STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075353	A. Building B. Wing	11/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mozaic Senior Life	4200 Park Avenue Bridgeport, CT 06604

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 - Minimal harm or potential for 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** 37721 Based on clinical record reviews, facility documentation, facility policy and interviews for one (1) of three (3) residents,(Resident #1), reviewed for accidents, the facility failed to ensure the comprehensive care plan included a resident's resistive behaviors. The findings include: Resident # 1's diagnoses included neurocognitive disorder with Lewy bodies, atrial fibrillation, and congestive heart failure. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 had moderate cognitive impairment, required supervision with bed mobility, transfers ambulation on the unit with the use of a walker, one person assist with toileting. The Resident Care Plan dated [DATE] identified Resident #1 had an alteration in activity of daily living (ADL) function and a history of falls with interventions directed to provide assist of one with ambulation with a rolling walker and provide frequent checks to the room for safety. A Physician's orders dated [DATE] directed assist of one with the rolling walker. A facility Reported Event summary dated [DATE] identified staff responded to a thumping sound in Resident #1's room where s/he was observed sitting on the floor at the foot of the bed with the walker at h/her side. Resident #1 was very agitated, weepy, difficult to redirect and complaining of a headache with pain all over. Resident #1 was unable to state the cause of the fall. No apparent injury was observed. Resident #1 was last seen in the common area at 4:00 AM. S/he was uncooperative with vitals and pupil assessment. The Advanced Practice Registered Nurse (APRN) was contacted, and orders were obtained to send to emergency department (ED) for evaluation. Resident #1 was subsequently transferred to a community hospital for further evaluation. Computed Tomography, CT scan (head) results dated [DATE] revealed an Interval acute/hyperacute left posterior parietal hematoma (bleeding) measuring up to 6 cm and underlying mass effect with a 3 mm left to right midline shift. Resident #1 subsequently expired at the outside hospital on [DATE]. An interview with APRN #1 on [DATE] at 2:30 PM identified Resident #1 experienced multiple falls secondary to a diagnosis of Lewy body dementia, had poor safety awareness and was more difficult to redirect in the preceding month prior to the incident. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with Nurse Aide, NA #1 on [DATE] at 2:45 PM identified she was the assigned nurse aide on [DATE] overnight to [DATE] during the 11:00 PM to 7:00 AM shift and that Resident #1 was well known to her. NA #1 stated Resident #1 was up periodically during the night which was normal behavior, and that NA #1 provided toileting assistance as needed. NA #1 stated she last assisted with toileting at 3:00 AM and then assisted resident #1 back to bed. NA #1 identified that Resident #1's bed alarm went off a few minutes after assisting Resident #1 back to bed, and NA #1 checked Resident #1's room and observed Resident #1 standing by h/her bed stating s/he wanted to walk around. NA #1 and Resident #1 exited the room together with Resident #1 ambulating with h/her walker. NA #1 stated she did not know where Resident #1 went on the unit but less than a minute later, heard a thump. NA #1 went to check Resident #1's room where she observed h/her on the floor next to the bed with the walker nearby yelling that s/he was in pain. NA #1 indicated resident #1 required assistance of one when ambulating with the walker but was non-compliant with allowing staff support. NA #1 stated that Resident #1 required an assist of one with the rolling walker but that s/he was non-compliant with allowing staff support. NA #1 indicated when Resident #1 did refuse assistance she would notify the nurse but could not recall if the nurse was notified on [DATE] at the time of the incident. An interview with Registered Nurse, RN #1 on [DATE] at 3:12 PM identified she was the assigned nurse on [DATE] overnight to [DATE] during the 11:00 PM to 7:00 AM shift. RN #1 stated she observed Resident #1 ambulating independently on the unit at intermittent times during the shift without staff assistance. NA #1 did not report to her Resident #1 was refusing assistance with ambulation during the shift. An interview with the Director of Nursing on [DATE] at 3:30 PM identified Resident #1 was known to be resistive with care and that the care plan should have included the problem with interventions in place to address the behavior. A review of the facility policy for Care Plans directed the care plan process to be interdisciplinary and address the current/potential needs of the resident. Each discipline would be responsible for performing an assessment, developing a problem statement, goal, and approach to achieve the goal.

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37721 Based on clinical record reviews, facility documentation, facility policy and interviews for 1 of 3 sampled residents (Resident #1) who were reviewed for accidents, the facility failed to ensure ambulatory assistance and supervision was provided for a resident who required assistance with ambulating who subsequently sustained a fall with significant injury. The findings include: Resident # 1's diagnoses included neurocognitive disorder with Lewy body dementia, atrial fibrillation, and congestive heart failure. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 had moderate cognitive impairment, required supervision with bed mobility, transfers, ambulation on unit the with the use of a walker, required one person assist with toileting and had no recent falls. The Resident Care Plan dated [DATE] identified Resident #1 had an alteration in activity of daily living (ADL) function and a history of falls. Interventions directed to provide assist of one with ambulation with a rolling walker and provide frequent checks to the room for safety. Physician's orders dated [DATE] directed assist of one with the rolling walker. A nurse's note dated [DATE] at 6:42 AM at 4:20 AM Resident #1 was observed sitting on floor (of h/her room) facing the foot of bed with rollator walker in front of her. Resident #1 was crying and complaining of headache and pain all over, voluntarily moving all four extremities,and was non complaint with obtaining vital signs. Resident #1 was subsequently transferred to the emergency room for further evaluation. A facility Reported Event summary dated [DATE] identified staff responded to a thumping sound in Resident #1's room where s/he was observed sitting on the floor at the foot of the bed with the walker at h/her side. Resident #1 was very agitated, weepy, difficult to redirect and complaining of a headache with pain all over. Resident #1 was unable to state the cause of the fall and no apparent injury was observed. Resident #1 was last seen in the common area at 4:00 AM. S/he was uncooperative with vitals and pupil assessment. The Advanced Practice Registered Nurse (APRN) was contacted, and orders were obtained to send Resident #1 to emergency department (ED) for evaluation. Computed Tomography, CT scan (head) results dated [DATE] revealed an Interval acute/hyperacute left posterior parietal hematoma (bleeding) measuring up to 6 cm and underlying mass effect with a 3 mm left to right midline shift in the brain. Resident #1 subsequently expired at the hospital on [DATE]. (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 0689 Level of Harm - Actual harm Residents Affected - Few	The hospital Discharge Summary dated [DATE] identified Resident #1 was evaluated following a fall at the facility. A CT scan of the head identified acute/hyperacute left posterior parietal hematoma measuring up to 6 cm. The hemorrhage was non-surgical, and Resident #1 was not a candidate for external ventricular drain (EVD), a drain, a device used relieve elevated intracranial pressure when the normal flow of cerebrospinal fluid (CSF) inside the brain is obstructed. The situation was discussed with the responsible party who agreed to transition Resident #1 to comfort measures. Resident #1 was placed on hospice services and subsequently expired on [DATE]. An interview with Nurse Aide, NA #1 on [DATE] at 2:45 PM identified she was the assigned nurse aide on [DATE] overnight to [DATE] during the 11:00 PM to 7:00 AM shift. Resident #1 was up periodically during the night ambulating independently. NA #1 stated she last assisted with toileting at 3:00 AM and then assisted Resident #1 back to bed. Resident #1's bed alarm went off a few minutes after assisting Resident #1 back to bed. NA #1 checked Resident #1's room and observed Resident #1 standing by h/her bed stating s/he wanted to walk around then noted that Resident #1 was ambulating independently with h/her walker around the unit. NA #1 then heard a thump and went to check Resident #1's room where she observed Resident #1 on the floor next to the bed with the walker nearby, yelling in pain. NA #1 indicated Resident #1 required assistance of one when ambulating and on [DATE] Resident #1 was non-compliant with requests that NA#1 made to go back to bed and continued to ambulate independently on the unit, without assistance from NA#1. NA #1 stated she did not observe Resident #1 return to h/her room as there were bed alarms from other residents going off that she had to attend to. NA#1 further stated that it was well known Resident #1 would not allow staff assist when ambulating and although the resident was unable to be re-directed from independent ambulation, and she did not report to the nurse that the resident was ambulating independently and unable to be re-directed. An interview with Registered Nurse, RN #1 on [DATE] at 2:25 PM identified she was the assigned nurse on [DATE] overnight to [DATE] during the 11:00 PM to 7:00 AM shift. RN #1 indicated she had checked on Resident #1 periodically during the overnight shift while also working on an alternate unit. Resident #1 was up at intermittent times during the night and was observed ambulating independently on the unit with a rolling walker, which RN #1 believed was h/her baseline functional level, which is why she did not intervene. NA #1 did not report to her that the resident was unable to be re-directed. RN #1 was notified in the early morning on [DATE] that Resident #1 was observed on the floor in h/her room with the walker by h/her side. Resident #1 was agitated, complaining of pain, and subsequently transferred to the hospital. An interview with APRN #1 on [DATE] at 2:30 PM identified Resident #1 experienced multiple falls secondary to a diagnosis of Lewy body dementia, had poor safety awareness and was more difficult to redirect in the preceding month prior to the incident. APRN #1 indicated staff should have been providing assist of one when ambulating Resident #1 as ordered. An interview with the Director of Nursing on [DATE] at 3:30 PM identified she would expect staff to provide assistance of one with a rolling walker when ambulating Resident #1 for safety.