Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 11/20/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075138	A. Building B. Wing	12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bloomfield Center for Nursing & Rehabilitation	355 Park Avenue Bloomfield, CT 06002

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for one (1) of three (3) residents (Resident #2) reviewed for abuse, the facility failed to ensure the resident was free from abuse. The findings include: 1) Resident #2's diagnoses included malignant neoplasm of the frontal lobe (cancerous brain tumor), epilepsy (seizure disorder), anxiety disorder and post-traumatic stress disorder. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had a Brief Mental Interview for Mental Status (BIMS) of fifteen (15) indicative of intact cognition, exhibited no behaviors, and required moderate assistance with bed mobility and was dependent on staff with transfers. The Resident Care Plan (RCP) dated 10/23/24 identified that Resident #2 has a behavior problem including accusatory behaviors related to malignant neoplasm of the frontal lobe with interventions that included to have two (2) caregivers at all times, encourage the resident to express feelings appropriately, approach/speak to the resident in a calm manner, divert attention, remove from an overstimulating environment and redirect to an alternate location as needed. A grievance dated 12/2/24 for Resident #2, filled out by Social Worker #1 identified that there was a customer service concern regarding the nurse's attitude and demeanor on 12/1/24. The action taken to resolve the grievance section was blank, as was the section indicating that follow-up was provided to the resident. The grievance was unsigned by Social Worker #1, Resident #2 and the Administrator. A statement was attached from RN #1 dated 12/1/24 and a statement was attached from LPN #3 which was undated. (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: 075138	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/20/2024
NAME OF PROVIDER OR SUPPLIER Bloomfield Center for Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 355 Park Avenue Bloomfield, CT 06002	

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Resident #2 on 12/20/24 at 12:43 PM identified that he/she requested pain medication and LPN #3 entered the room alone, with her coat on and a purse over her shoulder, with a straw in one hand and a medication cup in the other hand, as she had worked the 3:00 PM to 11:00 PM shift and told the resident she was on her way out the door. Resident #2 identified that he/she asked her to pick up his/her positioning wedge off the floor and place it under his/her knees, pull the covers up and retrieve the hand grabber from the radiator for him/her and LPN #3 appeared annoyed and started giving the resident an attitude with her responses. The resident identified that LPN #3 put the medication cup down on the over the bed table, grabbed the sheets roughly and pulled them up and bumped the over the bed table and the medication went flying out out and LPN #3 yelled and then started crawling on the floor looking for the medication. Resident #2 identified that the nurse could not find the medication and slammed the over the bed table and his/her headphones fell to the floor. The resident reported that he/she told LPN #3 that she was unprofessional and acting like a child and then LPN #3 started yelling at him/her stating, What did you say to me, who do you think you are? Resident #2 identified that she found the pill in his/her bed, gave it to LPN #3 and then LPN #3 slammed the bathroom door that was directly in front of his/her bed. Resident #2 stated he/she told LPN #3 to send the nursing supervisor, and she replied, I sure will. The resident identified that when the nursing supervisor (RN #1) arrived at his/her bedside, he reported to the resident that he had heard LPN #3 yelling at him/her and stated that LPN #3 was in the wrong and provided Resident #2 with a grievance form and identified that he/she could fill it out the next day. Resident #2 reported that he/she was unable to fill it out on the spot, as he/she so upset with the way LPN #3 treated him/her stating that LPN #3 made him/her feel like a piece of s*** and treated him/her like a child. The resident identified that he/she reported the incident to the DNS the next morning, stating he/she was mentally and emotionally abused and the resident thought that Social Worker #1 submitted it as a grievance but stated that no one ever followed back up with him/her. Review of the facility schedule dated 11/30/24 identified that LPN #3 worked the 3:00 PM to 11:00 PM shift on Resident #2's unit on 11/30/24. Review of the December 2024 Medication Administration Record (MAR) for Resident #2, identified that he/she was administered as needed oxycodone 30 milligrams (mg) at 12:32 AM on 12/1/24. Interview LPN #3 on 12/20/24 at 1:49 PM identified that she recalled the incident on 12/1/24 with Resident #2. She reported that she was leaving for the night after her 3:00 PM to 11:00 PM shift when Resident #2 rang the bell and requested help, so she brought his/her previously requested pain medication (oxycodone) and went to assist before she left for the night. She identified that although she entered the room alone, she was unaware that there were to be two (2) caregivers at all times with Resident #2, stating she thought only certain staff were required to enter the room with another staff member and was unaware of the care plan directing so. She identified that she set the medication cup down on the over the bed table and then assisted with the resident's requests, stating she bumped the table and the medication fell. She reported that she never slammed doors, became rough with the resident or engaged in any arguing or yelling back and forth with the resident. She identified that Resident #2 was yelling at her and calling her names for no apparent reason, so after she found the medication in the bed and administered it to Resident #2, she exited the room and reported the incident to RN #1, who did not ask her any additional questions. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075138	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/20/2024
NAME OF PROVIDER OR SUPPLIER: Bloomfield Center for Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 355 Park Avenue Bloomfield, CT 06002	

