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	05/20/2026

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **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 #1) reviewed for abuse, the facility failed to ensure the resident was free from physical restraints imposed for staff convenience. The findings include: Resident #1 had a diagnosis of Alzheimer's and insomnia. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had no cognitive assessment completed, had no behaviors, required maximal assistance with transfers and had no physical restraints. The Resident Care Plan (RCP) dated 3/4/26 identified a potential for falls, short/long term memory deficits, and alteration in activities of daily living (ADLs). Interventions directed to conduct frequent safety checks. Physician order dated 9/29/25 and last reviewed on 5/1/26 directed a seat belt alarm and to check function and placement every shift for Resident #1. Interview with the Rehabilitation Director on 5/20/26 at 9:13 AM identified Resident #1 was assessed to have an alarmed seat belt and was found the intervention was appropriate for the resident and that Resident #1's alarmed seat belt was self-releasing. Nursing note dated 4/23/26 at 12:27 AM identified Resident #1 was alert, confused and had no distress noted. Bed and chair alarm in place and functioning well, and Resident #1 was out of bed to wheelchair for safety. Facility email dated 4/22/26 at 4:19 PM from OT #1 addressed to the DNS indicated OT #1 observed Resident #1 this afternoon his/her self-releasing (seat) belt was tied. I did not see an aide or nurse nearby at the time to ask about it, so I wanted to bring it to your attention. I am not sure if it is broken or may need a new one. Resident #1 was currently on case load for positioning and OT #1 will let the therapist know. Facility reportable event dated 4/23/26 at 9:53 AM identified on 4/23/26 at approximately 8 AM, a message was received that Resident #1's seat belt had been tied in place on 4/22/26. Per the message, Resident #1 was seated in his/her wheelchair, and his/her alarmed seat belt was tied closed. Advanced Practice Registered Nurse (APRN) note dated 4/23/26 at 6:51 PM identified on 4/23/2026 Resident #1 was seen due to being found with his/her seat belt tied. Resident #1 had decreased safety awareness with multiple attempts to climb out of the wheelchair. Resident #1 examined no acute abdominal injury noted, and was at baseline cognition. Resident #1 was stable and currently in no acute distress. Reportable event summary dated 4/27/26 identified on 4/23/26 at approximately 8:00 AM an e-mail was received from OT #1 stating that Resident #1's alarmed seat belt was noted to be tied on 4/22/26 at approximately 3:45 PM. No injury was noted. Facility investigation determined that an alarmed seat belt, which the resident was able to release independently, was tied in a closed position between approximately 3:30 PM and 3:45 PM and through much of the evening shift. NA #1 was assigned to Resident #1 during the evening shift and reported that Resident #1 was very restless and repeatedly opening the alarmed seat belt, causing the alarm to sound. NA #1 stated that she tied the alarmed seat belt in an effort to maintain the resident's safety and prevent a potential fall with injury. Interview and documentation review with NA #1 on 5/18/26 at 12:35 PM identified she was assigned to provide care for Resident #1 on 4/22/26 during the 3 PM to 11PM shift. NA #1 stated Resident #1 was in his/her wheelchair at the start of her shift, and he/she kept trying to get out of the wheelchair. NA #1 stated she was busy and around 3:30 PM to 4 PM, she (continued on next page)

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

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	took disposable cleaning wipes and wrapped it around the Velcro part of the alarmed seat belt so he/she could not remove the seat belt. NA #1 further stated she took Resident #1 to the bathroom throughout the shift and put him/her back the wheelchair and re-tied the alarmed seat belt again after each toileting. NA #1 indicated she did this until 7 PM when she put Resident #1 back to bed, and stated she did not tie him/her down in the bed. NA #1 said tied the seat belt with the disposable cleaning wipes so the resident would not fall, and stated she knew that tying the alarmed seat belt would be considered a restraint. NA #1 stated she did not think it was a problem to tie the seat belt because she was doing it for safety reasons. NA #1 stated she did not tell the nurse or nursing supervisor that Resident #1 kept trying to get up and did not know she could contact the nursing supervisor. Interview with LPN #1 on 5/18/26 at 3:12 PM identified she was the charge nurse for Resident #1 on 4/22/26 on the 3 PM to 11 PM shift. LPN #1 stated she was not notified that Resident #1 was restless or trying to get up, and she did not recall seeing the alarmed seat belt tied. Interview with OT #1 on 5/19/26 at 9AM identified around 4 PM she observed Resident #1 with his/her seat belt alarm wrapped with what looked like a washcloth and she was not sure if the seat belt was broken. OT #1 stated there were no staff around and her manager had left for the day, so she decided to send an email to the Director of Nursing (DNS) to notify the DNS. OT #1 stated she did not check the seat belt alarm to make sure it was functional, and stated she probably should not have left Resident #1 with the seat belt tied. Interview