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	06/04/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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
	075201	A. Building B. Wing	06/04/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for 4 residents (Residents #43, 47, 61 and 65) the facility failed to notify the physician and/or resident representative when required. For 1 of 2 residents, (Resident #43) reviewed for death, the facility failed to ensure the physician was notified when medications were not administered according to the physician's orders, when blood sugar and blood pressures were not obtained as ordered, and when blood sugars were noted to be outside the parameter. For 1 of 3 residents (Resident #47) reviewed for accidents the facility failed to notify the physician of a fracture after a fall and a lung nodule.For 1 resident (Resident #61) reviewed for pain, the facility failed to notify the physician with the onset of new pain. For 1 of 5 residents (Resident #65) reviewed for infection control the facility failed to notify the resident representative following a change in condition. The findings include:1a. The hospital Discharge summary dated [DATE] identified Resident #43 was admitted to the hospital on [DATE] with diagnoses of acute heart failure with reduced ejection fraction (HFrEF) with hypertensive emergency due to medication nonadherence. Newly reduced Left Ventricular Ejection Fraction (LVEF) of 32%, hypertension emergency due to medication noncompliance. Comorbidities present on admission were diabetes type 2, hypertension, gout, gunshot wound to abdomen, chronic back pain, status post splenectomy, and Covid-19. Secondary diagnoses occurred during hospitalization included acute kidney injury, and diabetes with hyperglycemia. Resident #43 was discharged from the hospital on 2/26/25. Resident #43 was admitted to the facility on [DATE] with diagnoses that included chest pain, chronic congestive heart failure, hypertension, and diabetes.The care plan dated 2/27/25 identified Resident #43 was at risk for abnormal glucose levels, hypo/hyperglycemia secondary to diabetes. Interventions included to administer diabetic medications and/or Insulin as ordered.The admission MDS dated [DATE] identified Resident #43 had intact cognition and was independent with personal hygiene.The consultant cardiologist recommendations dated 4/30/25 included to start on SGLT2 inhibitor (medication used to treat type 2 diabetes) either Jardiance or Farxiga 10mg daily.The consultant visit summary dated 4/30/25 identified the heart failure with reduced ejection fraction was addressed. The form indicated to pick up Jardiance at an outside Pharmacy.The physician's order dated 5/1/25 directed to administer Jardiance 10 mg tablet (used to manage type 2 diabetes, heart failure, and chronic kidney disease (CKD) once a day at 8:30 AM. Review of the pharmacy documentation dated 5/1/25 at 8:47 AM identified medication not covered (Jardiance 10mg tablet once daily). An outside pharmacy filled and dispensed the medication. Resident #43 called the outside pharmacy yesterday (4/30/25) and requested all medications be filled and delivered to his/her significant other at his/her prior address.The nurse's note dated 5/1/25 at 12:38 AM identified Resident #43 was seen by the cardiologist on 4/30/25 related to recent heart failure and ejection fraction diagnoses. Recommendations to start either Jardiance or Farxiga 10mg daily. The care plan dated 5/1/25 identified Resident #43 had a recent diagnoses of chronic systolic heart failure (4/30/35) and was at risk for or complication due to disease process. Interventions included monitoring cardiorespiratory symptoms, increasing fatigue, and to administer medications as ordered. Further, the care plan dated 5/1/25 identified Resident #43 was at risk for alteration in cardiac output related to recent diagnosis of chronic systolic heart failure on 4/30/25. Interventions included to administer medications as ordered. The nurse's note dated 5/2/25 at 12:21 AM by RN #9 identified she spoke with the facility pharmacy regarding Resident #43 calling and telling the outside pharmacy that the medication would be picked up by his/her significant other. RN #9 indicated she would educate Resident #43 to not have anyone pick up medication while residing in the facility. The note failed to reflect that the physician, APRN, cardiologist, or the DNS were notified.Review of the APRN notes dated 5/8/25 and 5/13/25 identified Resident #43 had a nephrologist consultation on 5/7/25. Nephrologist recommendations included to continue Entresto and Jardiance. Chronic systolic heart failure (LVEF 32%). The APRN note failed to reflect documentation that she had been notified by the nursing staff that Resident #43 was not receiving the Jardiance daily at 8:30 AM per the physician's orders. The physician's order dated 5/29/25 directed to check blood pressure and pulse once a day at 9:30 AM. Review of the MAR dated 5/1/25 - 6/3/25 identified although the Jardiance 10mg was scheduled to be administered daily at 8:30 AM, the medication was not administered. The MAR identified the drug was unavailable and awaiting delivery from the pharmacy from 5/1/25 - 6/3/25, a total of 34 days.Review of the APRN note dated 6/3/25 identified Resident #43 had a nephrologist consultation on 5/7/25. Nephrologist recommendations

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	06/04/2025

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **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 3 residents (Resident #44) reviewed for hospitalization, the facility failed to ensure the resident or resident representative were notified of the bed hold policy at the time the resident was sent to the hospital. The findings include: Resident #44 was admitted to the facility on [DATE] with diagnoses that included seizure disorder, chronic lower back pain, and dementia. The census report identified the resident was sent to the hospital on 3/9/25, 3/21/25, and 4/23/25. Review of the clinical record failed to reflect that written notice, which specifies the duration of the bed-hold policy, had been provided to the resident and/or the resident representative when the resident was transferred to the hospital on 3/9/25, 3/21/25, and 4/23/25. Interview with the DNS on 6/2/25 at 10:21 AM indicated that she was not sure but thinks the supervisor sending the resident to the hospital was responsible to send a copy of the bed hold policy with the resident at the time of transfer. The DNS indicated that the supervisor is responsible to make a copy of the discharge packet being sent with the resident to the hospital for the facility's records, but she was aware the supervisors were not doing that. The DNS indicated that she was not sure if the supervisors had been educated to send a copy of the bed hold policy with resident's when they are being transferred to the hospital. After reviewing the clinical record, the DNS indicated there was not documentation that the bed hold policy had been provided to the resident and/or the resident representative when the resident was transferred to the hospital on 3/9/25, 3/21/25, and 4/23/25. Interview with SW #1 on 6/2/25 at 10:27 AM indicated she does not notify the resident or resident representative of the bed hold policy when a resident is sent to the hospital. After review of the clinical record, SW #1 indicated there no documentation regarding the bed hold policy for the hospitalizations on 3/9, 3/21, or 4/23/25. The interview with the Chief Clinical Officer (CCO) on 06/02/25 at 10:42 AM indicated that the nursing supervisor was responsible to provide the bed hold policy to the resident and/or resident representative and make a copy of all the documents being sent with the resident at the time of a hospital transfer. The COO indicated she was aware the facility was not providing the bed hold policy or making copies of the forms being sent with the resident to the hospital. Review of the Notice Regarding Reservation of the Residents Bed if the Resident is hospitalized identified the facility will for a Medicaid - assisted resident, the facility will reserve the bed for up to 7 days if the facility has not received information that the resident is not expected to return to the facility. The facility reserves the bed for up to an additional 8 days if the facility has not received information that the resident is not expected back to the facility. If a Medicaid -assisted resident wishes to reserve the bed during a period of hospitalization for any longer period, the bed will be reserved if payment is made by the resident or resident representative at the facilities usual Medicaid per diem rate. Review of the Bed Hold and readmission Rights Policy identified the purpose was to ensure compliance with federal and state regulations governing the rights related to bed hold. The bed hold is defined as a reservation of a resident's bed during a temporary absence such as hospitalization. Notification requirements upon admission and in advance of any transfer, the resident and his/her representative shall be provided with a copy of the facility's bed hold policy, specifics of any state Medicaid bed old coverage if applicable, and written notice regarding the duration of the bed hold and the residents' rights regarding readmission. A resident's bed will be held for up to 15 days for Medicaid beneficiaries provided the resident is hospitalized , Medicaid or other payer sources authorize the hold, and the resident agrees to any applicable private pay rate if Medicaid does not cover the full bed hold period. The following must be documented: provision of the bed hold notification to the resident or resident representative, bed hold acceptance or decline and applicable payer source, and dates of hospitalization.

