STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075221	A. Building B. Wing	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pines at Bristol for Nursing & Rehabilitation, The	61 Bellevue Avenue Bristol, CT 06010

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 - 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. **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 #1) reviewed for accidents, the facility failed to provide adequate supervision to a resident with dementia who required staff assistance, resulting in a fall with injury. The findings include:Resident #1 had diagnoses that included dementia, fall with fractured femur, stroke, anxiety, history of falls, and atrial fibrillation. A physician's order dated 4/7/20 directed to administer Apixaban (thin blood and prevents blood clots) 2.5 milligram (mg) twice a day and assistance of one with toileting and ambulation using a rolling walker. The Resident Care Plan (RCP) dated 6/3/20 identified Resident #1 was at high risk for falls due to stroke, limited mobility, incontinence, psychotropic medication use, seizure disorder, vision impairment, and dementia. Resident #1 had prior falls on 3/25/20, 3/30/20, and 6/26/20. Interventions included floor mats on both sides of the bed, assist resident with getting ready for bed after dinner, assist resident with putting clothes away, and ensure resident is in wheelchair on last rounds on the 7:00 AM to 3:00 PM shift. The Fall Risk Evaluation dated 6/26/20 at 8:39 AM identified Resident #1 was at high risk for falls due to confusion, need for assistance with elimination, recent fall, history of 1-2 falls in the last 6 months, history of fall with fracture within the last 6 months, 2 or more falls since admission to the facility, confined to a chair, loss of balance while standing, balance problem when walking, decrease in muscular coordination, and use of an assistive device. The quarterly Minimum Data Set (MDS) dated [DATE] identified Resident #1 had moderately impaired cognition, was frequently incontinent of bladder, occasionally incontinent of bowel, and required extensive assistance for transfers, toileting, and personal hygiene. The MDS further identified anticoagulants (blood thinner) were administered since admission. Facility Reportable Event dated 8/4/20 at 10:15 PM identified Resident #1 was found on floor next to the bed with an open area under the bottom lip, with complaints of pain to his/her head, right hip, and right leg. Resident #1 was transferred to the emergency room. NA #1's written statement dated 8/4/20 identified at 10:15 PM she toileted Resident #1 and needed to go get a brief. NA #1 identified she left Resident #1 alone because the other staff were busy with other residents, so she ran to get a brief. NA #1 identified when she returned to the room Resident #1 was lying on the floor next to his/her bed clinching a pair of underwear and bleeding from his/her mouth. NA #1 called for the nurse who called the supervisor. The nurse's note written by Registered Nurse (RN) #2 on 8/4/20 at 11:48 PM identified at 10:20 PM she was called to assess Resident #1 due to a fall upon arrival Resident #1 was observed on the floor face down bleeding from his/her lips. RN #2 indicated Resident #1 was awake and alert and responsive per his/her baseline. RN #2 identified the APRN was notified, new orders obtained to send Resident #1 to the hospital, 911 was called, and Resident #1 was transported to the hospital. Review of the facility summary of the investigation dated 8/5/20 written by RN #1 (prior Director of Nursing Services) identified Resident #1 was unable to explain what happened, NA #1 stated she left Resident #1 alone on the toilet when she went to get supplies and upon return Resident #1 was on the floor. The Emergency Discharge summary dated [DATE] at 3:52 AM identified Resident #1 presented with a lower lip laceration requiring Dermabond (topical skin (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	adhesive) facial contusion, hematoma, loose upper teeth, and headache. A CT scan showed no acute findings. The nurse's note dated 8/5/20 at 4:35 AM identified Resident #1 returned from the emergency room status post mechanical fall and the lower lip laceration was treated. Resident #1 has a facial contusion, subluxation of tooth, ecchymosis and swelling to left lower lip, left chin below the lip, and a linear bruise below left inner eye. The APRN note dated 8/5/20 at 12:12 PM identified Resident #1 was seen for complaints of left hip pain, X-ray ordered. Resident #1 had a fall last night and hit his/her mouth and the left side of his/her