STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075439	A. Building B. Wing	01/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bradley Home Infirmary/Pavilion	320 Colony Street Meriden, CT 06451

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policies, and interviews, for one (1) of three (3) sampled residents (Resident #1) who required staff assistance for ambulation, the facility failed to provide adequate supervision during ambulation with a rolling walker, which resulted in a fall with a right femoral neck fracture requiring surgical intervention. The findings include:Resident #1's diagnoses included dementia, lack of coordination, abnormal posture, and generalized weakness. The amended quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 had moderately impaired cognition (Brief Interview for Mental Status (BIMS) score of 7), short and long-term memory recall deficits and was dependent on staff for transfers in and out of the bed and chair and for ambulation with a rolling walker. The fall risk assessment completed 11/21/25 identified Resident #1 was at high risk of falls. The Resident Care Plan dated 11/21/25 identified Resident #1 had a self-care deficit and was at risk for falls due to weakness, decreased mobility, and history of falls. Interventions directed assistance of one (1) with transfers in and out of the bed and the chair, and assistance of one (1) with ambulation using a rolling walker. The physician's order dated 11/21/25 directed an assist with one (1) during mobility of forty-five (45) to seventy-five (75) feet as tolerated and to provide rest breaks as needed. The nurse's note dated 12/1/25 at 6:57 PM identified RN #1 (the 3 PM to 11 PM Nursing Supervisor), was called to the area where Resident #1 sustained a witnessed fall. While ambulating, Resident #1 was observed looking back at another resident, then lost his/her balance and fell, landing on his/her right side. Resident #1 was assessed by RN #1 and complained of discomfort to his/her back that subsided during the assessment. Neurological checks were normal, and Resident #1 had full range of motion at all extremities. Resident #1 was assisted to his/her feet and ambulated back to his/her room. Resident #1 complained of discomfort to the right upper leg. The family and the Advanced Practice Registered Nurse (APRN) were notified. The APRN directed an x-ray to the right hip and right upper femur which was scheduled for the following morning. The nurse's note dated 12/2/25 at 8:29 AM identified RN #2 (the 7 AM to 3 PM Nursing Supervisor), assessed Resident #1 and noted Resident #1 had increased confusion, was slow to respond verbally, and denied pain. The APRN was notified and directed a transfer to the ED for follow-up. The hospital record dated 12/5/25 identified Resident #1 sustained a closed fracture of the right hip and underwent a surgical procedure for an Open Reduction and Internal Fixation (ORIF) of the right hip insertion of the femoral neck on 12/3/25. The nurse's note dated 12/5/25 at 4:46 PM identified Resident #1 was readmitted to the facility. Review of the facility's summary report dated 12/9/25 indicated Resident #1 was walking with a staff member when Resident #1 turned to look at another resident then fell onto his/her right side sustaining a femoral neck fracture of the right side. An interview with NA #1 on 1/5/26 at 12:45 PM identified she worked the 3:00 PM to 11:00 PM shift on 12/1/25 and was responsible for providing care to Resident #1. NA #1 identified that Resident #1 required assistance (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: 075439	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/05/2026
NAME OF PROVIDER OR SUPPLIER Bradley Home Infirmary/Pavilion		STREET ADDRESS, CITY, STATE, ZIP CODE 320 Colony Street Meriden, CT 06451	

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	of one (1) staff member and use of a gait belt during ambulation. NA #1 reported that on 12/1/25 between 5:30 PM and 6:00 PM, she was assisting Resident #1 from the dining room back to the resident's room when another resident seated in a wheelchair nearby required assistance. NA #1 stated she left Resident #1 standing in the hallway and instructed the resident to remain there while she went to assist the other resident, who was out of NA #1's line of sight. When NA #1 returned, Resident #1 was actively walking toward his/her roommate and another staff member. As NA #1 approached, Resident #1 turned to look at another person nearby, lost his/her balance, and fell onto his/her right side. NA #1 confirmed she was not holding onto Resident #1 at the time of the fall, did not have a gait belt with her, did not apply a gait belt to the resident, and did not remain with the resident during ambulation as required. NA #1 further stated she should have seated Resident #1 to ensure safety before leaving to assist another resident. Interview with Director of Nursing (DON) on 1/5/26 at 1:45 PM identified that although there was no provider order for a gait belt to be used while staff assisted Resident #1 with transfers and ambulation, a gait belt should have been used. The DON identified that if a resident refused application of a gait belt, the refusal should have been documented. According to the physician's orders directing an assist of one (1) for ambulation, NA #1 should not have left Resident #1 standing alone in the hallway. The DON further identified that NA #1 failed to follow the facility's policy for ambulation. Review of the facility ambulation with walker policy identified assistance with the use of a walker during ambulation will be provided to residents as indicated by the MD order. The policy further identified if the Resident began to fall, the staff should draw the resident close to the staff member's body, support the resident, and gently and slowly lower the resident to the floor by sliding the resident down the staff member's leg. Attempts to interview OT #1 were unsuccessful.