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	01/12/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, facility documentation, facility policy, observations, and interviews for 2 of 2 residents (Resident #43 and #168) reviewed for environment and during observation of dining on 3 North and 3 South wings, the facility failed to provide a homelike environment. The findings included: 1.Resident #43 was admitted to the facility in June 2025 with diagnoses that included chronic kidney disease, anxiety, and depression. The admission MDS dated [DATE] identified Resident #43 had intact cognition. 2. Resident #168 was admitted to the facility in March 2022 with diagnoses that included chronic pain and chronic obstructive pulmonary disease. The quarterly MDS dated [DATE] identified Resident #168 had intact cognition. Review of the maintenance repair logbook dated 9/11/25 through 10/24/25 identified Resident #43 and Resident #168's room window shade needed to be repaired. On 10/24/25 Maintenance Technician #1 placed his initials and checked off that the shade was repaired. Review of the maintenance repair logbook dated 10/25/25 through 12/1/25 identified Resident #43 and Resident #168's room window shade needed to be repaired. Interview with Resident #43 on 1/5/26 at 12:55 PM identified the exterior window shade in the room had been missing for several months. Resident #43 indicated multiple times he/she complained to LPN #2 (charge nurse) and maintenance about the missing shade on the exterior window in his/her room. Resident #43 indicated he/she asked LPN #2 and maintenance to get a replacement shade for the window multiple times. Resident #43 indicated LPN #2 reported he entered it in the computer for maintenance, but the shade was never repaired. Resident #43 indicated that Maintenance Technician #1 had visited the room multiple times and said the shade needed to be ordered. Resident #43 indicated the shade was ordered approximately 3 months ago. Resident #43 identified without the shade the window was drafty, made the room cold, and allowed bright sunlight to interfere with television viewing. Interview with Resident #168 on 1/5/26 at 1:12 PM identified maintenance removed the broken shade approximately 3 months ago and said it would be replaced. Resident #168 indicated he/she notified LPN #2 multiple times and was told the shade had been ordered. Resident #168 identified the replacement had not occurred and the window remained drafty which is right next to his/her bed. Observation on 1/5/26 at 1:15 PM identified that the exterior window in Resident #43 and Resident #168's room lacked curtains or shade. (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

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	01/12/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with Director of Maintenance on 1/5/26 at 2:00 PM identified two maintenance technicians review the maintenance logs on each unit multiple times a day. The Director of Maintenance stated maintenance checks off and initials the log once repairs are completed. Observation on 1/6/26 at 10:00 AM confirmed that the exterior window continued to lack curtains or shade. Interview with Maintenance Technician #1 on 1/8/26 at 1:45 PM identified he or another maintenance technician review the maintenance repair books daily on each unit. Maintenance Technician #1 identified he was aware the shade in Resident #43 and Resident #168 room required replacement. Maintenance Technician #1 identified he informed Resident #43 and Resident #168 the shade needed to be ordered and provided by the contractor. Maintenance Technician #1 stated on 10/24/25 he initialed the maintenance log and signed off on the log that Resident #43 and Resident #168's shade was replaced because it was reported to the contractor. Maintenance Technician #1 stated he did not go up to the resident's room to verify installation. Maintenance Technician #1 further stated he received three to four additional reports that the shade had not been replaced, and each time he had informed the contractors, but did not return to the room to verify completion. Interview with the Director of Maintenance on 1/8/26 at 1:50 PM identified on or around 10/24/25 a painter brought the broken shade from Resident #43 and Resident #168's shade to him. The Director of Maintenance indicated the next day he delivered the shade to the contractor for replacement because it was under warrantee. The Director of Maintenance identified the contractor reported he was all set, so he assumed it was done without verifying installation. The Director of Maintenance identified subsequent to surveyor inquiry he realized the shade in room had not been replaced on 10/24/25. The Director of Maintenance indicated he located a new shade labeled with the room number in the contractor's area, and the shade was installed on 1/7/26. The Director of Maintenance stated maintenance staff should not assume work is completed based on the contractor. The Director of Maintenance identified maintenance technicians are responsible for verifying completion prior to initialing maintenance logs and Maintenance Technician #1 should not have initialed the log on 10/24/25. Interview with RN #8 (corporate nurse) on 1/12/26 at 12:00 PM stated the facility did not have a policy addressing homelike environment or procedures for maintaining maintenance repair logs. Review of the facility Resident Rights policy identified the residents have the right to be treated with consideration, respect, full recognition of their dignity, receive quality care and services with reasonable accommodations of their personal needs and preferences, and to treat their living quarters as their homes. 3. a. An observation in the dining room on 3 North on 1/5/2026 at 12:05 PM identified 19 residents seated among 6 of 7 dining tables without the benefit of tablecloths or other linens. Each resident had been served beverages and then staff placed a meal tray in front of each resident removing the plate cover from the main meal and placing them in the middle of the dining table in a pile. An observation and interview in 1/8/2026 at 8:30 AM of the 3 North dining room identified no tablecloths on the tables and residents eating breakfast served on the dietary trays during meal arrival on the unit from the kitchen. An interview with Licensed Practical Nurse (LPN #1), in response to being asked if the residents were always served meals on trays s/he indicated sometimes residents ask to have the tray. (continued on next page)

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	01/12/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with Nurse Aide (NA#1) on 1/8/2026 at 8:40 AM indicated no residents had asked to have the tray placed on the table and she/he further indicated meals came from the kitchen with everything the resident needed. We would then place the tray in front of the resident. b. An observation was made of the 3 South dining room on 1/8/2026 at 8:55AM identified the residents eating in the dining room were served on meal trays. An observation and interview with LPN#2 indicated the residents are routinely served on meal trays as they come up from the kitchen on carts. LPN # 2 further indicated years ago the residents were served in the dining room using a steam table which stopped potentially due to the kitchen staff no longer assisting with dining. LPN #2 indicated that the residents are hungry and want to eat and providing meal trays is easier. An observation and interview in the 3 South dining room with NA#2 and NA#3 on 1/8/2026 at 8:58 AM, NA#2 indicated the meals arrive from the kitchen on a cart with everything needed and NA#3 indicated it was better using the trays as no time is wasted removing the food from the trays to the tables. An interview with the Director of Nursing Services (DNS) on 1/8/2026 at 1:52 PM indicated s/he would follow up on the dining room not having tablecloths and meals being served on trays and the meal covers being piled in the middle of each table. The DNS indicated the reason for having no tablecloths and meals served on dietary trays could be due to the change to the recent new dining room furniture. Although requested, a facility dining policy was not provided.

