| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 075301 | A. Building<br>B. Wing | 11/17/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Caleb Hitchcock Health Center | 10 Loeffler Rd<br>Bloomfield, CT 06002 |

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 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>(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 0600<br><br>Level of Harm - Actual harm<br><br>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 abuse, the facility failed to ensure care was provided gently when staff repositioned Resident #1 and staff pulled on Resident #1's wrist to turn him/her in the bed. The findings include:Resident #1's diagnoses included dementia. The significant change Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of one out of fifteen, indicative of severe cognitive impairment, was incontinent of bowel and bladder, was dependent on staff for personal hygiene, and required maximal assistance with bed mobility. The Resident Care Plan (RCP) dated 9/17/2025 identified incontinence, alteration in mobility, becomes easily agitated with occasional aggressive outbursts. Interventions directed two (2) staff for personal care, wrap a bath towel around quarter side rails to prevent injury when resistive or combative with care, use a calm approach and an unhurried manner when dealing with Resident #1. The facility reportable event dated 9/30/2025 at 10:00 PM identified during morning care, Resident #1 was noted to flinch when his/her left hand was touched. On assessment, the left hand was mildly swollen with scattered bruising. The APRN assessed Resident #1, and an x-ray was obtained. X-ray results identified a distal (away from the arm) ulnar (larger of the two lower arm bones) fracture with mild displacement. Resident #1 was transferred to the hospital and returned to the facility on [DATE] with a splint in place. Review of hospital x-ray results dated 10/1/2025 identified a left wrist minimally displaced oblique fracture of the distal ulnar diaphysis (bone near the wrist that is angled and only slightly out of alignment). Narrowing of the radiocarpal joint (forearm bone on the thumb side) with negative ulnar variance (condition where the ulna bone is shorter than the radius bone) (smaller arm bone) may represent sequelae (caused by) of remote trauma. Soft tissue swelling of the distal forearm, impression: minimally displaced distal ulnar fracture. Review of the facility summary report dated 10/3/2025 identified Nurse Aide (NA) #1 and NA #2 provided incontinent care for Resident #1 on 9/30/2025 at 5 AM and NA #1 grasped Resident #1's shoulder and wrist and pulled him/her toward her (toward NA #1). A facility interview was conducted with NA #1, and NA #1's responses were erratic, stated I'm there for the heaviness and stated, she tossed him/her to me, and I tossed him/her back. NA #1 further described the resident as fussing and did not answer which part of Resident #1's body she grabbed or pulled. On 10/29/2025 at 3:25 PM voicemail message from MD #1 (facility contracted radiologist) at [JA1] 3:12 PM identified the cause of Resident #1's fracture was most likely caused by trauma. Interview and record review with NA #2 on 10/29/2025 at 12:46 PM identified on 9/30/2025 about 5 AM, she and NA #1 provided incontinence care for Resident #1. NA #2 stated Resident #1 was awake, smiling but not following commands, and was slightly resistive to turning, and as she turned Resident #1 toward NA #2 NA #1 grabbed the resident by the (left) wrist and shoulder and turned the resident towards her (NA #1). NA #2 stated NA #1 was getting frustrated, seemed to be in a hurry, and grabbed the resident's left hand hard and pulled him/her to roll over. NA #2 stated that when NA #1 grabbed Resident #1's wrist, he/she did not make any noise, but Resident #1 grimaced. Review of NA #1's statement dated 10/2/2025 at 11 AM obtained via phone by the DNS and Administrator, NA #1 identified NA #1 was waiting for the call because of the resident's arm, made erratic statements such as I'm there for the heaviness, and stated, she tossed him to me, and I tossed him back. NA #1 further stated Resident #1 was fussing, and did not provide information regarding where she grabbed or pulled Resident #1. 'Interview with NA #1 on 10/29/2025 at approximately 12:45 PM identified that NA #1 assisted NA #2 with care for Resident #1 on 9/30/2025, however, NA #1 declined to provide any additional information about the care provided. Interview with the DNS and Administrator on 10/29/2025 at 1:45 PM identified that the facility interview with NA #2 identified NA #1 was in a rush during care. When NA #2 and NA #1 turned Resident #1, he/she was not turning fast enough, so NA #1 yanked Resident #1 by the shoulder and wrist and NA #2 saw Resident #1 grimace. The DNS stated NA #1 should not have yanked Resident #1 over or grabbed Resident #1 by the wrist/hand to turn him/her over, and subsequent to the incident, NA #1's employment was terminated. The DNS stated at times Resident #1 was resistive and frightened during care, and NA #1 and NA #2 should have left the resident when he/she was not cooperating and reapproached later. Review of facility undated Abuse, Neglect and Exploitation Policy directed in part to prevent resident abuse. Abuse was defined as the willful infliction of injury resulting in harm or pain. Physical abuse was defined as including, but not limited to, hitting, slapping, and punching. Mistreatment was defined |

