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 03/27/2026

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** Based on clinical record review, observations, facility documentation review, facility policy review, and interviews for one of three residents (Resident #2) reviewed for abuse, the facility failed to ensure the resident was free from neglect and a dependent resident was provided with care timely. The findings include: Resident #2's diagnoses included Alzheimer's, dementia and diabetes with chronic kidney disease. The Resident Care Plan (RCP) dated 1/8/2026 identified a self-care deficit, and bladder and bowel incontinence. Interventions directed extensive assistance with personal hygiene and toilet use, and provide incontinent care as needed. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified that Resident #2 had a Brief Interview for Mental Status (BIMS) score of zero out of fifteen, indicative of severe cognitive impairment, was frequently incontinent of bowel and bladder and required total care with ADLs. APRN (psychiatry) note dated 2/3/2026 indicated Resident #2 was nonverbal during evaluations, and due to severe cognitive impairment, information for the evaluation was obtained through a combination of direct clinical observation, chart review and a report from caregivers familiar with the resident's baseline behavior and functioning. Nurse Aide (NA) care card dated 2/8/2026 directed bladder/bowel incontinent check as required for incontinence, wash, rinse and dry perineum, change clothing as needed after incontinence episodes, dependent with bathing/showering and dressing, and extensive assistance of two (2) for bed mobility. Review of facility reportable event dated 2/9/2026 identified an allegation that Resident #2 was left out of bed and unchanged for extended period of time. The APRN was notified, and a full body audit was performed with no apparent injury or ill effects noted. The facility summary dated 2/16/2026 identified Resident #2 was repositioned while up out of bed in his/her tilt in space wheelchair and received all due care. Medications were administered by the nurse who stated Resident #2 appeared comfortable and free of odors and reported Resident #2 and his/her visitors did not express any concerns on 2/9/2026. The summary identified the facility did not substantiate the allegation of abuse. Interview and observation on 3/26/2026 at 11:18 AM with NA #1 identified she worked from 7 AM to 3 PM on 2/9/2026 and Resident #2 was on her assignment. NA #1 stated Resident #2 was one of the first residents she provided peri/incontinent care for and transferred Resident #2 out of bed about 7 or 7:30 AM. NA #1 stated her usual routine was to transfer Resident #2 out of bed for breakfast and then return Resident #2 to bed after the breakfast meal. NA #1 stated on 2/9/2026 she did not put Resident #2 back to bed after the breakfast meal, and about 10 AM she repositioned Resident #2's tilt-in-space wheelchair (TIS w/c). NA #1 stated she did not provide any incontinent care at that time and checked only for any odors; she did not touch the incontinent brief and stated she relies only on smell for Resident #2. NA #1 stated a family member visited around 11:00-11:30 AM and wanted resident to eat in the TV room; and at 1:00 PM she informed the visitor the resident needed to return to bed for care, but the visitor declined care to be provided at that time. NA #1 stated she did not return to re-offer care and she did not notify the nurse; NA #1 stated she should have re-attempted to provide care and she should have checked the brief every two (2) hours. Although NA #1 stated she notified the nurse at the end of her shift that Resident #2's family had refused care, she (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	did not notify the nurse that the only care she provided for Resident #2 was before the breakfast meal was served approximately seven (7) hours prior. Interview and record review on 3/26/2026 at 1:28 PM with RN #1 identified she worked 7 AM to 3 PM on 2/9/2026, and she was not notified by NA #1 that Resident #2 had not received incontinent care since around 7 to 7:30 AM. RN #1 stated residents should be checked every two (2) hours to determine if they are wet or have had a bowel movement, and if so, the NA should put them back to bed and provide care. RN #1 stated staff should not check a resident for incontinence by using smell alone to determine if incontinence has occurred or if a brief needs to be changed. Interview and record review with NA #2 on 3/26/2026 at 12:56 PM identified she worked 3 to 11 PM on 2/9/2026, and stated incontinent care should be provided every two (2) hours, and Resident #2 was her patient. NA #2 stated that Resident #2 was out of bed in his/her TIS w/c. NA #2 returned Resident #2 to bed after the evening dinner meal and provided incontinent care at that time (approximately 12 hours after the morning care was provided before breakfast). NA #2 stated she was unable to provide incontinent care from 3 PM until after the evening meal because she was occupied in the dining room, and stated she notified LPN #1 after dinner that she had been unable to provide the care. NA #2 further stated she was not informed by NA #1, the off-going day shift NA, or the nurse that Resident #2 had not received peri/incontinence care since approximately 7 or 7:30 AM. Interview and record review with LPN #1 on 3/26/2026 at 12:14 PM identified she worked from 3 to 11 PM on 2/9/2026 and Resident #2 was her patient. LPN #1 stated she was