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	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ingraham Manor Rehab and Nursing	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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interviews and facility documentation/policies, for one (1) of three (3) residents (Resident #1) reviewed for advance directives, the facility failed to ensure advance directives/code status were readily accessible to staff during an emergency. Resident #1 was documented as a Full Code; however, when Resident #1 was found unresponsive and without a pulse, licensed staff were unable to determine the resident's code status and did not initiate the facility's emergency response. The findings included:Review of the hospital Discharge summary dated [DATE] identified Resident #1 was a Full Code (medical order directing staff to initiate all resuscitative measures, including CPR and advanced life support, if a resident has no pulse or respirations).Resident #1 was admitted to the facility on [DATE] with diagnoses which included Type II diabetes, acute kidney injury, and atherosclerotic heart disease.The Nursing admission assessment by RN #2 dated [DATE] at 10:37 PM (created date [DATE] at 10:09 AM) identified Resident #1 arrived to the facility by wheelchair, was oriented to person, time, situation, and was a Full Code.Review of physician's orders dated [DATE] identified Resident #1 was a Full Code.A progress note by RN #1 dated [DATE] at 6:09 AM identified Resident #1 was pulseless, without respiration, was pronounced expired, and the resident representative was notified.Interview with LPN #1 on [DATE] at 11:08 AM identified he/she went to Resident #1's room between 6:10 AM and 6:15 AM on [DATE] to obtain a blood glucose level and found him/her pulseless and without respirations. LPN #1 identified he/she did not know Resident #1's code status (medical order indicating whether resuscitation measures, such as CPR should be initiated if a person has no pulse or respirations) and was unable to confirm the code status because his/her computer was not on. LPN #1 indicated he/she performed a sternal rub with no response, then left the room, found LPN #2 and asked him/her to check on Resident #1 while he/she paged RN #1 to report Resident #1 was pulseless and without respirations. LPN #1 identified that the Electronic Medical Record (EMR) was the only location where she could find and confirm a residents code status. LPN #1 identified he/she should have confirmed Resident #1's code status, overhead paged a code blue to alert licensed staff that there was a resident who required CPR, and initiated CPR.Interview with RN #1 on [DATE] at 11:36 AM identified that on [DATE] LPN #1 notified him/her that Resident #1 was not breathing. RN #1 identified he/she arrived to the room approximately four (4) to five (5) minutes after the notification and assessed Resident #1. RN #1 identified that CPR should have been initiated but indicated he/she did not initiate CPR because he/she believed rigor mortis (temporary hardening of muscles after death) had already set in. RN #1 further identified that LPN #1 should have called a code, CPR should have been initiated, and emergency medical services (EMS) should have been activated. RN #1 further identified Resident #1's advanced directives were not yet signed at the time of the event, however, facility practice was to follow the advanced directives identified on the hospital discharge documents, which indicated Resident #1 was (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a Full Code. Interview with LPN #2 on [DATE] at 1:08 PM identified he/she was informed by LPN #1 on [DATE] that Resident #1 had expired and found him/her pulseless and non-responsive upon evaluation. LPN #2 identified facility practice was to follow the Advanced Directive indicated on the hospital discharge summary, however, LPN #2 was unaware Resident #1 was a full code.Interview with the Director of Nursing Services (DNS) on [DATE] at 3:02 PM identified residents would be considered a Full Code unless otherwise decided, following admission from the hospital.Interview with facility Administration on [DATE] at 4:02 PM identified the facility was transitioning from paper charts to an EMR system. Administration identified they were initially unsure whether advance directives were maintained in the paper charts. Administration reported reviewing several paper charts and locating advance directive documents under the advance directive tab. Administration identified the facility did not have a process to ensure advance directives for newly admitted residents were readily identifiable in the paper chart. Administration identified advance directives for newly admitted residents could be located within hospital documents or physician order sections of the paper chart but were unable to identify how long it would take to locate the documents during a medical emergency due to the volume of documentation in those sections. Administration reported they were unaware that LPN #1 was unable to identify where to access Resident #1's advance directives outside of the EMR.The Advanced Directive policy identified adult persons had the fundamental right to control the decisions related to the rendering of their own medical care and that advanced directives are a legally recognized written declaration specifying the person's wishes in directing future care.