with the Director of Nursing (DNS) on 5/19/26 at 9:30 AM identified when she came into work on 4/23/26, she saw the email from OT #1 that reported Resident #1's alarmed seat belt was found tied with something that looked like a cloth, but OT #1 was not sure if the seat belt was broken. Resident #1 was assessed by the APRN with no injuries were found and an investigation was started. NA #1 was assigned to Resident #1 on 4/22/26 on the 3 PM to 11 PM shift, and NA #1 stated she had tied the Velcro part of the alarmed seat belt with disposable washcloth around 3:45 PM to prevent Resident #1 from getting up. NA #1 stated she tied it for safety reasons which was to help prevent the resident from falling and NA #1 stated she had tied Resident #1's alarmed seat belt multiple times before. The DNS seat belts should not be tied to prevent a resident from getting up, and tying the seat belt would be considered a restraint. Review of facility Abuse Policy dated 5/23/2002 directed in part, abuse included willful unreasonable confinement.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **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 #1) reviewed for abuse, the facility failed to ensure staff reported an allegation of abuse or physical restraint use timely. The findings include: Resident #1 had a diagnosis of Alzheimer's and insomnia. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had no cognitive assessment completed, had no behaviors, required maximal assistance with transfers and had no physical restraints. The Resident Care Plan (RCP) dated 3/4/26 identified a potential for falls, short/long term memory deficits, and alteration in activities of daily living (ADLs). Interventions directed to conduct frequent safety checks. Physician order dated 9/29/25 and last reviewed on 5/1/26 directed a seat belt alarm and to check function and placement every shift for Resident #1. Interview with the Rehabilitation Director on 5/20/26 at 9:13 AM identified Resident #1 was assessed to have an alarmed seat belt and was found the intervention was appropriate for the resident and that Resident #1's alarmed seat belt was self-releasing. Facility email dated 4/22/26 at 4:19 PM from OT #1 addressed to the DNS indicated OT #1 observed Resident #1 in his/her wheelchair this afternoon his/her self-releasing (seat) belt was tied. I did not see an aide or nurse nearby at the time to ask about it, so I wanted to bring it to your attention. I am not sure if it is broken or may need a new one. Resident #1 was currently on case load for positioning and OT #1 will let the therapist know. Facility reportable event dated 4/23/26 at 9:53 AM identified on 4/23/26 at approximately 8 AM, a message was received that Resident #1's seat belt had been tied in place on 4/22/26. Per the message, Resident #1 was seated in his/her wheelchair, and his/her alarmed seat belt was tied closed. Interview and documentation review with NA #1 on 5/18/26 at 12:35 PM identified she was assigned to provide care for Resident #1 on 4/22/26 during the 3 PM to 11PM shift. NA #1 stated Resident #1 was in his/her wheelchair at the start of her shift, and he/she kept trying to get out of the wheelchair. NA #1 stated she was busy and around 3:30 PM to 4 PM, she took disposable cleaning wipes and wrapped it around the Velcro part of the alarmed seat belt so he/she could not remove the seat belt. NA #1 further stated she took Resident #1 to the bathroom throughout the shift and put him/her back the wheelchair and re-tied the alarmed seat belt again after each toileting. NA #1 indicated she did this until 7 PM when she put Resident #1 back to bed, and stated she did not tie him/her down in the bed. NA #1 said tied the seat belt with the disposable cleaning wipes so the resident would not fall, and stated she knew that tying the alarmed seat belt would be considered a restraint. NA #1 stated she did not think it was a problem to tie the seat belt because she was doing it for safety reasons. NA #1 stated she did not tell the nurse or nursing supervisor that Resident #1 kept trying to get up and did not know she could contact the nursing supervisor. Interview with LPN #1 on 5/18/26 at 3:12 PM identified she was the charge nurse for Resident #1 on 4/22/26 on the 3 PM to 11 PM shift. LPN #1 stated she was not notified that Resident #1 was restless or trying to get up, and she did not recall seeing the alarmed seat belt tied. Interview with OT #1 on 5/19/26 at 9AM identified around 4 PM she observed Resident #1 with his/her seat belt alarm wrapped with what looked like a washcloth and she was not sure if the seat belt was broken. OT #1 stated there were no staff around and her manager had left for the day, so she decided to send an email to the Director of Nursing (DNS) to notify the DNS. OT #1 stated she did not check the seat belt alarm to make sure it was functional, and stated she probably should not have left Resident #1 with the seat belt tied. Interview with the Director of Nursing (DNS) on 5/19/26 at 9:30 AM identified OT #1 did not try to call herself or the Administrator, or any other staff when she observed Resident #1's seat belt alarm tied. The DNS stated she did not know why OT #1 did not call or contact anyone, and stated the observation should have been reported immediately to ensure the seat belt was functional and safe for the resident. The DNS stated allegations of abuse, including use of restraints, are required to be reported immediately, (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and she was not notified until she received the email the next day, on 4/23/26 about 8 AM (approximately 16 hours after OT #1 made the observation). Review of facility Abuse Policy dated 5/23/2002 directed in part, abuse was defined as willful infliction of injury, unreasonable confinement, intimidation, or punishment and if observed by staff, must be reported immediately to the Nursing Director.