STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075329	A. Building B. Wing	09/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ingraham Manor	400 N Main St Bristol, CT 06010

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for 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 sampled resident (Resident #1) reviewed for wandering, the facility failed to ensure a wander assessment was completed accurately, and failed to ensure a resident with known wandering behaviors had a wander guard order in place for use, had the wander guard applied in accordance with the plan of care, and failed to ensure orders were initiated to check placement and function of a wander guard. The findings include: Based on review of the clinical record, facility documentation, facility policy, and interviews for one sampled resident (Resident #1) reviewed for wandering, the facility failed to ensure a wander assessment was completed accurately, and failed to ensure a resident with known wandering behaviors had a wander guard order in place for use, had the wander guard applied in accordance with the plan of care, and failed to ensure orders were initiated to check placement and function of a wander guard. The findings include: Resident #1's diagnoses included vascular dementia, and anxiety disorder. Wander risk assessment dated [DATE] identified Resident #1 had a score of eleven (11), which indicated he/she was a high risk (score 0 to 8 = low risk, 9 to 10 = at risk, 11 and above = high risk). Nursing note dated 7/5/2025 at 6:18 AM identified Resident #1 was agitated and combative during early morning hours, struck Nurse Aide (NA) during care, displayed aggressive behaviors toward staff, including attempting to hit staff with walker. Ambulating rapidly through the hallways, unsteady on feet and unable to redirect. All de-escalation and redirection attempts were unsuccessful, refused medications, food and fluids, threw Ensure supplement at nurse. Physician notified with new orders to transfer to hospital for evaluation. Transfer to hospital at 6:15 AM. Review of the Hospitalization Records dated 7/5 to 7/24/2025 identified Resident #1 was admitted to the Behavioral Health Unit on 7/5/2025 and was discharged back to the skilled nursing facility on 7/24/2025. A readmission wander risk assessment dated [DATE] identified Resident #1 had a score of eight (8) and was deemed to be low risk (score 0 to 8 = low risk, 9 to 10 = at risk, 11 and above = high risk to wander). Review of the wander assessment dated [DATE] identified it was incomplete. Sections G and H were left blank and not answered. Section G question indicated to complete 72 hours post admission, and required to answer, the resident: has not wandered (0 points), has wandered within the home without leaving grounds (1 point), has wandered aimlessly within the home or off the grounds (5 points). Section H question indicated to complete at 1 month, quarterly, annually, with significant change and screening. The section required to answer, the resident: has had no reported episodes of wandering in the past 6 months (0 points), has had no reported episodes of wandering the past 3 months (1 point), has wandered in the past month (5 points). Review identified per the assessment directions, section H should have been completed when the assessment was performed, and should have added 5 points to the assessment, for a score of 13, at high risk. Interview and record review with the DON (Director of Nursing) on 9/8/2025 at 2:05 PM identified Resident #1 was identified as at risk for wandering/elopement prior to transfer to the hospital on 7/5/2025. Review of Resident #1's wandering risk assessment dated [DATE] identified she was unaware section G and H were blank. The DON stated staff should complete the assessment in accordance with the assessment directions, and section H should be completed as a screening. The DON stated although the assessment dated [DATE] identified Resident #1 was a low risk, if the staff had completed sections in accordance with the directions (complete section H for the admission screening), Resident #1's new score would have been eleven (11), indicative of a high risk to wander. Interview failed to identify why the wander assessment was incomplete and inaccurate. a. Record review identified all physician orders for Resident #1 were discontinued on 7/17/2025 due to the transfer to hospital, and he/she was no longer in the facility. Review identified the orders that were discontinued included an order for wander guard use and to check wander guard placement every shift and function daily. Record review identified Resident #1 was readmitted to the facility on [DATE]; nursing note dated 7/24/2025 at 2:45 PM identified Resident #1 was alert and oriented to person only. The readmission Resident Care Plan dated 7/24/2025 identified an elopement risk/wanderer. Interventions directed Resident #1 to wear a wander guard, check for placement and function as ordered, document wandering behavior, distract from wandering by offering pleasant diversions, structured activities, food, conversation, television, or a book, and to provide structured activities such as toileting, walking inside and outside, reorientation strategies to include signs, pictures, and memory boxes. APRN note 7/25/2025 at 11 AM identified Resident #1 was seen after readmission. Resident #1 ambulated with a walker independently, and was alert and oriented to person only

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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)

