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	05/13/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews for one (1) of three (3) residents reviewed for medication errors (Resident #1), the facility failed to ensure the five rights of medication administration were followed, and subsequently, a resident was administered an excess of 26 units of the prescribed dose of Humalog insulin (a medication to lower blood glucose levels). The findings include: Resident #1 had diagnoses that included type 2 diabetes mellitus, heart failure, and hypertension. The physician's order dated 4/3/2025 directed to monitor blood sugars before meals and at bedtime and to administer 14 units of Humalog insulin 100 units/ml for blood sugar of 155 or less after meals, for a blood sugar of 155 or greater before meals, at 8:00 A.M., 12:00 P.M. and 5:00 P.M. hold insulin for a blood sugar of 90 or less. The admission [NAME] Data Set (MDS) assessment dated [DATE] identified Resident #1 had intact cognition (Brief Interview for Mental Status (BIMS) score of 15), was continent of bowel and bladder, independent with ADLs, and received insulin injections. The care plan dated 4/10/2025 identified Resident #1 had diabetes with interventions directing to assess signs of hypoglycemia or hyperglycemia, monitor blood glucose as ordered, diabetic foot checks, and administer insulin/oral glycemic agents as ordered. A vitals report dated 4/20/2025 at 8:03 A.M. identified RN #1 recorded Resident #1's blood sugar as 322. The facility accident and incident report dated 4/20/2025 identified that at 9:15 A.M. RN #1 administered 40 units of Humalog insulin to Resident #1; the order directed to administer 14 units before breakfast. RN #1 rechecked the blood sugar and notified RN #2 (supervisor) of the medication error. A nurse's note dated 4/20/2025 at 1:13 P.M. by the Assistant Director of Nurses (ADNS) identified at 12:30 P. M. APRN #1 was notified that Resident #1's current blood sugar was 199 and a new order was entered to notify APRN #1 prior to supper to determine if insulin will be needed. Review of the facility's summary dated 4/23/2025 identified on 4/20/2025 at approximately 9:15 A.M. RN #1 administered 40 units of Humalog Insulin and the order directed to administer 14 units of Humalog Insulin before meals. RN #1 reported she read 14 units, but inadvertently drew up 40 units, which she administered, and she realized the error and alerted the supervisor, APRN #1 and the family. RN #1 was provided education regarding the 5 rights and 3 checks for medication administration. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075353	A. Building B. Wing	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mozaic Senior Life	4200 Park Avenue Bridgeport, CT 06604

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with RN #1 on 5/12/2025 at 10:35 A.M. identified on 4/20/2025 at approximately 8:00 A.M. Resident #1's blood sugar was checked and recorded as 322. RN #1 identified on 4/20/2025 she reviewed and verified physician's orders prior to administering Humalog insulin. RN #1 identified she knew that the physician's orders directed to administer 14 units of Humalog insulin prior to the breakfast meal for a blood sugar of 322. RN #1 identified when she was almost done administering the Humalog insulin injection, she realized she accidentally administered 40 units of Humalog insulin rather than 14 units per order. RN #1 indicated on 4/20/2025 she was flustered because earlier in the shift she was having difficulty logging into the computer, and then a fire alarm went off. Interview with the Director of Nurses (DNS) on 5/12/2025 at 10:59 A.M. identified RN #1 administered the wrong dose of Humalog insulin to Resident #1 on 4/20/2025 at approximately 9:00 A.M. The DNS identified the cause of the medication error on 4/20/2025 was caused by RN #1 feeling flustered. The DNS identified the 5 rights of medication administration (right resident, right medication, right dose, right time, and right route) should be followed by all nurses at all times. Although attempted, an interview with RN #2 was not obtained. According to Fundamentals of Nursing: 11th edition, Mosby, [NAME] and [NAME], 2022: To prevent medication errors nurses must follow the five rights of medication administration consistently every time medications are administered. The five rights of medication administration include the right medication, right dose, right resident, right route, and right time.