STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075301	A. Building B. Wing	11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caleb Hitchcock Health Center	10 Loeffler Rd 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 - 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 review of the clinical record, facility documentation, facility policy and interviews for 1 of 2 residents (Resident #6) reviewed for hospitalization, the facility failed to ensure Resident #6 who exhibited self-injurious behaviors (biting, gnawing and sucking), had a comprehensive care plan developed and interventions implemented to minimize the risk of injury. The facility's failure to develop a comprehensive care plan with individualized interventions to address self-injurious behaviors resulting in the development of an open area, progressing to osteomyelitis (a bone infection) and gangrene which required a partial right third finger amputation. These failures resulted in the finding of immediate jeopardy. Additionally, for 1 of 3 residents (Resident #1) reviewed for accidents, the facility failed to ensure the resident care plan was comprehensive for Resident #1's history of fractures and seizures. The findings include: 1.Resident #6 was admitted to the facility from the hospital on [DATE] with diagnosis that included a urinary tract infection, hypertension and chronic obstructive pulmonary disease. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #6 was moderately cognitively impaired, was dependent on transfers, and toileting, required partial to moderate assistance for eating, personal hygiene, and showering. Additionally, the MDS identified Resident #6 did not exhibit any abnormal behaviors.The Resident Care Plan (RCP) dated 10/10/25 identified a problem with behavioral symptoms, being easily agitated with occasional verbal abusive/aggressive behavior and Resident #6 did not fully understand what was happening. Interventions included to establish and maintain familiar routines, psych referral as needed, monitor for changes in mood/behavior and report to the nurse. The RCP failed to identify the behaviors of gnawing, biting and sucking of the fingers to the right hand or interventions to discourage the behavior and protect the skin from breakdown.The Resident Care Plan dated 10/15/25 identified Resident #6 was at risk for skin breakdown related to decreased mobility and incontinence with interventions directed to conduct a systematic skin inspection weekly, keep skin clean dry, and report any signs of skin breakdown. Nursing notes dated 10/18/25 at 10:48 PM and written by Registered Nurse (RN) #3 identified Resident #6 continued to bite/suck on 3 fingers of his/her right hand (did not specify which 3 fingers), the areas were bloody with no signs and symptoms of infection. RN #3 also identified she placed a dry protective dressing to the areas (but failed to document an assessment/description of the open area/location where the blood was originating from). Advanced Practice Registered Nurse (APRN) #1 notes dated 10/20/25 at 5:44 PM identified Resident #6 was COVID-19 positive.Advanced Practice Registered Nurse (APRN) #1 notes dated 10/22/25 failed to identified Resident #6's skin was warm and dry and failed to document the skin breakdown to the right 3 fingers that was observed by RN #3 on 10/18/25. Nursing notes dated 10/26/25 (8 days after Resident #6 was noted with 3 right hand fingers that were bloody) at 1:37 PM and written by Registered Nurse (RN) #4 identified she was called to the unit by the charge nurse who reported to her that Resident #6's right 3rd finger looked infected. RN #4 identified she completed an assessment of Resident #6's right middle finger and the surrounding area, which was noted with redness, swelling, being warm to touch, the top of the 3rd finger was dark in color with a white patch at the tip. RN #4 (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 0656 Level of Harm - Actual harm Residents Affected - Few	also identified she called MD #1 and obtained an order to send Resident #6 to the emergency room for evaluation. Resident #6 was sent to the emergency room at 1:43 PM. Nursing notes (written after Resident #6 was transferred to the Emergency Room) dated 10/27/25 at 4:54 PM and written by RN #5 identified Resident #6's right 3rd finger was reddened, warm to touch, and swollen.ˆ Resident #6 denied pain or discomfort.ˆˆ RN #5 further noted that the finger was not like that on Saturday (on 10/25/25, but no assessment of the right hand was documented) and Resident #6 was afebrile.ˆ A hospital Discharge summary dated [DATE] identified Resident #6 was being transferred back to the long-term care facility status post gangrene, osteomyelitis and partial amputation of the right 3rd finger.Nursing notes dated 10/30/25 at 11:27 PM written by RN #3 identified Resident #6 was readmitted to the facility from the hospital with a diagnosis of right middle finger osteomyelitis with a partial amputation. Interview and RCP review with the DNS on 11/19/25 at 2:59 PM identified although there was a care plan for behaviors of being anxious, agitated and aggressive, the care plan failed to include the behaviors of gnawing, biting and sucking his/her fingers which therefore interventions were not implemented to discourage the behaviors and protect the skin to the fingers from breakdown. Additionally, the DNS identified the RCP should have included Resident #6's behaviors of gnawing, biting and sucking of the fingers with appropriate interventions.Interview on 11/19/25 at 3:09 PM with RN #3 (the RN that observed Resident #6's right hand to be bloody on 10/18/25) identified she was the full time 3:00 PM to 11:00 PM nurse on Resident #6's unit and was familiar with Resident #6. RN #3 also identified Resident #6 had the habit of sucking/gnawing/picking at his/her right-hand fingers but did not include that behavior in the Resident Care Plan and therefore interventions to discourage Resident #6 from sucking/gnawing/picking at his/her right-hand fingers and interventions to protect/monitor the skin to the right hand were not in place. RN #3 further indicated all nursing staff were responsible to up-date the care plan as changes occur and noted it was an oversight that she did not include that behavior with interventions in the care plan.Interview on 11/20/25 at 12:25 PMˆwith Nurse Aide (NA) #3 identified she observed Resident #6 putting his/her fingers in his/her mouth, noticed blood at times and she reported to the nurse on the unit but was unsure of who and when she reported it to.ˆ Interview on 11/20/25 at 2:40 PM with Person #1 identified Resident #6 had a history of biting and picking at his/her fingers before and during admission to the facility, and the fingers were scabbed.ˆ Person #1 further indicated he/she did not see Resident #6 until 10/26/25 (because Resident #6 had Covid) and indicated the fingers were very discolored and red.