STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075310	A. Building B. Wing	05/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center of Plainfield, LLC	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and staff interviews for one (1) of three (3) sampled residents (Resident #1) reviewed for falls, the facility failed to ensure adequate supervision and assistance during transfers. Specifically, staff failed to recognize and respond to signs of increasing transfer instability in the weeks prior to a fall; failed to recognize that Resident #1 was unable to bear weight at the initiation of a transfer and continued the transfer without seeking assistance; left Resident #1 unattended on the floor following a fall with a head strike; and transferred Resident #1 off the floor despite observable signs of significant pain. Resident #1 subsequently sustained an acute intertrochanteric fracture of the right proximal femur requiring surgical repair.Resident #1's diagnoses included dementia without behavioral disturbances, chronic pain syndrome, aphasia, generalized muscle weakness, right-sided hemiplegia, right-hand contracture, and atrial fibrillation managed with anticoagulant therapy (apixaban). The quarterly Minimum Data Set (MDS) dated [DATE] identified Resident #1 required substantial assistance for transfers, reported frequent pain, and had a history of falls within the facility. The Resident Care Plan (RCP) dated 3/13/26 identified Resident #1 as a moderate fall risk related to gait and balance problems, right-sided hemiparesis, and a history of falls, and noted that on 1/29/26, Resident #1 had increased difficulty with transfers secondary to increased lower extremity weakness. Interventions included providing an assist of one (1) for transfers and monitoring for fatigue. A physician's order dated 3/23/26 directed a one (1) person assist stand pivot transfer with a grab bar for toileting.Failure to Report and Respond to Increasing Transfer Instability: Interview with NA #1 on 5/19/26 at 12:15 PM identified that for at least two (2) weeks prior to the 4/21/26 fall, Resident #1 was increasingly difficult to transfer during evening and night hours and required an assist of two (2) due to increased weakness, and that she never reported this change to a licensed nurse. Interview with RN #3 on 5/20/26 at 10:30 AM identified she observed Resident #1 had increased intermittent fatigue at least two (2) days prior to the fall. Despite these observable changes, no licensed nurse was notified and no update to the plan of care or transfer approach was made. Interview with the DON on 5/19/26 at 2:51 PM confirmed that if NA #1 observed Resident #1 had been increasingly weak and difficult to transfer in the weeks leading up to the fall, she should have notified the charge nurse of the change in condition. Interview with the Rehab Director on 5/19/26 at 2:11 PM confirmed that if Resident #1 was having pain, spasms, or increased weakness, NA #1 should have requested a second person to assist with the transfer.Failure to Recognize Inability to Bear Weight and Abort the Transfer: Interview with NA #1 on 5/19/26 at 12:15 PM identified that on 4/21/26, as soon as Resident #1 attempted to stand during a transfer to the toilet, she could tell Resident #1 was increasingly weak and had to support most of Resident #1's weight and help pull Resident #1 up. NA #1 acknowledged she should have sat Resident #1 back down and requested assistance. Instead, she continued to assist Resident #1 to a fully upright position, at which point Resident #1's right knee gave out, NA #1 was unable to hold Resident #1, and Resident #1 fell forward, striking the right side of his/her face on the wall next to the toilet before falling to the floor.Failure to Maintain Supervision Following a Fall with Head Strike: (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	Interview with NA #1 on 5/19/26 at 12:15 PM identified that following the fall, Resident #1 was grimacing and moaning in pain. Rather than engaging the bathroom call bell and calling for assistance, NA #1 removed the gait belt from Resident #1's waist, placed it on the wheelchair, and left Resident #1 unattended on the bathroom floor to seek assistance at the nurse's station. NA #1 acknowledged she should have left the gait belt on Resident #1, engaged the bathroom call bell, and yelled for assistance immediately. The DON confirmed on 5/19/26 at 2:51 PM that following a fall, NA staff are not to leave residents unattended and that NA #1 should have engaged the bathroom call bell and yelled for assistance rather than leaving Resident #1 alone on the floor following a head strike.Failure to Cease Transfer in the Presence of Observable Significant Pain: The Change/Event note by RN #1 dated 4/21/26 at 10:39 PM identified Resident #1 complained of pain to the right knee and leg following the fall. Interview with RN #1 on 5/19/26 at 12:37 PM identified it took four (4) staff to stand Resident #1 and transfer Resident #1 first to the wheelchair and then to the bed, and that Resident #1 displayed facial grimacing throughout both transfers and complained of severe pain. Interview with RN #3 on 5/20/26 at 10:30 AM confirmed Resident #1 was clenching his/her jaw, displayed facial grimacing, and complained of pain during the transfers, and stated staff should have found a way to reposition Resident #1 to utilize the mechanical lift or notified the APRN to report the increase in pain and difficulty transferring Resident #1. Interview with APRN #1 on 5/19/26 at 1:52 PM confirmed that if four (4) staff were needed to transfer Resident #1 and he/she complained of pain upon standing and bearing weight, staff should have stopped and found a way to use the mechanical lift or notified the provider