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	06/04/2025

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 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. (continued on next page)

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	06/04/2025

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 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**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 6 residents (Resident #19) reviewed for PASARR, the facility failed to ensure the state mental health authority was notified when the resident received a new mental health diagnosis. The findings include: The PASARR dated 9/27/23 indicated a level 2 approval without specialized services. Resident #19 has a diagnosis of major depression, anxiety, and opioid dependance. Resident #19 was admitted to the facility in 10/5/23 with diagnoses that included stoke, fibromyalgia, and chronic pain. The quarterly MDS dated [DATE] identified Resident #19 had moderately impaired cognition, required maximum assistance with toileting and touching assistance with dressing and personal hygiene, had a diagnosis of depression and was receiving antianxiety, antidepressant and opioid medications. a. Review of the census report identified Resident #19 went to the hospital on 8/15/24 to 8/21/24.A physician's order dated 8/21/24 directed to administer Seroquel (antipsychotic medication) 12.5 mg daily at bedtime for delusional disorder. The annual MDS dated [DATE] identified Resident #19 had moderately impaired cognition, had a diagnosis of depression, chronic pain, stroke, and anxiety and was receiving antianxiety, antidepressant, opioid, and antipsychotic medications. Review of the diagnosis page identified Resident #19 received the diagnosis of delusional disorder on 9/19/24.The care plan dated 9/29/24 identified Resident #19 was receiving an antipsychotic medication. Interventions included initiating nonpharmacological interventions and attempting a gradual dose reduction to the lowest possible therapeutic level as indicated by the physician.A psychiatric note, written by APRN #2 dated 10/17/24 identified Resident #19 was on the medication Seroquel for diagnosis of delusional disorder that is moderate in severity. Interview with APRN #2 on 6/3/25 at 8:04 AM indicated Resident #19 had gone to the hospital in August 2024 and returned on Seroquel with a diagnosis of mood and sleep disorder. APRN #2 indicated that Resident #19 started with delusions in the hospital but continues with the delusions now. APRN #2 indicated after her initial reevaluation from the hospital Resident #19 was started on a low dose of Seroquel but due to the delusional symptoms she had increased the Seroquel, and she gave Resident #19 the diagnosis of delusional disorder by 10/17/24. APRN #2 indicated Resident #19 still has periods of delusions and it is still an active diagnosis. b. The quarterly MDS dated [DATE] identified Resident #19 had severely impaired cognition and has a diagnosis of chronic pain. Resident #19 is receiving antidepressant, opioid, and antipsychotic medications. Review of Resident #19's diagnosis report identified a new diagnosis of dementia and paranoia disorder on 12/12/24. A Neurological Consult dated 12/12/24 identified Resident #19 has dementia with hallucinations and paranoia with severe brain atrophy. The nurses note dated 12/12/24 at 12:00 PM noted Resident #19 had returned from the neurological appointment with recommendations to start Donepezil 5 mg at bedtime and Abilify 2mg as needed if Donepezil was not effective for a diagnosis of dementia with hallucinations and paranoia. APRN and resident representative updated. The psychiatric note written by APRN #2 dated 12/19/24 identified Resident #19 had a consultation with a neurological clinic and was started on Donepezil, and Abilify will be added as needed. APRN #2 noted she will add the diagnosis of dementia with hallucinations and paranoia. Interview with the psychiatric APRN, APRN #2, on 6/3/25 at 8:04 AM indicated the resident representative took Resident #19 to a neurological appointment to see if Resident #19 had dementia in mid-December 2024. APRN #2 indicated Resident #19 was given a diagnosis of dementia, hallucinations, and paranoia at that visit. Interview with the Director of social work, SW #1, on 6/3/25 at 8:32 AM indicated that she was responsible for the PASARRs for the residents in the facility. SW #1 indicated she would inform the DNS and MDS of new mental health diagnosis and she would do the new PASARR with the new diagnosis. SW #1 indicates that she took over as the Director earlier this year and did not go back and audit any PASARR's or diagnosis prior to her taking over the position. SW #1 indicates that she has only reviewed PASARR's for the new admissions and for and changes in diagnosis going forward. After clinical record review, SW #1 identified Resident #19 had a level 2 PASARR approval ion 9/27/23 that included the diagnosis of major depression and anxiety. SW #1 indicated when Resident #19 received the new diagnosis of delusional disorder in October 2024 there should have been a new PASARR submitted and when Resident #19 received a new diagnosis of hallucinations, paranoia, and dementia in December of 2024 there should have been another submission to PASARR for re-evaluation. SW #1 indicated that she will submit today to PASARR for a new level 2 re-evaluation with the new diagnosis. Interview with SW #2 on 6/3/25 at 8:38 AM indicated she is a part time social worker now but

