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	09/29/2025

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 - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on observations, interviews, review of facility documentation, and policy, the facility failed to maintain safe water temperatures and failed to monitor water temperatures in resident rooms/bathrooms to ensure residents were free from potential burns. The findings include:Resident #260?s diagnoses included paroxysmal atrial fibrillation, chronic systolic (congestive) heart failure, and cardiomyopathy.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #260 had a Brief Interview of Mental Status (BIMS) score of 15 indicating no cognitive impairment, and required partial/moderate assistance for personal hygiene, was independent for oral hygiene, transfers, and had the ability to walk 150 feet. The Resident Care Plan dated 9/4/25 identified Resident #260 was at risk for skin breakdown related to decrease in bed mobility, bowel and bladder incontinence. Interventions included incontinent care every 2 to 3 hours and scheduled skin checks. Observation on 9/22/2025 at 10:30 AM identified hot water temperatures exceeded 120 degrees Fahrenheit (F) in 25 out of 46 rooms observed. Water temperatures ranged from 120.2 degrees F to 148.5 degrees F.Observation and Interview on 9/22/2025 at 11:34 AM with Resident #260 identified his/her bathroom faucet water temperature was 121.6 degrees F. Resident #260 indicated that the water in his/her bathroom Is hot as anything!, that the water has been hot since he/she first admitted to the facility in February of 2024, and that it was especially difficult to regulate the temperature in the shower because it was so hot it took a while. Resident #260 further stated that he/she had told staff that the water was hot but didn't know if maintenance had been informed about the hot water temperature.Review of the facilities monthly domestic Hot Water Temperature Log from 8/1/2025 to 9/21/2025 identified that water temperatures were recorded high on 23 out of 52 days (greater than 120 degrees F) with no plan of correction documented or the implementation of measures to protect residents.Interview with the Maintenance Supervisor on 9/22/25 at 11:45 AM identified he checked the water temperature at the mixing valve in the boiler room daily during the morning and would record the temperatures in the log (3 different temps). For temperatures greater than 120 degrees F, he indicated he would adjust the mixing valve and watch the temperature decrease to under 120 degrees F. The Maintenance Supervisor indicated he would generally keep the temps around 118 F. According to the Hot Water Temperature Log indicating multiple temperatures above 120 degrees F for July, August, and September 2025 he failed to go into residents' rooms to check water temperatures and was unaware that he should have. Further, he identified that the facility would only check water temperatures in resident rooms for complaints of too hot or too cold water and he could not recall the last time he checked the water temperature in a resident's room.Interview and review of temperature documentation with the Director of Physical Plant and Administrator on 9/22/2025 at 2:38 PM identified the facility had taken temperatures in resident rooms previously identified by surveyors as above the requirement. After lowering the temperature at the mixing valves, the temperatures had returned to levels within the required range.Interview with the Director of Physical Plant and Maintenance Supervisor on 9/29/2025 at 10:38 AM identified that the water temperatures were checked daily at 3 mixing valves and not in resident care areas or (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	rooms. The Maintenance Supervisor indicated that he thought that temperatures would be cooler in resident care areas/rooms after going through the mixing valves. The Maintenance Supervisor indicated that if the water temperatures were recorded above 120 degrees F, they would lower the temperature by a couple degrees and check the next day at the mixing valves. The Maintenance Supervisor stated the facility did not check the resident care area/rooms after a high temperature reading because the water system would need some time for the water temperatures to cool down.Interview with the Director of Physical Plant and Maintenance Supervisor on 9/29/2025 at 10:50 AM identified maintenance staff were responsible for taking water temperatures and should ensure the temperature was adjusted to the mixing valve by watching the monitor. The Maintenance Supervisor indicated weekend staff were not trained to make the adjustment, and the facility failed to perform adjustments to the mixing valve for elevated temperatures on 9/20/2025 and 9/21/2025 but should have. The Maintenance Supervisor identified he would be providing training for all of his staff so that adjustments could be made on the weekends. The Director of Physical Plant indicated temperatures were being taken at the mixing valve and despite elevated temperatures, as identified on the temperature logs for July, August, and September, there were no water temperatures taken in the resident areas or resident rooms. Further, he stated they had changed their Water Temperature Log form, would be documenting times temperatures were taken, and if any temperatures were over 118 degrees F, then water temperatures would be taken in resident areas/rooms.Review of the facilities operations and maintenance manual directed, in part, that mixing valves and/or anti-scald valves are necessary to reduce the final water temperature to no more than 120 degrees F in patient/resident areas to prevent scalding.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of the clinical record, facility policy, and interviews for 1 of 4 sampled residents (Resident #245), reviewed for dining, the facility failed to ensure a dignified dining experience, and for 1 of 2 sampled residents (Resident #250) reviewed for urinary collection devices, the facility failed to maintain a urinary collection device for privacy. The findings include: 1. Resident #245's diagnoses included Alzheimer's disease, dementia, and osteoarthritis. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #245 had a Brief Interview of Mental Status (BIMS) score of 00 indicating severe cognitive impairment and required set up/clean up assistance with eating and partial/moderate assistance with transfers and bed mobility. The Dietary Change in Condition Nutrition assessment dated [DATE] identified Resident #245 fed him/herself and needed to be cued to eat with varied meal intakes ranging from 25% to 75%. The Resident Care Plan dated 7/17/25 identified Resident #245 was at risk for unintentional weight loss due to his/her hospice status. Interventions included assisting with meals as needed, monitor diet preferences, and offer substitutions of preferred foods. Review of the meal intake documentation amounts dated 8/25/25 through 9/25/25 indicated intakes varied from 0 to 100%. Observation and interview with Nurse Assistant (NA) #1 on 9/22/25 at 12:20 PM in the dining room identified Resident #245 sitting in a customized wheelchair, parallel to the corner of the kitchen counter with her/his back to the dining area. Ten residents were noted to be sitting at 2 long tables; one was being assisted by a NA. She indicated that Resident #245 was not sitting at the table with the rest of the residents because she had already tried to feed him/her and he/she refused. Additionally, she stated the reason for the separation was that Resident #245 was a puree consistency and would make a mess everywhere if seated at the table(with other residents). An observation on 9/22/25 at 12:31 PM during lunch, identified NA #1 sitting across from Resident #245 assisting him/her to eat. Resident #245 was not placed with other residents at the dining room tables while being assisted and was turned away (not facing) other residents who were still eating. An Observation on 9/24/25 at 12:03 PM during the lunch meal, identified Resident #245 sitting alone in the resident living room underneath the TV (not watching) facing residents in the dining room who were eating. Resident #245 remained in the living room watching other residents dine, did not have food, and was not being assisted. Observation on 9/25/25 at 9:32 AM identified Resident #245 awake, sitting alone in the resident living room, facing residents in the dining room who were eating breakfast. Interview with Licensed Practical Nurse (LPN) #1 on 9/25/25 at 12:15 PM identified Resident #245 did not dine with other residents because he/she needed to be fed to eat. Staff placed him/her alone, in the corner of the dining area while other residents dined and once the other residents had finished, (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	he/she was assisted with his her/meal. LPN #1 indicated that Resident #245 was always placed away from the other residents because he/she did not always want to eat so we didn't want the other residents looking at her and feeling bad thinking that will be them someday, especially since they all used to eat together. Interview with the Director of Nursing (DNS) on 9/25/25 at 12:37 PM identified the facility policy directed the dining experience was all inclusive, and residents who didn't choose to eat in their rooms were served meals in the common kitchen area, and ate at a table, regardless of their diagnoses, mentation, or food consistency. Additionally, she identified that although some residents chose to eat at the kitchen counter, it was not acceptable to have a resident seated by the counter with her/his back facing the tables where other residents were dining. The DNS indicated it was undignified for Resident #245 to be excluded during a dining experience by being placed with their back facing the table where other residents were eating or by placing a resident who was not being served within view of other residents who were eating. The Dining Experience Policy revised 4/15/24, directed in part that all residents will have an enjoyable, dignified and safe dining experience, which includes food items being passed out in a timely manner to each Resident upon arrival of the meal. 2. Resident #250's diagnoses included retention of urine, urinary tract infection, and a pressure ulcer of the sacral region. A physician's order dated 9/3/25 directed to check Resident #250's urinary collection device and provide care every shift. