STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075419	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/17/2026
NAME OF PROVIDER OR SUPPLIER Amberwoods of Farmington		STREET ADDRESS, CITY, STATE, ZIP CODE 416 Colt Highway Farmington, CT 06032	

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 the clinical record, facility documentation, facility policies, and interviews, for 1 of 2 residents (Resident #1) reviewed for accidents, the facility failed to ensure a resident who was non-ambulatory and dependent on staff for care remained free from injury during a transfer.The findings include:Resident #1 had diagnoses that included multiple sclerosis, obsessive-compulsive disorder, personality disorder, anxiety, morbid obesity, edema, chronic kidney disease, low back pain, arthritis, displaced comminuted fracture of the right femur, and fracture of the left femur. The Resident Care Plan (RCP) dated 3/20/2022 identified Resident #1 is to get out daily of bed at 10:45 AM into an electric wheelchair with interventions that directed use of a mechanical lift with the assistance of two staff. The quarterly Minimum Data Set (MDS) dated [DATE] identified Resident #1 had intact cognition and was dependent on staff for transfers. Review of the facility Reportable Event Form dated 6/20/2022 at 2:20 PM identified during transfer Resident #1 had a fall in his/her room witnessed by NA #1. Resident #1 complained of left arm pain, and transferred to the emergency room for further evaluation. The new intervention implemented for Resident #1 is three staff for transfers. Review of a written statement by NA #3 dated 6/20/2022 at 2:20 PM identified she assisted NA #1 with repositioning Resident #1 in the wheelchair when the mechanical lift tipped. Review of a written statement by NA #1 dated 6/20/2022 at 2:35 PM identified she and NA #3 were transferring Resident #1 from the bed to the wheelchair using a mechanical lift when the lift tipped over, causing Resident #1 to fall to the floor. NA #1 identified as Resident #1 was falling, his/her left arm grazed the wheelchair armrest and wheel. The nurse's note written by RN #1 (supervisor) dated 6/20/2022 at 4:16 PM identified she was called to assess Resident #1. RN #1 identified upon entering the room, she observed Resident #1 lying supine on the floor, with his/her head at the foot of the bed, and his/her feet toward the doorway. RN #1 identified the wheelchair was located next to Resident #1. RN #1 identified Resident #1 complained of left arm pain, appeared to be very anxious, and was short of breath. RN #1 identified Resident #1 remained on the floor until EMS arrived who assisted with lifting Resident #1 off the floor. RN #1 identified Resident #1 was transferred to the hospital. The emergency room Discharge summary dated [DATE] identified Resident #1 had fall from a mechanical lift, the X-rays and scans were negative. Resident #1 has a contusion on the left side of his/her back. The RCP care plan dated 6/20/2022 identified Resident #1 may fall during transfers. Interventions directed to approach the mechanical lift for positioning from the front of the wheelchair (not the side) and use 3 staff for transfers. The nurse's note dated 6/21/2022 at 12:51 AM identified Resident #1 returned from the emergency room at 11:45 PM. The physician's order dated 4/5/2023 directed for transfers provide the assistance of 3 using a mechanical lift with a large green trim sling. Interview with the Director of Nurses (DNS) on 2/13/2026 at 10:38 AM identified she was employed at the facility in June 2022 as the Assistant Director of Nurses not the DNS.The DNS indicated she did not recall Resident #1 falling out of a mechanical lift, but would investigate. A follow-up interview with the DNS on 2/13/26 at 1:30 PM she confirmed an incident occurred on 6/20/22 in which Resident #1's mechanical lift tipped over and a nurse aide lowered Resident #1 to the floor. The DNS stated she (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: 075419	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/17/2026

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Amberwoods of Farmington	416 Colt Highway Farmington, CT 06032

