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	05/19/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of the clinical record, facility policy, and interviews for 1 of 4 sampled residents, (Resident #97), reviewed for dignity, the facility failed to ensure the resident's body was not exposed while being transferred in the hallway following a shower. The findings include: Resident # 97's diagnosis included quadriplegia, diabetes, and feeding difficulties. The Minimum Data Set (MDS) assessment dated [DATE] identified Resident #97 had a Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive impairment, and was totally dependent on staff for bed mobility, transfers, eating, and bathing. The Resident Care Plan (RCP) dated 4/3/25 identified an Activities of Daily Living (ADL)deficit related to quadriplegia, spinal stenosis, and muscle weakness. Interventions included total dependence on 1 staff for bathing and showering and was totally dependent on 2 staff for repositioning and turning in bed. Observation on 5/12/2025 at 12:27 PM identified Resident # 97 being wheeled down the hallway, in a shower chair, after a shower with his/her buttocks exposed. The resident was noted to be wearing a hospital gown with no further covering. Staff, residents, and the surveyor were noted in the area and able to view Resident #97's buttocks. Observation and interview with the Director of Nursing (DNS) on 5/12/2025 at 12:27 PM identified that he had observed Resident #97 being wheeled down the hall with his/her buttocks exposed. The DNS indicated that the resident should have been covered up completely when being transferred to and from a shower. Subsequent to surveyor inquiry, NA #2 was asked by the DNS to cover Resident #97's buttocks to maintain privacy. Interview with NA #2 on 5/12/2025 at 12:47 PM identified that she was aware that residents needed to be covered completely when being transferred from the shower. Although NA #2 indicated she was aware of the facility policy, she indicated she had been in a hurry when taking Resident #97 from his/her shower. Review of the facility resident's rights policy dated revised 2/2024 directed, in part, to ensure the right to be treated with consideration, respect, and full recognition of your dignity and individuality. The right to privacy in accommodation, in receiving personal and medical care and treatment.

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075138	A. Building B. Wing	05/19/2025

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 0584 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observations, facility policy, and interview during a tour of the facility, the facility failed to maintain a clean and sanitary environment and an environment free of pests. The findings include: Observations on 5/14/2025 at 10:55 AM through 5/14/2025 at 11:25 AM identified the following: 1. On the A Wing, dirty trays were noted on the counter and fruit flies were noted in Resident #102's room. 2. On the C Wing the carpets were noted to be brown and stained yellow, and brown, and red in front of the nurse's station. Interview and observation with the Housekeeping Supervisor on 5/14/2025 at 11:24 AM identified although the pest control provider had been in the building to treat fruit flies in another resident's room, there were still fruit flies in Resident 102's room. The Housekeeping Supervisor indicated that although spot and steam cleaning of the carpet had been completed last week, carpet stains were still present. The Housekeeping Supervisor was unable to provide any documentation that carpet cleaning had been performed the previous week. Further, the Housekeeping Supervisor indicated that the facility had received a quote for replacement of the carpet. The Housekeeping Supervisor indicated that the quote would be provided to the surveyor. Although requested, a facility quote for carpet replacement was not provided. Review of the carpet spot cleaning policy directed, in part, check carpet for spots daily. Remove soil and moisture from spotted area, for dry spot vacuum to remove loose soil, for wet spot blot with clean white absorbent cloth, liberally spray carpet spot remover to area being cleaned. Review of carpet wet extracting and interim cleaning policies directed, in part, carpet wet extraction is done semiannually April and December, and to follow procedures for interim cleaning, and a cleaning schedule Sunday through Saturday for select areas and perform machine weekly maintenance.

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	05/19/2025

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 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of the clinical record, facility policy, and interviews for 1 of 6 sampled residents, (Resident #60), reviewed for abuse, the facility failed to ensure a resident who was exposed to a communicable illness was free to exit their room when wearing appropriate Personal Protective Equipment (PPE). The findings include: Resident #60's diagnoses included quadriplegia, congestive heart failure, and chronic obstructive pulmonary disease. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #60 had a Brief Interview of Mental Status (BIMS) score of 14 indicating intact cognition, was dependent with personal hygiene and rolling left and right, and used a motorized wheelchair. The Resident Care Plan (RCP) dated 4/29/2025 identified Resident #60 required assistance with activities of daily living. Interventions included using a mechanical lift for transfers, using 2 staff for turning and repositioning, and use of a motorized wheelchair for locomotion. A nurse progress note dated 5/5/2025 identified Resident #60 had tested negative for Covid after his/her roommate had tested positive for Covid. A nurse progress notes dated 5/7/2025 identified Resident #60 was on isolation precautions for Covid and had no shortness of breath or respiratory symptoms. A nurse progress notes dated 5/10/2025 identified Resident #60 was on contact/droplet precaution and had no respiratory distress. Review of physician orders failed to direct staff to place Resident #60 on droplet or contact precautions and/or isolation. An observation on 5/12/2025 at 1:30 PM identified a sign outside Resident #60's room indicating contact and droplet precautions. Resident #60 was not visible from the doorway, he/she was observed behind a privacy curtain without a mask, lacked any engaging activities such as television, radio, or personal activity, and lay silently in bed. A nurse progress note dated 5/13/2025 identified Resident #60 was not experiencing any signs or symptoms associated with Covid after an incidental exposure. An observation on 5/13/2025 at 9:34 AM identified Resident #60 was seated in bed behind a closed privacy curtain, not visible from the doorway of the room, sitting silently without a mask, without any type of any engaging activities such as television, radio, or personal activity. Resident #60's roommate was in bed sleeping. An interview with Nurse Aide (NA) #1 on 5/12/2025 at 11:31 AM identified Resident #60 was not allowed to leave his/her room due to his/her roommate testing positive for Covid. Further NA #1 was unable to identify when Resident #60 could leave his/her room. (continued on next page)

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	05/19/2025

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 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with Resident #60 on 5/13/2025 at 9:33 AM identified he/she missed church this week and was upset he/she could not attend religious services. An interview with the Infection Preventionist (IP) on 5/14/2025 at 9:36 AM identified that residents are not moved if their roommate tests positive for Covid as there is a presumed exposure to Covid. The IP was unable to correctly identify the contagious period for Covid, incubation period for Covid, and Centers for Disease Control (CDC) recommendations for cohorting residents with Covid. The IP stated Resident #60 had not been evaluated for wearing a surgical or N95 mask or checked for mask wearing compliance. Additionally, the IP indicated that room appropriate activities could not be offered to him/her during the isolation period. An interview with the Director of Recreation at 5/14/2025 on 11:28 AM identified that Resident #60 was usually active with recreation activities and had attended bible study, music activities, and plant programs that were offered in the past. She indicated if the resident was currently allowed out of the room, he/she would have been able to participate socially in activity programs for stimulation. Further, the Director of Recreation identified that Resident #60 had not attended or been offered any activities since 5/3/2025. An interview with the Director of Nursing Services (DNS) on 5/14/2025 at 12:21 PM identified that it was unsafe for the roommate of a Covid positive resident to leave the room due to the resident's exposure to Covid. The DNS indicated that it was safe for staff to enter and exit Resident #60's room while wearing a mask, but that it was not safe for Resident #60 to leave the room with a mask. The DNS stated Resident #60 had never been trialed for mask use or for compliance to be out of his/her room with a mask in place. The DNS further noted that Resident #60 was a quadriplegic and could not put on or take off a mask independently. An interview with the Administrator on 5/14/2025 at 12:51 PM identified she was not informed Resident #60 wished to leave his/her room, and that the facility failing to identify that restricting Resident #60 from leaving his/her room when he/she requested could be considered an involuntary seclusion. Review of the facility's operational guide for Covid identified, in part, exposed residents should be monitored for symptoms, receive testing, and wear source control (a mask) for 10 days following exposure.