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	06/04/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for 2 residents (Resident #19 and 86) reviewed for dementia care and/or pain, for Resident #19, the facility failed to develop and implement a comprehensive person centered care plan for dementia and for 1of 2 residents (Resident #86) the facility failed to ensure a comprehensive care plan was developed for a resident with a history of pain. The findings include:2. Resident #86 was admitted to the facility on [DATE] with diagnoses that included anxiety, hypertension, and pain. The physician's orders dated 2/26/25 directed to administer the following.Diclofenac sodium gel 1%, 2 grams topically, apply to the right shoulder, every 6 hours as needed, for pain.Lidocaine adhesive medicated patch 4%, 2 patches topically, apply to both shoulders once daily at 9:00AM and remove at 9:00 PM, for pain. Ibuprofen tablet; 600 mg; 1 tablet by mouth, every 6 hours as needed, for chest or back pain.Tylenol (Acetaminophen); 325 mg: 2 tablets by mouth, every 6 hours as needed, for pain. A physician's order dated 3/5/25 directed that Resident #86 may go LOA independently. The quarterly MDS dated [DATE] identified Resident #86 had intact cognition, was independent with upper and lower body dressing, personal hygiene, and ambulating 10 feet, and had been on a scheduled pain mediation regimen in the last 5 days. Review of the care plan dated 3/26/25 failed to identify Resident #86 had a comprehensive, person-centered care plan that included measurable objectives and goals for his/her diagnosis of pain. The nurse's note dated 4/30/25 at 6:51 PM identified that Resident #86 was alert and oriented, makes his/her own decisions and was seen in Urgent Care today, 4/30/25. Recommendations: x-ray: LS Spine, APRN was made aware. The Urgent Care progress note dated 4/30/25 identified Resident #86 presented today with complaints of lower back pain after falling, while in the hospital, last year. Resident #86 now resides at short term rehab (STR), and reports that the more he/she walks and moves the more the pain hurts; pain is mainly in the lower back and sometimes he/she has pain down the left leg. Resident #86 receives medications and care at STR but wants medications more frequently. The treatment plan directed for Resident #86 was to order an x-ray: LS Spine. The progress note further identified that Resident #86 was getting medications at the STR and there were providers on staff; it was not appropriate to prescribe more medications that were not being reconciled by the STR. The facility's medical APRN's progress note dated 5/1/25 identified Resident #86 was seen today for complaints of bilateral knee pain; resident reported this pain was not new and was requesting pain management. Voltaren cream was ordered to be applied topically 3 times a day. Resident reports that he/she had good effect with Voltaren cream in the past. Resident #86 previously had an Orthopedic (ortho) consult in October of 2024 where knee replacement was not recommended. Follow up with ortho outpatient for chronic knee pain. (continued on next page)

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	06/04/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Resident #86 on 6/1/25 at 8:30 AM identified that last year he/she fell off a stretcher while in the hospital and has experienced back pain ever since. Resident #86 further identified that in April of this year he/she did not feel like his/her back pain was being well managed at the facility and that the facility staff did not understand that the pain was crippling, at times; Resident #86 took an Uber to the Urgent Care because the facility was not giving him/her the medications that he/she needed. Resident #86 identified that the Urgent Care doctor told him/her that he/she will always have back pain but would need to ensure his/her pain was well managed in order to remain active. Resident #86 further identified that the facility has since made alterations to his/her pain management regimen and he/she is in a much better place with pain management and is also happy to be working with OT (Occupation Therapy). Resident #86 indicated that while his/her pain has been better managed and he/she remains independent with his/her own care and ambulation, he/she would like additional assistance from the nurse aides with tasks that require bending, such as making his/her bed. Interview with the MDS Coordinator (LPN #1) on 6/4/25 at 8:01 AM identified that she had been in her current role for approximately 6 months, and when she first stepped into the position there was a lot of catch-up that needed to be completed with MDS assessments and updating the care plans accordingly. LPN #1 indicated that Resident #86's comprehensive care plan should have included his/her diagnosis of pain with interventions and goals for pain management. LPN #1 further indicated that it was an oversight that Resident #86 did not have a care plan for pain management and that when she identified the oversight on 6/2/25, she created a pain management care plan. LPN #1 identified that she put into place self-audits to ensure all resident care plans are up to date. Interview with the DNS on 6/4/25 at 9:52 AM identified that she would expect Resident #86 to have a comprehensive care plan for pain and it would be the responsibility of the MDS Coordinator to ensure that the care plan was in place. The DNS further indicated that, recently, a new process was put in place to ensure baseline care plans reflect pain management and that pain management care plans were carried over to the comprehensive care pan, in order to ensure residents were properly managed for pain. The facility's Comprehensive Care-Planning policy directs nursing to develop and implement a comprehensive, person-centered care plan that includes measurable objectives and timelines to meet the physical, psychosocial, and functional needs for each resident. The comprehensive, person-centered care plan will: include measurable objectives and timeframes, describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being, include the resident's stated goals upon admission and desired outcomes, incorporate identified problem areas, incorporate risk factors associated with identified problems, build on the resident's strength, reflect the residents expressed wishes regarding care and treatment goals, and identify professional services that are responsible for each element of care. 1. Resident #19 was admitted to the facility in 10/5/23 with diagnoses that included stoke, fibromyalgia, and chronic pain. The quarterly MDS dated [DATE] identified Resident #19 had severely impaired cognition and required maximum assistance with dressing and personal hygiene and total assistance with toileting and dressing. Resident #19 had a diagnosis of chronic pain and was receiving antidepressant, opioid, and antipsychotic medications. (continued on next page)