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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 - Minimal harm or potential for actual harm Residents Affected - Few	could not determine whether the correct sling was used or whether the legs of the lift were opened during the transfer. The DNS identified staff are responsible for ensuring the proper sling size is used, properly positioning the mechanical lift including opening the base of the lift for stability. Interview with the Director of Maintenance on 2/13/26 at 2:45 PM identified he was not working at the facility in June 2022 and has been at the facility for about a year. The Director of Maintenance indicated that he does not have any records from June 2022 regarding any maintenance or repairs that may have been done to the mechanical lifts. Interview, review of facility documentation, and review of the clinical record with Registered Nurse (RN) #1 on 2/17/26 at 4:15 PM identified on 6/20/2022 she was supervisor on duty and did document a progress note regarding Resident #1's fall out of a mechanical lift. RN #1 stated that during transfers, nurse aides (NA) are responsible for selecting the appropriate sling based on the resident's weight and ensuring the legs of the mechanical lift are opened for stability. RN #1 indicated based on her review of the reportable event dated 6/20/2022 she could not determine whether the correct sling was used or whether the lift's legs were opened at the time of the incident. RN #1 indicated that upon entering the room, Resident #1 was already on the floor; however, she could not recall whether the sling remained attached to the lift, and based on the resident's position, she believed NA #1 and NA #1 had moved Resident #1 from over the bed to the area between the two beds but had not reached the wheelchair. RN #1 stated the mechanical lift had tipped before reaching the wheelchair, which was positioned at the foot of the bed. RN #1 indicated Resident #1's head was near the side of the bed and his/her feet toward the doorway. RN #1 further stated staff were moving the lift out from under the bed and turning toward the space between the beds to align with the wheelchair. RN #1 stated the lift should not have tipped and that it could have occurred if staff failed to open the legs of the lift during movement or if the lift malfunctioned. RN #1 identified she could not determine the exact cause of the incident.Interview with RN #1 on 2/17/26 at 6:00 PM identified she located a read and sign off form dated 2/8/22 signed by NA #1 that indicated she read the policy on mechanical lifts.RN #1 identified the handout was left at the nurse's station for staff to independently read and sign. Review of NA #1 employee file identified NA #1 start date was 2/4/2022 and completed general orientation. NA #1 was terminated on 2/10/2023. Although attempted, interviews with the prior DNS, LPN #2, NA #1, and NA #3 were not obtained. Review of the facility Guidelines for Use of Hoyer Lifts education identified always have 2 staff for transfers one to maneuver lift and one to monitor resident, inspect sling prior to use for being torn or holes, make sure when attaching the resident and sling to the lift the same colors are used on both sides for an even lift, once resident is lifted in ling the resident should be in a sitting position, place residents arms inside the sling, move the lift away from the bed and turn the resident so they are facing the staff member operating the lift, once away from bed lower the arm of the mechanical lift so resident is more stable (due to the center of gravity), and ensue the legs of the mechanical lift are open in the widest position when maneuvering the resident to provide a wide base of support to prevent the lift from tipping over. Review of the facility C.N.A. education and competency Policy identified to ensure all certified nursing assistants must meet state and federal requirements for education, competency, and ongoing training. All newly hired nursing assistants must complete orientation that includes safe handling and transfers. Initial employment requirements prior to assignment the facility will verify successful completion of skills competency validation and facility orientation. The nursing assistant will complete required annual in-service education. Competency validation for safe transfer techniques (including mechanical lifts) will be completed annually and re-evaluated with any identified performance concerns. Review of the facility Mechanical lift transfers policy identified was to ensure safe and proper use of the mechanical lifts for resident's transfers. The policy promotes resident safety, dignity, and prevention of staff injury. This policy applies to all licensed staff, certified nurse aides, rehabilitation staff, and any personnel trained and authorized to perform mechanical lift transfers within the facility. Mechanical lifts shall be maintained and inspected regularly to ensure safe operation. Staff training requirements all staff must receive annual validation and education on (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	safe resident handling principles. Training shall include sling selection and inspection, proper positioning, and emergency procedures. Must have a minimum of 2 trained staff members present during all mechanical lift transfers.

