STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075064	A. Building B. Wing	06/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milford Health and Rehabilitation Center	195 Platt Street Milford, CT 06460

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record and facility documentation, and interviews for one resident (Resident #1) reviewed for accidents, the facility failed to ensure staff notified the State Agency timely when a new fracture of indeterminate age was identified. The findings include: Resident #1's diagnoses included dementia, vascular parkinsonism, and epilepsy. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 was unable to complete a Brief Interview for Mental Status (BIMS), had severe cognitive impairment and was dependent for all ADLs (activities of daily living) and transfers. The Resident Care Plan dated 3/19/26 identified a deficit in self-care function related to left side hemiplegia and dementia. Interventions directed to provide personal care, and therapy referral as indicated. APRN #1 progress note dated 4/1/26 at 10:34 AM identified Resident #1 was seen for follow-up regarding continued overall decline, goals of care, dementia, and dehydration. The note indicated oral intake had declined to minimal or no intake, representing a worsening from the poor appetite noted the previous day. Additionally, Resident #1 was not taking medications as ordered, which represented an escalation from the prior day's difficulty with medication administration. An extensive discussion was held with the resident's significant other and Person #1 regarding advanced care planning and goals of care. Hospice consultation was recommended at that time. The resident's significant other and Person #1 expressed their wish for Resident #1 to be transferred to the emergency department for a higher level of care. A nursing note dated 4/1/26 at 12:00 PM identified Resident #1's responsible party met with APRN regarding Resident #1's status, and Person #1 had previously expressed a desire for all available treatment measures to be pursued, including consideration of a feeding tube, and discussed transfer to the hospital. Nursing note dated 4/1/26 at 1:10 PM identified Person #1 spoke with the APRN #1 by telephone and agreed with transferring Resident #1 to the hospital for further evaluation. The Hospital Discharge summary dated [DATE] identified imaging results from the CT chest, abdomen, and pelvis without contrast, identified age-indeterminate compression deformities of the T3 and T4 (spine) vertebral bodies that were new compared to imaging from 6/3/25. The report recommended correlation with point tenderness in the affected region. The imaging also identified a subacute-to-chronic right acetabular (hip socket) fracture and a varus-impacted subcapital fracture of the left femur (neck of the femur), with a recommendation to correlate the findings with any recent history of trauma. Resident #1 was seen by orthopedics with a plan to continue conservative management and weight-bearing as tolerated. Review of CT's Department of Health's FLIS Events Report Tracking System identified the facility did not submit a reportable event for Resident #1's injury of unknown origin noted on the hospital Discharge summary dated [DATE]. Interview and medical record review with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) on 6/16/26 at 12:40 PM identified they were not aware that Resident #1 had been diagnosed with age-indeterminate fractures of the hip. Upon review of the Hospital Discharge Summary and imaging findings, the DON and ADON confirmed the diagnosis and acknowledged the fractures constituted an injury of unknown origin that should have been reported to the State Agency. The DON and ADON stated the event was not reported to the State (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Agency. Interview with the Director of Nursing (DON) on 6/16/26 at 2:00 PM revealed the facility was unable to provide a policy regarding reporting of adverse events to the State Agency. The DON stated the facility relied upon and followed the requirements of the Connecticut Public Health Code for adverse event reporting.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for one resident (Resident #1) reviewed for accidents, the facility failed to ensure a thorough investigation was completed timely after an injury of unknown origin was identified. The findings include: Resident #1's diagnoses included dementia, vascular parkinsonism, and epilepsy. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 was unable to complete a Brief Interview for Mental Status (BIMS), had severe cognitive impairment and was dependent for all ADLs (activities of daily living) and transfers. The Resident Care Plan dated 3/19/26 identified a deficit in self-care function related to left side hemiplegia and dementia. Interventions directed to provide personal care, and therapy referral as indicated. APRN #1 progress note dated 4/1/26 at 10:34 AM identified Resident #1 was seen for follow-up regarding continued overall decline, goals of care, dementia, and dehydration. The note indicated oral intake had declined to minimal or no intake, representing a worsening from the poor appetite noted the previous day. Additionally, Resident #1 was not taking medications as ordered, which represented an escalation from the prior day's difficulty with medication administration. An extensive discussion was held with the resident's significant other and Person #1 regarding advanced care planning and goals of care. Hospice consultation was recommended at that time. The resident's significant other and Person #1 expressed their wish for Resident #1 to be transferred to the emergency department for a higher level of care. A nursing note dated 4/1/26 at 12:00 PM identified Resident #1's responsible party met with APRN regarding Resident #1's status, and Person #1 had previously expressed a desire for all available treatment measures to be pursued, including consideration of a feeding tube, and discussed transfer to the hospital. Nursing note dated 4/1/26 at 1:10 PM identified Person #1 spoke with the APRN #1 by telephone and agreed with transferring Resident #1 to the hospital for further evaluation. The Hospital Discharge summary dated [DATE] identified imaging results from the CT chest, abdomen, and pelvis without contrast, identified age-indeterminate compression deformities of the T3 and T4 (spine) vertebral bodies that were new compared to imaging from 6/3/25. The report recommended correlation with point tenderness in the affected region. The imaging also identified a subacute-to-chronic right acetabular (hip socket) fracture and a varus-impacted subcapital fracture of the left femur (neck of the femur), with a recommendation to correlate the findings with any recent history of trauma. Resident #1 was seen by orthopedics with a plan to continue conservative management and weight-bearing as tolerated. Interview and record review with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) on 6/16/26 at 12:40 PM identified they were not aware that Resident #1 had been diagnosed with age-indeterminate fractures of the hip. Upon review of the Hospital Discharge Summary and imaging findings, the DON and ADON confirmed the diagnosis and acknowledged the fractures constituted an injury of unknown origin that should have been assessed and investigated. Interview identified although Resident #1 had no recent falls, the facility had not conducted an investigation because they were unaware of the diagnosis. Interview with the Director of Nursing (DON) on 6/16/26 at 2:00 PM revealed the facility was unable to provide a policy governing the identification and investigation of injuries of unknown origin. The DON stated the facility relied upon and followed the requirements of the Connecticut Public Health Code for adverse event reporting.