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	01/12/2026

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on review of facility policy, observations, and interviews the facility failed to ensure that food items were maintained at a palatable and appetizing temperature at time of serving. The findings include:On 1/5/2026 at 12:38 PM, observation in the 4 North Dining Room identified Resident #2, Resident #54, Resident #59, Resident #109, Resident #130, Resident #178, and Resident # 201 complained that their food was cold. Resident #54 requested their meal to be reheated.On 1/6/2026 at 12:35 PM, a test /temperature tray test was conducted with Director of Dietary #1, and the following was identified: At 12:35 PM the test tray was prepared and plated in the kitchen located on the basement floor. The test meal was plated on dish, placed in a plastic base, covered with a plastic dome, and put onto a meal tray. The meal tray was then placed in an open meal delivery truck with other resident trays. The meal delivery truck left the kitchen at 12:40 PM for its destination to the fourth-floor unit.At 12:41 PM (1 minute after leaving the dietary department), the open meal delivery cart arrived on the fourth- floor south unit. The open meal delivery cart was left in front of the nurse's station.At 12:46 PM (6 minutes after leaving the dietary department) LPN #6 was observed at the nurse's station and in the hallway the nurse aides were observed passing beverages from the beverage cart.At 12:49 PM (9 minutes after leaving the dietary department) Director of Dietary #1 informed LPN #6 the meal trays needed to be passed out.At 12:51 PM (11 minutes after leaving the dietary department) the Director of Dietary #1 and Director of Admissions began delivering meals trays to the residents.Interview with LPN #6 on 1/6/2026 at 12:51 PM identified meals trays are usually delivered to the residents' room by assigned nurse aide. LPN#6 indicated first the nurse aides pass beverages and then come back to pass the meal trays. LPN#6 indicated that for that unit, there are 4 nurse aides, one is assigned to each hallway, and the remaining two are assigned in the dining room.At 12:55 PM (15 minutes after leaving the dietary department) the last resident tray was delivered, and temperatures of the test tray were taken by the surveyor with a calibrated thermometer in the presence of the Director of Dietary #1 identifying the following:BBQ Beef internal temperatures were 138.1 degrees Fahrenheit (F) with the surveyor's thermometer and 136 degrees F with the Director of Dietary's thermometerOrzo internal temperatures were 124.6 degrees F with the surveyor's thermometer and 120 degrees F with the Director of Dietary's thermometer.Collard Greens internal temperatures were 129.3 degrees F with the surveyor's thermometer and 128 degrees F with the Director of Dietary's thermometer.Interview with Director of Dietary #1 on 1/6/2026 at 12:51 PM identified the temperatures of the should be approximately 140 degrees F. Director of Dietary #1 stated although the plates were warm, they had no other equipment to keep food warm while being delivered. The Director of Dietary #1 indicated administration had spoken about covered meal carts, but there were concerns with the number of carts needed and their storage when not being used. Interview with Director of Dietary #2 on 1/6/2026 at 2:30 PM identified the facility was aware of concerns with food temperatures and the facility was working on a quality project to address the concerns.A review of the facility policy for Food Temperature Measurement identified proper, safe, and appetizing temperatures were defined as temperatures that were both appetizing to residents and that minimized the risk for burns.

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	01/12/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, review of facility policy and interviews, failed to ensure dishware and cookware were cleaned in a sanitary manner when using the three-bay sink. The findings include:An observation with the Dietary Director #2 on 1/6/2026 at 12:25 PM, identified Dietary Aide #1 at the 3-bay sink washing a rubber spatula and a metal serving spoon over the wash sink and then placing the items in the sanitizing sink filled with sanitizing solution. Dietary Aide #1 was observed not rinsing the items before being washed. The rinse sink faucet was off, and the rinse sink had no water. Additionally, the rinse sink contained a large metal bowl with a large amount of brown colored food residue. The sanitizing sink contained a metal pot, multiple metal serving spoons and spatulas, and cooking utensils, including tongs and a whisk. Spots of soap residual were noted floating in the pink sanitizing solution.Interview with Dietary Aide #1 on 1/6/2026 at 12:25 PM identified she used the rinsing sink sometimes. Dietary Aide #1 stated it depended on how dirty the dishes were and the type of dishes. Interview with Dietary Director #2 on 1/6/2026 at 12:27 PM identified the dishes should be rinsed before being placed in the sanitizing solution. Dietary Director #2 then directed Dietary Aide #1 to rewash the dishes and replace the sanitizing solution.A review of the facility policy for Ware washing-Pot and Pan sink indicated that items should be washed in the first sink compartment, then rinsed in the middle compartment by immersing the items in the water. The policy further indicated that dishes should be thoroughly rinsed because detergent residue raises the pH of the sanitizer in the third compartment, reducing the sanitizing capacity.

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	01/12/2026

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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on review of the facility infection control program, facility documentation, facility policy, and interview, the facility failed to ensure all staff were educated regarding the Covid-19 vaccine, offered the vaccine or provided with education on benefits and risks of the vaccine. The findings include:An interview and review of facility documents on 01/8/2026 at 10:25 AM with RN #1 the Infection Preventionist identified education was provided to all staff members regarding influenza vaccine. RN #1 indicated education for Covid 19 was only done by word of mouth and only staff member received the covid vaccine so far this year; however, the facility was unable to provide evidence that all staff members were educated on the risk and benefits of Covid 19 vaccine yearly. The facility policy Infection Prevention and control program provided onsite indicated education would be provided to all staff of the facility regarding Covid 19 vaccination.

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	01/12/2026

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 2 residents (Resident #57) reviewed for Advanced Directives, the facility failed to implement advanced directives according to the resident's expressed wishes and obtain written consent from the resident's health care representative, signed in the presence of two witnesses, for a do not resuscitate (DNR) order, as required by facility policy. The findings include:Resident #57 had diagnoses that included dementia, depression, and high blood pressure.A consent form dated [DATE] identified Resident #57 elected cardiopulmonary resuscitation (CPR) and all life saving measures.The physician's order dated [DATE] directed do not resuscitate (DNR), do not intubate (DNI), no tube feeding, and Registered Nurse (RN) pronouncement of death (despite Resident #57's wishes on [DATE] to be a full code).The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #57 had moderately impaired cognition, required supervision or set up assistance for personal hygiene, toileting and was independent when ambulating.The Resident Care Conference (RCC) note dated [DATE] identified Resident #57's advanced directives were reviewed, and Resident #57 remained a full code. The note further indicated Social Services reviewed Resident #57's advanced directives with his/her health care representative and who confirmed the resident full-code status.The Resident Care Plan (RCP) dated [DATE] identified Resident #57 advanced directives directed a full code. Interventions directed to review the advanced directives quarterly and to include the resident and/or responsible party for guidance in order to honor the resident's wishes.A physician's order dated [DATE] directed DNR, DNI, no tube feeding, and Registered Nurse (RN) pronouncement of death.The RCP dated [DATE] identified Resident #57 had established advanced directives DNR/DNR, no tube feeding and an RN may pronounce. Interventions directed to review the advanced directives quarterly and to include the resident and/or responsible party for guidance in order to honor the resident's wishes.Review of the clinical record on [DATE] failed to identify any signed consent forms or documentation indicating that Resident #57 or the resident's health care representative approved the change from full code to DNR/DNI, no tube feeding, and RN pronouncement of death.Interview with Person #1 on [DATE] at 1:00 PM identified in [DATE], he/she recalled discussing Resident #57's DNI/DNR status with staff and agreed with the change. Person #1 indicated he/she did not sign any consent or forms authorizing the change in code status.Interview and clinical record review with RN #6 (unit manager) on [DATE] at 2:12 PM identified Resident #57's advanced directive consent form dated 1/6 (year not documented) directed DNR/DNI, included one witness signature, and indicated consent was obtained by telephone. RN #6 identified when residents are evaluated for their advanced directives and or wishes, if the resident is capable, they can sign the consent form or the family, power of attorney or conservator signs on the resident's behalf. RN #6 stated verbal consent may be obtained by an RN with two witness signatures for CPR or DNR/DNI. RN #6 could not explain the advanced directives form and consent form lacked the year or why it contained only one witness signature. Although, attempted an interview with APRN #1 was not obtained.Review of the facility Advanced Directive policy in part directed facility staff should immediately document discussions with the residents or resident's representative including a resident's wish to refuse CPR. At a minimum, a verbal declination of CPR by the resident or if applicable should be witnessed by 2 staff members. Surrogate decision making/HCP (health care proxy) consent for a DNR order must be in writing, signed in the presence of 2 witnesses [AGE] years of age or older who must sign the consent form.

