STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075420	A. Building B. Wing	07/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summit at Plantsville Center for Health & Rehabili	261 Summit Street Plantsville, CT 06479

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 - 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)

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 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, review of facility documentation, facility policies, and interviews for one (1) of five (5) sampled residents (Resident #1) who were dependent on staff for transfers, the facility failed to ensure two (2) staff members were assisting the resident with a transfer in accordance with the care plan to prevent the resident from sustaining a laceration to the left shin. The findings include:Based on clinical record reviews, review of facility documentation, facility policies, and interviews for one (1) of five (5) sampled residents (Resident #1) who were dependent on staff for transfers, the facility failed to ensure two (2) staff members were assisting the resident with a transfer in accordance with the care plan to prevent the resident from sustaining a laceration to the left shin. The findings include:Resident #1's diagnoses included dementia with agitation, Alzheimer's Disease, anxiety and weakness.The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 had Brief Interview for Mental Status (BIMS) score of three (3) out of fifteen (15) indicating Resident #1 had short- and long-term memory problems, exhibited physical and verbal behaviors towards others, and was dependent on staff for transfers. The Resident Care Plan dated 5/2/25 identified Resident #1 had a deficit in functional mobility. Interventions directed for two (2) person partial or moderate assistance for transfers.The care plan identified Resident #1 was resistive to care related to dementia. Interventions directed to give clear explanation of all care activities prior to and as they occur during each contact and if the resident resists with activities of daily living, reassure the resident, leave and return five (5) to ten (10) minutes later and try again.The nurse's note dated 6/14/25 at 9:30 PM identified the charge nurse was called to Resident #1's room by the nurse aide at 8:00 PM and the nurse aide, Nurse Aide (NA) #1, stated Resident #1 was combative during the transfer from the wheelchair to the bed and hit his/her left lower leg on the wheelchair causing a laceration. The note identified Resident #1 complained of moderate pain to the area, the as needed Tylenol was administered, the Advanced Practice Registered Nurse (APRN) was notified, an order was given directing to send Resident #1 to the Emergency Department (ED), and Resident was transferred at 9:15 PM.The nurse's note dated 6/15/25 at 12:25 AM identified Resident #1 returned from the hospital at 11:30 PM on 6/14/25, there were sixteen (16) sutures to the left shin covered with a dry, clean, dressing, Resident #1 denied pain and an order directed to change the dressing daily and remove the sutures in eight (8) days.The facility's Summary Report dated 6/18/25 identified on 6/14/25 the nurse aide attempted to complete a transfer alone, despite Resident #1 being care planned for a two (2) person assist. During the attempted transfer, Resident #1 became more agitated and combative, attempted to kick the nurse aide and when doing so hit the wheelchair sustaining a laceration that required sixteen (16) sutures to be repaired. Review of the facility's fall investigation statement from the 3-11PM nurse aide, Nurse Aide (NA) #1, dated 6/14/25 identified during the transfer from the wheelchair to the bed without another staff member present to assist, Resident #1 became combative, and Resident #1 hit his/her left leg on the wheelchair sustaining a laceration.Interview and clinical record review with the Assistant Director of Nursing (ADON) on 7/9/25 at 12:24 PM identified Resident #1's care plan directed for two (2) staff members to transfer Resident #1. The ADON identified on 6/14/25 NA #1 transferred Resident #1 without another staff member which did not follow the care plan. Review of the facility policy titled Baseline/Comprehensive Person Centered Care Plan, last revised 3/2023, directed, in part, the interdisciplinary team will utilize the Comprehensive Person-Centered Care planning process to address resident strengths, needs and/or problems as identified on the admission discharge summary, as well as other professional assessments and orders from the healthcare provider, dietary team, therapy, social services and the MDS. The policy further directed, in part, the care plan is developed to include information necessary to properly care for the residents and will address the residents' preferences, goals, desired outcomes and plan for discharge and this will be implemented by qualified members of the facility staff. Although attempted, an interview with NA #1 was unable to be obtained.The facility identified the deficient practice and developed an immediate plan of correction for past noncompliance as of July 17, 2025.Resident #1 was assessed by the nurse, sustained a laceration to the left leg, was transferred to the Emergency Department and required sixteen (16) sutures.A full review of all residents requiring two (2) person assistance for transfers was conducted. Care plans and kardexes were cross-checked for accuracy.The nurse aides received mandatory in-service education on the importance of following the care plan, how to review the care plan and kardex for each resident prior to providing care.Conduct five (5) random resident

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, clinical record reviews, facility documentation and interviews for one (1) of five (5) resident units, the facility failed to ensure a medication cup containing pre-poured medications was secured in the medication cart when the medication cart was left unattended and not within the line of sight of the nurse. The findings include:During a tour of the facility with the Assistant Director of Nursing (ADON) on 7/9/25 observations of the medication cart on the Mountain Laurel unit at 9:50 AM identified the charge nurse, Licensed Practical Nurse (LPN) #3, walked away from her medication cart to assist a resident with putting his/her shoes on, leaving dispensed medications in a medication cup on top of the medication cart unattended in the hallway. The medication cart was noted not to be in LPN #3's line of sight. The observation was brought to the attention of the ADON at the time of occurrence and the ADON acknowledged that she saw the medication cup was left on top of the medication cart. Upon further observations several residents were noted to be sitting in the hallway in proximity to the medication cart. Review of the medication administration record identified the medications were that of Resident #5. The medication administration record identified the following medications were in the cup:Citalopram (antidepressant) 5 milligrams (mg), Empaglifozin (antidiabetic) 12.5mg, Folic acid 1mg, Loratadine (antihistamine) 10mg, Norvasc (blood pressure) 2.5mg, Risperidone (antipsychotic) 3mg, Apixaban (blood thinner) 5mg, Entresto (heart failure) 24-26mg, Metformin 875mg (antidiabetic), Senokot S 8.6-50mg, and Vitamin B12 500 micrograms (mcg). An interview with LPN #3 on 7/9/25 at 10:20 AM identified she was aware that she should not have left the medications on top of the medication cart unattended. LPN #3 indicated the ADON had asked her to assist a resident with his/her shoes when she walked away from the medication cart, and she stated it is her responsibility to ensure medications were secured. An interview with the ADON on 7/9/25 at 10:30 AM identified that medications should not be left unsecured/unattended on the medication cart and the charge nurse was responsible for ensuring medications are secured in the medication cart. The ADON stated it was not appropriate for the nurse to leave poured medications on top of medication cart as the facility policy is that medications are not to be left unattended if they are not secure. A review of the Medication Administration and Documentation policy directed, in part, the licensed nurse assures medications are not left unattended. Keep medications secured in a locked area or in visible control at all times.