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	05/19/2025

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 0637 Level of Harm - Potential for minimal harm Residents Affected - Some	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility policy, and interviews for 1 of 3 sampled residents, (Resident #96), reviewed for pressure ulcers, the facility failed to identify and complete a significant change Minimum Data Set (MDS) assessment for a resident with a decline in status. The findings include: Resident #96 's diagnoses included severe protein calorie malnutrition, vascular dementia, and difficulty walking. The quarterly Minimum Data Set assessment (MDS) assessment dated [DATE] identified Resident #96 had a Brief Interview for Mental Status (BIMS) score of 2 indicating severe cognitive impairment, and required supervision with bed mobility, supervision with transfers, and supervision ambulating. Additionally, Resident #96 and was at risk for skin breakdown but had no current pressure areas. Review of the Physical Therapy Discharge summary dated [DATE] through 3/18/2025 identified Resident #96 required partial/moderate assistance with bed mobility, required partial moderate assistance with transfers, and required partial moderate assistance to ambulate 10 feet. (A decline in 3 areas for the level of assistance required for bed mobility, transfers, and ambulation was noted from the MDS assessment dated [DATE] through the Physical Therapy Discharge Summary date of 3/18/2025.) The Resident Care Plan (RCP) dated 4/22/2025 identified Resident #96 had an Activities of Daily Living (ADL) self-care performance deficit. Interventions included limited assistance of 1 staff to turn and reposition in bed, limited assistance of 1 staff to transfer between surfaces, and extensive assistance of 1 staff for ambulation. Although the RCP had been updated to reflect the significant change in status, a significant change MDS assessment was not completed. An Advanced Practice Nurse Practitioner (APRN) note dated 5/9/2025 at 12:40 PM identified Resident #96 with a recent decline in function, staying in bed, less interactive, with a new pressure ulcer. Interview and record review with the Director of Nursing (DNS) on 5/18/2025 at 11:06 AM identified he had not been made aware of Resident #96 significant decline in his/her abilities when the decline had occurred in March. Following notification of Resident 96's new pressure ulcer development on 5/6/2025 he was also notified of the residents decline in the areas of bed mobility, transfers, and ambulation. Interview with the Minimum Data Set (MDS) Coordinator on 5/18/2025 at 11:16 AM, identified that she had not identified the significant change in condition until after she had met with rehabilitation on 5/18/2025 following the development of Resident #96's pressure ulcers. The MDS Coordinator identified that the significant change assessment should have been completed within 14 days of the decline, and that it had been an oversite on her part. Review of the Resident Assessment Instrument Manual, Significant Change in Status Assessment (SCSA dated October 2023 directed, in part, the SCSA is a comprehensive assessment for a resident that must be completed when the IDT has determined that a resident meets the significant change guidelines for either major improvement or decline and impacts more than one area of a resident's health. The significant change assessment will be completed within 14 days of the decline.

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	05/19/2025

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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of the clinical record, facility policy, and interviews for the only sampled resident, (Resident #22), reviewed for Resident Assessment and for 1 of 2 sampled residents, (Resident #102), reviewed for Activities of Daily Living the facility failed to accurately code the Minimum Data Set (MDS) assessment. The findings include: 1.Resident #22 's diagnoses included schizophrenia, encephalopathy and morbid obesity. Review of the clinical record identified Resident #22 had a level II PASRR outcome document on file. Review of the admission MDS assessment dated [DATE] identified that Resident #22 was positive for a PASRR level II assessment. Review of the annual MDS assessment dated [DATE] identified that Resident #22 was coded as no, indicating that there was no level II PASRR (a change from the 6/26/2024 assessment). Interview with the Director of Social Work on 5/15/2025 at 11:09 AM identified that the MDS dated [DATE] should have had the same coding as the MDS dated [DATE]. The Director of Social Work was unable to indicate why the MDS was miscoded, but that a correction could be submitted and she would discuss this with the MDS Coordinator. Review of the Resident Assessment Instrument Manual dated 10/2023 directed, in part, to review the PASRR report provided by the state. If a level II screening was required, code the MDS as yes. 2. Resident #102's diagnoses included malignant neoplasm of left breast, moderate protein calorie malnutrition, and dysphagia (trouble swallowing). The annual Minimum Data Set assessment dated [DATE] identified Resident #102 had a Brief Interview for Mental Status (BIMS) score of 12 indicating moderate cognitive impairment and was independent with eating. The Resident Care Plan in effect on 3/2025 identified Resident #102 had an Activity of Daily Living (ADL) self-care deficit with interventions that included both set up assistance for eating and extensive assistance for eating. The Documentation Survey Reports [Nurse Aid (NA) flow sheets] dated 3/2025, and 4/2025 identified Resident #22 was totally dependent on staff for eating (not independent). Observations on 5/14/2025 at 12:55 PM and 5/16/25 at 12:54 PM identified Resident #102 was being fed lunch by NA #4 and was totally dependent on staff for eating. The Nurse Aide Kardex (NA Care Card) dated 5/16/2025 identified Resident #22 required extensive assistance of 1 staff to eat, required set-up assistance by 1 staff to eat, to provide feeding/dining assistance as needed, and provide adaptive equipment (for self-feeding) including a lip plate, weighted utensils, and a 2 handled cup for all meals. (continued on next page)

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	05/19/2025

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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Interview and clinical record review of the MDS assessment, the Resident Care Plan, and NA flow sheet documentation with Director of Nursing Services on 5/16/2025 at 1:18 PM identified there was conflicting documentation for self-feeding, set up assistance prior to self-feeding, self-feeding with adaptive equipment, and feeding with staff assistance. The DNS was unable to explain why the MDS assessment was coded incorrectly, adding he would place a therapy request in for Resident #102 to be evaluated to determine how much assistance Resident #22 required to eat. Review of the Resident Assessment Instrument Manual dated 10/2023 directed, in part, to code the MDS with the intent to assess the ability of a resident to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident.

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	05/19/2025

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 0645 Level of Harm - Potential for minimal harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility policy, and interviews for 2 of 7 sampled residents (Resident #45 and Resident #60) reviewed for Preadmission Screening and Resident Review (PASRR), the facility failed to ensure the accuracy of a Level 1 PASRR and failed to subsequently submit for a Level 2 PASRR evaluation with an inaccuracy or a change in diagnosis. The findings include: 1. Resident #45 was admitted to the facility in 5/2018 with diagnoses that included anxiety disorder, major depressive disorder, and post-traumatic stress disorder (PTSD). The quarterly Minimum Data Set assessment dated [DATE] identified Resident #45 had a Brief Interview of Mental Status (BIMS) score of 13 indicating intact cognition, experienced feeling down, depressed or hopeless half or more than half the days in a 2 week time period and failed to be coded to indicate that a level II PASRR evaluation had been completed. The Resident Care Plan (RCP) dated 3/24/2025 identified Resident #45 required monitoring for psychotropic medications, used antidepressant medication, had a problem with his/her mood, and had both anxiety and a history of suicidal ideation. Interventions included administering medications as ordered, intervene as necessary, approach/speak in a calm manner, and provide behavioral health consults as needed. The RCP failed to include any information related to PASRR. Review of the clinical record PASRR information identified a level 1 PASRR completed on 8/17/2020 by the facility and listed the diagnosis of major depressive disorder, and post-traumatic stress disorder (PTSD). The Level 1 PASRR indicated that the resident had no history of suicidal talk and failed to identify Resident #45's history of suicidal ideation and history of two prior psychiatric hospitalizations. The PASRR level I outcome identified no referral to a level 2 PASRR was needed because the level 1 PASRR was negative. Further, the PASRR level I indicated, in part, a new screen must be submitted should a change occur. Subsequent to the Level 1 PASRR submission on 8/17/2020, Resident #45 was diagnosed with anxiety, with a documented onset date of 4/5/2024. The facility failed to submit a new PASRR with a change of condition for the diagnosis of anxiety and for evaluation of the need for a Level 2 PASRR. 2. Resident #60 was admitted to the facility on [DATE] with a diagnosis of anxiety, dependent personality disorder, major depressive disorder, and bipolar disorder. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #60 had a Brief Interview of Mental Status (BIMS) score of 14 indicating intact cognition, and experienced feeling down, depressed or hopeless half or more than half the days in a 2 week time period, and had diagnoses that included dependent personality disorder, anxiety, major depressive disorder, and bipolar disorder. The MDS did not indicate a level II PASRR assessment was competed. (continued on next page)

