STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075347	A. Building B. Wing	11/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Suffield House Rehabilitation and Healthcare Cente	1 Canal Road Suffield, CT 06078

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 - Minimal harm or potential for 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

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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 - 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 (1) of two (2) residents (Resident #1) reviewed for falls, the facility failed to provide adequate supervision for a resident at high risk for falls, who sustained seven (7) falls since admission to the facility leading up to a fall with injury. The findings include:Resident #1 was admitted to the facility on [DATE] with diagnoses that included orthopedic aftercare following an amputation and dementia. Resident #1's family member was his/her health care proxy.Review of the hospital Discharge summary dated [DATE] identified Resident #1 had impaired cognitive status, was disorientated to place, time and situation, had decreased awareness for safety, decreased awareness of deficits and was difficult to re-orient.The Nursing admission assessment dated [DATE] at 1:02 PM identified Resident #1 was orientated to person and confused, had episodes of bladder incontinence, was non-ambulatory and required staff assistance with elimination. Resident #1 could not bear weight and/or must have been assisted into chair or wheelchair. A Fall risk assessment dated [DATE] at 1:02 PM identified Resident #1 had a score of eight (8) indicating he/she was at low risk for falls. Physician's orders dated 10/7/25 directed Trazodone (antidepressant medication sometimes used to assist with sleep) 50 mg half tablet every 12 hours as needed for sleep or agitation. Physician's orders dated 10/7/25 directed non-weight bearing due to LLE amputee. 1. An Accident and Incident form (A&I) dated 10/8/25 at 1:30 PM identified Resident #1 had an unwitnessed fall and was found on his/her buttocks in front of his/her recliner. Resident #1 had an abrasion to his/her upper back; the APRN was notified and ordered a dressing. The RCP dated 10/8/25 identified Resident #1 was at risk for falls. Interventions included bed in lowest position, call bell within reach, transfer with assistance, lock wheelchair brakes prior to transfer and keep room free of clutter. 2. The A&I dated 10/9/25 at 12:15 AM identified Resident #1 had an unwitnessed fall from his/her bed to the floor with no injuries. The APRN and health care proxy were notified. The RCP was updated on 10/9/25 with interventions for bolsters to the side of the bed to promote boundary awareness and padding to the floor along the bed edge. A Psychiatric note dated 10/9/25 recommended to discontinue Trazadone due to reported inefficacy and initiate Seroquel (antipsychotic medication used to manage behavioral symptoms) 12.5 mg at bedtime. A Physician's order dated 10/9/25 - 11/3/25 directed Seroquel 12.5 mg every 12 hours for agitation/restlessness. A Nursing note dated 10/9/25 at 2:44 PM identified Resident #1 had complaints of back pain, the APRN was updated and directed a spine X-ray. The spine X-rays identified there were no compression deformities or fractures demonstrated radiographically. A note by APRN #1 dated 10/10/25 identified Resident #1 had recent falls and continued to be impulsive and unaware of limitations secondary to cognitive deficits. The note directed to continue scheduled Seroquel for behaviors, anxiety and agitation. 3. The A&I dated 10/11/25 at 10:20 AM identified Resident #1 had an unwitnessed fall without injuries when attempting to go to the bathroom. The health care proxy and APRN were notified with no new orders. A Nursing note dated 10/11/25 at 10:34 AM identified Resident #1 was found on floor and stated he/she was going home. The note indicated Resident #1's health care proxy was updated and requested a private duty Nurse Aid (NA) but was unwilling to pay. The RCP was updated on 10/11/25 with an intervention to check the incontinence brief and offer the urinal every two hours. A note by APRN #1 dated 10/12/25 identified Resident #1 had multiple recent falls and continued to require 1:1 supervision as he/she was impulsive with transfers. The note indicated a 1:1 private NA was discussed due to continued behaviors and fall risk. 4. The A&I dated 10/13/25 at 2:00 PM identified Resident #1 had an unwitnessed fall without injury and was found on the floor in his/her room with his/her head near the recliner. The APRN was updated. 5. The A&I dated 10/14/25 at 7:30 AM identified Resident #1 was witnessed sliding out of a standard wheelchair in the hallway. Resident #1 was assisted to the floor and had no injuries. The APRN and health care proxy were updated. An Occupational Therapy (OT) note dated 10/14/25 at 9:32 AM identified Resident #1 was evaluated for positioning in a tilt-in-space wheelchair (wheelchair that tilts the entire seating system for positioning and support) and would trial a Velcro removable lap tray to decrease falls. The RCP was updated on 10/14/25 with an intervention to apply a Dycem (wheelchair cushion) to chair/wheelchair. A Nursing note dated 10/15/25 at 1:20 PM identified a self-releasing lap buddy was applied to Resident #1's wheelchair by OT and Resident #1 was able to remove the lap buddy independently without cueing or assistance. A note by APRN #1 dated 10/15/25 identified Resident #1 continued to demonstrate impulsive behaviors and was unaware of limitations secondary to cognitive deficits. Resident #1 continued to require supervision as