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility documentation review and staff interviews for one of thee residents (Resident #1) reviewed for abuse, the facility failed to conduct a complete and thorough investigation regarding an allegation of abuse, to include obtaining statements from all staff that worked the shift of the alleged incident. The findings include: Resident #1 had a diagnosis of Alzheimer's and insomnia. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had no cognitive assessment completed, had no behaviors, required maximal assistance with transfers and had no physical restraints. The Resident Care Plan (RCP) dated 3/4/26 identified a potential for falls, short/long term memory deficits, and alteration in activities of daily living (ADLs). Interventions directed to conduct frequent safety checks. Physician order dated 9/29/25 and last reviewed on 5/1/26 directed a seat belt alarm and to check function and placement every shift for Resident #1. Interview with the Rehabilitation Director on 5/20/26 at 9:13 AM identified Resident #1 was assessed to have an alarmed seat belt and was found the intervention was appropriate for the resident and that Resident #1's alarmed seat belt was self-releasing. Facility email dated 4/22/26 at 4:19 PM from OT #1 addressed to the DNS indicated OT #1 observed Resident #1 this afternoon his/her self-releasing (seat) belt was tied. I did not see an aide or nurse nearby at the time to ask about it, so I wanted to bring it to your attention. I am not sure if it is broken or may need a new one. Resident #1 was currently on case load for positioning and OT #1 will let the therapist know. Facility reportable event dated 4/23/26 at 9:53 AM identified on 4/23/26 at approximately 8 AM, a message was received that Resident #1's seat belt had been tied in place on 4/22/26. Per the message, Resident #1 was seated in his/her wheelchair, and his/her alarmed seat belt was tied closed. Reportable event summary dated 4/27/26 identified on 4/23/26 at approximately 8:00 AM an e-mail was received from OT #1 stating that Resident #1's alarmed seat belt was noted to be tied on 4/22/26 at approximately 3:45 PM. No injury was noted. Facility investigation determined that an alarmed seat belt, which the resident was able to release independently, was tied in a closed position between approximately 3:30 PM and 3:45 PM and through much of the evening shift. NA #1 was assigned to Resident #1 during the evening shift and reported that Resident #1 was very restless and repeatedly opening the alarmed seat belt, causing the alarm to sound. NA #1 stated that she tied the alarmed seat belt in an effort to maintain the resident's safety and prevent a potential fall with injury. Interview and documentation review with NA #1 on 5/18/26 at 12:35 PM identified she was assigned to provide care for Resident #1 on 4/22/26 during the 3 PM to 11PM shift. NA #1 stated Resident #1 was in his/her wheelchair at the start of her shift, and he/she kept trying to get out of the wheelchair. NA #1 stated she was busy and around 3:30 PM to 4 PM, she took disposable cleaning wipes and wrapped it around the Velcro part of the alarmed seat belt so he/she could not remove the seat belt. NA #1 further stated she took Resident #1 to the bathroom throughout the shift and put him/her back the wheelchair and re-tied the alarmed seat belt again after each toileting. NA #1 indicated she did this until 7 PM when she put Resident #1 back to bed, and stated she did not tie him/her down in the bed. NA #1 said tied the seat belt with the disposable cleaning wipes so the resident would not fall, and stated she knew that tying the alarmed seat belt would be considered a restraint. NA #1 stated she did not think it was a problem to tie the seat belt because she was doing it for safety reasons. NA #1 stated she did not tell the nurse or nursing supervisor that Resident #1 kept trying to get up and did not know she could contact the nursing supervisor. Review of facility staffing identified there were two (2) NAs (NA #1 and NA #3) and one (1) LPN (LPN #1) that worked on Resident #1's unit on 4/22/26 during the 3 PM to 11 PM shift, and there was one (1) free-float supervisor (RN #3). Review of facility reportable event investigation failed to identify staff from the 3 PM to 11 PM shift on 4/22/26 were interviewed regarding the incident. Review identified NA #1 was interviewed and staff that worked the shift prior were interviewed. Interviews were not obtained from the 3 PM to 11 PM shift staff, NA #3, LPN #1 (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and RN #3. Interview with the Director of Nursing on 5/19/26 at 9:30 AM identified she did not interview any staff members on the 3 PM to 11 PM shift that worked on 4/22/26. The DNS stated she should have interviewed all staff that worked the shift, but did she not think it was necessary at the time because NA #1 already admitted to doing it. Review of facility Abuse Policy dated 5/23/2002 directed in part, to identify and interview all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegation.