STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075411	A. Building B. Wing	07/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Matulaitis Rehabilitation & Skilled Care	10 Thurber Rd Putnam, CT 06260

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 - Minimal harm or potential for 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 review of clinical records, review of facility documentation, review of facility policy/procedures and interviews for two of seven sampled residents (Residents #6 and #88) reviewed for accidents, the facility failed to ensure a gait belt was utilized when assisting the resident to ambulate, resulting in a fall with injury and failed to provide adequate supervision in the bathroom resulting in a fall. The findings include: Resident #6's diagnoses included dementia without behavioral disturbance, mood disturbance, anxiety, and difficulty walking. The fall risk assessment tool dated 1/7/26 identified a score of 10 indicating Resident#6 was at moderate risk for falls. Review of the care plan dated 3/14/26 identified Resident #6 was at risk for decline in functional mobility, functional limitation in self-care and falls related to dementia with interventions that directed staff support provided for safety, assist of 1 for transfers and hand-held ambulation and substantial/maximal assistance with toileting hygiene, verbal cues and staff support provided for safety. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident had severely impaired cognition (BIMS 5), required substantial/maximal assistance with toileting hygiene, lower body dressing, putting on and taking off footwear and personal hygiene, supervision or touching assistance to walk 10 feet, 50 feet or 150 feet. The physician's orders dated 6/9/26 directed Resident #6 receive an assist of 1 for transfers and hand-held assistance. The nursing note dated 6/16/26 at 6:46 AM identified Resident #6 had an unwitnessed fall in the bathroom; the bathroom call light was activated at 5:05 am. There was a question of head trauma, neurological assessment and fall prevention program was initiated. The Accident and Incident (A&I) report dated 6/16/26 identified NA #1 assisted Resident #6 to the bathroom, Resident #6 used the bathroom and then stood up from a seated position while NA #1 was getting clothes and fell. The A&I identified Resident #6 was an assist of 1 for transfers with hand-held ambulation and indicated the fall resulted in right wrist pain. Additionally, the report indicated that the likely cause of the fall was the height of the toilet. The toilet commode was high and could have been prevented by a lower commode chair and reminders to Resident #6 not to get up without assistance. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The report further identified interventions added post fall included, obtain an appropriate commode chair in resident bathroom and staff to remain at resident's side until assisted to safe position with toileting and for NA to gather items for toileting prior to sitting resident on the toilet. Review of NA #1's written statement dated 6/16/26 identified she sat Resident #6 on the toilet and turned to grab items left on Resident #6's dresser in the resident's room that adjoined the bathroom and made it to the dresser when NA#1 heard resident say oh no, Oh no and then a bang and returning to the bathroom found Resident #6 on the floor of the shower area and alerted the nurse. The Physical Therapy progress note dated 6/16/26 identified a post fall assessment for Resident #6 indicated Resident #6 had a fall at 5:05 AM and noted the commode may be too high for the resident and identified the commode was removed and a request made to replace commode with a lower commode. The Occupational Therapy note dated 6/18/26 identified Resident #6 was started on service after a fall and to increase safety and ability with functional mobility and transfers, toileting, and to reduce wrist pain. Interview with NA #1 on 7/1/2026 at 1:04 PM identified she transferred Resident #6 to the toilet commode and left the resident to retrieve items from the resident room dresser. NA#1 indicated Resident #6 was left alone on the commode and that Resident #6's feet were not able to touch the floor when seated on the commode. NA#1 identified Resident #6 had recently been moved to the room and she did not know if the commode was left over from another resident. NA#1 identified Resident #6 required hand-held assistance for transfers and to walk but indicated that she has never had to help Resident #6 get on to the toilet and indicated Resident #6 was left alone in the bathroom most times. NA#1 identified she did not use the gait belt to transfer or ambulate Resident #6 and could not identify if she was supposed to use the gait belt. NA#1 could not identify if Resident #6's feet should be able to touch the floor. Interview with RN #2 on 7/1/2026 at 1:55 PM identified Resident #6 was an assist of 1 and indicated NA#1 should have stayed with Resident #6 at all times until the resident was in a safe position. RN#2 identified the commode was a little bit high and indicated therapy fits the height of the commode and could not identify if the commode moved to the new room when Resident #6 was moved or if the commode was old. Interview with the Director of Rehabilitation on 7/1/2026 at 2:10 PM identified that therapy usually recommends the use of the commode, but nursing staff may use the commode if it is already in place such as if the roommate uses one and there is a shared bathroom. The Director of Rehabilitation indicated that therapy usually provided education if they introduced the commode as part of the resident's care but identified education is not standard practice if therapy does not introduce the equipment. Additionally, the Director of Rehabilitation indicated it is not standard to do a commode assessment unless a resident is having difficulty and was referred to therapy and identified Resident #6 was not referred to therapy for a commode issue until after the fall. The Director of Rehabilitation indicated an assist of 1 for toileting would mean that the staff member has to stay in close vicinity to the resident. Review of the facility policy for Free of Accident Hazards/Supervision/Devices identified each resident receives adequate supervision and assistance devices to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy for Fall Prevention identified all residents will receive adequate supervision, assistance, and assistive devices to aid in the prevention of falls and indicated each resident will be evaluated for safety risks. Review of the Certified Nurse Aide handbook (Titled Assisting in Long Term Care) pages 476 and 477, guideline for transfers, identified NA's should always use the correct transfer method as directed by the nurse of physical therapist and indicated that a transfer belt should be used for standing transfers unless contraindicated. Review of toileting procedure on Pg 344 identified the NA should assemble all supplies needed prior