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with RN #1 on 12/20/24 at 1:13 PM identified that he did hear LPN #3 yelling back and forth with the resident from his office diagonally across the hall from Resident #2. He reported that he spoke with LPN #3 when she exited Resident #2's room, she identified that she was frustrated. He identified that he did not ask her to write a statement, as he didn't think of it, and then she left the facility. RN #1 reported that he then went to speak with Resident #2 who reported that LPN #3 was yelling at him/her but RN #1 could not recall what Resident #1 stated that LPN #3 had said but identified that Resident #2 made an allegation of abuse against LPN #3. He identified that he provided Resident #2 with a grievance form but did not collect it and stated that he did not report the incident to the DNS, Administrator or oncoming 7:00 AM nurse supervisor prior to leaving for his shift and was unsure why. Interview with the DNS on 12/20/24 at 3:02 PM identified that there was no formal investigation done on the 12/1/24 incident involving Resident #2 and LPN #3 but reported that when Resident #2 reported the incident to him, he obtained statements from RN #1 and LPN #3 and had a soft-file in his office that he was trying to locate. When he spoke with RN #1 identified that LPN #3 was just loud and Resident #2 was upset about it, so he handled it as a customer service issue and LPN #3 was not allowed to care for Resident #2 any longer. He reported that he was unsure why RN #1 didn't report the incident to him if he thought it was an allegation of abuse, stating it's his expectation that all allegations of abuse/neglect be reported to him immediately. He was unable to identify when he had spoken with LPN #3 and obtained a statement, but reported she had not been suspended. Additionally, he identified that staff should never yell at a resident and LPN #3 should not have been in Resident #2's room alone without another staff present per the resident's plan of care. Although attempted, an interview with Social Worker #1 was not obtained. Review of the Abuse policy dated 12/2023 directed, in part, that each resident has the right to be free from abuse and neglect. Abuse is defined as the willful infliction of injury, intimidation or punishment with resulting physical harm, pain or mental anguish. Abuse includes verbal abuse, mental abuse and mistreatment. Staff will refrain from all actions that could be considered abuse, mistreatment and/or neglect. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse are reported immediately to the Administrator and DNS of the facility utilizing the chain of command. Abuse allegations require immediate action (keep patient safe, notify supervisor to start the investigation). Reporting timeline requirements for all allegations are to immediately notify supervisor and a 2-hour requirement to report to the Department of Public Health and Local Law Enforcement.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075138	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/20/2024
NAME OF PROVIDER OR SUPPLIER Bloomfield Center for Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 355 Park Avenue Bloomfield, CT 06002	

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for two (2) of three (3) residents (Resident #1 and #2) reviewed for mistreatment, the facility failed to ensure the State Agency was notified of allegations of abuse/neglect timely. The findings include: 1. Resident #1's diagnoses included a fracture of the right fibula (the outer shin bone), congestive heart failure and muscle weakness. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Mental Interview for Mental Status (BIMS) of fourteen (14) indicative of intact cognition and required maximal assistance with bed mobility and was dependent on staff for toileting hygiene. The Resident Care Plan (RCP) dated 11/12/24 identified that Resident #1 had bladder incontinence with interventions that included to check the resident every two (2) to three (3) hours for incontinence and clean the peri-area with each incontinence episode. Interview with Person #1 on 12/20/24 at 10:10 AM reported that there were two (2) incidents where incontinent care was requested but not provided for over 3 hours on the 3:00 PM to 11:00 PM shift. Person #1 called and spoke with the DNS after the 11/11/24 incident, but stated he/she never received follow-up. Person #1 identified that when incontinent care was also delayed on 11/29/24, Resident #1 was distraught which made him/her very upset and felt like Resident #1 was being neglected. Person #1 identified that he/she sent the DNS an email regarding the 11/29/24 incident but that he never responded, reporting that he/she eventually saw the DNS at the facility three (3) days later and he again stated that he would look into it, but Person #1 never received follow-up regarding Resident #1's care moving forward. Review of the FLIS Reportable Events website on 12/20/24 failed to identify the 11/11/24 nor 11/29/24 allegations regarding Resident #1 was reported to the State Agency by the facility. Interview with the DNS on 12/20/24 at 11:20 AM identified that although he was made aware by Person #1 of both the 11/11/24 and 11/29/24 incidents regarding delayed incontinent care for Resident #1, after interviewing staff he could not substantiate the claims of neglect stating it was a customer service issue, so he did not report either allegation to the State Agency. The DNS identified that he obtained statements from the Nurse Aides (NA's) that were working on 11/11/24, but did not obtain statements regarding the 11/29/24 allegation nor was he able to provide documentation that facility Accident & Investigations (A&Is) were completed for either the 11/11/24 or 11/29/24 allegations to unsubstantiate the neglect allegations. He reported he was unsure why they were not completed, identifying that they should have been. He identified that he did re-educate staff regarding customer service and incontinence care but was unable to provide the documentation. 2. Resident #2's diagnoses included malignant neoplasm of the frontal lobe (cancerous brain tumor), epilepsy (seizure disorder), anxiety disorder and post-traumatic stress disorder. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075138	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/20/2024
NAME OF PROVIDER OR SUPPLIER: Bloomfield Center for Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 355 Park Avenue Bloomfield, CT 06002	