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	06/04/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The care plan dated 12/1/24 identified Resident #19 was receiving an antipsychotic medication. Interventions included initiating nonpharmacological interventions and attempting a gradual dose reduction to the lowest possible therapeutic level as indicated by the physician. Review of Resident #19's diagnosis report identified a new diagnosis added on 12/12/24 of dementia and paranoia disorder. A Neurological Consult dated 12/12/24 identified Resident #19 has dementia with hallucinations and paranoia with severe brain atrophy. The nurses note dated 12/12/24 at 12:00 PM noted Resident #19 had returned from the neurological appointment with recommendations to start Donepezil 5 mg at bedtime and Abilify 2mg as needed if Donepezil was not effective for a diagnosis of dementia with hallucinations and paranoia. The psychiatric note written by APRN #2 dated 12/19/24 identified Resident #19 had a consultation with a neurological clinic and was started on Donepezil, and Abilify will be added as needed. APRN #2 noted she will add the diagnosis of dementia with hallucinations and paranoia. The care plan dated 2/14/25 failed to reflect the residents diagnoses of dementia or interventions to address such. The interview with APRN #2 on 6/3/25 at 8:04 AM indicated Resident #19 was given a diagnosis of dementia, hallucinations, and paranoia at that visit. The interview with LPN #1 (MDS Coordinator) on 6/3/25 at 9:30 AM indicated she was responsible for updating the care plans. LPN #1 indicated she updates the care plans after admission by day 21 and then quarterly with the care conferences. LPN #1 indicated that there were 2 care plans specific for a diagnosis of dementia that she uses in the EMR for residents. After clinical record review. LPN #1 indicated that Resident #19 did not have a care plan for dementia. LPN #1 indicated that although Resident #19 had care conferences on 2/7/25 and 5/13/25 and she did not add a dementia care plan. Interview with the DNS on 6/3/25 at 9:35 AM indicated that the charge nurse or supervisor were responsible to update the care plans when a resident receives a new diagnosis, but the MDS coordinator, LPN #1, was responsible to make sure the care plans were updated to reflect any changes within the last 90 days. Review of the Comprehensive Care Planning Policy identified nursing was to develop a comprehensive person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs are developed and implemented for each resident. The care planning process will include an assessment of the residents' strengths and needs, incorporate the residents' personal and cultural preferences in developing the goals of care, include measurable objectives and timeframes, incorporate identified problem areas and any risk factors, Assessments of residents are ongoing and care plans are revised as information about the resident and the resident condition changes. (continued on next page)

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	06/04/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Dementia Care Management Policy identified the facility shall individualize person-centered care for residents with dementia, supporting cognitive function, managing behavioral and psychological symptoms, and ensuring safety. Care plans will be tailored to the residents' cognitive abilities, cultural background, preferences, and history. This policy applies to all licensed nurses, nurse's aides, physicians, consultants, mental health professionals, and the interdisciplinary team members involved in the care of a resident with dementia.

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	06/04/2025

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 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. (continued on next page)

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	06/04/2025

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**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 6 residents (Resident #19) reviewed for PASARR and for 1 of 3 residents (Resident #32) reviewed for falls, for Resident #19 the facility failed to have a care plan for the resident who had positive level 2 PASARR and for Resident #32, the facility failed to revise the care plan following a fall with major injury that resulted in hospitalization. The findings include: 1. The PASARR dated 9/27/23 indicated that Resident #19 received a level 2 approval without specialized services. Resident #19 has a diagnosis of major depression, anxiety, and opioid dependance. Resident #19 was admitted to the facility on [DATE] with diagnoses that included stroke, fibromyalgia, and chronic pain. A physician's order dated 10/5/23 directed to administer Cymbalta extended release 30 mg once a day for depression. The quarterly MDS dated [DATE] identified Resident #19 had moderately impaired cognition and required maximum assistance with toileting and required touching assistance with dressing and personal hygiene. Resident #19 had a diagnosis of depression and was receiving antianxiety, antidepressant and opioid medications. The care plan dated 9/29/24 identified Resident #19 was receiving an antipsychotic medication. Interventions included initiating nonpharmacological interventions and attempting a gradual dose reduction to the lowest possible therapeutic level as indicated by the physician.The psychiatric note, written by APRN #2 dated 10/17/24 identified Resident #19 was on the medication Seroquel for diagnosis of delusional disorder that is moderate in severity. The psychiatric note written by APRN #2 dated 12/19/24 identified Resident #19 had a consultation with a neurological clinic and was started on Donepezil, and Abilify will be added as needed. APRN #2 noted she will add the diagnosis of dementia with hallucinations and paranoia. The care plan dated 1/1/25 failed to reflect Resident #19 has dementia, hallucinations, paranoia, or delusions or interventions to address such. Interview with SW #2 on 6/3/25 at 8:38 AM indicated she was the social worker when Resident #19 was admitted but she thought the MDS Coordinator was responsible to develop the care plan related to level 2 PASARR's. After clinical record review. SW #2 indicated there was not a care plan for the positive level 2 PASARR. SW #2 indicated that any resident that has a positive level 2 should have a specific care plan for the positive level 2 care plan. The interview with LPN #1 (MDS Coordinator) on 6/3/25 at 9:30 AM indicated she was responsible for updating all the care plans. LPN #1 indicated indicate social service was responsible to develop the initial level 2 PASARR care plan and she was responsible to update them quarterly if needed. The interview with the DNS on 6/3/25 at 9:40 AM indicated that the charge nurse or supervisor was responsible to do the baseline care plan on admission and the MDS Coordinator was responsible to develop the comprehensive care plan by day 21. The DNS indicated the social workers were responsible for all level 2 PASARR care plans. After surveyor inquiry, the care plan dated 6/3/25 identified Resident #19 had been determined a positive Level II. Resident #19 has the potential for altered thought process and difficulty adjusting to situations. Resident has the potential for alteration in psycho-social wellbeing. Interventions included for social services consult as needed, psychiatric supportive care as ordered and as needed, AIMS testing per facility protocol. Gradual dose reduction as ordered.Review of the Dementia Care Management Policy identified the facility shall individualize person-centered care for residents with dementia, supporting cognitive function, managing behavioral and psychological symptoms, describe any specialized services to be provided because of PASARR recommendations, and ensuring safety. Care plans will be tailored to the residents' cognitive abilities, cultural background, preferences, and history. This policy applies to all licensed nurses, nurse's aides, physicians, consultants, mental health professionals, and the interdisciplinary team members involved in the care of a resident with dementia. 2. Resident #32 was admitted to the facility on [DATE] with diagnoses that included vascular dementia, congestive heart failure, and hypertension.The quarterly MDS dated [DATE] identified Resident #32 had moderately impaired cognition, was always continent of bowel and bladder, was independent with dressing and toileting, and required set up for bathing. The care plan dated 3/13/25 identified Resident #32 was at risk for falls. Interventions included to monitor for changes in ADL status, cognition, mood, behaviors, continence, and gait/balance.Review of a facility A&I report dated 4/17/25 identified Resident #32 had an unwitnessed fall on 4/17/25. The A&I report identified Resident #32 had no visible injuries but reported chest pain and was transported to the hospital for evaluation. Review of the clinical record identified Resident #32 was hospitalized from [DATE] - 4/25/25 for acute kidney injury on chronic kidney injury and fluid volume overload. The documentation also identified