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation review, facility policy review, and interviews for 1 of 3 residents (Resident #1) reviewed for accidents, the facility failed to ensure staff were trained in the use of a mechanical lift. The findings include:Resident #1 had diagnoses that included multiple sclerosis, obsessive-compulsive disorder, personality disorder, anxiety, morbid obesity, edema, chronic kidney disease, low back pain, arthritis, displaced comminuted fracture of the right femur, and fracture of the left femur. The Resident Care Plan (RCP) dated 3/20/22 identified Resident #1 was to get out of bed at 10:45 AM daily into an electric wheelchair with interventions that directed use of a mechanical lift with the assistance of two staff.The quarterly Minimum Data Set (MDS) dated [DATE] identified Resident #1 had intact cognition and was dependent on staff for transfers. Review of the facility Reportable Event Form dated 6/20/22 at 2:20 PM identified during transfer Resident #1 had a fall in his/her room witnessed by NA #1. Resident #1 complained of left arm pain and transferred to the emergency room for further evaluation. The new intervention implemented for Resident #1 is three staff for transfers. Review of a written statement by Nurse Aide (NA) #3 dated 6/20/22 at 2:20 PM identified she assisted NA #1 with repositioning Resident #1 in the wheelchair when the mechanical lift tipped.Review of a written statement by NA #1 dated 6/20/22 at 2:35 PM identified she and NA #3 were transferring Resident #1 from the bed to the wheelchair using a mechanical lift when the lift tipped over, causing Resident #1 to fall to the floor. NA #1 identified as Resident #1 was falling, his/her left arm grazed the wheelchair armrest and wheel.The nurse's note written by RN #1 (supervisor) dated 6/20/22 at 4:16 PM identified she was called to assess Resident #1. RN #1 identified upon entering the room, she observed Resident #1 lying supine on the floor, with his/her head at the foot of the bed, and his/her feet toward the doorway. RN #1 identified the wheelchair was located next to Resident #1. RN #1 identified Resident #1 complained of left arm pain, appeared to be very anxious, and was short of breath. RN #1 identified Resident #1 remained on the floor until EMS arrived who assisted with lifting Resident #1 off the floor. RN #1 identified Resident #1 was transferred to the hospital. The emergency room Discharge summary dated [DATE] identified Resident #1 had fall from a mechanical lift. The X-rays and scans were negative. Resident #1 has a contusion on the left side of his/her back. The RCP care plan dated 6/20/22 identified Resident #1 may fall during transfers. Interventions directed to approach the mechanical lift for positioning from the front of the wheelchair (not the side) and use 3 staff for transfers. The nurse's note dated 6/21/22 at 12:51 AM identified Resident #1 returned from the emergency room at 11:45 PM. The physician's order dated 4/5/23 directed to provide assistance of three with transfers using a mechanical lift with a large green trim sling. Interview with the Director of Nurses (DNS) on 2/13/26 at 10:38 AM identified she was employed at the facility in June 2022 as the Assistant Director of Nurses not the DNS. The DNS indicated she did not recall Resident #1 falling out of a mechanical lift but would investigate.A follow-up interview with the DNS on 2/13/26 at 1:30 PM identified she confirmed an incident occurred on 6/20/22 because the mechanical lift tipped over which resulted in Resident #1 being lowered to the floor. The DNS identified staff are responsible for ensuring the proper sling size is used, properly positioning the mechanical lift including opening the base of the lift for stability. Interview with the DNS on 2/13/26 at 3:00 PM identified she and the Administrator were unable to provide evidence that NA #1 and NA #3 were trained on mechanical lift transfers.Interview, review of facility documentation, and review of the clinical record with Registered Nurse (RN) #1 on 2/17/26 at 4:15 PM identified she was supervisor on duty on 6/20/22. RN #1 indicated she did not recall the exact details of Resident #1's fall on 6/20/22, she confirmed she documented a progress note indicating that a mechanical lift tipped over, causing the resident's fall. RN #1 indicated based on her review of the reportable event dated 6/20/22 the mechanical lift tipped over causing Resident (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#1's fall. RN #1 indicated she could not determine whether the correct sling was used or if the mechanical lift legs were opened at the time of the incident. RN #1 identified on 6/20/22 when she entered the room Resident #1 was lying on the floor with his/her head near the side of the bed with his/her feet toward the doorway. RN #1 indicated she could not recall whether the