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had a Brief Mental Interview for Mental Status (BIMS) of fifteen (15) indicative of intact cognition, exhibited no behaviors, and required moderate assistance with bed mobility and was dependent on staff with transfers. The Resident Care Plan (RCP) dated 10/23/24 identified that Resident #2 has a behavior problem including accusatory behaviors related to malignant neoplasm of the frontal lobe with interventions that included to have two (2) caregivers at all times, encourage the resident to express feelings appropriately, approach/speak to the resident in a calm manner, divert attention, remove from an overstimulating environment and redirect to an alternate location as needed. Interview with Resident #2 on 12/20/24 at 12:43 PM identified that he/she requested pain medication and LPN #3 entered the room alone, with her coat on and a purse over her shoulder, with a straw in one hand and a medication cup in the other hand, as she had worked the 3:00 PM to 11:00 PM shift and told the resident she was on her way out the door. Resident #2 identified that he/she asked her to pick up his/her positioning wedge off the floor and place it under his/her knees, pull the covers up and retrieve the hand grabber from the radiator for him/her and LPN #3 appeared annoyed and started giving the resident an attitude with her responses. The resident identified that LPN #3 put the medication cup down on the over the bed table, grabbed the sheets roughly and pulled them up and bumped the over the bed table and the medication went flying out out and LPN #3 yelled and then started crawling on the floor looking for the medication. Resident #2 identified that the nurse could not find the medication and slammed the over the bed table and his/her headphones fell to the floor. The resident reported that he/she told LPN #3 that she was unprofessional and acting like a child and then LPN #3 started yelling at him/her stating, What did you say to me, who do you think you are. Resident #2 identified that she found the pill in his/her bed, gave it to LPN #3 and then LPN #3 slammed the bathroom door that was directly in front of his/her bed. Resident #2 stated he/she told LPN #3 to send the nursing supervisor, and she replied, I sure will. The resident identified that when the nursing supervisor (RN #1) arrived at his/her bedside, he reported to the resident that he had heard LPN #3 yelling at him/her and stated that LPN #3 was in the wrong and provided Resident #2 with a grievance form and identified that he/she could fill it out the next day. Resident #2 reported that he/she was unable to fill it out on the spot, as he/she so upset with the way LPN #3 treated him/her stating that LPN #3 made him/her feel like a piece of s*** and treated him/her like a child. The resident identified that he/she reported the incident to the DNS the next morning, stating he/she was mentally and emotionally abused and the resident thought that Social Worker #1 submitted it as a grievance but stated that no one ever followed back up with him/her Review of the FLIS Reportable Events website on 12/20/24 failed to identify that the incident regarding Resident #2 was reported to the State Agency. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075138	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bloomfield Center for Nursing & Rehabilitation	355 Park Avenue Bloomfield, CT 06002

