

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075232	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/29/2025
NAME OF PROVIDER OR SUPPLIER Cobalt Lodge Health Care and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 29 Middle Haddam Rd Cobalt, CT 06414	
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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. (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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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, facility documentation, facility policy, and staff interviews for one (1) of three (3) sampled residents (Resident #2) who was transferred to the hospital, the facility failed to provide the resident and responsible party with the correct transfer and discharge documents and readmit the resident when the resident was ready for discharge from the hospital. The findings include:Based on clinical record reviews, facility documentation, facility policy, and staff interviews for one (1) of three (3) sampled residents (Resident #2) who was transferred to the hospital, the facility failed to provide the resident and responsible party with the correct transfer and discharge documents and readmit the resident when the resident was ready for discharge from the hospital. The findings include: Resident #2's diagnoses included dementia, anxiety, and a history of alcohol abuse. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #2 rarely or never made decisions regarding tasks of daily living. The Resident Care Plan dated 6/28/25 identified Resident #2 as a long-term resident at the facility. Interventions aimed at encouraging family participation, to encourage the resident to participate in activities, inform the family of any changes, and social services to provide one (1) to one (1) support as needed. The nurse's note dated 8/31/25 at 8:41 PM identified Resident #2 had eloped from the facility and was found by the police walking along the road, although Resident #2 appeared unharmed, Resident #2 was sent to the hospital to be evaluated and treated and Resident #2's conservator was updated. Review of the clinical record failed to identify a bed hold notice was issued to Resident #2 and/or the conservator. Review of the clinical record failed to identify that a discharge summary was completed for Resident #2. The discharge notice given to Resident #2 identified the notice was dated 9/19/25 and Resident #2 had been discharged on 9/1/25. Interview with the hospital Social Worker (Person #2) on 9/26/25 at 2:58 PM identified she received written documentation from the Resident #2's Conservator (Person #3) regarding the meeting he/she had with the facility on 9/8/25 to discuss a safe discharge plan for Resident #2. Person #2 indicated he/she received a copy of the letter Person #3 received from the facility on 9/10/25 which indicated the facility's refusal to take Resident #2 back. Person #2 identified Resident #2 remained in the hospital under observation because they had not found placement for Resident #2. Interview with an Ombudsman from the Long-Term Care Ombudsman Program (Person #1) on 9/29/25 at 10:30 AM identified she had multiple conversations with the administrator at the facility regarding the discharge process. Person #1 identified she informed the administrator he needed to initiate a consultative process and then follow the involuntary discharge process if the facility still determined they wanted to discharge Resident #2. Person #1 explained she informed the administrator they would have to take Resident #2 back to the facility while the Conservator filed an appeal and wait for the appeal hearing. Person #1 stated training was offered to all nursing homes regarding changes to the discharge process, with the new process a discharge notice needed to be issued to a resident, conservator and filed with Person #1 the same day of discharge, and the facility failed to do this. Person #1 stated discharges cannot be back dated, he/she explained this to the administrator, and sent an email with this information to the administrator on 9/16/25. Person #1 identified as of 9/29/25 Resident #2 remains in the hospital on observation status, and the facility has continued to refuse to take Resident #2 back despite education on the regulations. Interview with Person #3 on 9/29/25 at 1:45 PM identified when Resident #2 initially eloped from the facility he/she was told Resident #2 climbed out of a window but was not given all the information leading up to the event. Person #3 explained he/she was initially concerned about Resident #2 returning to the facility and wanted Resident #2 evaluated at the hospital and after learning the details surrounding the reasons Resident #2 eloped, Person #3 felt it was in the best interest for Resident #2's safety and well-being for him/her to return to the facility and Person #3 met with facility staff the beginning of the week following the elopement. Person #3 explained he/she was unable to recall anyone saying Resident #2 was discharged and would need to apply for a readmission. Person #3 identified he/she had conversations with the facility staff regarding safety measurements and was ready to pay for one (1) to one (1) staff while establishing a safe plan. Person #3 stated he/she received a letter from the facility on 9/10/25 indicating they would not allow Resident #2 to return to the facility, so he/she has filed an appeal on behalf of Resident #2 to allow Resident #2 to return to the facility. Person #3 identified although a bed hold was not issued, Resident #2's bed was still open, and Resident #2's belongings were still at the facility. Person #3 indicated he/she did not sign discharge paperwork. Interview with the administrator on 9/29/25 at 2:00 PM identified the facility received</p>		