ˆ Interview on 11/21/25 at 1:23 PM with MD #2 noted that Resident #3 had a history of vascular disease, but it was not noted in the resident electronic medical record. Also, identifying if Resident #6 had history of gnawing, bleeding to his/her fingers, the expectation would for Resident #6's fingers to be monitored at least daily. Interview and care plan review with RN #1 (MDS Coordinator) on 11/24/25 at 1:54 PM failed to identify the RCP was comprehensive to include Resident #6's behaviors of gnawing, biting and picking at his/her fingers. Additionally, RN #1 identified the RCP was updated on 10/31/25 (after Resident #6 returned from the hospital) to include Resident #6's behaviors of picking of the skin with his/her fingers and mouth but failed to include interventions to discourage the behavior and prevent the skin from breakdown. Additionally, RN #1 further indicated that although she was responsible for developing resident care plans, any nurse can develop and initiate a care plan. Although a policy regarding care plans was requested, only a care plan policy pertaining to the baseline care plan was provided. The above deficiency resulted in the finding of Immediate Jeopardy (IJ). The facility Administrator was provided with the IJ template on 11/20/25 at 2:00 PM and submitted a removal plan which was approved by the State Agency on 11/21/25.The removal plan noted in part, a comprehensive audit was conducted for all care plans and behavior monitoring practices to confirm care plans were accurate and discrepancies were corrected. The Interdisciplinary Team was engaged, and direct care staff were educated on updated care plans to reinforce continuity of care. To prevent recurrence, the removal plan also indicated systems were strengthened through policy reviews related to behaviors, quality of care, clinical monitoring, (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	escalation and documentation. Staff were in-serviced regarding to ensure understanding of behavior recognition and documentation in the electronic medical record and care plans. 2. Resident #1's diagnoses included epilepsy (seizure disorder), left ulna (forearm/wrist bone) fracture with routine healing, and fracture of the right side of the skull and facial bones.The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 was severely cognitively impaired, was independent with eating, bed mobility, chair/bed transfers and walking. The Resident Care Plan (RCP) dated 2/4/25 identified Resident #1 was at risk for falls related to physical deconditioning and required assistance with activities of daily living (ADLs). Interventions included keeping personal items and frequently used items within reach, leave a night light on in the room, and providing toileting assistance every 2 hours.A progress note written by the physician (MD) #1 and dated 2/28/25 at 1:40 PM identified Resident #1 was hospitalized for an episode of hypotension (low blood pressure) and having a large blood-filled stool. While at the hospital Resident #1 had 2 tonic-clonic seizures (seizure with muscle stiffness and rhythmic jerking of limbs) and was started on Keppra (anti-seizure medication). The progress note further identified imaging was obtained during the hospital workup which showed multiple facial fractures and a periorbital hematoma.A physician order dated 3/4/25 directed to administer 7.5 milliliters (ml) of Keppra solution 100 milligrams (mg) per ml for a dose of 750 mg by mouth twice a day. A nursing note written by Registered Nurse (RN) #7 on 5/27/25 at 6:21 PM identified Resident #1 was sent to the hospital for evaluation following an x-ray report addendum received 5/27/25 which indicated Resident #1 may have a left intertrochanteric fracture following an unwitnessed fall on 5/22/25. A significant change Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 was severely cognitively impaired, used a wheelchair, required setup or clean-up assistance with eating, substantial/maximal assistance with bed mobility and was dependent with chair/bed transfers. The MDS assessment identified Resident #1 had a fracture related to a fall in the 6 months prior to readmission and had active diagnoses that included, in part, epilepsy and a hip fracture. The Resident Care Plan (RCP) dated 9/17/25 identified Resident #1 had pain related to having a left hip fracture with surgical repair. Interventions included to administer medications as ordered and position for comfort with physical support as needed. The RCP failed to include Resident #1's history of seizures, being on anti-seizure medication and therefore did not identify interventions if seizure activity were to occur. Furthermore, the RCP failed to include Resident #1's recent left ulna fracture and recent history of facial fractures.A Reportable Event (RE) form dated 9/30/25 at 7:00 AM identified Resident #1 presented with a swollen, bruised, painful left hand, and had x-rays performed which revealed an acute distal ulna fracture. The RE form further identified Resident #1 was sent to the hospital for evaluation and treatment.A physician order dated 11/13/25 directed to apply a left hand/forearm splint for non-weight bearing (NWB) to left upper extremity (LUE) when out of bed (OOB) twice a day (7:00 AM to 3:00 PM and 3:00 PM to 11:00 PM) with special instructions to remove splint at bedtime.Interview and clinical record review with RN #1 on 11/21/25 at 2:45 PM identified Resident #1's RCP failed to include a care plan for seizures and facial fractures identified in February 2025 and failed to include a care plan related to his/her ulna fracture identified on 9/30/25. RN #1 identified she had missed entering seizures into Resident #1's RCP and that it should be included because Resident #1 was on anti-seizure medication. RN #1 identified she had not realized the RCP should include Resident #1's history of ulna and facial fractures.Subsequent to surveyor inquiry on 11/21/25, RN #1 initiated a care plan addressing Resident #1 having a history of seizures and receiving antiseizure medication. Interventions included if Resident #1 had a seizure ensure a safe environment by cushioning the head, removing sharp objects, loosening tight clothing, and turning Resident #1 to his/her side, and to report any seizure like activity to providers.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for 1 of 2 residents (Resident #6) reviewed for hospitalization, the facility failed to protect the skin of a resident with known behaviors of picking and gnawing at his/her fingers, failed to monitor the fingers after gnawing caused skin deterioration of the finger, failed to document an assessment when the fingers were noted with breakdown which resulted in Resident #6 developing osteomyelitis (a bone infection),and gangrene requiring a partial right third finger amputation. These failures resulted in the finding of Immediate Jeopardy.ˆˆ Resident #6 was admitted to the facility from the hospital on [DATE] with diagnosis that included a urinary tract infection, hypertension and chronic obstructive pulmonary disease (there was no admitting diagnosis of peripheral vascular disease (PVD), diabetes or neuropathy). A progress note written by MD #3 prior to Resident #6's admission to the facility, obtained by the facility subsequent to surveyor inquiry and dated 7/14/25 identified in 2022, Resident #6 developed a nonhealing infection of the left toe, underwent angioplasty for critical left lower extremity ischemia with amputation of the 2nd left digit of the foot due to dry gangrene. Resident #6 also required amputation of the 3rd left toe related to gangrene in February 2023. A physician's admission progress note dated 10/6/25 and written by MD #2 failed to identify any history of peripheral vascular disease (PVD), although the physician's admission progress note did list a past history of amputation of replicated toes (a congenital condition of having extra toes). The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #6 was moderately cognitively impaired, was dependent on transfers, and toileting, required partial/moderate assistance for eating, personal hygiene, and showering. Additionally, the MDS identified Resident #6 did not exhibit any abnormal behaviors.ˆ The Resident Care Plan dated 10/15/25 identified Resident #6 was at risk for skin breakdown related to decreased mobility and incontinence with interventions directed to conduct a systematic skin inspection weekly, keep skin clean dry, and report any signs of skin breakdown.