STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075109	A. Building B. Wing	05/21/2026

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

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility policy and interviews for one (1) of three (3) sampled residents (Resident #1) reviewed for behaviors, the facility failed to notify the onˆcall provider when the resident's behaviors and altered mental status began to escalate following a fall until approximately six (6) hours later and failed to immediately transfer the resident following an APRN assessment which identified the resident required transfer to the Emergency Department (ED) for an urgent psychiatric and medical evaluation until approximately three (3) hours later. The findings include:Resident #1 was admitted to the facility on [DATE] with diagnoses including dementia with behavioral disturbances, Post Traumatic Stress Disorder (PTSD), depression, muscle weakness, and unsteadiness on feet.Review of the facility census identified Resident #1 was sent to the hospital on 3/31/26 and readmitted to the facility on [DATE] to a different room than the room occupied prior to the 3/31/26 transfer.The Nursing readmission Evaluation dated 4/29/26 identified Resident #1 was alert to person and place only, had cognitive and hearing impairments, and had an unsteady gait due to a right toe amputation.The Resident Care Plan (RCP) dated 4/29/26 identified Resident #1 had impaired cognitive functioning, impaired thought processes, and a history of wandering and refusing care and treatments. Interventions included presenting one task at a time, cueing, reorienting and supervising as needed, offering diversional activities, monitoring behavioral episodes, determining underlying causes, and providing psychiatric evaluation and treatment as needed.An Elopement Risk Evaluation dated 4/29/26 identified Resident #1 was not at risk for elopement.A nurse's note by RN #1 dated 4/29/26 at 4:40 PM identified Resident #1 arrived around 1:30 PM, was alert and oriented to self only, was wandering, and was going into the roommate's belongings. Resident #1 was placed on every fifteen (15) minute checks, fall mats were placed on both sides of the bed, and a request was made for the psychiatric APRN to evaluate Resident #1 due to behaviors.A nurse's note by LPN #1 dated 4/29/26 at 5:47 PM identified Resident #1 was alert, confused, and agitated upon arrival, ambulated to the roommate's side of the room, and was going through the roommate's belongings. Resident #1 was placed at the nurse's station for safety.A physician's order dated 4/29/26 directed trazodone 50 mg by mouth every 24 hours as needed for insomnia for five (5) days. A separate order directed every fifteen (15) minute monitoring.Review of the clinical record failed to identify an Elopement Risk Evaluation following documentation of wandering behaviors.Review of the April 2026 Medication Administration Record (MAR) identified trazodone was administered at 7:44 PM by LPN #2.A nurse's note by LPN #2 dated 4/29/26 at 8:53 PM identified Resident #1 was alert and confused at baseline, displayed no pain, was toileted before and after dinner and at bedtime, was medication compliant, and received trazodone with good effect.A nurse's note by RN #2 dated 4/30/26 at 4:41 AM identified that at 3:20 AM Resident #1 had an unwitnessed fall and was found sitting on the floor mat next to the bed and did not know how he/she got there. It identified no injuries, no pain, neurological signs within normal limits, and normal range of motion, and that Resident #1 was transferred with the assist of three (3) staff to a wheelchair and placed at the nurse's station. The note identified the onˆcall APRN was notified and conducted a video visit and instructed staff to assess pain and (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	monitor neurological vital signs per protocol and notify the provider of changes.An onˆcall APRN note dated 4/30/26 identified Resident #1 had an unwitnessed fall, denied head strike, loss of consciousness, or pain, had no injuries, remained at baseline, and was in no acute distress. It directed staff to assess pain per protocol, maintain fall precautions, monitor neurological vital signs, and notify the provider of any change. The note failed to identify that any behaviors were reported to the provider.A nurse's note by LPN #3 dated 4/30/26 at 8:07 AM identified Resident #1 reported falling while attempting to use the bathroom. The NA assigned to Resident #1 (NA #1) reported Resident #1 was combative during care. LPN #3 identified Resident #1 was confused and restless but was resting in bed at the time of documentation.Review of the clinical record failed to identify that the onˆcall provider was notified on the 11:00 PM to 7:00 AM shift of increased confusion, restlessness, or combativeness following the fall.A Situation Background Assessment and Recommendation (SBAR) note by RN #1 dated 4/30/26 at 7:49 AM identified Resident #1 had a change in condition with physical aggression, confusion, and restlessness. The note failed to identify if or when the provider was notified.A provider note by APRN #1 dated 4/30/26 identified she saw Resident #1 at 9:45 AM following reports of increased confusion, agitation, combativeness, and noncompliance with care and safety measures. It identified Resident #1 remained restless, confused, and difficult to redirect and due to acute behavioral changes, continued confusion, recent fall, and need for urgent psychiatric and medical evaluation, Resident #1 would be transferred to the ED.The Prehospital Care Report dated 4/30/26 identified Emergency Services was not alerted until 12:54 PM, more than three (3) hours after APRN #1 directed an urgent ED transfer. Emergency Services arrived at 1:06 PM. Resident #1 was found sitting in the wheelchair, alert but confused at baseline, calm and cooperative, and