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #250 was cognitively intact and required substantial/maximal assistance for bed mobility, was dependent with toileting and transfers, and failed to indicate indwelling collection device use. The Resident Care Plan (RCP) dated 9/12/25 identified Resident #250 was admitted with an indwelling urinary collection device. Interventions included observing complications, report signs of infection, provide incontinent care, perform hand hygiene, and place on personal protective equipment when providing high contact care. Observations on 9/24/25 at 11:47 AM and 9/25/25 at 11:25 AM identified Resident #250 had his/her door open, was in bed, and the urinary collection bag containing urine was visible from the hall without the benefit of a privacy cover. Observation and interview with Nurse Aide (NA) #4 on 9/26/25 at 1:00 PM identified Resident #250 in his/her room, seated in a wheelchair, with the urinary collection device bag containing urine able to be viewed from the hallway. NA #4 indicated that it was her responsibility to ensure Resident #250's urinary collection bag was covered, but that she did not have a privacy cover available. Subsequent to surveyor inquiry, NA #4 placed a pillowcase over the collection bag and indicated that she would need to speak with her charge nurse about where to obtain a privacy cover. Observation and Interview with Licensed Practical Nurse (LPN) #4 on 9/26/25 at 1:05 PM identified Resident #250 seated in a wheelchair with the urinary collection device collection bag containing urine in view from the hallway. LPN #4 was unsure why Resident #250's urinary collection bag was not maintained for privacy, indicated the urinary collection device bag should always be covered, and (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that the NA was responsible. Subsequent to surveyor inquiry, LPN #4 instructed NA #4 that the pillowcase was inappropriate and that she would need to call and obtain a proper privacy cover for Resident #250's urinary collection device bag. Interview with the Director of Nursing Services (DNS) on 9/26/25 at 1:50 PM identified urinary collection device collection bags should always be covered for privacy, NA's were responsible to ensure urinary collection device bag covers, and that urinary collection device covers were in stock, so she was unable to explain the lack of a privacy cover for Resident #250 collection device bag. Review of facility policy, Urinary Collection device Care, dated 9/2005, directed urinary collection devices are cared for by all Nursing Personnel and to provide privacy. The Resident [NAME] of Rights directed, in part, that you have the right to be treated with respect, consideration and full recognition of your dignity and individuality.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for 1 of 2 sampled residents (Resident #272) reviewed for dignity, the facility failed to meet the requirement to document and retain the resolution to a grievance following an orally expressed concern. The findings included:Resident #272 diagnoses included multiple sclerosis (MS), major depression, functional urinary incontinence and urinary tract infection (UTI). The quarterly Minimum Data Set assessment dated [DATE] identified Resident #272's Brief Mental Status Interview score of 15 indicating intact cognition and was totally dependent on staff for incontinent care, dressing, bathing, and required maximum assistance of 2 staff members for bed mobility. The Resident Care Plan in effect from 9/5/25 through 9/22/25 failed to reflect any concerns with the 11:00 PM to 7:00 AM shift for the provision of incontinent care, answering of a call bell, or resolution to a concern. A physician's order dated 9/3/25 directed assistance from 2 staff members for bed mobility.An interview with Resident #272 on 9/22/25 at 2:30 PM identified that he/she had concerns with NA #11 who worked the 11:00 PM to 7:00 AM shift. He/she did not like the way NA #11 spoke to him/her and described it as demeaning and feeling like he/she was being reprimanded at times. NA #11 did not always answer the call bell timely or did not return timely after the call bell was answered. Resident #272 stated that it made him/her apprehensive to ring for incontinent care when NA #11 was working and that NA #11 provided his/her care alone. A meeting was requested and held with the Director of Nursing Services (DNS); however, the resident could not recall the date. Resident #272 stated they discussed his/her concerns regarding NA #11, and the outcome was that NA #11 could provide his/her care due to being the primary NA on the 11:00 PM to 7:00 AM shift. An interview with the DNS on 9/24/25 at 9:15 AM indicated that a meeting was requested by Resident #272 and held with NA #11 and herself, but she had failed to document the meeting. The DNS indicated that Resident #272 discussed the timeliness of answering the call bell and returning to the room for care after answering the call bell, but she did not recall any discussion regarding the way NA #11 spoke to Resident #272 other than NA #11 was loud. In retrospect, she indicated that she should have documented the meeting since it involved nursing care issues.Interview with NA #11 on 9/29/25 at 8:28 AM identified that she met with Resident #272 and the DNS, could not recall the date, and discussed concerns related to NA waiting for the call bell to be answered and receiving incontinent care. She indicated Resident #272 expressed that she talked too loudly making him/her feel as though he/she was being reprimanded. It was not her intention to reprimand Resident #272, and she may have spoken loudly at times to ensure Resident #272 could hear her. NA #11 stated she continued to provide care to Resident #272 on the 11:00 PM to 7:00 AM shift.Interview with the Administrator on 9/29/25 at 12:15 PM indicated that he was aware of the meeting that took place with Resident #272, the DNS, and NA #11 but was unsure of date. The Administrator stated he was unsure why there was no documentation related to the investigation and conclusion and that it was unintentionally overlooked.The Director of Post Acute Services verified on 9/30/25 at 1:26 PM that a meeting did take place with Resident #272, the DNS and NA #11 on 9/10/25 but there was no documentation related to the meeting. A review of the Grievance Policy dated 11/10/24 directed, in part, all complaints, problems and/or grievances will be investigated by social services/nursing in a timely manner. The facility will promote the grievance process throughout the organization. This includes notifying residents of their rights related to grievances as well as educating all those affected by potential grievances or concerns on the facility grievance process. The facility will strive for prompt resolution outcome for all grievances or complaints.

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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 review of the clinical record, facility documentation, facility policy, and interviews for 1 of 2 sampled residents (Resident #272) reviewed for dignity, the facility failed to ensure 2 allegations of neglect occurring on 8/25/25 and 9/8/25, were reported to the State Agency (SA). The findings include:Resident #272 diagnoses included multiple sclerosis, major depression, functional urinary incontinence and Urinary Tract Infection (UTI). The quarterly Minimum Data Set assessment (MDS) dated [DATE] identified Resident #272 was cognitively intact with a Brief Mental Status Interview (BIMS) score of 15 and was totally dependent on staff for incontinent care, dressing, bathing, and required maximum assistance of 2 staff for bed mobility. The Resident Care Plan dated 7/16/25 identified urinary incontinence with interventions that included incontinent care every 2 to 3 hours, apply barrier cream, perform skin assessments during daily care, nurses perform weekly skin assessments, and notify the physician for signs of a UTI.A nursing note written by Licensed Practical Nurse (LPN) #5 dated 8/25/25 at 1:07 PM identified Resident #272 reported to her that he/she had not been offered assistance and did not receive incontinent care on the previous 11:00 PM to 7:00 AM shift (8/24/25 into 8/25/25), and staff had not answered his/her call bell. Resident #272's responsible party was aware. The nursing supervisor Registered Nurse (RN) #4) was notified and went to speak with Resident #272 to address his/her concerns. A review of nursing documentation, from 8/23/25 through 8/27/25 failed to include written documentation by RN #4 of an assessment or any information for Resident #272's allegation of neglect. An interview and review of the clinical record with RN #4 on 9/26/25 at 2:15 PM identified that she was aware of the nurses note dated 8/25/25 written by LPN #5. When she saw Resident #272 the resident made his/her allegation of neglect known and indicated that his/her brief was wet. RN #4 stated that she made the ADNS aware but failed to document the concern or perform a skin assessment for incontinence skin damage, indicating a skin check was due to occur on a subsequent shift. Although RN #4 indicated it was a good practice to assess and document Resident #272's information based on the information given to her, she was unable to state the facility policy for documentation on allegations of neglect/Reportable Events.b. A nursing note dated 9/8/25 at 4:35 PM written by LPN #5 identified that Resident #272 expressed a concern that he/she did not receive incontinent care on 9/7/25 into 9/8/25 on the 11:00 PM to 7:00 AM shift. LPN #5 immediately notified the nursing supervisor of the concern. A physician's note signed 9/11/25 for a visit on 9/9/25 identified Resident #272 had a conflict with the third shift Nurse Aid (NA). Resident #272 did not ask for assistance for incontinent care when he/she had been incontinent, and the NA never went to check on him/her or offer to provide incontinent care. Resident #272 requested an extra absorbent pad on the bed to catch the overflow of urine and waited 12 hours between shifts for the provision of incontinent care. An interview with the Director of Nursing (DNS) on 9/25/25 at 11:00 AM identified that she was away on 8/25/25 when the allegation occurred and was never made aware, however, the allegation should have been brought to the attention of the Assistant Director of Nursing (ADNS). Additionally, she was aware of the allegation of neglect occurring on 9/7/25 into 9/8/25 on the 11:00 PM to 7:00 AM shift. According to the facility abuse policy, reporting the allegations to the SA should have taken place per the facility policy, and that she and the ADNS were responsible for reporting requirements. An interview with the ADNS on 9/25/25 at 1:15 PM identified that she was aware of Resident #272's allegation made on 8/25/25 but could not locate any documentation related to the incident. The ADNS stated she recalled speaking to Resident #272 but could not provide any documentation as to whether the concerns were addressed or reported. The ADNS indicated that any allegation of neglect should be reported per the policy and was unable to explain why she had not completed a Reportable Event form or reported Resident #272's allegation of neglect to the State