

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  12/02/2025
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)
F 0550  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.  (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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on clinical record review, facility documentation review, facility policy review, and interviews for one resident (Resident #1) reviewed for resident rights, the facility failed to allow an alert and oriented resident to leave the facility at his/her own will. The findings include: Resident #1's diagnoses included dementia, sensorineural hearing loss, anxiety, and depression. Record review identified Person #1 was a court appointed Conservator of Person. The Resident Care Plan dated 8/29/2025 identified Resident #1 was alert and oriented and can communicate daily needs to staff using a communication board. Interventions directed to encourage Resident #1 to ask questions, and orient to facility and routines. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of fifteen out of fifteen (15/15), indicative of being alert and oriented, and ambulated independently. A physician order dated 8/11/2025 directed Resident #1 may go out on LOA (leave of absence) with medications and responsible party. The Elopement and Wandering assessment dated [DATE] identified Resident #1 was not at risk for elopement. A social services progress note dated 9/9/2025 at 9:12 AM identified SW #1 reached out to Person #1 due to Resident #1 attempted to get on a local city bus to go to Walmart. The note indicated that Person #1 revoked outdoor privileges for Resident #1. A nursing note dated 9/10/2025 at 2:48 PM by the DON identified she was called by the receptionist and notified Resident #1 was outside with SW #1. The note indicated Resident #1 was restricted by Person #1 from going outside the facility. Upon arrival, Resident #1 was agitated and refused to communicate with the DON. Resident #1 communicates via written communication due to hearing impairment and Resident #1 refused to look at written communication. Per SW #1, Resident #1 was physically aggressive towards her and was seen kicking the door to exit the facility. Increased behaviors were noted with an increase in physical and verbal aggression, unable to redirect Resident #1, and transferred to the hospital for evaluation. Record review failed to identify a new Elopement and Wandering Assessment was performed and failed to identify the RCP was updated when Person #1 directed to not allow Resident #1 outside the building on 9/9/2025. Interview with the DON on 11/25/2025 at 12:45 PM identified Resident #1 was alert and oriented with a BIMS of 15 and had a Conservator. The DON stated that prior to 9/8/2025, Resident #1 would routinely go outside and feed the birds but had no attempts on leaving the premises. Person #1 was aware of this and agreed to Resident #1 to continue doing this. On 9/8/2025, Resident #1 attempted to get on the city bus as he/she believed he/she was on the list to go to Walmart with recreation. Person #1 was notified of the incident and agreed that Resident #1 would not be allowed to go outside by him/herself going forward. The DON stated a Conservator can direct care related to allowing or not allowing a resident to go outside, but stated a resident has the right to go outside. Interview failed to identify why Resident #1, who was alert and oriented, was no longer allowed to go outside. Interview with SW #1 on 12/1/2025 at 12:30 PM identified on 9/10/2025, Resident #1 was attempting to go outside at the main lobby entrance and was in between the double doors leading to outside. SW #1 attempted to stop Resident #1 because Person #1 had directed to not allow him/her to go outside. As SW #1 attempted to stop Resident #1 and bring him/her back into the facility, he/she became more aggressive by attempting to kick SW #1 and the doors. Visitors had entered through the doors while SW #1 and Resident #1 were between the doors, and Resident #1 was able to exit to the outside. Resident #1 stated he/she wanted to feed the birds and had bread in his/her possession. SW #1 stated a Conservator can direct care related to allowing or not allowing a resident to go outside, but stated a resident has the right to go outside and the facility team should have allowed Resident #1 to go outside while ensuring his/her safety. Review of the facility Resident [NAME] of Rights Policy dated 7/2021 identified the resident has the right to treat his/her living quarters as their home. The resident has the right to choose activities, schedules, and health care consistent with his/her interest, and the right to participate in community activities both inside and outside the facility. The Policy further directed the resident has the right to make choices about aspects of their life that are significant to themselves.</p>		

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F 0600  Level of Harm - Actual harm  Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.  (continued on next page)

