STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075232	A. Building B. Wing	09/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cobalt Lodge Health Care and Rehabilitation Center	29 Middle Haddam Rd Cobalt, CT 06414

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, facility documentation, facility policy and interviews for one (1) of three (3) sampled residents (Resident #5) who had a change in condition, the facility failed to notify the provider of the change when first identified during morning care until eight (8) hours had passed. The findings include:Resident #5's diagnoses included dementia with behavioral disturbances, Parkinson's disease (a movement disorder of the central nervous system that worsens over time) and osteoarthritis (a joint disease that causes pain, stiffness and swelling of the affected joints). A physician's order dated 3/4/24 directed to transfer Resident #5 with an assist of two (2) utilizing a mechanical lift. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #5 had a Brief Interview for Mental Status (BIMS) score of four (4) out of fifteen (15) indicating Resident #5 rarely made decision regarding tasks of daily life and was dependent on staff assistance for bed mobility and transfers. The Resident Care Plan dated 8/21/25 identified Resident #5 had impaired physical mobility. Interventions directed to provide two (2) person assistance for transfers with the Hoyer (mechanical) lift and following therapy recommendations. The nurse's note dated 8/24/25 at 8:00 PM and written by the 3-11PM Nursing Supervisor, Registered Nurse (RN) #1, identified a nurse aide, Nurse Aide (NA) #11, reported to her Resident #5 was complaining of left knee and left hip pain. The note identified that upon assessment, Resident #5 was noted to complain of pain with light touch, and minimal movement and had the pain since he/she was put to bed the previous night (8/23/25) and was unable to recall if he/she had sustained a fall. The note identified an eight (8) centimeter (cm) by 8.5 cm blueish bruise was present on the left shin area. The note indicated Resident#5's family and provider were notified, and an order was obtained to transfer Resident #5 to the Emergency Department (ED) for evaluation at 6:55 PM accompanied by Emergency Medical Services (EMS). The hospital Emergency Department note dated 8/24/25 identified Resident #5 arrived appearing uncomfortable but in no acute distress, with an obvious deformity of the left lower extremity, swelling at the proximal femur (upper part of the thigh bone closer to the hip joint), and internal rotation and shortening of the leg suggesting an open fracture. The note identified an x-ray of the left femur was obtained and resulted with a significant left femur periprosthetic fracture (a fracture occurring around a previously implanted artificial hip joint) and per the Orthopedic physician Resident #5 was transferred to a trauma center, where surgery was to be performed (Open Reduction and Internal Fixation) to the left femur on 8/25/25. Interview with the 7AM-3PM nurse aide, Nurse Aide (NA) #11, on 9/3/25 at 11:46 AM identified on 8/24/25 when he went to provide care to Resident #5 around 9:30 AM, Resident #5 immediately complained to him of left leg pain. NA #11 stated he knew Resident #5 well and Resident #5 had never complained of pain, and when he looked at the area Resident #5 was pointing to the left knee which appeared swollen so he immediately notified RN #1 who reported she would come take a look at it. NA #11 identified he left Resident #5's room, went to go care for another resident, then returned later on but could not find RN #1 so he got Resident #5 dressed assuming RN #1 had assessed Resident #5. NA #11 identified that at 2:00 PM Resident #5 started yelling out and appeared to be in pain and Resident #5's leg was increasingly swollen from when he saw it earlier in the day, so he again notified RN #1 at which time she looked at the area and stated she was going to send Resident #5 to the hospital. NA #11 stated Resident #5 was still in bed when he left to go home after 3:00 PM. Interview with the 11PM-7AM Nursing Supervisor, RN #3, on 9/3/25 at 1:18 PM identified within the first few hours of her shift prior to receiving any care, Resident #5 started pointing to his/her left groin and left knee reporting he/she was in pain. RN #3 stated she had cared for Resident #5 for an extended period of time and never knew Resident #5 to complain of pain prior to that night so she assessed the area but did not notice any abnormalities at that time. RN #3 reported she gave Resident #5 acetaminophen (pain reliever) which was effective, so she reported the complaints of pain to the 7AM-3PM Nursing Supervisor, RN #1, at the change of shift. Interview with the 7AM-5PM charge nurse and nursing supervisor, RN #1 on 9/3/25 at 1:25 PM identified on 8/24/25, she was very busy and although she was notified, she did not assess Resident #5 until 2:00 PM. RN #1 identified although Resident #5 was having pain she did not give Resident #5 pain medications or contact the provider until around 6:00 PM, 8.5 hours after Resident #5 complained of pain around 9:30 AM. Interview with the 3-11PM charge nurse, Licensed Practical Nurse (LPN) #3, on 9/3/25 at 12:16 PM identified when she arrived for her shift on 8/24/25 at 3:00 PM she was supposed to take over for RN #1 and started to get report RN #1 told her she thought Resident #5's leg was fractured, but she wasn't sure. LPN #3 explained a nurse on the other unit