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	05/19/2025

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 0645 Level of Harm - Potential for minimal harm Residents Affected - Some	The Resident Care Plan (RCP) dated 4/29/2025 identified Resident #60 required monitoring for psychotropic medications, and had a mood problem related to bipolar disorder, major depressive disorder, anxiety, dependent personality disorder, and insomnia. Interventions included administering medications as ordered, provide behavioral health consults as needed, and monitor/record/report mood patterns of depression, anxiety, and sad mood to the physician. The RCP failed to include any information related to PASRR. A Level 1 PASRR completed on 10/12/2017 by the facility listed the diagnosis of anxiety and did not include the diagnoses of dependent personality disorder, major depressive disorder, and bipolar disorder. The outcome for the Level 1 PASRR indicated that Resident #60 was coming to the facility from out of state, had a diagnosis of schizoaffective disorder, and no referral for a level 2 PASRR was needed as the level 1 was negative due to insufficient evidence of a major mental illness. The PASRR outcome further directed in part, should there be a discrepancy in the reported information, a status change should be submitted to the PASRR vendor for further evaluation. The facility failed to review Resident #60's Level 1 PASRR for accuracy, failed to include all of Resident #60's mental illness diagnoses, and failed to submit a status change for further evaluation with the appropriate mental health diagnoses to the PASRR vendor for a determination if a level II was required. Subsequent to the Level 1 PASRR submission on 10/12/2017, Resident #60 was diagnosed with unspecified dementia with an onset date of 4/5/2024. The facility failed to submit a PASRR re-evaluation for Resident #45 with a change of condition for the diagnosis of dementia. Interview and review of the clinical record with the Social Worker (SW) #1 on 5/15/2025 at 10:21 AM identified that for residents not admitted directly from the hospital, the facility completed the level 1 PASRR form themselves and it was checked for accuracy. SW #1 identified neither Resident #45's nor Resident #60's Level 1 PASRRs were coded correctly and was unable to explain why a new PASRR was not submitted for evaluation for a level II for reasons of either inaccurate information or a change in mental health diagnoses. She indicated she was not employed by the facility as the time that either of the resident's PASRR information was completed by the facility and that she would bring the inaccuracies to the team for further discussion. Interview and review of the clinical record on 5/15/2025 at 10:40 AM with the Administrator identified that PASRRs for residents were completed when a resident was admitted to the facility or if the resident had a change in level of condition. Further, she noted that neither Resident #45's nor Resident #60's level 1 PASRR contained accurate and complete medical diagnoses information, and she was going to direct SW #1 to submit an updated PASRR form to the PASRR vendor for further evaluation. Review of the RAI manual dated October 2023. directed, in part, to complete the PASRR question with an admission assessment, annual assessment, significant change in status assessment, significant correction to prior comprehensive assessment. Review the Level I PASRR form to determine whether a Level II PASRR was required. Review the PASRR report provided by the State if Level II screening was required and code according to the evaluation. Although requested, the facility did not have a policy for PASRR.

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	05/19/2025

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of the clinical record, facility policy and interviews for 2 of 2 sampled residents, (Resident# 97, Resident #102), reviewed for Activities of Daily Living (ADL's), for Resident #97, the facility failed to develop a comprehensive Resident Care Plan (RCP) for the use of a 24-hour positioning plan and specialized communication needs, and for Resident #102, failed to ensure the RCP reflected a dental problem for a resident with dental issues. The findings include: 1. Resident #97's diagnosis included quadriplegia, diabetes, and feeding difficulties. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #97 had a Brief Interview for Mental Status (BIMS) score of 15 indicating moderate cognitive impairment, spoke Spanish, required an interpreter, had a limitation in range of motion in both upper and lower extremities, and was totally dependent on staff for ADL's. The Resident Care Plan (RCP) in effect from 1/1/2025 through 5/15/2025 failed to identify the 24-hour positioning plan per the physician order or that Resident #97 had communication barriers and required specialized services to communicate. The physician's orders in effect for April and May 2025, directed to transfer Resident #97 out of bed to a power wheelchair with chest and pelvic positioning belts to maintain upright positioning per a 24-hour positioning plan. The Occupational Therapy (OT) progress notes dated 4/3/2025 through 5/15/2025 described Resident #97's out of bed routine was to transfer out of bed to a power wheelchair and to utilize chest and pelvic belts to maintain upright posture per the 24-hour positioning plan. The 24-hour rehabilitation positioning plan directed that on the 7:00 AM to 3:00 PM shift, Resident #97 was to be out of bed to a custom wheelchair (CWC) as tolerated, and on the 3:00 PM to 11:00 PM shift placed back to bed. During an interview on 5/15/2025 at 12:22 PM with Resident #97 he/she was noted to require a translator in order to communicate. Google translator was utilized. The Nurse Aid (NA) care card (directs NA care) dated 5/16/25 failed to identify Resident #97 had a 24-hour positioning plan or that he/she was Spanish speaking and required an interpreter for communication. Interview and review of the RCP with the Director of Nursing Services (DNS) on 5/16/2025 at 1:18 PM failed to identify that Resident #97 had a 24 hour positioning plan or was Spanish speaking and utilized [NAME] (virtual assistive device) for interpretation. Additionally, the DNS indicated that the MDS Coordinator as well as any nursing staff could have updated the RCP to reflect the resident's care requirements. 2. Resident #102's diagnoses included malignant neoplasm of the left breast, moderate protein calorie malnutrition, and dysphagia (difficulty swallowing). (continued on next page)

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	05/19/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The admission Minimum Data Set assessment (MDS) dated [DATE] identified Resident #102 did not have any dental issues. The quarterly MDS dated [DATE] identified Resident #102 had a Brief Interview for Mental Status (BIMS) score of 12 indicating moderate cognitive impairment, was independent after set up help with eating, and required partial/moderate assistance with oral hygiene. The RCP in effect from 1/7/2025 through 5/16/2025 failed to identify any dental issues or problems. A dental hygienist note dated 1/7/2025 identified that Resident #102 had lower right tooth pain at crowned tooth #31 and had no other pathology was noted at the time of the exam. Digital palpation did elicit a mild pain response, but no mobility (of the teeth) was detected. As per the dentist, Resident #102 will be scheduled for further evaluation. A dentist's note dated 1/8/2025 identified that Resident #102 had complained of discomfort of the lower right side of his/her mouth. Resident #102's tooth hurt when biting down. A previous evaluation on 10/24/2024 resulted in a recommendation for a referral to a provider in the community for evaluation for course of treatment. Nursing staff was made aware of the discomfort. Interview and review of the RCP with Director of Nursing (DNS) on 5/16/2025 at 1:20 PM failed to identify why Resident #102 did not have a RCP related to his/her ongoing dental issues since 1/7/2025. Review of the baseline and comprehensive person-centered care plan policy dated 3/2023 directed, in part, the comprehensive person-centered care plan will be developed after the comprehensive assessment, reviewed and revised by a team of qualified persons after each assessment, will be revised episodically as the plan of care changes, and will reflect the resident's current status. The comprehensive person-centered care plan will be kept current by all disciplines on an ongoing basis. Disciplines will be responsible for updating the care plan when there is a new problem identified that needs the discipline to intervene.

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	05/19/2025

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 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 1 of 3 sampled residents, (Resident # 96), reviewed for pressure ulcers, the facility failed to update the Resident Care Plan (RCP) with interventions to prevent the development of a pressure ulcer when the resident became more dependent on staff, and for 1 of 3 sampled residents, (Resident #104), reviewed for accidents, the facility failed to update the Residents Care Plan (RCP) after unwitnessed falls. The findings include: 1. Resident #96's diagnoses included severe protein calorie malnutrition, vascular dementia and difficulty walking. The quarterly Minimum Data Set assessment (MDS) dated [DATE] identified Resident #96 had a Brief Interview for Mental Status (BIMS) score of 2 indicating severe cognitive impairment, required supervision with bed mobility, supervision with transfers, and supervision ambulating. Additionally, Resident #96 was at risk for skin breakdown and had no current pressure areas. Review of the Physical Therapy Discharge summary dated [DATE] through 3/18/25 identified Resident #96 required partial/moderate assistance with bed mobility, partial/moderate assistance with transfers, and partial/moderate assistance to ambulate 10 feet. (A decline in 3 areas was noted to have occurred from the MDS assessment dated [DATE] to the Physical Therapy Discharge summary dated [DATE] in the areas of bed mobility, transfers, and ambulation). The Resident Care Plan (RCP) dated 4/22/25 identified a potential for skin breakdown. Interventions included obtaining labs as ordered, treatments as ordered, and updating the physician and responsible party with changes as needed. The RCP failed to include new iterventions for preventative measures for pressure ulcer development when the resident became more dependent on staff for turning in bed, transfers, and walking. Review of weekly skin assessments from 4/24/25 to 5/1/25 identified that Resident #96 had intact skin. A nurse's note dated 5/6/2025 at 12:58 PM identified a Deep Tissue Injury (DTI) on Resident #96's right hip and a stage 2 (partial thickness skin loss) of the left hip. Resident #96 was seen by the wound nurse practitioner and new orders were put into place. On 5/6/2025 the RCP was updated (subsequent to pressure injury develoment) to include Resident #96's new Deep Tissue Injury (DTI) pressure ulcer to the right hip and stage 2 pressure ulcer on the left hip both related to immobility. Interventions included a dietitian evaluation/intervention as needed, monitor signs and symptoms of wound infection, alternating air mattress placement, and weekly wound evaluations per the protocol. (continued on next page)

