STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075146	A. Building B. Wing	09/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Middlebury	778 Middlebury Rd Middlebury, CT 06762

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 accidents, the facility failed to ensure the resident who required staff assistance for mobility, had leg rests applied on the wheelchair prior to pushing the wheelchair. The failure resulted in a fall with injury. The findings include: Based on clinical record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #1) reviewed for accidents, the facility failed to ensure the resident who required staff assistance for mobility, had leg rests applied on the wheelchair prior to pushing the wheelchair. The failure resulted in a fall with injury. The findings include: Resident #1 had diagnoses that included legal blindness, abnormal posture, and anxiety. Review of a Brief Interview for Mental Status (BIMS) assessment dated [DATE] identified Resident #1 was alert and oriented (score fourteen out of fifteen). The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 was dependent on staff for mobility in the wheelchair. The Resident Care Plan (RCP) dated 7/14/2025 identified Resident #1 had limited physical mobility related to weakness. Interventions directed one (1) person assist for transfers with rolling walker, and out of bed to wheelchair with ROHO cushion. The Situation, Background, Assessment, and Recommendation (SBAR) nursing note dated 8/28/2025 at 5:30 P. M. (completed by RN #1) identified Resident #1 fell forward from the wheelchair onto the ground, striking his/her face. RN #1 identified that Resident #1 had skin tears on the forehead, right hand, right elbow, bilateral knees, a scrape on the bridge of the nose, and a laceration to the right forehead. A facility reportable event (RE) form dated 8/28/2025 at 5:30 P.M. identified Resident #1 was being pushed in his/her wheelchair outside the building and fell on the pavement, resulting in a laceration to the right forehead. The fall was witnessed by Housekeeper #1. Resident #1 was transferred to the hospital for evaluation and returned with one (1) suture to the right forehead. Review of RN #1's nursing post fall review dated 8/28/2025 identified Resident #1 had a witnessed fall outdoors while being transported in the wheelchair without leg rests. Housekeeper #1's written statement dated 8/28/2025 identified at 5:30 P.M., she was pushing Resident #1 back to his/her room when his/her foot got stuck in the wheel on the wheelchair, and Resident #1 fell forward out of the wheelchair onto the pavement. The hospital Discharge summary dated [DATE] identified Resident #had a laceration above his/her right eye/right frontal scalp and required one (1) suture. Interview and facility documentation review with Housekeeper #1 on 9/19/2025 at 10:31 A.M. identified on 8/28/2025 at approximately 5:30 P.M., she assisted Resident #1 back inside the building after an outdoor recreation activity. While she was pushing the wheelchair, Resident #1's foot got caught, and Resident #1 fell forward onto the pavement. Housekeeper #1 stated Resident #1's leg rests were not on the wheelchair during transport. Housekeeper #1 identified on 8/28/2025 that she was unsure if Resident #1 required leg rests on the wheelchair during transport, and that she should have asked if leg rests were required before transporting Resident #1. Interview with the Director of Nursing Services (DNS) on 9/19/2025 at 10:45 A.M. stated on 8/28/2025 identified there were no leg rests on Resident #1's wheelchair when Housekeeper #1 was pushing the wheelchair, and Resident #1 fell out of the wheelchair and sustained a laceration to his/her forehead. The DNS stated Housekeeper #1 should not have transported Resident #1 without the leg rests in place on the wheelchair. The DNS stated Resident #1 was dependent on staff for wheelchair mobility, and all residents who are dependent for wheelchair mobility require the use of leg rests when staff are pushing the wheelchair. The DNS stated staff are responsible for ensuring that leg rests are on wheelchairs during resident transport. Interview failed to identify why the leg rests were not on the wheelchair. Although requested, a wheelchair transport policy was not provided. Facility documentation review identified staff education was initiated on 8/28/2025 and included all residents who are dependent for wheelchair mobility must have leg rests on the wheelchair. Audits of wheelchair leg rests were initiated on 8/28/2025, and a QAPI meeting was held on 8/28/2025. Based on review of the facility documentation, past- compliance was identified.