STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075201	A. Building B. Wing	11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Haven Center for Nursing & Rehabilitation	310 Terrace Ave West Haven, CT 06516

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, facility documentation, facility policy and interviews for one (1) of three (3) sampled residents (Resident #1) reviewed for facility discharges, the facility improperly discharged the resident by discharging him/her one (1) day prior to the thirty (30) day date and six (6) days prior to an involuntary discharge appeal's hearing. The findings include:Resident #1's diagnoses included depression, pain, hypertension (high blood pressure) and type II diabetes mellitus. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of fifteen (15) out of fifteen (15) indicating the resident had no memory recall deficits and was independent with eating, personal hygiene, bed mobility, transfers and ambulating. The Notice of Intent to Discharge form dated 8/27/25 identified Resident #1 was served a thirty (30) day involuntary discharge notice stating the facility intended to discharge Resident #1 on 9/26/25 due to Resident #1 no longer requiring the services of the facility due to improved health and Resident #1's nonpayment and the facility was planning on discharging Resident #1 to a hotel. The form identified Resident #1 had the right to appeal the discharge by requesting a hearing within twenty (20) days. The Notice of Administrative Hearing form dated 9/17/25 and addressed to Resident #1, identified an administrative hearing was requested for the involuntary discharge and the hearing was scheduled for 10/1/25 at 10:00 AM. The social service note dated 9/22/25 at 10:46 AM identified the Administrator met with Resident #1 to discuss discharge planning and Resident #1 expressed the hotel accommodation as presented on the thirty (30) day discharge notice was not his/her first choice, and discharge to a Residential Care Home (RCH) was a suitable option. The note indicated the RCH was enthusiastic about accepting Resident #1 and the required information was faxed to the RCH and Resident #1 was accepted. The social service note dated 9/23/25 at 1:33 PM identified the Administrator spoke with Resident #1 regarding discharge location and Resident #1 had accepted the RCH bed. The note identified the Administrator contacted the RCH to confirm placement details and discharge was scheduled for 9/25/25 at 12:00 PM (one (1) day prior to the Intent to Discharge thirty (30) day notice of 9/26/25 and six (6) days prior to the hearing date). The note identified transportation was scheduled and the Social Worker (SW) #1 would accompany Resident #1 to the RCH to support the discharge process and ensure a smooth transition. The social service note dated 9/25/25 at 3:00 PM identified SW #1 was present to support Resident #1 at the RCH and upon arrival Resident #1 was asked to present social security documentation as well as paying first and last month's rent. The note identified Resident #1 was unable to pay the full amount so Resident #1 chose to instead discharge to the original hotel location. The note indicated SW #1 verified with Resident #1 that he/she had all of their belongings, documentation, identification and medications and Resident #1 agreed with the plan. The social service note dated 9/25/25 at 3:50 PM identified the Administrator was contacted by SW #1 who reported although Resident #1's social security income was shared with the RCH upon acceptance of the bed, Resident #1 was unable to afford the presented cost and elected to discharge to the previously identified hotel. The note indicated the Administrator met Resident #1 at the hotel, assisted with the check-in process and ensured Resident #1 had all essential items and (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resources. Review of the clinical record and facility documentation identified the appeal's hearing date had been rescheduled to 10/6/25. The Administrative Hearing documentation dated 10/10/25 identified the hearing was held by telephone on 10/6/25 to address the facility's discharge of Resident #1 to a motel. The document identified on 9/25/25, the twenty-ninth (29th) day after the notice of discharge was served, the facility social worker (SW #1) brought Resident #1 to an RCH and then to a motel later the same day. The Notice of Decision identified on 10/10/25 the Fair Hearing Officer found the facility improperly discharged Resident #1 while his/her appeal was pending and before the thirty (30) days and the discharge was ordered rescinded. Review of the clinical record identified that Resident #1 was readmitted from the hotel to the facility on [DATE]. Interview with Resident #1 on 11/25/25 at 10:49 AM identified he/she arrived at the RCH on 9/25/25 and due to issues regarding payment and sharing a room, he/she stated he/she did not want to reside at the RCH. Resident #1 identified he/she was not given the choice to go back to the facility and reported both SW #1 and the Administrator stated that he/she was already discharged and if he/she did not want to stay at the RCH then he/she would need to go to the hotel that had been previously discussed. Interview with SW #1 on 11/25/25 at 1:38 PM identified she had been newly employed by the facility two (2) weeks prior to Resident #1's discharge and when she started there was no social worker so the Administrator had been handling everything and was the one to complete Resident #1's discharge planning. SW #1 stated that she was not involved until the day of the discharge on [DATE]. SW #1 identified Resident #1 should not have been discharged from the facility prior to the appeal's hearing that was scheduled for 10/6/25 and had she known the details of Resident #1's discharge notice and hearing. Interview with the Administrator on 11/25/25 at 2:03 PM identified leading up to Resident #1's involuntary discharge, she