STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075258	A. Building B. Wing	10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Douglas Manor	103 North Road Windham, CT 06280

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, facility documentation, policies and interviews for one (1) of three (3) sampled residents (Resident #1) who were at risk for falls, the facility failed to ensure a Fall Risk Evaluation was completed quarterly. The findings include: Resident #1's diagnoses included dementia without behavioral disturbances, anxiety, muscle weakness, history of falls and macular degeneration (an eye disease that affects central vision). A Fall Risk Evaluation dated 6/4/25 identified Resident #1 was at risk for falls. The Resident Care Plan dated 07/29/25 identified Resident #1 was at risk for falls related to cognitive impairment, generalized weakness, previous history of falls, use of an antidepressant and a history of vertigo (a sensation that the environment around you is off balance and spinning in circles). Interventions included instructing the resident to request assistance prior to attempting to transfer or walk within his/her capacity to understand, keeping the area clutter free and well-lit, offering the resident periods of rest in bed and therapy evaluation as needed. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of zero (0) out of fifteen (15) indicating Resident #1 was not able to make decisions regarding tasks of daily life, had difficulty focusing and disorganized thinking, required substantial assistance with transfers, was independent with wheelchair mobility and had sustained a fall since the prior assessment. The Post Fall Evaluation dated 10/5/25 at 3:23 PM identified Resident #1 sustained an unwitnessed fall at 2:40 PM in his/her room. Resident #1 was leaning forward in the wheelchair, fell out of the wheelchair, hitting his/her forehead against another wheelchair that was in the room and a moderate amount of bleeding was noted. The note identified pressure and a dressing were applied, the physician was notified, and a new order was obtained to transfer Resident #1 to the Emergency Department (ED) for evaluation. Review of the clinical record from 6/5/25 through 10/4/25 failed to identify a Fall Risk Evaluation was completed within those four (4) months, coinciding with the 9/23/25 comprehensive assessment. Interview with the Director of Nursing (DON) on 10/15/25 at 1:52 PM identified fall risk evaluations are to be completed by nursing on admission, quarterly, after each fall and with any change in condition. The DON explained Fall Risk Evaluations should have been completed around the 7/25/25 and 9/23/25 resident assessments and she was unsure why they were not completed. Review of the Fall Risk Assessment policy (undated) directed, in part, that a fall risk assessment is to be completed on admission, quarterly, after falls and with any health changes.

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
	075258	A. Building B. Wing	10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Douglas Manor	103 North Road Windham, CT 06280

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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	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075258	A. Building B. Wing	10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Douglas Manor	103 North Road Windham, CT 06280

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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 reviews, facility documentation, facility policy and interviews for one (1) of three (3) sampled residents (Resident #1) who were reviewed for falls, the facility failed to adherence to the care plan-specifically by ignoring repeated observations of the resident's forward leaning and rocking and leaving a roommate's wheelchair as an obstruction and to ensure a wheelchair that was not in use was positioned in a way to maintain a clutter-free environment and prevent the resident from sustaining a laceration to left eyelid when the resident leaned forward and fell out of the wheelchair resulting in transfer to the ED for the treatment and evaluation. The findings include:Resident #1's diagnoses included dementia without behavioral disturbances, anxiety, muscle weakness, history of falls and macular degeneration (an eye disease that affects central vision). The Fall Risk Evaluation dated 6/4/25 identified that Resident #1 was at risk for falls. The Resident Care Plan dated 7/29/25 identified Resident #1 was at risk for falls related to cognitive impairment, generalized weakness, previous history of falls, and use of an antidepressant. Interventions included instructing the resident to request assistance prior to attempting to transfer or walk within his/her capacity to understand, keeping the area clutter free and well-lit, offering the resident periods of rest in bed and therapy evaluation as needed. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of zero (0) out of fifteen (15) indicating Resident #1 was not able to make decisions regarding tasks of daily life, had difficulty focusing and disorganized thinking, required substantial assistance with transfers, was independent with wheelchair mobility and had sustained a fall since the prior assessment. The Post Fall Evaluation dated 10/5/25 at 3:23 PM identified Resident #1 sustained an unwitnessed fall at 2:40 PM in his/her room. Resident #1 was leaning forward in the wheelchair and fell out of the wheelchair hitting his/her forehead against another wheelchair in the room. A moderate amount of bleeding was noted. The note identified pressure, and a dressing were applied, the physician was notified, and a new order was obtained to transfer Resident #1 to the Emergency Department (ED) for evaluation. The hospital documentation dated 10/5/25 identified Resident #1 was seen in the ED post head injury, reporting Resident #1 sustained a left eyelid laceration requiring repair with seven (7) sutures. The note indicated imaging of the head was completed and the results reported a soft tissue injury of the left frontal region and there was no acute intracranial hemorrhage (bleeding within the skull). The Reportable Event Summary dated 10/10/25 identified the investigation following the fall, noted that a travel wheelchair belonging to Resident #1's roommate had been left in the room following an appointment earlier that morning. Education was provided to staff regarding proper storage of equipment to maintain a safe environment and prevent clutter in resident rooms and high traffic areas. Interview with the 7AM-3PM charge nurse, Licensed Practical Nurse (LPN) #1, on 10/15/25 at 11:03 AM identified she noticed Resident #1 would rock his/her knees, cross his/her arms and lean forward while in the wheelchair. LPN #1 indicated Resident #1 was transferred to her unit several months ago (6/27/25) and thought the behavior was Resident #1's baseline so she did not report the behavior to anyone. Interview with the Occupational Therapy Assistant (Rehab Director) on 10/15/25 at 11:14 AM identified Resident #1 had been on Physical Therapy (PT) services at the time of the fall, she had not observed Resident #1 leaning forward in the wheelchair or rocking. The Rehab Director indicated if the nursing staff observed this behavior, they should have encouraged Resident #1 to lean back and/or put Resident #1 back to bed if he/she appeared fatigued. The Rehab Director identified if Resident #1 was not fatigued and the behavior was ongoing, therapy should have been notified for possible positioning changes, and the therapy department had not been notified. The Rehab Director identified Resident #1 was safe to self-propel in the wheelchair independently. The Rehab Director identified the travel wheelchair belonging to Resident #1's roommate should not have been stored in the room, impeding Resident #1's path of mobility and Resident #1 required verbal cues to navigate around obstacles. Interviews with Nurse Aides (NA) #1, #2 and #4 on 10/15/25 identified that Resident #1 frequently crossed his/her arms, rocked back and forth and would lean forward while in the wheelchair. NA #1 reported she was unsure why the travel wheelchair was just inside the doorway of the Resident #1's room on 10/5/25 and the wheelchair should have been removed from the room. Interview with the 7AM-3PM nursing supervisor, Registered Nurse (RN) #2, on 10/15/25 at 12:20 PM identified although she did not witness Resident #1's fall, Resident #2 reported to her Resident #1 was leaning forward in the wheelchair and then fell forward out of the wheelchair, hitting his/her head on the brake handle of the travel wheelchair. RN #2