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	05/19/2025

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Nurse Practitioner wound assessment note dated 5/6/2025 identified an initial visit to assess Resident #96's pressure injuries. Significant contributors for increased risk of wound incidence and/or impeding healing included but are not limited to diabetic and vascular complicating factors, generalized muscle weakness, impaired mobility, and inevitable effects of aging. Education was provided regarding pressure relief, general offloading, and frequent repositioning. Interview and review of the clinical record with the DNS on 5/18/2025 at 11:06 AM failed to identify that the RCP had been reviewed and revised with interventions for the prevention of pressure ulcer development following Resident #96's decline identified on the Physical Therapy Discharge summary dated [DATE] in the areas of bed mobility, transfers, and ambulation. The DNS indicated the RCP had not been updated prior to the development of the pressure ulcer, because up to that point, he believed that Resident #96 was mobile and ambulatory. Additionally, the DNS indicated that although the facility conducted weekly at risk meetings with the MDS Coordinator, Rehabilitation, and the Dietician, he was never made aware of Resident #96's decline in bed mobility, transfer status, or ambulation until 5/6/25 when the pressure injuries to the right and left hip were identified. Interview with the MDS Coordinator on 5/18/2025 at 11:16 AM, identified she had met with rehab on 5/18/2025, after a significant change had occurred, and that she had only discussed the decline with rehabilitation, (not updating the RCP), after the DNS had questioned her about the decline of function in the 3 areas of bed mobility, transfers, and ambulation. Review of the NHCA pressure injury prevention management program policy dated 3/2023 directed, in part, to identify potential risk factors and implement preventative measures to prevent skin breakdown. 2. Resident #104 was admitted to the facility in June of 2024 with diagnoses that included hypertension, generalized body weakness, and dementia. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #104 had a Brief Interview for Mental Status (BIMS) score of 14 indicating no cognitive impairment, required moderate assistance for personal hygiene and was independent for bed mobility and transfers. The Resident Care Plan (RCP) dated 10/23/2024, identified Resident #104 was at risk for falls due to poor balance, psychoactive drug use, and unsteady gait. Interventions included use of appropriate footwear (non-skid socks, non-slip soles or shoes/sneakers) when ambulating or mobilizing in a wheelchair, encourage the resident to be out of the room when awake for socialization and/or recreation, use a low bed, and note any changes in gait and report as needed. A Reportable Event form dated 12/21/2025 at 6:52 AM written by Registered Nurse (RN) #4, identified that Resident#104 was found lying in front of his/her bed. Resident #104 suffered a laceration to the mid forehead measuring 2 centimeters (cm) by 0.5 cm. Resident #104's physician and family were notified and an investigation into the incident was initiated. A Reportable Event form dated 12/28/2025 at 5:00 AM written by RN #4, identified that Resident#104 had an unwitnessed fall in his/her room in front of his/her bed. Resident #104 did not sustain any injuries. Resident #104's physician and family were notified and investigation into the incident was initiated. (continued on next page)

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	05/19/2025

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Although Reportable Events describing Resident #104's falls on 12/21/2025 and 12/28/2025 were noted, a review of the RCP failed to identify any new interventions that had been implemented to prevent further falls. Interview with RN #4 on 5/15/25 at 10:35 AM, identified that he was responsible for updating Resident #104's RCP after the falls. RN #4 indicated that the RCP should have been updated, and new post fall interventions initiated to mitigate further falls. RN #4 was unable to explain why he did not update the RCP. Interview and clinical record with the Director of Nursing Services (DNS) on 5/19/2025 at 11:10 AM, identified that Resident #104's RCP should have been updated after the falls. The DNS could not explain why RN#4 failed to update the RCP. Review of facility policy titled, Baseline/Comprehensive Person-Centered Care Plan (CPCCP), identified, in part, the CPC/CP will be kept current by all disciplines on an ongoing basis. Disciplines will be responsible for updating the care plan when there is a new problem that requires disciplines to intervene.

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	05/19/2025

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 observation, review of clinical records, facility policy, and interviews for 1 of 4 sampled residents (Resident #2) reviewed for dignity, the facility failed to ensure a portable oxygen cylinder was stored in a safe manner. The findings include: Resident #2 diagnoses included chronic obstructive, obstructive pulmonary disease, respiratory failure, and congestive heart failure. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had a Brief Interview for Mental Status (BIMS) score of 14, indicating no cognitive impairment, required supervision with bed mobility, maximal assistance with lower body dressing, and partial moderate assistance to sit on the side of the bed. The Resident Care Plan Conference (RCC) dated 5/15/2025 identified Resident #2 had emphysema related to a history of smoking. Interventions directed staff to monitor for symptoms of dyspnea on exertion, monitor for signs and symptoms of respiratory infection, and administer oxygen as ordered. Observation and interview with Resident #2 on 5/16/2025 at 1:37 PM identified a green portable oxygen cylinder laying sideways on the seat of a manual wheelchair located at the base of the bed. Resident #2 stated the tank was brought in so that he/she could leave the room and socialize with other residents. Interview with Social Worker (SW) #1 on 5/16/2025 at 1:47 PM identified that during a RCP meeting, it was decided to provide Resident #2 with an extra oxygen tank so he/she could move freely throughout the facility and that she knew how to administer oxygen to residents. SW #1 indicated that although not professionally trained, she knew how to turn on the oxygen tank, had provided oxygen to Resident #2 in the past, and had done so to help so that Resident #2 did not have to wait for a nurse. Observation and interview with the Director of Nursing (DNS) on 5/16/2025 at 2:30 PM identified that oxygen should be administered only by a nurse and SW #1 did not have the competency and qualifications to administer oxygen. Review of the Oxygen Therapy Policy directed, in part, that staff identified hazards such as delivering oxygen to residents with COPD because overcorrected oxygen levels may have led to carbon dioxide retention.

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	05/19/2025

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and review of facility policy for the only sampled resident, (Resident #60), reviewed for Activities, the facility failed to provide activities that met the needs of a resident with a physical impairment. The findings include: Resident #60's diagnoses included quadriplegia, congestive heart failure, and chronic obstructive pulmonary disease. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #60 had a Brief Interview of Mental Status (BIMS) score of 14 indicating intact cognition, was dependent with personal hygiene and rolling left and right, and used a motorized wheelchair. The Resident Care Plan (RCP) dated 4/29/2025 identified Resident #60 would maintain involvement in cognitive stimulation and social activities. Interventions included inviting him/her to the scheduled activities and provide him/her with an activity calendar. An interview with Resident #60 on 5/13/2025 at 9:34 AM identified he/she was upset that there are no options for recreation activities that he/she could participate in due to his/her hands being paralyzed. An interview on 5/14/2025 at 11:28 AM with the Director of Recreation identified that Resident #60 was not being offered any specialized recreation programs, but she recognized military service on Veteran's Day, placed bingo markers on a bingo card for him/her, and when arts and crafts required the use of hands, she would provide the hands on assistance. The Recreation Director further indicated that although there were other residents who had physical limitations, the facility did not offer specialized recreation activities for residents with physical limitations. Review of the Facility's Therapeutic Recreation Policy identified in part that the therapeutic recreation department will provide resident centered activities based on a resident's age, and physical and cognitive limitations.

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	05/19/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility policy and interviews for 2 of 3 sampled residents (Resident #32 and Resident #76) reviewed for pressure ulcers, the facility failed to perform weekly skin checks as ordered, failed to perform weekly pressure ulcer risk assessments, failed to ensure the dietician conducted a nutritional assessment for a resident with a pressure ulcer, and for Resident #76, failed to develop a comprehensive care plan. The findings include: 1. Resident #32 was admitted on [DATE] with diagnoses that included diabetes, chronic kidney disease, dementia and congestive heart failure. The admission baseline Resident Care Plan (RCP) dated 3/26/2025 identified a potential for skin breakdown. Interventions included dietician evaluation/interventions as needed, skin checks with care for changes, report changes to the nurse, turn and reposition every 2 to 3 hours and as tolerated, and weekly skin evaluations. The admission MDS assessment dated [DATE] identified Resident #32 had a Brief Interview of Mental Status score of 7 indicating severe cognitive impairment, and was totally dependent on staff for bed motility, transfers, and wheelchair mobility. Additionally, Resident #32 was always incontinent of bladder, frequently incontinent of bowel, and although he/she did not have a current pressure ulcer, was at risk for pressure ulcer development. Review of the Clinical Record identified a nurses note dated 3/25/25 indicating Resident #32 had a reddened heel, a Hospice Clinical Note and Visit Report sheet identifying a pressure injury to the sacrum on 4/21/2025, and a left big toe in-house acquired deep tissue injury on 4/28/25. Review of the physician orders dated 3/27/2025 directed to apply barrier cream to the buttocks every shift and apply skin prep to the right and left heel every shift, bunny boots and off load when in bed, and physician's orders dated 4/30/2025 directed to cleanse the sacrum with normal saline, apply medical honey and cover with a foam border. a. Physician's orders dated 3/25/2025 directed facility staff to conduct weekly skin assessments on Wednesdays and document findings in Point Click Care (the electronic health record) using the Skin & Wound Total Body Skin Assessment form. Review of the clinical record identified 2 Total Body Skin Assessments dated 4/16/2025 and 5/14/2025 resulting in 5 missing assessments out of 7 opportunities. (4/2, 4/9/, 4/23, 4/30, 5/7/2025) b. A Braden Scale for Predicting Pressure Sore Risk dated 3/26/2025 identified a score of 14 indicating moderate risk of pressure ulcer development. Review of the clinical record failed to identify any further Braden Scale assessments after the initial assessment on admission. c. The Nutritional Evaluation dated 3/28/2025 identified Resident #32 had no skin integrity issues. (continued on next page)

