STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075047	A. Building B. Wing	01/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hewitt Health & Rehabilitation Center, Inc	45 Maltby Street Shelton, CT 06484

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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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F 0580 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 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 the provider was notified at the time a change in behavioral symptoms was noted. The findings include:Resident #1's diagnoses included dementia with behavioral disturbances, anxiety, major depressive disorder, centrilobular emphysema (damage to the air sacs in the center area of the lungs which can spread outwards and leads to difficulty breathing and reduced oxygen supply to the bloodstream) and congestive heart failure. The Resident Care Plan dated 10/9/25 identified Resident #1 had chronic progressive decline in intellectual functioning characterized by deficit in memory, judgment, decision making and thought process' related to dementia with psychotic disturbances, displayed inappropriate behavior and at times refused to wear supplemental oxygen, refused medication and could be resistive to care. Interventions included administering medications as ordered by the provider, observing for and reporting changes in cognitive status to the provider, redirecting the resident's undesirable behavior and if he/she was resistive to or refuses care, leave and reapproach the resident in five (5) to ten (10) minutes. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of eight (8) out of fifteen (15) indicating some memory recall deficits, disorganized thinking, difficulty focusing attention, had not exhibited behavioral symptoms in the past seven (7) days and was independent with bed mobility, transfers and ambulating. The nurse's note dated 12/27/25 at 12:57 AM identified a nurse aide changed Resident #1's bed sheets due to the sheets being soiled and Resident #1 became angry and threw the linens out into the hallway stating he/she did not want new linens. The note reported that staff attempted to redirect Resident #1 twice. The nurse's note dated 12/27/25 at 1:09 PM identified Resident #1 was given fluids with the lunch meal and threw them all over the floor and began screaming at the nurse aide. Review of the clinical record from 11/28/25 through 12/26/25 failed to identify any previous angry outbursts from Resident #1 or that the nursing supervisor or the provider were notified on 12/27/25 of Resident #1's change in behavior. The nurse's note dated 12/29/25 at 2:25 AM identified Resident #1 became very upset when the oxygen tubing was changed and the charge nurse later re-approached Resident #1 and explained why the tubing had to be changed and Resident #1 settled down. The Advanced Practice Registered Nurse (APRN) note dated 12/29/25 at 4:42 AM identified nursing called her to report Resident #1 became agitated when the oxygen tubing was changed and the extension set to make the tubing longer was thrown away. The note indicated Resident #1 returned to the bedroom and may have lit a part of his/her bed on fire and the fire was self-extinguished by the time the nursing staff responded to the room. The note identified Resident #1 was placed on one (1) to one (1) monitoring and no other matches were found and she ordered a continuation of the 1 to 1 monitoring, a psychiatric evaluation to be completed in the morning and to notify the provider of any further change in condition. The nurse's note dated 12/29/25 at 1:45 PM identified at 7:00 AM Resident #1 was transferred to the hospital after making a threatening statement towards the building. The note indicated Resident #1 was extremely agitated, throwing things, yelling at staff and the provider and Resident #1's responsible party were made aware. The hospital documentation dated 12/29/25 identified Resident #1 presented to the emergency department for evaluation of agitation, complaints of feeling unwell, and concerns for a bladder infection. The emergency department note identified the crisis team was consulted regarding Resident #1's agitation and the report that Resident #1 had set his/her bed on fire. The note indicated Resident #1 was diagnosed with a urinary tract infection and started on antibiotics and Resident #1 was cleared by the crisis team and deemed safe to return to the facility. The nurse's note dated 12/31/25 at 8:21 PM identified Resident #1 returned to the facility. Interview with the charge nurse, Licensed Practical Nurse (LPN) #2, on 1/2/26 at 11:56 AM identified although Resident #1 was unusually angry on 12/27/25, she did not report Resident #1's outbursts to either the nursing supervisor or provider, stating she attributed Resident #1's behaviors to not liking change. LPN #2 stated she documented Resident #1's behaviors in the psychiatric APRN book even though she knew they were not set to visit the facility again for three (3) more days. LPN #2 reported looking back, she should have notified the nursing supervisor on 12/27/25 so the on-call provider could have been notified of Resident #1's change in behavior, explaining Resident #1 was unable to be redirected and had no available as needed medication to calm him/her down. Interview with LPN #1 on 1/2/26 at 1:47 PM identified although Resident #1 had a history of refusals, on 12/29/25, Resident