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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 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>(continued on next page) |

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|---|---|
| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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 abuse, the facility failed to ensure staff reported an allegation of abuse timely. The findings include:Resident #1's diagnoses included dementia. The significant change Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of one out of fifteen, indicative of severe cognitive impairment, was incontinent of bowel and bladder, was dependent on staff for personal hygiene, and required maximal assistance with bed mobility. The Resident Care Plan (RCP) dated 9/17/2025 identified incontinence, alteration in mobility, becomes easily agitated with occasional aggressive outbursts. Interventions directed two (2) staff for personal care, wrap bath towel around quarter side rails to prevent injury when resistive or combative with care, use a calm approach and an unhurried manner when dealing with Resident #1. The facility reportable event dated 9/30/2025 at 10:00 PM identified during morning care, Resident #1 was noted to flinch when his/her left hand was touched. On assessment the left hand was mildly swollen with scattered bruising. The APRN assessed Resident #1, and an x-ray was obtained. X-ray results identified a distal (away from the arm) ulnar (larger of the two lower arm bones) fracture with mild displacement. Resident #1 was transferred to the hospital and returned to the facility on [DATE] with a splint in place. Record review identified Resident #1 returned to the facility on [DATE]. Review of hospital x-ray results dated 10/1/2025 identified a left wrist minimally displaced oblique fracture of distal ulnar diaphysis (bone near the wrist that is angled and only slightly out of alignment). Narrowing of radiocarpal joint (forearm bone on the thumb side) with negative ulnar variance (condition where the ulna bone is shorter than the radius bone) (smaller arm bone) may represent sequelae (caused by) of remote trauma. Soft tissue swelling of the distal forearm, impression: minimally displaced distal ulnar fracture. Review of facility summary report dated 10/3/2025 identified Nurse Aide (NA) #1 and NA #2 provided incontinent care for Resident #1 on 9/30/2025 at 5 AM. NA #2 reported she positioned Resident #1 on his/her left side and turned him/her towards NA #1. NA #2 reported NA #1 grasped Resident #1's shoulder and wrist and pulled him/her toward her (toward NA #1). Facility interview with NA #4 identified Resident #1 was pleasant and cooperative during the 3 to 11 PM shift and had no signs of distress. Facility interview with NA #2 identified about 5 AM, she and NA #1 provided incontinent care, and she positioned Resident #1 on his/her left side and turned him/her toward NA #1. NA #1 grasped Resident #1's shoulder and wrist and pulled Resident #1 toward her. Facility interview with NA #1 indicated she was waiting for the call (from the facility) because of the resident's arm. The Summary indicated NA #1's responses were erratic, stated I'm there for the heaviness and stated she tossed him/her to me, and I tossed him/her back. further, NA #1 described the resident as fussing and did not answer which part of Resident #1's body she grabbed or pulled. The Summary indicated Resident #1 sustained a left distal ulna fracture, and NA #1's employment was terminated. Interview, and facility documentation and record review with NA #2 on 10/29/2025 at 12:46 PM identified she was assigned to Resident #1 on 9/30/2025, and about 5 AM, she and NA #1 provided incontinence care for Resident #1. NA #2 stated she was on the left side of Resident #1 and turned Resident #1 toward NA #2. NA #2 stated Resident #1 was awake, smiling but not following commands, and was slightly resistive to turning and NA #1 grabbed the resident by the (left) wrist and shoulder and turned resident towards her (NA #1). NA #2 stated NA #1 was getting frustrated, seemed to be in a hurry and grabbed the residents left hand hard and pulled him/her to roll over. NA #2 stated when NA #1 grabbed Resident #1's wrist, he/she did not make any noise, but Resident #1 grimaced. NA #2 stated she and NA #1 should have stopped providing care when Resident #1 was not listening/following directions and should have returned and reapproached Resident #1 later. NA #2 stated she should have notified the nurse of the incident when it occurred. Review of NA #1's statement dated 10/2/2025 at 11 AM obtained via phone by the DNS and Administrator, NA #1 identified NA #1 was waiting for the call because of the resident's arm, made erratic statements such as I'm there for the heaviness, and stated, she tossed him to me, and I tossed him back. NA #1 further stated Resident #1 was fussing, and did not provide information regarding where she grabbed or pulled Resident #1. Interview with NA #1 on 10/29/2025 at approximately 12:45 PM identified that NA #1 assisted NA #2 with care for Resident #1 on 9/30/2025, however, NA #1 declined to provide any additional information about the care provided. Interview with the DNS and Administrator on 10/29/2025 at 1:45 PM identified the facility investigation included an interview with NA #2. NA #2 indicated NA #1 was in a |