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	06/04/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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	06/04/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for 5 residents (Resident #43, 32, 44, 62 and 65) the facility failed to provide care according to professional standards of practice. For 1 resident (Resident #43) reviewed for death, the facility failed to ensure medications were administered according to the physician's orders, failed to obtain blood sugar and blood pressures as ordered, failed to follow the physician's order to notify the physician with a blood sugar outside the parameter and failed to complete ongoing assessments after the resident experienced a change in condition. For Resident #32 the facility failed to obtain weights according to the physician's order.For 1 of 4 residents (Resident #44) reviewed for skin condition, the facility failed to ensure a newly identified open area was assessed upon identification and weekly until healed.For 1 of 4 residents (Resident #62) reviewed for skin conditions, the facility failed to complete and document skin checks as per the physician's order and facility policy. For Resident #65 the facility failed to complete vital signs according to the physician's order. 1a. The hospital Discharge summary dated [DATE] identified Resident #43 was admitted to the hospital on [DATE] with diagnoses of acute heart failure with reduced ejection fraction (HFrEF) with hypertensive emergency due to medication nonadherence. Newly reduced Left Ventricular Ejection Fraction (LVEF) of 32%, hypertension emergency due to medication noncompliance. Comorbidities present on admission were diabetes type 2, hypertension, gout, gunshot wound to abdomen, chronic back pain, status post splenectomy, and Covid-19. Secondary diagnoses occurred during hospitalization included acute kidney injury, and diabetes with hyperglycemia. Resident #43 was discharged from the hospital on 2/26/25. Resident #43 was admitted to the facility on [DATE] with diagnoses that included chest pain, chronic congestive heart failure, hypertension, and diabetes.The care plan dated 2/27/25 identified Resident #43 was at risk for abnormal glucose levels, hypo/hyperglycemia secondary to diabetes. Interventions included to administer diabetic medications and/or Insulin as ordered.The admission MDS dated [DATE] identified Resident #43 had intact cognition and was independent with personal hygiene.The consultant cardiologist recommendations dated 4/30/25 included to start on SGLT2 inhibitor (medication used to treat type 2 diabetes) either Jardiance or Farxiga 10mg daily. The consultant visit summary dated 4/30/25 identified the heart failure with reduced ejection fraction was addressed. The form indicated to pick up Jardiance at an outside Pharmacy.The physician's order dated 5/1/25 directed to administer Jardiance 10 mg tablet (used to manage type 2 diabetes, heart failure, and chronic kidney disease (CKD) once a day at 8:30 AM. Review of the pharmacy documentation dated 5/1/25 at 8:47 AM identified medication not covered (Jardiance 10mg tablet once daily). An outside pharmacy filled and dispensed the medication. Resident #43 called the outside pharmacy yesterday (4/30/25) and requested all medications be filled and delivered to his/her significant other at his/her prior address.The nurse's note dated 5/1/25 at 12:38 AM identified Resident #43 was seen by the cardiologist on 4/30/25 related to recent heart failure and ejection fraction diagnoses. Recommendations to start either Jardiance or Farxiga 10mg daily. The care plan dated 5/1/25 identified Resident #43 had a recent diagnoses of chronic systolic heart failure (4/30/35) and was at risk for or complication due to disease process. Interventions included monitoring cardiorespiratory symptoms, increasing fatigue, and to administer medications as ordered. Further, the care plan dated 5/1/25 identified Resident #43 was at risk for alteration in cardiac output related to recent diagnosis of chronic systolic heart failure on 4/30/25. Interventions included to administer medications as ordered. The nurse's note dated 5/2/25 at 12:21 AM by RN #9 identified she spoke with the facility pharmacy regarding Resident #43 calling and telling the outside pharmacy that the medication would be picked up by his/her significant other. RN #9 indicated she would educate Resident #43 to not have anyone pick up medication while residing in the facility. The note failed to reflect that the physician, APRN, cardiologist, or the DNS were notified.The nurse's note dated 5/8/25 at 8:34 PM by RN #6 identified Resident #43 was seen by the nephrologist on 5/7/25 and the plan of care was to continue Entresto, start Jardiance, and follow up with the cardiologist for perfusion scan and echocardiogram.Review of the APRN notes dated 5/8/25 and 5/13/25 identified Resident #43 had a nephrologist consultation on 5/7/25. Nephrologist recommendations included to continue Entresto and Jardiance. Chronic systolic heart failure (LVEF 32%). The APRN note failed to reflect documentation that she had been notified by the nursing staff that Resident #43 was not receiving the Jardiance daily at 8:30 AM per the physician's orders. The physician's order dated 5/29/25 directed to check blood pressure and pulse once a day at 9:30 AM. Review of the MAR dated 5/1/25 - 6/3/25