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	05/19/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the clinical record failed to identify the Dietician had evaluated Resident #32 following development of pressure ulcers. 2. Resident #76 was readmitted on [DATE] with diagnoses that included diabetes, chronic kidney disease, and intellectual disability. A nursing readmission assessment dated [DATE] identified that Resident #76 did not have any skin integrity issues. The re-admission MDS assessment dated [DATE] identified Resident #76 with a Brief Interview of Mental Status score of 13 indicating no cognitive impairment and required substantial maximal assistance with bed mobility, transfers, and ambulating 10 feet. Additionally, Resident #76 was always incontinent of bowel, was at risk to develop pressure ulcers, and had a current unhealed pressure ulcer determined to be unstageable. A Skin and Wound Evaluation dated 4/22/2025 identified a pressure ulcer, deep tissue injury that was present on admission. a. A discontinued physician orders dated 4/18/2025 had directed facility staff to conduct weekly skin assessments and document findings in Point Click Care (the electronic health record) using the Skin & Wound Total Body Skin Assessment form. The order was discontinued on 4/18/2025 and never reinstated. Review of the clinical record identified Total Body Skin Assessments dated 5/6/2025 and 5/13/2025 resulting in 2 missing assessments out of 4 opportunities. (during the week of 4/20/2025 and 4/27/2025. b. A Braden Scale for Predicting Pressure Sore Risk dated 4/18/2025 identified a score of 14 indicating moderate risk of pressure ulcer development. Review of the clinical record failed to identify any further Braden Scale assessments after the initial assessment on admission. c. The Nutritional Evaluation dated 4/21/2025 identified Resident #76 had no skin integrity issues. Review of the clinical record failed to identify the dietician had evaluated Resident #76's pressure ulcer present on readmission, since his/her readmission. d. A physician order dated 4/18/2025 directed to cleanse buttocks with soap and water, pat dry, and apply zinc oxide every shift. Although the resident was readmitted to the facility on [DATE] with an unable to stage pressure ulcer, the RCP and Nurse Aide (NA) care card failed to reflect interventions to prevent deterioration or further pressure ulcer development since Resident #76's readmission. (continued on next page)

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	05/19/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DNS on 5/19/25 at 2:55 PM identified that Skin & Wound Total Body Skin Assessment forms are to be routinely completed weekly, Braden scale risk evaluations are to be completed weekly for 4 weeks on admission and readmission, the dietician is to conduct a nutritional assessment when a pressure ulcer has developed, and that RCP's are updated with changes in condition. The DNS was unable to explain why Resident #32 and Resident #76, did not have weekly Skin & Wound assessments, Braden scale risk evaluations were not completed weekly for 4 weeks per the facility policy, why the Dietician did not see the residents for nutritional assessments, although she did attend morning report where she could have received the information, or why the RCP's were not updated timely to reflect the changes in condition, Interview with the Dietician on 5/19/2025 at 3:50 PM identified that she did not see the residents for nutritional assessments/updates to the progress notes as she was not aware/informed the residents had pressure injuries. Further, had she been aware, would have evaluated Resident #32 and #76 more extensively for nutritional needs. Review of the Pressure Injury Prevention Protocol directed to identify potential risk factors and implement preventative measures to prevent skin breakdown. Review of the Pressure Injury Nutrition Protocol directed the Dietician to ensure that residents have adequate fluid and nutritional intakes. Review of the Braden Scale policy directed Braden Scale evaluations for all residents upon admission/readmission, then weekly for a total of 4 weeks. Review of the Resident Care Plan Policy directed dated 3/2023 directed, in part, the comprehensive person-centered care plan will be developed after the comprehensive assessment, reviewed and revised by a team of qualified persons after each assessment, will be revised episodically as the plan of care changes, and will reflect the resident's current status.

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	05/19/2025

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 0689 Level of Harm - Minimal harm or potential for 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 observation, review of the clinical record, facility policy, and interviews for 1 of 4 sampled residents (Resident #2) reviewed for dignity, the facility failed to ensure a portable oxygen cylinder was stored in a safe manner to prevent a potential hazard, for 1 of 3 residents (Resident #60) reviewed for hospitalization, the facility failed to follow physician orders to transfer a resident to the Emergency Department following an accidental occurrence in a dependent resident, and for 1 of 3 residents, (Resident #93) reviewed for accidents, the facility failed to provide a side rail assessment and evaluation prior to using side rails resulting in an injury. The findings include: 1. Resident #2 diagnoses included chronic obstructive, obstructive pulmonary disease, respiratory failure, and congestive heart failure. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had a Brief Interview for Mental Status (BIMS) score of 14, indicating no cognitive impairment, and required supervision for bed mobility, sitting to lying, sitting to standing, and was independent with mobility once in a wheelchair. Additionally, Resident #2 required oxygen therapy. The Resident Care Plan (RCP) dated 5/15/2025 identified Resident #2 had emphysema related to a history of smoking. Interventions directed staff to monitor for symptoms of dyspnea (shortness of breath) on exertion, monitor for signs and symptoms of respiratory infection, and administer oxygen as ordered. Observation and interview with Resident #2 in his/her room on 5/16/2025 at 1:37 PM identified a green portable oxygen tank cylinder on the seat of a wheelchair unsecured and lying sideways. Observation and interview with the Director of Nursing (DNS) on 5/16/2025 at 2:30 PM identified that the oxygen storage tank in Resident #2's room was improperly stored. The DNS indicated the tank should have been secured in an oxygen tank holder and not laid on the seat of the wheelchair. The DNS indicated that subsequent to surveyor observation, the oxygen tank would be removed and secured. Review of the Oxygen Safety Policy directed, in part, that oxygen cylinders must be stored in a stand or chained area, all cylinders in use must be in a stand, and all connections on tanks must be tight. According to Occupational Safety and Health Administration, (OSHA) compressed gas cylinders must be secured in an upright position regardless of whether they are in use or in storage. Compressed gas cylinders can only be horizontal for short durations when they are being hoisted or carried. 2. Resident #60's diagnoses included quadriplegia, congestive heart failure, and chronic obstructive pulmonary disease. The annual Minimum Data Set assessment dated [DATE] identified Resident #60 had a Brief Interview of Mental Status (BIMS) score of 15 indicating intact cognition, was dependent with eating, personal hygiene and rolling left and right, and had bilateral range of motion limitations in the upper extremities. (continued on next page)

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	05/19/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Resident Care Plan (RCP) in effect from 7/19/2024 to 7/22/2024 identified Resident #60 required assistance with activities of daily living. Interventions included using a mechanical lift for transfers, using 2 staff for turning and repositioning, and use of a motorized wheelchair for locomotion. A nursing note dated 7/21/2024 at 4:26 PM identified that Resident #60 had a Q-tip stuck in his/her right nostril and that the Q-tip was not visible while attempting to visualize. The nursing supervisor was made aware and removed the entire Q-tip which had been embedded in Resident #60's nostril. A change in condition provider note dated 7/22/2024 at 7:51 PM identified the facility's Advanced Practice Registered Nurse had been updated on the Q-tip being stuck in Resident #60's nostril and directed facility staff to send Resident #60 to the Emergency Department (ED)for Q-tip removal. A nursing note dated 7/23/2024 at 5:16 AM identified a call was received from the ED medical doctor to inform the facility a Computed Tomography scan (CT) of Resident #60 did not identify any foreign body within his/her nose and the maxillofacial area was clear of any foreign body. The NA Resident Care Card (directs NA care) dated 5/14/2025 identified Resident #60 was totally dependent on staff for oral care and dressing. An interview with Resident #60 on 5/16/2025 at 10:33 AM identified that staff were using a Q-Tip in his/her nose when the Q-tip became stuck. Resident #60 further identified a nurse removed the Q-tip with a long pair of tweezers and then sent him/her to the hospital. An interview on 5/16/2025 at 10:48 AM with Licensed Practical Nurse (LPN) #3 identified that when an object was placed in Resident #60's hands, he/she could bring it to his/her face, but he/she did not have the ability to independently grasp an object. Further, LPN #3 identified on 7/21/2024 Resident #60 notified her that a Q-tip had been stuck in his/her nostril. LPN #3 stated she notified the nursing supervisor (RN #4), and he removed the Q-tip with a large pair of tweezers. She was unable to explain why Resident #60 was sent to the hospital to have the Q-tip removed per APRN orders if the Q-tip was already removed. An interview and review of clinical records on 5/19/2025 at 8:39 AM with Physical Therapist (PT) #2 and Occupational Therapist (OT) #1 identified around and on the date of 7/21/2024, Resident #60 did not have the ability to independently grasp an object and bring it towards his/her face or bring his/her arm to his/her head to itch their nose or scratch their head due to quadriplegia. PT #2 further stated that during a formal evaluation on Resident #60's upper extremity range of motion in March of 2023, Resident #60 was found to have no active range of motion. An interview with the Medical Director on 5/19/2025 at 11:24 AM identified that sending Resident #60 to the Emergency Department for removal of the Q-tip would have been the correct action to take. Further, he indicated that the facility should not have independently removed the lodged Q-tip as harm could have occurred if there was another object at the end of the Q-tip, there was bleeding, and there was the possibility of infection. The Medical Director stated that if there was an order to send Resident #60 to the hospital, he/she should have immediately been sent to the hospital. (continued on next page)