had no social worker, so she was acting as both the Administrator and the social worker. The Administrator identified because Resident #1 agreed to the RCH placement, she thought Resident #1 could voluntarily leave the facility prior to the appeal's hearing scheduled for 10/1/25 and was unaware Resident #1 was to remain in the facility until the hearing date unless the facility was unable to meet Resident #1's needs or Resident #1 was a danger to him/herself or others and reported Resident #1 did not fit those exceptions. The Administrator indicated she did not direct SW #1 to not allow Resident #1 to return to the facility after the failed RCH admission 9/25/25. Title 42 of the Code of Federal Regulations (C.F .R.) S 483.15(c)(1)(ii) provides the facility may not transfer or discharge the resident while the appeal is pending, pursuant to S 431.230 of this chapter when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to S 431.220(a)(3) of this chapter unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. Review of the Transfer/Discharge policy dated 01/19/18 directed, in part, that the notice of transfer or discharge will be made by the facility at least 30 days before the resident is transferred or discharged . The exception to the 30-day notice is if: The safety or health of the individuals in the facility would be endangered; The resident's health improves sufficiently to allow a more immediate transfer or discharge; An immediate transfer or discharge is required by the resident's urgent medical needs; The resident has not resided in the facility for 30 days. If the information in the notice changes prior to affecting the transfer or discharge, the facility will update the recipients of the notice as soon as practicable once the update information becomes available. The facility will provide and document sufficient preparation and orientation to the resident(s) to ensure safe and orderly transfer or discharge.

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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 records, facility documentation, facility policy and interviews for one (1) of three (3) sampled residents (Resident #1) who were reviewed for medication administration, the licensed nursing staff failed to ensure the resident consumed oral medications and applied a topical patch prior to exiting the room and the medications were not left at the bedside. The findings include:Resident #1's diagnoses included pain, type II diabetes mellitus and dysphagia (difficulty swallowing). The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of fifteen (15) out of fifteen (15) indicating the resident had no memory recall deficits and was independent with eating. A physician's order dated 10/14/25 directed to administer lidocaine 5 percent (%) adhesive patch topically (to the surface of the skin) to the lower back daily at 6:00 AM. The Self-Administration of Medication assessment dated [DATE] identified it was not appropriate for Resident #1 to self-administer any medications and Resident #1 did not want to self-administer medications. The Resident Care Plan dated 10/15/25 identified that Resident #1 is at risk for pain related to their physical condition. Interventions directed to monitor for pain and administer medications as applicable. Observations and interview with Resident #1 on 11/25/25 at 10:49 AM identified an unopened lidocaine patch labeled 11/25/25 11-7 on Resident #1's over-the-bed table. Resident #1 explained that the 11PM-7AM nurse placed the lidocaine patch and all of his/her oral medications in a cup on the over-the-bed table and the nurse left the room without ensuring that he/she took the medications. Resident #1 identified the 11PM-7AM nurse always leaves the lidocaine patch for him/her to apply. Resident #1 identified he/she takes the oral medications with breakfast and applies the lidocaine patch herself when he/she was ready, and he/she just has not gotten to it yet. Review of the active physician's orders on 11/25/25 failed to reflect a physician's order directing Resident #1 may self-administer the lidocaine patch or any other medications. Observations on 11/25/25 at 1:16 PM identified the unopened lidocaine patch labeled 11/25/25 11-7 was still present on Resident #1's over-the-bed table. Observations of Resident #1's room and interview with the Regional Nurse, Licensed Practical Nurse (LPN) #2, on 11/25/25 at 1:28 PM identified an unopened packaging of a lidocaine patch labeled 11/17 11-7 present on Resident #1's over-the-bed table. LPN #2 identified Resident #1 was not to self-administer any medications, including the lidocaine patch and should not have been left at the bedside for Resident #1 to apply. LPN #2 explained to Resident #1 that he needed to dispose of the lidocaine patch and when Resident #1 was ready for the patch, Resident #1 could request a new one from the nurse on duty, to which Resident #1 agreed, and the lidocaine patch was removed from the room and disposed of. Review of the facility schedule identified Licensed Practical Nurse (LPN) #1 was assigned to Resident #1 on the 11PM-7:00 AM shift on 11/17/25 and 11/25/25. Interview with Resident #1 on 11/25/25 at 1:35 PM identified he/she was unsure of what happened to the lidocaine patch that was on his/her over-the-bed table this morning and he/she was about to put the patch on but it was not there. Resident #1 stated he/she had an extra patch in his/her drawer (dated 11/17/25) that he/she did not apply so he/she placed it on the over-the-bed table in preparation of applying the patch. Although attempted, an interview with LPN #1 was not obtained. Review of the Medication Administration and Documentation policy (undated) directed, in part, that all medications must be administered by the same person who prepared the dose for administration and assures that medications are not left unattended and that they're kept secured in a locked area or in visible control at all times.