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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075358	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bickford Health Care Center	14 Main Street Windsor Locks, CT 06096

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #6) reviewed for ADLs, the facility failed to ensure the record directed staff how to transfer the resident, and failed to ensure an assessment was completed timely for a change in transfer ability. The findings include: Resident #6's diagnoses included dementia, anxiety, and rheumatoid arthritis. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified that Resident #6 had a Brief Interview for Mental Status (BIMS) score of eleven out of fifteen, indicative of moderate cognitive impairment and required substantial/maximal assistance with toilet use and transfers, was dependent with wheelchair use, and was 60 inches tall (5 feet) and weight was 94 pounds. The Resident Care Plan (RCP) dated 1/6/2026 indicated an alteration in mobility. Interventions directed to transfer with assistance of one (1) staff to wheelchair. Additional review of the RCP identified although the RCP continued to direct one (2) staff for transfers, the transfer status was updated on 7/15/2025 to include two (2) staff for transfers. The RCP directed both one (1) and two (2) staff were required for transfers. A physician's order dated 1/8/2026 directed out of bed with assistance of one (1) to wheelchair with cushion and max assistance for car transfers from wheelchair, use gait belt and max assistance with wheelchair positioning. Nurse Aide (NA) care card directed transfer assist of one (1), and mobility assist of one (1). Record review identified Resident #6 was discharged from the facility on 3/18/2026. Interview and facility documentation review with NA #2 on 3/24/2026 at 11:26 AM identified she reads the resident NA care cards prior to providing resident care, and she did not recall how Resident #6 transferred.Interview and review of facility documentation with NA #3 on 3/25/2026 at 11:40 AM identified she was the regular NA providing care for Resident #6, and stated Resident #6 required one (1) staff assist for transfers in/out of the wheelchair. NA #3 stated she thought it would be safer to use a mechanical lift for the transfers for Resident #6 due to weakness. Interview and review of record on 3/25/2026 at 12:05 PM with RN #3 (supervisor) indicated Resident #6's transfer status was via mechanical lift (Hoyer lift) because Resident #6's legs were weak. Interview and facility documentation review with RN #2 on 3/24/2026 at 10:55 AM identified Resident #6 required a mechanical lift (Hoyer lift) for transfers in/out of the wheelchair. RN #2 further indicated the NAs need to follow the care card for resident transfer status. Record review of failed to identify a physician order, RCP, or NA care card directed transfers with mechanical lift. Additional interview with RN #2 on 3/24/2026 at 1:24 PM identified Resident #6 did not have a physician order for NA care card that directed use of the Hoyer lift. Interview and record review on 3/25/2026 at 1:27 PM with DON identified she was not aware that staff were using a mechanical lift to transfer Resident #6. The DON stated if there was a change in the resident's transfer status, there should have been an RN assessment or therapy evaluation to determine if a mechanical lift was appropriate. Further, the physician/APRN and responsible party should be notified, orders obtained, and the RCP and NA care card should be updated. The DON stated if Resident #6 was still in the facility, she would make a request for a therapy evaluation of transfer status. Although attempted, interviews with the previous DNS/ DNS #3 and NA #4 were not obtained during the survey. Although requested, a facility policy was not provided regarding direction for staff (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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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	regarding transfer status or resident assessments. Review of facility Hoyer Lift (mechanical lift) dated 11/2025 directed in part, a Hoyer lift should be used for residents who are too heavy to move by yourself or who are not able to be transferred by other means. Review of facility Care Plans Policy dated 11/2025 directed in part; it is the policy of the facility to have an Interdisciplinary Care Plan for each resident. The RCP will address the residents' needs on an individual basis, including physical needs.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, facility documentation review, facility policy review, and interviews for one of five residents (Resident #4) reviewed for accidents, the facility failed to ensure the resident was transferred in accordance with physician orders and the plan of care, and for one of five residents (Resident #7) reviewed for accidents, the facility failed to ensure an alarm was in use in accordance with physician orders and the plan of care. The findings include: Resident #4's diagnoses included mild cognitive impairment, peripheral vascular disease, diabetes mellitus, and anxiety. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #4 had a Brief Interview for Mental Status (BIMS) score of six out of fifteen (6/15), indicative of severe cognitive impairment, and required substantial/maximal assistance with transfers. Physician order dated 9/12/2025 directed staff to transfer Resident #4 out of bed to a tilt-in-space custom wheelchair (CWC) per 24-hour positioning plan with two-persons using a mechanical lift. The Resident Care Plan dated 9/19/2025 identified Resident #4 had an alteration in ADL (activities of daily living) function. Interventions directed to use a Hoyer (mechanical) lift for transfers with assistance of two (2) staff. The facility Reportable Event Form dated 10/6/2025 at 11:22 AM identified during a transfer Resident #4 banged his/her left leg on the left leg of the custom wheelchair (CWC) and had a two (2) centimeter (CM) open hematoma (collection of clotted blood within tissues). Resident #4 denied any pain. A treatment was provided, and the wound was monitored. On 10/7/2025 the wound was noted to be a nine (9) cm coagulated (clotted blood) hematoma. Resident #4 was transferred to the hospital for evaluation on 10/9/2025, and was followed by a wound physician. The Reportable Event summary dated 10/10/2025 identified NA #1 received discipline and education regarding the transfer of Resident #4. Interview with the Director of Therapy (DOT) on 3/19/2026 at 10:35 AM identified Resident #4 was evaluated on 3/12/2025, and