ˆ Nursing notes dated 10/18/25 at 10:48 PM and written by Registered Nurse (RN) #3 identified Resident #6 continued to bite/suck on 3 fingers of his/her right hand (did not specify which 3 fingers), the areas were bloody with no signs and symptoms of infection. RN #3 also identified she placed a dry protective dressing to the areas (but failed to document an assessment/description of the open area/location where the blood was originating from and failed to notify the physician).ˆ(refer to F 658)ˆ Advanced Practice Registered Nurse (APRN) #1 progress notes dated 10/20/25 at 5:44 PM identified Resident #6 was COVID-19 positive and failed to document the skin breakdown to the right 3 fingers that was observed by RN #3 on 10/18/25.ˆˆˆ . ˆ Nursing notes dated 10/19/25 through 10/25/25 failed to identify any monitoring, physician notification or assessment of Resident #6 ?s fingers to the right hand where blood was observed on 10/18/25, despite RN #3 applying a dry, protective dressing on 10/18/25.ˆ Advanced Practice Registered Nurse (APRN) #1 notes dated 10/22/25 identified Resident #6's skin was warm and dry and failed to document the skin breakdown to the right 3 fingers that was observed by RN #3 on 10/18/25.ˆˆˆReview of physician orders from 10/18/25 when skin breakdown to Resident #6's right 3 fingers was observed by RN #3 through 10/26/25 failed to reflect a treatment was obtained for Resident #6's right 3 fingers.ˆˆˆ Nursing notes dated 10/26/25 (8 days after Resident #6 was noted with 3 right hand fingers that were bloody) at 1:37 PM and written by RN #4 identified she was called to the unit by the charge nurse who reported to her that Resident #6's right 3rd finger looked infected.ˆ RN #4 identified she completed an assessment of Resident #6's right middle finger and the surrounding area, which was noted with redness, swelling, being warm to touch, the top of the 3rd finger was dark in color with a white patch at the tip. Also identifying she called MD # 1 and obtained an order to send Resident #6 to the emergency room for evaluation. Resident #6 was sent to the emergency room at 1:43 PM.ˆ Nursing notes (written after Resident #6 was transferred to the Emergency Room) dated 10/27/25 at 4:54 PM (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	and written by RN #5 identified Resident #6's right 3rd finger was reddened, warm to touch, and swollen.ˆ Resident #6 denied pain or discomfort.ˆˆ Also identifying that the finger was not like that on Saturday (on 10/25/25, but no assessment of the right hand was documented) and Resident #6 was afebrile.ˆ A hospital Discharge summary dated [DATE] identified Resident #6 was being transferred back to the long-term care facility status post gangrene, osteomyelitis and partial amputation of the right 3rd finger.ˆ Nursing notes dated 10/30/25 at 11:27 PM written by RN #3 identified Resident #6 was readmitted to the facility from the hospital with a diagnosis of right middle finger osteomyelitis with a partial amputation.ˆˆˆ An interview on 11/19/25 at 2:17 PM with RN #2 identified that if a resident had a wound the documentation would be found in the wound management section of the electronic medical record (EMR), however he was unable to provide any documentation contained in the wound management section of the EMR. RN#2 further identified he worked on 10/19/25 (1 day after Resident #6's right hand was bloody) and there were no treatment orders for Resident #6's fingers.ˆAdditional RN#2 indicated the 24-hour shift report dated 10/18/25 failed to identify any concerns with Resident #6.ˆ Interview and clinical record review with the Director of Nursing (DNS) on 11/19/25 at 2:59 PM failed to identify an assessment of Resident #6's right hand at the time it was observed to be bloody on 10/18/25 until 10/26/25 identifying Resident #6's right 3rd finger and the surrounding area had redness, swelling, being warm to touch, and the top of the 3rd finger was dark in color with a white patch at the tip.ˆ The DNS further identified documentation of the wound to the fingers should have been completed in EMR of the wound management section, the care plan should have been updated, and the physician should have been notified, and a treatment should have been obtained by RN #3 on 10/18/25 when the area was observed.ˆ Interview on 11/19/25 at 3:09 PM with RN #3 (the RN that observed Resident #6's right hand to be bloody on 10/18/25) identified she was the full time 3:00 PM to 11:00 PM nurse on Resident #6's unit and was familiar with Resident #6.ˆ RN #3 also identified Resident #6 had the habit of sucking/gnawing/picking at his/her right hand fingers, but did not include that behavior in the Resident Care Plan and therefore interventions to discourage Resident #6 from sucking/gnawing/picking at his/her right hand fingersˆ and interventions to protect/monitor the skin to the right hand were not in place.ˆ RN #3 further indicated all nursing staff were responsible to up-date the care plan as changes occur and noted it was an oversight that she did not include that behavior with interventions in the care plan (please refer to F 656).ˆ An interview on 11/20/25 at 10:30 AM with RN #4 identified she evaluated Resident #6 on 10/26/25 after being notified by RN #5 with concerns about Resident #6's fingers. RN#4 also, identified there was no dressing in place to the resident's right hand. Additional RN#4 indicated the right-hand middle finger was greenish, black in color, no odor, no drainage, felt it was infected and was not aware of any behavioral concerns of gnawing, biting or sucking of the fingers.ˆˆ Interview on 11/20/25 at 12:25 PMˆwith NA #3 identified she observed Resident #6 putting his/her fingers in his/her mouth, noticed blood at times and she reported to the nurse on the unit but was unsure of who and when she reported it to.ˆ Interview on 11/20/25 at 12:52 PM with RN #5 identified Resident #6 had a dressing in place to Resident #6's fingers because he/she was picking at them but couldn't identify when the dressing was in place.ˆ Interview on 11/20/25 at 2:40 PM with Person #1 identified Resident #6 had a history of biting and picking at his/her fingers before and during admission to the facility, and the fingers were scabbed.ˆ Person #1 further indicated he/she did not see Resident #6 until 10/26/25 (because Resident #6 had Covid) and indicated the fingers were very discolored and red.ˆ Interview on 11/21/25 at 11:44 AM with RN #4 (the wound care nurse) identified RN #3 should have notified the provider on 10/18/25 regarding the breakdown of the resident's fingers, obtained an order for treatment and updated the care plan to include wound care interventions. RN#4 identified the policy for open skin areas was to notify the provider of any changes to the skin. RN #4 provided a video of Resident #6's right 3rd finger that she provided to MD #1 on 10/26/25 to relay the condition of the 3rd right finger, identifying she did not think the wound could have deteriorated that quickly in just 1 day and had interventions been (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	in place the infection could have been avoided.