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	01/12/2026

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 review of the clinical record, review of facility documentation, facility policy and interviews for 1 of 2 residents (Resident # 123) reviewed for abuse, the facility failed to ensure the resident was free from verbal and psychological abuse. The findings include Resident #123's diagnoses included heart failure (unspecified), spontaneous rupture of extensor tendons in the right lower leg, and polyneuropathy. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #123 as cognitively intact and required substantial assistance with showering/bathing and bed mobility and was dependent for transfers. No behavioral concerns were noted. The care plan dated 8/11/25 identified Resident #123 had Activities of Daily Living (ADL). Interventions included: using a Hoyer lift, noted non-ambulatory status, and assistance with bathing and dressing. A review of the grievance log dated 9/27/25 identified Resident #123 had a complaint of poor customer service by a Nurse Aide (NA#8) who told the resident to worry about her/himself when the resident was advocating for her/his roommate. NA #8 stated she was not going to break her back turning a fat crippled. When told she was being too rough, NA #8 overcompensated and hardly cleaned Resident #123 at all during incontinent care. When NA #8 was asked to leave the room by Resident #123, NA #8 was heard talking derogatorily about Resident #123 as she was leaving and out in the hallway. Action taken indicated NA #8 was no longer employed by the facility. On 9/28/25 at 12:51 AM, a nurse's note indicated: The patient had some complaints about her/his NA this shift, which made her/him emotional. The nursing supervisor was alerted, and the issue was resolved by the nursing supervisor. On 10/2/25, Resident #123 received mental health support from the facility psychiatric service.A review of progress notes for Resident # 123 failed to indicate the social work followed up with Resident #123 regarding the incident. A request for the last six months of Accidents and Incidents made on 1/7/26 at 12:20 PM identified the facility did not have any reports for the allegations made by Resident # 123 on 9/27/25. An interview with Resident #123 on 1/7/26 at 12:48 PM identified she/he was advocating for her/his prior roommate who had memory issues. Resident #123 reported NA #8 told her/him to mind her/his business. NA #8 came over to help Resident #123; however, she was grimacing and was scornful toward helping her/him. Resident #123 reported before leaving the room, NA #8 said something that made her/him feel horrible. She called Resident # 123 a name she/he did not want to repeat. Resident #123 reported informing the unit manager of the concern and stated NA #8 had not provided care to her/him since. An interview on 1/8/26 at 9:11 AM with Unit Manager Registered Nurse (RN #5) indicated she recalled the incident and immediately reported it to the unit supervisor and DNS; however, she was unsure of the outcome. An interview on 1/8/26 at 9:15 AM with DNS indicated she pulled the staff member from the schedule. She reported that based on the statements she received from Resident #123 and NA #8, she was unable to substantiate abuse. The DNS stated, Resident #123 did not directly say the words abuse. The DNS was unable to provide a clear answer as to who made the statement fat crippled, nor were there any other statements from witnesses. A review of NA # 8 employee file indicated she/he was hired on 8/4/25 and terminated on 11/16/25. The file identified that a background check was completed with no adverse results found. Further review identified NA # 8 last day of work was 9/27/25. The file indicated NA #8 was terminated due to poor job performance. The facility's Abuse Policy and Procedure provided to the surveyor onsite indicated, in part, that Verbal abuse is the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families or within their hearing distance. Staff will maintain a manner of courtesy and respect toward residents and their families. Staff will refrain from all actions that could be considered abuse, mistreatment, and/or neglect. The policy further indicated the reporting timeline for all allegations was: 1. Immediately to supervisors, 2. Within 24 hours to the Department of Public Health if the allegation did not result in serious bodily injury.

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	01/12/2026

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 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, facility documentation, facility policy and interviews for 1 of 2 residents (Resident # 123), reviewed for abuse, the facility failed to ensure allegation of verbal abuse was reported to the appropriate state agency timely. The findings include: Resident #123's diagnoses included heart failure (unspecified), spontaneous rupture of extensor tendons in the right lower leg, and polyneuropathy. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #123 as cognitively intact and required substantial assistance with showering/bathing and bed mobility and was dependent for transfers. No behavioral concerns were noted. The care plan dated 8/11/25 identified Resident #123 had Activities of Daily Living (ADL). Interventions included: using a Hoyer lift, noted non-ambulatory status, and assistance with bathing and dressing. A review of the grievance log dated 9/27/25 identified Resident #123 had a complaint of poor customer service by a Nurse Aide (NA#8) who told the resident to worry about her/himself when the resident was advocating for her/his roommate. NA #8 stated she was not going to break her back turning a fat crippled. When told she was being too rough, NA #8 overcompensated and hardly cleaned Resident #123 at all during incontinent care. When NA #8 was asked to leave the room by Resident #123, NA #8 was heard talking derogatorily about Resident #123 as she was leaving and out in the hallway. Action taken indicated NA #8 was no longer employed by the facility. On 9/28/25 at 12:51 AM, a nurse's note indicated: The patient had some complaints about her/his NA this shift, which made her/him emotional. The nursing supervisor was alerted, and the issue was resolved by the nursing supervisor. On 10/2/25, Resident #123 received mental health support from the facility psychiatric service.A review of progress notes for Resident # 123 failed to indicate the social work followed up with Resident #123 regarding the incident. A request for the last six months of Accidents and Incidents made on 1/7/26 at 12:20 PM identified the facility did not have any reports for the allegations made by Resident # 123 on 9/27/25. An interview with Resident #123 on 1/7/26 at 12:48 PM identified she/he was advocating for her/his prior roommate who had memory issues. Resident #123 reported NA #8 told her/him to mind her/his business. NA #8 came over to help Resident #123; however, she was grimacing and was scornful toward helping her/him. Resident #123 reported before leaving the room, NA #8 said something that made her/him feel horrible. She called Resident # 123 a name she/he did not want to repeat. Resident #123 reported informing the unit manager of the concern and stated NA #8 had not provided care to her/him since. An interview on 1/8/26 at 9:11 AM with Unit Manager Registered Nurse (RN #5) indicated she recalled the incident and immediately reported it to the unit supervisor and DNS; however, she was unsure of the outcome. Interview on 1/08/26 at 9:15 AM with DNS indicated based on the statements she received from Resident #123 and NA#8 she was unable to substantiate abuse, and a report was not submitted. A review of NA # 8 employee file indicated she/he was hired on 8/4/25 and terminated on 11/16/25. The file identified that a background check was completed with no adverse results found. Further review identified NA # 8 last day of work was 9/27/25. The file indicated NA #8 was terminated due to poor job performance. The facility's Abuse Policy and Procedure provided to the surveyor onsite indicated, in part, that Verbal abuse is the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families or within their hearing distance. Staff will refrain from all actions that could be considered abuse, mistreatment, and/or neglect. The policy further indicated the reporting timeline for all allegations was: 1. Immediately to supervisors, 2. Within 24 hours to the Department of Public Health if the allegation did not result in serious bodily injury.

