STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075439	A. Building B. Wing	02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bradley Home Infirmary/Pavilion	320 Colony Street Meriden, CT 06451

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, facility documentation, facility policy and interviews for three (3) of three (3) sampled residents (Residents #1, #2 and #3) who were reviewed for the use of antipsychotic medication, the facility failed to ensure the resident's targeted behaviors were being monitored. The findings include:1. Resident #1's diagnoses included bipolar disorder, depressive episodes and Alzheimer's disease. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of nine (9) out of fifteen (15) indicating Resident #1 had some memory recall deficits. The Resident Care Plan dated 12/23/25 identified Resident #1 received an antipsychotic medication related to a diagnosis of bipolar disorder. Interventions included observing for target behaviors of excessive crying and suicidal ideation. A physician's order initiated on 11/25/25 directed to administer Aripiprazole 5 mg by mouth in the morning for bipolar disorder and on 1/13/26 Aripiprazole was decreased to 2 mg. A physician's order dated 1/21/26 directed to increase the Aripiprazole back to 5 mg at bedtime. Review of the January 2026 and February 2026 Medication Administration Records failed to reflect documentation targeted behaviors were monitored every shift related to the use of the Aripiprazole. 2. Resident #2's diagnoses included schizophrenia, major depressive disorder and anxiety disorder. A physician's order dated 6/9/25 directed to administer Clozaril 25 milligram (mg) and 50 mg to equal a total dose of 75 mg to be given by mouth daily at bedtime for schizophrenia. The annual Minimum Data Set assessment dated [DATE] identified Resident #2 had a Brief Interview for Mental Status (BIMS) score of fifteen (15) out of fifteen (15) indicating Resident #2 had no memory recall deficits. The Resident Care Plan dated 11/25/25 identified Resident #2 received psychotropic medication related to diagnoses of schizophrenia and depression. Interventions included observing for target behaviors of paranoia, delusions, and hallucinations. Review of the January 2026 and February 2026 Medication Administration Records failed to reflect documentation targeted behaviors were monitored every shift related to the use of the Clozaril. 3. Resident #3's diagnoses included dementia with behavioral disturbances and cognitive communication deficit. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #3 had a Brief Interview for Mental Status (BIMS) score of nine (9) out of fifteen (15) indicating Resident #3 had some memory recall deficits. A physician's order dated 11/21/25 directed to administer Rexulti one (1) mg by mouth one (1) time a day related to dementia with behavioral disturbances. The Resident Care Plan (RCP) dated 12/2/25 identified that Resident #3 utilizes psychotropic medication related to diagnoses of dementia and depression. Interventions included observing for targeted behaviors. Review of the January 2026 and February 2026 Medication Administration Records failed to reflect documentation specific targeted behaviors were monitored every shift related to the use of the Rexulti. Interview with the psychiatric Advanced Practice Registered Nurse (APRN) on 2/3/26 at 10:19 AM identified all residents on antipsychotic medications should have behavior monitoring put into place upon the initiation of the medications to ensure specific (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075439	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/03/2026
NAME OF PROVIDER OR SUPPLIER Bradley Home Infirmary/Pavilion		STREET ADDRESS, CITY, STATE, ZIP CODE 320 Colony Street Meriden, CT 06451	

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	targeted behaviors are monitored so the resident was treated appropriately. Interview and clinical record review with the Director of Nursing (DON) on 2/3/26 at 1:30 PM identified targeted behavior monitoring should have been put into place every shift for Residents #1, #2 and #3 upon the initiation of the antipsychotic medications. Review of the Psychotropic Medication Use policy (undated) directed, in part, that psychotropic medication management is an interdisciplinary process that requires adequate monitoring for efficacy and adverse consequences to include expressions or indications of distress and resident complaints, behaviors and symptoms. Documentation must include that behavioral interventions (non-pharmacological) were attempted but not successful, and these interventions were deemed clinically contraindicated. Residents receiving psychotropic medications are monitored and the response to treatment is documented. Monitoring may include behavior flow sheets, progress notes and medication administration records. Review of the Behavioral Assessment Intervention policy dated 6/2023 directed, in part, that if the resident is being treated for altered behavior or mood, the interdisciplinary team will observe for changes in the individual's behavior, mood and function. If antipsychotic medications are used to treat behavioral symptoms, the interdisciplinary team will monitor their indication. The facility will comply with regulatory requirements related to the use of medications to manage behavioral changes.