ˆ A progress note obtained by the facility on 11/21/25, dated 7/14/25 and written by MD #3 prior to Resident #6's admission to the facility identified in 2022, Resident #6 developed a nonhealing infection of the left toe, underwent angioplasty for critical left lower extremity ischemia with amputation of the 2nd left digit of the foot due to dry gangrene. Resident #6 also required amputation of the 3rd left toe related to gangrene in February 2023 and underwent revascularization. The clinical record failed to identify Resident #6's history of lower extremity ischemia or toe amputation prior to the facility obtaining prior MD progress notes on 11/21/25. Interview on 11/21/25 at 1:23 PM with MD #2 indicated that Resident #3 had a history of vascular disease (PVD) and amputation of some toes, but it was not noted in the EMR upon Resident #6's admission on [DATE]. MD#2 identified if Resident #6 had history of gnawing, bleeding to his/her fingers, the expectation would for Resident #6's fingers to be monitored at least daily due to the history of PVD.ˆˆ Interview on 11/24/25 at 9:53 AM with Licensed Practical Nurse (LPN) #1 identified on 10/13/25 and 10/20/25 she performed a skin assessment for Resident #6 documenting the resident's skin was intact and that she usually performs skin assessments for residents on their shower day. The assessment was not completed by an RN.Interview on 11/25/25 at 12:25 PM with MD #1 (Medical Director) identified Resident #6 had a diagnosis of PVD which made Resident #6 more at risk for delayed healing or no healing at all, risk for infection and risk for ischemia (low or no blood flow) of any extremities with open or emaciated areas identified.ˆ MD #1 identified Resident #6 had poor vasculature, blood flow and circulation due to PVD. MD #1 identified Resident #6 was at risk due to poor circulation, had gnawed, emaciated fingers, Resident #6 skin should have been monitored at least daily, the wound care nurse should have been notified with a treatment plan put in place, including monitoring, daily assessment with documentation having occurred daily in the progress notes.ˆ Review of the policy for Skin integrity dated 10/7/25 directed, in part, the facility was to provide proper treatment and care to maintain skin integrity. Also, identifying the attending physician will be notified of the presence, progression towards healing, or lack of healing of any skin tears, or any changes in the resident's medical condition. Further, identifying interventions will be modified in the resident's care plan as needed and report assessment and changes in condition to the provider.ˆ The above deficiency resulted in the finding of Immediate Jeopardy (IJ). The facility Administrator was provided with the IJ template on 11/20/25 at 2:00 PM and submitted a removal plan which was approved by the State Agency on 11/21/25.The Removal Plan noted in part, when the concern was identified on 10/26/25 the DNS and charge nurses performed a thorough skin assessment of Resident #6, documented the findings and conducted a comprehensive audit for all resident care plans and behavior monitoring practices for accuracy. The removal plan also indicated staff education was conducted related to resident behaviors, clinical monitoring, escalation, documentation and physician notification. Additionally, the removal plan identified staff participated in education training and competency to ensure understanding of policies related to resident behaviors, quality of care, clinical monitoring, escalation and documentation.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on review of facility documentation, facility policy and interviews regarding the employment of an Infection Preventionist, the facility failed to designate an individual with the required training and certification to oversee the Infection Control Program. The findings include: Interview with the Director of Nursing Services (DNS) on 11/19/25 at 2:00 PM identified that she was designated as the Infection Preventionist (IP) in October 2025 until a new IP was hired to the position.Interview with Registered Nurse (RN) #8 on 11/24/25 at 10:30 AM identified she was a full time RN-Designee at the Assisted Living Services Agency (another entity of the Long Term Care Facility) and was not actively a facility employee. RN #8 identified she had assisted the previous IP in the past around 2 times a week with training on support in her IP position but since the DNS took over coverage for the IP position, she only helped to answer questions periodically when the DNS called her. RN #8 identified that she did not review infection prevention documents and reports at the facility, and that the last time she assisted with the creation of reports was when the previous IP was in the position. Interview with the DNS on 11/24/25 at 1:00 PM identified that she contacted RN #8 at times with questions but that she managed all the Infection Preventionist duties including surveillance, antibiotic stewardship, reports, etc. on her own. The DNS identified she had not started or completed specialized training for Infection Prevention because it had not been her intention to cover the IP position for any length of time, and she was not aware of the free online training offered by the Centers for Disease Control and Prevention (CDC). The DNS further identified the facility had just posted an advertisement for a part-time (24 hour) infection preventionist.Review of the Infection Prevention and Control policy directed, in part, the designated IP is responsible for the oversight of the program and serves as a consultant to the staff on infectious diseases, surveillance, implementing isolation precautions, staff and resident exposures, and investigations of exposures of infectious disease. The policy failed to identify the specialized infection prevention training requirements of the designated IP that were necessary to meet federal regulations.

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Caleb Hitchcock Health Center	10 Loeffler Rd Bloomfield, CT 06002

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility documentation, facility policy, and interviews regarding the facility Infection Control program, the facility failed to document Covid-19 staff effected on a line list, failed to document and complete Covid-19 testing per facility policy, and failed to provide facility-initiated education to non-nursing personnel related to Covid-19, The findings include: Review of a Department of Public Health (DPH) Facility Licensing and Investigations Section (FLIS) Resolution Report dated [DATE] identified the facility had a COVID -19 outbreak which was declared as resolved on [DATE] and involved 2 residents (Resident #6 and Resident #66) and 2 staff members.a. Review of the facility COVID-19 outbreak documentation for [DATE]-[DATE] failed to identify a line list for staff members. The nurse aide (NA) and Life Enrichment Director who tested positive for COVID-19 during the outbreak were not documented on a staff line list which would have documented their age, gender, primary floor assignment, symptom onset date, symptoms (fever, cough, body aches, headache, shortness of breath, loss of appetite, chills, and sore throat), chest x-ray (if done), type of test performed (PCR or antigen), pathogen detected (COVID-19), symptom resolution date, hospitalized (Y/N), died (Y/N).Interview with the DNS on [DATE] at 12:50 PM identified she did not have an employee line list for the COVID-19 outbreak. The DNS identified she was unsure of exactly everything that needed to be done specifically in regards to the outbreak, but that she had notified the local and state DPH and had documented the line list information for the residents. (please refer to F 882).b. Review of the facility COIVD-19 outbreak documentation for [DATE]-[DATE] failed to identify documentation of resident testing completed in response to a COVID-19 positive resident/staff member.Interview with the DNS on [DATE] at 12:50 PM identified that resident testing completed in response to a COVID-19 positive resident/staff member would be found in