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	06/04/2026

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 Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation/policies, and interviews, for one (1) of three (3) sampled residents (Resident #1) who required assistance with Activities of Daily Living (ADL's), the facility failed to ensure safe bedˆlevel care for a cognitively impaired resident who required the assistance of two staff for bed mobility. Specifically, staff performed a oneˆperson turn using an unsafe technique, which resulted in the resident sliding from the bed and sustaining an acute fracture of the right tibia. The findings include:Resident #1's diagnoses included chronic obstructive pulmonary disease, dementia, and anxiety.The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 was severely cognitively impaired (Brief Interview for Mental Status (BIMS) score of 0), was impaired on the lower extremity on one side, required maximum assistance with all care, and was dependent on staff for transfers.The Resident Care Plan dated 4/24/26 identified Resident #1 had a self-care deficit and was at high risk for falls. Interventions directed assistance of two (2) to turn and reposition every two (2) hours, side rails for positioning, provide incontinent care every two (2) hours, provide a low-level air mattress, keep call bell in reach, apply proper footwear, and physical therapy as needed.The fall report dated 5/9/26 at 4:50 AM identified Resident #1 required assistance of two (2) for bed mobility.A written statement dated 5/9/26 at 4:50 AM by NA #2 identified NA #2 was changing Resident #1's bed sheets and Resident #1 was rolled onto the side. When NA #2 attempted to pull out the sheet under Resident #1, Resident #1 started sliding off the bed and onto the floor.The nurse's note by RN #1 (the 11:00 PM to 7:00 AM supervisor) dated 5/9/26 at 8:29 AM identified the nurse was called to Resident #1's room after Resident #1 fell. NA #2 (the 11:00 PM to 7:00 AM nurse aide) stated she turned Resident #1 onto his/her side and when pulling the sheet towards herself, Resident #1 slid out of the opposite side of the bed onto the floor. Resident #1 was lying on his/her left side on the door side of the bed, between the bed and the bedside table. Upon assessment Resident #1 complained of right knee pain and the area below the right knee was slightly swollen. The physician directed an x-ray to the right hip, knee, tibia, and fibula, and Tylenol was administered.The nurse's note by RN #2 (the 3:00 PM to 11:00 PM supervisor) dated 5/9/26 at 4:38 PM identified the x-ray results were positive for an acute fracture to the right tibia. Resident #1's daughter and the Advanced Practice Registered Nurse (APRN) were updated and directed to send Resident #1 to the Emergency Department (ED) for further evaluation.The nurse's note by RN #1 dated 5/9/26 at 9:50 PM identified Resident #1 returned to the facility wearing an immobilizer splint to the right leg. After further tests were performed in the ED, Resident #1 was diagnosed with tibial fracture. Orders directed non weightbearing to the right lower extremity, use of the splint and a follow up appointment with orthopedics.The APRN note dated 5/12/26 at 8:45 AM identified an unspecified fracture of the upper end of the right tibia and mild arthritic changes to the right hip. Orders directed to continue with the ordered splint and follow up with orthopedics.An interview with PT #1 (the Rehabilitation Director) on 6/3/26 at 1:50 PM identified before Resident #1 fell on 5/9/26 the resident's level of care was at bed level and required two (2) staff to assist the resident due to a diagnosis of dementia, an inability to follow direction and an inability to actively participate in any purposeful movement in bed. PT #1 (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	identified Resident #1 had been at this level for at least the past year. PT #1 further identified if a staff member were to roll a resident without the assistance of a second staff member, the safest way to roll the resident would be in the direction of the staff member rather than to roll the resident away from the staff member.An interview with NA #1 on 6/3/26 at 2:20 PM identified on 5/9/26 NA #1 was in her first week of orientation at the facility and was in Resident #1's room when the resident fell. NA #1 was assisting Resident #1's roommate behind the closed privacy curtain when she heard NA #2 say, oh, shoot. NA #1 then walked around the curtain and saw Resident #1 fall out of the bed and onto the floor on the opposite side of where both NA #1 and NA #2 were standing.An interview with the DON on 5/5/26 at 12:00 PM identified Resident #1 required bed-level care and was an assist of two (2) for bed mobility. The DON defined bed mobility as any significant change in bed position which would require 2 staff to assist, such as boosting a resident up in bed. The DON further identified that the safest way for NA #1 to have independently rolled Resident #1 would have been to roll Resident #1 toward NA #1, not away from NA #1. She identified that if NA #1 had rolled Resident #1 toward her rather than away from her, Resident #1 would not have fallen on the floor on the opposite side of the bed. The DON further identified she initiated training for safe turning practice.Although attempted, an interview with NA #2 was not obtained.Although requested, a policy for bed mobility was not provided.Review of the facility Fall Risk Management Program identified prevention plans based on each resident's risk factors can eliminate or reduce the incidents of resident falls as well as prevent major injury to the resident. The program further identified it would focus, in part, on the assessment process, care planning, and consistent implementation of fall interventions.