not notified that care was not provided for Resident #2 since before breakfast or that care was offered and declined by a family member. LPN #1 stated resident should be checked and changed every two (2) hours, and to check the brief by assessing the brief indicator (line on the brief that changes color when wet) and feeling the brief for wetness. Further, use of smell is an additional indicator that a resident may be soiled (example an odor from a bowel movement), but stated relying on smell alone was inappropriate. Interview and record review with Corporate RN #2, the Administrator, and the DNS on 3/26/2026 at 2:30 PM identified that Resident #2 had dementia and severe cognitive impairment, was nonverbal, transferred with a mechanical lift, and was dependent on staff for personal hygiene and incontinent care. interview identified Resident #2 received personal care and incontinent care about 7 or 7:15 AM, and NA #1 next attempted to provide care around 1 PM (approximately 6 hours after the care was last provided) but the visitor refused care. RN #2 stated care was not re-offered before the end of the shift at 3 PM, approximately seven (7) hours and 45 minutes after care was last provided. The evening NA did not provide inconvenient care until approximately 7 PM (approximately 12 hours after care was last provided). The DNS stated residents should be checked every two (2) to three (3) hours for incontinent, and that checking for incontinence by smell alone was not sufficient; checking for incontinence required checking the actual incontinent brief for soiling, wetness or checking the indicator line on the brief. The DNS stated NA #1 should have notified the nurse when care was not provided timely. Review of facility ADL: Eating dated 2/9/2026 indicated Resident #2's total intake of 960 milliliters of fluid. Additional interview with NA #2 on 3/26/2026 at 3:08 PM identified when she provided incontinent care for Resident #2 on 2/9/2026 about 7 PM, Resident #2's brief was heavily wet, and Resident #2 was also incontinent of a bowel movement. Review of the facility Abuse Policy & Procedure directed in part, that each resident had the right to be free from abuse and neglect. Neglect means the failure of employees to provide goods and services to a resident that are necessary. Review of Certified Nursing Assistant Job Description directed in part, to makes rounds on assigned residents at the beginning of each shift and every two (2) hours thereafter.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, interviews, and facility policy review for ADL care, the facility failed to ensure that staff providing resident care maintained fingernails free of decorative items, including fake nails with decorations attached. The findings include: Interview and observation with NA #1 on 3/26/2026 at 11:18 AM identified NA #1 worked on a resident unit and provided residents with personal care (ADL care, incontinent care and meal service). NA #1 was observed to have gel-like fingernails between approximately 1/4 and 1/2 inch long with the tips neat and had straight edges across the tip of the nails. The gel-like fingernails were observed to have multiple round silver/white glitter rhinestone-like raised items, approximately 1/16th of an inch, attached to several fingernails on each hand that were firm to the touch and felt like bumps raised from the nail structure. Further, several fingernails had an attached silver-colored metal-like design that covered parts of the sides and tips of several fingernails. The silver metal-like design was raised from the nail surface and was a decorative design. NA #1 stated the glitter-like rhinestone-like items and the silver metal-like designs were glued onto the nails. Interview with DNS on 3/26/2026 at 11:58 AM identified that while staff may have gel fake nails, the nails should be at a comfortable length, and stated no attached jewels or sharp areas were allowed due to concern for infection. Interview with the DNS, Administrator and Regional RN #2 on 3/27/2026 at 3 PM identified the facility allowed staff to wear gel fingernails, Regional RN #2 stated the items attached to NA #1's fingernails were observed by her to be securely in place, and she thought the gel covered the top of the gems. Observation on 3/27/2026 at 10:40 AM of NA #1 identified the gel-like nails remaining in place with the silver/white glitter rhinestone-like raised items and the silver-colored metal-like design visible on multiple fingernails. Review of facility Personal Appearance and Dress Policy directed in part, fingernails are to be clean and well-manicured. For employees involved in direct resident/patient care or where infection control may be an issue, fingernails should not be so long that they compromise the resident's safety. Review of The World Health Organization (WHO) guidelines directed in part, to generally prohibit artificial nails and extenders for all healthcare workers in direct patient care, including nursing home settings, to prevent infection transmission. The guidelines further identified gel nails, being a form of artificial enhancement, are included in these prohibitions as they can harbor bacteria and are difficult to sanitize, even after alcohol gel use. Review of Centers for Disease Control (CDC) Hand Hygiene for Healthcare Workers directed in part, do not wear artificial fingernails or extensions when having direct contact with high-risk patients, germs can live under artificial fingernails both before and after using an alcohol-based hand sanitizer and hand washing.