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	05/19/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Director of Nursing Service (DNS) on 5/19/2025 at 12:19 PM identified it was not within the nurse's scope of practice to remove a Q-tip with tweezers when the Q-tip was lodged up Resident #60's nostril and could not be visualized. The DNS could not explain why the nursing supervisor removed the Q-tip himself when there was an order to transport the resident to the hospital for removal. Further, the DNS stated the facility did not fill out an accident or reportable incident form for the incident because Resident #60 was not injured. Attempts to contact the nursing supervisor (RN #4) for interview were unsuccessful. Review of the facility's Accident and Incident policy identified, in part, that it is the responsibility of staff to report incidents and accidents that occur at the facility. Occurrences are to be investigated in a timely manner and preventative measures are to be initiated. 3. Resident #93 was admitted to the facility in April of 2025 with diagnoses that included hypertension, generalized body weakness and dementia. The Nursing admission assessment dated [DATE] identified Resident #93 was alert but confused and required maximum assistance for personal hygiene, toileting hygiene, and transfers. The Resident Care Plan (RCP) dated 4/29/2025, identified Resident #93 with a functional mobility limitation related to dementia and weakness. Interventions included staff assistance with transfers and bed mobility. The RCP failed to indicate side rail use. A Reportable Event form dated 4/30/25 at 6:25 AM written by RN #7, identified that NA #6 reported to RN #7 that she was doing her safety rounds, and witnessed Resident #93's right hand get caught in the side rail which resulted in an injury/skin tear measuring 5.0 centimeters (cm) by 5.0 cm on the back of his/her right hand. RN #7 indicated that the APRN was notified, and treatment was started according to the APRN order. A nurse's note dated 4/30/2025 at 4:35 AM written by RN #7 identified NA #6 had reported to her that she had witnessed Resident #93's right hand get caught in the side rail resulting in a skin tear measuring 5.0 centimeters (cm) by 5.0 cm on the back of his/her right hand. RN #7 indicated that Resident #93 was alert but confused and was not able to explain what had happened. RN #7 assessed Resident #93's right hand, the APRN was notified, and treatment was started according to the APRN order. Attempts to interview NA #6 were unsuccessful. Interview with RN #7 on 5/19/2025 at 10:15 AM, identified that she was notified by NA #6 that Resident #93's right hand had been caught in the side rail, and he/she had sustained a skin tear. RN #7 indicated that she immediately went to assess Resident #93 and identified that 2 half side rails were in use. RN #7 identified that Resident #93 seemed confused and was constantly moving in bed and she was afraid that Resident #93 may roll out of bed and therefore side rails were being used for safety and to assist with mobility. RN #7 could not identify if a side rail assessment had been performed on admission or prior to the side rail use, but stated that a side rail assessment was required per the facility policy, prior to side rail use to ensure side rail safety. (continued on next page)

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	05/19/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and clinical record with the DNS on 5/19/2025 at 11:00 AM, failed to identify a side rail assessment had been completed. The DNS indicated that it was the facility protocol to conduct a side rail assessment prior to side rail use. The DNS could not explain why a side rail assessment had not been completed for Resident #93. Review of facility policy titled, Side Rail Policy, identified, in part, that upon admission, re-admission, significant change, a change in mobility and as needed, the resident will be evaluated for partial side rails to assist with bed mobility. A licensed nurse shall do the initial evaluation which will include observation of the resident's movement in bed and the resident's use of partial side rail to assist with turning and repositioning. The facility shall obtain informed consent from the resident or the resident's representative for the use of side rail and use of side rails will be documented within the resident plan of care.

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	05/19/2025

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, review of facility policy, and interviews for 1 of 2 residents, (Resident #95), reviewed for nutrition, the facility failed to obtain daily weights for a resident with Congestive Heart Failure (CHF) per the physician's order. The findings include: Resident #95 was admitted to the facility in July of 2024 with diagnoses that included hypertension, Congestive Heart Failure (CHF), and diabetes. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #95 had a Brief Interview for Mental Status (BIMS) score of 10 indicating moderate cognitive impairment, and required maximum assistance for toileting, personal hygiene, bed mobility, and transfers. A Resident Care Plan (RCP) in effect for the month of December 2024 identified Resident #95 with a potential for altered cardiac status related to CHF and hypertension. Interventions included monitoring changes in lung sounds on auscultation (i.e. crackles) and evaluating respiratory status for signs of shortness of breath, dyspnea (shortness of breath) on exertion, fatigue, anxiety, cyanosis and monitor weights for weight changes. A physician order dated 12/10/2024 directed to weight Resident #95 every day on the day shift for CHF (monitoring) and notify the physician for a weight gain or loss of 2.5 pounds (Lbs.) in a day (24 hours) or 5 Lbs. in a week. A physician order dated 4/18/2025 directed to administer Torsemide (a diuretic) 20 milligrams (mg) by mouth one time a day for CHF. Further review of Resident #95's clinical record and weights identified that for the month of December; Resident #95 was weighed 8 days out of 22 opportunities; for the month of January 2025 Resident #95 was weighed 7 days out of 31 opportunities; for the month of February 2025, Resident #95 was weighed 2 days out of 28 opportunities; for the month of March 2025, Resident #95 was weighed 6 days out of 30 opportunities, and for the month of April 2025, Resident #95 was weighed 14 days out of 30 opportunities. Further review of the clinical record failed to identify documented weight refusals. Review of APRN #1's progress note dated 4/29/2025 at 9:30 AM identified that Resident #95 had a significant history of CHF and had been off diuretics for quite some time due to weight loss. APRN #1 further identified that Resident #95 had recently experienced episodes of respiratory failure with hypoxia and a chest x-ray revealed pulmonary congestion. APRN #1 indicated that Resident #95 was restarted on torsemide, and his/her breathing and oxygen saturations improved. Interview and clinical record review with RN #2 on 5/14/2025 at 1:35 PM, identified that Nurse Aides (NA's) weigh residents and the nurse enters the weight in Electronic Medical Record (EMR). RN#2 identified that Resident #95's physician's order for daily weights was current and therefore he/she should have been weighed daily as directed and weights documented in the EMR. RN #2 indicated that any weight refusals should also be documented in the clinical record. RN #2 could not explain why Resident #95 was not weighed as directed by the physician. (continued on next page)

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	05/19/2025

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with APRN #1 on 5/14/2025 at 2:30 PM identified that Resident #95's order for daily weights was due to CHF. APRN #1 indicated that Resident #95 should have been weighed daily as directed in the orders. APRN #1 indicated that even though Resident #95 was not being weighed daily as directed, he was assessing him/her often and had not identified significant changes. Interview and clinical record with the DNS on, 5/19/2025 at 11:00 AM, identified Resident #95 should have been weighed as directed by the physician and any refusals documented in the clinical record. The DNS was unable to explain why Resident #95 was not weighed daily as directed by the physician. Although requested, a CHF policy was not provided. Review of facility policy titled, Weights Policy and Procedure, identified in part, that, each resident will be weighed upon admission, readmission, monthly or significant change in condition. Significant weight changes will have verification of weight measurement for accuracy and documentation purpose .If a resident refuses to be weighed or circumstances prevent weighing the resident, the IDT will document reason in the resident's medical record and care plan and attempt to weigh resident another time done.