the individual resident charts. The DNS identified that she did not have a list of residents tested with the dates and results of those tests, but she indicated that testing would be done on all exposed residents on days 1, 3, and 5 after exposure.Interview and facility documentation review with the DNS on [DATE] at 1:30 PM identified in response to a COVID-19 positive resident/staff member during an outbreak all residents on the affected neighborhood (unit) would be tested.c. Review of the clinical record for residents listed on the census list for the affected unit(s) (neighborhoods) with a COVID-19 positive resident test on [DATE] and [DATE] failed to identify that COVID-19 testing was completed per policy on days 1, 3, 5 following identification of exposure to a COVID-19 positive staff/resident.Review of the facility COVID-19 outbreak documentation for [DATE]-[DATE] identified there were 11 residents on the affected neighborhood on [DATE] when Resident #66 tested positive. Review of the clinical record for the 10 remaining residents (not including Resident #66) identified that 1 out of 10 residents were tested for COVID-19 on [DATE], 1 out of 10 residents were tested for COVID-19 on [DATE], 2 out of 10 residents were tested for COVID-19 on [DATE], 0 out of 10 residents were tested for COVID-19 on [DATE] which contradicts that Resident #6 was listed on the resident line list as testing positive on [DATE]. The clinical record further identified 8 out of 9 residents (not including Resident #6 and Resident #66) were tested for COVID-19 on [DATE], 0 out of 9 residents were tested for COVID-19 on [DATE], 2 out of 9 residents were tested for COVID-19 on [DATE]. The clinical record failed to identify any testing of residents on the affected neighborhood from [DATE]-[DATE]. The clinical record further identified 1 out of 9 residents were tested for COVID-19 on [DATE] which was the date the COVID-19 outbreak was declared resolved.Interview with the DNS on [DATE] at 1:30 PM identified the licensed nurses on the affected neighborhood would know which residents required testing based on education that goes out to staff following identification of a positive resident/staff. The DNS identified she did not obtain a specialized order for testing on days 1, 3, and 5 to trigger the nurse to obtain the test on the applicable day, that the nurse would utilize the as needed (PRN) order for COVID-19 testing in each resident's orders and the nurse would administer tests using that PRN (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	COVID-19 test order, and the results would be documented in the electronic medical record.d. Review of the facility COIVD-19 outbreak documentation for [DATE]-[DATE] failed to identify documentation of staff testing completed in response to a COVID-19 positive resident/staff member.Interview with the DNS on [DATE] at 1:30 PM identified the facility does not perform staff testing in response to a COVID-19 positive resident/staff member. The DNS identified that the staff could test themselves if they chose to, but it was not required for staff to test in response to exposure. The DNS indicated that staff were expected to wear surgical masks when working in response to the facility outbreak so testing was not required for them.e. Review of the Respiratory Season In-Service education provided on [DATE] that was initiated in response to the facility COVID-19 for [DATE]-[DATE] identified 62 staff signatures all of which were nurse aides or licensed nurses. The education signature sheets failed to identify signatures from any non-nursing departments. (please refer to F 882).Review of the Respiratory Season In-Service education initiated in response to the facility COVID-19 for [DATE]-[DATE] failed to identify symptoms of infection for COVID-19, information related to personal protective equipment required when treating COVID-19 positive residents including an N95 mask, and when isolation precautions was warranted. The education directed to follow facility policy for isolation precautions but failed to include that policy with the education.Interview with the DNS on [DATE] at 1:00 PM identified she had provided the Respiratory Season In-Service education to non-nursing departments and had provided those signature sheets on [DATE] but that she would provide the signature sheets again.Subsequent to surveyor inquiry review of Respiratory Season In-Service education identified 78 staff signatures which included only 13 non-nursing staff member signatures.Review of the Infection Outbreak Response and Investigation policy directed, in part, a single case of COVID-19 would trigger declaration of an outbreak. The policy directed staff will be educated on the mode of transmission of the organism, symptoms of infection, and isolation or other special procedures which includes special environmental infection control measures that are warranted based on the organism. The policy directed surveillance activities will increase to daily for the duration of the outbreak. The policy directed in the absence of the Infection Preventionist, the DNS will assume responsibility for all reporting requirements and outbreak investigations. The policy directed a line list about each person affected by the outbreak will be maintained.Review of the [NAME] Communicable Disease Reporting Policy reviewed by the DNS on 10/2025 directed, in part, the facility will identify, document, and report all suspected or confirmed communicable diseases as required by state and local health authorities. The policy directed COVID-19 was immediately reportable (within hours). The policy directed the outbreak would be reported via the state reporting system, phone or fax and the date and time of the report to local/state health departments would be documented. The policy directed to maintain line listings and daily surveillance. The policy directed that annual training on communicable diseases, signs/symptoms, transmission-based precautions, and reporting requirements would be provided and additional training provided during outbreaks.Review of the Coronavirus Testing directed, in part, the facility will conduct testing through the use of rapid point of care testing (antigen test) and anyone with even mild symptoms of COVID-19 should receive a viral test as soon as possible. The policy directed in response to an outbreak investigation, outbreak testing will be performed either through contact tracing or broad-based (facility wide) testing, and the facility may choose to conduct focused testing based on known close contacts if they have the ability to identify close contacts of the individual with COVID-19, but if the facility does not have the expertise, resources, or ability to identify all close contacts, the facility should instead investigate the outbreak at a facility-wide or group-level (affected neighborhood). The policy directed that testing would be performed on days 1, 3, and 5 (with the exposure as day 0). The policy directed the facility may elect to initially expand testing only to healthcare personnel and residents on the affected units as opposed to the entire facility. The policy directed for documentation of testing for symptomatic residents and staff, document: date and time of signs and symptoms, date when testing conducted, date when results obtained, actions facility took based on (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	results. The policy directed upon indemnification of a new positive case during an outbreak the document: date the case was identified, date other staff and residents are tested, dates that staff and residents who tested negative are retested, results of all tests.

