8/14/2025 at 11:39 AM an interview and review of the RCP with the DNS identified Resident #32 had a history of refusals of care and the resident did not have care plan for refusals. Also, identifying she did not know the policy for refusal of care 3.Resident #90 had diagnoses that included dementia, diabetes, and chronic pulmonary edema. The Resident Care Plan (RCP) dated 4/14/25 identified Resident #90 had a self-care deficit for activities of daily living (ADL) related to physical limitations. Interventions included to provide assistance of 1 staff member for ADL's, obtain occupational therapy evaluation and treatment per physician orders, and use assistive/adaptive equipment such as rolling walker and wheelchair. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #90 was moderately cognitively impaired, had no functional limitation in range of motion to upper or lower extremities, used a wheelchair, required setup or clean-up assistance with eating, and required substantial/maximal assistance with personal hygiene, bed mobility and chair/bed transfers. The MDS assessment further identified Resident #90 had received occupational therapy services that began on 4/9/25. A Status Update Form signed by Occupational Therapist (OT) #2 on 5/6/25 directed to place a left palm roll at night with evening care and remove in the morning with morning care. A physician order dated 5/6/25 directed to place a right hand palm guard on at bedtime and off in the morning every day and evening shift. The order failed to identify the correct hand for placement of the palm guard (per OT note dated 5/6/25, the left palm required a palm roll). The Resident Care Plan (RCP) dated 6/12/25 identified Resident #90 had a self-care deficit for activities of daily living (ADL) related to physical limitations. Interventions included Resident #90 required assist of 1 staff member for ADL's, obtain occupational therapy evaluation and treatment per physician orders, and use assistive/adaptive equipment such as rolling walker and wheelchair. The RCP failed to identify Resident #90 had limited range of motion in his/her left hand which required use of a palm guard splint for management. Additionally, the use of the palm guard also limited Resident #90's range of motion and use of the left hand while it was being worn. Review of the Medication Administration Record for June 2025 for the dates of 6/1/25-6/30/25 identified documentation that Resident #90 had a right palm guard placed on at bedtime on the 3:00 PM to 11:00 PM shift and removed in the morning on the 7:00 AM to 3:00 PM shift (a discrepancy regarding Resident #90's left hand requiring the palm). Observation on 8/11/25 at 1:24 PM in Resident #90's room identified Resident #90 wore a blue palm guard splint on his/her left hand (not right hand). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 8/12/25 at 10:46 AM in Resident #90's room identified Resident #90 wore a blue palm guard splint on his/her left hand (not right hand). Interview with OT #2 on 8/13/25 at 2:30 PM identified Resident #90 had an order for a left palm guard because he/she had a contracture with hand tightness of the 3rd, 4th, and 5th fingers on his/her left hand. OT #2 identified Resident #90 had limited range of motion in his/her left hand and that it was a progressive contracture that was getting worse so the palm guard was being used to help decrease/slow down the progression of the left hand's contracture (not right hand). OT #2 identified Resident #90 had 2 different palm guards, one with finger separators that was worn at night and one without finger separators that was worn in the day time. OT #2 was not aware the physician order entered by the nursing staff on 5/6/25 directed for the palm guard to be worn on the right hand. OT #2 indicated Resident #90 always had it on the left hand when he/she was seen by OT #2. Observation on 8/14/25 at 9:10 AM on the second floor west wing hallway identified Resident #90 self-propelled his/her custom wheelchair down the hall and wore a blue palm guard splint on his/her left hand. Review of the Resident Care Card (that directs the Nurse Aide on what type of care Resident #90 required) dated 8/15/25 identified under the category of Special Needs that Resident #90 had a palm roll to the left hand on at bedtime and off in the morning. Interview and review of the clinical record with MDS Coordinator Registered Nurse (RN) #1 on 8/14/25 at 1:50 PM identified when completing the MDS assessments she collected the information she needed from the Nurse Aide (NA) documentation, nursing notes/documentation and rehabilitation/therapy notes/documentation. RN #1 identified she must have missed the order for Resident #90's palm guard. Interview with MDS Coordinator RN #7 on 8/15/25 at 11:40 AM identified Resident #90's limited range of motion in his/her left hand should be in the RCP and RN #1 must have missed it. Review of the Care Plans, Comprehensive Person-Centered policy directed, in part, the comprehensive person-centered care plan includes measurable objectives and timeframes. The policy directed assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. Review of the facility policy for Requesting, refusing and/or discontinuing care or treatment identified residents have the right to request, refuse and/or discontinue treatment. Treatment refers to medical care, nursing care, and interventions provided to maintain or restore health and well-being, improve functional level, or relieve symptoms. Also, identifying if a resident requests, discontinues or refuses care or treatment, an appropriate member of the interdisciplinary team (IDT) will meet with the resident to determine why he or she was requesting, refusing or discontinuing care treatments. If the decision to refuse or discontinue treatment results in a significant change of condition, a reassessment would occur, and appropriate changes would be made to the Resident's care plan.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility policy and interviews for 1 of 3 residents (Resident #15) reviewed for advance directives, the facility failed to update the resident care plan (RCP) for a resident with comfort measures only (CMO) and no intravenous hydration (IVs). The findings include:Resident #15 had diagnoses that included dementia, anemia, and hypertension.A Do Not Resuscitate Consent Form dated [DATE] identified do not resuscitate (DNR) was discussed with Resident #15's responsible party by the Advanced Practice Registered Nurse (APRN) #4 and Resident #15's responsible party signed the form in agreement with changing Resident #15 to DNR.An APRN #4's progress note dated [DATE] at 11:53 AM identified Resident #15's code status/advance directives was changed by probate court on [DATE] from full code to DNR. The note further identified an order was in place for DNR and registered nurse may pronounce (RNP)(the RN may officially declare a resident deceased).An APRN advance directives order dated [DATE] directed DNR, RNP.The Resident Care Plan (RCP) dated [DATE] identified Resident #15 advance directives would be honored and reevaluated as needed. Interventions included to discuss advance directives with the Resident #15 and/or his/her responsible party and that Resident #15 was a full code (CPR would be performed). The RCP failed to identify Resident #15's advance directives order for DNR, RNP.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #15 was severely cognitively impaired and required substantial/maximal assistance with eating, bed mobility, and chair/bed transfers.An interview with MDS Coordinator Registered Nurse (RN) #1 on [DATE] at 1:50 PM identified she attended the RCP meetings for the long-term care residents. RN #1 identified she reviewed the advance directives if needed due to a resident's decline. RN #1 further identified she did not give a copy of the RCP to the resident/responsible party for review at the RCP meeting because the family knew the care plan and they didn't need to look at it. An interview with Licensed Practical Nurse (LPN) #3 on [DATE] at 10:10 AM identified after a change in advance directives the order would be updated by the Nursing Supervisor. LPN #3 further identified it would be the RN/Supervisor who would then be responsible for updating the care plan. LPN #3 could not identify why Resident #15's RCP had not been updated after a change in his/her advance directives.An interview with the Nursing Supervisor Registered Nurse (RN) #6 on [DATE] at 10:20 AM identified that she did not think anyone was responsible for updating the care plan for a change in advance directives. RN #6 indicated in her experience when she entered advance directives orders for new admissions it would automatically populate in the RCP without her having to go in to the RCP separately. Interview with the MDS Coordinator (RN #7) on [DATE] at 11:40 AM identified that the resident's current RCP was reviewed in the RCP meetings and that the code status was reviewed. RN #7 indicated she tried to stay away from specifics in the RCP regarding advance directives because they could change, and she was unaware why the RCP for Resident #15 indicated he/she was a full code. RN #7 indicated Resident #15's RCP should not say Resident #15 was a full code but instead that the advance directives were according to physician's orders. Review of the Advance Directives policy directed, in part, the resident has the right to formulate an advance directive , including the right to accept or refuse medical treatment. The policy directed the plan of care for each resident is consistent with his or her documented treatment preferences and/or advance directive. The policy directed changes or revocations of a advance directive must be submitted to the administrator, and the interdisciplinary team would be informed of changes so that appropriate changes can be made in the resident medical record and care plan.