STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075322	A. Building B. Wing	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Essex Meadows Health Center	30 Bokum Rd Essex, CT 06426

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 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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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, facility documentation, facility policy and interviews for one (1) of three (3) sampled residents (Resident #1) who were at risk for falls, the facility failed to ensure the provider was notified immediately when there was swelling of the heft hip and increased pain after the resident experienced a fall two (2) days prior. The findings include:Resident #1's diagnoses included dementia without behavioral disturbances, muscle weakness, unsteadiness on feet, pain and repeated falls. The Fall Risk Evaluation dated 8/30/25 identified that Resident #1 was at risk for falls. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of seven (7) out of fifteen (15) indicating Resident #1 did not make decisions regarding tasks of daily living and required supervision with bed mobility, transfers and ambulating. The Resident Care Plan dated 9/2/25 identified Resident #1 was a fall risk, had a history of frequent falls and fractures, arthritis to both knees and osteopenia (a loss of bone density) and was highly prone to fractures. Interventions directed two (2) quarter side-rails to be in the up position while in bed for mobility and a scoop mattress in place to the bed for improved boundary awareness. A physician's order dated 10/6/25 directed the assistance of one (1) staff for contact guard with gait-belt and rolling walker for transfers and ambulating. The nurse's Post Fall Evaluation dated 10/17/25 at 11:42 PM identified Resident #1 was observed self-ambulating stating he/she needed to use the bathroom after being toileted less than one (1) hour prior and when Resident #1 took a step backwards he/she lost his/her balance and fell, hitting his/her head on the bottom metal bedrail of the bed. The note reported Resident #1 was immediately assessed, Resident #1 had no loss of consciousness, neurological signs were within normal limits, vital signs were obtained, his/her blood pressure was slightly elevated, and Resident #1 was noted with a skin tear to the left wrist and a bump to the back of the head. The note did not identify that range of motion or rotation of the extremities were checked during the post-fall assessment but reported that the family and the provider were notified of the fall, Resident #1 was not transferred to the hospital, and no new orders were documented. Review of the nurse's notes from 10/17/25 at 11:42 AM through 10/19/25 at 4:10 AM identified Resident #1 had no ill effects from the 10/17/25 fall. The nurse's note dated 10/19/25 at 4:10 AM identified Resident #1 was complaining of pain that was noted to be eight (8) out of ten (10) on the pain scale, edema and swelling were noted to the left hip and acetaminophen (a pain reliever) was administered with good effect. The note failed to reflect documentation a provider was notified of the edema and swelling. The Post Fall Evaluation dated 10/19/25 at 6:13 AM identified a physician (MD #1) was notified of the pain and swelling to Resident #1's left hip and they requested an order for an x-ray but failed to identify MD #1's response. The note did not indicate that the physician gave an order. The nurse's note dated 10/19/25 at 2:53 PM identified Resident #1 continued with pain, six (6) out of ten (10), to the left hip and swelling. The note indicated MD #1 was notified and a new order was obtained for a left hip x-ray to be completed in-house. The radiology report dated 10/19/25 identified Resident #1 had sustained an acute mildly displaced fractures (new bone fractures where the bone fragments are only slightly out of alignment) of the left superior (positioned above/towards the head end of the body) ischial ramus (the bottom of the pelvis that forms the lower and back part of the hip bone) and the left inferior (below/towards the feet) pubic ramus were seen. The Situation Background Assessment Recommendation note dated 10/20/25 at 12:41 PM identified Resident #1 was on bedrest since the 10/17/25 fall due to pain with movement. The nurse's note dated 10/20/25 at 2:29 PM identified Resident #1 had increased pain since the 10/17/25 fall, the left arm and elbow had extensive bruising, the left foot was externally rotated, MD #1 and the family were notified and agreed to send Resident #1 to the shoreline clinic for further evaluation. The nurse's note dated 10/20/25 at 10:00 PM identified Resident #1 returned to the facility with no new orders. Interview with the 7PM-7AM charge nurse, Licensed Practical Nurse (LPN) #1, on 10/29/25 at 1:07 PM identified she worked on 10/18/25 into 10/19/25, and NA #4 notified her in the evening on 10/18/25 Resident #1 was complaining of increased pain, and she had difficulty turning Resident #1 and providing care. LPN #1 identified although she notified RN #3, who then assessed the left hip area, she did not document the findings until 10/19/25 at 4:10 AM and did not notify the provider until around 6:00 AM. LPN #1 identified she did not call the provider instead she sent a text message and did not hear back prior to leaving the facility at 7:00 AM. LPN #1 explained she notified RN #4 and requested he follow-up. LPN #1 identified RN #4 had not reported to her at 7:00 PM shift change on 10/18/25 that Resident #1 had complained of or showed signs and symptoms of

