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	01/22/2026

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **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 were reviewed for community provider appointments, the facility failed to ensure a preoperative order directing to hold a blood thinner for forty-eight (48) hours prior to the scheduled procedure was transcribed correctly resulting in the medication being administered the day prior to and the morning of the procedure, the resident was transported to the appointment and then subsequently the procedure was cancelled due to the error. The findings include:Resident #1's diagnoses included neuromuscular dysfunction of the bladder (lack of bladder control due to brain, spinal cord or nerve problems), recurrent urinary tract infections, and atrial fibrillation. A December monthly physician's order directed to administer Eliquis (a blood thinner) oral 5 milligram tablet (mg) by mouth twice daily. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of fifteen (15) out of fifteen (15) indicating Resident #1 was alert and oriented. The Resident Care Plan dated 10/15/25 identified Resident #1 had an indwelling catheter due to a neurogenic bladder. Interventions included monitoring for signs and symptoms of a Urinary Tract Infection (UTI) and reporting to the provider as needed with changes. The nurse's note dated 12/4/25 at 2:38 PM identified a call was received from the hospital's Interventional Radiology (IR) department and their staff reported the appointment for Resident #1's suprapubic tube (a catheter that's inserted through a small opening in the lower abdomen directly into the bladder to drain urine) placement had been rescheduled for 12/11/25 at 9:00 AM.A physician's order created on 12/4/25 directed to hold the Eliquis for two (2) days, 12/9/25 and 12/10/25, for the suprapubic tube replacement preparation. The nurse's note dated 12/5/25 at 6:36 PM identified the following bloodwork, International Normalized Ratio (INR), Complete Blood Count (CBC), and Comprehensive Metabolic Panel (CMP) were faxed to the hospital in preparation of Resident #1's suprapubic tube change. The report of consultation dated 12/11/25 identified the procedure, replacement of the suprapubic catheter was cancelled. The nurse reported the medication Eliquis was held on 12/9/25 but not on 12/10/25. The note directs the Eliquis needs to be held for forty-eight (48) hours, and the procedure will be rescheduled. Review of the December 2025 Medication Administration Record (MAR) identified although the 9:00 AM and 5:00 PM doses of Eliquis were held on 12/9/25, the 9:00 AM and 5:00 PM on 12/10/25 and the 9:00 AM dose prior to the procedure on 12/11/25 were administered. Interview and review of a written statement dated 12/16/25 with the 3-11PM nursing supervisor, Registered Nurse (RN) #1, on 1/22/26 at 11:21 AM identified on 12/4/25 she received a call from the hospital's Interventional Radiology (IR) staff regarding preoperative instructions for Resident #1's suprapubic tube placement scheduled for 12/11/25. RN #1 explained the instructions included blood work that was required to be obtained and faxed to them, Resident #1 was to have nothing by mouth after 12:00 AM on 12/11/25 except for medications with sips of water and the Eliquis was to be held starting on 12/9/25 at 9:00 AM (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and restarted at 5:00 PM on 12/11/25 after Resident #1 returned from the procedure. RN #1 identified she verified the orders with the provider and then placed the orders that same day. RN #1 stated after the scheduled procedure she was notified by the Director of Nursing (DON) that the hold order for the Eliquis was placed incorrectly, stating she chose the start date of 12/9/25 at 12:00 AM and then entered the hold date so it would last for two (2) days but did not confirm the end date shown or the time to restart the Eliquis were correct. Interview with the DON on 1/22/26 at 12:32 PM identified although the facility does not have a policy and procedure for the licensed nurses to verify the accuracy of order transcription after they enter verbal orders, per standards of nursing practice, RN #1 should have ensured the orders she entered were complete and accurate and she should have re-checked the start and end dates and times prior to submitting the order. The DON indicated since RN #1 received the preoperative orders verbally and did not document a nurse's note the preoperative orders given, a second check by a licensed nurse on the next shift did not occur. Review of the Transcription of Orders policy dated 01/2024 directed, in part, that orders from an authorized licensed independent practitioner are accepted by a RN or Licensed Practical Nurse (LPN). Orders are considered but not limited to medications, labs, diagnostics and consultations and can be written in the electronic health record or obtained over the phone, verbally and/or from discharge and transfer paperwork from the hospital, physician's office visit or consultant's recommendations. Transcribing is the recording of orders by an RN, LPN or by clerical/non-licensed unit clerk with appropriate training and competency per state regulations. Although requested, a facility policy for physicians' orders was not provided.