Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075390	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beacon Brook Center for Health & Rehabilitation	89 Weid Drive Naugatuck, CT 06770

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, facility documentation review, and staff interviews for one of three residents (Resident #1) reviewed for accidents, the facility failed to ensure the record was complete and accurate to include physical therapy directions regarding use of a gait belt. The findings include: Resident #1 had a diagnosis of falls, and anemia. The admission MDS dated [DATE] identified Resident #1 had a BIMS of 15 indicating intact cognition, was dependent for toileting, and required maximal assistance with transfers. The Resident Care Plan (RCP) dated 1/13/2026 identified deficit in functional mobility and a potential for falls. Interventions directed assistance of one (1) staff for transfers. Advanced Practice Registered Nurse (APRN) note dated 1/27/2026 at 9:45 AM identified a fall on 1/27/2026 with a skin tear on the left knee and right forearm. The note identified Resident #1 was alert and oriented to baseline with pupils equal, round, and reactive, and cranial nerves intact. Multiple Steri-Strips were applied to right forearm skin tear, which appears clean, dry, and intact. The left knee abrasion was noted with steri-strips (Band-Aid to help close cuts/tears), over the laceration area. Denied pain, continue Tylenol as needed, continue to monitor. Facility reportable event form dated 1/30/2026 at 6:40 PM identified Resident #1 fell on 1/27/26 while transferring from his/her bed to a wheelchair due to weakness and buckling of his/her legs. Record review failed to identify a gait belt was used during the transfer or was required to transfer the resident. Interview and record review with the Director of Rehabilitation on 2/18/2026 at 11:22 AM identified Resident #1 received physical therapy prior to the fall and on 1/27/2026, Resident #1 required an assist of one (1) staff for transfers and required use of a gait belt. The Director of Rehabilitation was unable to provide documentation or communication to nursing that a gait belt was required for transfers. Interview with Physical Therapist (PT) #1 on 2/18/2026 at 12:20 PM identified he was the primary Physical Therapist who provided therapy for Resident #1. PT #1 stated prior to the fall, Resident #1 required assist of one (1) staff for transfers and required the use of a gait belt for transfers. Further, PT #1 stated he did not document in his physical therapy notes that a gait belt was required to be used when transferring Resident #1 because he thought it was a facility policy to use a gait belt. Interview and record review with the Director of Nursing (DNS) on 2/18/2026 at 1:10 PM identified at the time of the fall on 1/27/2026, Resident #1 required assist of one (1) staff for stand pivot transfers. During the transfer Resident #1's knees buckled and he/she fell to the floor, sustaining the skin tears. The DNS stated there was no physician order or care plan that directed use of a gait belt, and the facility did not have a policy that directed use of a gait belt for a one (1) person transfer. Further, the DNS stated there was no communication from therapy that directed use of a gait belt, and if Physical Therapy required a gait belt to be used they should document the recommendation and notify nursing. Review of facility Charting and Documentation Policy dated January 2025 directed in part, to provide a complete account of the patients total stay (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	from admission through discharge, provide information about the patient that will be used in developing a plan of care.