sling was still attached to the lift but believed NA #1 and NA #3 had moved Resident #1 from the bed to an area between the two beds and had not yet reached the wheelchair. RN #1 stated Resident #1's wheelchair was positioned at the foot of the bed and the mechanical lift tipped over before reaching it. RN #1 stated that mechanical lifts do not typically tip over unless staff failed to open the legs for stability or if the mechanical lift malfunctioned. RN #1 indicated she could not identify the exact cause of the incident. RN #1 identified that during transfers, nursing assistants must select the appropriate sling based on the resident's weight and must ensure the lift's legs are fully opened. RN #1 identified she is responsible for staff education, training, and competency validation. RN #1 indicated nursing assistants must receive education and demonstrate competency in mechanical lift use upon hire and annually. RN #1 identified agency staff receive only a brief, two-page general orientation that covers mandatory facility education but does not include training or competency validation for mechanical lift use. RN #1 confirmed agency staff do not demonstrate competency with mechanical lifts while working at the facility. RN #1 stated she and the Administrator could not locate documentation of mechanical lift competency for NA #1 at hire or annually and the mandatory general orientation NA #1 completed on 2/4/22 did not include mechanical lift training or competency validation. RN #1 further stated she could not locate the agency general orientation packet for NA #3.Review of NA #1 employee file identified NA #1 start date was 2/4/2022 and she completed general orientation. NA #1 was terminated on 2/10/2023. Although attempted, interviews with the prior DNS, LPN #2, NA #1, and NA #3 were not obtained. Review of the facility C.N.A. Education and Competency Policy identified to ensure all certified nursing assistants must meet state and federal requirements for education, competency, and ongoing training. All newly hired nursing assistants must complete orientation that includes safe handling and transfers. Initial employment requirements prior to assignment the facility will verify successful completion of skills competency validation and facility orientation. The nursing assistant will complete required annual in-service education. Competency validation for safe transfer techniques (including mechanical lifts) will be completed annually and re-evaluated with any identified performance concerns. Review of the facility Contracted Services Policy identified companies who contract with our facility will adhere to all state and federal requirements. Mandatory education the contractor agrees to complete facility orientation to include all mandatory education and annual training as required by facility in accordance with regulations for any providers entering the facility. Contractors will be able to work in the facility once this training is completed and documentation provided to the facility DNS or upload into portal for agency staff. Random audits may be performed for compliance with facility practices, including infection control procedures.Review of the facility Mechanical lift transfers policy identified was to ensure safe and proper use of the mechanical lifts for resident's transfers. The policy promotes resident safety, dignity, and prevention of staff injury. This policy applies to all licensed staff, certified nurse aides, rehabilitation staff, and any personnel trained and authorized to perform mechanical lift transfers within the facility. Mechanical lifts shall be maintained and inspected regularly to ensure safe operation. Staff training requirements all staff must receive annual validation and education on safe resident handling principles. Training shall include sling selection and inspection, proper positioning, and emergency procedures. Must have a minimum of 2 trained staff members present during all mechanical lift transfers. Review of the facility Guidelines for Use of Hoyer Lifts identified always have 2 staff for transfers one to maneuver lift and one to monitor resident, inspect sling prior to use for being torn or holes, make sure when attaching the resident and sling to the lift the same colors are used on both sides for an even lift, once resident is lifted in ling the resident should be in a sitting position, place residents arms inside the sling, move the lift away from the bed and turn the resident so they are facing the staff member operating the lift, (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	once away from bed lower the arm of the mechanical lift so resident is more stable (due to the center of gravity), and ensue the legs of the mechanical lift are open in the widest position when maneuvering the resident to provide a wide base of support to prevent the lift from tipping over.