STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075413	A. Building B. Wing	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northbridge Health Care Center	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)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 review of the clinical record, facility documentation, and facility policy, and interviews for one sampled resident (Resident #2) reviewed for discharge, the facility to develop and implement a discharge plan timely. The findings include: Resident #2 had diagnoses that included diabetes mellitus, anxiety, depression, and difficulty walking. The quarterly MDS dated [DATE] identified Resident #2 had a BIMS score of fifteen (15), indicative of intact cognition, and was independent with personal care, transfers and ambulation with a cane. The MDS further identified Resident #2 had an active discharge plan with a plan to return to the community and a referral was made to the local contact agency. The RCP dated 9/18/2025 identified Resident #2 was admitted for long term rehab. Interventions directed to encourage to ask questions, orient to facility, and introduce self and function to resident at each interaction. Additional review of the care plan failed to identify a discharge plan. Record review failed to identify referrals were made for potential discharge to another level of care. The interdisciplinary care plan meeting dated 9/18/2025 identified Resident #2's care area for Discharge Planning was checked off as N/A (not applicable) and MFP (Money Follows the Person) had been handwritten in the box. Interview with Social Worker #1 on 10/14/2025 at 9:50 A.M. identified when Resident #2's was admitted , he/she initially required assistance with ADLs and was currently independent with ADLs. A referral was sent to MFP during February 2024 for discharge to the community with home health care. SW #1 stated Resident #2 was still at the facility and had no discharge plans because he/she was waiting for MFP (since February 2024 - 20 months prior). SW #1 stated on 10/8/2025, Resident #2 requested to be transferred to a nursing home where his/her spouse resides. A referral was sent at that time, and Resident #2 was placed on their waiting list. Interview failed to identify any additional contacts were made for follow-up with MFP or alternate settings for potential discharge since February 2024. Review of the facility Discharge Planning Policy dated 1/2019, directed in part, discharge planning will be addressed upon admission and throughout the resident's stay. Residents who indicate a desire to return to the community will work with social service staff to formulate a viable discharge plan.

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for two of three residents (Resident #1 and Resident #2) reviewed for abuse, the facility to develop and implement a comprehensive care plan to address a relationship between the residents. The findings include: Based on review of the clinical record, facility documentation, facility policy, and interviews for two of three residents (Resident #1 and Resident #2) reviewed for abuse, the facility to develop and implement a comprehensive care plan to address a relationship between the residents. The findings include: 1. Resident#1 had diagnoses that included paraplegia, anxiety, and depression. The annual [NAME] Data Set (MDS) dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of fifteen (15), indicative of intact cognition, and was independent with wheelchair mobility. The Resident Care Plan (RCP) dated 8/28/2025 identified Resident #1 had a history of trauma with the potential for traumatization. Interventions directed to encourage express feelings/concerns, support as needed and to provide a safe place. 2. Resident #2 had diagnoses that included anxiety, depression, and difficulty walking. The quarterly MDS dated [DATE] identified Resident #2 had a BIMS score of fifteen (15), indicative of intact cognition, and was independent ambulation with a cane. The RCP dated 9/18/2025 identified Resident #2 allegedly touched a peer inappropriately on 6/4/2024. Interventions directed to separate the resident from the peer immediately, psych to follow-up as needed, social service visits as needed, room change and provide emotional support as indicated. Record review identified Resident #1 and Resident #2 had a court appointed Conservator of Person (COP). Facility reportable event dated 9/24/2025 at 12:37 PM identified Resident #1 reported he/she visited Resident #2 daily after lunch and played dominoes, and he/she no longer feels comfortable around Resident #2. Resident #1 reported that he/she had consented to intimate contact with Resident #2 until 9/23/2025. Resident #1 reported Resident #2 asked him/her to get into his/her bed, but Resident #1 was unable to self-transfer into the bed. The Report indicated Resident #2 denied any sexual interaction with Resident #1. Additional facility reportable event information dated 9/30/2025 identified both residents have a COP, and the facility staff were aware that in the past, Residents #1 and #2 would hang out, visit, and play dominos together. Record review for Resident #1 and Resident #2 failed to identify documentation that the care plan included the residents relationship and interventions to provide guidance for the staff regarding the relationship. Interviews with NA #1, NA #2, and NA #3 on 10/14/2025 at various times identified they cared for Residents #1 and #2, and they were aware that Resident #1 and Resident #2 had a friendly relationship. NA #1, NA #2, and NA #3 identified that Resident #1 would come down to visit with Resident # 2 in his/her room with the door closed, and they did not check on the residents, or monitor, when the door was closed when the visits occurred. Interview with Social Worker (SW) #1 on 10/14/2025 at 9:50 A.M. identified she was aware Resident #1 and Resident #2 had a friendship. Interview with SW #2 on 10/14/2025 at 10:01 A.M. identified she was aware that Resident #1 would visit Resident #2 in his/her room with the door closed, and they would also play dominoes in the lounge Interview with the Memory Care Coordinator on 10/14/2025 at 11:25 A.M. identified she was aware Resident #1 and Resident #2 had a friendly relationship. Interview with LPN #1 on 10/14/2025 at 10:48 A.M. identified she was aware Resident #1 and Resident #2 had a friendship. Interview with LPN #2 on 10/14/2025 at 11:08 A.M. identified she was aware Resident #1 and Resident #2 had