

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/29/2026
NAME OF PROVIDER OR SUPPLIER Hebrew Center for Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation review, facility policy review, and interviews for one of four residents (Resident #2) reviewed for a medication errors, the facility failed to ensure a medication to treat Parkinson's disease (Sinemet) was transcribed timely, and failed to ensure medication was administered in accordance with physician orders. The Sinemet was not administered for nineteen (19) days, in accordance with physician orders, which resulted in significant medication error and a significant decline in the resident's physical condition. The findings include: Resident #2 was admitted to the facility on [DATE] with diagnoses that included Parkinson's disease (brain disorder when brain cells stop producing a chemical(dopamine) that helps movement, causing stiff muscles, shaking and slow movement). A hospital discharge summary and interagency referral form (W-10) dated 6/9/2026 directed to administer Carbidopa-Levodopa (generic name for Sinemet) 25-100 milligrams (mg) per tablet (drug that changes into chemical Dopamine used to treat Parkinson associated symptoms), administer two (2) tablets, four (4) times a day. The Summary identified the last dose administered was on 6/9/2026 at 1:03 PM. A follow up appointment was scheduled on 6/29/2026 with neurology. APRN #1 admission note dated 6/10/2026 at 9:00 AM identified evaluation was completed for orders after admission from the hospital. The note directed to continue all medications as listed on the hospital W-10 (review of the W-10 identified page 7 directed Carbidopa-Levodopa 25-100 mg, take two (2) tablets four (4) times a day at 7 AM, 11 AM, 3 PM and 7 PM). An admission Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 6/12/2026 identified Resident #2 had Brief Interview for Mental Status (BIMS) of fourteen (14), indicated Resident #2 was alert and oriented, and required set up for personal hygiene with moderate assistance for transfer and walking 10 feet with a walker. An APRN note dated 6/16/2026 (7 days after admission) identified Resident #2 complained of a stiff neck that had worsened since admission, and was now unable to move his/her neck to the left and right. The APRN noted resting tremors unchanged from previous assessment. Tylenol 650 mgs, three (3) times a day and use of a daily Lidocaine patch (topical local anesthetic used to numb irritated nerves and relieve local pain) was initiated. An APRN note on 6/18/2026 (9 days after admission) identified Resident #2 requested to see the APRN as Resident #2 felt he/she was not receiving sufficient therapy. Physical therapy (PT) also requested APRN to see Resident#2 due Resident #2 declined to participate in therapy until he/she spoke to a doctor. Resident #2 identified his/her current therapy was not improving his/her deconditioning (loss of physical strength and function due to illness). A resident care plan (RCP) dated 6/23/2026 identified Resident # 2 had a deficit in self-care and in functional mobility with weakness. Interventions directed partial assistance of one (1) staff completing less than half of the effort for transfers, and ambulation with rolling walker within room. A social service note dated 6/23/2026 (14 days after admission) identified therapy reported Resident #2 now required assistance (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 0760 Level of Harm - Actual harm Residents Affected - Few	of two (2) staff for standing and completion of activities of daily living (ADLs) and was now non-ambulatory due to current functional status. APRN note dated 6/24/2026 (15 days after admission) identified she was asked to evaluate Resident #2 by Physical Therapy urgently due to acute weakness and significant functional decline. PT #2 reported Resident #2 had a significant change as he/she was unable to stand up and was extremely weak. Neurological examination was non-focal although Resident #2 was overall weak. New orders were placed for labs and x-ray to rule out infection. APRN follow-up note dated 6/25/2026 (16 days after admission) identified Resident #2 reported no pain but was limited by weakness and an inability to walk. PT and occupational therapy (OT) to evaluate other interventions, and plan to continue to monitor for further functional decline. Record review identified all prescribed medications were reviewed by the APRN with each visit. Additional record review failed to identify Resident #2 was receiving the Carbidopa-Levodopa 25-100 mg as directed on the hospital W-10 discharge summary; no physician order was located that the order was written and included in the admission orders at the facility. A neurology consult dated 6/29/2026 identified Resident #2 had become significantly weaker, and his/her Parkinson's disease was worsened. Recommendations directed to not discharge Resident #2 from rehabilitation services until he/she is able walk with walker again. A facility reportable event (RE) dated 6/29/2026 (20 days after admission) at 6:00 PM identified a medication error of clinical significance. The RE indicated during an outpatient (neurology) appointment it was identified Resident #2's Sinemet had been omitted during the transition process from the hospital to the facility; Resident #2 had not received the ordered Sinemet since admission on [DATE]. The medication was started immediately, and the neurologist was updated that an order was placed. APRN order dated 6/29/2026 (20 days after admission) directed Carbidopa-Levodopa (Sinemet) 25-100 milligrams (mg) per tablet, give two (2) tablets, four (4) times a day. APRN note dated 6/30/2026 identified Resident #2 was seen by a neurologist with recommendations to restart Sinemet. Resident #2 continued to be weak on exam, had difficulty lifting his/her head and had frequent drooling. Orders directed to continue Sinemet. APRN note dated 7/2/2026 (3 days after the Sinemet was restarted) identified Resident #2 had improved and able to hold up head much better with less drooling. Improvement was consistent with