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, facility documentation, facility policy and interviews for one (1) of three (3) sampled residents (Resident #7) who were reviewed for an allegation of abuse, the facility failed to ensure the resident was free from physical abuse when the resident's behavior escalated and a staff member pushed the resident to the floor resulting in a fracture. The findings include:Resident #7's diagnoses included vascular dementia with psychosis (condition where cognitive decline caused by damage to blood vessels in the brain is accompanied by psychotic symptoms) and major depressive disorder. The admission Minimum Data Set assessment dated [DATE] identified Resident #7 had a Brief Interview for Mental Status (BIMS) score of four (4) out of fifteen (15) indicating Resident #7 rarely made decision regarding tasks of daily life and required moderate assistance with transfers and ambulating. The Resident Care Plan dated 7/29/25 identified Resident #7 has impaired cognition or impaired thought processes related to dementia. Interventions directed to reorient and supervise the resident as needed and provide the resident with necessary cues and stop care if the resident becomes agitated. The nurse's note dated 8/29/25 at 6:15 PM identified the Director of Nursing (DON) was called to the dining room regarding reports that Resident #7 lunged at a staff member, Licensed Practical Nurse (LPN) #4, with a fork and then Resident #7 fell. The note indicated Resident #7 refused to be assessed for injuries, was removed from the dining room and supervised by the DON until Emergency Medical Technicians (EMTs) arrived to transfer Resident #7 to the hospital for further evaluation. The hospital Emergency Department (ED) note dated 8/29/25 identified Resident #7 was brought to the ED for increased agitation and altered mental status after Resident #7 tried to poke a staff member with a fork resulting with Resident #7 falling. The note identified Resident #7 had swelling, tenderness and deformity noted to the right wrist, an x-ray was obtained and resulted with fractures to the right distal (furthest from the body's center/midline) radius and ulna (the bones of the lower arm between the elbow and the wrist) which required reduction (a medical procedure to realign the bones into the correct anatomical position) and the arm was splinted. The note also identified Resident #7 was found to have a Urinary Tract Infection (UTI), was started on antibiotics and admitted to the hospital. Interview and review of the video surveillance of the 8/29/25 incident with the DON on 9/3/25 at 12:45 PM identified around 5:54 PM Resident #7 was observed to be sitting at a table in the front corner of the dining room when Resident #7 stood up and LPN #4 came walking towards him/her. The DON indicated Resident #7 was noted to have a fork in his/her right hand down by their side at hip level. The DON explained LPN #4 appeared to [NAME] forward towards Resident #7, LPN #4 could be seen swinging at Resident #7 multiple times and when Resident #7 fell to the floor, LPN #4 leaves and walks out of the dining room. The DON identified Resident #7 was not observed with his/her right arm extending the fork towards LPN #4 and the fork was not raised higher than Resident #7's naval. The DON identified the cameras have no sound and LPN #4 reported to her Resident #7 was cursing so he approached Resident #7 to request he/she stop, the incident took place and LPN #4 subsequently said he pushed Resident #7 in self-defense. The DON explained LPN #7 ws suspended pending investigation and LPN #4 should never have approached Resident #7 knowing Resident #7 was agitated and should have backed up if he thought Resident #7 was threatening him with the fork and not continued to walk towards Resident #7 and he should not have pushed or made contact with Resident #7. The DON identified had LPN #4 not resigned following the incident, they would have terminated his employment. Interview with NA #12 on 9/3/25 at 1:05 PM identified Resident #7 had been confused and argumentative prior to going to the dining room for dinner on 8/29/25. NA #12 explained just prior to the incident Resident #7 had been swearing and making inappropriate comments and LPN #4 requested that he/she stop swearing at which time LPN #4 and Resident #7 started arguing back and forth. NA #12 identified Resident #7 then stood up with a fork in his/her hand and LPN #4 started walking towards Resident #7 and jerked his body towards Resident #7 in a threatening manner and stated, go ahead. NA #12 identified although Resident #7 did not raise the fork up towards LPN #4, LPN #4 pushed Resident #7 to the floor and then walked out of the room. Interview with LPN #4 on 9/4/25 at 9:41 AM identified that on 8/29/25 he was in the dining room administering another resident medication when Resident #7 started swearing, he asked Resident #7 to stop swearing and told him/her to relax and Resident #7 then stood up at the table with a fork in his/her hand and threatened to stab him with the fork. LPN #4 denied arguing with Resident #7 however he did continue to walk towards Resident #7 and Resident #7 lunged at him with the fork, lost his/her

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, facility policy and interviews for two (2) of three (3) sampled residents (Resident #5 and #8) who required weekly skin audits or quarterly elopement assessments, the facility failed to ensure the assessments were completed in accordance with the facility's policy. The findings include:1.Resident #5's diagnoses included dementia with behavioral disturbances, Parkinson's disease (a movement disorder of the central nervous system that worsens over time) and osteoarthritis (a joint disease that causes pain, stiffness and swelling of the affected joints). The quarterly Minimum Data Set assessment dated [DATE] identified Resident #5 had a Brief Interview for Mental Status (BIMS) score of four (4) out of fifteen (15) indicating Resident #5 rarely made decision regarding tasks of daily life, was dependent on staff assistance for bed mobility and transfers, and no skin abnormalities were present. Review of the Body Audit Tool assessment dated [DATE] identified no skin injuries were present. Upon further review, the clinical record failed to identify Body Audit assessments were completed between 8/4/25 through 8/234/25, when they were due on 8/10/25 and 8/17/25. Interview with the Director of Nursing (DON) on 9/3/25 at 12:29 PM identified body audits are to be completed weekly for all residents and documented in the clinical record. Review of the Skin Monitoring policy dated 5/16/18 directed, in part, that it is the policy of the facility to monitor the skin condition of residents on a weekly basis at a minimum and/or daily with routine care. Weekly Skin Monitoring will be completed at a minimum of once per week and findings will be documented in the Weekly Body Audit Tool in the Electronic Health Record (EHR). 2. Resident #8's diagnoses included dementia without behavioral disturbances, adjustment disorder with mixed anxiety and depressed mood, history of alcohol abuse, restlessness and agitation. A Wandering Risk Scale dated 9/9/24 identified that Resident #8 was at a high risk for wandering. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #8 had a Brief Interview for Mental Status (BIMS) score of six (6) out of fifteen (15) indicative of severe impaired cognition and was independent with transfers and ambulating. Review of the clinical record failed to identify Wandering Risk Scale evaluations were completed between 9/9/24 and 6/9/25 when due in December and March. The Wandering Risk Scale dated 6/9/25 identified Resident #8 was at risk for wandering. The nurse's note dated 8/31/25 at 8:41 PM identified just after 8:00 PM she received a call from the Nursing Supervisor that staff were unable to find Resident #8 in the facility. The supervisor communicated staff were searching for Resident #8 and found the window and screen in his/her bedroom were open. Interview with the Director of Nursing (DON) on 9/4/25 at 8:50 AM identified that all residents are to be evaluated for elopement risk on admission and quarterly and she was unsure why a Wandering Risk Scale evaluation was not completed in 12/2024 or 3/2025. Review of the Wanderguard policy (undated) directed, in part, that all residents are assessed on admission and quarterly for the potential to wander away from the facility. If the resident is deemed at risk to wander, a Wanderguard signaling device will be placed on their wrist or ankle after consent for the device is obtained from the family. In the event that a resident is found to be missing from the building the person who is unable to locate the resident will institute the policy for elopement of a resident.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for two (2) of three (3) sampled residents (Resident #8 and #4) who were identified to be at risk for elopement, the facility failed to develop a care plan and implement interventions when it was identified that Resident #8 was at risk for elopement and failed to implement their Elopement policy when the resident was discovered missing. The failures resulted in the finding of Immediate Jeopardy. For Resident #4 who was at risk of elopement, the facility failed to ensure a Wanderguard alarmed door was shut and latched completely to prevent the resident from exiting out the door and into the parking lot, subsequently falling and sustaining injuries. For one (1) of three (3) sampled residents (Resident #5) who were dependent on staff for transfers, the facility failed to ensure the resident was transferred by two (2) person assistance via a mechanical lift per the physician's order to prevent a fracture. The findings include:: 1.Resident #8's diagnoses included dementia without behavioral disturbances, adjustment disorder with mixed anxiety and depressed mood, history of alcohol abuse, restlessness and agitation. The Wandering Risk Scale dated 6/9/25 identified Resident #8 was at risk for wandering. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #8 had a Brief Interview for Mental Status (BIMS) score of six (6) out of fifteen (15) indicative of severe impaired cognition and was independent with transfers and ambulating. The Resident Care Plan (RCP) dated 6/26/25 identified that Resident #8 had impaired cognitive function and impaired thought processes due to dementia. Interventions directed to keep the resident's routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion and monitor, document and report as needed any changes in cognitive function, specifically changes in decision making ability, memory, recall and general awareness and difficulty expressing self. Review of the clinical record failed to identify a care plan was developed and interventions were put into place when Resident #8 was identified to be at risk for wandering on 6/9/25. Review of the nurse's note dated 8/31/25 at 8:41 PM, written by the Director of Nursing (DON), identified just after 8:00 PM she received a call from the 3-11PM Nursing Supervisor, Registered Nurse (RN) #1, staff were unable to find Resident #8 in the facility. The supervisor identified staff were searching for Resident #8 and found the window and screen in Resident #8's bedroom open. The DON instructed the supervisor