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	05/19/2025

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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, facility documentation, facility policy and interviews for 1 of 2 sampled residents (Resident #66) reviewed for hydration, the facility failed to ensure the correct intravenous solution was administered per the physician's order. The findings include: Resident #66's diagnoses included dementia, acute kidney failure, and malnutrition. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #66 had a Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment, and was independent with eating and bed mobility, required supervision with transfers, and once standing could ambulate 150 feet independently. The Resident Care Plan dated 5/1/2025 identified Resident #66 was at risk for dehydration secondary to infection and poor PO (by mouth) intake. Interventions included peripheral IV fluids, staff were directed to administer IV medications per MD order, and to monitor signs and symptoms of dehydration. APRN #1's provider order dated 5/7/2025 directed staff to administer Sodium Chloride (NS) solution 0.45 %, intravenously, every hour set at 75 milliliters per hour (ml/hr.) for 2 days, due to tachycardia (rapid heart rate). The order was cancelled on 5/7/2025 at 7:05 PM. Review of APRN #1's order dated 5/7/2025 (after receiving laboratory values) directed staff to change the IV administration to Dextrose intravenous solution 5% (dextrose), use 65 ml/hr. intravenously every hour for tachycardia/hypernatremia (high sodium) for 2 days. Review of the Facility Reported Incident (FRI) event dated 5/8/2025 at 10:15 AM, identified LPN #8 had administered D5½ NS to a resident with a high sodium level instead of D5W after the APRN changed the order to D5W. The RN assessed Resident #66 who was noted to be lethargic and tachycardic, and it was then identified the wrong IV fluids had been infused. APRN #1 was notified, assessed Resident #66, and directed him/her to be transferred to the Emergency Department for evaluation. Review of hospital ED record dated 5/8/2025 identified Resident had hypernatremia with altered mental status and tachycardia on admission. Interview with LPN #7 on 5/15/2025 at 6:27 AM identified she worked on the 11:00 PM to 7:00 AM shift that began on 5/7/2025 and took over care from LPN #8 who had worked on the 3:00 PM to 11:00 PM shift on 5/7/2025. She indicated that the incorrect IV solution was hung during the LPN #8's shift and that LPN #8 verbally informed her D5W (the correct solution) was being administered to Resident #66. She stated that per protocol, both nurses were supposed to verify IV solutions together during shift change, but she was late for work that day, and LPN #8 had to leave, so only a verbal report was given. LPN #7 reported that during her initial rounding, she checked the IV site but not the fluid being administered. She also stated she did not take vital signs upon assuming care. At 6:00 AM, during rounds, LPN #7 reported that although Resident #66 vital signs were normal, she identified that Resident #66 was lethargic and not interacting as he/she normally did. LPN #7 reported her findings to the on-coming nurse but never identified that the incorrect IV solution was running into Resident #66 during her shift. (continued on next page)

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	05/19/2025

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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with RN #4 on 5/15/2025 at 7:16 AM identified that he was the nursing supervisor on the 3rd shift with LPN #7, on 5/7/2025 into 5/8/2025 when the wrong IV solution was being administered to Resident #66. RN #4 explained that per the facility policy, facility staff should have verified that the IV fluid being administered correctly matched the APRN order. RN #4 stated nurses should have followed the 5 rights of medication administration (right patient, time, route, medication, and dose). RN #4 indicated although he could not recall the medication error, as the supervisor, he should have gone into Resident #66's room and verified the IV solution correctly matched the APRN order. Interview and review of the clinical record with RN #2 on 5/15/2025 at 8:55 AM identified she was the supervising nurse on for 1st shift on 5/7/2025. Although a review of APRN #1's order indicated that Sodium Chloride ½ normal saline was the originally ordered solution, she had provided a bag of D5W ½ NS for LPN #8 instructing him to wait until she heard from the provider to run any IV fluids for Resident #66. RN #2 indicated that the APRN subsequently called and changed the order to D5W, but the facility did not have that solution in stock. RN #2 indicated she felt LPN #8 must have administered what was available, but should have called the APRN, and not substituted D5W ½ NS for D5W without a new APRN order. RN #2 did not indicate who was responsible (LPN #8 or RN #2) to call the provider for a new order, or what action she had taken when the correct solution was not available, stating only that she told LPN #8 to wait until the correct solution was delivered from the pharmacy. Additionally, at approximately 10:00 PM, she indicated, while passing Resident #66's room, prior to leaving the shift, she noted Resident #66 had an IV running but failed to check to see if the correct solution was being administered to Resident #66. Interview and review of the clinical record with LPN #8 on 5/18/2025 at 6:42 PM identified he had verified with RN #2 that he was administering the correct IV solution, showing her the bag of solution originally provided by her (D5 ½ NS). After confirming he had the correct solution with RN #2, at approximately 6:00 PM, he had begun administering D5 ½ NS, the incorrect solution, and not the APRN ordered solution of D5W. He further stated that he had done so after seeing D5 on the bag, believing it was the correct solution ordered for Resident #66. Interview with the Director of Nursing Services (DNS) on 5/19/2025 at 11:08 AM identified LPN #8 administered the wrong IV solution and that the next shift nurse, LPN #7, failed to check that the correct solution had been hung by LPN #8. The DNS stated that policy required IV sites to be monitored every two hours. He could not explain why the incorrect fluid was administered to Resident #66 or why the oncoming nurse failed to recognize the incorrect IV fluid being administered. The DNS stated the expectation was for the nurse to assess Resident #66 and to verify the correct IV fluids were being administered. Interview and clinical record review with APRN #1 on 5/19/2025 at 1:38 PM identified he assessed Resident #66 on 5/7/2025, noted poor intake, elevated sodium, and tachycardia with a normal [NAME] Blood Cell count (high WBC could indicate infection). APRN #1 indicated that Sodium Chloride ½ NS was ordered approximately at 5:00 PM indicating D5W ½ NS had never been ordered. APRN #1 further stated after receiving a high laboratory value of sodium, he changed Resident #66's order to D5W at approximately 8:00 PM. APRN #1 indicated that on 5/8/2025 at 10:15 AM he assessed the resident due to an altered mental status, thought that Resident #66 may have been septic, and subsequently sent Resident #66 to the emergency room for evaluation. Although APRN #1 noted that sodium levels increased from 152 to 158, he did not believe that administering the wrong IV fluids (containing sodium) caused the change in condition for Resident #66 and that he would not be concerned until the sodium level had reached 160. (continued on next page)

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	05/19/2025

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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Pharmacist #1 on 5/19/2025 at 4:00 PM identified that while administering D5W ½ NS to a hypernatremic resident would not be helpful, it would have been difficult to say the error caused Resident #66 to further decline. She noted the sodium increase was unlikely caused solely by the IV fluids, as less than a liter was administered. Pharmacist #1 stated, Resident #66 was febrile and in metabolic overload, which could have contributed to the lethargy. Review of the Hydration policy dated 9/2024 directed, in part, staff follow MD orders for fluid intake, IV fluids, and lab values. Review of the Continuous medication Administration Policy dated 1/2022 directed, in part, the licensed nurse will evaluate the venous access site every 2 hours.

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	05/19/2025

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of the clinical record, facility documentation, facility policy and interviews for the only sampled resident (Resident #90) reviewed for hemolytic treatment, the facility failed to follow a fluid restriction for a resident on hemolytic treatment. The findings include: Resident #90 was admitted to the facility in April of 2025 with diagnoses that included end stage renal disease, dependence on renal hemolytic treatment, congestive heart failure (CHF) and anemia. The admission Minimum Data Set assessment dated [DATE] identified Resident #90 had a Brief Interview for Mental Status (BIMS) score 14 indicating no cognitive impairment, required substantial/maximum assistance for personal hygiene and bed mobility, was dependent on toileting and transfers and was receiving hemolytic treatment. The Resident Care Plan (RCP) in effect for April and May 2025 identified Resident #90 was on hemolytic treatment due to end stage renal failure. Interventions included checking and changing the dressing daily at the access site and documenting, entering pre and post weights from the hemolytic center into Resident #90's electronic health record. A physician's order dated 4/7/2025 directed to observe the right chest access port for signs and symptoms of infection: redness, swelling, drainage and pain every shift. Access port for hemolytic treatment is located at the right chest. An APRN's note dated 4/21/2025 at 11:45AM identified that Resident #90 was seen today for evaluation of hemolytic treatment associated hypotension. The note further identified that Resident #90 had been seen today by a nephrologist and a consultation was issued. Per the nephrologist Resident #90 has been having periods of hypotension during his/her hemolytic treatment sessions and a recommendation was made to decrease Resident #90's fluid restriction to 1000cc daily to help address the issue. A review of physician's order dated 4/21/2025 directed hemolytic treatment 3 times per week on Tuesday, Thursday, and Saturday and to maintain a fluid restriction of 1000 cubic centimeters (cc) in 24 hours. Dietary would provide a total of 540 cc giving 180cc (6oz) per meal, nursing would provide 150 cc per shift for medication administration/free water every shift. A review of Resident #90's clinical records from admission in April through 5/14/2025 nurses notes, Medication Administration Record (MAR), and Treatment Administration Record (TAR) from 4/21/2025 to 5/14/2025 failed to identify daily documentation and/or a tally of fluid intake consumed by Resident #90 in a 24-hour period since the physician order directing the fluid restriction was obtained. An APRN's note dated 4/25/2025 at 11:00 AM, identified that Resident #90 was seen today for the evaluation of respiratory failure as requested by the nursing supervisor. The note indicated that Resident #90 had been sent out to the emergency room (ER) the previous evening for the evaluation of shortness of breath, pleural effusion, and possible pneumonia. The note identified that Resident #90 was evaluated in the ER and subsequently sent back to the facility. The APRN indicated that Resident #90 was new to hemolytic treatment, had been gaining weight and showing signs of fluid overload, and a fluid restriction of 1000cc daily had been recommended by his/her nephrologist. (continued on next page)