expected response to Sinemet medication. A review of the facility nursing schedule revealed RN #1 was the day supervisor on 6/10/2026. RN #1 was unavailable for interview during the survey. Interview and record review with RN #3 on 7/23/2026 at 1:15 PM identified she was the day shift manager for Resident #2's unit. RN #3 stated she did not complete an additional medication reconciliation of Resident #2's medications to compare orders with the hospital W-10 to ensure all medications were ordered. RN #3 stated she just didn't get to it. Interview and record review with APRN #1 on 7/29/2026 at 2:00 PM identified she could not recall Resident #2, but she did the best she could when she verified the orders. Record review and interview with PT #1 and the Assistant Administrator on 7/29/2026 at 12:00 PM identified Resident #2 was admitted for short-term rehabilitation focusing on a goal to safely climb up/down six (6) steps to enable access into the home after discharge. Staff identified Resident #2 regressed in mobility; upon admission he/she had been able to sit on the side of bed with no back support with partial assistance of one (1) staff and was able to ambulate with walker up to 300 feet independently. A therapy reassessment on 6/21/2026 (7 days after admission) identified a decreased ability to walk independently, and was only able to walk 100 feet with partial to moderate assistance with the walker. On 6/24/2026 (15 days after admission), Resident #2 could not initiate a step after maximum assistance of one (1) staff to stand on the parallel bars, was unable to advance his/her legs, and required therapy to provide physical assist to maintain stability. Interview identified after the Sinemet was re-started on 6/30/2026, Resident #2 experienced an improvement and (continued on next page)		

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F 0760 Level of Harm - Actual harm Residents Affected - Few	required supervision/touch assistance for transfers, was able to walk 150 feet with supervision, and was able to negotiate six (6) steps. Interview with MD #1, Resident #2's attending physician, on 7/29/2026 at 11:33 AM identified that not providing the Sinemet from admission to the facility until it was identified by the neurologist on 6/29/2026 (20 days after admission) had a significant impact on Resident #2's medical condition contributing to Resident #2's worsening Parkinson's symptoms, as identified by the neurologist during Resident #2's outpatient appointment. Interview identified Resident #2 should have received the medication as ordered by the discharging hospital on 6/9/2026. Interview and record review with the DON on 7/29/2026 at 2:00 PM identified RN #1 had not transcribed Resident #2's medication as ordered per the hospital W-10 into Resident #2's medical record on admission upon 6/9/2026. The DON stated on admission or readmission the shift supervisor would review the W-10 medications and transcribe them into the resident's electronic medical record (EMR). The RN supervisor would then reconcile the transcribed medications back to the W-10 to ensure accuracy. The expectation was this reconciliation occurred prior to contacting the physician/APRN for verification of the orders. Additionally, the physician/APRN who verified the orders would also have a copy of the medications listed on the W-10 so she/he could double check as the staff reviewed the orders with him/her. The DON identified RN #1 and APRN #1 who verified Resident #2's medications had missed Resident #2's Sinemet medication that was listed on the hospital W-10. RN #1 did not enter the medication into the EMR when Resident #2 was admitted on [DATE]. The DON stated she did not know why RN #1 and APRN #1 missed Resident #2's Sinemet order. The DON stated a second medication reconciliation was also expected to be completed on the next shift by the RN supervisor utilizing the medication reconciliation worksheet, and document the comparison of the EMR medications to the W-10 from the hospital. Further, the DON stated that RN #2 did identify the medication error on 6/10/2026, however the error was not addressed and corrected at that time. The DON stated the error should have been corrected when RN #2 identified it, and she did not know why it was not done. Interview with RN #2 on 7/23/2026 at 12:45 PM identified she had completed Resident #2's second medication reconciliation during the 11:00 PM to 7:30 AM shift on 6/9/2026 and revealed she did not have time to contact the physician/ARPN that night. RN #2 stated at the end of her shift she notified the day shift of the need to obtain a physician order for Resident #2's Sinemet, and she could not recall who she reported the information to, and RN #2 was unable to provide documentation that the information was communicated. The facility Medication Reconciliation Policy dated 4/2023 directed in part, that the medication reconciliation process was completed by nursing staff at admission, readmission and discharge. The purpose was to identify clarifications and discrepancies that need to be resolved with the medical provider to ensure residents' safety and prevent negative outcomes related to medication management. The Policy directed nursing staff to complete the medication reconciliation evaluation in the EMR prior to calling the healthcare provider for initial verification of orders. If discrepancies are identified, contact the provider and obtain orders as needed. The facility admission and Discharge Policy dated 6/2025 directed in part, to complete a medication reconciliation in the EMR by the licensed nurse. Orders are reviewed and discrepancies resolved with the healthcare provider when validating admission or readmission orders. Facility documentation review identified staff education was initiated on 7/2/2026 for facility licensed nursing staff regarding verification of new orders and a mandatory second licensed nurse double check of all new admission and re-admission orders against the hospital transfer/discharge documentation before the Medication Administration Record (MAR) is finalized. Education included a process if a discrepancy was identified. A QAPI was developed and meeting held on 6/30/2026 and audits were initiated. Based on review of facility documentation, past non-compliance was identified on 7/2/2026.