

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075323	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/14/2025
NAME OF PROVIDER OR SUPPLIER  Cambridge Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2428 Easton Tnpk Fairfield, CT 06825	

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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on clinical record review, facility documentation review, facility policy review, and interviews for one of four residents (Resident #4), reviewed for behaviors, the facility failed to ensure the physician/designee was notified timely when an antipsychotic medication was not available for administration as ordered. The findings include:</p> <p>Resident #4 was admitted with diagnoses that included schizophrenia (mental disorder characterized by hallucinations, delusions, disorganized thinking and behaviors), morbid obesity, and pain. A quarterly minimum data set (MDS) assessment dated [DATE] identified Resident #4 had mildly impaired cognition (BIMS of 9) and had no behaviors during the prior seven (7) days. A resident care plan dated 8/20/2024 identified Resident #4 had behaviors that included negative thoughts, and refusal of care that required mood stabilizers/anti-psychotics. Interventions directed to reapproach as needed, speak calmly, and to administer medications as ordered.</p> <p>A physician's order dated 10/14/2024 directed Abilify (antipsychotic medication used to treat schizophrenia) 400 milligrams (mgs) injected intramuscularly (IM) one time a day every month on the first day of the month for schizophrenia.</p> <p>Review of manufacturer information identified Abilify Injection was directed to be stored in the refrigerator between 36 and 46 degrees Fahrenheit.</p> <p>A facility reportable event (RE) form dated 11/6/2024 at 8:15 AM identified Resident #4 attempted self-harm by wrapping his/her hands around his/her neck and applying pressure. Staff redirected and calmed Resident #4, and Resident #4 was placed on one-to-one (1:1) observation until he/she was transferred to the hospital.</p> <p>A hospital psychiatry note dated 11/7/2024 identified a call was placed to the facility and RN #2/evening supervisor verified Resident #3's Abilify was on hold for November and the resident had not received it when scheduled on 11/1/2024.</p> <p>(continued on next page)</p>

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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with LPN #1/charge nurse on 1/14/2025 at 12:00 PM identified Resident #4 was scheduled to receive Abilify 400 mgs IM on 11/1/2024 at 8 AM and she was unable to locate the medication. LPN #1 spoke with the pharmacy and was informed it was delivered. LPN #1 notified the supervisor, RN #1 and RN #1 suggested LPN re-check the refrigerator and re-check the unit. LPN #1 then signed the Medication Administration Record (MAR) to identify the medication was unavailable, and she wrote a nursing note to identify the same. LPN #1 stated she did not call RN #1 again to say she could not locate the medication, and she did not notify the APRN. LPN #1 stated she was not aware she should have notified the APRN as she had notified RN #1, and she passed the information to the next shift nurse/LPN #4 during shift report.</p> <p>Interview with the psychiatric APRN (APRN #2) on 1/14/2025 at 11:08 AM identified she was unaware that Resident #4 had not received the 11/1/2024 scheduled monthly dose of Abilify. APRN #2 stated she or the medical APRN (APRN #1) should have been notified the Abilify does was missed, and she would have established an alternate plan. APRN #2 stated Resident #4 had an infection identified at the hospital, and the missed Abilify dose may or may not have contributed to Resident #4's behaviors.</p> <p>Interview with APRN #1 on 1/14/2025 at 11:22 PM identified although she could not recall being notified of Resident #4's missed dose of Abilify on 11/1/2024, if she was notified, she would have contacted APRN #2 or the covering psychiatric service provider and she would have documented in the medical record. APRN #1 stated she would have ordered the Abilify to be given on another day and time. Further, APRN #1 was unable to identify any documentation in the clinical record to indicate she was notified of the missed dose.</p> <p>Interview with RN #1 on 1/14/2025 at 12:50 PM identified she was the supervisor on 11/1/2024 and stated she was notified by LPN #1 that she could not find Resident #4's 8:00 AM dose of Abilify. RN #1 stated she directed LPN #1 to recheck the medication cart and to look in the refrigerator. When LPN #1 did not call her back, she thought LPN #1 must have found the medication and administered it to Resident #4 as scheduled. RN #1 stated she did not follow up with LPN #1 again regarding the medication and she was unaware it was not given. RN #1 stated she did not know why LPN #1 did not contact her again, or contact the APRN when the dose was missed.