Agency. Interview with NA #11 on 9/29/25 at 8:28 AM indicated that (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she met with Resident #272 and the DNS but could not recall the date. Resident #272 had been concerned that he/she sometimes had to wait to have the call bell answered or when answered he/she had to wait for her to come back because she was attending to another resident. NA #11 stated the resident thought that she talked too loudly which made him/her feel as though he/she was being reprimanded. Further, she had always provided incontinent care to Resident #272 and had never failed to provide incontinent care when she was assigned to Resident #272.Interview with LPN #6 on 9/29/25 at 8:45AM identified that she was Resident #272's charge nurse on 9/7/25 into 9/8/25 on the 11:00 PM to 7:00 AM shift. She was not made aware of any allegation by Resident #272 that he/she did not receive incontinent care. LPN #6 stated that Resident #272 did not want NA #11 to provide care to him/her and a NA from another unit needed to come over to the unit to help. Interview with RN #9 on 9/29/25 at 9:09 AM identified that she was the supervisor on 9/7/25 into 9/8/25 on the 11:00 PM to 7:00 AM shift. RN #9 indicated that she did not recall any allegations of neglect reported by Resident #272 or staff that the facility failed to provide incontinent care to the resident.Interview with RN #6 on 9/29/25 at 9:50 AM indicated she was the RN supervisor on 9/8/25 on the 7:00 AM to 3:00 PM shift and had not received any reports of Resident #272 failing to receive incontinent care on 9/7/25 into 9/8/25 on the 11:00 PM to 7:00 AM shift. RN #6 indicated if she was made aware she would have initiated an investigation, interviewed and assessed Resident #272, contacted the NA and nurse that worked on 9/7/25 into 9/8/25 on the 11:00 PM to 7:00 AM shift, and reported the allegation to the DNS or ADNS. RN #6 indicated if Resident #272 had reported an allegation of neglect, the facility policy directed reporting to the State Agency. Interview and review of the clinical record with APRN #1 on 9/29/25 at 9:55 AM identified she was aware of the allegation of neglect for the failure to provide incontinent care on 9/7/25 into 9/8/25 on the 11:00 PM to 7:00 AM shift as reported by Resident #272 during his/her visit on 9/8/25. APRN #1 stated she documented in her note and immediately reported the concern to the DNS. A review of APRN #1's note date 9/9/25 at 7:47 AM indicated that the resident had concerns related to overnight care, particularly being changed during the night, and that she informed both nursing staff and the DNS. Interview with the Administrator on 9/29/25 at 12:15 PM indicated that the 2 allegations of neglect should have been reported per the facility policy. The Administrator indicated that there were many concerns related to Resident #272 and somehow it just got overlooked. The Administrator indicated that it was his responsibility along with the DNS to ensure the Abuse policy for the reporting requirement was followed.A review of the Abuse Policy dated 5/1/24 directed, in part, that the alleged allegation will be reported to the Connecticut Department of Public Health immediately but no later than 2 hours.

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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 review of clinical records, facility documentation, facility policy, and interviews for 1 of 2 sampled residents (Resident #272) reviewed for dignity, the facility failed to ensure 2 allegations of neglect occurring on 8/25/25 and 9/8/25, were investigated. The findings include:Resident #272 diagnoses included multiple sclerosis, major depression, functional urinary incontinence and Urinary Tract Infection (UTI). The quarterly Minimum Data Set assessment (MDS) dated [DATE] identified Resident #272 was cognitively intact with a Brief Mental Status Interview (BIMS) score of 15 and was totally dependent on staff for incontinent care, dressing, bathing, and required maximum assistance of 2 staff for bed mobility. The Resident Care Plan dated 7/16/25 identified urinary incontinence with interventions that included incontinent care every 2 to 3 hours, apply barrier cream, perform skin assessments during daily care, nurses perform weekly skin assessments, and notify the physician for signs of a UTI.A nursing note written by Licensed Practical Nurse (LPN) #5 dated 8/25/25 at 1:07 PM identified Resident #272 reported to her that he/she had not been offered assistance and did not receive incontinent care on the previous 11:00 PM to 7:00 AM shift (8/24/25 into 8/25/25), and staff had not answered his/her call bell. Resident #272's responsible party was aware. The nursing supervisor Registered Nurse (RN) #4) was notified and went to speak with Resident #272 to address his/her concerns. A review of nursing documentation, from 8/23/25 through 8/27/25 failed to include written documentation by RN #4 of an assessment or any information for Resident #272's allegation of neglect. An interview and review of the clinical record with RN #4 on 9/26/25 at 2:15 PM identified that she was aware of the nurses note dated 8/25/25 written by LPN #5. When she saw Resident #272 the resident made his/her allegation of neglect known and indicated that his/her brief was wet. RN #4 stated that she made the ADNS aware but failed to document the concern or perform a skin assessment for incontinence skin damage, indicating a skin check was due to occur on a subsequent shift. Although RN #4 indicated it was a good practice to assess and document Resident #272's information based on the information given to her, she was unable to state the facility policy for documentation on allegations of neglect/Reportable Events.b. A nursing note dated 9/8/25 at 4:35 PM written by LPN #5 identified that Resident #272 expressed a concern that he/she did not receive incontinent care on 9/7/25 into 9/8/25 on the 11:00 PM to 7:00 AM shift. LPN #5 immediately notified the nursing supervisor of the concern. A physician's note signed 9/11/25 for a visit on 9/9/25 identified Resident #272 had a conflict with the third shift Nurse Aid (NA). Resident #272 did not ask for assistance for incontinent care when he/she had been incontinent, and the NA never went to check on him/her or offer to provide incontinent care. Resident #272 requested an extra absorbent pad on the bed to catch the overflow of urine and waited 12 hours between shifts for the provision of incontinent care. An interview with the Director of Nursing (DNS) on 9/25/25 at 11:00 AM identified that she was away on 8/25/25 when the allegation occurred and was never made aware, however, the allegation should have been brought to the attention of the Assistant Director of Nursing (ADNS). Additionally, she was aware of the allegation of neglect occurring on 9/7/25 into 9/8/25 on the 11:00 PM to 7:00 AM shift. According to the facility abuse policy, an investigation should have taken place per the facility policy, and that she and the ADNS were responsible for investigating allegations of neglect. An interview with the ADNS on 9/25/25 at 1:15 PM identified that she was aware of Resident #272's allegation made on 8/25/25 but could not locate any documentation related to the incident. The ADNS stated she recalled speaking to Resident #272 but could not provide any documentation as to whether the concerns were addressed or reported. The ADNS indicated that any allegation of neglect should be investigated per the policy and was unable to explain why she had not begun an investigation into Resident #272's allegation of neglect to the State Agency. Interview with NA #11 on 9/29/25 at 8:28 AM indicated that she met with Resident #272 and the DNS but could not recall the date. Resident #272 had been concerned that he/she sometimes had to wait to have the call bell (continued on next page)

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Mozaic Senior Life	4200 Park Avenue Bridgeport, CT 06604

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	answered or when answered he/she had to wait for her to come back because she was attending to another resident. NA #11 stated the resident thought that she talked too loudly which made him/her feel as though he/she was being reprimanded. Further, she had always provided incontinent care to Resident #272 and had never failed to provide incontinent care when she was assigned to Resident #272.Interview with LPN #6 on 9/29/25 at 8:45AM identified that she was Resident #272's charge nurse on 9/7/25 into 9/8/25 on the 11:00 PM to 7:00 AM shift. She was not made aware of any allegation by Resident #272 that he/she did not receive incontinent care. LPN #6 stated that Resident #272 did not want NA #11 to provide care to him/her and a NA from another unit needed to come over to the unit to help. Interview with RN #9 on 9/29/25 at 9:09 AM identified that she was the supervisor on 9/7/25 into 9/8/25 on the 11:00 PM to 7:00 AM shift. RN #9 indicated that she did not recall any allegations of neglect reported by Resident #272 or staff that the facility failed to provide incontinent care to the resident.Interview with RN #6 on 9/29/25 at 9:50 AM indicated she was the RN supervisor on 9/8/25 on the 7:00 AM to 3:00 PM shift and had not received any reports of Resident #272 failing to receive incontinent care on 9/7/25 into 9/8/25 on the 11:00 PM to 7:00 AM shift. RN #6 indicated if she was made aware she would have initiated an investigation, interviewed and assessed Resident #272, contacted the NA and nurse that worked on 9/7/25 into 9/8/25 on the 11:00 PM to 7:00 AM shift, and reported the allegation to the DNS or ADNS. RN #6 indicated if Resident #272 had reported an allegation of neglect, the facility policy directed conducting an investigation. Interview and review of the clinical record with APRN #1 on 9/29/25 at 9:55 AM identified she was aware of the allegation of neglect for the failure to provide incontinent care on 9/7/25 into 9/8/25 on the 11:00 PM to 7:00 AM shift as reported by Resident #272 during his/her visit on 9/8/25. APRN #1 stated she documented in her note and immediately reported the concern to the DNS. A review of APRN #1's note date 9/9/25 at 7:47 AM indicated that the resident had concerns related to overnight care, particularly being changed during the night, and that she informed both nursing staff and the DNS. Interview with the Administrator on 9/29/25 at 12:15 PM indicated that the 2 allegations of neglect should have been investigated per the facility policy. The Administrator indicated that there were many concerns related to Resident #272 and somehow it just got overlooked. The Administrator indicated that it was his responsibility along with the DNS to ensure the Abuse policy for investigations was followed.A review of the Abuse Policy dated 5/1/24 directed, in part, that the allegations of neglect will be investigated.

