STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075323	A. Building B. Wing	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cambridge Health and Rehabilitation Center	2428 Easton Tnpk Fairfield, CT 06825

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 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. (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

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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 0684 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 record review, facility documentation review, and staff interviews for one of three residents (Resident #2) reviewed for abuse, the facility failed to ensure wound care orders were accurately transcribed and failed to provide wound care treatments to the resident's right hand in accordance with physician orders. The findings include: Resident #2 had a diagnosis of surgical amputation of the right index finger, end stage renal disease, and type 2 diabetes. The admission Minimum Data Set (MDS) dated [DATE] identified Resident #1 had a BIMS of 15 indicating intact cognition, and had venous and arterial ulcers. The Resident Care Plan (RCP) dated 7/22/2025 identified a self-care deficit and a surgical amputation of the right index finger. Interventions directed to provide treatments as ordered. Orthopedic provider note dated 8/21/2025 at 12:46 PM identified Resident #2 was seen for a follow up visit due to cellulitis of the right index finger and underwent a right-hand disarticulation (separate bones at the joints) of the right index finger and an amputation on 8/6/2025. The note directed a wet to dry dressing to be changed daily at the facility. Physician order dated 8/21/2025 directed a wet to dry dressing to be changed daily to the right middle finger, and the order was entered into the EMR to change every shift for surgical wound until further notice from surgeon. Interview and record review with RN #4 (Wound Nurse) on 9/22/2025 at 10:31 AM identified Resident #2's orders were not transcribed correctly following his/her appointment with the orthopedic physician on 8/21/2025. The dressing was ordered to be changed daily, and the order was entered into the electronic medical record (EMR) to change it every shift in error. Interview identified although RN #4 stated she conferred with the nurse to put the order in (the EMR) the interview failed to identify if RN #4 should have checked to make sure her revision matched the physician orders. a. Orthopedic provider note dated 9/4/2025 at 12:55 PM directed soapy water soaks for 20 minutes before reapplying saline wet to dry dressing to the right hand wound site. Physician order dated 9/5/2025 directed a wet to dry dressing to be changed daily to the right middle finger every day shift for surgical until further notice from surgeon. Record review failed to identify an order was entered in the EMR to provide soapy water soaks for 20 minutes before applying the saline wet to dry dressing. Interview and record review with RN #4 (Wound Nurse) on 9/22/2025 at 10:31 AM identified the physician orders following her/his orthopedic office visit on 9/4/2025 were not transcribed correctly - they omitted the soapy water soaks for 20 minutes prior to applying the new dressing. RN #4 indicated she revised the order on 9/7/2025 to make it clearer for staff but she did not check to ensure her revision matched the physician recommendations following the resident's orthopedic office visit on 9/4/2025. Interview identified although RN #4 stated she conferred with the nurse to put the order in (the EMR) the interview failed to identify if RN #4 should have checked to make sure her revision matched the physician orders. b. Physician order dated 8/21/2025 directed a wet to dry dressing to be changed daily to right middle finger every shift for surgical until further notice from surgeon. Orthopedic provider note dated 9/4/2025 at 12:55 PM identified Resident #2 was being seen post operation for his/her right index finger. Upon physical exam, the dressing was removed, and the dressings were dated 8/31/2025 (4 days prior to the office visit). Facility incident report dated 9/4/2025 at 7:51 PM identified the facility met with Resident #2 and family regarding a concern that treatments were not completed timely. LPN #2 facility statement dated 9/5/2025 identified LPN #2 signed the Treatment Administration Record (TAR) for Resident #2 on 9/2/2025 during the 11 PM to 7 AM shift when she was not the nurse assigned to Resident #2. The statement indicated LPN #2 did not know why she signed on the TAR to indicate the resident's treatment was completed. LPN #4 facility statement dated 9/5/2025 identified she did not complete the dressing change on 9/3/2025 on the 3 PM to 11 PM shift because Resident #2 refused, but she forgot to document the resident refusal. LPN #3 facility statement dated 9/8/2025 identified she had Resident #2 on her assignment on 9/2/2025 during the 11 PM to 7 AM shift, and she did not provide the treatment to Resident #2's right middle finger because it did not come up on the TAR for her to do. Further, LPN #3 identified she did not complete the treatment on 9/3/2025 during the 7 AM to 3 PM shift because the resident was out of the facility at a medical appointment (unrelated). Review of the TAR and medical record for the month of September identified the right index finger dressing was not completed on 9/3/2025 during the 7 AM to 3 PM shift, and was not accurately documented on 9/2/2025, and on 9/3/2025 during the 3 PM to the 11 PM shift. Review of the facility Incident Summary dated 9/11/2025, Electronic Medical Record (EMR), the TAR, and interviews, identified the order was initially written correctly for the daily treatment to her/his right index finger. However, the order was