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	01/12/2026

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 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, review of facility documentation, facility policy and interviews for 1 of 2 residents reviewed for abuse, the facility failed to conduct an investigation regarding an allegation of verbal and psychological abuse. The findings include Resident #123's diagnoses included heart failure (unspecified), spontaneous rupture of extensor tendons in the right lower leg, and polyneuropathy. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #123 as cognitively intact and required substantial assistance with showering/bathing and bed mobility and was dependent for transfers. No behavioral concerns were noted. The care plan dated 8/11/25 identified Resident #123 had Activities of Daily Living (ADL). Interventions included: using a Hoyer lift, noted non-ambulatory status, and assistance with bathing and dressing. A review of the grievance log dated 9/27/25 identified Resident #123 had a complaint of poor customer service by a Nurse Aide (NA#8) who told the resident to worry about her/himself when the resident was advocating for her/his roommate. NA #8 stated she was not going to break her back turning a fat crippled. When told she was being too rough, NA #8 overcompensated and hardly cleaned Resident #123 at all during incontinent care. When NA #8 was asked to leave the room by Resident #123, NA #8 was heard talking derogatorily about Resident #123 as she was leaving and out in the hallway. Action taken indicated NA #8 was no longer employed by the facility. On 9/28/25 at 12:51 AM, a nurse's note indicated: The patient had some complaints about her/his NA this shift, which made her/him emotional. The nursing supervisor was alerted, and the issue was resolved by the nursing supervisor. On 10/2/25, Resident #123 received mental health support from the facility psychiatric service.A review of progress notes for Resident # 123 failed to indicate the social work followed up with Resident #123 regarding the incident. A request for the last six months of Accidents and Incidents made on 1/7/26 at 12:20 PM identified the facility did not have any reports for the allegations made by Resident # 123 on 9/27/25. Review of the Department of Public Health Facility Licensing and Investigations Section (FLIS) Reportable events during the survey failed to identify any reports from facility related to allegation of verbal or psychological abuse reported on 9/27/2025. An interview with Resident #123 on 1/7/26 at 12:48 PM identified she/he was advocating for her/his prior roommate who had memory issues. Resident #123 reported NA #8 told her/him to mind her/his business. NA #8 came over to help Resident #123; however, she was grimacing and was scornful toward helping her/him. Resident #123 reported before leaving the room, NA #8 said something that made her/him feel horrible. She called Resident # 123 a name she/he did not want to repeat. Resident #123 reported informing the unit manager of the concern and stated NA #8 had not provided care to her/him since. An interview on 1/8/26 at 9:11 AM with Unit Manager Registered Nurse (RN #5) indicated she recalled the incident and immediately reported it to the unit supervisor and DNS; however, she was unsure of the outcome. An interview on 1/08/26 at 9:15 AM with DNS indicated she pulled the staff member from the schedule. She reported that based on the statements she received from Resident #123 and NA #8, she was unable to substantiate abuse. The DNS stated, Resident #123 did not directly say the words abuse. The DNS was unable to provide a clear answer as to who made the statement fat crippled, nor were there any other statements from witnesses. The facility's Abuse Policy and Procedure indicated, in part, that Verbal abuse is the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families or within their hearing distance. Staff will maintain a manner of courtesy and respect toward residents and their families. Staff will refrain from all actions that could be considered abuse, mistreatment, and/or neglect. The policy indicated: Immediate investigation into allegation (interview residents and other witnesses).

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	01/12/2026

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, review of facility policy and staff interviews for 1of 3 sampled residents (Resident # 6), reviewed for pressure ulcer development and for care meetings, the facility failed to revised the resident's care plan regarding a change in condition in the resident' s pressure ulcer develop and failed to ensure resident care planning meeting was scheduled timely .The findings included: 2.a.Resident #6's diagnosis included a pressure ulcer, heart failure and acute embolism and thrombosis of the deep vein of the left upper extremity. The significant change Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #6 had severe cognitive impairment and was at risk for pressure ulcer but had no pressure ulcers. A Third Eye Health Note dated 11/10/2025 at 12:59 AM by the on-call Advanced Practice Registered Nurse (APRN) on 11/09/2025 at 3:47 PM indicated notification of a pressure injury to the left heel and an order for a dressing and a pressure-relieving boot were provided. The staff was also directed to follow up with wound physician. A nurse's note dated 11/10/2025 at 4:50 PM labeled E-Interact SBAR Summary for Providers indicated Resident #6's left heel was noted to be discolored with intact skin. Off-loading boots were applied, an RN assessment had been completed and family was present. A care plan updated on 11/10/2025 indicated Resident #6 had a stage 2 pressure ulcer(partial-thickness skin loss that appears as a shallow open wound or as a blister indicting damage to the top layers of skin) related to edema (swelling) with interventions to monitor for infection, notify the physician and family with changes, no shoe to the left foot until further orders and weekly wound evaluations. A wound physician consultation on 11/25/2025 indicated the left heel wound was a stage 2 pressure ulcer (blister) and the following week (12/5/2025) the wound physician consult indicated the left heel pressure ulcer worsened to a stage 3 pressure ulcer (full thickness loss of skin, looking like a crater).However, a review of Resident # 6's care plans during the survey failed to reflect the resident's care plan had been revised to reflect the change in the resident's pressure wound from a stage 2 to stage 3.An interview and clinical record review with the wound Nurse (RN #4) on 1/8/2026 at 1:05 PM indicated the weekly wound evaluation with pictures and the nursing care plan were not updated when the wound declined from a stage 2 to a stage 3 pressure ulcer on 12/5/2025 further indicating s/he would update the care plan now. The facility policy labeled Baseline/Comprehensive Person-Centered Care Plan indicated the comprehensive person-centered care plan will be kept current by all disciplines on an ongoing basis and upon any change in status.b. Resident #6's diagnosis included frequent falls and clavicle fracture.The significant change in condition Minimum Data Set (MDS) assessment dated [DATE] identified Resident #6 had moderate cognitive impairment and required substantial to maximum assistance from staff to complete most activities of daily living (ADL).The Resident Care Plan (RCP) dated 10/26/2025 identified Resident #6 had a fracture of the left upper extremity. Interventions included: obtaining an orthopedic consultation, to provide medications as ordered and to obtain a therapy evaluation with treatment as indicated.An interview, clinical record review, and facility document review, with SW#1 on 1/12/2026 at 9:10 AM identified the process for completing the care planning schedule for residents was completed by several team members. SW#1 indicated the MDS nurses developed a schedule for the upcoming MDS assessments needing to be completed for the month which also required a care plan meeting to be scheduled for each resident with an invitation to participate in the meeting communicated to the resident and or his/her representative. SW #1 further indicated any additional assessments needing completion after the schedule was sent out for the month is emailed by the MDS nurses to inform the interdisciplinary team of the need for the assessment to be completed and a care plan meeting to be scheduled with invitations to the meeting sent by the receptionist and Resident Relations staff member.An interview and facility document review on 01/23/2026 at 9:30 AM with the front desk receptionist #1 identified the October (continued on next page)