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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** Based on interviews, review of the clinical record, and policy for 1 of 5 residents (Resident #157) reviewed for nutrition, for the only sampled resident (Resident #259) reviewed for mood and behavior, and the only sampled resident (Resident #272) reviewed for care planning, the facility failed to follow the Resident Care Plan. The findings include: 1. Resident #157's diagnoses included Alzheimer's disease, depression, and anxiety. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #157 was severely cognitively impaired, required substantial, maximal assistance for transfers, and bathing, was independent with eating, and weighed 111 pounds. The Resident Care Plan (RCP) in effect from 4/8/25 through 9/25/25 identified Resident #157 as at risk for unintended weight loss related to dementia and depression, due to variable intakes. Interventions included to record percentage of meals consumed, monitor weight as ordered, report significant changes in weight to the registered dietician, and physician, and provide the diet as ordered. Review of the vital sign reports identified Resident #157's weight on 4/1/25 was 110.8 pounds and on 9/22/25 Resident #157 weighed 97.4 pounds [a 13.4-pound (lb.) loss]. a. A physician's order dated 7/7/25 directed to give 4-ounces of nutritional shake and document the percent consumed daily. Review of the Medication Administration Record (MAR) dated 7/1/25 through 9/26/25 directed to administer a nutritional supplement daily at 2:00 PM but failed to include the physician order for documentation of the percentage of supplement taken by Resident #157. b. Review of the meal consumption amounts in the vital sign record identified from 5/15/25 to 9/25/25, 402 meals were served consisting of breakfast, lunch, and dinner over a 134 day period. The facility failed to document the percentage of meals Resident #157 ate 149 times. 2. Resident #259's diagnoses included Parkinson's disease, dementia, and hypertension. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #259 was severely cognitively impaired and required substantial maximal assistance for transfers, personal and oral hygiene, was dependent for eating, and bathing, and weighed 139 pounds. The Resident Care Plan (RCP) dated 4/25/35 through 9/26/25 identified inadequate oral intake related to alterations in appetite secondary to covid 19. Interventions included to record percentage of meals consumed, provide diet as ordered, and assist with meals as needed. Review of meal consumption amounts in the vital sign record identified that from 4/23/25 through 9/26/25, a total of 471 meals consisting of breakfast, lunch, and dinner were served for a period of 157 days. Out of 471 meals, the facility failed to document the percentage of food Resident #157 ate 167 times. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Dietician Manager on 9/25/2025 at 11:04 AM identified, per the Resident Care Plan and standards of practice, every meal served to Resident #157 and Resident #259 should have had the percentage eaten recorded in the clinical record. Additionally, for Resident #157, according to the physician's order dated 7/7/25, the percentages of the nutritional shake intake should have been recorded on the Medication Administration Record but had not been. The Dietician Manager indicated that nursing staff were responsible for the documentation. Interview with the Director of Nursing Services (DNS) on 9/26/25 at 10:31 AM identified that that percentages of meal consumption were not being thoroughly documented and that the Nurse Aids (NA)were responsible. The DNS indicated that education was provided to the NAs regarding documentation of percentage of meal consumption to ensure the task was completed. Interview with NA #3 on 9/26/25 at 12:12 PM identified she was responsible for documenting meal consumption amounts after every meal. Although requested, a facility policy for NA documentation of meal consumption was not provided. 3. Resident #272 diagnosis included multiple sclerosis, major depression, functional urinary incontinence and urinary tract infection. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #272 had a Brief Mental Status Interview score of 15 and was cognitively intact. Resident #272 was totally dependent on staff for incontinent care, dressing, bathing and required maximum assistance of 2 staff for bed mobility. The Resident Care Plan dated in effect from 9/5/25 through 9/29/25 identified accusatory behaviors with interventions that included administering medications as ordered, follow-up with psychiatric services, and provide 2 staff with care due to behaviors. In addition, the Resident Care Plan directed that Resident #272 required 2 staff members to assist with bed mobility. Physician's order in effect from 9/5/25 through 9/29/25 directed the assistance of 2 staff members for bed mobility. Interview with Resident #272 on 9/25/25 at 10:15 AM identified that 2 staff members do not always provide care to him/her. Resident #272 indicated that this occurred on all 3 shifts and most of the time incontinent care and his/her bed bath were provided by 1 Nurse Aid (NA) in the room. Observations on 9/26/25 of NA #5 at 10:45 AM and 1:15 PM identified she provided Resident #272 with a full bed bath at 10:45 AM without the assistance of another staff member. NA #5 provided an incontinent check for Resident #272 at 1:15 PM without the benefit of another staff member. In an interview and review of Resident #272's Resident Care Card (directs NA how to provide care) with NA #5 on 9/26/25 at 1:25 PM she identified that according to the Resident Care Card; Resident #272 required 2 staff members for bed mobility and due to accusatory behaviors. NA #5 was unable to explain why she did not have another staff member assist her with Resident #272, but according to the Resident Care Card she should have. Interview and review of Resident #272's care plan with the Resident Care Coordinator (RN #3) on 9/26/25 at 1:30 PM identified that Resident #272 required 2 staff members for care related to (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	accusatory behaviors and for bed mobility. RN #3 indicated that it was nursing's responsibility to ensure the plan of care was followed. RN #3 could not explain why staff did not follow Resident #272's plan of care as it was the policy of the facility to do so. Interview and review of facility documentation with Licensed Practical Nurse (LPN) #6, who worked the 11:00 to 7:00 AM shift, on 9/29/25 at 8:45 AM stated Resident #272 required the assistance of 1 staff member for his/her incontinent care and was unaware that Resident #272 was care planned for 2 staff members for care and accusatory behaviors. A review of the Comprehensive Care Plan Policy dated 5/14/25 directed, in part, that the care plan be implemented as a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and all services that are identified in the resident's comprehensive assessment and meet professional standards of quality. The care plan process will be ongoing. Resident specific interventions will reflect the resident's needs and preferences and align with the resident's cultural identity, as indicated. Qualified staff who are responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, interviews, and facility policy for the only sampled resident (Resident #272) reviewed for resident care planning, the facility failed to ensure the Resident Care Plan was updated when there were allegations of neglect. The findings include:Resident #272 diagnoses included multiple sclerosis, major depression, functional urinary incontinence, and Urinary Tract Infection. The quarterly Minimum Data Set assessment (MDS) dated [DATE] identified Resident #272 had a Brief Mental Status Interview (BIMS) score of 15 indicating he/she was cognitively intact, and was totally dependent on staff for incontinent care, dressing, bathing, and required maximum assistance of 2 staff for bed mobility. The Resident Care Plan in effect from 7/16/25 through 9/26/25 and plan of care failed to reflect 2 allegations of neglect for the lack of incontinent care occurring on 8/24/25 and 9/7/25.A nursing note written by LPN #5 (who worked the 7:00 AM to 3:00 PM shift) dated 8/25/25 at 1:07 PM identified Resident #272 reported to her that he/she had not been offered assistance and did not receive incontinent care on the previous 11:00 PM to 7:00 AM shift (8/24/25 into 8/25/25), and staff had not answered his/her call bell. Resident #272's responsible party was aware. The nursing supervisor (RN #4) was notified and went to speak to Resident #272 to address his/her concerns. A nursing note dated 9/8/25 at 4:35 PM written by LPN #5 identified that Resident #272 expressed a concern that he/she did not receive incontinent care on 9/7/25 into 9/8/25 on the 11:00 PM to 7:00 AM shift. LPN #5 immediately notified the nursing supervisor of the concern. Interview and review of Resident #272's Resident Care Plan with Resident Care Coordinator (RN #3) on 9/26/25 at 1:30 PM identified that she was not made aware of any allegations of neglect or concerns related to incontinent care on 11:00 PM to 7:00 AM shift. RN #3 stated she would have updated the Resident Care Plan had she been made aware and that nursing or the social workers were also responsible to ensure the Resident Care Plan was updated when allegations of neglect occurred. RN #3 indicated the facility policy was to update the Resident Care Plan timely and was unable to explain why the other disciplines who were responsible had not completed the update for Resident #272's Resident Care Plan. The Comprehensive Care Plan Policy dated 5/14/25 directed, in part, that the care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment, and as needed.