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	05/19/2025

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with NA #5 on 5/14/2025 at 1:00 PM identified that maintaining fluid intake was not part of NA's assignment/responsibility but was part of licensed nurses' responsibility. An interview with RN #2 on 5/14/2025 at 1:10 PM identified that both nursing assistants and nurses were responsible for maintaining Resident #90's fluid intake. RN #2 was unable to explain why the physician ordered fluid intake was not maintained for Resident #90 since he/she had an order for a 1000 cc fluid restriction within every 24 hour time frame since 4/21/2025. Interview and clinical record review with LPN #6 on 5/14/2025 at 1:17 PM identified that the fluid restriction order was not visible in the MAR where nurses would be directed to maintain the fluid restriction and document fluid amounts consumed by Resident #90 on each shift. LPN #6 identified that the order was not placed right, and subsequent to surveyor inquiry, she would activate the order to be visible on the MAR. LPN#6 indicated that the nurse who acknowledged the order was responsible to ensure the order was visible on the MAR. Interview with the DNS on 5/14/2025 at 2:30 PM, identified that although there was a physician's order directing a 1000 cc fluid restriction, the dietician had mapped the amount of fluid to be served with meals and therefore it was not necessary or a requirement that fluid intake amounts be maintained. The DNS indicated that the facility has other ways of assessing residents for fluid overload including a physician's assessment and obtaining labs. The DNS did not explain how the facility was able to track the entire amount of fluid taken in by Resident #90 in a 24 hour period. Interview with the hemolytic treatment nurse (RN#5) on 5/16/2025 identified that a 1000 cc fluid restriction was recommended by resident #90's nephrologist since resident #90 was not tolerating hemolytic treatments due to experiencing hypotensive episodes during treatment hindering excess fluid extraction and effectiveness of the treatment. Interview with Resident #90 on 5/16/2025 at 9:30AM identified that he/she was not aware that he/she was on fluid restriction until 2 days ago. Resident #90 identified that he/she consumes both food/fluids from home and from the facility. Resident #90 indicated that she does not keep track of her fluid intake. Interview on 5/19/20255 at 11:30 AM with the Dietician identified that she placed Resident #90's 1000 cc fluid restriction per 24-hour order after she was instructed by the hemolytic treatment center dietician and per Resident #90's nephrologists' recommendation. The Dietician further identified that Resident #90 had experienced weight gain and was not tolerating hemolytic treatment as expected due hypotensive episodes during hemolytic treatment. The Dietician identified it was a standard practice and expectation that nursing staff would maintain fluid intake records for a resident who was on fluid restriction. The Dietician further identified that she had mapped out the fluid amount to be given with each meal as a guide for staff. The Dietician indicated that she could have forgotten to activate the order to appear on the MAR so that nursing staff would have been alerted to the 1000 cc fluid restriction and to enter the total amounts on the MAR. (continued on next page)

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	05/19/2025

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Intake and Output Policy identified, in part, that nursing personnel are responsible for documenting fluid intake and/or output totals in the POC section of PCC. The NA is responsible for documenting the totals with meals and fluid taken with meals and those fluid taken in between meals that have been provided by the NA. The nurse is responsible for documenting fluid given to the resident including supplements and those given with medication pass etc. etc. The nurse will assess the total intake to determine if the resident is meeting fluid goals. Although requested, the fluid restriction policy and hemolytic treatment policies were not provided.

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	05/19/2025

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 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 clinical record review, review of facility policy, and interviews for 1 of 5 sampled residents (Resident #46) reviewed for medication administration, the facility to ensure medications that had been dispensed and were going to be administered were safely stored. The findings include: Resident #46 was admitted to the facility in July of 2024 with diagnoses that included hypertension, congestive heart failure (CHF), and diabetes. The annual Minimum Data Set (MDS) assessment dated MDS 5/2/2025 identified Resident #46 had a Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive impairment, and was independent for eating, required moderate assistance with personal hygiene, and maximum assistance for toileting transfers. A Resident Care Plan in effect for the month of May of 2025 identified Resident #46 with Potential for altered cardiac status related to CHF and hypertension. Interventions included monitoring changes in lung sounds on auscultation (i.e. crackles), evaluating respiratory status: signs of dyspnea (shortness of breath), dyspnea on exertion, fatigue, anxiety, cyanosis and monitoring weight and/or weight changes. Interview and observation with Resident #46 on 5/13/2025 at 10:02 AM identified he/she had medications (5 pills in a medication cup) at the bedside table. Resident #46 indicated that LPN #7 had left the medications this morning, at the bedside, for self-administration. Interview and observation with LPN #7 on 5/13/2025 at 10:10 AM identified 5 pills in a medication cup on Resident #46's bedside table. LPN #7 identified that she had left Resident #46's room before the administered the medications. LPN #7 indicated that per the facility policy, she should have ensured that Resident #46 took all his/her pills before leaving the room because he/she had not been assessed or approved to self-administer medications. LPN #7 identified the physician ordered pills in the medication cup as 1 pill of trazodone 25 mg, 1 pill of Carvedilol 6.25mg, 1 pill of Ativan 0.5mg, and 2 pills of Torsemide 20 mg. Interview and record review with DNS at on 5/13/2025 3:30 PM failed to identify Resident #46's completed self-administration assessment/evaluation for medication administration. The DNS identified that LPN #7 should not have left Resident #46's medications on bedside table for self-administration. The DNS indicated that he would re-educate staff. Review of facility policy titled, Medication Pass Policy, identified in part, that, medications are administered safely and timely per the physician's orders .always observe the resident until they have swallowed all medications that have been administered. Do not leave medications in medication cup at the bedside or on tableside.

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	05/19/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical records, staff interviews, and policy review for 1 of 2 sampled resident, (Resident #60), reviewed for infection control, the facility failed to ensure staff wore the appropriate Personal Protective Equipment (PPE) when providing resident care. The findings include: Resident #60 was admitted in April of 2024 with diagnoses that included chronic obstructive pulmonary disease (COPD), heart failure, and quadriplegia. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #60 had a Brief Interview of Mental Status (BIMS) score of 14 indicating intact cognition, was dependent with personal hygiene and rolling left and right and used a motorized wheelchair. The Resident Care Plan (RCP) dated 4/29/2025 identified Resident #60 had COPD. Interventions included monitoring for signs and symptoms of respiratory insufficiency and to monitor/document/report any signs and symptoms of respiratory infection. Nurse progress notes dated 5/7/2025 identified Resident #60 was on isolation precautions for Covid and had no shortness of breath or respiratory symptoms. An observation on 5/12/2025 at 11:31 AM identified signage was posted on Resident #60's door, visible prior to entry, which stated Covid/ precautions with directions that providers and staff must wear gloves, a gown, and an N-95 mask when entering the room. Further observation noted Nurse Aide (NA) #1 was wearing gown, gloves, and surgical mask versus an N-95 mask when providing care for Resident #60 in a room requiring airborne precautions. An interview with NA #1 at that time identified that she was aware she needed to wear an N-95 mask in an airborne precaution room and stated she had forgotten to place the correct mask according to the signage. An interview with the Infection Preventionist on 5/14/2025 at 9:36 AM identified that staff should be using the Personal Protective Equipment (PPE) identified on the sign outside the door for a resident who was on precautions per the facility policy. Review of the facility's Precautions to Prevent Infections policy identified, in part, that clear signage should be posted outside the resident's room indicating the type of precautions and required PPE for use, and staff should be aware of the expectations about hand hygiene, and gown/glove/facemask use.