

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075413	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/05/2025
NAME OF PROVIDER OR SUPPLIER Northbridge Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2875 Main Street Bridgeport, CT 06606	

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)
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, facility documentation, and staff interviews for one of three residents (Resident #1) reviewed for accidents, the facility failed to ensure the RN supervisor was notified timely of a change in condition was identified, to ensure an Registered Nurse (RN) assessment was completed timely. The findings include:</p> <p>Resident #1 had a diagnosis of type 2 diabetes, anemia, and Charcot's joint of the left ankle (nerve damage). The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of 15 (alert and oriented/intact cognition) and was independent after set up for showering and independent with transfers. The Resident Care Plan (RCP) dated 2/24/2025 identified an Activities of Daily Living (ADL) deficit. Interventions directed to assist gathering and setting up clothing and toiletries.</p> <p>Facility reportable event form dated 4/12/2025 identified on 4/13/2025 Resident #1 indicated that he needed cream applied to the right leg due to a burn that he/she received on 4/12/2025 during a shower. Resident #1 denied discomfort and indicated he/she did not notify staff when the burn occurred on 4/12/2025.</p> <p>Facility summary dated 4/17/2025 identified Resident #1 sustained a first degree burn to the right lower extremity from running hot water over wash cloth that he/she placed on his/her right lower extremity during a shower.</p> <p>Nursing note dated 4/13/2025 at 11:33 PM identified Resident #1 stated he/she needed lotion to his/her right leg, area was noted to be red and bumpy. Resident #1 resident stated he/she burned the leg on 4/12/2025 with a hot cloth during a shower but did not notify any staff. The note further identified the RN supervisor was notified via a text message to call when possible.</p> <p>Nursing note (RN supervisor) dated 4/14/2025 at 10:34 AM identified Resident #1 was noted with a first degree burn to the right leg which the resident stated happened during a shower on 4/12/2025. Area was noted to measure 18 centimeters long, 7.5 centimeters wide and had no depth. The Advanced Practice Registered Nurse (APRN) made notified and treatment orders were obtained.</p> <p>Interview with NA #1 on 5/5/2025 at 12:09 PM identified she gave Resident #1 a shower on 4/12/2025 around 10 AM. NA #1 stated Resident #1 was independent with the shower after she washed his/her back. NA #1 checked the water temperature before washing Resident #1's back, and temperature was not too hot - it was lukewarm, and Resident #1 had no complaints about the water temperature. Resident #1 was then independent with the remainder of the shower.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 075413
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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview and record review with RN #1 on 5/5/2025 at 12:31 PM identified she was working as the RN supervisor from 7 AM to 11 PM on 4/13/2025 when the burn was identified. Review of a text message on RN #1's phone identified LPN #1 sent a text message that stated, call me when you can, no rush. RN #1 stated she was not notified Resident #1 had a burn. RN #1 stated LPN #1 had sent her a text message to call when possible, however, she forgot to call. RN #1 stated if she had known Resident #1's leg was burned, she would have completed an assessment and notified the APRN.</p> <p>Interview and record review with the Administrator on 5/5/2025 at 2:43 PM identified an RN assessment should have been completed when the burn was identified. The Administrator indicated LPN #1 should have notified RN #1 of the burn, and stated LPN #1 should have followed up with RN #1 after the text message was sent. The Administrator was unable to provide documentation that an assessment was completed when the burn was identified on 4/13/2025.</p> <p>Although requested, an assessment policy was not provided for surveyor review.</p>		