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, review of the clinical record and policy for 1 of 1 sampled resident (Resident #131) reviewed for death, the facility failed to ensure the Registered Nurse Pronouncement was comprehensive to include a full assessment. The findings include:Resident #131's diagnoses included congestive heart failure, cerebral infarction, and hypertension.A Resident Care Plan dated 4/17/25 identified Resident #131 had a self-care deficit related to impaired mobility and incontinence. Interventions included to aid in bathing resident as needed and provide assistance with eating, dressing, grooming and oral care as needed.The quarterly Minimum Data Set assessment dated [DATE] identified Resident #131 was cognitively intact, required substantial maximal assistance for toileting, bathing, and transfers. Also, identifying Resident #131 required set up assistance for eating.A physician's order dated 6/22/25 directed Do Not Resuscitate (DNR), Register Nurse Pronouncement (RNP), and comfort measures only.Nursing notes dated 6/22/25 at 5:34 AM and written by RN #5 identified Resident #131 was observed to not be breathing and without a heartbeat. RN pronounced Resident #131 at 5:20 AM. The next of kin, funeral home, and the Advance Practice Registered Nurse (APRN) covering for the physician was notified of Resident #131's death (the assessment failed to include pupillary reaction and lack of blood pressure).In an interview and clinical record review with RN #2 and RN #8 on 8/14/25 at 3:27 PM identified a RNP assessment needed to include heartbeat, respirations, blood pressure, and to check if pupils are dilated or responsive. Also, identifying a heartbeat should be checked for 1 full minute. Further, identifying the RN pronouncement note written on 6/22/25 was incomplete, and was missing blood pressure and pupillary reactions.Interview and clinical record review on 8/15/25 at 1:18 PM with Registered Nurse #5 identified that a RNP assessment should include breathing, blood pressure, pulse and pupils' responsiveness. Also, RN #5 identified her note from 6/22/25 failed to include pupillary responsiveness and blood pressure. RN #5 further identified she had become busy with something else, the nurse's note was incomplete, and she was responsible for performing a complete assessment upon death.Department of Public Health Public Health Code: Pronouncement of Death by a Registered Nurse7-62-1. Definitions(a) Determination of Death means observation and assessment that a person has ceasedvital bodily functions irreversibly including, but not limited to, the following: pulse,respiration, heartbeat, and pupil reaction.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for 1 of 3 residents (Resident #87) reviewed for falls, the facility failed to provide supervision for a resident who required assistance of 1 with toileting and supervision with ambulation, resulting in a fall. The findings include: Resident #87 had diagnoses that included Alzheimer's disease, macular degeneration, and hypertension.A Fall Risk Evaluation assessment dated [DATE] at 10:10 AM and completed by Registered Nurse (RN) #1 identified Resident #87 was at a high risk for falls related to poor recall, judgement, and safety awareness. Additionally, the Fall Risk Evaluation identified Resident #87 had 1-2 falls in the past 3 months. The Resident Care Plan (RCP) dated 7/2/24 identified Resident #87 was at risk for falls related to medication side effects, history of falls, and deconditioning. Interventions included to transfer Resident #87 with contact guard assistance/ hand hold assistance and a rolling walker, toilet Resident #87 on first rounds, have commonly used articles within easy reach, re-education with Resident #87 on fall precautions and to request assistance with transfers and ambulation. The RCP further identified Resident #87 had an activities of daily living (ADL) self-care deficit related to physical limitations. Interventions included that Resident #87 required assistance of 1 staff member with ADLs, and Resident #87 required limited assistance with bed mobility, extensive assistance with transfers using contact guard/hand hold, and extensive assistance with toilet hygiene.The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #87 was cognitively intact, had no falls since the previous assessment (7/12/24), used a walker for mobility, required setup or clean-up assistance with eating, partial/moderate assistance