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	01/12/2026

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and November 2025 care plan meetings had no care plan meetings scheduled for Resident #6.An interview, clinical record and facility document review with Resident Relations #1 on 1/12/2026 at 09:40 AM indicated not finding an email regarding the need to schedule a care plan meeting and invite the responsible party further indicating an upcoming care plan meeting for Resident #6 was scheduled in January 2026 and viewed the scanned copy of the invitation within Resident #6's electronic chart.An interview and facility document review with MDS Nurse #1 on 1/12/2026 at 9:50 AM provided an email sent to the interdisciplinary team members communicating the need to complete a significant change MDS assessment along with the care plan review dates. MDS Nurse identified a care plan meeting needed to be scheduled.An interview on 1/12/2026 at 11:50 AM with Social Worker (SW) 4, SW #1, and SW #3 in attendance identified SW #1 was assigned at the beginning of October 2025 the responsibility of being the Social Worker for the unit Resident #6 resided. SW # 1 indicated she/he sent an email indicating the need to schedule a care plan meeting but was overlooked. SW#1 further indicted the social worker for Resident #6 would have been responsible for scheduling an additional care plan meeting.Review of the facility Residents [NAME] of Rights policy; in part, identified residents had the right to make choices regarding aspects of their life that were significant to them and the facility policy labeled Baseline/Comprehensive Person Centered Care Plan indicated the resident and/or representative had the right to participate in the development/implementation/revision of the care planning process and the MDS Nurse was responsible to schedule the care plan meetings in accordance with regulation and resident/representative needs.

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	01/12/2026

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 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 review of clinical records, facility documentation, facility policies, observation, interviews, for 1 of 2 residents (Resident #17) reviewed for respiratory care, the facility failed to ensure an RN assessment was conducted when the resident had a change in respiratory status. The findings include: Resident #17's diagnoses included atherosclerotic heart disease, type 2 diabetes, and vascular dementia. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #17 had a Brief Interview of Mental Status (BIMS) score of two (2) indicative of severe cognitive impairment, required maximal assistance with personal hygiene, and moderate assistance with rolling left and right. The Resident Care Plan (RCP) dated 10/16/2025 identified Resident #17 had a communication problem and expressive aphasia. Interventions included anticipating and meeting needs, allowing adequate time for responses, not rushing the resident, and asking yes/no questions when appropriate. The RCP failed to include the resident's diagnosis of immunodeficiency. Interview and observation with LPN #4 on 1/5/2026 at 12:22 PM identified Resident #17 had a hard, wet cough. LPN #4 stated she was unaware Resident #17 had a cough prior to observation with the surveyor. Observation on 1/6/2026 at 9:58 AM identified Resident #17 continued to have a hard wet cough. Review of the clinical record from 1/05/2026 at 12:00 PM through 1/07/2026 at 9:30 AM failed to identify any documentation of Resident #17's new cough, an RN assessment, provider notification, or monitoring of vital signs, including temperature, pulse, respirations, blood pressure, or oxygen saturation. Interview and observation with LPN #4 on 1/7/2026 at 10:00 AM identified on 1/5/2026 she did not document Resident #17's new cough and did not report the change in his/her respiratory status to the RN or APRN. LPN #4 stated on 1/5/2026 she auscultated Resident #17's lungs and she found them clear and did not observe further coughing at that time. Observation with LPN #4 identified she asked Resident #17 if he/she was still coughing the resident responded, yes. LPN #4 then auscultated Resident #17's lungs and identified the presence of rhonchi and rales. Interview with RN #3 (supervisor) on 1/7/2026 at 10:40 AM identified she was not notified on 1/5/2026 by LPN #4 that Resident #17 developed a new cough. RN #3 identified she would have expected to be notified. RN #3 stated had she been notified she would have conducted an RN assessment and notified the APRN. The facility Change of Conditions Notification policy identified in part that the facility will inform the resident, resident's healthcare provider, and the resident's family/legal representative when there is a change in condition. Staff will identify the change in condition and notify the licensed nurse. The licensed nurse per state regulations will conduct a complete physical/mental evaluation and document the findings in the medical record.

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	01/12/2026

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical record, observations, facility policy, and interviews for 1 of 2 residents (Resident #17) reviewed for positioning/mobility, the facility failed to apply a right upper extremity splint per the physician's order, for a resident with contractures. The findings include: Resident #17 diagnoses included hemiplegia and hemiparesis of the right side, contracture of the right hand and right wrist, and vascular dementia.A physician's order dated 8/27/2021 directed to apply a right palm guard between 6 AM and 8 AM up to 8 hours for prevention of contractures to the right hand and check skin prior to and following application. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #12 had a Brief Interview of Mental Status (BIMS) score of two (2) indicative of severe cognitive impairment, did not display behaviors of rejection of care, and required maximal assistance with personal hygiene, upper and lower body dressing.The Resident Care Plan (RCP) dated 10/16/2025 identified Resident #17 had an Activities of Daily Living (ADL) self-care performance deficit with right sided weakness. Interventions included placing a right wrist, hand, finger orthotic (WHFO) on at 8:00 AM and take off at bedtime.Observation on 1/6/2026 at 10:00 AM identified Resident #17 was in bed with both hands visible and resting on top of the bedcovers without a splint, palm guard, or hand guard on his/her right hand. Observation and interview on 1/7/2026 at 10:00 AM with Licensed Practical Nurse (LPN) # 4 identified Resident #17 did not have a splint or hand guard applied to his/her right hand. LPN #4 stated Resident #17 should have had a palm guard applied at 8:00 AM and the Nurse Aide (NA) was responsible for placing the palm guard on him/her.Observation and interview on 1/7/2026 at 10:18 AM with NA #6 identified Resident #17 did not have a splint or hand guard applied to his/her right hand although the Kardex directed to apply Resident #17's right palm guard at 8:00 AM. NA #6 identified she was not aware she was responsible for applying Resident #17's right palm guard. NA #6 stated she never placed Resident #17's palm guard on him/her at any time. LPN #4 and NA #6 were unable to locate Resident #17's palm guard within his/her room. LPN #4 indicated she would contact Occupational Therapy (OT) for a replacement palm guard.Interview with OT #1 on 1/7/2026 at 11:03 AM identified that Resident #17 required a right palm guard to maintain his/her skin integrity, prevent skin breakdown, reduce the risk of infection, and prevent his/her fingernails from growing into his/her right palm. OT #1 identified staff were responsible for applying and removing Resident #17's right palm guard. OT #1 stated he had not been notified Resident #17 was missing his/her palm guard. OT #1 stated he should have been notified due to the urgency of the situation.Subsequent to surveyor inquiry OT #1 obtained a replacement palm guard and placed it on Resident #17's right hand.Review of facility ADL policy identified; in part, that staff will provide assistance to complete ADL activities per the patient centered evaluation and care plan. The care includes personal device care utilizing essential personal care items such as hearing aids, contact lenses, glasses, orthotics, and walker, etc.