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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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interviews, and facility documentation/policies, for one (1) of three (3) residents (Resident #1) reviewed for cardiopulmonary resuscitation (CPR), the facility failed to initiate CPR and activate Emergency Medical Services (EMS) for a resident identified as a Full Code after the resident was found pulseless and without respirations. The facility's failure to initiate life-saving measures resulted in Immediate Jeopardy. The findings included:Review of the hospital Discharge summary dated [DATE] identified Resident #1 was a Full Code (medical order directing staff to initiate all resuscitative measures, including CPR and advanced life support, if a resident has no pulse or respirations).Resident #1 was admitted to the facility on [DATE] with diagnoses which included Type II diabetes, acute kidney injury, and atherosclerotic heart disease.The Nursing admission assessment by RN #2 dated [DATE] at 10:37 PM (created date [DATE] at 10:09 AM) identified Resident #1 arrived to the facility by wheelchair, was oriented to person, time, situation, and was a Full Code.Review of physician's orders dated [DATE] identified Resident #1 was a Full Code.Review of vital signs obtained on [DATE] at 12:18 AM included a blood pressure (BP) of 168/70 and a temporal temperature of 98 degrees Fahrenheit.Review of vital signs obtained on [DATE] at 4:25 AM included a BP of 137/44 and a temporal temperature of 95 degrees Fahrenheit.A progress note by RN #1 dated [DATE] at 6:09 AM identified Resident #1 was pulseless, without respiration, was pronounced expired, and the resident representative was notified.A progress note by RN #1 dated [DATE] at 7:06 AM identified the provider was notified Resident #1 expired and an order was received to release remains to the funeral home.Interview with LPN #1 on [DATE] at 11:08 AM identified he/she went to Resident #1's room between 6:10 AM and 6:15 AM on [DATE] to obtain a blood glucose level and found him/her pulseless and without respirations. LPN #1 identified he/she did not know Resident #1's code status (medical order indicating whether resuscitation measures, such as CPR should be initiated if a person has no pulse or respirations) and was unable to confirm the code status because his/her computer was not on. LPN #1 indicated he/she performed a sternal rub with no response, then left the room, found LPN #2 and asked him/her to check on Resident #1 while he/she paged RN #1 to report Resident #1 was pulseless and without respirations. LPN #1 identified that the Electronic Medical Record (EMR) was the only location where she could find and confirm a residents code status. LPN #1 identified he/she should have confirmed Resident #1's code status, overhead paged a code blue to alert licensed staff that there was a resident who required CPR, and initiated CPR.Interview with RN #1 on [DATE] at 11:36 AM identified that on [DATE] LPN #1 notified him/her that Resident #1 was not breathing. RN #1 identified he/she arrived to the room approximately four (4) to five (5) minutes after the notification and assessed Resident #1. RN #1 identified that CPR should have been initiated but indicated he/she did not initiate CPR because he/she believed rigor mortis (temporary hardening of muscles after death) had already set in. RN #1 further identified that LPN #1 should have called a code, CPR should have been initiated, and EMS should have been activated. Interview with MD #1 on [DATE] at 12:14 PM identified the facility should have initiated CPR and activated EMS once Resident #1 was determined to be pulseless and without respirations, even if the resident appeared to have expired. MD #1 further identified the facility was required to activate EMS because there was no physician's order authorizing a registered nurse to pronounce the resident's death.Interview with LPN #2 on [DATE] at 1:08 PM identified she was informed by LPN #1 on [DATE] that Resident #1 expired. LPN #2 went to check on Resident #1 and identified he/she was pulseless. LPN #2 indicated she moved Resident #1's head, tapped his/her face, and called out his/her name but received no (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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	response. LPN #2 identified Resident #1 was resting with hands folded and fingers intertwined on his/her abdomen. LPN #2 identified he/she moved Resident # 1's left arm with ease to palpate for a radial pulse and further identified there was no stiffness of the extremity or fingers. LPN #2 identified she did not initiate CPR at that time, however, indicated he/she should have initiated CPR once Resident #1 was identified without pulse and respiration, a code should have been called, and EMS activated. Interview with the Director of Nursing Services (DNS) on [DATE] at 3:02 PM identified when a resident with a full code status is found without a pulse and respirations, staff should call for help, call a code blue three (3) times over the intercom with the room number and location, and initiate CPR immediately. The DNS further indicated that the resident would be considered a full code unless otherwise decided following admission from the hospital.Review of the CPR policy directed that CPR would be performed on appropriate residents by CPR certified staff members and that the supervisor or charge nurse would be in charge of providing organization and directives.The facility submitted a Plan of Correction for past noncompliance dated [DATE] which was accepted by the State Agency during an on-site inspection on [DATE] at 5:08 PM. The Plan of Correction included the following: The facility audited all resident charts to confirm code status was active in the electronic medical record (EMR).Educated all nursing staff on Response to Unresponsive Residents and Code Status, CPR, and a Mock Code was conducted followed by a code debrief on all 3 shifts.A Code Procedure Checklist (competency evaluation) was performed for all licensed staff.Code blue mock drills would be conducted weekly x4 then monthly x3.The Corrective action plan was scheduled for QAPI review on [DATE].