with toileting hygiene, substantial/maximal assistance with lower body dressing, and supervision or touching assistance with chair/bed (getting in out of a chair or the bed) and toilet transfers (getting on/off the toilet), and walking 10 to 50 feet.A Fall Risk Evaluation assessment dated [DATE] at 3:16 AM and completed by Licensed Practical Nurse (LPN) #4 identified Resident #87 had diminished safety awareness, had impaired mobility, was continent, required assistance with toileting, used an assistive device (walker) and had no falls in the past 3 months.Review of Resident #87's physician's orders failed to identify mobility/transfer orders.Review of the task section in the electronic medical record (EMR) identified Resident #87's toileting ability was last updated on 5/5/24 and Resident #87 required assistance of 1 staff member for toileting. The tasks identified Resident #87's ADL ability was last updated on 5/5/24 and Resident #87 required assistance of 1 staff member. The tasks identified Resident #87's transfer ability was last updated on 7/4/24 and Resident #87 required supervision with transfers using a rolling walker. The tasks identified Resident #87's ambulation ability was last updated 7/4/24 and Resident #87 required supervision with a rolling walker and indicated Resident #87 ambulated with distant supervision with frequent reminders to use his/her walker. The tasks further identified Resident #87's bed mobility ability was last updated on 7/4/24 and was left blank, but the previous bed mobility ability dated 2/8/24 identified Resident #87 required assistance of 1 person with bed mobility. A facility Reportable Event (RE) Form dated 10/18/24 at 2:45 AM identified Resident #87 was observed lying on his/her right side on his/her bathroom floor with his/her head inside the doorway and blood observed on the floor underneath his/her head. The RE identified skin tears were observed on Resident #87's bilateral knees and the right forehead. The RE further identified Resident #87 sustained a hematoma under the right eye, and Resident #87 was disoriented after being non-responsive to verbal or light tactile stimuli for over a minute. The RE indicated prior to the event Resident #87 walked independently with a rolling walker (a discrepancy with the task section in the EMR which Nurse Aides follow which identified Resident #87 required supervision with a rolling walker), independently transferred (a discrepancy with the task section in the EMR which Nurse Aides follow which identified Resident #87 required supervision with a rolling walker), independently toileted him/herself (a discrepancy with the task section of the EMR which identified Resident #87 required assistance of 1 for toileting), and required assistance of 1 staff member for bathing. The RE identified 911 was called and Resident #87 was sent to the hospital for evaluation. A nursing note written by Registered Nurse (RN) #5 on 10/18/24 at 5:35 AM identified a Nurse Aide (NA) had heard a sound coming from Resident #87's bathroom and upon investigation had found Resident #87 lying prone on the bathroom floor with the right side of his/her face down and his/her head in the bathroom doorway. The nursing note identified the NA alerted the charge nurse who then requested evaluation by RN #5. The note identified when RN #5 entered the bathroom, Resident #87 was breathing but was not responsive to verbal stimuli. The note identified within

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, interviews, and facility policy for 1 of 4 residents (Resident #2) reviewed for respiratory care, the facility failed to obtain a physician's order for a resident utilizing a continuous positive airway pressure (CPAP) machine nightly. The findings include: Resident #2's diagnoses included obstructive sleep apnea (OSA), acute respiratory failure with hypercapnia (retention of carbon dioxide) and asthma. A respiratory care evaluation form dated 7/17/25 identified Resident #2 had his/her own CPAP machine with a nasal mask at the bedside which the resident indicated he/she had worn on the prior night and to continue to observe and educate the resident with CPAP use. An Advanced Practice Registered Nurse (APRN) progress note dated 7/21/25 at 9:45 AM and written by APRN #2 identified Resident #2 had a history of obstructive sleep apnea, should be encouraged to use the CPAP machine during his/her skilled nursing facility (SNF) stay and the resident should be educated on the importance of adherence with use of the CPAP machine to prevent respiratory complications. A physician's progress note dated 7/21/25 at 6:27 PM identified Resident #2 had a history of OSA and was using his/her own CPAP machine while at the facility. The progress note indicated the resident was encouraged to continue use of the CPAP machine while at the facility. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 was cognitively intact and required partial/moderate assistance with bed mobility, toileting, and transfers. The MDS indicated a pulmonary diagnoses and OSA but failed to indicate use of a CPAP machine. A Resident Care Plan (RCP) dated 8/7/25 identified Resident #2 utilized CPAP therapy with interventions that included educating the resident on the importance of CPAP therapy and to encourage the residents use of the CPAP machine. Observations on 8/11/24 at 12:21 PM and 8/12/25 at 11:00 AM identified Resident #2 had a CPAP machine on his/her bedside table which he/she indicated was his/her own machine from home and that he/she wore and utilized the CPAP machine every night while at the facility. Interview and observation with LPN #3 on 8/14/25 at 10:20 AM identified Resident #2 had a CPAP machine at his/her bedside and that it had always been there. LPN #3 indicated she was unsure when the resident's family member brought the CPAP machine in or if there was a physician's order for the resident to use it. Although LPN #3 identified there should have been a physician's order for Resident #2 to use the CPAP machine, she deferred reviewing the resident's physician's orders due to needing to tend to her assignment. Observation, interview, and review of the clinical record with the Nursing Supervisor (RN #2) on 8/14/25 at 10:24 AM identified although she saw a note and diagnosis of OSA in Resident #2's hospital discharge record, the resident did not have a physician's order to use a CPAP machine. An observation with RN #2 indicated a CPAP machine was resting on Resident #2's bedside table and the resident stated he/she used it every night and that LPN #4 helped him/her put it on at night. RN #2 identified the CPAP machine should not have been there and the resident should not have used the CPAP machine without a physician's order in place. RN #2 was unsure why a physician's order was not obtained by a nurse for Resident #2's CPAP machine and that she would need to investigate it further. Interview with Person #1 on 8/14/25 at 3:49 PM identified although she was asked to bring in Resident #2's CPAP machine from home the day after the resident was admitted , she was unable to indicate which nurse had asked her to do so. Person #1 indicated Resident #2 did use the CPAP machine while at home and he/she would need help to put it on. Person #1 further identified that Resident #2 was a reliable source and if the resident indicated he/she was using the CPAP machine while at the facility then that was the truth. Observation, interview, and review of the clinical record with LPN #4 on 8/14/25 at 3:58 PM indicated that although there was not a physician's order for Resident #2 to wear a CPAP machine, he did help the resident put the CPAP machine on before bed. LPN #4 indicated he was aware the resident's family member brought the CPAP machine into the facility from home and had observed the resident with the CPAP machine on at night. LPN #4 identified it would have been the admitting nurse or the respiratory therapist that should have obtained an order for the CPAP machine and he was unsure why an order was not obtained. LPN #4 further indicated he wasn't really paying attention to the fact that the resident didn't have an order for the CPAP machine and that he didn't let anyone know that an order was needed but he should have. Subsequent to surveyor inquiry, an order was obtained on 8/14/25 which directed CPAP at hour of sleep (HS) no ramp time, 4-12 mm HG (millimeters of mercury). Assist resident to situate the mask for comfort and effective seal at bedtime for CPAP. Attempts to interview APRN #2 were unsuccessful. Review of facility policy, CPAP/BiPAP Support, dated March 2015, directed CPAP provided a spontaneously

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075241	A. Building B. Wing	08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Glen Health Care Center	162 South Britain Rd Southbury, CT 06488

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on review of facility documentation, facility policy and interviews related to facility bi-monthly narcotic audits, the facility failed to ensure that bimonthly narcotic audits were completed to monitor for possible drug diversion in the facility. The findings include: An interview with the interim DNS on 8/12/25 at 12:30 PM identified that she was unable to locate any facility documentation of bi-monthly narcotic audits conducted by the facility since the previous re-certification survey dated 12/22/23. The DNS indicated that she had only been employed by the facility since March 2025 as the ADNS and had been the interim DNS since July 2025. She stated that she had not completed any bi-monthly