to call the police, and all available staff were notified to aid in the search. The note identified a call was received at 11:33 PM that a neighboring town police department found Resident #8 walking along a road, Resident #8 was noted to be alert and stated that he/she was just going for a walk. The note indicated Resident #8 was in the presence police officers and Emergency Medical Services (EMS) when the DON and Administrator arrived on scene and although Resident #8 appeared to be unharmed, Resident #8 was sent to the hospital for evaluation, and the conservator was updated. The police report dated 8/31/25 identified that at 8:42 PM the police were dispatched to the facility for reports of a missing person and upon arrival they spoke with the nursing supervisor, RN #1, who stated Resident #8 walked away from the facility. RN #1 reported Resident #8 was last seen by staff at around 7:00 PM (1 hour and 42 minutes prior) in his/her room and when Resident #8's room was checked, the window was noted to be open. Interview with the charge nurse, Licensed Practical Nurse (LPN) #1, on 9/3/25 at 3:05 PM identified on 8/31/25 she checked on Resident #8 at the start of the 3-11PM shift and interacted with Resident #8 around 4:30 PM when she administered medications to him/her. LPN #1 identified at around 6:50 PM she went to check on Resident #8 again and was unable to locate Resident #8 in his/her room or the common areas. LPN #1 stated she asked a nurse aide, Nurse Aide (NA) #2, and other co-workers if they had seen Resident #8 and they reported they had not, so they all did a quick interior search of the building and were unable to locate Resident #8. LPN #1 indicated she and NA #2 notified the nursing supervisor, RN #1, at 7:00 PM Resident #8 was unable to be located. LPN #1 identified after notifying RN #1, a missing person's code was never called, and the police did not arrive at the facility until after 8:00 PM. Interview with RN #1 on 9/3/25 at 1:25 PM identified on 8/31/25 it was very busy and could not recall if LPN #1 or NA #2 had reported to her around 7:00 PM they were unable to locate Resident #8 and thought it was more around 8:25 PM. RN #1 said she checked the recreation room, therapy room and the exterior of the building, but was unable to locate Resident #8. RN #1 identified when she checked Resident #8's room she saw the window was open and the screen was pushed up. RN #1 identified she then called the DON at 8:41 PM (over 1.5 hours after it was identified Resident #8 was missing and sixteen (16) minutes after she started searching) and was directed by the DON to call the police. RN #1

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on review of facility documentation, facility policy and interviews for three (3) of five (5) nurse aides reviewed for performance evaluations, the facility failed to ensure annual performance evaluations were completed. The findings include:1.NA #7 had a hire date of 10/3/88. Review of the personnel file identified the last annual performance review was dated 11/13/23 and an annual performance review was due in 2024. Documentation of the performance review was not available for review and could not be located. 2.NA #10 had a hire date of 10/19/99. Review of the personnel file identified an annual performance review dated August 2019 that was unsigned by both the employee and the evaluator. Documentation of annual performance reviews after 2019 were not available for review and could not be located. 3.NA #8 had a hire date of 1/30/21. Review of the personnel file identified an annual performance review dated 10/1/21 that was unsigned by both the employee and the evaluator. Documentation of annual performance reviews after 2021 were not available for review and could not be located. Interview with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) on 9/8/25 at 10:00 AM identified annual performance evaluations are to be done yearly but that they were unable to locate the performance evaluations for NA #7, #8 and #10. They reported currently the facility does not have Human Resources staff and they were unaware annual performance evaluations had not been completed consistently in the prior years. Although requested, a facility policy for nurse aide performance evaluations was not provided.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility documentation, facility policy and interviews for five (5) sampled Nurse Aides (NA #6, #7, #8, #9 and #10), the facility failed to ensure the nurse aides received at least twelve (12) hours of in-service training annually. The findings include:Review of NA #6, #7, #8, #9 and #10's personnel files failed to reflect documentation the nurse aides received annual in-service training. Interview with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) on [DATE] at 10:00 AM identified the facility has been without a Staff Development Coordinator since [DATE], stating she was terminated for not completing requirements of the job. They reported annual in-service training had not been completed since at least 12/2024, and they could not locate in-service records from the past year. They identified that nurse aide in-service training was to be completed on orientation and then annually. Review of the facility Training Policy directed, in part, that all employees are required to complete annual in-service education to comply with state and federal regulations and ensure they remain up to date with best practices. Job specific training is based on their roles, for nurses and aides medication administration, wound care, care planning, CPR/first aid, and infection control practices.