STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075326	A. Building B. Wing	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evergreen Center for Health & Rehabilitation	205 Chestnut Hill Road Stafford Springs, CT 06076

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 review of the clinical record, facility documentation, facility policy and interviews for one (1) of three (3) residents (Resident #1) reviewed for falls, the facility failed to ensure the resident's side-rail was locked into place prior to directing the resident to turn onto their left side in bed resulting in a fall with injury. The findings include:Based on review of clinical records , facility documentation, facility policy and interviews for one (1) of three (3) sampled residents (Resident #1) who required assistance of one (1) staff member with bed mobility, the facility failed to ensure the resident's side-rail was locked into place prior to directing the resident to turn in bed which resulted in the resident falling out of bed and sustaining injuries. The findings include: Resident #1's diagnoses include dementia with agitation, a history of falling and age-related osteoporosis (weak, brittle bones). The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of three (3) out of fifteen (15) indicating severe impaired cognition and required substantial assistance for bed mobility and transfers. The Resident Care Plan dated 7/8/25 identified Resident #1 had a deficit in self-care and functional mobility due to dementia. Interventions directed to utilize padded side-rails and partial to moderate assistance of one (1) staff with bed mobility. The resident kardex (care card) dated 7/16/25 identified Resident #1 utilized side-rails for assistance with bed mobility. The nurse's note dated 7/17/25 at 7:50 AM identified during care, NA #1 instructed Resident #1 to roll onto their side and grab the side-rail, the side-rail was not locked, and Resident #1 fell out of bed. The note indicated Resident #1's head hit the corner of the table and sustained a laceration to the head and bruising to the knees, Resident #1 was alert and complained of a headache. The note identified that the Medical Director was in the facility at the time of the incident and an order was obtained to transfer Resident #1 to the Emergency Department (ED) for further evaluation. The Facility Reported Incident form dated 7/17/25 identified at 6:45 AM Resident #1 was receiving care in bed by NA #1, Resident #1 rolled onto his/her left side reaching for the side-rail with his/her right hand and when Resident #1 grabbed onto the side-rail and applied pressure, the side-rail lowered and Resident #1 subsequently rolled off the bed, striking his/her head on the bedside table sustaining a three (3) centimeter (cm) by 0.2 cm laceration (a cut/tear in the skin) and bruising to the right knee and lower leg. The report identified Resident #1 was assessed, the family and provider were notified of the incident, and a new order was obtained to transfer the resident to the Emergency Department (ED) for evaluation. The hospital ED note dated 7/17/25 identified Resident #1 was seen in the ED following a witnessed fall out of bed with a head strike sustaining a laceration to the head and abrasions (superficial injury to the skin caused by scraping or rubbing) to the right knee. The note identified imaging was completed and were negative for any acute fractures, two (2) staples were placed to the laceration to the back of the head and Resident #1 was to follow-up with their Primary Care Physician (PCP) for staple removal in ten (10) to fourteen (14) days. The nurse's note dated 7/17/25 at 3:15 PM identified Resident returned to the facility with two (2) staples to the back of the head and bruising to the right forearm, right knee, and right shin. Interview with NA #1, on 8/7/25 at 9:05 AM identified on 7/17/25 Resident #1 required a bed change with morning care. NA #1 identified she lowered the left side-rail, made the left side of the bed and then raised the left side-rail back up. NA #1 reported she turned Resident #1 onto his/her left side and requested Resident #1 turn a little more, when Resident #1 grabbed onto the left side-rail with his/her right arm, the side-rail lowered down and Resident #1 rolled off the left side of the bed, hitting their head on the nightstand and falling to the floor, landing on his/her right side between the bed and the window. NA #1 reported she yelled for the nurse and the 11PM-7AM Nursing Supervisor came to assess Resident #1. NA #1 identified that although she pulled the left side-rail back up after lowering it to put the fitted sheet on the mattress, she failed to ensure the side-rail clicked and locked back into place. Interview with the Director of Maintenance on 8/6/25 at 12:55 PM identified following Resident #1's fall out of bed on 7/17/25, all the beds within the facility were checked, the side-rails were inspected and found to be in working order without issues. The Director of Maintenance reported the side-rails are inspected annually and as needed and the last inspection was 12/16/24 through 12/24/24. Interview with the Director of Nursing (DON) on 8/6/25 at 1:25 PM identified that for all residents who utilize side-rails for bed-mobility/enablers, staff are expected to ensure the side-rails are locked into place prior to providing any bed-level care to a resident. The DON reported following her investigation of the 7/17/25 fall, if NA #1 had ensured the left side-rail was raised in the locked position, Resident #1 would not have fallen out of bed and sustained the laceration to his/her