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	06/04/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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	06/04/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**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 5 residents (Resident #142) reviewed for pressure ulcers, the facility failed to ensure an RN assessment of a pressure ulcer was completed on admission. The findings included:Review of the hospital Discharge summary dated [DATE] identified Resident #142 was admitted to the hospital on [DATE] and discharged on 1/25/25. Resident #142 had left foot osteomyelitis, and a debridement with a left trans metatarsal amputation (TMA). Surgery was consulted for wound debridement to sacral wound growing pseudomonas. Recommendations included to continue local wound care and no plan for surgical debridement given resident's heart failure exacerbation and Covid-19 status.Resident #142 was admitted to the facility on [DATE] with diagnoses that included diabetes, congestive heart failure, and osteomyelitis. The diagnoses form failed to reflect documentation of the stage 4 sacral pressure ulcer, and left trans metatarsal amputation (TMA).The nurse's note dated 1/25/25 at 6:00 PM by RN #2 identified Resident #142 arrived from the hospital with oxygen at 2 Liters via nasal cannula with no complaints of pain. Left arm PICC line and foley catheter in place. Left foot amputation wrapped with gauze, and stage 4 coccyx wound covered with Mepilex foam dressing. Review of the admission Braden Scale by RN #2 dated 1/25/25 at 6:28 PM identified Resident #142 was at mild risk for skin breakdown.Review of the admission observation form by RN #2 dated 1/25/25 at 6:54 PM identified Resident #142 alterations in skin assessment were not completed. The admission observation form failed to reflect documentation of a pressure ulcer assessment.Review of the physician's order dated 1/25/25 - 1/29/25 failed to reflect documentation for an order to apply an LAL mattress, and specialty cushion for the wheelchair.A physician's order dated 1/26/25 directed to medicate prior to wound care twice a day at 8:30 AM and 4:30 PM. Tylenol 650mg tablet every 6 hours for pain at 12:30 AM, 6:30 AM, 12:30 PM, and 6:30 PM. Oxycodone 5mg tablet every 8 hours as needed for pain. Morphine 15mg tablet at bedtime at 8:30 PM for pain management. A physician's order dated 1/27/25 directed to monitor for pain every shift with appropriate pain scale, wound consult as needed and administer Amoxicillin-Potassium Clavulanate (antibiotic) 875mg - 125mg tablet every 12 hours at 8:30 AM and 8:30 PM for osteomyelitis. Further, perform weekly body audit on shower day during 3:00 PM - 11:00 PM shift every Wednesday.Additionally, pack sacral wound with 1/4 strength Dakin's solution wet to dry gauze followed by dry clean dressing once a day on the 7:00 AM - 3:00 PM shift and as needed. The wound physician consult dated 1/29/25 identified Resident #142 was seen for initial evaluation and treatment recommendations regarding stage 4 pressure injury to sacrum. Resident #142 was on Doxycycline and Amoxicillin (antibiotics). A wound care assessment was performed, measurement 13 cm x 12 cm x 3 cm, with moderate serosanguinous drainage, 100% necrotic, foul-smelling drainage, and debridement done on 1/29/25. Treatment Dakin 1/4 strength wet to moist packing for now. Recommended Resident #142 to be sent back to the hospital for evaluation of the sacrum wound. Wound needs surgical debridement under anesthesia as wound is infected that showed necrotic tissue to bone with foul smell. Resident #142 would not be able to tolerate bedside debridement performed today needs more invasive intervention. A physician's order dated 1/29/25 directed to send Resident #142 to the hospital for evaluation due to sacral wound infection. The nurse's note date 1/29/25 failed to reflect documentation for the 7:00 AM - 3:00 PM shift regarding the wound physician's assessment and recommendation.The nurse's note dated 1/29/25 at 8:52 PM by RN #3 identified the 7:00 AM - 3:00 PM supervisor indicated to her that the wound physician assessed Resident #142 sacral pressure ulcer wound today and directed to transfer Resident #142 to the hospital for evaluation secondary to sacral pressure ulcer wound infection. Resident #142 was transferred to the hospital at 4:05 PM. Interview and clinical record review with the DNS on 6/3/25 at 6:45 AM identified she was not aware that the stage 4 sacral pressure ulcer was not assessed by a Registered Nurse upon the resident's admission to the facility. The DNS indicated it is the RN supervisor's responsibility to assess wounds on new admissions. The DNS indicated if she was aware that a wound assessment was not completed on Resident #142 on admission day, she would have completed the assessment on Monday 1/27/25. Interview and clinical record review with RN #1 on 6/3/25 at 12:42 PM identified she was not aware that a wound assessment was not performed and documented on Resident #142 on admission. RN #1 indicated if she was aware of the issue she would have performed the wound assessment. RN #1 indicated it is the responsibility of the RN supervisor on admission to perform the wound assessment and document.Interview with MD #2 on 6/4/25 at 10:04 AM identified his initial

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	06/04/2025

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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on review of facility documentation, facility policy, and interviews, the facility failed to ensure the DNS did not serve as the nursing supervisor. The findings include:Review of the Daily Staffing Breakdown dated 2/10/25 identified that subsequent to an RN Supervisor call-out, the DNS served as the Night Shift RN Supervisor, from 11:00 PM through 7:00 AM.Review of the Daily Staffing Breakdown dated 2/15/25 identified that subsequent to an RN Supervisor call-out, the DNS served as the Day Shift RN Supervisor, from 7:00 AM through 3:00 PM.Review of the Daily Staffing Breakdown dated 2/27/25 identified that subsequent to an RN Supervisor call-out, the DNS served as the Evening Shift RN Supervisor, from 3:00 PM through 11:00 PM. Interview with the DNS on 6/4/25 at 11:00 AM identified that the facility had an average daily census that was greater than 60 residents, and she had served as the RN Supervisor on 2/10/25, 2/15/25, and 2/27/25 subsequent to staff callouts. The DNS indicated that she could not recall how many additional shifts or hours she had put in as an RN Supervisor, since becoming the DNS. The DNS further indicated that she had picked up the additional hours and served as the RN Supervisor in an effort to meet the needs of the residents, following staff call-outs. The DNS identified that in the last month, the facility had hired an evening shift supervisor, a night shift supervisor, and a few per diem nurses that will pick up supervisor shifts, and finding supervisor coverage had improved following the new hires.During an interview with the Chief Clinical Officer (CCO), the Administrator, the DNS, and the survey team on 6/4/25 at 10:30 AM, the CCO identified that she was aware that there had been staffing shortages and the facility was actively recruiting and hiring nursing staff, including RN Supervisors. The facility's Staffing Guidelines policy directs the DNS will determine numbers and assignments of staff. The staffing coordinator will be responsible each month to complete a 28-day schedule and ensure that there is adequate staffing scheduled to meet the needs of each unit/floor. The DNS and staffing coordinator will assess and ensure coordination and maintain adequate staffing. The number of staff will be determined based on resident care, acuity, facility assessment, and services needed. This would include the type of staff members and healthcare professionals required to provide those services. Based on this assessment, adequate qualified staff will be maintained and recruited/hired as needed to maintain sufficient staffing.

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	06/04/2025

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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. (continued on next page)