immediately for further direction. The DON confirmed on 5/19/26 at 2:51 PM that if four (4) staff were needed to transfer Resident #1 from the floor, staff should have stopped, lowered Resident #1 back to the floor, and notified the on-call provider for additional direction.On 4/22/26, Resident #1 was transferred to the Emergency Department following continued complaints of right hip and leg pain and an observed shortening of the right leg by approximately 1.5 to 2 inches compared to the left leg. Hospital documentation confirmed an acute, impacted intertrochanteric fracture of the right proximal femur. An Open Reduction and Internal Fixation was completed on 4/27/26.Review of the Change in Condition policy dated 8/1/22 directed, in part, the facility is to notify the resident and/or healthcare decision maker and the attending physician of changes in the resident's medical condition. Changes in condition shall be properly documented in the resident's medical record in accordance with policies, procedures and protocols of the facility and the resident's treatment and plan of care is updated timely. The RN supervisor is responsible for monitoring and ensuring appropriate policies, procedures, protocols and standards of care are put into practice for all residents with potential for and/or actual changes in condition. The RN supervisor contacts the attending physician or covering physician timely regarding the change in condition and provides assessment. Update the resident's plan of care and treatments as ordered by the attending physician and monitor for effects of treatment plan. The licensed nurse conducts rounds on all residents throughout the shift and interacts primarily with NAs for resident's current status as a standard of practice. Rounds include observing residents and communicating with the NAs as appropriate. NAs identify changes in the resident's status and reports to the licensed nurse a change in ADL status, altered mental status or other medical conditions not consistent with the resident's normal plan of care. NA staff are responsible for knowing the appropriate care to give and what to report on their resident as noted on the NA assignments, care card and communicated during shift report.Review of the Pain Management policy dated 1/8/25 directed, in part, all residents will be evaluated as part of the nursing assessment process for the presence of pain with change in condition or a new onset of pain. Assess the resident for recurring, chronic or uncontrolled pain. Unrelieved pain has negative physical and psychological consequences including the potential for threatening functional ability. Whenever a resident's pain medication is deemed to be ineffective for controlling the resident's pain and other care planned interventions are ineffective, the resident's attending physician is to be notified. The licensed nurse may administer medications or other (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	non-pharmacological interventions as indicated and initiate a pain assessment for a new onset of pain or pain that is not relieved with treatment and notify the attending physician. Residents receiving pain medication on an as needed basis are to have their pain level assessed before giving the medication and about one (1) hour after receiving pain medication indicating the relief received by utilizing the pain scale zero (0) to ten (10) or cognitively impaired scale. This information is to be documented in the Electronic Medication Administration Record (EMAR). The licensed nurse is to update the attending physician for resident's identified with unmanageable pain management. Chronic uncontrolled pain may be referred to additional resources upon attending physician order. All staff are to report any observations or communications of pain to the assigned nurse as soon as practical.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on review of the clinical record, facility documentation, facility policy, and staff interviews for one (1) of three (3) sampled residents (Resident #1) reviewed for pain management, the facility failed to manage Resident #1's pain in accordance with facility policy and the resident's care plan. Specifically, licensed nurses failed to reassess pain within one (1) hour after administration of as-needed pain medication on multiple occasions; failed to recognize observable signs of significant pain during post-fall transfers as a change in condition requiring provider notification; and failed to administer pain medication in a timely manner following a fall that resulted in a major injury. Resident #1 subsequently sustained an acute intertrochanteric fracture of the right proximal femur requiring surgical repair.Resident #1's diagnoses included dementia without behavioral disturbances, chronic pain syndrome, aphasia, and generalized muscle weakness. The RCP dated 3/13/26 identified Resident #1 had chronic pain related to chronic pain syndrome and on 4/20/26 had pain and spasms to the right calf. Interventions included administering analgesia per orders, anticipating the resident's need for pain relief, responding immediately to any complaints of pain, and evaluating the effectiveness of pain interventions. The RCP further identified Resident #1 had a communication deficit related to aphasia, requiring the use of alternative communication tools and allowing adequate time to respond. Physician's orders dated 8/30/25 directed acetaminophen 650 mg by mouth every four (4) hours as needed for pain and oxycodone-acetaminophen 5-325 mg by mouth every four (4) hours as needed for pain. The Pain Management policy dated 1/8/25 directed, in part, that residents receiving pain medication on an as-needed basis are to have their pain level assessed before administration and