</p> <p>Interview with LPN #4 on 1/14/2025 at 1:06 PM identified she was assigned Resident #4 on 11/1/2024 on the 3 to 11 PM shift and she could not recall that LPN #1 had reported Resident #4 did not receive his/her scheduled 8:00 AM dose of Abilify. LPN #4 stated if she was aware, she would have contacted the pharmacy to check to see if had been delivered. She would then have notified the supervisor and the APRN.</p> <p>Interview with the acting DON on 1/14/2025 at 1:30 PM identified that she would have expected LPN #1 to notify the supervisor and the APRN that she was unable to provide Resident #4's Abilify as scheduled, and she did not know why LPN #1 did not. The DON stated LPN #1 was re-educated that she needed to administer medications as prescribed and if she could not, that the supervisor and APRN needed to be notified.</p> <p>The facility policy Change in Condition dated 4/2023 directed in part, that the facility must consult with the resident's healthcare provider when there is a need to alter treatment.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Facility documentation review identified staff education was initiated on 11/6/2024 regarding licensed nurses to administer medications as prescribed and to update the MD/APRN if medication is missing or omitted. A QAPI meeting was held on 11/6/2024 and audits were initiated on 11/15/2024. Based on review of facility documentation, past non-compliance was identified with a correction date of 11/15/2024.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on clinical record review, facility documentation review, facility policy review, and interviews for one of four residents (Resident #4), reviewed for behaviors, the facility failed to ensure an antipsychotic medication was administered in accordance with a physician order, and for one of four residents (Resident #2) reviewed for a change in condition, the facility failed to ensure oxygen was administered in accordance with physician orders and failed to ensure an assessment was completed timely for a resident with an identified change in condition. The findings include:</p> <p>a.</p> <p>Resident #4 was admitted with diagnoses that included schizophrenia (mental disorder characterized by hallucinations, delusions, disorganized thinking and behaviors), morbid obesity, and pain. A quarterly minimum data set (MDS) assessment dated [DATE] identified Resident #4 had mildly impaired cognition (BIMS of 9) and had no behaviors during the prior seven (7) days. A resident care plan dated 8/20/2024 identified Resident #4 had behaviors that included negative thoughts, and refusal of care that required mood stabilizers/anti-psychotics. Interventions directed to reapproach as needed, speak calmly, and to administer medications as ordered.</p> <p>A physician order dated 10/14/2024 directed Abilify (antipsychotic medication used to treat schizophrenia) 400 milligrams (mgs) injected intramuscularly (IM) one time a day every month on the first day of the month for schizophrenia.</p> <p>A facility reportable event (RE) form dated 11/6/2024 at 8:15 AM identified Resident #4 attempted self-harm by wrapping his/her hands around his/her neck and applying pressure. Staff redirected and calmed Resident #4, and Resident #4 was placed on one-to-one (1:1) observation until he/she was transferred to the hospital.</p> <p>A hospital psychiatry note dated 11/7/2024 identified a call was placed to the facility and RN #2/evening supervisor verified Resident #3's Abilify was on hold for November and the resident had not received it when scheduled on 11/1/2024.</p> <p>Record review identified the Medication Administration Record (MAR) directed Abilify 400 mgs IM was due to be administered on 11/1/2024 at 8 AM. Further review identified the MAR included a code that indicated the medication was not administered. Record review failed to identify a new physician order for administration of the Abilify on a different date or time for November 2024 prior to transfer to the hospital on [DATE].