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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 observations, review of the clinical record, facility policy, and interviews for 1 of 2 residents (Resident #125) reviewed for accidents and hazards, the facility failed to follow physician's orders for a resident with a known behavioral issue. The findings include:Resident #125's diagnoses included Alzheimer's disease, anxiety, and epilepsy.A physician order in effect on 9/22/25 directed staff to follow the Resident Care Plan (RCP) as outlined.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #125 had a Brief Interview of Mental Status (BIMS) score of 0 indicating severely impaired cognition, exhibited verbal and physical symptoms directed towards others 4 to 6 days a week, and was dependent on staff for personal hygiene, dressing, and with chair/bed-to-chair transfers.The Resident Care Plan in effect on 9/22/25 identified Resident #125 was at risk for an activity of daily living problem due to the resident being observed throwing silverware across the table towards another resident. Interventions included Resident #125 was to be provided with plastic silverware from the dietary staff to prevent injuries.The Resident Care Card (NA care directive) in effect on 9/22/25 identified that plastic utensils were to be used at mealtimes for Resident #125.Observation on 9/22/25 at 11:57 AM identified Resident #125 was sitting in the dining room. He/she was in possession of a metal spoon and metal fork and using the metal spoon to eat ice cream.Observation and interview on 9/25/25 at 12:25 PM with Nurse Aide (NA) # 6, who was sitting at the dining room table with Resident #125, identified that Resident #125 was eating spaghetti with a metal fork and did not have plastic silverware. NA # 6 indicated that she was aware that he/she should be eating with plastic and not with metal silverware, stating that homemakers were responsible for setting the table with the correct type of silverware. NA #6 failed to remove his/her metal silverware after surveyor inquiry. Observation and interview on 9/25/2025 at 12:30 PM of Resident #125 with Homemaker #1 identified he/she was eating food with metal silverware. Homemaker #1 indicated she was the person who set the table for meal service, was aware Resident #125 needed plastic silverware because he/she had a history of throwing silverware at other residents and stated the resident must have reached across the table and taken another resident's silverware. Plastic silverware was not observed on Resident #125's table. The only 2 Residents dining at the table with Resident #125 were noted to have and be using metal silverware. Subsequent to surveyor inquiry, Homemaker #1 removed the residents metal silverware and provided Resident #125 with plastic silverware which had been obtained from behind the dining serving station. An interview with the Director of Nursing Services (DNS) on 9/26/2025 at 11:00 AM identified the expectation for staff was to follow all provider orders and the Resident Care Plan. Resident #125 had to use plastic silverware because he/she had a history of throwing silverware at other residents, and that the nurses, nurse aides, and homemakers were all responsible to ensure the correct silverware was provided and that Resident #125 should have been given plastic silverware.Review of the facility's Dining Experience policy failed to include distribution of adaptive equipment or special utensils for eating or setting tables in the Resident Dining Room.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, facility documentation, facility policy, and interviews for 1 of 3 residents (Resident #21) reviewed for pressure ulcers, the facility failed to complete a timely Registered Nurse (RN) assessment of a pressure ulcer, failed to clarify and follow a physician order for pressure ulcer treatment, and failed to ensure the appropriate air mattress pressure setting according to the Resident Care Plan (RCP). The findings include:Resident #21 had diagnoses that included Alzheimer's disease (dementia), pulmonary fibrosis, and heart failure.A quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #21 was severely cognitively impaired, was at risk for developing pressure ulcers, used a wheelchair, and was dependent for bed mobility and transfers with no noted current pressure ulcers.The Resident Care Plan (RCP) dated 11/21/24 identified Resident #21 had a potential for alteration in skin integrity related to the need for staff assistance with positioning, and incontinence of bowel and bladder. Interventions included offload heels (remove pressure), and observe skin for signs/symptoms of redness, irritation, or breakdown weekly and with care, report irregularities to the nurse/physician.a. Licensed Practical Nurse (LPN) #9's progress note dated 11/29/24 at 8:24 AM identified an open area was observed on the right buttock which measured 5.0 centimeters (cm) length by 4.0 cm width by 0.1 cm depth (5.0 x 4.0 x 0.1 cm). The note identified the open area connected to a darkened area at the coccyx but did not indicate darkened area measurements. Barrier cream was applied for protection, and the Advanced Practice Registered Nurse (APRN) and responsible party were notified. The note failed to include notification of an in-house Registered Nurse (RN) Supervisor or the wound nurse.A physician order dated 11/30/24 directed to apply Zinc Oxide 20% to gluteal/sacral area every shift after care. Interview with LPN #7 on 9/25/25 at 2:15 PM identified that she was the nurse on 11/30/24 and was not on duty 11/29/24. LPN #7 indicated that she could not find a completed pressure ulcer packet from 11/29/24, and that was why she completed one on 11/30/24. Further, LPN#7 indicated that for any resident who developed a new pressure ulcer, the facility policy directed a pressure ulcer packet be completed as well as notification of the nursing supervisor, physician, family, and wound nurse. Interview and clinical record review with Wound Certified Registered Nurse, (RN) #2, on 9/25/25 at 3:05 PM identified when a new open area was found the policy required the nurse to complete a skin assessment, fill out a pressure ulcer packet, and give the information to the RN who would then write a nursing note and sign off the assessment as completed by the charge nurse. The clinical record failed to identify an RN assessment had been completed until 11/30/24 at 9:58 AM (24 hours after onset). The 11/30/24 assessment identified Resident #21 had a deep tissue pressure ulcer (localized tissue damage from prolonged pressure or shear) to the left gluteal/sacral area (a discrepancy from LPN #9's documentation of a right buttock open area). The area was noted to be 5.0 cm x 8.0 cm x less than 0.1 cm. and the tissue was characterized as an intact maroon discoloration.Interview with the Director of Nursing Services (DNS) on 9/29/25 at 10:50 AM indicated upon discovery of a new wound, the charge nurse was to fill out a pressure ulcer packet and document the findings in the clinical record. She identified if the wound nurse was not available at the time of discovery, the RN Supervisor should have been asked to assess Resident #21's wound and would have documented the assessment in a progress on 11/29/24 (the day of discovery). The DNS was unable to identify why facility staff had not ensured documentation of an assessment or a nurse's note by a Registered Nurse until 11/30/34.b. A physician order dated 9/18/25 directed treatment to the left gluteal wound as cleanse wound with normal saline or wound cleanser and pat dry, pack with MeSalt (used for absorption, cleansing, and healing) and cover with a dry clean dressing daily and as needed. Additionally, apply miconazole (antifungal) 2% cream, topically to the gluteal area daily, do not apply onto the gluteal wound. The order did not specify which area of the gluteal wound the medication was to be applied. Observation of Resident #21's wound care and interview with RN #2 and Physician #1 (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on 9/25/25 at 9:15 AM identified Physician #1 indicated a Stage 4 pressure ulcer that had a fungal rash to the peri-wound (periphery) caused by the wound drainage with a treatment order in place for miconazole cream to the affected area. RN #2 was observed to cleanse the wound on the left buttock, pack the open area with Mesalt, then applied a dry clean dressing covering the wound. RN #2 failed to apply miconazole to the peri-wound prior to placing the dry clean dressing and indicated that the girls would apply it later when performing incontinent care. RN #2 was unable to explain how the girls would apply the miconazole cream to Resident #21's peri-wound without removing the dressing.Observation and interview with RN #2 on 9/25/25 at 9:35 AM identified that the miconazole should have been applied to Resident #21's peri-wound prior to the application of the dry clean dressing and that the miconazole was in the clinical record as a separate order, not part of the MeSalt treatment order. RN #2 was unable to identify how the nurses would know to apply the miconazole during the dressing change. c. The Resident Care Plan (RCP) dated 7/17/25 identified Resident #21 had an alteration in skin integrity related to a left gluteal stage 4 pressure ulcer. Interventions included offloading (pressure relief), turn and position frequently, and check the placement and function of the group 2 low air loss mattress set to alternating therapy every shift.Review