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DNS on 12/20/24 at 3:02 PM identified that there was no formal investigation done on the 12/1/24 incident involving Resident #2 and LPN #3 but reported that when Resident #2 reported the incident to him, he obtained statements from RN #1 and LPN #3 and had a soft-file in his office that he was trying to locate. The DNS reported that although all allegations of abuse/neglect should be reported to the State Agency and then investigated, when he spoke with RN #1, he reported that LPN #3 was just loud and Resident #2 was upset about it so he handled it as a customer service issue and LPN #3 was not allowed to care for Resident #2 any longer. He reported that he was unsure why RN #1 didn't report the incident to him if he thought it was an allegation of abuse, stating it's his expectation that all allegations of abuse/neglect be reported to him immediately so that if applicable, he can report the allegation to the State Agency timely. Review of the Abuse policy dated 12/2023 directed, in part, that each resident has the right to be free from abuse and neglect. Abuse is defined as the willful infliction of injury, intimidation or punishment with resulting physical harm, pain or mental anguish. Abuse includes verbal abuse, mental abuse and mistreatment. Staff will refrain from all actions that could be considered abuse, mistreatment and/or neglect. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse are reported immediately to the Administrator and DNS of the facility utilizing the chain of command. Abuse allegations require immediate action (keep patient safe, notify supervisor to start the investigation). Reporting timeline requirements for all allegations are to immediately notify supervisor and a 2-hour requirement to report to the Department of Public Health and Local Law Enforcement.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075138	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/20/2024
NAME OF PROVIDER OR SUPPLIER: Bloomfield Center for Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 355 Park Avenue Bloomfield, CT 06002	

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for two (2) of three (3) residents (Resident #1 and #2) reviewed for abuse and neglect, the facility failed to provide evidence that allegations of abuse and/or neglect were thoroughly investigated in accordance with facility policy. The findings include: 1. Resident #1's diagnoses included a fracture of the right fibula (the outer shin bone), congestive heart failure and muscle weakness. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Mental Interview for Mental Status (BIMS) of fourteen (14) indicative of intact cognition and required maximal assistance with bed mobility and was dependent on staff for toileting hygiene. The Resident Care Plan (RCP) dated 11/12/24 identified that Resident #1 had bladder incontinence with interventions that included to check the resident every two (2) to three (3) hours for incontinence and clean the peri-area with each incontinence episode. Review of an email correspondence provided by Person #1 sent to the DNS on 11/30/24 at 9:27 AM identified that he/she just got off the phone with Person #2, who claimed Resident #1 was left in a soiled diaper all night despite calling to be changed, to the point where he/she was so wet that he/she removed the diaper and bedding on their own. The email identified that this incident was not the first time that had occurred and reported that Person #1 left the DNS a voicemail as well requesting a call back, as things needed to change. The DNS did not reply back by email to Person #1. Interview with Person #1 on 12/20/24 at 10:10 AM reported that on 2 occasions (11/11 and 11/29/24) the resident had to wait 3 hours to receive incontinent care after requesting incontinent care on the 3:00 PM to 11:00 PM shift, he/she called and spoke with the DNS after the 11/11/24 incident and was assured by the DNS that he would investigate and speak with the staff and provide staff education but stated he/she never received follow-up. Person #1 identified that when it happened again on 11/29/24, Resident #1 was distraught which made him/her very upset and felt like Resident #1 was being neglected. Person #1 identified that he/she sent the DNS an email regarding the 11/29/24 incident but that he never responded, reporting that he/she eventually saw the DNS at the facility three (3) days later and he again stated that he would look into it, but Person #1 never received follow-up regarding Resident #1's care moving forward. Interview with the DNS on 12/20/24 at 11:20 AM identified that although he was made aware by Person #1 of both the 11/11/24 and 11/29/24 incidents regarding Resident #1, after interviewing staff he could not substantiate the claims of neglect stating it was a customer service issue. The DNS identified that he obtained statements from the Nurse Aides (NA's) that were working on 11/11/24, but did not obtain statements or do an investigation regarding the 11/29/24 allegation nor was he able to provide documentation that facility Accident & Investigations (A&Is) were completed for either the 11/11/24 or 11/29/24 allegations of the neglect allegations. He reported he was unsure why they were not completed, identifying that they should have been. He identified that he did re-educate staff regarding customer service and incontinence care but was unable to provide the documentation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075138	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/20/2024
NAME OF PROVIDER OR SUPPLIER Bloomfield Center for Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 355 Park Avenue Bloomfield, CT 06002	