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	01/12/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, review of facility policy and staff interviews for 1 of 2 residents reviewed for elopement risk (Resident #10), the facility failed to replace a resident's expired Wander Guard per facility policy for a resident at risk for elopement. The findings include: Resident #10 was admitted on [DATE] with diagnoses that included dementia and stroke.A nursing admission assessment dated [DATE] identified Resident #10 had cognitive and hearing impairment.An elopement risk evaluation dated [DATE] identified Resident #10 was at risk for elopement related to a history of wandering/elopement, being cognitively impaired, and having the physical ability to leave the building. Interventions included applying a wander device.A physician's order dated [DATE] directed to check the placement of the Wander Guard device. The order also indicated the specific serial number of the device assigned to Resident #10 and noted an expiration date of 10/2025. The physician's order did not indicate a location on the resident's body.A physician's order dated [DATE] directed to check the location of the Wander Guard on Resident #10's left wrist every shift.A physician's order dated [DATE] directed to check the expiration date of the Wander Guard every 7 days on the day shift. Additionally, the order indicated the specific serial number of the device and noted an expiration date of 9/2027. The order further indicated the device was located on the resident's right lower extremity.A review of the Treatment Administration Record (TAR) identified from [DATE] through [DATE], nursing staff had documented checking the placement of the Wander Guard device that had an expiration date of 10/2025 and the device that expired on 9/2027. The TAR also indicated that nursing staff had documented checking the expiration date of the Wander Guard device with an expiration date of 9/2027.On [DATE] at 12:00 PM, Resident #10 was observed in his/her room eating lunch. A Wander Guard device was observed on Resident #10's left wrist with an expiration date of 10/2025 written in blue. The resident denied having any other devices, and when the resident raised her/his pant legs, no devices were noted on the left or right ankles.On [DATE] at 12:11 PM, an observation and interview with LPN#7 identified that Resident #10's Wander Guard device had a written expiration date of 10/2025. LPN#7 indicated that she had seen the date on the Wander Guard device on [DATE] but had not informed the manager because it had been a Saturday. LPN#5 further indicated that the unit managers usually changed the Wander Guard devices.On [DATE] at 12:31 PM, an interview with the unit manager (RN#5) identified when there was a physician's order for checking a Wander Guard device, it usually meant that a device had been applied. RN#5 indicated the unit managers change the Wander Guard device but was not able to identify why Resident #10 had a device that expired 10/2025 (3 months ago).On [DATE] at 12:48 PM, an interview with the nursing supervisor (RN#3) indicated that she put the order dated [DATE] to check the expiration date of a Wander Guard device that expired 9/2027, but could not recall why. RN#3 indicated that what may have happened was that an LPN may have come to her for a new Wander Guard device for Resident #10, and after giving the LPN the new device, placed a new order with the new device's expiration date and serial number. RN#3 indicated that Wander Guard devices were kept in an administration office that nursing supervisors and managers had access to and that either the supervisor or the managers would provide the devices to the LPN's who would then place them on the resident. An observation with RN#3 of Resident #10's Wander Guard device identified that the device was functioning but had an expiration date of 10/2025 and had a serial number matching the serial number of the device placed on [DATE].A review of the facility policy for Wander Guard/Secure Care Alarm indicated that the expiration dates and/or battery life of the Wander Guard devices would be checked weekly and documented in TAR. The policy further indicated that any device that has expired would be discarded and replaced.

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	01/12/2026

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, facility documentation, facility policy, and interviews for the one sampled resident (Resident #12) reviewed for dialysis, the facility failed to monitor fluid intake for a resident on fluid restrictions. The findings include:Resident #12 had diagnoses that included hypertensive stage 5 chronic kidney disease, renal agenesis, and dependence on renal dialysis.A physician's orders dated 5/30/2025 directed a fluid restriction of 1500 milliliters (ml) per day and document intake of fluids in the plan of care (POC) every shift.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #12 had a Brief Interview of Mental Status (BIMS) score of 14 indicative of intact cognition, required supervision for eating and drinking, and was receiving dialysis.The Resident Care Plan (RCP) dated 11/15/2025 identified Resident #12 had renal failure and required dialysis. Interventions directed to encourage/provide intake of fluids throughout the day and monitor/evaluate food/beverage intake via intake records and observation.a. Review of Resident #12's intake and output flowsheets from 12/1/2025 through 12/31/2025 identified staff documented fluid intake for 43 of 155 shifts (failed to document 112 opportunities for fluid intake).b. Review of Resident #12's intake and output flowsheets from 1/1/2026 through 1/11/2026 identified staff documented fluid intake for 18 out of 55 shifts (failed to document 37 opportunities for fluid intake).Interview and observation with Resident #12 on 1/5/2026 at 12:10 PM identified his/her bedside table had multiple cups of liquid on it. Resident #12 stated he/she could drink as much as he/she wanted throughout the day without limitation.Observation on 1/8/2026 at 6:47 AM identified Resident #12's tray contained a 2-liter bottle of soda half full, a 20-ounce bottle of soda one-third full, two opened Ensure drink boxes, one 16-ounce cup of red-colored liquid two-thirds full, one 16-ounce cup of tea-colored liquid three-quarters full, and two 8-ounce Styrofoam cups of water half full.Interview with LPN #5 on 1/8/2026 at 6:59 AM identified she did not document Resident #12's total fluid intake for the shift in Point Click Care (PCC) because she could not see the nurse's aide documentation for fluid intake for the shift. LPN #5 stated she only documents yes or no to indicate whether a resident is on fluid restrictions.Interview with LPN #4 on 1/8/2026 at 7:58 AM identified she documented yes or no in PCC to indicate whether Resident #12 met their fluid requirements and did not document the total amount of fluids consumed. LPN #4 stated it is the NA responsibility to document fluid intake from the fluids listed on the meal tickets. LPN #4 identified Resident #12's fluid intake may be incomplete because all fluid intake is not recorded. Interview with NA #6 on 1/12/2026 at 8:22 AM identified she documented Resident #12's fluid intake from what she observed on his/her dietary tray.Interview with the Director of Nursing Services (DNS) on 1/12/2026 at 11:37 AM identified for residents on fluid restrictions the nurse aides are required to document the total amount of fluid consumed during a shift, including fluids provided between meals. The DNS stated she was aware of the inconsistent documentation of fluid intake.The facility Intake and Output/PCC Policy identified in part that nursing personnel are responsible for documenting fluid intake totals in the POC section of PCC. The NA is responsible for documenting the total amounts of fluids taken with meals and those fluids taken in between meals that have been provided by the NA. If a Resident does not take any po fluids during a given shift, write zero in the shift total.

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	01/12/2026

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on review of observations, interviews, and review of facility policy the facility failed to ensure medication carts were locked when left unattended and medications, including narcotics were properly secured. The findings include:1. Observation on 1/08/2026 at 6:01 AM identified an unattended, unlocked medication cart in the hallway on the Three North unit outside of the data closet.Interview with Licensed Practical Nurse (LPN) #8 on 1/08/2026 at 6:04 AM identified that he did not lock the medication cart before entering a resident room at the opposite end of the hallway to provide routine care. LPN #8 indicated he did not push the lock hard enough. LPN #8 identified the medication cart contained narcotics. LPN #8 stated he was aware of the facility policy requiring medication carts to be locked when not in use, not in view, or unattended, and that narcotic medications require double locking for safety. 2. Observation on 1/08/2026 at 6:22 AM identified an unattended, unlocked medication cart in the hallway on the Four North hallway. A packet of medication, labeled with Resident #69's name and the medication name of Acetaminophen 325 mg, was on top of the medication cart.Interview on 1/08/2026 at 6:24 AM with LPN #5 identified the unlocked medication cart contained various types of medications that included narcotics. LPN #5 stated she did not lock the medication cart because she was using two different medication carts to pass medications. LPN #5 identified she forgot to put Resident #69's Acetaminophen 325 mg back into the medication cart drawer. LPN #5 stated medications should not be left on top of the medication cart. LPN #5 identified she was aware of the facility policy requiring medication carts to be locked when not in use, not in view, or unattended, and that narcotic medications require double locking for safety.Interview the Director of Nursing on 1/12/2026 at 11:55 AM identified all nurses receive training to keep medication carts locked when not in use. The DNS stated her expectation is the nurses would lock the medication carts whenever they step away from the cart.Review of the facility Medication Pass policy identified in part medications should not be left/stored on top of the medication cart.

