

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 11/24/2025
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)		
F 0684 Level of Harm - Minimal harm or potential for 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 record review, facility documentation review, and staff interviews for one of three residents (Resident #2) reviewed for abuse, the facility failed to ensure wound care orders were accurately transcribed and failed to provide wound care treatments to the resident's right hand in accordance with physician orders. The findings include: Resident #2 had a diagnosis of surgical amputation of the right index finger, end stage renal disease, and type 2 diabetes. The admission Minimum Data Set (MDS) dated [DATE] identified Resident #1 had a BIMS of 15 indicating intact cognition, and had venous and arterial ulcers. The Resident Care Plan (RCP) dated 7/22/2025 identified a self-care deficit and a surgical amputation of the right index finger. Interventions directed to provide treatments as ordered. Orthopedic provider note dated 8/21/2025 at 12:46 PM identified Resident #2 was seen for a follow up visit due to cellulitis of the right index finger and underwent a right-hand disarticulation (separate bones at the joints) of the right index finger and an amputation on 8/6/2025. The note directed a wet to dry dressing to be changed daily at the facility. Physician order dated 8/21/2025 directed a wet to dry dressing to be changed daily to the right middle finger, and the order was entered into the EMR to change every shift for surgical wound until further notice from surgeon. Interview and record review with RN #4 (Wound Nurse) on 9/22/2025 at 10:31 AM identified Resident #2's orders were not transcribed correctly following his/her appointment with the orthopedic physician on 8/21/2025. The dressing was ordered to be changed daily, and the order was entered into the electronic medical record (EMR) to change it every shift in error. Interview identified although RN #4 stated she conferred with the nurse to put the order in (the EMR) the interview failed to identify if RN #4 should have checked to make sure her revision matched the physician orders. a. Orthopedic provider note dated 9/4/2025 at 12:55 PM directed soapy water soaks for 20 minutes before reapplying saline wet to dry dressing to the right hand wound site. Physician order dated 9/5/2025 directed a wet to dry dressing to be changed daily to the right middle finger every day shift for surgical until further notice from surgeon. Record review failed to identify an order was entered in the EMR to provide soapy water soaks for 20 minutes before applying the saline wet to dry dressing. Interview and record review with RN #4 (Wound Nurse) on 9/22/2025 at 10:31 AM identified the physician orders following her/his orthopedic office visit on 9/4/2025 were not transcribed correctly - they omitted the soapy water soaks for 20 minutes prior to applying the new dressing. RN #4 indicated she revised the order on 9/7/2025 to make it clearer for staff but she did not check to ensure her revision matched the physician recommendations following the resident's orthopedic office visit on 9/4/2025. Interview identified although RN #4 stated she conferred with the nurse to put the order in (the EMR) the interview failed to identify if RN #4 should have checked to make sure her revision matched the physician orders. b. Physician order dated 8/21/2025 directed a wet to dry dressing to be changed daily to right middle finger every shift for surgical until further notice from surgeon. Orthopedic provider note dated 9/4/2025 at 12:55 PM identified Resident #2 was being seen post operation for his/her right index finger. Upon physical exam, the dressing was removed, and the dressings were dated 8/31/2025 (4 days prior to the office visit). Facility incident report dated 9/4/2025 at 7:51 PM identified the facility met with Resident #2 and family regarding a concern that treatments were not (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 075323
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	completed timely. LPN #2 facility statement dated 9/5/2025 identified LPN #2 signed the Treatment Administration Record (TAR) for Resident #2 on 9/2/2025 during the 11 PM to 7 AM shift when she was not the nurse assigned to Resident #2. The statement indicated LPN #2 did not know why she signed on the TAR to indicate the resident's treatment was completed. LPN #4 facility statement dated 9/5/2025 identified she did not complete the dressing change on 9/3/2025 on the 3 PM to 11 PM shift because Resident #2 refused, but she forgot to document the resident refusal. LPN #3 facility statement dated 9/8/2025 identified she had Resident #2 on her assignment on 9/2/2025 during the 11 PM to 7 AM shift, and she did not provide the treatment to Resident #2's right middle finger because it did not come up on the TAR for her to do. Further, LPN #3 identified she did not complete the treatment on 9/3/2025 during the 7 AM to 3 PM shift because the resident was out of the facility at a medical appointment (unrelated). Review of the TAR and medical record for the month of September identified the right index finger dressing was not completed on 9/3/2025 during the 7 AM to 3 PM shift, and was not accurately documented on 9/2/2025, and on 9/3/2025 during the 3 PM to the 11 PM shift. Review of the facility Incident Summary dated 9/11/2025, Electronic Medical Record (EMR), the TAR, and interviews, identified the order was initially written correctly for the daily treatment to her/his right index finger. However, the order was entered into the electronic TAR as scheduled to complete the treatment every shift instead of daily, leading to Resident #2 refusing some of the treatments on 11-7. It was also noted there were dialysis days the treatment was not completed on the 7am to 3pm shift as she/he was not in the facility. c. Record review identified Resident #2 was transferred to the hospital for evaluation on 9/18/2025 at 12:50 PM for an unrelated issue. Hospital emergency department note dated 9/18/2025 at 3:37 PM identified Resident #2 would be discharged back to the facility. Hospital Discharge summary dated [DATE] review identified wound care directions for the right index finger were as follows: Cleanse right hand with normal saline. Primary dressing: Baci, xeroform, calcium alginate ABD secondary dressing and rolled