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	11/25/2025

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 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 policy and interviews for one (1) of three (3) sampled residents (Resident #1) who were a potential for falls, the facility failed to implement a care plan intervention directing staff to encourage the resident to sleep in his/her own bedroom after the resident was observed by multiple staff sleeping in a chair in the dining room just prior to the resident sustaining a fall with fractures. The findings include:Resident #1's diagnoses included dementia without behavioral disturbances, muscle weakness, anxiety and major depressive disorder. 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) indicating poor memory recall, had behaviors of rejection of care and wandering, was independent with bed mobility, transfers and ambulation, and had one (1) fall with minor injuries in the past ninety (90) days. The Resident Care Plan dated 9/12/25 identified Resident #1 had a behavior of sleeping in the dining room at bedtime. Interventions directed staff to encourage the resident to sleep in his/her own bedroom. The nurse's note dated 10/25/25 at 3:20 AM identified the Nursing Supervisor was called to the dining room by the charge nurse at 1:45 AM where Resident #1 was observed sitting on the floor in front of a chair with his/her back resting against the chair. The note identified Resident #1 reported he/she was attempting to walk and slipped, and Resident #1 was noted to be wearing shoes and no slip or fall hazards were noted surrounding the area. The note indicated Resident #1 reported severe eight (8) out of ten (10) pain to the right thigh area, there was no shortening or rotation noted to the extremities, and Range of Motion (ROM) was limited due to the pain. The note indicated the on-call Advanced Practice Registered Nurse (APRN) was notified, an order was obtained to transfer Resident #1 to the Emergency Department (ED) and Resident #1 was transferred to the hospital at 2:45 AM (one hour after the fall). The hospital documentation dated 10/25/25 identified imaging of Resident #1's pelvis showed Resident #1 had sustained an acute minimally displaced fracture (when the bone fragments remain close together and without a significant movement out of alignment) of the sacral ala (a break in the triangular shaped bone at the bottom of the spine), acute minimally displaced fractures of the bilateral inferior (below/away from the head) and left superior (positioned above/towards the head end of the body) pubic rami (the bony branches that extend from the pubis to the ischium in the pelvis) and a minimally displaced age indeterminate (unknown when it occurred) fracture of the anterior wall (front facing) of the right acetabulum (the socket part of the ball-and-socket hip joint where the femoral head meets with the pelvis). Interviews with the 11PM-7AM nurse aide, Nurse Aide (NA) #2 and charge nurse, Licensed Practical Nurse (LPN) #1, on 11/6/25 identified that although they observed Resident #1 sleeping in the dining room with the lights off prior to the fall on 10/25/25, they did not turn the lights on, wake Resident #1 or encourage him/her to return to his/her room to sleep per the plan of care. Interview with APRN #1 on 11/6/25 at 2:01 PM identified it was not safe for Resident #1 to be sleeping in the dining room with the lights off, out of view from staff and the staff should have turned the lights on and encouraged Resident #1 to return to his/her room. Interview with the Assistant Director of Nursing (ADON) on 11/6/25 at 2:28 PM identified that all staff are expected to follow the plan of care, and both NA #2 and LPN #1 should have woken Resident #1 when they observed him/her sleeping in the dining room and encouraged Resident #1 to return to their room. Review of the Baseline/Comprehensive Person-Centered Care Plan policy dated 3/2023 directed, in part, that the Person-Centered Care Plan is developed to include information necessary to properly care for the resident and will address the resident's preferences, goals and desired outcomes. The Comprehensive Person-Centered Care Plan will be implemented by qualified members of facility staff.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. (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 0697 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 had sustained a fall with injury, the facilityfailed to medicate the resident for severe pain while waiting one (1) hour to be transferred to the hospital. The findings include:Resident #1's diagnoses included dementia without behavioral disturbances, muscle weakness, anxiety and major depressive disorder. 