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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 review of the clinical record, facility documentation, facility policy and interviews for 1 of 3 residents (Resident #1) reviewed for accidents, the facility failed to follow professional standards of practice for the monitoring of neurological assessments following an unwitnessed fall. Additionally, for 1 of 2 residents (Resident #6) reviewed for hospitalization, the facility failed to follow professional standards of practice regarding completing a skin assessment when Resident #6 was observed to sustain bloody areas to the fingers of the right hand caused by the behaviors of sucking, biting and picking and failed to ensure routine skin assessments were completed by a Registered Nurse (RN) and not a Licensed Practical Nurse (LPN). The findings include: 1.Resident #1 had diagnoses that included epilepsy (seizure disorder), vascular dementia, and fracture of right sided skull and facial bones with routine healing. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 was severely cognitively impaired, was independent with eating, bed mobility, chair/bed transfers and walking. The Resident Care Plan (RCP) dated 2/4/25 identified Resident #1 was at risk for falls related to physical deconditioning and required assistance with activities of daily living (ADLs). Interventions included keeping personal items and frequently used items within reach, leave a night light on in the room, and to provide toileting assistance every 2 hours. A nursing note written by Registered Nurse (RN) #7 on 2/20/25 at 6:45 PM identified at 5:30 PM Resident #1 was observed lying on his/her back next to a pool of blood. The nursing note identified Resident #1 was alert but unable to describe what happened due to his/her dementia. The nursing note further identified pressure was applied to the right eyelid and left side of the nose to stop the bleeding and neurological (neuro) checks were within normal limits. The note further identified Resident #1 was sent to the hospital for evaluation and treatment and left the building at 6:05 PM. A physician order dated 2/20/25 directed to obtain neurological checks (neuros) (neurological assessment including mental status, pupillary exam, hand grasps)/vital signs (vitals) after an unwitnessed fall every 15 minutes for 4 times (5:30 PM, 5:45 PM, 6:00 PM, and 6:15 PM), every 30 minutes x 2 (6:45 PM and 7:15 PM) with special instructions: if neuros/vitals are not at baseline, document in a progress note and notify the physician (MD). A physician order dated 2/20/25 directed to obtain vital signs every hour for 2 times after an unwitnessed fall (8:15 PM and 9:15 PM). A physician order dated 2/20/25 directed to obtain vital signs every 4 hours for 4 times after an unwitnessed fall (1:15 AM, 6:15 AM, 11:15 AM, and 4:15 PM). A physician order dated 2/20/25 directed to obtain vital signs every shift for 7 days for an unwitnessed fall starting on 2/21/25 (temperature, pulse, respirations, blood pressure, oxygen saturation). The Medication Administration Record (MAR) dated 2/20/25 noted although neuro checks were signed off as completed on 2/20/25 at 5:30 PM and documented as being within normal limits (WNL), (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documentation failed to show what information was obtained during the neuro check to allow for comparison to previous/future neuro checks. The MAR failed to identify neuros were completed on 2/20/25 at 5:45 PM or 6:00 PM prior to Resident #1 being transported to the hospital at 6:05 PM. A nursing note dated 2/21/25 at 4:26 PM identified Resident #1 had returned from the hospital at 8:30 AM and had bruising to both eyes, face, right neck, left knee, and the left chest. The nursing note identified vital signs were obtained on readmission and at 1:30 PM. The note failed to identify neuro checks were obtained. The Medication Administration Record (MAR) dated 2/21/25 identified vital signs were obtained at 11:15 AM and 4:15 PM. A nursing note written by RN #4 on 5/22/25 at 2:49 PM identified at 2:00 PM Resident #1 was observed lying on the floor in the common area and identified Resident #1 was last seen sitting in a chair. The note identified Resident #1 denied hitting his/her head and neuro checks were stable. A physician order dated 5/22/25 directed to obtain neuros/vitals after an unwitnessed fall every 15 minutes for 4 times (2:00 PM, 2:15 PM, 2:30 PM, and 2:45 PM), every 30 minutes for 2 times (3:00 PM and 3:30 PM), with special instructions: if neuros/vitals are not at baseline, document in a progress note and notify the MD. A physician order dated 5/22/25 directed to obtain vital signs every 4 hours for 4 times after an unwitnessed fall (4:00 PM, 9:00 PM, 2:00 AM, and 7:00 AM). A physician order dated 5/22/25 directed to obtain vital signs every shift for 7 days for an unwitnessed fall starting on 5/21/25 (temperature, pulse, respirations, blood pressure, oxygen saturation). The Medication Administration Record (MAR) dated 5/22/25 identified neuro checks were completed at 2:00 PM, 2:15 PM, 2:30 PM, 3:00 PM, and 3:30 PM and were documented as being at baseline, but documentation failed to show what information was obtained during the neuro check to allow for comparison to previous/future neuro checks. The MAR failed to identify neuros were completed at 2:45 PM on 5/22/25 per physician order. Interview with MD #1 on 11/24/25 at 1:10 PM identified she was unsure of the specific neuro check policy without looking at it, but that it would direct nursing to obtain neuro checks every 15 minutes for a span of time, every 30 minutes, then hourly and so forth for a 3-day span of time. MD #1 was unaware that the facility policy directed to obtain neuro checks every 15 minutes for 4 times, then every 30 minutes for 2 times only (a total of 2 hours of neuro checks monitoring) with no further neuro checks required to be obtained. MD #1 identified she would revisit the policy. Review of the [NAME] Fall Prevention Program policy directed, in part, following an unwitnessed fall the facility will initiate neuro checks every 15 minutes for 4 times, and every 30 minutes for 2 times. The policy failed to identify what components of the neuro checks are evaluated when the neuro checks are conducted. 2. Resident #6 was admitted to the facility from the hospital on [DATE] with diagnosis that included a urinary tract infection, hypertension and chronic obstructive pulmonary disease. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #6 was moderately cognitively impaired, was dependent on transfers, and toileting, required partial moderate assistance for eating, personal hygiene, and showering. Additionally, the MDS identified Resident #6 did not exhibit any abnormal behaviors. a. The Medication Administration Record (MAR) for October 2025 identified on 10/13/25 and 10/20/25 weekly skin assessments were completed by a Licensed Practical Nurse (LPN) #1 and not a Registered Nurse (RN). Interview on 11/24/25 at 9:53 AM with Licensed Practical Nurse (LPN) #1 identified on 10/13/25 and 10/20/25 she performed a skin assessment for Resident #6 and that she usually performed skin assessments for residents on their shower day. Interview and record review on 11/24/25 at 10:20 AM with the DNS identified an LPN completed the skin assessments on 10/13/25 and 10/20/25. The DNS further identified LPN's cannot complete skin assessments and the facility policy stated that. The DNS also identified she was responsible for making sure a Registered Nurse performed the assessments and did not know the reason LPN #1 completed skin assessment in lieu of a RN. b. The Resident Care Plan dated 10/15/25 identified Resident #6 was at risk for skin breakdown related to decreased mobility and incontinence with interventions directed to conduct a systematic skin inspection weekly, keep skin clean dry, and report any signs of skin breakdown. Nursing notes dated 10/18/25 at 10:48 PM and written by Registered Nurse (RN) #3 identified Resident #6 continued to bite/suck on 3 fingers of his/her right hand, the areas were bloody with no signs and symptoms of infection. RN #3 also identified she placed a dry protective dressing to the areas (but failed to document an assessment noting a description of the open area/location where the blood was originating from). Advanced Practice Registered Nurse (APRN) #1 notes dated 10/20/25 at 5:44 PM identified Resident #6 was COVID-19 positive and did not document an assessment of Resident #6's right fingers. Nursing notes dated 10/19/25 through 10/25/25 failed to identify any monitoring or assessments of Resident #6 's fingers to the right hand where blood was observed on 10/18/25. A hospital Discharge summary dated [DATE] identified Resident #6 was being transferred back to the long-term care facility status post gangrene, osteomyelitis and partial amputation of the right 3rd finger. Nursing notes dated 10/30/25 at 11:27 PM written by RN #3 identified Resident #6 was readmitted to the facility from the hospital with a diagnosis of right middle finger. Review of the policy for Documentation in the Medical record dated February 2025 identified that each Resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation. Also, identifying all licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy.