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **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) reviewed for community provider coordination, the facility failed to ensure a complete and accurate clinical record to include communication with the provider regarding preoperative instructions. The findings include:Resident #1's diagnoses included neuromuscular dysfunction of the bladder (lack of bladder control due to brain, spinal cord or nerve problems), recurrent urinary tract infections, and atrial fibrillation. A December monthly physician's order directed to administer Eliquis (a blood thinner) oral tablet 5 milligrams (mg) by mouth twice daily. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of fifteen (15) out of fifteen (15) indicating Resident #1 was alert and oriented. The nurse's note dated 12/4/25 at 2:38 PM identified a call was received from the hospital's Interventional Radiology (IR) department and their staff reported the appointment for Resident #1's suprapubic tube (a catheter that's inserted through a small opening in the lower abdomen directly into the bladder to drain urine) placement had been rescheduled for 12/11/25 at 9:00 AM. A physician's order created on 12/4/25 directed to hold the Eliquis for two (2) days, 12/9/25 and 12/10/25, for the suprapubic tube replacement preparation. Review of the clinical record from 12/4/25 through 12/11/25 failed to reflect documentation of the complete preoperative instructions the 3-11PM nursing supervisor had received on 12/4/25. The only update was the nurse's note dated 12/5/25 at 6:36 PM which identified the following International Normalized Ratio (INR), Complete Blood Count (CBC), and Comprehensive Metabolic Panel (CMP) were faxed to the hospital in preparation of Resident #1's suprapubic foley change. The report of consultation dated 12/11/25 identified the procedure, replacement of the suprapubic catheter was cancelled. The nurse reported the medication Eliquis was held on 12/9/25 but not on 12/10/25. The note directs the Eliquis needs to be held for forty-eight (48) hours, and the procedure will be rescheduled. Review of the December 2025 Medication Administration Record (MAR) identified although the 9:00 AM and 5:00 PM doses of Eliquis were held on 12/9/25, the 9:00 AM and 5:00 PM on 12/10/25 and the 9:00 AM dose prior to the procedure on 12/11/25 were administered. Interview and review of a written statement dated 12/16/25 with the 3-11PM nursing supervisor, Registered Nurse (RN) #1, on 1/22/26 at 11:21 AM identified on 12/4/25 she received a call from the hospital's Interventional Radiology (IR) staff regarding preoperative instructions for Resident #1's suprapubic tube placement scheduled for 12/11/25. RN #1 explained the instructions included blood work that was required to be obtained and faxed to them, Resident #1 was to have nothing by mouth after 12:00 AM on 12/11/25 except for medications with sips of water and the Eliquis was to be held starting on 12/9/25 at 9:00 AM and restarted at 5:00 PM on 12/11/25 after Resident #1 returned from the procedure. RN #1 identified although she verified the orders with the provider and then placed the orders that same day, she did not write a note regarding the preoperative instructions Interview with the Director of Nursing (DON) on 1/22/26 at 12:32 PM identified licensed nurses are responsible for documenting all communication with community providers in the clinical record. Review of the Charting and Documentation policy dated 01/2025 directed, in part, that the charting/documentation is to provide a complete account of the resident's total stay from admission through discharge, provide information about the resident that will be used in developing the plan of care, and as a tool for measuring the quality of care provided to the resident. Licensed staff and interdisciplinary team members shall document all assessments, observations, evaluations and services provided in the resident's medical record in accordance with state law. Documentation (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	shall entail pertinent changes in the resident's condition, reaction to treatment, medications, etc. as well as routine observations. Documentation shall be completed at the time of service, but no later than the shift in which the assessment, observation or care service occurred. Documentation shall be accurate, relevant and complete, containing sufficient details about the resident's care and/or response to care. Document as often as necessary and as the need arises. Document medications, treatments, vital signs and weights as required/requested.