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #2's diagnoses included malignant neoplasm of the frontal lobe (cancerous brain tumor), epilepsy (seizure disorder), anxiety disorder and post-traumatic stress disorder. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had a Brief Mental Interview for Mental Status (BIMS) of fifteen (15) indicative of intact cognition, exhibited no behaviors, and required moderate assistance with bed mobility and was dependent on staff with transfers. The Resident Care Plan (RCP) dated 10/23/24 identified that Resident #2 has a behavior problem including accusatory behaviors related to malignant neoplasm of the frontal lobe. Interventions included to have two (2) caregivers at all times, encourage the resident to express feelings appropriately, approach/speak to the resident in a calm manner, divert attention, remove from an overstimulating environment and redirect to an alternate location as needed. Interview with Resident #2 on 12/20/24 at 12:43 PM identified that he/she requested pain medication and LPN #3 entered the room alone, with her coat on and a purse over her shoulder, with a straw in one hand and a medication cup in the other hand, as she had worked the 3:00 PM to 11:00 PM shift and told the resident she was on her way out the door. Resident #2 identified that he/she asked her to pick up his/her positioning wedge off the floor and place it under his/her knees, pull the covers up and retrieve the hand grabber from the radiator for him/her and LPN #3 appeared annoyed and started giving the resident an attitude with her responses. The resident identified that LPN #3 put the medication cup down on the over the bed table, grabbed the sheets roughly and pulled them up and bumped the over the bed table and the medication went flying out out and LPN #3 yelled and then started crawling on the floor looking for the medication. Resident #2 identified that the nurse could not find the medication and slammed the over the bed table and his/her headphones fell to the floor. The resident reported that he/she told LPN #3 that she was unprofessional and acting like a child and then LPN #3 started yelling at him/her stating, What did you say to me, who do you think you are?. Resident #2 identified that she found the pill in his/her bed, gave it to LPN #3 and then LPN #3 slammed the bathroom door that was directly in front of his/her bed. Resident #2 stated he/she told LPN #3 to send the nursing supervisor, and she replied, I sure will. The resident identified that when the nursing supervisor (RN #1) arrived at his/her bedside, he reported to the resident that he had heard LPN #3 yelling at him/her and stated that LPN #3 was in the wrong and provided Resident #2 with a grievance form and identified that he/she could fill it out the next day. Resident #2 reported that he/she was unable to fill it out on the spot, as he/she so upset with the way LPN #3 treated him/her stating that LPN #3 made him/her feel like a piece of s*** and treated him/her like a child. The resident identified that he/she reported the incident to the DNS the next morning, stating he/she was mentally and emotionally abused and the resident thought that Social Worker #1 submitted it as a grievance but stated that no one ever followed back up with him/her. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075138	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/20/2024
NAME OF PROVIDER OR SUPPLIER: Bloomfield Center for Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 355 Park Avenue Bloomfield, CT 06002	

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with RN #1 on 12/20/24 at 1:13 PM identified that he did hear LPN #3 yelling back and forth with the resident from his office diagonally across the hall from Resident #2. He reported that he spoke with LPN #3 when she exited Resident #2's room, she identified that she was frustrated. He identified that he did not ask her to write a statement, as he didn't think of it, and then she left the facility. RN #1 reported that he then went to speak with Resident #2 who reported that LPN #3 was yelling at him/her but RN #1 could not recall what Resident #1 stated that LPN #3 had said but identified that Resident #2 made an allegation of abuse against LPN #3. He identified that he provided Resident #2 with a grievance form but did not collect it and stated that he did not report the incident to the DNS, Administrator or oncoming 7:00 AM nurse supervisor prior to leaving for his shift and was unsure why. Interview with the DNS on 12/20/24 at 3:02 PM identified that there was no formal investigation done on the 12/1/24 incident involving Resident #2 and LPN #3 but reported that when Resident #2 reported the incident to him, he obtained statements from RN #1 and LPN #3 and had a soft-file in his office that he was trying to locate. He identified that he communicated Resident #2's concerns to Social Worker #1 and thought she wrote up a grievance on the incident but was unsure why it wasn't located in the grievance book and why there was no follow-up in the clinical record, as there should have been. The DNS reported that when he spoke with RN #1, he reported that LPN #3 was just loud, and Resident #2 was upset about it, so he handled it as a customer service issue and LPN #3 was not allowed to care for Resident #2 any longer. He was unable to identify when he had spoken with LPN #3 and obtained a statement but reported she had not been suspended, as he didn't think it was a case of abuse or neglect. Additionally, he identified that staff should never yell at a resident and LPN #3 should not have been in Resident #2's room alone without another staff present per the resident's plan of care. Review of the Abuse policy dated 12/2023 directed, in part, that each resident has the right to be free from abuse and neglect. When any allegations of abuse, mistreatment or neglect is observed, reported, or suspected by any employee, the complaint is to be thoroughly investigated and reported.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075138	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/20/2024
NAME OF PROVIDER OR SUPPLIER Bloomfield Center for Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 355 Park Avenue Bloomfield, CT 06002	