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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, observations, interviews and facility policy for 1 of 3 sampled residents (Resident #12) reviewed for pressure ulcers, the facility failed to ensure the alternating pressure mattress was set correctly. The findings include: Resident #12 was admitted to the facility in January 2024 with diagnoses that included dementia, osteoporosis, and mobility impairment. The quarterly Minimum Data Set, dated [DATE] identified Resident #12 was severely cognitively impaired, was dependent on staff for all of activities of daily living, required assistance of 2 for transfers with a mechanical lift, and was at risk for developing pressure ulcers/injuries. Additionally, the MDS identified Resident #12 did not have a pressure ulcer.The physician's orders (undated) directed to apply Triad paste (a zinc-based sterile wound dressing in paste form) to the coccyx two times a day, skin prep to bilateral heels twice a day, mechanical lift for transfers and weekly skin checks. The physician's orders lacked an order for the alternating pressure air mattress (that Resident #12 was observed to be lying on), as directed per the facility policy.The Resident Care Plan dated 11/3/25 identified Resident #12 as being at risk for skin breakdown related to incontinence and decreased mobility. Interventions included applying Triad paste to coccyx twice a day, skin prep to bilateral heels twice a day, inspect the skin weekly, transfer using a stand lift, and incontinent care after each incontinent episode and as needed. The care plan failed to reflect the use of an alternating pressure mattress as a preventive measure for skin breakdown. Observation on 11/18/25 at 10:45 AM (during the initial tour of the facility) noted although Resident #12 was not in bed, an alternating pressure mattress was present on the bed and set at 240 pounds (lbs.). Resident #12's clinical record identified that Resident #12's weight was 100 lbs. Observations on 11/19/25 at 2:35 PM and 11/20/25 at 8:49 AM noted Resident #12's was lying in bed on his/her back with the alternating pressure mattress set at 240 lbs. (despite Resident #12's weight of 100 lbs.). Interview and review of the clinical record with RN #1 (Resident Care Plan Coordinator) on 11/20/25 at 12:35 PM identified that Resident #12 did not have the alternating pressure mattress in his/her care plan nor were there any settings established for alternating pressure mattress. RN #1 indicated that the alternating pressure mattress was in place as a preventive intervention to prevent skin breakdown. Furthermore, RN #1 indicated that the Nurse Aide (NA) care card did not reflect that Resident #12 was on an alternating pressure mattress and the mattress should be set by Resident #12's weight. RN #1 indicated that the charge nurse and NA should know how to set the air mattress according to Resident #12's weight and was not sure of the reason the mattress was set at 240 lbs. Interview with NA #4 on 11/20/25 at 1:00PM indicated she was unaware of Resident #12's alternating pressure mattress setting. In addition, NA #4 was unsure where to obtain the information.Subsequent to surveyor inquiry, the alternating pressure air mattress setting was changed to reflect weight of 100 lbs and Resident #12's care plan was updated to include the alternating pressure air mattress.The manual for the alternating pressure mattress utilized on Resident #12's bed, printed in 2021, directed to set the air mattress according to the weight and height of the patient, adjust the weight setting to the most comfortable level without bottoming out. The pressure in mattress will slowly increase to the weight settings displayed on panel, approximately 45 minutes. Once fully inflated the air mattress is ready to use. May set the cycle time if needed.The facility Air Mattress Policy dated 3/15/25 directed, in part, the facility shall provide appropriate pressure-redistribution surfaces, including air mattress systems, when clinically indicated for residents who are at risk for or have existing pressure injuries. Air mattresses will be ordered based on individualized assessment, provider order and Interdisplinary team review. All use must comply with standards of practice, manufacturer recommendations, and state/federal regulations.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **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 1 of 3 sampled residents (Resident #4) reviewed for positioning and mobility, the facility failed to obtain a physician's order, develop a plan of care and provide staff education for a resident's lower extremity brace. The findings include: Resident #4 was admitted to the facility in January 2024 with diagnoses that included difficulty in walking, unsteadiness on feet and unspecified abnormalities of gait and mobility. The quarterly Minimum Data Set (MDS) assessment dated [DATE], identified Resident #4 had no cognitive impairment and was independent with toileting, bed mobility and transfers. The MDS further indicated Resident #4 required partial/moderate assistance with lower body dressing and had a diagnosis of weakness and difficulty in walking. The Resident Care Plan (RCP) dated 8/27/25 identified Resident #4 required assistance with activities of daily living and had an AFO (Ankle-Foot-Orthosis) for the right lower extremity. The RCP failed to indicate directives for application of the AFO, goals, or interventions for the AFO brace. Observations on 11/18/25 at 11:57 AM, 11/20/25 at 8:38 AM, and 11/21/25 at 11:22 AM noted Resident #4 with shoes on both feet and an AFO brace on his/her right lower extremity. The brace had metal bars on both sides and was secured with a black strap that wrapped around the resident's ankle/calf area. The brace rested inside a black rubber soled shoe, went under the resident's right foot and extended up the leg, ending at Resident #4's right mid-calf area. Interview and review of facility documents on 11/21/25 at 11:36 AM with Nurse Aide (NA) #4 identified although she puts Resident #4's AFO brace on every morning, she had not received any education or instruction as to how to put the brace on or what the brace was for. NA #4 indicated Resident #4 came to the facility with the brace and would ask her to put it on for him/her every day. Review of the Nurse Aide (NA) care card (Individualized Resident Assignment) with NA #4 failed to identify that Resident #4 utilized a AFO brace and lacked directions for application of the AFO brace (when the AFO was to be worn and removed). Interview with Resident #4 on 11/21/25 at 11:37 AM identified he/she had the AFO brace for over 30 years and was prescribed the brace by a podiatrist because his/her arch was starting to collapse. Resident #4 indicated the brace was to be put on his/her right lower extremity every morning and removed at night and was kept in his/her shoe. Resident #4 identified he/she came to the facility with the brace and was last seen by the prescribing podiatrist a couple of years ago. Resident #4 further indicated the nursing staff at the facility would put the AFO brace on his/her right lower extremity daily. Interview and review of the clinical record and facility documents on 11/21/25 at 11:42 AM with RN #6 identified although the NA's have been putting the AFO brace on Resident #4's right lower extremity daily, there was not a physician's order for the brace nor was it listed on the NA care card. RN #6 indicated it was an error, she would contact the physician to obtain an order for the brace and make sure the NA care card was updated. RN #6 was unsure of the reason this was not done when Resident #4 came to the facility with the brace and would notify therapy to educate the NA's as well. Interview and review of the clinical record at 11/21/25 at 11:58 AM with the Occupational Therapist (OT) #1 identified she had worked with Resident #4 for toileting and mobility and the resident had the AFO brace since he/she came to the facility. OT #1 indicated she was unsure what the brace was for and had never evaluated the resident for the brace. OT #1 identified although the nursing staff have been putting the AFO brace on Resident #4 daily, it was not indicated in the resident's physician's orders or on the NA care card. OT #1 indicated a physician's order should have been obtained, education should have been provided to the nursing staff for Resident #4's AFO brace and she was unsure of the reason that was not done. Additionally, OT #1 indicated she would need to ask the Physical Therapist (PT) about it. Interview and review of the clinical record with PT #1 on 11/21/25 12:58 AM identified although he was aware Resident #4 came to the facility with the AFO brace and was wearing it daily to the right (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075301	A. Building B. Wing	11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caleb Hitchcock Health Center	10 Loeffler Rd Bloomfield, CT 06002