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	06/04/2025

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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**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 resident (Resident #36) reviewed for discharge, the social worker failed to assist the resident when he/she requested to be transferred to another facility. The findings include: Resident #36 was admitted to the facility in January 2023 with diagnoses that included chronic pain, thoracic intervertebral disc degeneration, and chronic obstructive pulmonary disease. The quarterly MDS dated [DATE] identified Resident #36 had intact cognition and required supervision with toileting, dressing, and personal hygiene. Review of the January 2025 monthly physician's orders identified Resident #36 may go on a leave of absence (LOA) independently. The social worker note dated 1/22/25 at 10:37 AM identified she called Facility 1 and Facility 2 to follow up on Resident #36's request for transfer to another facility. The social worker note dated 1/27/25 at 1:50 PM identified she spoke with the resident at bedside and updated the resident she had made the calls for a transfer. The social worker identified she had called a facility and left a message for the admission director.The care plan dated 4/29/25 failed to reflect discharge planning or goals.The care plan meeting note dated 4/29/25 identified Resident #36 would like a transfer to another facility. Interview with Resident #36 on 6/1/25 at 8:30 AM indicated that he/she had informed the social worker and Administrator he/she wanted to be transferred to another nursing facility starting in January of this year after a bed bug problem and has continued to ask but nothing is being done. Resident #36 indicated that he/she does not understand why he/she is being held here in this facility when he/she has requested for months to be transferred to any other nursing facility. Resident #36 indicated that he/she just wants out of this facility. Resident #36 indicated he/she has a friend that does entertainment at other facilities and informed him/her that they do have empty beds, but the social worker here keeps telling him/her there are no beds available in any other nursing home. Resident #36 indicated that the social worker keeps informing him/her that all the beds in the area are full and he/she cannot be discharged at this time. Resident #36 indicated that this has gone on since January and he/she is very mad that he/she cannot be moved to another facility and wonders why it is taking so long to occur. The interview with SW #1 on 6/1/25 at 1:30 PM indicated that it would be the social workers' responsibility to assist a resident that wanted to transfer to another facility. The social worker note dated 6/1/25 at 2:56 PM identified Resident #36 approached her expressing interest in transferring to another facility located in Connecticut. Resident #36 specifically inquired about Facility #3. This writer contacted the facility to request an update on current bed availability via phone. Will follow up with the resident once a response is received. The writer will continue to assist with the transfer process as needed. The interview with SW #2 on 6/3/25 at 11:06 AM indicated if a resident wanted to transfer to another facility, she would send the referral and document what facility she sent the referral to and the response. SW #2 indicates that it shouldn't take more than a couple of weeks for a resident to transfer if that is what he/she wants and there is a bed available. SW #2 indicated that since January she was the only social worker, and she was doing the best she could. SW #2 indicated that she was aware Resident #36 wanted to be transferred to another facility since January 2025 but was waiting for Resident #36 to provide her with names of nursing homes. SW #2 indicated that Resident #36 initially gave her one name of a nursing home and 2 names for assisted livings. SW #2 indicated that Resident #36 was not appropriate for the assisted living and needed long term care. SW #1 indicated she did not go back to Resident #36 and inform him/her the names were for assisted living facilities and not long-term care facilities. SW #2 indicated that she was not sure if Resident #36 knew any names of the nursing facilities in the area. SW #2 indicated that she had not provided Resident #36 with a list of nursing homes in the area or within the state of Connecticut to pick from. SW #2 indicated she does not recall if she every called back facility #1 or facility #2 to see if they had a bed available and would accept Resident #36 and noted she does not have any notes as follow up from those facilities. SW #2 indicated she was sure she had spoken to Resident #36 multiple times because Resident #36 wanted to go to another facility but didn't put notes in and does not really recall what the conversations were about other than Resident #36 still wanted to be discharged somewhere else. After surveyor inquiry, the social worker note dated 6/3/25 at 11:40 AM identified she met with the resident at bedside. Per Resident #36's request, this writer placed calls to facility #3, facility #4, and facility #2 to inquire about potential transfer options. Resident #36 was present during the calls but was unable to personally speak with any staff and left voicemails requesting return calls. Resident #36 was educated on the process, and informed the social worker will

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	06/04/2025

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 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. (continued on next page)

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	06/04/2025

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 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, facility documentation, facility policy, and interviews for 1 resident (Resident 36) reviewed for choices, the facility failed to ensure food choices were honored. The findings include: Resident #36 was admitted to the facility in January 2023 with diagnoses that included chronic pain, thoracic intervertebral dis degeneration, and chronic obstructive pulmonary disease. The quarterly MDS dated [DATE] identified Resident #36 had intact cognition, required supervision with toileting, dressing, and personal hygiene and was independent with eating. The care plan dated 12/30/24 identified Resident #36's has behaviors of hoarding and hiding hard boiled eggs in dresser drawers. Interventions included getting psychiatric evaluation for food insecurity and to provide specific food preferences. Review of physician's order dated 1/1/25 to 1/31/25 directed a regular diet. The dietitian note dated 3/27/25 at 1:29 PM indicated that she was asked to see Resident #36 for meal preferences. Spoke with resident at chairside in room this afternoon. Reviewed meal preferences such as request for he/she likes tilapia, hard boiled eggs, and salads. Preferences relayed to dietary/kitchen. The dietitian quarterly assessment dated [DATE] at 12:24 PM identified the resident is on a regular diet and eats independently. Resident #36's food preferences reviewed and updated with the kitchen. Spoke with Resident #36 and he/she likes hard boiled eggs, bacon and sausage. Resident meal intakes varied, and Resident #36 was at risk for malnutrition related to chronic conditions. Recommendations and goals were to honor food preferences as needed. The dietitian note dated 5/12/25 at 10:48 AM identified she was asked to see Resident #36 because of food complaints. Spoke with Resident #36 and he/she reports discrepancies on his/her meal tickets, and that he/she dislikes scrambled eggs. Concerns and meal preferences relayed to the food service director, kitchen staff, and social worker. Interview with Resident #36 on 6/1/25 at 8:30 AM indicated that the resident has verbalized his/her preference of 2 hard-boiled eggs daily, which is on the meal ticket. Resident #36 identified he/she does not like scrambled eggs and it has been over 3 weeks since he/she has received a hard-boiled egg. Resident #36 indicated that he had spoken to the Administrator last Friday and notified him that he/she was not receiving the 2 hard-boiled eggs daily with breakfast. Resident #36 indicated the Administrator then questioned Resident #36 if he/she was aware of the price of eggs currently being over $5 a dozen. Resident #36 indicated that the Administrator did nothing to fix his/her problem of not receiving hard boiled eggs. Observation on 6/1/25 at 8:45 AM identified Resident #36 did not receive hard boiled eggs with breakfast. Resident #36's meal ticket identified Resident #36 wanted 2 hard boiled eggs daily.Interview with [NAME] #1 on 6/1/25 at 9:35 AM indicated residents that requested hard boiled eggs receive them when they are available. [NAME] #1 indicated Resident #36 requested hard boiled eggs daily and it is on the meal ticket for breakfast. [NAME] #1 indicated when the hard-boiled eggs are not available, she substitutes them with toast or sausage for Resident #36. [NAME] #1 indicated that there have not been any eggs to make hard boiled eggs for at least a month. [NAME] #1 indicated that there were not any eggs this morning to make hard boiled eggs to give to Resident #36. [NAME] #1 indicated that Resident #36 has complained about not receiving hard boiled eggs daily and she has reported it to the Food Service Director (FSD) a few times every week and FSD informs her that he will take care of it. The interview with the Food Service Director on 6/1/25 at 10:15 AM indicated he places the food orders on Wednesdays, and the deliveries are on Mondays or Tuesdays. The FSD indicated that the food order must be approved by the purchase company before the food is delivered. The FSD indicated that he did not receive the egg order for the last 2 Mondays, so he resubmitted the order on Thursday those weeks. The FSD indicated that he was not aware the facility was not receiving eggs and Resident #36 was not receiving hard-boiled eggs daily. Review of the Resident [NAME] of Rights identified residents have the right to be treated equally with other residents in receiving care and services. Residents have the right to be treated with consideration, respect, and full recognition of their dignity and individuality. Residents have the right to receive quality care and services with reasonable accommodation of your individual needs and preferences.