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation review, facility policy review, and interviews for one of four residents (Resident #1) reviewed for medication errors, the facility failed to ensure a medication was discontinued timely in accordance with physician orders. The facility failed to ensure a medication was discontinued after readmission from a hospital causing two (2) of the same type of heart medications (calcium channel blockers) to be administered for five (5) days. The findings include: Resident #1s diagnoses included cardiomyopathy (enlarged heart), chronic obstructive pulmonary disease (COPD), diabetes mellitus, and chronic kidney disease. A resident care plan (RCP) dated 4/9/2026 identified Resident # 1 had an altered cardiac status. Interventions directed to administer medications as ordered. A quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 4/13/2026 identified Resident #1 had Brief Interview for Mental Status (BIMS) of eleven (11), indicating moderately cognitively impaired and required moderate assistance for personal hygiene and transfers. Record review identified Resident #1 was transferred to the hospital on 6/19/2026 for chest pain and was readmitted to the facility on [DATE]. A hospital discharge summary and interagency referral form (W-10) dated 6/20/2026 directed Resident #1 to start Nifedipine extended release (XL) (calcium channel blocker that treats high blood pressure and chest pain) 60 milligrams (mg) daily, and to stop taking Amlodipine 10 mg tablet (calcium channel blocker that treats high blood pressure and chest pain). A nursing note dated 6/20/2026 at 8:42 PM identified Resident #1 was readmitted from the hospital, and all orders were approved by provider. A physician order dated 6/20/2026 directed Nifedipine extended release (ER) 60 mg one time a day for hypertension. A physician order dated 6/21/2026 directed Amlodipine Besylate 10 mg tablet daily (order was entered by RN #1). A facility reportable event (RE) dated 6/29/2026 at 10:30 AM identified a medication error of clinical significance. Resident #1 was inadvertently given an overlap of medications for five (5) days with no ill effects. Resident #1 was transferred to the hospital for a separate event, and the medication error was discovered during a chart review. Record review identified Resident #1 was transferred to the hospital on 6/28/2026 for chest pain. A facility RE summary dated 7/3/2026 identified on 6/29/26, it was noted Resident #1 had received Amlodipine in error. A medical work up included an EKG, laboratory work and a chest x-ray with no adverse effects noted. Interview and record review with RN #5 on 7/23/2026 at 1 PM identified he completed the second reconciliation on the 11:00 PM to 7:30 AM shift on 6/20/2026 and did not recall details of the review. Interview and record review with RN #4 on 7/23/2026 at 12:20 PM identified she was the shift manager on the 7 AM to 3 PM shift on 6/20/2026 when Resident #1 was readmitted . RN #4 stated she did not complete an additional reconciliation of Resident #1's medication to the hospital W-10 when Resident #1 was readmitted because she just didn't get to it. Interview with Pharmacist #1 on 7/23/2026 at 1:20 PM identified that although Nifedipine extended release (ER) 60 mg and Amlodipine besylate 10 mg both had the same mechanism to address hypertension (calcium channel blockers) they were not likely to cause any negative effect on Resident #1. Interview and record review with the DON on 7/29/2026 at 2:00 PM identified RN #1 had not followed the hospital W-10 directions to discontinue the Amlodipine when Resident #1 was readmitted on [DATE]. The DON stated on admission or readmission, the shift supervisor should review the W-10 medications and transcribe them into the resident's electronic medical record (EMR). The RN supervisor would then reconcile the transcribed medications back to the W-10 to ensure accuracy. The DON stated she expected the reconciliation to occur prior to contacting the physician/APRN for verification of the orders. The DON (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated an error occurred when RN #1 did not identify the W-10 directed to no administer Amlodipine, and the error was not identified with subsequent checks of the orders for accuracy (a second check on the next shift and an additional check on the next day shift were due to be completed). The DON stated she did not know why the orders were not transcribed correctly, or why the additional order checks were not completed accurately. RN #1 was not available for interview during the survey. The facility Medication Reconciliation Policy dated 4/2023 directed in part, medication reconciliation process was to be completed at admission and readmission to identify discrepancies. Nursing staff complete the medication reconciliation in the EMR prior to calling the healthcare provider for initial verification of orders. If discrepancies are identified, the provider is contacted and orders were obtained as needed. The facility's admission and Discharge policy dated 6/2025 directed in part, a medication reconciliation was to be completed in the EMR by the licensed nurse. Orders are reviewed and discrepancies resolved with the healthcare provider when validating admission or readmission orders. Facility documentation review identified staff education was initiated on 7/2/2026 for facility licensed nursing staff regarding verification of new orders and a mandatory second licensed nurse double check of all new admission and re-admission orders against the hospital transfer/discharge documentation before the Medication Administration Record (MAR) is finalized. Education included a process if a discrepancy was identified. A QAPI was developed and meeting held on 6/30/2026 and audits were initiated. Based on review of facility documentation, past non-compliance was identified on 7/2/2026.		