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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 record review, facility documentation review, and staff interviews for one of three residents (Resident #2) reviewed for neglect, the facility failed to ensure the medical record was complete and accurate to include accurate documentation of wound care provided. The findings include:Resident #2 had a diagnosis of surgical amputation of the right index finger, end stage renal disease, and type 2 diabetes. The admission Minimum Data Set (MDS) dated [DATE] identified Resident #1 had a BIMS of 15 indicating intact cognition, and had venous and arterial ulcers. The Resident Care Plan (RCP) dated 7/22/2025 identified a self-care deficit and a surgical amputation of the right index finger. Interventions directed to provide treatments as ordered. Physician order dated 8/21/2025 directed a wet to dry dressing to be changed daily to right middle finger every shift for surgical until further notice from surgeon. Facility incident report dated 9/4/2025 at 7:51 PM identified the facility met with Resident #2 and family regarding a concern that treatments were not completed timely. LPN #2 facility statement dated 9/5/2025 identified LPN #2 signed the Treatment Administration Record (TAR) for Resident #2 on 9/2/2025 during the 11 PM to 7 AM shift when she was not the nurse assigned to Resident #2. The statement indicated LPN #2 did not know why she signed on the TAR to indicate the resident's treatment was completed. LPN #4 facility statement dated 9/5/2025 identified she did not complete the dressing change on 9/3/2025 on the 3 PM to 11 PM shift because Resident #2 refused, but she forgot to document the resident refusal. LPN #3 facility statement dated 9/8/2025 identified she had Resident #2 on her assignment on 9/2/2025 during the 11 PM to 7 AM shift, and she did not provide the treatment to Resident #2's right middle finger because it did not come up on the TAR for her to do. Further, LPN #3 identified she did not complete the treatment on 9/3/2025 during the 7 AM to 3 PM shift because the resident was out of the facility at a medical appointment (unrelated). Review of the Medication Administration Record (MAR) and medical record for the month of September identified the TAR was signed to indicate the treatment was completed on 9/2/2025 during the 11 PM to 7 AM shift. Further review failed to identify the residents dressing was changed on 9/3/2025 on the 7am to 3pm shift and further record review identified the residents dressing was changed on 9/3/2025 on the 3pm to 11pm shift. Review of the facility Incident Summary dated 9/11/2025, Electronic Medical Record (EMR) TAR, and interviews, identified the order was initially written correctly for the daily treatment to her/his right index finger. However, the order was entered into the electronic TAR as scheduled to complete the treatment every shift instead of daily, leading to Resident #2 refusing some of the treatments on 11-7. It was also noted there were dialysis days the treatment was not completed on the 7am to 3pm shift as she/he was not in the facility. Interview and record review with the Director of Nursing (DNS), Administrator, and RN#2 on 9/18/2025 at 2:45 PM identified LPN #2 and LPN #3 did not complete Resident #2's right finger treatment on 9/2/2025. Further, LPN #2 was not assigned to Resident #2 and should not have signed the TAR to indicate she had completed the treatment when she did not perform the dressing change. Interview failed to identify why LPN #2 signed the TAR. LPN #3 failed to sign the TAR or write a nursing note to indicate why she did not perform the scheduled dressing change. LPN #4 signed the TAR to indicate she had performed the dressing change on 9/3/2025 when she did not complete the treatment. Interview failed to identify why LPN #4 signed the TAR. Further, the interview identified staff should sign the TAR when they perform the treatment; the TAR should not be signed if the treatment is not performed, and should be signed by the nurse assigned. Review of Charting and Documentation Policy January of 2025 directed staff that documentation shall be accurate, relevant, and complete, containing sufficient details about the patients care or responses to care.