STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075079	A. Building B. Wing	10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Norwich Sub-Acute and Nursing	93 West Town Street Norwich, CT 06360

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 Level of Harm - 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)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #1) reviewed for falls, the facility failed to provide adequate supervision for a resident identified at risk for falls, to prevent a fall with injury. The failure resulted in a resident fall with laceration that required seven (7) stitches. The findings include: Resident #1 was admitted to the facility with diagnoses that included Alzheimer's disease, dementia, anxiety, generalized muscle weakness, and depression. The quarterly Minimum Data Set (MDS) dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of 7 that indicated severe cognitive impairment, and required staff assistance for transfers. The Resident Care Plan (RCP) dated 7/11/2025 identified Resident #1 was at risk for falls due to confusion, deconditioning and gait/balance problems. Interventions directed assistance of two (2) staff for turning and repositioning, beveled edge mattress, and to transfer per physician orders.A physician order dated 9/5/2025 directed assistance of one (1) staff for transfers and mobility. Review of facility documents identified Resident #1 experienced falls without injury on 8/2 and 8/10/2025 due to attempts to stand without assistance. A facility reportable event (RE) form dated 9/15/2025, identified on 9/12/2025 at 8:00 AM Resident #1 was observed sitting on the edge of the bed, leaned forward and fell striking his/her head. Resident #1 had a left eyebrow laceration with bleeding and complaint of left upper arm and shoulder pain. Resident #1 was transferred to the hospital for evaluation and returned with sutures. A hospital provider note dated 9/12/2025 at 8:44 AM identified Resident #1 experienced a ground level fall resulting in a laceration to the left eyebrow that was repaired as per procedure note for skin repair that required seven (7) nylon sutures for closure. The RE summary dated 9/19/2025 identified Resident #1 required one (1) staff assist for transfers, and staff observed Resident #1 fall when waiting for the Nurse Aide (NA) to return with his/her wheelchair to transfer him/her out of bed. The NA indicated Resident #1 was leaning too far forward and fell to the floor. Record review identified Resident #1 returned to the facility on 9/12/2025 at 8:00 PM. Left side of face bruised, cheek with a large hematoma, and Tylenol 1000 mg was administered for knee pain. Interview with NA #1 on 10/15/2025 at 10:00 AM identified she provided care for Resident #1 on 9/12/2025 and was aware he/she required one (1) staff assist for transfers. NA #1 stated she also was aware Resident #1 was a fall risk and was known to stand up without assistance to attempt to self-transfer. After AM care was provided on 9/12/2025, NA #1 assisted Resident #1 to sit on the edge of the bed facing the window, dressed and ready to stand pivot transfer to the wheelchair with NA #1's assistance. NA #1 stated Resident #1's roommate had called out for assistance repeatedly while she was providing care for Resident #1, and had become insistent that assistance was needed. NA #1 turned and walked to the end of Resident #1's bed with her back towards Resident #1, to see the roommate. NA #1 stated she routinely pulled the privacy curtain but could not recall if she had the curtain drawn between Resident #1 and the roommate at that time. As NA #1 was at the foot of Resident #1's bed and turned towards the roommate's bed, she observed Resident #1 falling forward out of the bed towards onto his/her left side, hitting his/her head on the floor. NA #1 stated she could not reach Resident #1 in time to prevent the fall. Interview with RN #1 on 10/15/2025 at 10:15 AM identified she was the nursing supervisor on 9/12/2025 and assessed Resident #1 after the fall. RN #1 stated NA #1 had left Resident #1's side when he/she was sitting on the side of the bed and NA #1 should not have left Resident #1 alone when sitting on the side of the bed. Resident #1 was known to be impulsive, was a known fall risk and had previously fallen due to attempts stand without assistance. RN #1 stated NA #1 should have transferred Resident #1 into the wheelchair before she left Resident #1's side. Interview with LPN #1 on 10/15/2025 at 11:20 AM identified she regularly cared for Resident #1, and stated Resident #1 was a known fall risk to due to poor safety awareness. LPN #1 continued that Resident #1, once awake, needed her/his care needs addressed immediately or Resident #1 would attempt to get out of bed without assistance. LPN #1 stated staff knew to complete care and transfer Resident #1 into the wheelchair promptly to maintain safety. LPN #1 responded to the room after the fall and observed bleeding from a cut above the left eyebrow. NA #1 reported Resident #1's roommate was repeatedly asking for assistance and NA #1 decided to leave Resident #1 sitting on the edge of the bed to see what the roommate needed. NA #1 reported she had turned her back to Resident #1 when Resident #1 fell onto the floor and hit his/her head. LPN #1 stated NA #1 should not have left Resident #1 sitting on the side of the bed, as Resident #1 was a known fall risk with poor safety awareness; NA #1 should have completed the transfer and then addressed