face bleeding was unable to be controlled so Resident #1 was sent to emergency room for CT scan of the head. In the emergency room Dermabond was applied to the lip laceration. A physician order dated 8/5/20 directed to obtain an X-ray of the left hip. The nurse's note dated 8/5/20 at 2:27 PM identified Resident #1's X-ray results of the left hip showed a post op left hip hardware with anatomic alignment and osteopenia without fracture. The nurse's note written by RN #3 dated 8/8/20 at 4:13 PM identified Resident #1 was noted with fading bruising around his/her left orbital area, chin area down to neck, and part of the jaw. RN #3 indicated Resident #1 complained of mild pain but can chew his/her food and drink. The investigation form dated 8/10/20 completed by RN #1 (the Director of Nursing Services at the time of the incident on 8/4/2020) identified NA #1 placed Resident #1 on the toilet with a wheelchair present, NA #1 left the resident unattended on the toilet to obtain supplies. Upon return, NA #1 found Resident #1 on the floor between the bed and dresser with a bleeding lip. Resident #1 was transferred to the hospital and required Dermabond to the laceration on the lower lip. RN #1 identified Resident #1 should not have been left alone and staff should obtain supplies prior to providing care.Interview with the Certified Occupational Therapy Assistant (COTA) on 2/20/26 at 12:03 PM identified in August of 2020 therapy documented per the physician's order Resident #1 required the assistance of one for toileting. The COTA indicated staff would automatically know not to leave Resident #1 alone in the bathroom because when they wrote the physician order it automatically transfers onto Resident #1's care plan and the nurse aide care card. The COTA identified residents requiring assistance of one staff for toileting must have supervision and should not be left alone, especially with a diagnosis of dementia. The COTA identified Resident #1 had a diagnosis of dementia, was a high fall risk, required assistance for toileting and should not have left alone in the bathroom by NA #1. Interview with RN #1 (former Director of Nursing Services) on 2/20/26 at 1:02 PM identified she was the Director of Nursing Services on 8/4/20; however, she does not recall Resident #1's fall. RN #1 indicated if a resident was at risk for falls, with a diagnosis of dementia, and required assistance for all ADLs including toileting, the resident may have needed consistent supervision on the toilet, depending on the individual resident's needs. RN #1 indicated Resident #1 required supervision in the bathroom it should have been on the care plan. Interview with Licensed Practical Nurse (LPN) #1 on 2/20/26 at 1:45 PM identified on 8/4/20 he was the nurse assigned to Resident #1. LPN #1 identified that a nurse aide notified him that Resident #1 was on the floor, so he notified the supervisor. LPN #1 indicated Resident #1 would at times get up without calling for assistance. LPN #1 further indicated that NA #1 was aware Resident #1 should not be left alone in the bathroom. LPN #1 identified Resident #1 who had diagnosis of dementia and required the assistance of one should not have been left alone in the bathroom by NA #1. Interview with NA #1 on 2/20/26 at 2:04 PM identified on 8/4/20 she was assigned to care for Resident #1. NA #1 identified she was aware that Resident #1 had a habit of getting up unassisted, wandered at times, was at risk for falls, and should not be left alone in the bathroom. NA #1 identified on 8/4/20 she left Resident #1 alone in the bathroom because she needed supplies and no one was around to help. NA #1 further identified when she returned to the room Resident #1 was on the floor. Interview and clinical record review with the DNS on 2/20/26 at 3:00 PM identified she was not the DNS at the facility on 8/4/20 when Resident #1 experienced a fall. The DNS identified on 8/4/20, Resident #1 was toileted by NA #1, NA #1 left Resident #1 alone in the bathroom to retrieve supplies, and upon returning NA #1 found Resident #1 on the floor bleeding from his/her lip. The DNS identified NA #1 should not have left Resident #1 unattended in the bathroom. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility Fall Prevention Program Policy identified the purpose of the program is to reduce the incidence of falls in residents identified at high risk for falls. Participation in the program is determined by a residents Fall Risk Assessment Score, history of falls, and recommendations from the nursing staff. Residents at high risk for falls will have interventions initiated to prevent falls.