STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075109	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hebrew Center for Health and Rehabilitation	1 Abrahams Blvd West Hartford, CT 06117

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 0600

Level of Harm - Minimal harm or potential for 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.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 47460

Based on clinical record review, facility documentation review, facility policy review, and interviews for two of three residents (Resident #1 and #2) reviewed for abuse, the facility failed to ensure residents (Resident #1 and #2) were free from mistreatment. The findings include:

a. Resident #1's diagnoses included depression and anxiety. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 was alert and oriented, had no behaviors and required supervision for bathing and toilet use and moderate assistance for transfers and toilet use. The Resident Care Plan (RCP) dated 8/31/2024 identified Resident #1 required assistance with self-care. Interventions directed two (2) half rails/mobility bars up for assistance with bed mobility, toilet use and transfer assist of two (2).

Review of Facility Reportable Event Form identified on 9/15/2024 at 10:15 AM Resident #1 was alert and oriented, and alleged a NA hit him/her in the left eye with a towel and slammed the railing down on his/her hand. Assessment identified no injuries. The APRN was notified with new orders to monitor the left eye and right forehand every shift for 14 days.

Review of NA #1's written statement dated 9/15/2024 identified she told Resident #1 staff were serving breakfast and as soon as she was done, she would take the resident to the bathroom. Resident #1 yelled, was cursing, threw his/her breakfast tray on the floor, slammed his/her phone down on the side table and when NA #1 put the railing up, the resident alleged NA #1 hit his/her hand. NA #1 denied that occurred. The statement further indicated NA #1 took Resident #1 to the bathroom and Resident #1 threw his/her underwear at NA #1. NA #1 placed a towel in the sink to use for care, and Resident #1 alleged that NA #1 hit him/her in the eye with the towel. NA #1 denied hitting Resident #1 with the towel.

Review of facility documentation dated 9/23/2024 identified the Administrator, Assistant Administrator and DNS met with NA #1 and NA #1 admitted that when Resident #1 told her she hit his/her hand on the side rail, she continued to work with Resident #1 and did not notify the nurse. NA #1 further stated that she continued to work with Resident #1 in the bathroom after being accused of hitting him/her in the eye.

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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: 075109	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/10/2024
NAME OF PROVIDER OR SUPPLIER Hebrew Center for Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1 Abrahams Blvd West Hartford, CT 06117	

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and facility documentation review with NA #2 on 10/10/2024 at 12:28 PM identified she heard Resident #1 screaming and saw Resident #1's meal tray on the floor in his/her room; Resident #1 told NA #2 that he/she pushed it over because he/she wanted someone to set up the breakfast. NA #2 stated she was in the room when NA #1 moved the side rail down and Resident #1 alleged the side rail hit his/her hand. NA #2 stated then the resident slammed his/her phone on the over bed table, and she did not see if Resident #1's hand was hit by the side rail or the phone. NA #2 further stated she was in the room when Resident #1 and NA #1 were in the bathroom and heard Resident #1 say that NA #1 hit him/her with the towel, although she did not witness the incident. NA #1 then left the room as LPN #1 entered. Interview, clinical record review and facility documentation review on 10/10/2024 at 1:05 PM with LPN #1 identified responded to the room when she heard a loud noise, and she observed Resident #1 on the toilet with NA #1 providing care. Resident #1 was upset, and stated NA #1 was singing over him/her, stated he/she threw a brief at NA #1 and then NA #1 threw a towel in Resident #1's face. LPN #1 stated as she was trying to speak with Resident #1, NA #1 continued talking, and she had to ask NA #1 to stop talking, and NA #1 left the room. Resident #1 further stated he/she felt ignored and frustrated. Although attempted, an interview with NA #1 was not obtained during survey. Interview, clinical record review and facility documentation review on 10/10/2024 at 2:32 PM with the ADNS and DNS identified on 9/15/2024 staff reported Resident #1 was angry he/she had to wait for care, and that NA #1 had slammed the railing down when assisting the resident and the railing hit the resident's hand. Resident #1 further stated he/she threw a brief at NA #1 and NA #1 in turn threw a towel at Resident #1 and the towel hit his/her eye. The DNS stated NA #1 sang loudly to drown out Resident #1, and indicated the interaction should not have occurred. The DNS indicated their investigation substantiated the allegation of abuse, and NA #1's employment at the facility as terminated. b. Resident #2's diagnoses included low back pain, anxiety and depression. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 was alert and oriented, had no behaviors and was independent eating. The Resident Care Plan (RCP) dated 8/10/2024 identified Resident #2 had an ADL self-care deficit due to functional limitations and chronic pain. Interventions directed to assist with ADLs, put creamers in coffee, use of a straw for all fluids and open syrup. Review of Facility Reportable Event Form dated 9/19/2024 identified an allegation of intimidation and bullying by NA #1, no injuries were identified, and NA #1 was suspended. Review of facility documentation dated 9/23/2024, identified the Administrator, Assistant Administrator and DNS met with NA #1 on 9/23/2024 and NA #1 reported that she did not give Resident #2 a large cup of coffee because she did not have enough coffee for the unit, and further indicated that she had asked the Food Services Director for more coffee carafes and that he had told her he didn't have enough. Further, the documentation indicated when NA #1 was asked about playing music when Resident #2 tried to make announcements, she denied the allegation and laughed. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Hebrew Center for Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 1 Abrahams Blvd West Hartford, CT 06117	

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and facility documentation review with the Food Services Director (FSD) on 10/10/2024 at 12:25 PM identified that the facility has several carafes (for coffee) in the storage area and NA #1 never spoke to him about carafes or requested additional coffee. He further indicated that each floor has a coffee maker that can be used for residents, and it only takes three (3) minutes to brew a pot so additional coffee could have been provided when Resident #2 requested. Interview on 10/10/2024 at 12:53 PM with Dietary Aide (DA) #1 identified that she offered to make coffee for Resident #2 on several occasions and was told by NA #1 that Resident #2 could wait for the coffee. DA #1 stated she thought NA #1 was having a bad day, and she had wanted to help, but NA #1 had directed Resident #2 could wait, and she later got the coffee and filled the large cup for Resident #2. Although attempted, an interview with NA #1 was not obtained during survey. Interview, clinical record review and facility documentation review on 10/10/2024 at 2:32 PM with the ADNS and DNS identified NA #1 should have provided the coffee as requested by Resident #2. The interview failed to identify why the coffee was not provided. The DNS indicated their investigation substantiated the allegation of abuse, and NA #1's employment at the facility as terminated. Review of facility Abuse Policy & Procedure directed in part, that each resident has a right to be free from abuse. Willful means an individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. This also includes the deprivation by an individual, including a caretaker, of goods or services. Facility documentation review identified staff education was initiated on 9/23/2024 regarding abuse and the facility abuse policy. Audits were initiated on 9/24/2024, and a QAPI meeting was held on 9/23/2024. Based on review of facility documentation, past non-compliance was identified.