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F 0600  Level of Harm - Actual harm  Residents Affected - Few	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on clinical record review, facility documentation review, facility policy review, and interviews for one of four residents (Resident #3) reviewed for abuse, the facility failed to ensure the resident was free from mistreatment and failed to ensure adequate supervision of a resident (Resident #1) on one-to-one observation, resulting in the resident hitting Resident #3. The findings include: A. Resident #1 was admitted to the facility during 9/2025 with diagnoses that included dementia, sensorineural hearing loss, esophageal perforation, anxiety, and depression. Record review identified Person #1 was a court appointed Conservator of Person. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of fifteen out of fifteen (15/15), indicative of being alert and oriented, had no behaviors noted, and ambulated independently. Physician order dated 9/29/2025 directed regular diet with thin liquids. The Resident Care Plan dated 10/7/2025 identified Resident #1 had episodes of anxiety with combative behaviors with care, and a history of resident-to-resident physical abuse. Interventions directed a private room, monitor resident per facility protocol and physician orders, use whiteboard/cards for communication related to hearing impairment, and psychiatry follow up as indicated. Record review identified Resident #1 had the following behaviors and visual monitoring on the following dates: 1. On 10/4/2025, Resident #1 was placed on every 30-minute check related to increased wandering behaviors and was observed eating other resident's food. 2. On 10/20/2025, Resident #1 was involved in a resident-to-resident altercation with Resident #2: Resident #1 kicked Resident #2 on the right leg. Interventions included a room change and Resident #1 remained on every 30-minute checks. 3. On 10/24/2025, Resident #1 was observed attempting to remove his/her wander guard device and was combative toward nursing staff. Resident #1 and was transferred to the hospital for evaluation. Resident #1 returned from the hospital the same day with a new order for Olanzapine (antipsychotic) 5 milligrams (mg) every 24 hours as needed for agitation. Every 30-minute checks were increased to every 15-minute checks. 4. On 10/25/2025, Resident #1 was involved in a resident-to-resident altercation: Resident #1 hit Resident #4 approximately two/three times, in an attempt to take his/her glasses. Resident #4 retaliated and hit Resident #1 back, causing Resident #1 to fall to the ground. Resident #1 sustained a hematoma and was transferred to the hospital for evaluation. Resident #1 was readmitted to the facility on [DATE] with diagnoses of hypokalemia (low potassium blood level), hypocalcemia (low calcium blood) and hypomagnesemia (low magnesium blood levels). Upon readmission on [DATE], Resident #1 had a new physician order for continuous one-to-one (1:1) monitoring. 5. On 11/6/2025, Resident #1 was involved in a resident-to-resident altercation. Resident #1 was in the recreation room waiting in line to purchase an item, when Resident #2 approached Resident #1, stood up from his/her wheelchair, and struck Resident #1 in the face without provocation. Resident #2 indicated it was in retaliation of the previous altercation (occurred on 10/20/2025) between the two. Resident #1 did not sustain any injuries and was maintained on 1:1 monitoring. B. Resident #3's diagnoses included hemiplegia and hemiparesis (paralysis and weakness) following cerebral infarction (stroke), anxiety, and depression. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #3 had a Brief Interview for Mental Status (BIMS) score of fifteen out of fifteen (15/15), indicative of being cognitively intact and was dependent on transfers and ADLs. The Resident Care Plan dated 11/1/2025 identified Resident #3 had a stroke with left side hemiparesis with left side facial droop. Interventions directed assist of two (2) with Hoyer for transfers, and provide emotional support as needed. A facility reportable event form dated 11/19/2025 at 3:35 PM identified Resident #3 was sitting close to the door and observed Resident #1 enter the dining room unaccompanied. Resident #3 alerted staff that Resident #1 entered the dining room, and the staff called out to the Nurse Aide (NA) doing the 1:1 safety monitoring and was not with Resident #1 at the time. Resident #3 reported that Resident #1 came over to his/her side and punched him/her on the right side of the face, knocking off his/her glasses. The form indicated Resident #3 had no injury. The facility investigation identified Resident #3 reported to the DON that Resident #1 had hit him/her - with a closed fist causing his/her glasses to fall off and called him/her derogatory names and racial slurs. Recreation Aide (RA) # 2 called out for the NA assigned to the 1:1 safety monitoring, who was not present with Resident #1. The facility summary dated 11/21/2025 identified the incident was a resident to resident physical assault with injury while Resident #1 was unattended by the NA assigned to 1:1 safety monitoring. Social services note dated 11/21/2025 at 2:44 PM identified Resident #3</p>		