gauze netting to be changed three (3) times a week - two (2) times at the facility and once a week at the wound care center. Nursing note dated 9/19/2025 at 12:41 AM identified Resident #2 returned to the facility at 5:03 PM. Record review failed to identify the right index finger wound care orders from the hospital were transcribed into the medical record and failed to identify the wound care was provided in accordance with the hospital physician orders. Interview and record review with RN #4 on 9/22/2025 at 12:55 PM identified Resident #2 went to the hospital on 9/18/2025 and returned on 9/19/2025 around 5 PM but when the resident came back her/his orders were not transcribed into the EMR. RN #4 stated Resident #2 was receiving the prior treatment, not the new orders from the hospital. RN #4 stated she did not know why they were not transcribed but indicated they should have been transcribed. Subsequent to surveyor inquiry (on 9/22/2025) wound care instructions following the residents visit to the emergency department on 9/18/2025 were transcribed accurately into the medical record. Interview and record review with the Director of Nursing (DNS), Administrator, and RN #2 on 9/18/2025 at 2:45 PM identified Resident #2's wound care orders were not transcribed correctly into the EMR following new orders obtained on 8/21/2025, 9/4/2025 and 9/18/2025. Interview failed to identify why the orders were not transcribed correctly. Further, the interview identified staff should sign the TAR when they perform the treatment; the TAR should not be signed if the treatment is not performed, and should be signed by the nurse assigned. Review of facility Transcription of Orders Policy dated January of 2024, directed in part, orders from an authorized licensed independent practitioner are accepted by a Registered Nurse. Orders can be written in the electronic health record, obtained over the phone, verbally, from discharge or transfer paperwork from the hospital, physician office visits, or consultant's recommendations. Review of facility Medication Error Policy dated May of 2023 directed a medication error is a discrepancy between what the healthcare provider ordered and what the resident received.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, facility documentation review, and staff interviews for one of three residents (Resident #2) reviewed for neglect, the facility failed to ensure the medical record was complete and accurate to include accurate documentation of wound care provided. The findings include: Resident #2 had a diagnosis of surgical amputation of the right index finger, end stage renal disease, and type 2 diabetes. The admission Minimum Data Set (MDS) dated [DATE] identified Resident #1 had a BIMS of 15 indicating intact cognition, and had venous and arterial ulcers. The Resident Care Plan (RCP) dated 7/22/2025 identified a self-care deficit and a surgical amputation of the right index finger. Interventions directed to provide treatments as ordered. Physician order dated 8/21/2025 directed a wet to dry dressing to be changed daily to right middle finger every shift for surgical until further notice from surgeon. Facility incident report dated 9/4/2025 at 7:51 PM identified the facility met with Resident #2 and family regarding a concern that treatments were not completed timely. LPN #2 facility statement dated 9/5/2025 identified LPN #2 signed the Treatment Administration Record (TAR) for Resident #2 on 9/2/2025 during the 11 PM to 7 AM shift when she was not the nurse assigned to Resident #2. The statement indicated LPN #2 did not know why she signed on the TAR to indicate the resident's treatment was completed. LPN #4 facility statement dated 9/5/2025 identified she did not complete the dressing change on 9/3/2025 on the 3 PM to 11 PM shift because Resident #2 refused, but she forgot to document the resident refusal. LPN #3 facility statement dated 9/8/2025 identified she had Resident #2 on her assignment on 9/2/2025 during the 11 PM to 7 AM shift, and she did not provide the treatment to Resident #2's right middle finger because it did not come up on the TAR for her to do. Further, LPN #3 identified she did not complete the treatment on 9/3/2025 during the 7 AM to 3 PM shift because the resident was out of the facility at a medical appointment (unrelated). Review of the Medication Administration Record (MAR) and medical record for the month of September identified the TAR was signed to indicate the treatment was completed on 9/2/2025 during the 11 PM to 7 AM shift. Further review failed to identify the residents dressing was changed on 9/3/2025 on the 7am to 3pm shift and further record review identified the residents dressing was changed on 9/3/2025 on the 3pm to 11pm shift. Review of the facility Incident Summary dated 9/11/2025, Electronic Medical Record (EMR) TAR, and interviews, identified the order was initially written correctly for the daily treatment to her/his right index finger. However, the order was entered into the electronic TAR as scheduled to complete the treatment every shift instead of daily, leading to Resident #2 refusing some of the treatments on 11-7. It was also noted there were dialysis days the treatment was not completed on the 7am to 3pm shift as she/he was not in the facility. Interview and record review with the Director of Nursing (DNS), Administrator, and RN#2 on 9/18/2025 at 2:45 PM identified LPN #2 and LPN #3 did not complete Resident #2's right finger treatment on 9/2/2025. Further, LPN #2 was not assigned to Resident #2 and should not have signed the TAR to indicate she had completed the treatment when she did not perform the dressing change. Interview failed to identify why LPN #2 signed the TAR. LPN #3 failed to sign the TAR or write a nursing note to indicate why she did not perform the scheduled dressing change. LPN #4 signed the TAR to indicate she had performed the dressing change on 9/3/2025 when she did not complete the treatment. Interview failed to identify why LPN #4 signed the TAR. Further, the interview identified staff should sign the TAR when they perform the treatment; the TAR should not be signed if the treatment is not performed, and should be signed by the nurse assigned. Review of Charting and Documentation Policy January of 2025 directed staff that documentation shall be accurate, relevant, and complete, containing sufficient details about the patients care or responses to care.		