STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075402	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mansfield Center for Nursing and Rehabilitation	100 Warren Circle Storrs Mansfield, CT 06268

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (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 0656 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 clinical record reviews, facility documentation, facility policy and interviews for one (1) of three (3) sampled residents (Resident #1) who was dependent on staff for transfers and exhibited behavioral symptoms, the facility failed to follow the resident's plan of care when the resident exhibited behaviors during a mechanical lift transfer which resulted with the resident sustaining an injury. The findings include: Resident #1's diagnoses included severe dementia with agitation, hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following a subarachnoid hemorrhage (bleeding in the space between the brain and the membrane that covers it) affecting the left non-dominant side, muscle weakness and need for assistance with personal care. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of five (5) out of fifteen (15) indicative of severely impaired cognition, required substantial assistance with bed mobility and was dependent on staff for transfers. The Resident Care Plan dated 11/7/25 identified that Resident #1 exhibited behaviors of intermittent resistance to care, combativeness and restlessness. Interventions directed in moments of restlessness or agitation offer the resident television programs of his/her choice, provide redirection as able, offer recreational/diversional activities, speak and approach in a calm, explain care step by step before proceeding, if combative or resistive to care, stop the task and/or leave the room, notify the provider if the behavior increases or persists, administer medications as ordered and monitor and document for side effects and effectiveness. The nurse's note dated 11/17/25 at 11:56 PM identified at approximately 9:00 PM the charge nurse, Licensed Practical Nurse (LPN) #1, entered Resident #1's room to administer medications when she observed a quarter sized raised area above Resident #1's right eye with discoloration as well as an area to the top outside area of the right ear with minor bleeding. The note identified the areas were not observed during the 5:00 PM medication pass and due to Resident #1's cognitive status, Resident #1 was unable to communicate what had occurred when questioned. The note indicated the nursing supervisor, Registered Nurse (RN) #1, was notified, came to assess Resident #1, the areas were noticeably larger than the previous observation, so the on-call provider was notified, an order was obtained to send Resident #1 to the Emergency Department (ED) for evaluation and Resident #1 was transferred at 11:15 PM. The hospital documentation dated 11/18/25 identified Resident #1 sustained a forehead hematoma (a closed wound of localized bleeding outside of blood vessels due to an injury/trauma), receives an anticoagulant medication, no altered mental status was noted, head and cervical spine imaging was conducted and the results were negative for acute injuries, and Resident #1 was transferred back to the facility on [DATE]. The nurse's note dated 11/18/25 at 9:50 PM identified Resident #1 returned to the facility around 4:56 PM. Interview with the Director of Nursing (DON) on 12/4/25 at 10:05 AM identified initially they were unable to identify where Resident #1's injuries came from so they were treating the incident as an injury of unknown origin. The DON explained during their investigation a nurse aide, Nurse Aide (NA) #1, reported on 11/19/25 Resident #1 was accidentally hit by the hoyer lift on 11/17/25. Interview with NA #1 on 12/4/25 at 10:28 AM identified on 11/17/25 between 7:00 PM and 8:00 PM, she went into Resident #1's room to get him/her ready for bed and transfer him/her from the wheelchair to the bed. NA #1 indicated although Resident #1 was fidgety, visibly anxious, restless, and flailing his/her arms around while sitting in the wheelchair she continued to hook up the lift and begin to mechanically lift Resident #1 out of the wheelchair. NA #1 identified as Resident #1 was lifted out of the wheelchair, one (1) of the loops above Resident #1 came detached from the hook, Resident #1 tipped forward in the sling, hitting his/her head on the middle supporting bar (the mast) of the hoyer lift. NA #1 identified she lowered Resident #1 back down into the wheelchair, secured the loop and then lifted Resident #1 back up again and into bed. NA #1 identified looking back she should not have transferred Resident #1 when Resident #1 was already restless and flailing around and although there was no mark or visible injury on Resident #1's head and face she should have notified the nurse of the behaviors and reapproached Resident #1 when it was safe to transfer Resident #1 back to bed. Interviews with both LPN #1 and RN #1 on 12/4/25 identified that on 11/17/25 prior to discovering the injuries to the Resident #1's face and ear, NA #1 did not report to them Resident #1 was displaying any behaviors and NA #1 did not ask for assistance with the hoyer transfer which required two (2) staff be present for safety and if NA #1 had, they could have assisted in calming Resident #1 down, redirecting and assisting with the transfer and if needed providing as needed medication for agitation and