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for one (1) of three (3) residents (Resident #2) reviewed for abuse, the facility failed to follow the resident's plan of care directing to provide two (2) caregivers at all times. The findings include: Resident #2's diagnoses included malignant neoplasm of the frontal lobe (cancerous brain tumor), epilepsy (seizure disorder), anxiety disorder and post-traumatic stress disorder. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had a Brief Mental Interview for Mental Status (BIMS) of fifteen (15) indicative of intact cognition, exhibited no behaviors, and required moderate assistance with bed mobility and was dependent on staff with transfers. The Resident Care Plan (RCP) dated 10/23/24 identified that Resident #2 has a behavior problem including accusatory behaviors related to malignant neoplasm of the frontal lobe with interventions that included to have two (2) caregivers at all times, encourage the resident to express feelings appropriately, approach/speak to the resident in a calm manner, divert attention, remove from an overstimulating environment and redirect to an alternate location as needed. Interview with Resident #2 on 12/20/24 at 12:43 PM identified that he/she requested pain medication and LPN #3 entered the room alone, with her coat on and a purse over her shoulder, with a straw in one hand and a medication cup in the other hand, as she had worked the 3:00 PM to 11:00 PM shift and told the resident she was on her way out the door. Resident #2 identified that he/she asked her to pick up his/her positioning wedge off the floor and place it under his/her knees, pull the covers up and retrieve the hand grabber from the radiator for him/her and LPN #3 appeared annoyed and started giving the resident an attitude with her responses. The resident identified that LPN #3 put the medication cup down on the over the bed table, grabbed the sheets roughly and pulled them up and bumped the over the bed table and the medication went flying out out and LPN #3 yelled and then started crawling on the floor looking for the medication. Resident #2 identified that the nurse could not find the medication and slammed the over the bed table and his/her headphones fell to the floor. The resident reported that he/she told LPN #3 that she was unprofessional and acting like a child and then LPN #3 started yelling at him/her stating, What did you say to me, who do you are. Resident #2 identified that she found the pill in his/her bed, gave it to LPN #3 and then LPN #3 slammed the bathroom door that was directly in front of his/her bed. Resident #2 stated he/she told LPN #3 to send the nursing supervisor, and she replied, I sure will. The resident identified that when the nursing supervisor (RN #1) arrived at his/her bedside, he reported to the resident that he had heard LPN #3 yelling at him/her and stated that LPN #3 was in the wrong and provided Resident #2 with a grievance form and identified that he/she could fill it out the next day. Resident #2 reported that he/she was unable to fill it out on the spot, as he/she so upset with the way LPN #3 treated him/her stating that LPN #3 made him/her feel like a piece of s*** and treated him/her like a child. The resident identified that he/she reported the incident to the DNS the next morning, stating he/she was mentally and emotionally abused and the resident thought that Social Worker #1 submitted it as a grievance but stated that no one ever followed back up with him/her (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075138	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/20/2024
NAME OF PROVIDER OR SUPPLIER Bloomfield Center for Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 355 Park Avenue Bloomfield, CT 06002	

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview LPN #3 on 12/20/24 at 1:49 PM identified that she recalled the incident on 12/1/24 with Resident #2. She reported that she was leaving for the night after her 3:00 PM to 11:00 PM shift when Resident #2 rang the bell and requested help, so she brought his/her previously requested pain medication (oxycodone) and went to assist before she left for the night. She identified that she set the medication cup down on the over the bed table and then assisted with the resident's requests, stating she bumped the table and the medication fell. She reported that she never slammed doors, became rough with the resident or engaged in any arguing or yelling back and forth with the resident, stating she was unsure why both Resident #2 and RN #1 would have reported that. She identified that Resident #2 was yelling at her and calling her names for no apparent reason, so after she found the medication in the bed and administered it to Resident #2, she exited the room and reported the incident to RN #1, who did not ask her any additional questions and told her she could go home for the night. She reported that several days later, the DNS requested that she write a statement about the incident but identified that she was never suspended or spoken to about the incident after the initial request. LPN #3 reported that she has not cared for Resident #2 since but identified that she was never told that she could have no contact with him/her. LPN #3 identified that although she entered the room alone, she was unaware that there were to be two (2) caregivers at all times with Resident #2, stating she thought only certain staff were required to enter the room with another staff member and was unaware of the care plan directing so, stating she should always follow a resident's plan of care. Interview with the DNS on 12/20/24 at 3:02 PM identified that staff should never yell at a resident and LPN #3 should not have been in Resident #2's room alone without another staff present per the resident's plan of care. He stated that his expectation was that all staff review and is aware of a resident's plan of care prior to providing care was unsure why LPN #3 was providing care to Resident #2 alone and why she was not aware that two (2) staff were required at all times. Review of the Baseline/Comprehensive Person-Centered Care Plan policy dated 3/2023 directed, in part, that 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 MDS. 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, desired outcomes and plan for discharge. The Person-Centered Care Plan will be implemented by qualified members of the facility staff.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075138	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/20/2024
NAME OF PROVIDER OR SUPPLIER Bloomfield Center for Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 355 Park Avenue Bloomfield, CT 06002	