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	01/12/2026

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 0777 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain x-rays/tests when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, facility documentation, facility policies, observation, interviews for 1 of 2 residents (Resident #104) reviewed for diagnostic testing, the facility failed to ensure test results were provided to the physician timely. The findings include:Resident #104 had diagnoses that included a coagulation defect and a thyroid nodule.A physician specialist consult report dated 8/26/2025 directed to obtain a thyroid ultrasound next week, a CT scan of the thorax in 6 months, and to return for a follow-up visit in 3 months.The physician's orders dated 8/26/2025 directed to obtain a thyroid ultrasound with confirmation of booking.The annual Minimum Data Set (MDS) dated [DATE] indicated Resident #104 had mild cognitive impairment.Review of Resident #104's radiology thyroid ultrasound report dated 8/27/2025 at 4:41 PM identified that the exam was completed on 8/27/2025 at 4:41 PM and the results were provided to the facility on 8/27/2025 at 8:50 PM. The radiology report indicated Resident #104's thyroid nodules required a follow-up but were not suspicious for malignancy.The RCP dated 8/29/2025 identified Resident #104 was at risk for untoward effects from anticoagulant therapy with interventions including providing medication as ordered, observe for bruising and bleeding, and report any side effects to the physician.A physician specialist consult report dated 12/2/2025 requested a follow-up from the last appointment 3 months ago (8/26/2025). The physician specialist consult report identified Resident #104 still needed a thyroid ultrasound to be done (3 months, 6 days after the original order).A nursing progress note dated 12/03/2025 at 11:31 AM identified that the ordering physician's office was called, staff confirmed a copy of the thyroid scan was received for review and placed in Resident #104's medical record.A Health Status Note dated 12/09/2025 at 2:01 PM identified Resident #104's thyroid ultrasound results were faxed over to the physician's office, who ordered the thyroid scan.An interview and clinical record review on 1/13/2026 at 10:15 AM with RN #3 (supervisor) identified on 12/2/25 when Resident #104 returned from the appointment with the specialty physician the consultation report identified the thyroid scan still needed to be done. RN #3 stated she thought the results had been faxed to the physician by staff but was unable to provide any evidence that the test results were faxed and received by the physician office timely (98 days or 3 months and 6 days after the test results were obtained by the facility). RN #3 stated when results are faxed the nurses follow up after sending a fax to a provider and write a progress note in the resident's chart. RN #3 stated she was unable to find any documentation in Resident #104's clinical record to identify that the thyroid ultrasound was obtained and results were received.Interview on 1/12/2025 at 11:55 AM with RN #5 (unit manager) identified she was new to the facility at that time Resident #104's thyroid ultrasound was completed. RN #5 stated she was learning from different staff members and did not know if Resident #104's ultrasound results were sent to the ordering physician.The facility Change of Condition Notification policy directed in part a change in condition which may require treatment is to be reported to the health care provider and documented in the electronic health record.

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	01/12/2026

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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, observations, and interviews for 1 of 1 resident (Resident #168) reviewed for dental, the facility failed to obtain outside resources for routine dental service to meet the resident's needs. The findings include:Resident #168 was admitted to the facility in March 2022 with diagnoses that included chronic pain and chronic obstructive pulmonary disease. The physician order dated 1/14/25 directed a dental evaluation. The quarterly MDS dated [DATE] identified Resident #168 had moderate cognition and was able to eat independently. The physician order dated 6/2/25 directed for a regular diet with no salt packets. The RCP dated 6/9/25 identified Resident #168 was dependent on staff for physical needs. Interventions directed to provide a regular diet, assist with meals as needed, and honor food preferences as able. Review of the dental note written by RDH #1 (dental hygienist) dated 7/22/25 at 1:59 PM identified Resident #168 was seen for a dental consultation regarding x-rays, findings, and fabrication of a lower denture. RDH #1 indicated Resident #168's X-rays revealed the presence of two submerged implants in the lower arch that are not visible upon oral examination. RDH #1 identified Resident #168 reported prior to coming into the facility the resident was in treatment with a dentist who had pulled his/her teeth and placed the implants. RDH #1 identified Resident #168's community dentist was unable to complete the work because the resident was admitted to the facility. RDH #1 indicated a recommendation was made for Resident #168 to return to the community dentist who placed the implants to complete treatment. RDH #1 indicated nursing informed and a referral letter was placed the resident's medical record. RDH #1 indicated Resident #168 will be seen in the facility for routine dental care if the resident chooses too. Review of MD #3's (dentist) referral letter dated 7/22/25 identified Resident #168 was being referred to the community dentist to complete interrupted dental treatment and to fabricate dentures. MD #3 indicated the facility staff would provide any additional information as requested and asked that the consultation summary be faxed back to the facility upon completion.The quarterly MDS dated [DATE] identified Resident #168 had intact cognition. Interview on 1/5/26 at 1:25 PM with Resident #168 identified prior to admission the resident had been working with his/her dentist in the community. Resident #168 stated approximately 6 months ago, he/she saw the facility dentist who was supposed to make his/her lower dentures. Resident #168 indicated he/she had not seen the dentist since and informed LPN #2 multiple times he/she still wanted lower dentures made. Observation on 1/5/26 at 1:35 PM identified Resident #168 had an upper denture but did not have a lower denture. Interview with the DNS on 1/7/26 at 11:00 AM identified RN #3 was responsible for ensuring residents signed a consent form for dental treatment and for obtaining provider orders for dental consultations. The DNS stated RN #3 was also responsible for following up on dental recommendations, including referral to community dentists. The DNS identified the scheduler is responsible for booking appointments with community dentists and arranging transportation. The DNS identified her expectation is it should be completed within a day. The DNS was unable to explain why Resident #168 had not been seen by the community dentist. Interview and clinical record review with RN #3 (day supervisor) on 1/7/26 at 12:25 PM identified she was responsible for ensuring residents were seen by the dentist. RN #3 identified emergency dental needs are communicated directly to the RDH and non-emergent needs were entered into the dental book. RN #3 identified she does not maintain a tracking system to confirm which residents are seen by the hygienist or dentist. RN #3 stated on 7/22/25 when the dentist wrote the referral letter for Resident #168, the unit manager should have notified her, obtained a provider order for a community dental consultation, and submitted an appointment request to the scheduler. RN #3 stated she had no knowledge of the 7/22/25 referral and confirmed with the scheduler that no community dental appointment had been scheduled for Resident #168 since July 2025. RN #3 indicated there had been communication failures with the prior unit manager and prior scheduler that contributed to Resident (continued on next page)

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	01/12/2026

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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#168's missed referral. RN #3 stated Resident #168's referral appointment should have been scheduled within one day of the referral.Interview with RDH #1 (dental hygienist) on 1/7/26 at 1:00 PM identified Resident #168's lower dentures are implants and they do not have equipment to fabricate implant-supported lower dentures. RDH #1 stated on 7/22/25 the dentist scanned Resident #168's X-rays and a referral letter into his/her medical record so Resident #168 could be seen by the community dentist. RDH #1 indicated on 7/22/25 she informed the unit manager. RDH #1 identified on 12/17/25 Resident #168 was seen and noted the resident still had not received lower dentures, which she reported to the unit manager. Interview with the Scheduler on 1/7/26 at 2:50 PM identified she was responsible for scheduling outside consultant appointments. The Scheduler stated she had not received any requests to schedule a community dental appointment for Resident #168. Although requested, a dental policy was not provided.