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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 observation, review of the clinical record, facility documentation, facility policy, and interviews for one sampled resident (Resident #1) reviewed for wandering, the facility failed to ensure a resident with known wandering behaviors was not able to leave the unit without staff knowledge, resulting in a fall with injury in the stairwell. The findings include: Based on observation, review of the clinical record, facility documentation, facility policy, and interviews for one sampled resident (Resident #1) reviewed for wandering, the facility failed to ensure a resident with known wandering behaviors was not able to leave the unit without staff knowledge, resulting in a fall with injury in the stairwell. The findings include: Resident #1's diagnoses included vascular dementia, and anxiety disorder. Wander risk assessment dated [DATE] identified Resident #1 had a score of eleven (11), which indicated he/she was a high risk (score 0 to 8 = low risk, 9 to 10 = at risk, 11 and above = high risk). Nursing note dated 7/5/2025 at 6:18 AM identified Resident #1 was agitated and combative during early morning hours and displayed aggressive behaviors toward staff. Resident #1 was ambulating rapidly through the hallways, unsteady on feet and unable to redirect. All de-escalation and redirection attempts were unsuccessful. Physician notified with new orders to transfer to hospital for evaluation. Transfer to hospital at 6:15 AM. Review of the Hospitalization Records dated 7/5/2025 to 7/24/2025 identified Resident #1 was admitted on [DATE] and was discharged back to the skilled nursing facility on 7/24/2025. Record review identified all physician orders for Resident #1 were discontinued on 7/17/2025 due to the transfer to hospital, and he/she was no longer in the facility. Review identified the orders that were discontinued included an order for wander guard use and to check wander guard placement every shift and function daily. APRN note 7/25/2025 at 11 AM identified Resident #1 was seen after readmission, Resident #1 ambulated with a walker independently, and was alert and oriented to person only. Record review identified although prior orders were re-instated upon readmission on [DATE], the order for wander guard use was not re-instated/renewed. The readmission Resident Care Plan dated 7/24/2025 identified an elopement risk/wanderer. Interventions directed Resident #1 to wear a wander guard, check for placement and function as ordered, document wandering behavior, distract from wandering by offering pleasant diversions, structured activities, food, conversation, television, or a book, and to provide structured activities such as toileting, walking inside and outside, reorientation strategies to include signs, pictures, and memory boxes. Review of the nursing progress notes from 7/25/2025 to 8/6/2025 identified Resident #1 was noted to have wandering behaviors on 7/25/2025, 7/28/2025, 8/3/2025, 8/4/2025, and 8/5/2025. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of one out of fifteen (1/15), indicative of being severely cognitively impaired, ambulated with a walker, and had no wandering behaviors. The facility reportable event form dated 8/6/2025 at 9:50 AM identified Resident #1 had dementia with behaviors and ambulated independently. The form identified Resident #1 was found on the floor, on A**** High side (location of facility unit), on his/her right side and complained of pain to the right hip. Resident #1 had a laceration to the head and face and was transferred to the hospital for evaluation. The facility incident summary dated 8/8/2025 identified Resident #1 was last observed by nursing staff at the nursing station at approximately 9:30 AM and was subsequently found about 20 minutes later by housekeeping staff on the egress stairwell. The summary indicated Resident #1 was wearing sneakers, and passed through a door that is equipped with a delayed-egress mechanism that complies with fire safety regulations, releasing after 15 seconds of sustained pressure. Resident #1 was transferred to the hospital and was identified to have a right hip fracture. Interview with the Administrator and Director of Maintenance on 9/8/2025 at 9:30 AM identified the door leading into the stairwell where Resident #1 was found sounds an alarm when the door is opened to alert staff someone is exiting through the door. Interview with the Administrator on 9/8/2025 at 11:00 AM identified Resident #1 was at risk for wandering/elopement and had a wander guard device at the time of the incident. The Administrator stated the facility did not have a locked (dementia) unit and the egress doors on Resident #1's unit do not have a wander guard alarm but alarm to alert staff that someone is exiting. Interview and observation with the Administrator on 9/8/2025 at 12:30 PM identified Resident #1 resided on the third (3rd) floor and was found on 8/6/2025 lying on the floor in the stairwell, at the bottom of the first (1st) flight of stairs. Coming from the 3rd floor, Resident #1 made it down one (1) set of stairs and was found on the floor on the landing. Interview failed to identify how Resident #1, with known wandering behaviors, was able to access the stairwell from