the evaluation directed staff to utilize a Hoyer lift for transfers with the assistance of two (2) staff members for resident safety. The DOT stated the resident's plan of care directed use of the Hoyer lift for transfers with two-person staff, and the facility policy directed two (2) staff for Hoyer lift transfers. Interview with NA #1 on 3/24/2026 at 9:25 AM identified on 10/6/2025, during morning care, Resident #4 reported bilateral lower extremity pain during morning care, and was wearing geri-sleeves on his/her legs for skin protection. NA #1 stated she requested assistance from the nurse to transfer Resident #4 out of bed, and the nurse responded that she would assist after she completed her medication pass. NA #1 stated she then performed the Hoyer lift transfer independently, without the benefit of a second staff member present, and transferred Resident #4 into the CWC alone. Further, NA #1 stated Resident #4 was wearing geri-sleeves on his/her legs for skin protection when she provided care, and did not removed them when she provided care. NA #1 stated the transfer was completed without any observable incident, and stated she maintained support of the Resident #4's lower extremities throughout the transfer and did not notice any bumps or trauma. Following completion of the transfer, Resident #4 reported bilateral lower extremity pain and she notified the nurse. NA #1 stated a Hoyer lift transfer requires two (2) staff and stated that she should have waited for assistance in accordance with the resident's plan of care and facility policy, before transferring Resident #4. Interview with DON #2 on 3/24/2026 at 12:00 PM identified any Hoyer lift transfer requires two (2) staff for safety. On 10/6/2025, NA #1 stated she transferred Resident #4 using a Hoyer lift transfer independently, without the required two-person assistance. DON #2 stated Resident #4 likely sustained the injury/hematoma to his/her leg during the transfer, and NA #1 should not have completed the transfer alone. Interview with DON #1 on 3/24/2026 at 12:55 PM identified on 10/6/2025 NA #1 stated she transferred Resident #4 using a Hoyer lift transfer independently, without the required two-person assistance. DON #1 NA #1 should not have completed the transfer alone and she was not able to identify how the injury occurred; Resident #4 had complained of pain prior to the transfer. DON #1 stated Resident #4 complained of (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pain after the transfer, she assessed Resident #4 and identified a hematoma with an open are on the left lower leg. DON #1 stated although Resident #4 complained of the pain after the transfer, and the hematoma was identified after the transfer, she could not determine if the injury occurred as a result of the transfer. 2. Resident #7's diagnoses included dementia, osteoporosis, repeated falls, and major depressive disorder. The significant change in condition Minimum Data Set (MDS) assessment dated [DATE] identified Resident #7 had a BIMS score of six out of fifteen (6/15), indicative of being severe cognitive impairment and required substantial/maximal to dependent assistance with transfers. Physician order dated 6/24/2025 directed to ensure the motion sensor alarm was on when in bed, check sensor in room on wall for green light and check alarm box at desk that it is turned on. The Resident Care Plan dated 7/9/2025 identified Resident #7 was at risk for falls. Interventions directed sensor motion alarm in place for all shifts (24/7), kept by the East-Wing charge nurse, and to always remain in the on position, call bell in reach and remind resident to use it for assistance. The facility Reportable Event Form dated 7/31/2025 at 7:15 AM identified Resident #7 was observed sitting on bathroom floor with his/her back to the wall, and complained of right arm pain. Resident #7 was transferred to the hospital, and was diagnosed with a right non-displaced clavicle fracture. Resident #7 returned to the facility the same day with a right arm sling and orders to follow-up with an orthopedic physician in one week. A nursing note dated 7/31/2025 at 9:18 PM identified Resident #7 returned from the hospital at 6:45 PM and diagnosed with a right nondisplaced clavicle fracture. Vital signs were stable, had no complaints and was in no acute distress. The Reportable Event Summary dated 8/5/2025 identified care was last offered at 6:30 AM by NA #5, was seen again by NA #5 at 6:50 AM, and was seen at 7 AM by the RN supervisor. NA #5 stated the alarm did not sound during the night shift and was not aware there was a sensor alarm in the resident's room over her bed. At 7:20 AM staff NA #6 observed Resident #7 on the floor in the T-Wing Hall bathroom, and indicated the alarm was not sounding. Resident #7 stated he fell on the ground and complained of arm pain. The summary further indicated RN #4 documented the bed sensor on the wall was turned on. Resident #7 was diagnosed with a non-displaced right clavicle fracture. Facility investigation identified seven (7) staff indicated they did not hear an alarm sound, and the alarm box was found to be in the off position by DNS; the facility conclusion was the motion sensor box at nursing station appeared to be off. Interview with DON #2 on 3/24/2026 at 12:00 PM identified on 7/31/2025, Resident #7 had physician-ordered and care plan-directed motion sensor alarms in place, including a bedside alarm that also sounded an alarm at the nursing station, that would alert staff to any attempts to ambulate independently. DON #2 stated the facility investigation identified no staff heard an alarm sound prior to the fall. DON #2 stated that RN #4 initially indicated the alarms were in the on position, however, subsequent review determined the alarms were in the off position and the alarm system at the nursing station was not activated at the time of the incident. Interview with DON #1 on 3/24/2026 at 12:55 PM identified on 7/31/2025 at approximately 7:20 AM, she was notified that Resident #7 had a fall, and no motion sensor alarms were sounding. DON #1 stated that, per the resident's plan of care, both the bedside alarm and the corresponding alarm at the nursing station were required to be in the on position to alert staff when the resident attempted to ambulate. DON #1 stated the facility investigation determined the alarms were in the off position at the time of the incident. Review of the Care Plan Policy dated 11/2025 directed in part, the care plan will address resident needs on an individual basis. Although requested, the facility did not provide a policy for surveyor review regarding following physician orders.