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	01/12/2026

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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observations, review of facility policy, and interviews, the facility failed to ensure garbage and refuse were disposed of properly. The findings include:a.Observation and interview on 1/6/2026 at 12:00 PM with the Director of Dietary #1 of the refuse areas identified the following: The door/lid of the dumpster was observed to be open with garbage and debris on the ledge of the entrance/opening of the dumpster, including food residual, purple gloves, food wrappers, and straws. There was also a pale yellow-brown sludge-like substance on the ledge. Garbage and debris were noted around and under the dumpster on the ground, including purple gloves, clear gloves, Styrofoam cups and bowls, a full container of apple sauce, multiple empty containers of apple sauce, food leftovers, and white bags containing garbage. The Director of Dietary #1 identified the kitchen was responsible for maintaining the garbage. The Director of Dietary #1 stated he brought shovels in so he could clean up the garbage around the dumpster. The Director of Dietary #1 indicated that the garbage keeps falling around the dumpster and on the lip of the opening because when the flipping mechanism of the dumpster flips a garbage can, some of the contents of the garbage can fall outside the dumpster. Additionally, the Director of Dietary #1 identified although garbage is bagged, at times the bags may rip.b.Observation and interview on 1/6/2026 at 12:20 PM with the Director of Dietary #1 identified the following:A large black garbage can next to the dumpster inside the garbage can there were white bags of garbage as well as loose garbage on top of the bags, including gloves, the lid of a metal can, and food scraps. Director of Dietary # indicated that the black garbage cans belonged to housekeeping because the kitchen used green cans.A review of the facility policy for Waste Management for Foodservice indicated that trash should not be left alongside the dumpster. Additionally, the policy indicated that staff should confirm that the lid or door to the dumpster was closed before leaving the area.

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	01/12/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical records, facility documentation, facility policy, observations, and interviews for 3 of 8 residents (Resident #15, Resident #115, and Resident #123), reviewed for infection control, the facility failed to properly place a soiled Personal Protective Equipment (PPE) bin (Resident #15) in the resident's room and failed to wear appropriate PPE during direct care (Resident #115 and Resident #123). The findings included: 1.Resident #15's diagnosis included Enterocolitis due to Clostridium Difficile(C-Diff). A significant change in status Minimum Data Set (MDS) dated [DATE] identified Resident #15 had mildly impaired cognition. A physician's order dated 12/08/2025 directed to provide Contact/enteric precautions for C-Diff. The RCP dated 12/31/2025 identified Resident #15 had a C-Diff infection with interventions including to initiate contact-enteric precautions on acute onset of diarrhea, provide medications as ordered, observe bowel movements for changes and report to the physician. An observation and interview on 01/08/2025 at 12:15 PM with RN # 1 the infection preventionist (IP) found signage outside Resident #15's door and the curtain pulled between the 2 beds in the room, PPE available outside the door of the room and next to the unused PPE cart was a trash bin to place used PPE. RN #1 indicated the bin should have been located inside the room and did not know why it was outside the room. The facility policy labeled Precautions to Prevent Infection indicated contact precautions are intended to prevent transmission of infectious agents spread through direct or indirect contact with the resident or his/her environment. The policy further indicated when implementing precautions a trash can is positioned inside the resident room near the exit for discarding personal protective equipment (PPE) after use or before providing care to another resident in the room. 2. Resident #115 had diagnoses that included a pressure ulcer of the right heel, ESBL (Extended-Spectrum Beta-Lactamase) resistance, and type 2 diabetes. The physician's orders dated 1/14/2025 directed Enhanced Barrier Precautions (EBP) for a foley catheter related to Extended-Spectrum Beta-Lactamase (ESBL) resistance on every shift. The Resident Care Plan (RCP) dated 10/16/2025 identified Resident #115 required Enhanced Barrier Precautions (EBP) due to the presence of a urinary catheter and required for the duration of his/her stay related to a CDC targeted multidrug resistant organism. Interventions included to don gown and gloves when performing high contact care activities including dressing, bathing, transferring, changing linens, assisting with toileting, care of indwelling medical device, and providing wound care. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #115 had a Brief Interview of Mental Status (BIMS) score of one (1) indicative of severe cognitive impairment, required maximal assistance with personal hygiene and bed mobility, had an unstageable pressure ulcer, an infection to his/her foot, and an indwelling urinary catheter. Observation and interview with RN #4 (wound nurse) on 1/12/2026 at 9:54 AM identified signage (continued on next page)

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	01/12/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	posted on the outside entry door of Resident #115's room indicating Resident #115 was on EBP. The signage directed providers and staff to wear gloves and gown with high contact activities. RN #4 was observed without a gown on provide wound care to Resident #115. RN #4 indicated he was not aware Resident #115 was on EBP. RN #4 stated he was aware during wound care that gowns and gloves must be worn when a resident is on EBP. RN #4 stated he did not wear the required PPE because he was in a rush. Review of the facility Precautions to Prevent Infections policy identified in part that EBP is required for residents infected with a MDRO, and those with chronic wounds, pressure ulcers, or indwelling medical devices. The policy further identified that gowns and gloves are to be worn when providing high contact care for these residents. 3. Resident #123's diagnoses included heart failure (unspecified), spontaneous rupture of extensor tendons in the right lower leg, and polyneuropathy. The annual Minimum Data Set assessment dated [DATE] identified that Resident #123 was cognitively intact and required substantial assistance with showering/bathing and bed mobility and was dependent for transfers. The care plan dated 11/8/25 identified that Resident #123 had Activities of Daily Living (ADLs) interventions, which included the use of a Hoyer lift, non-ambulatory status, and assistance with bathing and dressing. The care plan also included cellulitis interventions, such as providing antibiotics as ordered and monitoring and documenting the affected area for redness, swelling, warmth, and any drainage. A physician's order dated 12/18/25 directed staff to apply skin prep to right axilla abrasions every shift until healed and included special instructions for Enhanced Barrier Precautions (EBP) due to MRSA in the wound. An observation on 1/5/26 at 11:24 AM of Resident #123's room revealed a sign indicating EBP. NA #4 was observed entering the room without PPE. An interview on 1/5/26 at 11:47 AM with NA #4 indicated that she had just finished providing care to Resident #123. She reported that Resident #123 was on EBP due to a wound. She stated that the EBP sign and wearing PPE only applied to nursing staff when they needed to change Resident #123's wound. She explained that since she was not changing the wound and was only providing care, PPE did not apply to her. An interview on 1/08/26 at 11:10 AM with the DNS indicated that all staff providing care for residents on EBP should wear PPE. She reported that staff had been previously educated on the importance of wearing PPE and was unsure why NA #4 did not don PPE prior to providing care. The facility Precautions to Prevent Infections policy indicated, in part, that EBP falls between standard and contact precautions and requires gown and glove use for certain residents during specific high-contact care activities.