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation/policies, and interviews for one (1) of three (3) residents (Resident #1) reviewed for cardiopulmonary resuscitation (CPR), the facility failed to ensure licensed nursing staff provided necessary emergency services when three (3) licensed nurses (LPN #1, LPN #2, and RN #1) did not initiate cardiopulmonary resuscitation (CPR) or activate emergency medical services (EMS) for a resident who was documented as a Full Code and the Registered Nurse pronounced the resident deceased without a physician order authorizing Registered Nurse Pronouncement (RNP). The findings included:Review of the hospital Discharge summary dated [DATE] identified Resident #1 was a Full Code (medical order directing staff to initiate all resuscitative measures, including CPR and advanced life support, if a resident has no pulse or respirations).Resident #1 was admitted to the facility on [DATE] with diagnoses which included Type II diabetes, acute kidney injury, and atherosclerotic heart disease.The Nursing admission assessment by RN #2 dated [DATE] at 10:37 PM (created date [DATE] at 10:09 AM) identified Resident #1 arrived to the facility by wheelchair, was oriented to person, time, situation, and was a Full Code.Review of physician's orders dated [DATE] identified Resident #1 was a Full Code.Review of vital signs obtained on [DATE] at 12:18 AM included a blood pressure (BP) of 168/70 and a temporal temperature of 98 degrees Fahrenheit.Review of vital signs obtained on [DATE] at 4:25 AM included a BP of 137/44 and a temporal temperature of 95 degrees Fahrenheit.A progress note by RN #1 dated [DATE] at 6:09 AM identified Resident #1 was pulseless, without respiration, was pronounced expired, and the resident representative was notified.A progress note by RN #1 dated [DATE] at 7:06 AM identified the provider was notified Resident #1 expired and an order was received to release remains to the funeral home.Interview with LPN #1 on [DATE] at 11:08 AM identified he/she went to Resident #1's room between 6:10 AM and 6:15 AM on [DATE] to obtain a blood glucose level and found him/her pulseless and without respirations. LPN #1 identified he/she did not know Resident #1's code status (medical order indicating whether resuscitation measures, such as CPR should be initiated if a person has no pulse or respirations) and was unable to confirm the code status because his/her computer was not on. LPN #1 indicated he/she performed a sternal rub with no response, then left the room, found LPN #2 and asked him/her to check on Resident #1 while he/she paged RN #1 to report Resident #1 was pulseless and without respirations. LPN #1 identified that the Electronic Medical Record (EMR) was the only location where she could find and confirm a residents code status. LPN #1 identified he/she should have confirmed Resident #1's code status, overhead paged a code blue to alert licensed staff that there was a resident who required CPR, and initiated CPR.Interview with RN #1 on [DATE] at 11:36 AM identified that on [DATE] LPN #1 notified him/her that Resident #1 was not breathing. RN #1 identified he/she arrived to the room approximately four (4) to five (5) minutes after the notification and assessed Resident #1. RN#1 identified he/she auscultated Resident #1's lungs and heart, evaluated his/her eyes, checked for a blood pressure, and determined Resident #1 had expired. RN #1 further identified he/she contacted the Administrator to report Resident #1 expired. RN #1 identified that CPR should have been initiated but indicated he/she did not initiate CPR because he/she believed rigor mortis (temporary hardening of muscles after death) had already set in. RN #1 further identified that LPN #1 should have called a code, CPR should have been initiated, and EMS should have been activated. Interview with MD #1 on [DATE] at 12:14 PM identified the facility should have initiated CPR and activated EMS once Resident #1 was determined to be pulseless and without respirations, even if the resident appeared to have expired. MD #1 further identified the facility was required to activate EMS because there was no physician's order (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	authorizing a registered nurse to pronounce the resident's death.Interview with LPN #2 on [DATE] at 1:08 PM identified she was informed by LPN #1 on [DATE] that Resident #1 expired. LPN #2 went to check on Resident #1 and identified he/she was pulseless. LPN #2 indicated she moved Resident #1's head, tapped his/her face, and called out his/her name but received no response. LPN #2 identified Resident #1 was resting with hands folded and fingers intertwined on his/her abdomen. LPN #2 identified he/she moved Resident # 1's left arm with ease to palpate for a radial pulse and further identified there was no stiffness of the extremity or fingers. LPN #2 identified she did not initiate CPR at that time, however, indicated he/she should have initiated CPR once Resident #1 was identified without pulse and respiration, a code should have been called, and EMS activated.Interview with the Director of Nursing Services (DNS) on [DATE] at 3:02 PM identified when a resident with a full code status is found without a pulse and respirations, staff should call for help, call a code blue three (3) times over the intercom with the room number and location, and initiate CPR immediately. The DNS further indicated that the resident would be considered a full code unless otherwise decided following admission from the hospital. The DNS identified a physician's order was required for an RNP.Review of the CPR policy directed that CPR would be performed on appropriate residents by CPR certified staff members and that the supervisor or charge nurse would be in charge of providing organization and directives.The Pronouncement of Death policy identified it was the policy of the facility to permit a Registered Nurse (RN) to make a determination and pronouncement of death when certain conditions, as outlined in the procedures below, have been met. These procedures included: an attending physician must determine that the prognosis for a patient is for an anticipated death (anticipated death was defined as death which was expected to occur within 120 days due to illness, infirmity, or disease), the physician must document such determination in the patient's medical or clinical record, and the physician must authorize in writing, at the time of determination and documentation, that Registered Nurses in the facility may make a determination and pronouncement of death.