| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 075329 | A. Building<br>B. Wing | 11/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Ingraham Manor | 400 N Main St<br>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 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<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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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, facility documentation review, and staff interviews for one of three residents (Resident #1) reviewed for accidents, the facility failed to ensure assistance was provided safely and in accordance with physician orders to prevent a fall with injury. The findings include:Resident #1 had a diagnosis of difficulty in walking, and osteoarthritis. The significant change Minimum Data Set (MDS) dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition, and required [NAME] assistance for transfers. Physician order dated 10/6/2025 directed to transfer Resident #1 with the assistance of one (1) staff with a rolling walker. The facility reportable event form dated 10/11/2025 at 12:05 AM identified Resident #1 was found on the floor, transferred to the hospital and identified with a fractured humorous (upper arm bone). Nursing note dated 10/11/2025 at 1:09 AM identified at 12:05AM while staff were assisting Resident #1 with a transfer, Resident #1 fell forward behind his/her wheelchair and landed in a prone (face down) position. Resident #1 was alert and oriented and uses an assistive device that was not being used at the time of the transfer. Resident #1 complained of ten (10) out of ten (10) right upper extremity pain, emergency services were called, and Resident #1 was transferred to the hospital for evaluation. Nursing note dated 10/11/2025 at 11:10 AM identified Resident #1 returned from the hospital at 1045 AM with splint to right arm and long immobilizer to right leg. The facility reportable event summary dated 10/14/2025 identified Resident #1 was standing while his/her brief was being tightened and his/her knee buckled and (the resident) fell forward. The NA called for help, the nurse assessed Resident #1 and new orders were obtained to transfer to the hospital. Hospital x-rays identified a fractured right humorous and a fractured right patella (knee). Interview with NA #1 on 10/28/2025 at 1:40 PM identified she was the NA providing care for Resident #1 on 10/11/2025 when the fall occurred. NA #1 stated Resident #1 required assistance of one (1) for transfers. NA #1 used a wheelchair to bring Resident #1 to the bathroom and returned Resident #1 to his/her recliner, using the wheelchair. NA #1 stated she locked the wheelchair and stood Resident #1 up facing the front of the wheelchair to adjust his/her brief. She did not use Resident #1's walker. Resident #1 held onto the wheelchair arms, and he/she was holding onto the wheelchair, the wheelchair moved, and Resident #1 fell to the floor. Interview with the Director of Rehabilitation on 10/28/2025 at 12:07 PM identified prior to the fall, Resident #1 had the ability to stand with the assistance of one (1) staff with a supportive device, and at the time of the fall required assist of one (1) staff with a rolling walker. The Director of Rehabilitation further stated a wheelchair should not be used as a supportive or assistive device to support a resident while they stand, but a walker, grab bar, or railing should be used instead. Interview with the Administrator on 10/28/2025 at 2:26 PM identified staff informed her that NA #1 was adjusting Resident #1's brief while standing up and holding onto the back of the wheelchair with the wheelchair locked. Resident #1's knee buckled, and he/she fell to the floor. Review of facility undated Fall Prevention Policy directed staff to ensure each resident receives adequate supervision and appropriate assistive devices to prevent falls. |