STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075243	A. Building B. Wing	03/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pierce Memorial Baptist Home, Inc.	44 Canterbury Road Brooklyn, CT 06234

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, review of facility documentation, review of facility policy, and staff interviews, for two of six sampled residents (Resident #17 and Resident #24) reviewed for accidents, the facility failed to ensure that staff utilized a gait belt during assisted ambulation in accordance with the facility's policy, which resulted in a fall with injury, and failed to ensure that a resident who required staff assistance for transfers did not sustain a skin tear during a staff-assisted transfer. The findings include: Resident #24 had diagnoses that included anemia, osteoarthritis, weakness, and difficulty walking.The fall risk assessment dated [DATE] identified Resident #24 received a total score of 3, a score of 3 indicates a low fall risk.The Resident Care Plan (RCP) dated 2/12/26 identified Resident #24 had limited physical mobility related to weakness. The care plan interventions directed staff to transfer the resident with assistance of one and to ambulate the resident with assistance of one using a gait belt and walker.The admission MDS assessment dated [DATE] identified Resident #24 had intact cognition, required extensive assistance for toileting, personal hygiene, dressing, transfers, and ambulation. It further identified the resident utilized both a rolling walker and a wheelchair for mobility and had no documented history of falls.The nurses' aide care card, updated on 3/11/26 identified Resident #24 was alert and oriented but could be forgetful, and required assistance of one with a rolling walker for transfers and ambulation.The facility reportable event report dated 3/12/26 at 3:20 PM identified Resident #24 experienced a fall while ambulating in the hallway. The facility's investigation identified NA #1 had not utilized a gait belt while assisting the resident during ambulation. An intervention put in place following the fall consisted of re-educating NA #1 regarding the purpose of using the gait belt and competency in proper gait belt application.LPN #1's nurse's note dated 3/12/26 at 8:12 PM identified Resident #24 was walking in the hallway with NA #1 using a rolling walker when the resident lost balance and fell to the floor. The RN completed an assessment and noted a skin tear to the resident's left forearm. Resident #24 denied hitting his/her head. Range of motion was intact to all extremities, and the resident reported left elbow pain rated 7 out of 10 on a 0-to-10 pain scale.The physician's orders dated 3/12/26 directed staff to transfer Resident #24 to the hospital for evaluation following the fall.The twoˆview left elbow Xˆray (an imaging diagnostic test) dated 3/12/26 at 5:23 PM completed at the hospital identified Resident #24 presented after a fall with left elbow pain and limited range of motion. The radiology findings identified posterior elbow softˆtissue swelling and a nondisplaced fracture of the left olecranon.The nurse's notes dated 3/12/26 at 11:19 PM identified Resident #24 returned from the hospital with a sling to the left arm. The nurse assessed the resident's hand and fingers, performed rangeˆofˆmotion checks and documented that the left hand and fingers were warm to the touch. Resident #24's neurological checks were within normal limits.The physician's orders dated 3/13/26 directed staff to ensure proper positioning of the left arm sling every shift, to ensure the hard splint was properly positioned to the left arm and/or elbow, to monitor circulation, motion, and sensation of the left upper extremity, and to maintain nonˆweightˆbearing status to the left upper extremity.The revised Resident Care Plan (RCP) dated 3/16/26 identified Resident #24 had limited physical mobility related to weakness. The (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 0689 Level of Harm - Actual harm Residents Affected - Few	care plan interventions directed staff to transfer the resident with assistance of one from the bed to the wheelchair, and wheelchair to toilet, remove resident from the ambulation list at this time, and resident is non-ambulatory with nursing staff at this time. Interview with LPN #1 on 3/25/26 at 10:00 AM identified NA #1 was assisting Resident #24 with ambulation in the hallway when the resident lost his/her balance and fell to the floor. LPN #1 also identified that the nursing supervisor was called to assess the resident following the fall and Resident #24 was directed to be sent to the hospital for further evaluation. She identified that NA #1 acknowledged she had not applied a gait belt to Resident #24 and reported that she had forgotten to apply the gait belt. She further identified that the facility's policy required the use of a gait belt during transfers and/or ambulation whenever a resident required assistance.Interview with OTA #1 on 3/25/26 at 10:10 AM identified that all staff should use a gait belt for all transfers and/or ambulation unless a resident is independent with transfers and ambulation. He identified that the purpose of a gait belt is to allow staff to maintain a secure grasp on the resident in case the resident loses balance. He identified that Resident #24 required assistance of one for transfers and ambulation, and that staff should have been using a gait belt whenever assisting the resident. He further identified that NA #1 may have been able to maintain control of Resident #24 if a gait belt had been used at the time of the fall, and could have assisted the resident to the floor, thereby preventing a major injury. In addition, he identified that Resident #24 was removed from the ambulation list following the fall and could only ambulate with physical therapy.Interview with the DNS on 3/25/26 at 10:33 AM identified that all staff are required to use