was transported to the ED.Interview with LPN #3 on 5/21/26 at 12:32 PM identified Resident #1 was awake throughout the night, restless, increasingly confused, and resistive to care following the fall but she could not recall notifying the nursing supervisor or the provider, stating she should have.Interview with NA #1 on 5/21/26 at 12:19 PM identified Resident #1 had no behaviors prior to the fall but was resistive to care and repeatedly trying to get out of bed afterwards.Interview with RN #2 on 5/21/26 at 2:55 PM identified staff did not report any behaviors or insomnia to her prior to the fall and did not report that behaviors escalated following the fall. She identified that had she been notified, she would have assessed the resident, reviewed asˆneeded medications, and notified the onˆcall provider.Interview with RN #1 on 5/21/26 at 1:14 PM identified Resident #1 was calm the evening of 4/29/26 after receiving trazodone. When RN #1 returned at 7:00 AM on 4/30/26, Resident #1 had extreme altered mental status and could not be redirected. RN #1 identified he should have notified the provider immediately but waited until APRN #1 arrived.Interview with APRN #1 on 5/21/26 at 1:33 PM identified upon evaluating Resident #1 on 4/30/26, Resident #1 was loud, restless, difficult to redirect, and significantly different from baseline. Due to acute changes after a fall, history of blood clots, and anticoagulant therapy, she ordered immediate ED transfer and identified that nursing should have notified the supervisor and provider immediately at the onset of restlessness, confusion, and escalating behaviors.Interview with the DON on 5/21/26 at 2:20 PM identified the hospital reported Resident #1 was stable without behaviors prior to readmission. Staff reported Resident #1 was restless, agitated, and combative upon return on 4/29/26. The DON identified the onˆcall provider should have been notified overnight on 4/30/26 when behaviors escalated and that Resident #1 should have been transferred to the ED immediately following APRN #1's assessment.Review of the Change of Condition Notification policy dated 4/2023 directed that the provider must be notified when there is a significant change in the resident's physical, mental, or psychosocial status or when treatment must be altered. The policy required a complete assessment, documentation of symptoms, and documentation of provider notification.Review of the Behavior Management Program policy dated 10/2022 directed that the facility provide services to support the resident's highest practicable physical, mental, and psychosocial wellˆbeing, review behavioral history prior to admission, identify antecedents, and implement appropriate interventions such as redirection, diversion, and reˆapproach techniques.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **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 (1) of three (3) sampled residents (Resident #1) reviewed for behaviors, the facility failed to permit the resident to return to the facility following a hospital Emergency Department (ED) visit, despite the resident's bed not yet being filled, and without documentation that readmission would endanger the health or safety of Resident #1 or other residents. The findings include:Resident #1 was admitted to the facility on [DATE] with diagnoses including dementia with behavioral disturbances, Postˆ Traumatic Stress Disorder (PTSD), depression, muscle weakness, and unsteadiness on feet.Review of the facility census identified Resident #1 was transferred to the hospital on 3/31/26 and was readmitted on [DATE]. The Nursing readmission Evaluation dated 4/29/26 identified Resident #1 was alert to person and place only, had cognitive and hearing impairments, and had an unsteady gait related to a right toe amputation.The Resident Care Plan (RCP) dated 4/29/26 identified impaired cognition, dementiaˆ related behaviors, wandering, and refusal of care. Interventions included reorientation, cueing, offering diversional activities, supervising as needed, monitoring behavioral episodes, determining underlying causes, and psychiatric evaluation and treatment as indicated.An Elopement Risk Evaluation dated 4/29/26 identified Resident #1 was not at risk for elopement.Nursing documentation from 4/29/26 identified Resident #1 was confused, restless, wandering to the roommate's side of the room, and going through belongings. Staff redirected Resident #1 to the nurse's station for safety and administered asˆ needed trazodone, which was documented as effective in calming the resident.Nursing documentation from later that evening identified Resident #1 remained confused but redirectable and displayed behaviors consistent with dementia. Staff interviews completed on 5/21/26 identified Resident #1 was confused and restless upon readmission but was easily redirectable, responded well to trazodone, did not wander into other residents' rooms, and did not display violent or dangerous behaviors.On 4/30/26, Resident #1 was transferred to the ED due to increased confusion and behavioral changes. Review of the Prehospital Care Report dated 4/30/26 identified Emergency Services found the resident alert but confused at baseline, calm, cooperative, and voicing no complaints.A nurse's note dated 4/30/26 at 1:33 PM identified the facility notified the APRN of altered mental status and obtained an order for hospital transfer. No documentation identified the resident posed a danger to self or others during this period.A Social Services note dated 5/1/26 identified the Administrator, DON, Admissions Director, and SW notified the responsible party that the facility would not readmit Resident #1 due to behavioral concerns and issued a discharge notice. The Notice of Transfer/discharge date d 5/1/26 stated Resident #1's health or safety, or the health and safety of others, would be endangered by readmission; however, the medical record