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, facility documentation, policy, and staff interviews for one of three sampled residents (Resident #1) who was dependent on staff for transfers and toileting, the facility failed to ensure the nurse aide care card was updated to reflect the resident's current non-ambulatory status. This lapse resulted in a fall with significant injury to Resident #1, who was then treated for a traumatic subarachnoid hemorrhage (internal bleeding into the space between the brain and the membranes that cover it), a right femoral neck fracture (broken thigh bone that required surgery), and a right distal clavicle fracture. The findings include: Resident #1's diagnoses included unsteadiness on feet, polyneuropathy, atrial fibrillation, and cognitive communication deficit. The physician's order dated 5/28/25 directed Resident #1 to ambulate with rehabilitation staff only. The admission Minimum Data Set assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of eight (8) out of fifteen (15) indicating Resident #1 had some memory recall deficits, required maximum assistance of one (1) for transfers and toileting, moderate assistance of one (1) for bed mobility, and was non-ambulatory. A physician's order dated 8/29/25 identified Resident #1 was not functionally ambulatory. The Resident Care Plan dated 8/29/25 identified Resident #1 had a self-care deficit and was at risk for falls. Interventions directed to assist the resident with daily living skills, keep the call bell within the resident's reach, and provide the assistance of one (1) for transfers. Upon further review, the care plan failed to identify Resident #1's ambulation status. The social service note dated 9/11/25 at 3:05 PM identified a care plan meeting was held with Resident #1's spouse. The note indicated Resident #1 was not receiving therapy at this time and had recently been discharged at the beginning of the month. The note identified Resident #1 was not functionally ambulatory and utilized a wheelchair for mobility. The undated nurse aide care card that was in place on 9/12/25 identified assistive devices Resident #1 used, a walker and wheelchair and had required assistance of one (1) for transfers. The care card failed to identify Resident #1's ambulation status or that Resident #1 was non-ambulatory. The nurse's note dated 9/12/25 at 8:11 PM identified the 3-11PM nursing supervisor, Registered Nurse (RN) #1, was called to Resident #1's room at 10:00 PM. The note identified a nurse aide, Nurse Aide (NA) #1, was transferring Resident #1 and Resident #1 lost his/her balance and fell forward. The note indicated Resident #1 was laying on his/her right side with his/her right arm extended underneath his/her head and blood was noted, Emergency Medical Services (EMS) was called, and Resident #1 was transferred to the hospital. In a written statement dated 9/12/25 NA #1, who had been assigned as Resident #1's caregiver identified Resident #1 was in front of him with the walker ambulating to the bathroom, as they passed by the bathroom door Resident #1 reached over to turn on the lights, putting his/her weight on the walker causing the walker to topple over. The Emergency Department note dated 9/13/25 identified Resident #1 was ambulating to the bathroom with a caregiver behind him/her when Resident #1 fell forward striking his/her head on the ground. The hospital discharge paperwork dated 9/17/25 identified Resident #1 was diagnosed and treated for a traumatic subarachnoid hemorrhage, right femoral neck fracture and right distal clavicle fracture. The nurse's note dated 9/17/25 at 8:59 PM identified Resident #1 returned to the facility. The note indicated Resident #1 had surgery on the right hip on 9/15/25 and a mediplex dressing was in place and to remain on the surgical site until follow-up on 9/29/25 with the orthopedic surgeon. The facility summary report dated 9/18/25 identified it was determined Resident #1 had been recently made non-ambulatory by physical therapy (PT) and the care card was not updated to reflect the change. Interview with the Physical Therapist (PT) #1 on 9/26/25 at 12:20 PM identified she had treated Resident #1 for therapy services at which time Resident #1's ambulation status was to ambulate with therapy staff only and Resident #1 was discharged from physical therapy services on 8/29/25. PT #1 explained at the time of discharge Resident #1 required assistance from one (1) staff member for transfers and was non-ambulatory. PT #1 identified on 8/29/25 she entered a status change to not functionally ambulatory into the physician orders and communicated the change with the nursing staff. PT #1 identified due to Resident #1 suffering a subdural hematoma and subsequent deconditioning, Resident #1's status has deteriorated since the fall and now requires a Hoyer lift for transfers and staff support for sitting. Interview with the Director of Nursing (DON) on 9/26/25 at 1:00 PM identified once a resident's ambulation status was on the physician's orders, the nurse was responsible to update the nurse aide care card. The DON stated the nurse aide care card for Resident #1 failed to identify Resident #1's ambulation status prior to, and after the change on 8/29/25 and only identified Resident #1 having a wheelchair and walker for</p>		