STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075356	A. Building B. Wing	12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Notre Dame Health and Rehabilitation Center	76 West Rocks Road Norwalk, CT 06851

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. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075356	A. Building B. Wing	12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Notre Dame Health and Rehabilitation Center	76 West Rocks Road Norwalk, CT 06851

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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, facility documentation review, and interviews for one of three residents (Resident #1) reviewed for accidents, the facility failed to ensure a resident with a diagnosis of dementia and a known fall risk was properly supervised and failed to ensure the resident was not left alone in the bathroom, to prevent a fall with injury. The findings include:Resident #1 had a diagnosis of dementia. The admission Minimum Data Set (MDS) dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of 6 indicating severely impaired cognition, had no behaviors, and was dependent on staff assistance for toileting and transfers. The Resident Care Plan (RCP) dated 11/12/2025 identified a risk for falls and self-care deficit. Interventions directed to provide assistance of one (1) staff with transfers and toileting. Facility reportable event dated 12/1/2025 at 2 PM identified Resident #1 was noted lying on the bathroom floor, and complained of right hip pain. Resident #1 was unable to explain what happened. The report identified Resident #1's baseline mental status was confused, a fall risk, and required total care with ADLs and transfers. Resident #1 was transferred to the hospital for evaluation. Additional information indicated NA #1had assisted Resident #1 to the bathroom and the fall was not witnessed by staff. NA #1 left Resident #1 sitting on the toilet for privacy and was waiting outside the door when she heard a noise and observed Resident #1 on the floor. Nursing note dated 12/1/2025 at 7:24 PM identified Resident #1 was noted to be the floor of the bathroom, with open purpura (red/purple skin discoloration) to the left shin. Resident #1 denied having bumped his/her head however, given Resident #1's state of dementia with confusion, writer unable to verify the credibility of Resident #1's account. Vital signs were within normal parameters and noted Resident #1 was receiving Coumadin (Blood thinner). The MD/APRN was notified, and Resident #1 was transferred to the hospital for evaluation. Orthopedic progress note dated 12/2/2025 at 7:16 AM identified Resident #1 had an unwitnessed fall after using the toilet. X-ray results identified a displaced right femoral neck fracture (broken and shifted out of place top of the thigh bone). Reportable event summary dated 12/8/2025 identified Resident #1 was confused (BIMS 6) and required assistance with ADLs. On 12/1/2025 at approximately 6:45 PM Resident #1 was assisted to the bathroom by a NA, who left the resident sitting on the toilet for privacy per the resident's request. The NA was waiting outside the bathroom door when she heard a noise and entered the bathroom and observed Resident #1 sitting on the floor next to the toilet seat. The NA activated the call light and the RN supervisor responded. Resident #1 was observed sitting on the floor next to the toilet and was unable to explain what happened. Resident #1 stated I stood up and I think I'm walking with my daughter. Resident #1 complained of right hip pain and had a skin tear on the left shin. A neurological assessment was conducted, and Resident #1 was able to move upper extremities but not his/her lower extremities. The physician was notified, and Resident #1 was transferred to the hospital. A hospital update was obtained on 12/2/2025 and identified Resident #1 was admitted with a diagnosis of a right displaced femoral neck fracture. Interview with Physical Therapist #1 on 12/9/2025 at 10:58 AM identified prior to the fall, Resident #1 required assistance of one (1) staff for transfers. Physical Therapist #1 stated Resident #1 would need assistance when standing up from the toilet. Interview with NA #1 on 12/9/2025 at 11:31 AM identified she was taking care of Resident #1 at the time of the fall on 12/1/2025. NA #1 assisted Resident #1 to the bathroom and placed him/her on the toilet. NA #1 stated she then gave Resident #1 the call bell and directed him/her to ring when finished, and she stood outside the bathroom door with the door ajar. Another NA was in a room across the hall and called NA #1 for help. NA #1 left Resident #1's room to assist another NA, leaving Resident #1 alone in the bathroom. NA #1 stated when she was across the hall in the other room, she heard Resident #1 scream and she went back into the room and found the resident sitting upright on the bathroom floor by the door. NA #1 stated she should not have left Resident #1 alone in the bathroom; she stated she should have waited until Resident #1 was out of the bathroom before leaving the room. NA #1 failed to provide supervision for a resident with a diagnosis of dementia and a known fall risk, while in the bathroom to prevent a fall. Interview and record review with the Administrator and Director of Nursing (DNS) on 12/9/2025 at 12:28 PM identified on 12/1/2025 Resident #1 required assistance of one (1) staff for transfers and toileting. Resident #1 was transferred to the toilet by NA #1 and NA #1 stood outside the bathroom door per residents request for privacy. The DNS further stated staff should stay in the room while residents with dementia are using the bathroom. Interview identified Resident #1 had a diagnosis of dementia with a BIMS score of 6 (indicating severely impaired cognition), and