of the clinical record failed to identify a physician order for the placement and/or monitoring of the low air loss mattress for Resident #21.Periodic observations throughout the day of Resident #21 on 9/25/25 from 8:34 AM through 3:30 PM identified Resident #21 was lying on his/her back, in bed. The air mattress was observed to be functioning, and the lights indicated the low air loss mattress was set to static and firm (number 8 the highest setting). Interview with LPN #7 on 9/25/25 at 2:25 PM identified a resident with an air mattress in place should have an order in the clinical record for the nurse to sign off (indicating observed use). LPN #7 identified physician orders did not include resident specific settings for an air mattress and that when signing off the air mattress on the Treatment Administration Record, she was only signing that the mattress was in place and functioning (by pressing on and ensuring the bed frame could not be felt, bottoming out). She indicated it was not her responsibility to monitor specific settings. Interview with RN #2 on 9/25/25 at 3:05 PM identified air mattresses were put in place for residents who had a Stage 2 or greater pressure ulcer and that settings for air mattresses were not the same for all residents. RN #2 identified that the preferred setting for an air mattress was to the resident's comfort level and alternating, adding that as long as the air mattress wasn't bottoming out it was satisfactory. When he put air mattress orders into the clinical record, he would enter the order as group 2 low air loss mattress set to alternating therapy. RN #2 identified the facility owned their own air mattress, but there was more than one model which made it difficult to include the resident specific pump settings within the order so the nurses would not see the specific settings beyond alternating therapy. The responsibility for ensuring air mattress settings were correct was his, and there should not be air mattresses set to a static firm setting. RN #2 indicated if the resident was turned and positioned every 2 hours a static firm mattress setting on the air mattress wouldn't cause actual harm, it just wouldn't provide the optimal level of therapeutic benefit. Interview, record review and observation with RN #2 on 9/25/25 at 3:30 PM identified Resident #21 was lying in bed with the air mattress pump set on static and firm (setting at 8). RN #2 identified that the air mattress should not be set at the firmest setting, nor on static, and subsequently adjusted the settings to alternating and medium (setting at 5). He was unable to identify how settings became set to static and firm and was unable to identify how long the settings had been incorrect. RN #2 further identified there should be a physician order for a group 2 air mattress set to alternating therapy, but he was unable to identify why Resident #21's order was missing. RN #2 noted that alternating was part of the RCP. Interview with the Maintenance Supervisor on 9/29/25 at 10:20 AM identified he set up the air mattresses on the units after receiving a call from the nurse or a work order in the computer. He did not know what the mattresses were supposed to be set to, all mattresses he installed were set to medium, and the nurses were responsible for any adjustments.Interview with Director of Nursing Services (DNS) and RN #2 on 9/29/25 at 11:15 AM (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	identified RN #2 did not routinely check air mattress settings after air the mattress was provided to a resident, unless the resident was obese. RN #2 identified he did not direct the settings for air mattresses to the Maintenance Department.Interview with Physician #1 on 9/29/25 at 11:58 AM identified Resident #21 had a stage 4 pressure ulcer which required placement of an air mattress to provide pressure relief and offloading of the wound. Physician #1 identified that if Resident #21's air mattress was set to firm and static, this could contribute to delayed healing as the standard of practice for air mattress settings was by the resident's weight, and that alternating pressure settings were the best for providing maximum pressure relief.Review of the Pressure Ulcer-Stage IV policy directed, in part, a skin inspection will be conducted each time a resident is bathed and when care is provided with special attention given to bony prominences, and the nurse should be notified of an observed changes in the skin (redness, rash, irritation, break in the skin). Further, a pressure relieving air mattress will be placed on the resident's bed and to avoid positioning the resident on the Stage IV ulcer site.Review of the Use of Support Surfaces policy directed, in part, that support services will be utilized in accordance with physician orders and manufacturer recommendations. The policy directed, for powered devices, or those requiring air, the licensed nurse will check each shift and as needed for proper functioning and/or inflation. The effectiveness of support surfaces will be monitored through ongoing assessment of the resident and/or wound such as lack of progression towards healing or changes in wound characteristics.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for the only sampled resident (Resident #228) reviewed for change in condition, the facility failed to prevent a significant (designation based on accepted clinical standards of practice without regard to the status of the resident) medication error for a resident with a transdermal narcotic medication. The findings include:Resident #228 had diagnoses that included progressive neuropathy, asthma, and chronic pain syndrome.A quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #228 was cognitively intact, required supervision or touching assistance with eating, and substantial/maximal assistance with bed mobility and transfers, and received opioid pain medication. The Resident Care Plan (RCP) dated 4/24/25 identified Resident #228 had a diagnosis of chronic pain. Interventions included to update the physician with new or increased pain, administer medications per current physician orders, and to observe and record any complaints of pain.A physician order signed 5/23/25 directed to check for fentanyl patch placement every shift. A physician order dated 5/30/25 directed for a fentanyl patch 25 micrograms/hour (mcg/hr.), apply 1 patch transdermally (to the skin) and a separate order for fentanyl patch 12.5 mcg/hr. provide a total dose of 37.5 mcg/hr. for chronic pain syndrome every 72 hours (3 days) and remove the old patch with each application.A nursing note by Licensed Practical Nurse (LPN) #8 on 6/8/25 at 4:54 PM identified a new fentanyl patch was placed to the left upper arm. The note failed to identify the dosage of the fentanyl patch and/or the number of fentanyl patches in place on the left upper arm.A nursing note dated 6/8/25 at 10:58 PM identified Resident #228 had a fentanyl patch in place to the left upper arm. A nursing note dated 6/9/25 at 7:53 AM identified a total of 75 mcg/hr. doses (double the dose of the physician order for 37.5 mcg/hr.), was removed from Resident #228 and the on-call Advanced Practice Registered Nurse (APRN) was notified. Resident #228's temperature was 97.5 (normal 97.8 degrees Fahrenheit to 99.1 degrees F.), respirations 18 (normal 12 to 18), heart rate 69 (normal 60 to 100) blood pressure was 109/64 (normal 90/60 to 120/80), and oxygen 94% (normal 95% to 100%) on room air. New physician orders were received for the correct application of a fentanyl patch (37.5 mcg/hr.), recheck the vital signs at 10:00 AM, and have Resident #228's APRN follow-up.A nursing note dated 6/9/25 at 8:23 AM identified the correct dose of fentanyl was applied to Resident #228 (1 fentanyl patch 25 mcg/hr. and 1 fentanyl patch 12.5 mcg/hr. patch) for a total of fentanyl patch 37.5 mcg/hr. to the right upper arm. Resident #228's APRN was in to see him/her with no new orders given, and a notification call was placed to the responsible party.A Reportable Event Form dated 6/9/25 identified at 7:20 AM on 6/9/25 (3) fentanyl 25 mcg/hr. patches were observed on Resident #228's left upper arm and that the order was for the application of fentanyl patches to equal 37.5 mcg/hr. patch every 72 hours. The on-call APRN was notified and a return call from the responsible party was pending.Vital signs obtained on 6/9/25 at 11:11 AM identified Resident #228's temperature was 98.2 F, respirations were 18, heart rate was 60, blood pressure was 114/71)Review of the Medication Administration Record (MAR) dated 6/8/25 identified LPN #8 signed off the order to check fentanyl patch placement. Both the fentanyl patch 25 micrograms/hour (mcg/hr.), and 12.5 mcg/hr. orders totaling 37.5 mcg./hr. had been signed off by LPN #8 as administered to Resident #228's on 6/8/25 and placed on the right upper arm, as well as the removal of the old patches from the left upper arm. A Record of Written Discussion dated 6/10/25 identified LPN #8 was provided written action for the failure to follow the 5 rights of administering medications. A written explanation by LPN #8 indicated she did not realize that she inadvertently placed 3 fentanyl 25 mcg/hr. (25 x 3 = 75 mcg/hr.) patches instead of 3 fentanyl 12.5 mcg/hr. (12.5 x 3 = 37.5 mcg/hr.) patches and would administer medications going forward using the 5 rights of medication administration. Interview with Director of Nursing Services (DNS) on 9/29/25 at 10:50 AM identified she had met with LPN #8 regarding the medication error and LPN #8 had inadvertently placed the wrong dosage of fentanyl patches on Resident #228. The DNS identified (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that she did not consider the error to be a significant medication error due to no harm had occurred and therefore there was no adverse outcome. Further, the DNS identified LPN #8 had received education.Interview with Pharmacy Regional Director on 9/29/25 at 12:48 PM identified after application of a fentanyl patch it took 12 to 24 hours for the level of medication in the blood to reach a level of efficacy. The Pharmacy Director identified that after a fentanyl patch was removed it took 20-27 hours for 50% of the medication to be eliminated further identified there was no maximum dosage for opioids. The significance of a narcotic medication error was patient specific, and she would not consider Resident #228's medication error as significant due to no adverse effect.Although attempted, an interview with LPN #8 was not obtained. Review of the Medication-Transdermal policy directed, in part, transdermal patches ordered by a physician are applied by a licensed nurse to alternate sites of patch application and the location recorded in the Medication Administration Record (MAR).Review of the Medication Administration policy directed, in part, to check the accuracy and completeness of each medication ordered in the MAR, to verify the resident's name, drug name, drug dosage, route of administration, and time of administration (5 Rights) by comparing the medication container with the MAR. The medication label is to be read 3 times before preparing the medication, narcotics should be compared to the MAR and medication container, and that labels should be read for a second time to ensure accuracy. According to the National Institute of Health, Fentanyl is a potent synthetic opioid similar to morphine, which produces analgesia but to a greater extent. This robust pharmacologic agent is typically 50 to 100 times more potent (than morphine).

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and facility policy review, for 1 ([NAME] House) of 21 units within the facility failed to safely store medications and biologicals. The findings include:Observation on 9/22/25 at 9:38 AM identified the [NAME] House nurses' station/ medication room door unlocked and the door fully open. The charge nurse was observed at the end of the unit, with her medication cart, out of sight of the medication room door. Observation on 9/22/25 at 11:37 AM identified the [NAME] House nurses' station/ medication room door unlocked and open. The medication cart had been stored in the room and was noted to be unlocked and visible from the hallway. Two residents were self-propelling in their wheelchairs in the hallway, and one visitor was in the dining area outside of the nurse's station/medication room. No staff were visible in the area.Interview and observation with Licensed Practical Nurse (LPN) #2 on 9/22/25 at 11:46 AM identified the facility policy directed medication carts be locked when not in use. Additionally, she identified it was her responsibility to lock the medication cart, but she did not because she ran out in a hurry to help a Nursing Assistant (NA) in a resident's room. Subsequent to surveyor inquiry LPN #2 locked the medication cart and afterward closed and locked the nurse's station/medication room door when not occupied.Interview with the Director of Nurses (DNS) on 9/29/25 at 9:47 AM identified it was facility policy that medication carts and medication rooms were locked when nurses were not in view of the area. The DNS indicated that it was the responsibility of the nursing staff working on the unit to ensure medication carts and doors were kept locked.The Medication Storage Policy revised 5/29/25 directed in part that all medication housed on premises will be stored in the pharmacy and/or medication rooms according to manufacturer suggestions. Additionally, all drugs and biologicals will be stored in locked compartments, schedule II drugs and Schedule III, IV, and V medications are stored under double lock and key.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of the clinical record, facility documentation, facility policy and interviews for 2 of 3 residents (Resident #21 and Resident #179) reviewed for pressure injury, the facility failed to perform hand hygiene and wound care under clean conditions and for 1 of 2 residents (Resident #250) reviewed for urinary collection devices, the facility failed to maintain appropriate infection control practices. The findings include:1. Resident #21 had diagnoses that included Alzheimer's disease (dementia), pulmonary fibrosis, and heart failure. A quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #21 was severely cognitively impaired, had 1 unhealed Stage 4 pressure ulcer, and was dependent for bed mobility. The Resident Care Plan (RCP) dated 7/17/25 identified Resident #21 had an alteration in skin integrity related to a left gluteal Stage 4 pressure injury. Interventions included having the wound team follow the resident, ensure offloading (pressure reduction), perform frequent turning and positioning, and perform treatments per the physician orders. A physician order signed 9/18/25 directed treatment to the left gluteal wound, cleanse the wound with normal saline (NS) or wound cleanser (WC) and pat dry followed by packing the wound with Mesalt (dry normal saline wound dressing), followed by covering with a dry, clean dressing daily and as needed. A separate physician order dated 9/18/25 directed to apply miconazole nitrate 2% cream (antifungal cream) topically to gluteal area daily with additional instructions not to apply onto the gluteal wound. Observation of Resident #21's wound care and interview on 9/25/25 at 9:15 AM with RN #2 and Physician #1 identified RN #2 placed treatment supplies including wound cleanser, dressing package, gauze, and Mesalt package on top of Resident #21's bedside table without the benefit of cleansing the tabletop. After repositioning Resident #21, RN #2 removed the soiled dressing from Resident #21's left upper gluteal/coccyx area and folded it into his gloved hand. RN #2 then stepped aside to allow MD #1 to assess the wound. RN #2 removed his gloves with the soiled dressing and placed clean gloves without first performing hand hygiene. He proceeded to cleanse the wound with wound cleanser, and then placed the gauze, Mesalt, and dressing supplies on the bed next to Resident #21's buttocks. RN #2 sprayed the wound cleanser onto Resident #21's wound, wiped the wound with gauze, sprayed the wound again, and wiped the wound with a different area of the gauze. RN #2 then placed the soiled gauze down on the bed. Without changing his gloves and/or performing hand hygiene, he picked up the Mesalt and compressed one end into Resident #21's wound. He then placed a dry clean dressing over the Mesalt to cover the wound. RN #2 covered Resident #21 back up with his gloved hands, removed and discarded his gloves without hand hygiene, and subsequent to surveyor inquiry exited the room to obtain the miconazole. Continued observation of RN #2 identified he entered with the tube of miconazole and a new DCD and placing both on the bed next to Resident #21. The DCD he had placed earlier was removed and discarded. RN #2 then cleansed around the wound and changed gloves without performing hand hygiene. RN #2 applied the miconazole into his gloved hand and applied it to Resident #21 around the peri-wound extending onto the buttocks and placed a new dry clean dressing over the wound. Without removing his soiled gloves, he covered Resident #21 with a blanket and then removed his soiled gloves. Without performing hand hygiene, he picked up the wound cleanser and the tube of miconazole. RN #2 placed the wound cleanser on a small counter near the entry of the resident's room and walked out setting the tube of miconazole onto the top of the treatment cart and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	washed his hands with soap and water. The tube of miconazole was placed back into the treatment cart without the benefit of wiping it down with a disinfectant cloth or placing it inside a plastic bag. RN #2 then pushed the treatment cart down the hall to resume wound rounds with Physician #1. Interview with RN #2 on 9/25/25 at 3:05 PM identified that he should have sanitized the bedside table prior to placing treatment supplies onto it and should have performed hand hygiene after removing his soiled gloves during wound care, and after removing the old/soiled dressing prior to cleansing the wound. Additionally, RN #2 identified he should have cleansed the outside of the antifungal cream tube prior to placing it into the treatment cart and it should be a dedicated tube for Resident #21 since it was brought into the room. RN #2 identified that he had felt rushed while performing the wound care for Resident #21 during the wound rounds because Physician #1 was waiting for him to finish the wound rounds, and that made him feel pressured, so he rushed the treatment process which resulted in him not following proper infection prevention procedure. Subsequent to surveyor inquiry a physician order dated 9/25/25 directed treatment to left gluteal wound: Cleanse wound with NS or WC and pat dry followed by, apply miconazole 2% cream to peri-wound area followed by packing with Mesalt followed, by cover with a dry clean dressing daily and as needed. Review of the Infection Control-Hand Hygiene policy directed, in part, all staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors, that hand hygiene could be done both by handwashing with soap and water or by using an alcohol based hand rub, and that hand hygiene would be performed according to accepted standards of practice after handling contaminated objects; before applying and after removing PPE, including gloves; before and after handling clean or soiled dressings; before performing resident care procedures; after handling items potentially contaminated with blood, body fluids, secretions, or excretions; and when, during resident care, moving from a contaminated body site to a clean body site. Further, if a task requires gloves, perform hand hygiene prior to donning (placing) gloves and immediately upon removal of gloves. 