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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. (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 0658 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 policy and interviews for one (1) of three (3) sampled residents (Resident #1) who had a fall, the facility failed to assess the resident when there was swelling of the heft hip and increased pain after the resident experienced a fall two (2) days prior. The findings include:Resident #1's diagnoses included dementia without behavioral disturbances, muscle weakness, unsteadiness on feet, pain and repeated falls. The Fall Risk Evaluation dated 8/30/25 identified that Resident #1 was at risk for falls. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of seven (7) out of fifteen (15) indicating Resident #1 did not make decisions regarding tasks of daily living and required supervision with bed mobility, transfers and ambulating. The Resident Care Plan dated 9/2/25 identified Resident #1 was a fall risk, had a history of frequent falls and fractures, arthritis to both knees and osteopenia (a loss of bone density) and was highly prone to fractures. Interventions directed two (2) quarter side-rails to be in the up position while in bed for mobility and a scoop mattress in place to the bed for improved boundary awareness. A physician's order dated 10/6/25 directed the assistance of one (1) staff for contact guard with gait-belt and rolling walker for transfers and ambulating. The nurse's Post Fall Evaluation dated 10/17/25 at 11:42 PM identified Resident #1 was observed self-ambulating stating he/she needed to use the bathroom after being toileted less than one (1) hour prior and when Resident #1 took a step backwards he/she lost his/her balance and fell, hitting his/her head on the bottom metal bedrail of the bed. The note reported Resident #1 was immediately assessed, Resident #1 had no loss of consciousness, neurological signs were within normal limits, vital signs were obtained, his/her blood pressure was slightly elevated, and Resident #1 was noted with a skin tear to the left wrist and a bump to the back of the head. The note did not identify that range of motion or rotation of the extremities were checked during the post-fall assessment but reported that the family and the provider were notified of the fall, Resident #1 was not transferred to the hospital, and no new orders were documented. The nurse's note dated 10/19/25 at 4:10 AM identified Resident #1 was complaining of pain that was noted to be eight (8) out of ten (10) on the pain scale, edema and swelling were noted to the left hip and acetaminophen (a pain reliever) was administered with good effect. The note failed to reflect documentation an assessment of the left hip was conducted. The nurse's note dated 10/19/25 at 2:53 PM identified Resident #1 continued with pain, six (6) out of ten (10), to the left hip and swelling. The note indicated MD #1 was notified and a new order was obtained for a left hip x-ray to be completed in-house. The radiology report dated 10/19/25 identified Resident #1 had sustained an acute mildly displaced fractures (new bone fractures where the bone fragments are only slightly out of alignment) of the left superior (positioned above/towards the head end of the body) ischial ramus (the bottom of the pelvis that forms the lower and back part of the hip bone) and the left inferior (below/towards the feet) pubic ramus were seen. The nurse's note dated 10/20/25 at 2:29 PM identified Resident #1 had increased pain since the 10/17/25 fall, the left arm and elbow had extensive bruising, the left foot was externally rotated, MD #1 and the family were notified and agreed to send Resident #1 to the shoreline clinic for further evaluation. The nurse's note dated 10/20/25 at 10:00 PM identified Resident #1 returned to the facility with no new orders. Interview with the 7PM-7AM charge nurse, Licensed Practical Nurse (LPN) #1, on 10/29/25 at 1:07 PM identified she worked on 10/18/25 into 10/19/25, and NA #4 notified her in the evening on 10/18/25 Resident #1 was complaining of increased pain, and she had difficulty turning Resident #1 and providing care. LPN #1 identified although she notified RN #3, who then assessed the left hip area, she did not document the findings until 10/19/25 at 4:10 AM and did not notify the provider until around 6:00 AM. LPN #1 identified she did not call the provider instead she sent a text message and did not hear back prior to leaving the facility at 7:00 AM. LPN #1 explained she notified RN #4 and requested he follow-up. LPN #1 identified RN #4 had not reported to her at 7:00 PM shift change on 10/18/25 that Resident #1 had complained of or showed signs and symptoms of pain or regarding any swelling to the left hip. Interview with a 7AM-3PM nurse aide, Nurse Aide (NA) #3, on 10/29/25 at 1:21 PM identified she worked the 7AM-7PM shift on 10/18/25 and cared for Resident #1. NA #3 reported although she usually provides care and gets Resident #1 up out of bed for breakfast, on 10/18/25 Resident #1 was sleeping, so she let him/her sleep. NA #3 identified when she went to provide care and get Resident #1 up prior to lunch, what usually took her fifteen (15) to twenty (20) minutes to complete, it took over an hour. NA #3 explained Resident #1 was trying to sit up when she was turning Resident #1 side to side, especially