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, facility documentation, facility policy and interviews for one (1) of three (3) sampled residents (Resident #1) reviewed for a change in condition, the facility failed to ensure a complete and accurate clinical record to include an antipsychotic medication was transcribed correctly and signed off as administered. The findings include:Resident #1's diagnoses included bipolar disorder, depressive episodes and Alzheimer's disease. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of nine (9) out of fifteen (15) indicating Resident #1 had some memory recall deficits. The Resident Care Plan dated 12/23/25 identified Resident #1 received an antipsychotic medication related to a diagnosis of bipolar disorder. Interventions included observing for targeted behaviors of excessive crying and suicidal ideation. A physician's order dated 11/25/25 directed to administer Aripiprazole 5 mg by mouth in the morning for bipolar disorder and on 1/13/26 the Aripiprazole was decreased to 2 mg. A physician's order dated 1/13/26 directed to administer a one-time dose of Aripiprazole 2 mg in the morning on 1/14/26. A physician's order dated 1/21/26 directed to increase the Aripiprazole back to 5 mg at bedtime. The nurse's note dated 1/20/26 at 6:57 PM identified the Director of Nursing was notified by staff that Resident #1 had been found around 4:24 PM by a nurse aide with the call bell cord wrapped around his/her neck. The note indicated the cord was immediately removed, no marks were noted to the neck, no distress was noted, Resident #1 was unable to verbalize why the cord was around his/her neck, one-to-one constant observation was immediately implemented, the psychiatric Advanced Practice Registered Nurse (APRN) was in-house and assessed Resident #1 and Resident #1 was sent to the Emergency Department for evaluation. The note identified Resident #1 returned to the facility the same day with a letter stating he/she was not a harm to self or others and the one-to-one constant observation continued. Review of the January 2026 Medication Administration Record identified the one-time dose of Aripiprazole 2 mg had been signed off as administered at 9:00 AM on 1/14/26, however documentation failed to identify the Aripiprazole 2 mg had been administered at 8:30 PM on 1/14/26 and 1/15/26. Interview with the 3-11PM charge nurse, Licensed Practical Nurse (LPN) #3, on 2/3/26 at 12:20 PM identified she did not administer the 1/14/26 dose of Aripiprazole 2 mg to Resident #1 at 8:30 PM because the 7AM-3PM nursing supervisor, Registered Nurse (RN) #2, had communicated to her the Aripiprazole 2 mg was administered on the 7AM-3PM shift, as the provider had ordered a one-time dose at 9:00 AM and the Aripiprazole was to be administered at 8:30 PM daily starting on 1/15/26. LPN #3 explained she left a note for RN #2 to review the order in the morning, and she did not sign off. LPN #3 identified she should have written a note to explain why the 8:30 PM had not been signed off as administered. Interview with RN #2 on 2/3/26 at 12:40 PM identified although she transcribed the 1/14/26 order directing to administer Aripiprazole 2 mg daily at bedtime, Resident #1 had already received the Aripiprazole at 9:00 AM on 1/14/26 so the order was supposed to go into effect on 1/15/26 at 8:30 PM and the order should not have shown up on the Medication Administration Record to administer on 1/14/26 at 8:30 PM. RN #2 indicated she transcribed the order incorrectly. RN #2 identified she should have ensured the order was entered correctly before signing it. Interview with the 3-11PM charge nurse, LPN #2, on 2/3/26 at 12:49 PM identified although she did not sign off the Aripiprazole on 1/15/26 at 8:30 PM, she did administer the medication. LPN #2 indicated she was responsible for ensuring all of her documentation was completed and correct before she leaves. Interview and clinical record review with the Director of Nursing (DON) on 2/3/26 at 1:30 PM identified RN #2 should have ensured she transcribed the Aripiprazole 2 mg order on (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/14/26 correctly, and then checked the order again before signing it, and although a medication error was not made, the resident could have been given double the dose. The DON explained staff are expected to sign off on all medications and treatments for the residents and ensure that documentation was complete and accurate, and if medications or treatments are not administered staff should be writing a note to indicate the reason. Review of the Charting and Documentation policy dated 07/2017 directed, in part, that all services provided to the resident, progress towards the care plan goals, or any changes in the resident's medical, physical, functional or psychological condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Although requested, a policy on Transcription of Physician's Orders was not available