a gait belt during transfers and/or ambulation for any resident who requires assistance. She identified that the gait belt is used to maintain the staff's grasp in the event the resident loses balance and to help prevent a major injury if a fall occurs. She further identified that NA #1 was recently hired but had been trained and deemed competent in the use of the gait belt during orientation. She further identified that NA #1 had not used a gait belt while assisting Resident #24 with ambulation, which resulted in a fall and left elbow fracture. Additionally, the DNS noted that NA #1 received reeducation and competency validation regarding proper gait belt use following the incident.Attempts to interview NA #1 were unsuccessful during the survey period.The facility's policy for Gait Belt Use and Ambulation identified that staff are required to use a gait belt with residents who cannot independently ambulate and/or transfers, and a gait belt is used to support, guide the resident and to avoid using the resident's clothing or limbs to support their weight. Resident #17 had diagnoses that included type 2 diabetes mellitus, dementia, venous insufficiency, anxiety, and peripheral vascular disease.The annual MDS assessment dated [DATE] identified Resident #17 had severe cognitive impairment, required extensive assistance for toileting, personal hygiene, dressing, and transfers, was non-ambulatory and utilized a rolling walker and wheelchair for mobility.The nursing aide care card identified that Resident #17 required the assistance of one staff member with a rolling walker for transfers. The Accident and Incident (A&I) report dated 11/20/25 at 7:45 PM identified that Resident #17 was transferred by NA #2 and NA #8 and was noted to have a skin tear to his/her left lower leg that measured 2.5 cm in length by 1.5 cm in width following the transfer. The facility's investigation identified Resident #17 did not have a skin tear prior to the transfer. Statements obtained from NA #2 and NA #8 identified that Resident #17 was giving them a hard time during the transfer. NA #2 identified that she attempted to talk to the resident, but nothing helped, and NA #8 identified that they could have waited for Resident #17 to calm down.LPN #2's nurse's note dated 11/20/25 at 9:54 PM identified that NA#2 and NA #8 transferred Resident #17, after which the resident was noted to have a skin tear on the left lateral lower leg. The skin tear measured 2.5 cm in length by 1.5 cm in width. The nursing supervisor, physician, and family were notified of the incident.The Resident Care Plan (RCP) dated 11/20/25 identified Resident #17 had a skin tear to the left lateral lower leg. Care plan interventions directed staff to use protective sleeves to the leg, identify the potential causative factor and resolve when possible, and encourage good nutrition and hydration to promote healthier skin.The Occupational Therapy (OT) screening dated 11/24/25 identified Resident #17 was seen for an OT screen related to sustaining a skin tear while (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	being transferred. The OT screen identified that Resident #17 had not had a change in his/her functional mobility. The plan was to request the maintenance department to place a cushion liner on the right side of the bed frame, where Resident #17 had been pressing his/her left leg against the metal frame.The physician's initial wound consultation dated 11/25/25 at 10:56 AM identified the skin tear to the left lower extremity was evaluated. The skin tear measured 2 cm in length by 0.7 cm in width by 0.1 cm in depth, with a small amount of serosanguineous drainage. The treatment plan directed to cleanse the wound with normal saline, apply silver hydrogel to the base of the wound, and cover it with a dry, clean dressing daily and as needed when soiled or dislodged.The weekly wound physician's progress notes from 12/2/25 through 12/23/25 identified Resident #17 had a skin tear to the left lower leg. Documentation reflected that the wound physician continued to monitor the condition and provided an ongoing treatment plan for the skin tear throughout this period.The nurse's notes dated 12/30/25 at 10:35 AM identified that Resident #17's skin tear to the left lower leg was documented as healed.Interview with LPN #2 on 3/26/26 at 11:00 AM identified that NA #2 had reported a skin tear that had occurred during Resident #17's transfer. She identified that NA #2 had reported Resident #17 did not have a skin tear prior to the transfer and that the skin tear to the left lower leg had been obtained after the resident was transferred from the wheelchair to the bed. She identified that Resident #17 required assistance of one staff member for transfers. She further identified that she could not recall whether Resident #17 had been agitated at the time of the transfer. She also identified that Resident #17 had not been using a leg rest on his/her wheelchair because he/she could self^propel while in the wheelchair.Interview with the DNS on 3/26/26 at 1:30 PM identified that Resident #17's skin tear had been noted after the resident was transferred from the wheelchair to the bed. She reviewed the witness statements obtained from NA #2 and NA #8, which identified that the resident had been agitated and that staff should have waited prior to transferring the resident; however, she identified that Resident #17 had been agitated during the transfer. She further identified that Resident #17 should have been free from any type of accident while care was being provided by her staff.Attempts to interview NA #2 and NA #8 were unsuccessful during the survey period.The facility's policy for Accidents and Supervision identified that the facility would maintain the resident environment free of accident hazards to the greatest extent possible and ensure that each resident received adequate supervision and appropriate assistive devices to prevent accidents.