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	06/05/2026

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 - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation, facility policies, and interviews, for one (1) of two (2) sampled residents (Resident #1) reviewed for falls, the facility failed to ensure a resident, who had a known history of forwardˆleaning posture, impaired sitting balance, fatigue in the afternoon, and required staff assistance for transfers, was protected from falling forward from the wheelchair during a staffˆassisted transfer. This failure resulted in the resident falling forward from the wheelchair, striking the head, and sustaining cervical spine fractures. The findings include:Resident #1 was admitted to the facility on [DATE] with diagnoses that included osteoarthritis and dementia.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had moderately impaired cognition (Brief Interview for Mental Status (BIMS) score of 10), used a walker and/or wheelchair within the last seven (7) days, and was dependent on staff for chairˆtoˆbed and bedˆtoˆchair transfers.The Resident Care Plan (RCP) dated 4/30/26 identified Resident #1 had a selfˆcare deficit related to cognitive impairment, decreased independence with activities of daily living (ADL), decreased strength and endurance, decreased range of motion, and fluctuating ADL performance. The RCP identified Resident #1 was at risk for falls related to muscle weakness and decreased balance. Interventions included assist of two (2) staff for transfers using a fourˆwheeled walker, use of antiˆtippers on the wheelchair, and staff assistance with mobility.The Fall Risk Evaluation dated 4/14/26 identified Resident #1 scored fifteen (15), indicating a high fall risk.1.The Accident and Incident (A&I) form by LPN #1 dated 4/17/26 at 8:15 PM identified Resident #1 was found on the back with no injuries. A Nurse Aide (NA) identified Resident #1 lost strength during a transfer and was eased to the floor. The form identified Resident #1 required assistance for wheelchair mobility prior to the fall and had no change in mobility after the fall.A Situation, Background, Assessment Recommendation (SBAR) note by RN #1 dated 4/17/26 at 11:04 PM identified Resident #1 had a fall and a referral to rehabilitation was ordered for transfer concerns in the evening hours.A Physical Therapy note dated 4/20/26 identified Resident #1 received gait training focused on correcting center of mass over base of support, symmetrical stance, and weight shifting. Resident #1 demonstrated retropulsion and required maximum cues for leaning forward and maintaining center of gravity.A Nurse's note by RN #1 dated 5/5/26 at 11:35 PM identified Resident #1's wheelchair posture included a forwardˆleaning trunk and head at midˆchest level. When asked to lift the head, Resident #1 was unable to do so. Transfers required moderate to maximum assistance in the evenings.2.The A&I form by RN #1 dated 5/13/26 at 3:00 PM identified Resident #1 was observed on the floor with no injuries. The form identified Resident #1 required maximum assistance for transfers prior to the fall and had no change after the event.An SBAR note by RN #1 dated 5/13/26 at 11:36 PM identified Resident #1 was witnessed on the floor on the right side and had impaired sitting posture earlier in the afternoon. Resident #1 bent at the waist and was unable to maintain upright shoulder positioning.A Physical Therapy note dated 5/14/26 at 2:22 PM identified a nursing referral was received to evaluate the wheelchair, possible need for tiltˆinˆspace positioning, and concerns regarding poor sitting posture in the evenings. Therapy recommended using the recliner chair in the (continued on next page)

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 - Actual harm Residents Affected - Few	early afternoon for rest breaks and positional change.A Physical Therapy treatment note dated 5/14/26 identified Resident #1 had a fall from the wheelchair on 5/13/26. Nursing reported Resident #1's posture tended to flex forward later in the day, likely related to fatigue due to spending extended periods in the wheelchair. Therapy again recommended transferring Resident #1 to the recliner after lunch for rest breaks and positional change.3.The A&I form by RN #2 dated 5/19/26 at 5:35 PM identified Resident #1 was being pushed in the wheelchair to the dining room by NA #1 when Resident #1 fell forward from the wheelchair and struck the head on the floor. Resident #1 was sent to the hospital.A Nurse's note by RN #2 dated 5/19/26 at 6:32 PM identified Resident #1 fell forward from the wheelchair, resulting in an abrasion with bleeding to the left forehead.The Hospital Discharge summary dated [DATE] identified computed tomography (CT) imaging revealed a posteriorly angulated type II dens fracture, minimally displaced fractures of the bilateral posterior arch of C1, and a possible minimally displaced left C4 lamina fracture.The Resident Care Plan (RCP) updated on 5/23/26 identified Resident #1 had a self^care deficit related to cognitive impairment, decreased independence with activities of daily living (ADL), decreased strength and endurance, decreased range of motion, and fluctuating ADL performance. The updated intervention was to recommend utilizing the recliner after lunch for a change in position.Interview with RN #1 on 6/5/26 at 12:50 PM identified Resident #1 leaned forward in the wheelchair most afternoons, possibly due to fatigue or disease process. She identified she submitted a referral dated 5/13/26, to rehabilitation for decreased transfer ability in the afternoons and it was suggested to use a mechanical lift for transfers. Resident #1 previously self^propelled the wheelchair but lost that ability and had decreased lower extremity strength in the evenings. She identified leg rests should be used when assisting Resident #1 in the wheelchair due to fatigue and forward leaning.Interview with NA #1 on 6/5/26 at 12:58 PM identified she worked the 3:00 PM to 11:00 PM shift on 5/19/26 and Resident #1 had been in the wheelchair since the start of the shift. Resident #1 was leaning forward when she pushed the wheelchair to the dining room, and she did not use leg rests. She identified she normally did not use leg rests for Resident #1.Interview with the Rehabilitation Director on 6/5/26 at 1:18 PM identified forward^leaning posture and fatigue were recent concerns. Therapy recommended transferring Resident #1 to the recliner for rest breaks. Resident #1's baseline posture included forward leaning with the head down.Interview with the Director of Nursing Services (DNS) on 6/5/26 at 1:50 PM identified Resident #1 was on the Physical Therapy caseload and that therapy would identify a need for leg rests. She identified leg rests were not included in the RCP. She identified Resident #1's body position naturally leaned forward. She identified Resident #1 would go to bed after lunch and then Resident #1's family member would visit every day around 2:30 PM and Resident #1 would be placed back into his/her wheelchair.The Safe Resident Handling and Transfers policy identified residents require safe handling to prevent or minimize risk of injury to the resident and employees. It identified lifting and transferring should be performed according to the resident's individual plan of care.