

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075310	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/23/2025
NAME OF PROVIDER OR SUPPLIER Colonial Health & Rehab Center of Plainfield, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 16 Windsor Ave Plainfield, CT 06374	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075310	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/23/2025
NAME OF PROVIDER OR SUPPLIER Colonial Health & Rehab Center of Plainfield, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 16 Windsor Ave Plainfield, CT 06374	
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	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record, facility documentation, and facility policy review, and interviews for one of three residents (Resident #1) reviewed for accidents, the facility failed to ensure resident was transferred safely to prevent an injury. The findings include: Resident #1's diagnoses included dementia and osteoporosis. Physician order dated 9/8/2025 directed assist of two (2) with mechanical lift for transfers. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of three out of fifteen, indicative of severe cognitive impairment and was dependent for transfers. The Resident Care Plan (RCP) dated 9/29/2025 identified Resident #1 had an alteration in mobility. Interventions directed transfer with assistance of two (2) with mechanical lift. Review of the Nurse Aide (NA) care card dated 10/3/2025 directed transfers with assist of two (2) with mechanical lift. Review of facility Reportable Event dated 10/4/2025 at 4:05 PM identified Resident #1 was being transferred from the bed to wheelchair via mechanical lift by two (2) NAs when the left top strap came off the loop, causing Resident #1 to partially slip from the mechanical lift pad and strike his/her head and shoulder on the ground. Resident #1 sustained a 5 centimeter (cm) by 4 cm hematoma (accumulation of blood) to the back right side (parietal region) of his/her head. New orders were obtained that directed transfer to the hospital for evaluation. The NA care card was updated to use green middle loops all the way around sling when transferring with mechanical lift. Review of facility Summary Report dated 10/7/2025 identified initial hospital report indicated a L3 (lumbar vertebrae number #3) acute (new) fracture, re-review by radiology requested for clarification, results indicated no acute fracture of L3, however there was an L2 acute fracture. The Summary further identified orthopedic follow was recommended but was declined by responsible party. Interview and record review with NA #2 on 10/22/2025 at 12:06 PM identified on 10/4/2025 when transferring Resident #1, she secured the lower mechanical lift pad/sling straps while NA #1 secured the upper pad/sling straps to the mechanical lift. NA #2 stated she was standing behind Resident #1's wheelchair, while NA #1 operated the lift. Resident #1 was lifted off the bed and while NA #1 was moving the lift and Resident #1 over the floor toward the wheelchair, the upper left strap jumped/jerked and came off the mechanical lift hook. Resident #1 slipped out of pad/sling and landed on his/her shoulder and head. NA #2 stated Resident #1 was cooperative and did not move during the transfer. NA #2 further stated she did not check the straps NA #1 had attached, and wondered if NA #1 had secured the straps fully down on the hook. Interview and record review with NA #1 on 10/22/2025 at 12:39 PM identified she and NA #2 transferred Resident #1 out of bed on 10/4/2025. NA #2 applied the lower straps of the pad/sling to the mechanical lift, while she applied the upper straps using the middle loop. Resident #1 was lifted off the bed, and next thing she knew resident fell down and landed on head and shoulder. NA #1 further stated that prior to moving Resident #1 off the bed, she did not pull on the straps or check that straps were all the way in the lift hook, and she should have made sure the pad/sling was tight and connected to the lift correctly prior to moving Resident #1 off the bed. Interview, clinical record and facility documentation review on 10/22/2025 at 1:51 PM with the DNS identified Resident #1 was being transferred by NA #1 and NA #2 from his/her bed to wheelchair via mechanical lift on 10/4/2025. During the transfer one (1) of the upper straps came off the mechanical lift hook and Resident #1 fell out of the sling and hit his/her right parietal (side) region of his/her head. Although interview identified Resident #1 was transferred with two (2) staff, interview failed to identify why NA #1 did not verify the sling straps were properly in place prior to moving the resident. Review of the undated facility Transfer Policy & Procedure directed in part, residents will be transferred safely. Mechanical-Hoyer lift: special care and attention needs to be used when transferring any resident using a Hoyer Lift as injuries and even death may result from improper techniques or use of the lift. Lift resident slowly, maintaining control of both the sling and the lift. Review of facility documentation identified staff education was initiated on 10/4/2025 for the NAs involved. Additional education was initiated on 10/7/2025 for all nursing staff regarding mechanical (Hoyer) lift safety and to confirm all straps are securely attached to the swivel bar before lifting. Audits were initiated on 10/5/2025, and a QAPI meeting was held on 10/7/2025. Based on review of facility documentation, past non-compliance was identified.</p>		