did not contain documentation supporting that conclusion. Resident #1's bed remained unfilled until 5/2/26.Interviews conducted on 5/21/26 with LPN #1, LPN #2, NA #2, LPN #3, RN #2, and RN #1 identified they did not observe Resident #1 to be violent, aggressive toward staff or other residents, or wandering into other resident rooms. Staff consistently identified Resident #1's behaviors as consistent with dementia and redirectable.Interview with APRN #1 on 5/21/26 identified she was unaware of any dangerous behaviors or incidents involving Resident #1 that would have placed others at risk, and further identified she had not documented any assessment indicating Resident #1 posed a danger to others.Interview with the Admissions Director on 5/21/26 identified the facility decided not to readmit Resident #1 following the 4/30/26 ED visit. The Admissions Director reported Resident #1's bed was filled on 5/2/26 and that room rearrangement or alternative placement options within the facility were not explored prior to refusal of readmission.Interview with the DON on 5/21/26 identified there was no documentation supporting that Resident #1 was violent, wandering into other resident rooms, or posed a safety risk to others. The DON reported staff did not provide statements or (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documentation supporting danger to self or others and acknowledged that the facility did not explore alternative accommodations before denying readmission.Review of the Involuntary Discharge/Discharge/Transfer policy dated 6/2023 directed the facility to discharge or transfer residents only for permissible reasons, including when the health or safety of individuals in the facility is endangered, and required the basis for transfer or discharge to be documented in the resident's medical record. The policy required a physician statement indicating the discharge or transfer is not medically contraindicated. Review of the record failed to identify such documentation.Review of the Behavior Management Program policy dated 10/2022 directed the facility to identify behavioral antecedents and implement individualized interventions, including redirection, reˆapproach, and diversion techniques, prior to discharge or transfer decisions. Review of the record failed to identify the use or consideration of such interventions prior to the refusal to readmit.Review of the Change of Condition Notification policy dated 4/2023 required staff to notify the provider of significant mental or psychosocial changes and required documentation of assessments, symptoms, and provider notification. Review of the record failed to identify documentation supporting that behavioral symptoms endangered others or that provider assessment supported involuntary discharge.Although requested, the facility did not provide a Consultative Discharge Process policy which outlines interdisciplinary review prior to refusal of readmission.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility policy and interviews for one (1) of three (3) sampled residents (Resident #1) reviewed for medication administration, the facility failed to ensure medications were administered per physician's order and failed to notify the provider of missed doses. The findings include:Resident #1 was admitted to the facility on [DATE] with diagnoses including dementia with behavioral disturbances, hypertension, congestive heart failure, longstanding persistent atrial fibrillation, and deep vein thrombosis (DVT) of the left upper extremity.The Resident Care Plan (RCP) dated 4/29/26 identified Resident #1 had altered cardiac status, a DVT to the left upper arm, and was at risk for adverse effects related to anticoagulation therapy. Interventions included administering medications as ordered.A physician's order dated 4/29/26 directed apixaban 5 mg twice daily by mouth for DVT prophylaxis. Another physician's order dated 4/29/26 directed clopidogrel bisulfate 75 mg by mouth daily for blood clot prevention. A separate order directed hydralazine 50 mg by mouth every eight (8) hours for hypertension.Medication Administration Notes by LPN #3 dated 4/30/26 at 5:18 AM and 5:20 AM identified clopidogrel, apixaban, and hydralazine were not administered because the medications were not available.Review of the April 2026 Medication Administration Record (MAR) identified the three medications were scheduled for administration on 4/30/26 at 6:00 AM and were documented as Other/See Nurse Notes. Review of the MAR further identified apixaban and hydralazine had been administered as scheduled the evening prior.Interview with LPN #3 on 5/21/26 at 12:32 PM identified the ordered medications had not arrived from the pharmacy during the morning medication pass. LPN #3 reported she did not check the Pyxis automated dispensing system for emergency supply, could not explain why she failed to do so, and identified she did not notify the nursing supervisor or provider of the missed medication doses.Interview with APRN #1 on 5/21/26 at 1:33 PM identified licensed nurses are required to administer medications according to physician orders, check the emergency stock when medications are unavailable, and notify the provider when a dose is missed to obtain further instruction.Interview with the DON on 5/21/26 at 2:20 PM identified clopidogrel, apixaban, and hydralazine were stocked in the Pyxis on 4/30/26 and should have been removed and administered per order. The DON reported nursing staff are required to notify the nursing supervisor and provider when medications are unavailable or doses are missed.Review of the Medication Pass policy dated 10/2018 directed medications must be administered safely and timely per the physician's orders within one hour before or after the scheduled time and per the ten rights of medication administration, including right drug, right dose, right route, right time, and right documentation.