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility policy and interviews for one (1) of three (3) residents (Resident #1) reviewed for incontinent care, the facility failed to complete a bladder evaluation on admission for a resident admitted to the facility with urinary incontinence. The findings include: Resident #1's diagnoses included a fracture of the right fibula (the outer shin bone), congestive heart failure and muscle weakness. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Mental Interview for Mental Status (BIMS) of fourteen (14) indicative of intact cognition and required maximal assistance with bed mobility and was dependent on staff for toileting hygiene. Additionally, the MDS reported that Resident #1 was frequently incontinent of bowel and bladder. The Resident Care Plan (RCP) dated 11/12/24 identified that Resident #1 had bladder incontinence with interventions that included to check the resident every two (2) to three (3) hours for incontinence and clean the peri-area with each incontinence episode. Review of the November 2024 Nurse Aide (NA) flowsheets identified that Resident #1 was always incontinent of urine. Review of the Nurse Aide care card identified that Resident #1 was incontinent of urine and directed staff to check the resident every two (2) to three (3) hours and as required for incontinence. Review of the clinical record failed to identify that a urinary evaluation had been completed since the resident was admitted on [DATE]. Interview with the DNS on 12/20/24 at 11:20 AM identified that he expected that all residents who are identified as incontinent of either bowel or bladder on admission be evaluated for incontinence per policy to help guide interventions for the resident's plan of care. He identified that he was aware that Resident #1 had been incontinent of urine since admission but was unsure why a urinary evaluation had not been completed stating it must have been missed. Review of the Urinary Management policy dated 06/2023 directed, in part, that residents are evaluated for urinary management needs on admission and with a significant change. The Bladder Evaluation is completed for all residents with episodes of incontinence within three (3) days of admission and indicated by a change in the resident's condition or a significant event. Documentation in the Electronic Health Record should identify: Implementation of the voiding pattern evaluation for residents for a minimum of three (3) days, the current level of continence and toileting needs and documentation in the Care Plan of any preventative or care interventions.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075138	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/20/2024
NAME OF PROVIDER OR SUPPLIER Bloomfield Center for Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 355 Park Avenue Bloomfield, CT 06002	

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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for two (2) of three (3) residents, (Resident #1 and #2), reviewed for mistreatment, the facility failed to ensure the residents were provided social services support timely after an allegation of abuse/neglect. The findings include: 1. Resident #1's diagnoses included a fracture of the right fibula (the outer shin bone), congestive heart failure and muscle weakness. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Mental Interview for Mental Status (BIMS) of fourteen (14) indicative of intact cognition and required maximal assistance with bed mobility and was dependent on staff for toileting hygiene. The Resident Care Plan (RCP) dated 11/12/24 identified that Resident #1 had bladder incontinence. Interventions included to check the resident every two (2) to three (3) hours for incontinence and clean the peri-area with each incontinence episode. Interview with Person #1 on 12/20/24 at 10:10 AM reported that there were two (2) incidents (11/11 and 11/29/24) where incontinent care was requested but not provided for over 3 hours on the 3:00 PM to 11:00 PM shift. Person #1 called and spoke with the DNS after the 11/11/24 incident, but stated he/she never received follow-up. Person #1 identified that when incontinent care was also delayed on 11/29/24, Resident #1 was distraught which made him/her very upset and felt like Resident #1 was being neglected. Person #1 identified that he/she sent the DNS an email regarding the 11/29/24 incident but that he never responded, reporting that he/she eventually saw the DNS at the facility three (3) days later and he again stated that he would look into it, but Person #1 never received follow-up regarding Resident #1's care moving forward. Review of social service notes for November 2024 failed to identify any documentation regarding either the 11/11/24 or 11/29/24 allegation of neglect. Interview with Social Worker #1 (Director of Social Services) on 12/20/24 at 11:39 AM identified that she was on medical leave during the month of November 2024 and Social Worker #2 was covering for her. She reported that for all allegations of abuse or neglect, she handles the allegations seriously and will notify the DNS and Administrator immediately. Social Worker #1 reported that social services is responsible for the initial meeting with the resident following allegations of abuse and/or neglect and then following-up daily for three (3) days to offer support. Interview with Social Worker #2 on 12/20/24 at 12:11 PM identified that both the 11/11/24 and 11/29/24 allegations appeared to be allegations of neglect, stating she had not seen or followed-up with Resident #1 because she was never made aware of the allegations. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075138	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/20/2024
NAME OF PROVIDER OR SUPPLIER: Bloomfield Center for Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 355 Park Avenue Bloomfield, CT 06002	