a friendship and Resident #1 would visit Resident #2 in his/her room with the door closed. Interview with the Administrator on 10/14/2025 at 11:15 A.M. identified Resident #1 and Resident #2 had a friendly relationship, and would visit in Resident #2's room with the door closed. The Administrator was unable to explain why a care plan had not been developed and implemented for Resident #1 and Resident #2 to address their relationship, and care plans should have been developed. Interview with Resident #1 on 10/14/2025 at 11:55 A.M. identified that he/she would visit Resident #2 daily in his/her room and had an intimate relationship with Resident #2 until 9/23/2025. Interview with the Director of Nurses (DNS) on 10/14/2025 at 12:25 P.M. identified Resident #1 and Resident #2 both had COPs. Each residents COP was aware the residents had a friendly relationship and spent time together. The DNS was unable to explain why care plans had not been developed and implemented for Resident #1 and Resident #2 to address their relationship, and indicated care plans should have been developed. Review of the facility Comprehensive Care Plans Policy dated 11/2017, directed in part, care plans reflect the resident preferences by recognizing each resident as an individual to identify and meet those needs in a resident-centered environment

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation and facility policy, and interviews for one of three residents (Resident #1) reviewed for abuse, the facility failed to provide adequate supervision to prevent a resident-to-resident sexual incident. The findings include: 1. Resident #1 had diagnoses that included paraplegia, anxiety, and depression. The annual [NAME] Data Set (MDS) dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of fifteen (15), indicative of intact cognition, and was independent with wheelchair mobility. The Resident Care Plan (RCP) dated 8/28/2025 identified Resident #1 had a history of trauma with the potential for traumatization. Interventions directed to encourage express feelings/concerns, support as needed and to provide a safe place. 2. Resident #2 Resident #2 had diagnoses that included anxiety, depression, and difficulty walking. The quarterly MDS dated [DATE] identified Resident #2 had a BIMS score of fifteen (15), indicative of intact cognition, and was independent ambulation with a cane. The RCP dated 9/18/2025 identified Resident #2 allegedly touched a peer inappropriately on 6/4/2024. Interventions directed to separate the resident from the peer immediately, psych to follow-up as needed, social service visits as needed, room change and provide emotional support as indicated. Record reviews identified Residents #1 and #2 resided on different floors of the facility, and both residents had a court appointed Conservator of Person (COP). Facility reportable event dated 9/24/2025 at 12:37 PM identified Resident #1 reported he/she visited Resident #2 daily after lunch and played dominoes, and he/she no longer feels comfortable around Resident #2. Resident #1 reported that he/she had consented to Resident #2 touching/sucking on his/her breasts, and he/she touched and kissed Resident #2's XXXX (genitals), until 9/23/2025. Resident #1 reported Resident #2 asked him/her to get into his/her bed, but Resident #1 was unable to self-transfer into the bed. The Report indicated Resident #2 denied any sexual interaction with Resident #1. Additional review identified Resident #2 had no roommate. Social Worker (SW) #1's note dated 9/24/2025 at 2:33 P.M. identified she met with Resident #1, who reported Resident #2 touched him/her in a manner that made him/her uncomfortable. Resident #1 stated the last time it had happened was one week ago when he/she played dominoes with Resident #2. SW #1's note dated 9/24/2025 at 2:39 P.M. identified she met with Resident #2 regarding the reported incident between Resident #2 and Resident #1, and Resident #2 denied the incident. APRN note dated 9/25/2025 at 5:10 PM identified Resident #1 was seen for alleged sexual assault by Resident #2. Resident #1 was tearful while he/she recounted the event, and indicated he/she had a consensual sexual relationship with Resident #2 in the past. Resident #1 reported that Resident #2 engaged in acts that he/she did not want or consent to. Resident #1 denied any penetrative sex and no physical injuries were noted. Facility reportable event summary dated 9/29/2025 identified the residents were separated and educated that if they choose to visit in the future, visiting should occur in a common area with staff knowledge. Further, Resident #2 was placed on every one (1) hour checks. Additional facility reportable event information dated 9/30/2025 identified both residents have a COP, and the facility staff were aware Residents #1 and #2 would hang out, visit, and play dominos together. Resident #2 had no roommate, and during June 2024 had touched another resident inappropriately. Resident #1 will no longer visit Resident #2's floor, Resident #1 stated prior incidents were consensual, and Resident #2 denied the allegation. Interviews with NA #1, NA #2, and NA #3 on 10/14/2025 at various times identified they cared for Residents #1 and #2, and they were aware that Resident #1 and Resident #2 had a friendly relationship. NA #1, NA #2, and NA #3 identified that Resident #1 would come down to visit with Resident # 2 in his/her room with the door closed, and they did not check on the residents, or monitor, when the door was closed when the visits occurred. Interview with SW #1 on 10/14/2025 at 9:50 A.M. identified she was aware of the friendship between Resident #1 and Resident #2. SW #1 identified on 9/24/2025, she was notified that Resident #1 stated he/she did not want to go to the XXX floor anymore because Resident #2 had touched him/her. Resident #1 reported that he/she would meet Resident #2 in the sitting room to play dominoes, and Resident #2 touched Resident #1's breasts. SW #1 identified Resident #1 reported he/she told Resident #2 not to touch his/her breasts and Resident #2 touched his/her breast anyway. SW #1 further identified Resident #2 had a previous history of inappropriately touching another resident. Interview with SW #2 on 10/14/2025 at 10:01 A.M. identified she was aware that Resident #1 would visit Resident #2 in his/her room with the door closed, and they would also play dominoes in the lounge. Although SW #2 stated she was aware Resident #2 had a previous history of inappropriately touching