to assisting the resident with use of the bedside commode. And directed on page 345 that when assisting resident to use the bathroom, the resident should be assisted with sitting comfortably on the toilet with feet flat on the floor. Although requested, the facility failed to provide a policy for ADLs/toileting. Resident #88's diagnoses included vertigo, diabetes type II, and syncope. The quarterly MDS assessment dated [DATE] identified Resident #88 was cognitively intact, independent with bed mobility, transfers, dressing, personal hygiene and utilized a walker for ambulation. The care plan dated 12/22/25 identified Resident #88 was at risk for falls related to vertigo/syncopal episodes with interventions that included independent with ambulation using walker and sneakers during the day, assist of 1 at night, encourage fluids, assessment and treatment for postural/orthostatic hypotension. The APRN's progress note dated 3/25/26 at 3:10 AM identified Resident #88 had a witnessed fall with injury. The resident fell backwards and hit his/her head on the table in the room. RN#2 noted two small injuries to Resident #88's head that appeared to be scabs that were scraped off. Skin tears were also noted to the right upper extremity. Vital signs were noted to be stable with a reported blood pressure reading of 127/85 (normal BP parameters are less than 120mm Hg systolic (top number) and less than 80 mm Hg diastolic (bottom number)). Instructions were to complete neurological checks per protocol, assess for pain, fall precautions per facility protocol, and primary team to re-evaluate fall risk care plan, notify a clinician of any change in condition/neuro check. RN#2's nursing note dated 3/25/26 at 6:54AM identified the resident was observed sitting on the floor when RN#2 was called to the room. Resident #88 stated he/she felt dizzy and lost balance. There were no complaints of pain, hand grasp was strong, first aid was administered to the head x2 and right upper extremity (x3), skin wounds to right upper extremity measured 2x4cm, 2x4cm, and 2x2.5cm, head wounds cleansed with normal saline and left open to air, pupils were equal, round, reactive to light and accommodation. The APRN recommended to monitor for any signs and symptoms of infection, assess for pain per protocol, and to complete fall precautions per facility policy. Neuro-checks to be completed per protocol and to notify a physician with any changes in condition. RN #4's nursing note dated 3/25/26 at 9:06AM identified Resident #88 had a BP of 190/100, the resident reported increasing pressure in his head. Resident #88 was sent to the ER. RN #4's nursing note dated 3/25/26 at 2:00PM identified that the hospital reported Resident #88 was returning to the facility. CT Scan to head was negative. Two stiches were applied to the right forehead. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility Accident and Investigation report post fall huddle with the RN Supervisor#3, RN#2, and NA#2 identified the fall occurred due to dizziness. Summary of the investigation Staff re-education completed was on the use of gait belts with transfers. Interview with NA#2 on 7/1/26 at 9:19AM identified she was walking with the resident back from the bathroom when the resident saw a tissue on the floor. The resident reached down for the tissue after NA#2 told the resident she would get it for him. NA#2 said Resident #88 lost his/her balance and fell hitting his/her head on the bed rail. NA#2 said she was not utilizing a gait belt during the time of the fall because she had forgotten it at home, and when she went to the room they are sometimes on the back of the door but there was none. NA#2 stated it was the facility policy to utilize a gait belt, and Resident #88 was an assist of 1 during the night with the use of a gait belt. Resident #88 was standing and the bed alarm was going off at the time Resident #88 started to ambulate to the bathroom. On the return from the bathroom NA#2 was still not utilizing a gait belt and when the resident went to fall NA#2 hooked the resident's arm in her arm, however the resident still fell and hit their head and scraped their arm. NA#2 then yelled for help once Resident #88 fell. RN#2 was the nurse who responded to the room to complete the assessment, first aid, and notified the APRN. Interview with RN#2 on 7/1/26 at 1:54PM identified she was the RN to respond to Resident #88's room on 3/25/26. RN#2 completed her assessment, first aid, and then notification to the provider. RN#2 said that the APRN advised to not send out the resident and to monitor the resident in the facility due to the information provided. RN#2 identified the areas on the head did not look too deep and stopped bleeding after pressure, so she didn't have a concern with the resident needing stitches. RN#2 identified that she completed the vitals for Resident #88 and although the blood pressure was elevated BP and the resident was complaining of dizziness at the time of the fall, RN#2 administered the as needed hydralazine for the elevated blood pressure and meclizine for the dizziness. However, after administering the medication RN#2 did not notify any provider that the BP had remained elevated and passed the report along in the shift-to-shift report to the first shift nurse. RN#2 said the resident had no complaints therefore didn't have a concern. RN#2 further identified Resident #88 was a assist of 1 at nighttime, which meant a hands-on assist with a gait belt due to the fact he had diabetes, dizziness, and a history of falls, and blood pressure issues. Interview with the DNS on 7/1/26 at 10:10AM identified Resident #88 was an assist of 1 with a gait belt with ambulation at the time of the fall on 3/25/26. NA#2 was not utilizing a gait belt at the time of the fall and should have been. Re-education with staff was completed regarding gait belts. The DNS further identified if she was reviewing the blood pressures on the neuro checks as the nurse on at the time of the fall she would have been concerned about the elevated blood pressure and would have notified a provider. Review of the gait belt policy identified NA's are the utilize a gait belt according to the CNA book pages 476-477. Pages 476-477 directed to always use the correct transfer method as directed. Disregarding these instructions can result in injury to the resident or to you. If you have difficulty transferring with the resident by the indicated method consult the nurse. Review of the free of accident hazards/supervision/devices policy directed the facility must ensure that the resident environment is free of accident hazards as it is possible and each resident received adequate supervision and assistance devices to prevent accidents. Review of the fall prevention policy directed all residents received adequate supervision, assistance, (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and assistive devices to aid in the prevention of falls. Care plans will be created and implemented based on the individuals risk factors to aid in the prevention of falls.