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) indicating poor memory recall, had behaviors of rejection of care and wandering, was independent with bed mobility, transfers and ambulation, and had one (1) fall with minor injuries in the past ninety (90) days. The Resident Care Plan dated 9/12/25 identified Resident #1 had a behavior of sleeping in the dining room at bedtime. Interventions directed staff to encourage the resident to sleep in his/her own bedroom. The nurse's note dated 10/25/25 at 3:20 AM identified the Nursing Supervisor was called to the dining room by the charge nurse at 1:45 AM where Resident #1 was observed sitting on the floor in front of a chair with his/her back resting against the chair. The note indicated Resident #1 reported he/she was attempting to walk and slipped, and Resident #1 was noted to be wearing shoes and no slip or fall hazards were noted surrounding the area. The note identified Resident #1 reported severe pain, eight (8) out of ten (10), to the right thigh area, there was no shortening or rotation noted to the extremities, and Range of Motion (ROM) was limited due to the pain. The note indicated the on-call Advanced Practice Registered Nurse (APRN) was notified, an order was obtained to transfer Resident #1 to the Emergency Department (ED) and Resident #1 was transferred to the hospital at 2:45 AM (one hour after the fall). The pain assessment dated [DATE] identified Resident #1 was complaining of pain to the right front thigh when attempting to move the leg or get up. Review of the October 2025 Medication Administration Record (MAR) identified an order to administer acetaminophen 325 milligrams (mg), give two (2) tablets (650 mg) by mouth every six (6) hours as needed for pain. Upon further review, the MAR failed to reflect documentation the acetaminophen had been administered on 10/25/25 for Resident #1's complaint of severe pain post fall. The hospital documentation dated 10/25/25 identified imaging of Resident #1's pelvis showed Resident #1 had sustained an acute minimally displaced fracture (when the bone fragments remain close together and without a significant movement out of alignment) of the sacral ala (a break in the triangular shaped bone at the bottom of the spine), acute minimally displaced fractures of the bilateral inferior (below/away from the head) and left superior (positioned above/towards the head end of the body) pubic rami (the bony branches that extend from the pubis to the ischium in the pelvis) and a minimally displaced age indeterminate (unknown when it occurred) fracture of the anterior wall (front facing) of the right acetabulum (the socket part of the ball-and-socket hip joint where the femoral head meets with the pelvis). Interview with the 11PM-7AM Nursing Supervisor, Registered Nurse (RN) #1, on 11/6/25 at 12:13 PM identified the charge nurse called her on 10/25/25 to report Resident #1's fall, and when she responded she observed Resident #1 laying on the dining room floor with his/her head and shoulders supported by the foot of the recliner. RN #1 stated Resident #1 was holding his/her right thigh and complaining of pain and when she attempted to turned Resident #1 onto his/her left side to inspect for skin injuries, Resident #1 started screaming in pain. RN #1 identified she did not medicate Resident #1 with pain medication, reporting that it would have been the responsibility of the charge nurse. Interview with the 11PM-7AM charge nurse, Licensed Practical Nurse (LPN) #1, on 11/6/25 at 12:44 PM identified that she was the first to respond to Resident #1 screaming in the dining room on 10/25/25, the lights were off, Resident #1 was lying on the floor on his/her back up against the reclining chair, grabbing his/her right leg. LPN #1 explained when the Nursing Supervisor, RN #1, arrived, RN #1 turned Resident #1 to the left side to assess for injuries and Resident #1 immediately began yelling out in pain. LPN #1 identified although Resident #1 was yelling out in pain and grabbing his/her right leg post fall and was not transferred to the hospital until one (1) hour later, she did not attempt to medicate Resident #1 with the as needed pain reliever medication. Interview with APRN #1 on 11/6/25 at 2:01 PM identified if Resident #1 was complaining of severe eight (8) out of ten (10) pain, she would have expected Resident #1 to be made comfortable and pain relievers administered prior to being transferred to the hospital, as Resident #1 had acetaminophen available for pain. Interview with the Assistant Director of Nursing (ADON) on 11/6/25 at 2:28 PM identified either RN #1 or LPN #1 should have addressed Resident #1's pain in the one (1) hour prior to Resident #1 being transferred to