</p> <p>Interview with LPN #1/charge nurse on 1/14/2025 at 12:00 PM identified Resident #4 was scheduled to receive Abilify 400 mgs IM on 11/1/2024 at 8 AM and she was unable to locate the medication. LPN #1 spoke with the pharmacy and was informed it was delivered. LPN #1 notified the supervisor, RN #1 and RN #1 suggested LPN re-check the refrigerator and re-check the unit. LPN #1 then signed the Medication Administration Record (MAR) to identify the medication was unavailable, and she wrote a nursing note to identify the same. LPN #1 stated she did not call RN #1 again to say she could not locate the medication, and she did not notify the APRN. LPN #1 stated she was not aware she should have notified the APRN as she had notified RN #1, and she passed the information to the next shift nurse/LPN #4 during shift report.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with RN #1 on 1/14/2025 at 12:50 PM identified she was the supervisor on 11/1/2024 and stated she was notified by LPN #1 that she could not find Resident #4's 8:00 AM dose of Abilify. RN #1 stated she directed LPN #1 to recheck the medication cart and to look in the refrigerator. When LPN #1 did not call her back, she thought LPN #1 must have found the medication and administered it to Resident #4 as scheduled. RN #1 stated she did not follow up with LPN #1 again regarding the medication and she was unaware it was not given. RN #1 stated she did not know why LPN #1 did not contact her again or contact the APRN when the dose was missed.</p> <p>Interview with LPN #4 on 1/14/2025 at 1:06 PM identified she was assigned Resident #4 on 11/1/2024 on the 3 to 11 PM shift and she could not recall that LPN #1 had reported Resident #4 did not receive his/her scheduled 8:00 AM dose of Abilify. LPN #4 stated if she was aware, she would have contacted the pharmacy to check to see if had been delivered and notified the supervisor and APRN.</p> <p>Interview with the acting DON on 1/14/2025 at 1:30 PM identified that she would have expected LPN #1 to administer Resident #4's Abilify on 11/1/2024 at 8 AM as ordered. The DON stated if LPN #1 could not locate the medication she should have notified the supervisor or APRN.</p> <p>Medication Pass Policy dated 9/23/2024 directed in part, to administer medications per the physician's orders.</p> <p>Facility documentation review identified staff education was initiated on 11/6/2024 regarding licensed nurses to administer medications as prescribed and to update the MD/APRN if medication is missing or omitted. A QAPI meeting was held on 11/6/2024 and audits were initiated on 11/15/2024. Based on review of facility documentation, past non-compliance was identified with a correction date of 11/15/2024.</p> <p>b.</p> <p>Resident #2 had a diagnosis of chronic obstructive pulmonary disease (COPD), emphysema, acute and chronic respiratory failure. The quarterly Minimum Data Set (MDS) dated [DATE] identified the Resident had a Brief Interview for Mental Status (BIMS) score of 14 (indicating alert and oriented), had a diagnosis of COPD and respiratory failure, and required oxygen use. The Resident Care Plan dated 12/5/2024 identified COPD, and respiratory failure. Interventions directed to monitor for difficulty breathing, shortness of breath at rest, and provide oxygen via nasal cannula per physician orders.</p> <p>Physician order dated 12/30/2024 directed oxygen at five (5) liters to keep oxygen saturation level above 90 percent.</p> <p>Nursing note dated 12/31/2024 at 12:30 PM, written by LPN #3, identified Resident #2 was on five (5) liters oxygen via nasal cannula and complained of shortness of breath. The APRN gave new orders for oxygen at ten (10) liters via a non-rebreather (mask). Resident #2 continued to state he/she cannot breathe, and orders were obtained to transfer Resident #2 to the hospital.</p> <p>Record review failed to identify an RN assessment was completed when Resident #2 complained of shortness of breath.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Emergency Medical Services (EMS) run sheet dated 12/31/2024 identified EMS was notified at 1:18 PM and at the resident at 1:30 PM. On EMS arrival, it appeared the oxygen tank was empty and that the resident had not been receiving oxygen. The resident blood oxygen level was 86 percent (normal 90% and above) on room air, resident anxious and breathing rate of 32 (normal 16 to 20). Placed on a non-rebreather mask and voiced ease of breathing with application.</p> <p>Hospital note dated 12/31/2024 at 2:54 PM identified Resident #2 was seen for COPD exacerbation, with recent Influenza A exposure and low blood oxygen levels, currently at 85% on five (5) liters of oxygen. Hospital documentation dated 12/31/2024 at 8:02 PM identified Resident #2 was admitted for acute on chronic respiratory failure secondary to COPD exacerbation triggered by influenza.