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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DNS on 12/20/24 at 12:32 PM identified that he could not recall if he had notified Social Worker #2 of the allegations of neglect that were communicated to him regarding Resident #1 on 11/11/24 and 11/29/24 but reported that he should have made Social Worker #2 aware. He reported that social services is responsible for following-up with the resident initially and then for three (3) days following an allegation of abuse and/or neglect to offer support and that all interactions should be documented in the clinical record. He identified that Social Worker #2 was not able to provide services to Resident #1 if she was not made aware. 2. Resident #2's diagnoses included malignant neoplasm of the frontal lobe (cancerous brain tumor), epilepsy (seizure disorder), anxiety disorder and post-traumatic stress disorder. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had a Brief Mental Interview for Mental Status (BIMS) of fifteen (15) indicative of intact cognition, exhibited no behaviors, and required moderate assistance with bed mobility and was dependent on staff with transfers. The Resident Care Plan (RCP) dated 10/23/24 identified that Resident #2 has a behavior problem including accusatory behaviors related to malignant neoplasm of the frontal lobe that included interventions to have two (2) caregivers at all times, encourage the resident to express feelings appropriately, approach/speak to the resident in a calm manner, divert attention, remove from an overstimulating environment and redirect to an alternate location as needed. Interview with Resident #2 on 12/20/24 at 12:43 PM identified that he/she requested pain medication and LPN #3 entered the room alone, with her coat on and a purse over her shoulder, with a straw in one hand and a medication cup in the other hand, as she had worked the 3:00 PM to 11:00 PM shift and told the resident she was on her way out the door. Resident #2 identified that he/she asked her to pick up his/her positioning wedge off the floor and place it under his/her knees, pull the covers up and retrieve the hand grabber from the radiator for him/her and LPN #3 appeared annoyed and started giving the resident an attitude with her responses. The resident identified that LPN #3 put the medication cup down on the over the bed table, grabbed the sheets roughly and pulled them up and bumped the over the bed table and the medication went flying out out and LPN #3 yelled and then started crawling on the floor looking for the medication. Resident #2 identified that the nurse could not find the medication and slammed the over the bed table and his/her headphones fell to the floor. The resident reported that he/she told LPN #3 that she was unprofessional and acting like a child and then LPN #3 started yelling at him/her stating, What did you say to me, who do you are. Resident #2 identified that she found the pill in his/her bed, gave it to LPN #3 and then LPN #3 slammed the bathroom door that was directly in front of his/her bed. Resident #2 stated he/she told LPN #3 to send the nursing supervisor, and she replied, I sure will. The resident identified that when the nursing supervisor (RN #1) arrived at his/her bedside, he reported to the resident that he had heard LPN #3 yelling at him/her and stated that LPN #3 was in the wrong and provided Resident #2 with a grievance form and identified that he/she could fill it out the next day. Resident #2 reported that he/she was unable to fill it out on the spot, as he/she so upset with the way LPN #3 treated him/her stating that LPN #3 made him/her feel like a piece of s*** and treated him/her like a child. The resident identified that he/she reported the incident to the DNS the next morning, stating he/she was mentally and emotionally abused and the resident thought that Social Worker #1 submitted it as a grievance but stated that no one ever followed back up with him/her. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075138	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/20/2024
NAME OF PROVIDER OR SUPPLIER Bloomfield Center for Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 355 Park Avenue Bloomfield, CT 06002	

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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of social service notes from 11/30/24 through 12/7/24 failed to identify any documentation regarding the above incident. Interview with the DNS on 12/20/24 at 3:02 PM identified that he communicated Resident #2's concerns to Social Worker #1. He identified that the SW should have documented all encounters with the resident in the clinical record and provided support to the resident intially following the allegation for an additional three (3) days and as needed and was unsure if she had, as no documentation was available. Although attempted, an interview with Social Worker #1 was not obtained.