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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	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, facility documentation, facility policy and interviews for one (1) of three (3) sampled residents (Resident #1) who was dependent on staff for transfers, the facility failed to ensure two (2) staff members were present during a mechanical lift transfer resulting in the resident tipping in the lift, hitting his/her head and sustaining an injury. The findings include:Resident #1's diagnoses included severe dementia with agitation, hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following a subarachnoid hemorrhage (bleeding in the space between the brain and the membrane that covers it) affecting the left non-dominant side, muscle weakness and need for assistance with personal care. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of five (5) out of fifteen (15) indicative of severely impaired cognition, required substantial assistance with bed mobility and was dependent on staff for transfers. The Resident Care Plan dated 11/7/25 identified Resident #1 had a self-care deficit and was dependent on staff for all Activities of Daily Living (ADL). Interventions directed, in part, to transfer the resident via a hoyer (mechanical) lift with the assistance of two (2) staff. A physician's order dated 11/16/25 directed to administer the blood thinner medication that prevents blood clots from forming, Xarelto 20 milligram (mg) tablet by mouth once daily. The nurse's note dated 11/17/25 at 11:56 PM identified at approximately 9:00 PM the charge nurse, Licensed Practical Nurse (LPN) #1, entered Resident #1's room to administer medications when she observed a quarter sized raised area above Resident #1's right eye with discoloration as well as an area to the top outside area of the right ear with minor bleeding. The note identified the areas were not observed during the 5:00 PM medication pass and due to Resident #1's cognitive status, Resident #1 was unable to communicate what had occurred when questioned. The note indicated the nursing supervisor, Registered Nurse (RN) #1, was notified, came to assess Resident #1, the areas were noticeably larger than the previous observation, so the on-call provider was notified, an order was obtained to send Resident #1 to the Emergency Department (ED) for evaluation and Resident #1 was transferred at 11:15 PM. The hospital documentation dated 11/18/25 identified Resident #1 sustained a forehead hematoma (a closed wound of localized bleeding outside of blood vessels due to an injury/trauma), receives an anticoagulant medication, no altered mental status was noted, head and cervical spine imaging was conducted and the results were negative for acute injuries, and Resident #1 was transferred back to the facility on [DATE]. The nurse's note dated 11/18/25 at 9:50 PM identified Resident #1 returned to the facility around 4:56 PM. Interview with the Director of Nursing (DON) on 12/4/25 at 10:05 AM identified initially they were unable to identify where Resident #1's injuries came from so they were treating the incident as an injury of unknown origin. The DON explained during their investigation a nurse aide, Nurse Aide (NA) #1, reported on 11/19/25 Resident #1 was accidentally hit by the hoyer lift on 11/17/25. The DON indicated the facility was unable to identify that a second nurse aide was present during the hoyer transfer, as all staff interviewed denied assisting NA #1 with the transfer of Resident #1 on 11/17/25. Interview with NA #1 on 12/4/25 at 10:28 AM identified on 11/17/25 between 7:00 PM and 8:00 PM, she went into Resident #1's room to get him/her ready for bed and transfer him/her from the wheelchair to the bed and she could not remember who assisted her with the hoyer lift transfer. NA #1 indicated although Resident #1 was fidgety, visibly anxious, restless, and flailing his/her arms around while sitting in the wheelchair she continued to hook up the lift and begin to mechanically lift Resident #1 out of the wheelchair. NA #1 identified as Resident #1 was lifted out of the wheelchair, one (1) of the loops above Resident #1 came detached from the hook, Resident #1 tipped forward in the sling, hitting his/her head on the middle supporting bar (the mast) of the hoyer lift. NA #1 stated she was in a rush and forgot to ensure that all the loops were securely attached. NA #1 identified she lowered Resident #1 back down into the wheelchair, secured the loop and then lifted Resident #1 back up again and into bed. NA #1 identified looking back she should not have transferred Resident #1 when Resident #1 was already restless and flailing around and although there was no mark or visible injury on Resident #1's head and face she should have notified the nurse of the behaviors and reapproached Resident #1 when it was safe to transfer Resident #1 back to bed. NA #1 indicated she should have ensured the loops of the hoyer pad were securely attached to the hooks on the lift prior to lifting Resident #1. Interview with LPN #1 on 12/4/25 at 10:49 AM identified on 11/17/25 prior to discovering the injuries to Resident #1's face and ear, she had previously seen Resident #1 around 5:00 PM for medication administration and Resident #1 had no injuries at that time. LPN