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	lower extremity, he was unsure of the purpose of it and was unaware there was not a physician's order for the brace. PT #1 indicated it would have been his responsibility to assess and evaluate the resident for the brace and provide education and training for the nursing staff. PT #1 further identified there should have been a physician's order and a plan of care in place for Resident #4's AFO brace and he was unable to indicate the reason that was not done. Subsequent to surveyor inquiry on 11/21/24, the NA Care Card was updated and directed application of a right ankle support for Resident #4. Subsequent to surveyor inquiry on 11/22/25 the RCP identified Resident #4 was to wear a brace to the right ankle with an intervention that included education for direct care staff on proper application of the brace. The RCP interventions further indicated Resident #4 should be monitored for changes in functional status and monitored for abnormalities in skin integrity with therapy services to evaluate the brace quarterly and as needed. Interview with the DNS on 11/24/25 at 9:40 AM identified Resident #4 was admitted to the facility with the AFO brace and should have had an OT evaluation with education for the staff as well as a physician's order for use of the right lower extremity brace. The DNS was unsure of the reason that was not done, and it would have been the responsibility of nursing to notify the PT or OT of the brace after admission. The OT would have been responsible for evaluating and educating staff and continuing to monitor the use of the brace. The DNS indicated the specifics of the AFO brace should have been in Resident #4's care plan and on the NA care card as well. Interview with Person #2 on 11/24/25 at 1:34 PM identified Resident #4 was prescribed the AFO brace over 30 years ago by a local podiatrist and the resident wore it every day. Person #2 indicated the tendons in Resident #4's right ankle were weak, identified he/she was unaware the facility had not evaluated the brace or educate the staff as the resident has had therapy on multiple occasions and she thought it would have been addressed. Person #2 indicated he/she did not bring the AFO brace into the facility and Resident #4 had been admitted with the brace. Person #2 further identified Resident #4 last saw the prescribing podiatrist in 2023 and he/she was going to let the facility know he/she wanted another follow-up scheduled. Review of the facility policy, Orthotic Device Policy, dated 1/25, directed a splint was an orthopedic device used to support a body part and a physician or qualified therapist must provide a written order specifying use and goals of treatment. The policy directed a comprehensive assessment shall be conducted and staff applying the splint must be properly trained and competent in the correct application and care procedures. The policy further directs application and responses must be documented in the resident's medical record and the need for the splint would be regularly reassessed by the physician or therapy team.

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	075301	A. Building B. Wing	11/25/2025

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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. Based on observations, interviews, facility documentation and facility policy for 1 of 1 supply closets observed, the facility failed to ensure the nursing supply closet on the secured Memory Care unit was locked/secured. Review of the Resident Listing Report dated 11/18/25 indicated there were 12 residents living on the facility's secured Memory Care unit.An observation on the secured Memory Care unit on 11/18/25 at 10:30 AM identified the nursing supply closet was unlocked and contained 20 bottles of peri wash (8.1 ounces (oz) each), 24 bottles of non-alcohol mouthwash (4 oz each bottle), 22 bottles of body cream (5 oz in each bottle), 12 tubes of barrier cream, 25 bottles of body lotion (8 oz in each bottle). 40 fingernail clippers, 8 disposable razors, 2 containers of Sani cloth bleach wipes with 75 wipes in each, 5 containers of Sani cloth PDI- germicidal wipes with 160 wipes in each, 5 cans of shaving cream (11oz in each can), and 17 bottles of Purell hand sanitizers (12 oz. in each bottle).A second observation on 11/18/25 at 3:00 PM identified that the nursing supply closet was still unlocked with the above items still present from the 11/18/25 observation.The Safety Data Sheet (SDS) dated 3/15/18 identified that the PDI Germicidal Wipes identified product hazards as they may be harmful if swallowed and may cause eye irritation. The SDS dated 8/12/2016 identified that the PDI Sani-Cloth Bleach Germicidal Wipes identified may cause eye and skin irritation and if excessive amounts inhaled or ingested seek medical attention. The SDS dated 8/9/16 for body cream and barrier moisture protection identified may cause eye irritation and if ingested rinse mouth, drink 3 to 4 glasses of water and seek medical attention if any gastrointestinal (GI) symptoms persist. The peri wash (SDS) dated 2/25/15 identified that may cause slight irritation to the skin and eyes. Lastly, Purell Instant Hand Sanitizer SDS dated 2/16/18 identified that eye contact required immediate flushing of the eyes for at least 15 minutes and seek medical attention. If swallowed, do not induce vomiting, rinse mouth with water and obtain medical attention.Observation and interview with Registered Nurse (RN) #4 regarding the nursing supply closet on 11/18/25 at 3:10 PM identified that the supply closet was supposed to always be locked and that the Nursing Supervisor, Maintenance Director and Housekeeping Director had keys to the closet. Nurse Aides and/or any staff member must ask for the supply closet key to obtain supplies and ensure the door was locked upon exiting. RN #4 could not indicate the reason the door was unlocked and the length of time it had been unlocked. Interview with NA #5 on 11/19/25 at 9:25 AM identified that the nursing supply closet was to be always locked. Staff must ask the nurse on the unit to unlock the supply closet due to safety concerns with the residents. NA #5 stated that if the door was found unlocked then it needed to be reported to the nurse. NA #5 stated she did not realize the nursing supply closet was not locked.Interview with Facility Operations Manager on 11/20/25 at 9:00 AM identified that he was made aware by the second shift nurse a little after 3:00PM on 11/18/25 that the nursing supply closet door was not locked. He indicated that it was the first time he was made aware and that there were no repair requests in the maintenance repair portal. Furthermore, he indicated that the door had an automatic lock and was unsure when and how it broke.Subsequent to surveyor inquiry, the Facility Operations Manager replaced the lock on the nursing supply door on 11/18/25 in the afternoon to automatically lock. Review of the facility policy Secured Storage Closets (clean and dry), dated 11/2025 directed, in part, all storage closets within the skilled nursing facility, whether designated as clean, dirty, equipment, chemical, linen or general storage must always remain locked when not actively in use. Only authorized personnel may have access to these areas. This is to ensure the safety of residents, staff and visitors by maintaining secure control of all storage areas.