approximately one (1) hour after receiving the medication, and that if pain medication is deemed ineffective and other care-planned interventions are ineffective, the attending physician is to be notified.Failure to Reassess Pain Within One Hour of As-Needed Medication Administration: A Medication Administration Note dated 4/20/26 at 3:16 AM identified oxycodone-acetaminophen was administered for pain; however, the follow-up pain assessment was not documented until 5:33 AM - two (2) hours and fifteen (15) minutes later - exceeding the one (1) hour reassessment requirement established by facility policy. A Medication Administration Note dated 4/21/26 at 8:16 PM identified oxycodone-acetaminophen was again administered for pain; the follow-up pain assessment was not documented until 11:10 PM - two (2) hours and fifty-four (54) minutes later - after Resident #1 had already sustained a fall. That follow-up identified the medication was ineffective, with a pain level of eight (8) out of ten (10). Review of the clinical record dated 4/21/26 further failed to identify that methocarbamol 1000 mg, administered at 10:23 PM, was reassessed within one (1) hour of administration as required by policy. Interview with RN #3 on 5/20/26 at 10:30 AM confirmed she administered oxycodone-acetaminophen at approximately 8:00 PM for right leg pain and did not reassess Resident #1's pain within one (1) hour, acknowledging she should have done so and, if the medication was ineffective, should have administered acetaminophen and notified the supervisor. Interview with the DON on 5/19/26 at 2:51 PM confirmed that when pain relief medications are administered, licensed nurses should reassess the resident's pain level within one (1) hour, and if ineffective, administer an additional pain relief medication and notify the supervisor and provider.Failure to Recognize Observable Pain During Post-Fall Transfers as a Change in Condition: The Change/Event note by RN #1 dated 4/21/26 at 10:39 PM identified Resident #1 complained of pain to the right knee and leg following the fall at 10:15 PM. Interview with RN #1 on 5/19/26 at 12:37 PM and interview with RN #3 on 5/20/26 at 10:30 AM both confirmed that Resident #1 displayed facial grimacing, clenched his/her teeth, and complained of severe pain throughout transfers that required four (4) staff members. Despite these observable signs of significant pain, neither licensed nurse identified them as a change in condition requiring provider notification or a halt to the transfer. Interview with APRN #1 on 5/19/26 at 1:52 PM confirmed that the increased pain with movement and the shortening of Resident #1's right leg should have been identified and reported to a (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	provider at the time it was identified, and that licensed nurses should reevaluate the effectiveness of pain medication per policy and notify the provider of unrelieved pain. The DON confirmed on 5/19/26 at 2:51 PM that staff should have stopped the transfer, lowered Resident #1 to the floor, and notified the on-call provider for direction.Failure to Provide Timely Pain Medication Following a Fall with Identified Pain: The Change/Event note by RN #1 dated 4/21/26 at 10:39 PM identified Resident #1 complained of pain to the right knee and leg following the fall at 10:15 PM. Review of the clinical record failed to identify that pain medication was administered until 11:12 PM - approximately fifty-seven (57) minutes after the fall and the identification of pain. Interview with RN #1 on 5/19/26 at 12:37 PM confirmed Resident #1 should have been medicated for pain immediately following the fall. The DON confirmed on 5/19/26 at 2:51 PM that Resident #1 should have been medicated with pain relief medication immediately following the fall with identified pain.On 4/22/26, Resident #1 was transferred to the Emergency Department following continued complaints of right hip and leg pain and an observed shortening of the right leg by approximately 1.5 to 2 inches compared to the left leg. Hospital documentation confirmed an acute, impacted intertrochanteric fracture of the right proximal femur. An Open Reduction and Internal Fixation was completed on 4/27/26.Review of the Pain Management policy dated 1/8/25 directed, in part, all residents will be evaluated as part of the nursing assessment process for the presence of pain with change in condition or a new onset of pain. Assess the resident for recurring, chronic or uncontrolled pain. Unrelieved pain has negative physical and psychological consequences including the potential for threatening functional ability. Whenever a resident's pain medication is deemed to be ineffective for controlling the resident's pain and other care planned interventions are ineffective, the resident's attending physician is to be notified. The licensed nurse may administer medications or other non-pharmacological interventions as indicated and initiate a pain assessment for a new onset of pain or pain that is not relieved with treatment and notify the attending physician. Residents receiving pain medication on an as needed basis are to have their pain level assessed before giving the medication and about one (1) hour after receiving pain medication indicating the relief received by utilizing the pain scale zero (0) to ten (10) or cognitively impaired scale. This information is to be documented in the Electronic Medication Administration Record (EMAR). The licensed nurse is to update the attending physician for resident's identified with unmanageable pain management. Chronic uncontrolled pain may be referred to additional resources upon attending physician order. All staff are to report any observations or communications of pain to the assigned nurse as soon as practical.