2. Resident #179 diagnoses included type 2 diabetes, rhabdomyolysis, and Alzheimer's disease. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #179 had a Brief Interview of Mental Status (BIMS) score of 00 indicating severe cognitive impairment. Additionally, the MDS identified Resident #179 was dependent on staff for hygiene, dressing, and transfers. The Resident Care Plan dated 9/23/25 identified Resident #179 was at risk of infection transmission due to an indwelling medical device, chronic wound or surgical incision. Interventions included hand hygiene and signage indicating personal protective equipment (PPE) use was required for high contact care. The physician's order dated 9/22/25 directed to perform treatment to the sacral wound every shift: apply topical Triad paste twice a day after care. The physician's order dated 9/23/25 directed Enhanced Barrier Precautions every shift for a wound. Observation of Resident #179's room on 9/25/25 at 10:52 AM identified an Enhanced Barrier Precautions sign posted outside the Resident #179's door. The sign directed that everyone was to (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	clean their hands prior to entering, and after leaving the room. Additionally, the sign directed that gloves and a gown were to be applied for high contact activities such as dressing, bathing/showering, transferring, providing hygiene, changing linens, assisting with toileting, device care, and wound care. An observation of Licensed Practical Nurse (LPN) #2 and the Wound Nurse (RN) #2 on 9/25/25 at 10:54 identified gloves and a gown were placed on without the benefit of performing hand hygiene prior to entering Resident #179's room. LPN #2 was on the right side of the resident with a basin and cloth, while RN #2 was on left side assisting with Resident #179's positioning. LPN #2 removed Resident #179's brief and handed the soiled brief to RN #2 while she cleaned up the resident's peritoneal area. RN #2 disposed of the brief into the trash receptacle, removed and disposed of his soiled gloves and applied new gloves without the benefit of hand hygiene. LPN #2 removed her soiled gloves and applied clean gloves without the benefit of hand hygiene, she then sprayed the skin cleanser on a washcloth and cleaned Resident #179's wound, applied the Triad paste to a 4 centimeter (cm) by 4 cm gauze, dabbed it on the wound and applied a clean brief before repositioning the resident. LPN #2 and RN #2 removed their gloves and gowns and discarded them in the trash receptacle. Upon exiting the room RN #2 performed hand hygiene with the hand sanitizer outside the resident's room, while LPN #2 did not. Interview with LPN # 2 on 9/25/25 at 11:10 AM identified it was facility policy to perform hand hygiene before and after resident care, or when gloves were visibly soiled, as well as when putting on and taking off PPE and between glove changes. Additionally, LPN #2 identified although there was a mounted alcohol based hand rub dispenser outside Resident #179's room and a private bath in the room with soap and water, she did not perform hand hygiene prior to applying PPE, and between glove changes because she did not feel cleansing items were available in the room. LPN #2 was unable to explain why she did not follow the policy for performing hand hygiene prior to applying PPE. Interview with RN #2 on 9/25/25 at 11:16 AM identified it was facility policy to perform hand hygiene before and after care, before and after glove application, before and after putting on and taking off PPE and when hands were visibly soiled. Additionally, RN #2 identified that he should have performed hand hygiene when changing gloves but did not because there was no hand sanitizer in the room. RN #2 identified he performed hand hygiene prior to coming onto the unit and did not need to immediately before donning PPE. The Enhanced Barrier Precautions Policy dated 9/2/25 directed in part to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms and ensure access to alcohol-based hand rub in every resident room (ideally both inside and outside of the room). The Hand Hygiene Policy dated 5/25/25 directed, in part, that all staff will perform hand hygiene procedures to prevent the spread of infection. Additionally, the use of gloves does not replace hand hygiene, and if the task requires gloves hand hygiene should be performed prior to donning gloves and immediately after removing gloves. 3. Resident #250's diagnoses include retention of urine, urinary tract infection, and pressure ulcer of the sacral region. A physician's order dated 9/3/25 directed to check Resident #250's urinary collection device and provide care every shift. The admission Minimum Data Set (MDS) assessment dated [DATE] identified that Resident #250 was (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cognitively intact, required substantial/maximal assistance for bed mobility, and was dependent with toileting and transfers. The Resident Care Plan (RCP) dated 9/12/25 identified Resident #250 had bowel incontinence, had a chronic sacral wound, and an indwelling urinary collection device was in place. Interventions included observing complications, report signs of a Urinary Tract Infection (UTI), provide incontinent care, and place personal protective equipment when providing high contact care. Observation and interview with Nurse Aide (NA) #4 and LPN #4 on 9/26/25 at 1:00 PM identified Resident #250 seated in a wheelchair with the urinary collection device hung low under the wheelchair with the front bottom half of the drainage bag resting on the floor. Both LPN #4 and NA #4 indicated the collection bag should not have been resting on the floor. NA #4 and LPN #4 stated that it was NA #4's responsibility to ensure urinary collection bags were not on the floor and proceeded to instruct NA #4 to reposition the collection bag educating her to always suspend urinary collection devices so that there is no floor contact. Interview with the Director of Nursing Services on 9/26/25 at 1:50 PM identified Resident #250's urinary collection device collection bag should not have been resting on the floor and that it was the NA responsibility to ensure urinary collection devices are appropriately positioned off the floor. Review of facility policy, Urinary Collection device Care, dated 9/2005, directed urinary collection devices are cared for by all Nursing Personnel and to keep the drainage bag off the floor.

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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 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation, and interviews for the only sampled resident (Resident#295) reviewed for hospitalization, the facility failed to provide the required notification of discharge/transfer to the State Ombudsman's Office. The findings include:Resident #295's was admitted with diagnosis including multiple fractures, diabetes, and small cell lung cancer.The admission Resident Care Plan dated 8/7/25 identified Resident #295 had hyperglycemia related to diabetes with interventions directed to monitor and record intake of food, monitor blood glucose per the physician's orders, and monitor for signs of hypoglycemia.The 5-day Minimum Data set (MDS) assessment dated [DATE] identified Resident #295 was cognitively intact, and required substantial, maximal assistance for bathing and toileting, and partial, moderate assistance for transfers.Review of the nursing note dated 8/10/25 at 4:11PM identified Resident #295 was observed with intermittent body tremors, non-verbal, eyes open, and could not follow commands. Resident #295's blood sugar was 32 and he/she was given Glucagon intramuscularly. The Advance Practice Registered Nurse was notified and directed Resident #295 be sent to the emergency room (ER) for evaluation and next of kin was notified.Review of the Nursing Progress Note dated 8/11/25 at 6:31AM identified Resident #295 was admitted to the hospital.Review of the Social Worker Progress note dated 8/11/25 at 2:40 PM identified Resident #295's family was educated on the bed hold policy which was declined and the family member indicated he/she was planning to retrieve Resident #295 belongings.An interview with Social Worker (SW) #2 on 9/26/2025 at 11:34 AM identified the ombudsman was not notified of Resident #295 transfer to the hospital on 8/10/25. Social Worker #2 stated that the facility policy to notify the ombudsman of a transfer did not include residents residing on the short term rehabilitation unit. SW #2 was not aware of the requirement to notify the ombudsman when a short-term rehabilitation resident was transferred to the hospital.Although a policy was requested for the notification of the ombudsman following resident transfer/discharge the facility failed to provide one.