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	03/05/2025

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 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** 40172 Based on a review of clinical records, facility documentation, facility policy, and interviews for one (1) of three (3) residents (Resident #1) reviewed for accidents, (Resident #1), the facility failed to ensure a resident who is dependent on staff for transfers and all care remained free from significant injuries of unknown origin which included a left femur fracture (bone in upper thigh) and a right humerus (bone in upper arm) fracture. The findings include: Resident #1 had diagnoses that included Alzheimer's disease and generalized muscle weakness. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of three (3) indicative of severely impaired cognition, was non ambulatory, and was dependent on staff for mobility in the wheelchair. The care plan dated 12/30/24 identified Resident #1 demonstrates poor body alignment due to Alzheimer's disease with interventions that directed to assist resident in getting in and out of Tilt in Space wheelchair (TIS) (a specialized wheelchair that tilts the seat and back of the wheelchair simultaneously) and position the resident in TIS wheelchair with a head rest, foam cushion, elevating leg rests, calf wraps, arm rests, and lateral supports. A physician's order dated 1/16/2025 directed for transfers use a swing Hoyer lift for transfers and to provide the assistance of two (2) for bed mobility. A nurse's note dated 2/9/2025 at 3:24 P.M. written by Registered Nurse (RN) #2 (7:00 A.M.-3:00 P.M. shift supervisor), identified she was notified by Licensed Practical Nurse (LPN) #4 who observed a greenish light purplish bruise on Resident #1's right upper arm and Resident #1 screamed when the arm was slightly lifted. RN #2 identified Resident #1 had swelling and limited mobility. RN #2 notified the on-call MD and an order was obtained for a STAT (immediate) X-ray of the right arm. Review of Resident #1's right shoulder X-ray report dated 2/9/2025 at 11:57 P.M. identified a transverse fracture involving the neck of the humerus (a bone fracture where the break occurs perpendicular to the long axis to the bone) with minimal callus (early stages of healing) and mild displacement (broken bones are not in alignment). (continued on next page)

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 0689 Level of Harm - Actual harm Residents Affected - Few	A nurse's note dated 2/10/2025 at 10:31 A.M. written by the Director of Nursing Services (DNS) identified, she assessed Resident #1 secondary to a report of swelling of the right upper arm and a bruise. The DNS identified that the resident had an X-ray that showed a transverse fracture involving the neck of the humerus with minimal callus and mild displacement. The DNS identified upon assessment Resident #1 was also noted with swelling to the left knee the APRN #1 was notified and the Resident #1 was transferred to the hospital. for evaluation. Review of the facility's accident and incident report dated 2/10/2025 identified that on 2/9/2025 at 8:50 A.M. resident was noted with an injury of unknown origin. The facility's incident report summary dated 2/14/2025 identified Resident #1 needs assistance with ADLs, is non-ambulatory, and transfers via a mechanical lift. On 2/9/2025, at approximately 8:50 A.M. during care the nurse aide noted a bruise on Resident #1's right upper arm the aide called the nurse who also noted the bruise along with swelling and pain to the right arm when arm was lifted. The physician was called and an order for an X-ray was obtained. The X-ray results were obtained and indicative of a transverse fracture involving the neck of the right humerus with minimal callus and mild displacement. The physician was notified, orders obtained to transfer Resident #1 to the emergency department. While in the hospital multiple X-rays were obtained, the left knee showed an obliquely displaced fracture of the distal femur with medial displacement (a fracture that occurs at an angle and the broken bones are not aligned). A thorough investigation was initiated and did not reveal a known or documented fall or injury. All statements prior to the day shift on 2/7/2025 revealed normal shifts with no increase in pain. The facility was unable to determine the exact cause of Resident #1's injuries. The hospital discharge summary dated 2/12/2025 identified Resident #1 presented to the hospital from the facility when staff noticed bruising and swelling to Resident #1's right upper extremity. Per documentation from the facility Resident #1 is bedbound and uses a Hoyer lift with no known falls or traumatic injuries. A trauma work-up further identified that the resident had a right displaced humeral neck fracture and a left displaced distal femur fracture. Interviews on 3/4/2025 and 3/5/2025 with Licensed Practical Nurse (LPN) #2, LPN #3, Nurse Aide (NA) #3 NA #4, NA #5, and NA #7 at various times who cared for the resident in the 72 hours prior to the injury being discovered, failed to identify any failed to identify any abnormalities to the lower and upper extremities, bruising, falls, accidents, behaviors, or incidents with the Hoyer lift prior to 2/9/2025. Interview with LPN #4 on 3/4/2025 at 1:35 P.M. identified on 2/9/2025 during the 7:00 A.M.-3:00 P.M. shift she was called to Resident #1's room by NA #2 who observed a bruise on Resident #1's right upper forearm. LPN #4 identified she observed a small red purple bruise on Resident #1's right upper forearm and when she lifted Resident #1's right arm the resident yelled out. LPN #4 LPN #4 indicated she notified RN #1, the on-call MD, and an order was obtained for an X-ray. Interview with RN #1 on 3/4/2025 at 1:55 P.M. identified on 2/9/2025 during the 3:00 P.M. to 11 :00 P.M. shift she observed a discoloration on Resident #1's right bicep and Resident #1 reported pain with movement of h/her right arm. RN #1 identified an X-ray was obtained of Resident #1's right upper extremity towards the end of her shift. RN #1 indicated prior to 2/9/2025 Resident #1 had no abnormalities to the lower extremities, bruising, falls, or accidents. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interview with the Director of Nursing Services (DNS) on 3/4/2025 at 12:00 P.M. identified on 2/9/2025 she was notified by RN #1 that Resident #1 had swelling to the right upper arm and a bruise was noted, the on-call provider was notified and an order for a STAT X-ray was obtained. The DNS identified on 2/10/2025 the facility received the results of Resident #1's X-ray that showed a transverse fracture involving the neck of the right humerus and Resident #1 was transferred to the hospital. The DNS identified while Resident #1 was in the hospital a second fracture was identified of the left femur and severe osteoporosis. The DNS identified that Resident #1 does not ambulate, is not able to self-propel in the wheelchair, requires assistance of two (2) staff with bed mobility, and two (2) staff for transfers using a Hoyer lift, and does not exhibit any behaviors. The DNS identified staff interviews indicated Resident #2 had no recent falls in the last 6-7 months. The DNS identified although a complete and thorough investigation was completed the DNS could not determine what caused Resident #1's right humerus fracture and left femur fracture. Interview with the Orthopedic Surgeon (OS) that treated Resident #1 in the hospital on 3/5/2025 at 11:30 A. M. identified on 2/10/2025 Resident #1 presented to the hospital from the facility for evaluation of a right transverse humerus fracture, and subsequently a left femur fracture was identified. The OS identified per the facility report Resident #1 was non-ambulatory, required use of a Hoyer lift, and had no falls, and even with severe osteoporosis routine movements and positioning it would not attribute to a right transverse humerus fracture or a left distal spiral fracture. MD #2 identified Resident #1's right humerus fracture was a transverse fracture which is caused by direct impact from trauma. MD #2 identified Resident #1's left femur fracture was a spiral fracture which is caused by a twisting motion during trauma. MD #2 identified he attributes Resident #1's humerus and femur fractures to some type of trauma, such as a fall. Although attempted interviews with RN #1 and NA #6 were not obtained. Review of the resident safe handling policy identified that is facility policy to ensure that residents are handeled safely to prevent or minimize risks for injury and provide a safe, secure and comfortable experience for the resident.