narcotic audits and that audits would have been conducted by the previous DNS at the facility. The interim DNS was able to provide a facility binder that contained all the current yellow narcotic reconciliation sheets for the residents in the facility receiving narcotics but there were no complete narcotic audit forms. The DNS presented 3 yellow narcotic reconciliation sheets with a date of July 2025 in the middle of the sheet indicating that these 3 narcotic sheets must have had some type of partial audit. However, the DNS could not state what type of audit would have been conducted and was unable to provide any further documentation related to narcotic audits by the facility. On 8/12/25 at 1:00 PM the Administrator stated she was not aware of the location of any bi-monthly narcotic audits that may have been conducted by the facility. She indicated that she and the DNS would contact the previous two DNS' to locate the bimonthly narcotic forms. Per the administrator and the DNS on 8/14/25 several attempts were made to contact the previous two DNS' without success.A review of the Controlled Substance Policy dated November 2022 directed, in part, the facility complies with all laws, regulations, and other requirements related to the handling, storage, disposal and documentation of controlled medications.Controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow-up. The Director of Nursing services documents irreconcilable discrepancies is a report to the administrator.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, facility policy and interviews for 1 of 3 residents (Resident #15) reviewed for pressure ulcer/injury, the facility failed to ensure Resident #15 was placed on Enhanced Barrier Precautions (EBP) for a Stage 3 pressure ulcer. The findings include:Resident #15 had diagnoses that included dementia, anemia, and hypertension.The Resident Care Plan (RCP) dated 6/28/25 identified Resident #15 was at risk for alteration in skin integrity related to impaired mobility, incontinence, shearing, friction, and cognition. Interventions included to observed skin condition with care daily and report abnormalities, and provide preventative skin care routinely and as needed. The RCP further identified Resident #15 had actual skin breakdown related to a stage 2 pressure injury on the right buttock. Interventions included administer treatment per physician orders, encourage and assist to turn and position as needed, and obtain wound consult as needed. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #15 was severely cognitively impaired, was at risk of developing pressure injuries, had 1 unhealed Stage 2 pressure injury, and required substantial/maximal assistance with eating, bed mobility, and chair/bed transfers.An Advanced Practice Registered Nurse (APRN) wound progress note identified Resident #15's right buttock wound advanced to a Stage 3 pressure ulcer.Observation of Resident #15's room on 8/14/25 at 9:16 AM failed to identify measures were initiated for Enhanced Barrier Precautions related to Resident #15 having a Stage 2 pressure ulcer as evident by a lack of posted signage, lack of personal protective equipment in proximity to Resident #15's room, and lack of a laundry bin inside of Resident #15's room.Observation on 8/14/25 at 9:16 AM identified Licensed Practical Nurse (LPN) #1 and Advanced Practice Registered Nurse (APRN) #1 entered Resident #15's room to change Resident #15's right buttock wound dressing, but failed to don appropriate personal PPE of (gowns). LPN #1 and APRN #1 were observed to perform hand hygiene and demonstrated appropriate use and changing of gloves throughout the dressing change, but they did not wear a gown at any time during the dressing change. LPN #1 identified staff were alerted to wear PPE by signage posted at the doorway and a bin with necessary PPE outside the doorway of the room. LPN #1 identified any resident on EBP or any other type of precautions would have a sign posted at the doorway that shows what PPE needs to be worn inside that resident's room. Subsequent to surveyor inquiry, an observation on 8/14/25 at 1:00 PM identified an EBP sign posted at the doorway of Resident #15's room. No bin with PPE was observed outside the room.Review of the Enhanced Barrier Precautions policy directed, in part, EBP apply when a resident has a wound or indwelling medical device and does not have secretions that are unable to be contained. The policy directed EBP's used targeted gown and glove use for high contact resident care activities which included wound care. The policy directed signs are posted on the door or wall outside the residents' rooms which communicate the type of precautions and PPE required. The policy further directed PPE and alcohol-based hand rub are readily available for staff.