</p> <p>Interview and record review with LPN #3 on 1/13/2025 at 11:10 AM identified she was the charge nurse during the 7 AM to 3 PM shift on 12/31/2024, and Resident #2 stated he/she was short of breath with a pulse ox (blood oxygen level) 80's on five (5) liters of oxygen. LPN #3 stated during the shift, at an unidentified time, the supervisor/RN #3 raised the head of bed upright and the resident's oxygen saturation increased to 92 percent. The APRN was notified Resident #2 continued to complain of shortness of breath and directed ten (10) liters of oxygen via a non-rebreather mask. LPN #3 stated she changed the oxygen from an oxygen concentrator to a full portable cylinder oxygen tank at around 11 AM because the concentrator could not provide ten (10) liters. Resident #2 continued to complain of shortness of breath afterwards and was transferred to the hospital. LPN #3 stated she replaced the first full portable cylinder oxygen tank with another full portable cylinder oxygen tank at an unidentified time because the first tank was empty. LPN #3 stated she did not check the oxygen level in the second tank afterwards, and then when EMS arrived, they said the portable tank was empty. LPN #3 stated she did not check the oxygen level in the tank because the bag attached to the oxygen mask was inflated. LPN #3 stated she never rechecked the second tank to ensure it still had oxygen in it, and she should have. When Resident #2 was complaining of shortness of breath she did not verify the tank had oxygen left in it, and she should have checked the tank to ensure it was not empty or running low.</p> <p>Interview with Oxygen Representative #1 from the facility oxygen supplier on 1/13/2025 at 12:04 PM identified they supply the facility with size E tanks for oxygen use. Oxygen Representative #1 stated a size E tank would last less than one (1) hour if the oxygen was running at ten (10) liters.</p> <p>Interview and observation with LPN #3 on 1/13/2025 at 1:28 PM identified the full portable cylinder oxygen tank was a size E tank.</p> <p>Interviews identified the first oxygen tank was placed at approximately 11 AM, and per the oxygen company the tank would last less than one (1) hour. EMS run sheet dated 12/31/2024 identified they were called at 1:18 PM (2 hours and 18 minutes after the first oxygen tank was started).</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with RN #3 on 1/13/2025 at 12:33 PM identified she was the supervisor on 12/31/2024 during the 7 AM to 3 PM shift and was notified about 10 AM that Resident #2 was short of breath. RN #3 stated she assessed the resident, and his/her pulse ox was 88% on an oxygen concentrator set at five (5) liters, and she raised the head of the bed which increased the pulse ox to 92 to 94%. RN #3 stated although she was aware Resident #2 was placed on an oxygen mask, she did not assess the resident again because she did not know the resident was on a non-rebreather at ten (10) liters of oxygen and that LPN #3 had placed the resident on a portable oxygen tank; she stated LPN #3 did not notify her and she did not return to reassess Resident #2's respiratory status prior to Resident #2's transfer to the hospital. Interview failed to identify why RN #3 did not return to reassess Resident #2's respiratory status.</p> <p>Interview with the DNS and Administrator on 1/13/2025 at 2:15 PM identified Resident #2 was on ten (10) liters of oxygen and when EMS arrived, they stated the oxygen tank was empty. LPN #3 stated she just went in the resident's room to check the oxygen tank before EMS arrived, and had switched the first oxygen tank out with a second oxygen tank around 11:30 AM to 12 PM. The DNS indicated LPN #3 should have monitored the oxygen level in the tank; LPN #3 should have checked the oxygen gauge every 30 to 45-minutes to make sure the oxygen tank was not running low or empty. The DNS further indicated an RN assessment should have done after the resident was placed on ten (10) liters of oxygen via a non-rebreather mask, and she did not know why this was not completed.</p> <p>Facility undated Portable Oxygen Cylinder Policy directed in part, for staff to look at the pressure gauge to determine how much oxygen is in the cylinder.</p> <p>Facility Change in Condition Policy dated April 2023 directed in part, for a resident with a change of condition, the licensed nurse, per state regulations, conducts a complete physical/mental evaluation and documents findings in the medical record.</p> <p>Facility documentation review identified although education was initiated on 1/3/2025 and included use of oxygen tanks and checking to ensure the oxygen supply levels, audits and a QAPI meeting were not completed and no past non-compliance was identified.</p>		