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	06/04/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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	06/04/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, facility documentation, facility policy, and interview, the facility failed to ensure that surveillance monitoring for a respiratory outbreak was accurate and thorough, failed to ensure that the laundry area was maintained in a clean and sanitary manner and for 1 resident (Resident #65) the facility failed to ensure that infection control protocols were implemented following the onset of respiratory symptoms during an active outbreak. The findings include:1. During a review of the infection control program with RN #1 and the DNS on [DATE] at 8:54 AM, the DNS identified that the facility had one outbreak since the prior recertification survey. The DNS identified that the facility had an influenza A outbreak in February 2025 and approximately 8 residents were involved. The DNS identified she did not have the surveillance tracking list available for surveyor review as she kept it in her office and would need to locate it for review.Subsequent to surveyor inquiry, the DNS provided a February 2025 influenza surveillance tracking log, which identified a total of 10 residents who tested positive for influenza A from [DATE] - [DATE]. A review of the clinical record for Resident #65 identified that on [DATE], Resident #65 reported symptoms of feeling feverish and coughing. The clinical record identified treatment orders including influenza testing and Tamiflu (an antiviral medication used to treat influenza A and B). Further review of the clinical record failed to identify any documentation related to the influenza testing results for Resident #65.A review of the February 2025 influenza surveillance tracking log failed to identify surveillance tracking or documentation related to Resident #65 including onset of symptoms, initiation of Tamiflu, or influenza test results. Subsequent to surveyor inquiry, the DNS provided a report dated [DATE] for Resident #65 identified as a rapid viral respiratory culture result. Review of the report identified negative results for adenovirus, influenza A, influenza B, parainfluenza 1, 2, and 3, and RSV.Interview with the DNS on [DATE] at 10:00 AM identified Resident #65 should have been added to the influenza surveillance tracking log following the report of symptoms and need for influenza testing. The DNS identified she did not have a rationale why this was not done but identified it should have been.The facility policy on Outbreaks of Communicable Disease directed that outbreaks within the facility would be promptly identified and appropriately handled. The policy further directed that the Infection Preventionist and DNS would be responsible for receiving surveillance information and tabulating data and maintaining a line listing of identified cases with the appropriate line listing report. The facility policy on the Infection Prevention Program directed that if a problem was identified with an outbreak or infection cluster, surveillance continues to determine whether the problem was controlled. The policy also directed documentation related to surveillance data must include the date an infection was detected, the resident's name, signs and symptoms and type of infection. 2. Review of the monthly environmental rounding log documentation from 12/2024 - 5/2025 failed to identify issues with the facility laundry area.Observation during a tour of the facility laundry area with RN #1 and the DNS on [DATE] at 10:00 AM identified a large basin (approximately 96 long x 18 across x 24 deep) positioned directly behind 4 out of service washing machines. The basin was observed to be approximately 50% full of cloudy light gray liquid, and approximately 25 % of the surface appeared to have a light beige film covering. The basin was also observed to have 10 deceased black winged insects on the surface of the liquid and 2 black winged insects flying directly above the surface. Interview with RN #1 and the DNS during the observation identified they were both not aware of the liquid in the basin and that the washing machines directly in front of the basin had not been in use for at least a year. Interview with the Director of Maintenance on [DATE] at 10:15 AM identified she was first notified of the liquid in the basin on [DATE] sometime in the afternoon. The Director of Maintenance identified that she had not had any reports of drain issues for the basin prior to [DATE] and that she had contacted a plumber to address the issue. The Director of Maintenance also identified that she believed the housekeeping staff were pouring mop water into both the basin and into 2 utility sinks in the laundry area that fed into the basin and that was causing the issue. The Director of Maintenance identified she would be contacting a plumber to address the issue.Observation on [DATE] at 6:30 AM of the laundry room basin identified that all water had been drained. The entire basin bottom was observed to be covered in thick black (approximately 2 inches) sludge material.Interview with Laundry Aide #1 on [DATE] at 8:05 AM identified that she had worked at the facility for 8 years. Laundry Aide #1 identified that for the past 5 years, the facility had been sending out all laundry including linens and personal items and that the laundry area with the basin was used for holding washed items that had been returned by the

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	06/04/2025

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 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on review of facility documentation, facility policy, and interview, the facility failed to ensure the Infection Preventionist (IP) worked at least part-time at the facility managing the Infection Prevention and Control Program. The findings include:A review of the Infection Control program with RN #1 (IP) and the DNS on 6/2/25 at 8:54 AM identified that RN #1 was working in multiple roles at the facility including managing the Infection Prevention and Control Program, wounds, staff development, and supervision during the 7:00 AM - 3:00 PM shift. RN #1 identified that she worked on the Infection Prevention and Control Program when she was able but did not have a specific amount of time set aside to cover the program. The DNS identified that she and RN #1 worked together on the program when time allowed but they were unable to quantify the amount of time that had been designated to the Infection Prevention and Control Program. Review of an influenza outbreak surveillance tracking list for February 2025 identified that the facility had an influenza outbreak that began on 2/3/25 and ended 2/26/25. Review of the 2025 influenza outbreak surveillance tracking log failed to identify Resident #65 as a potential resident, who had symptoms consistent with the influenza, who required influenza testing. Review of the nurse staffing daily assignment sheets for February 2025 identified RN #1 was assigned as the RN supervisor during the 7:00 AM - 3:00 PM shift 21 of 28 days in February. A review of RN #1's punch details for February 2025 identified that RN #1's (RN Supervisor) schedule corresponded to her assigned RN Supervisor dates on the daily assignment sheets. Further review of the punch details failed to identify any additional punches (or additional hours worked) outside of the assigned RN Supervisor role. The facility job description for the Infection Control Coordinator, RN, identified that the primary purpose of the position was to plan, organize, develop, and direct the infection control program and its' activities in accordance with current federal, state, and local standards, guidelines, and regulations that govern such programs to ensure that an effective infection control program was maintained at all times. The facility assessment directed that the administrative personnel included one designated Infection Preventionist.

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	06/04/2025

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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on review of facility documentation, facility policies, and interviews, the facility failed to ensure nurse aides received no less than 12 hours of in-services, annually, including dementia management training. The findings include:Review of the facility's 2024 - 2025 nursing staff in-servicing and competency documents failed to identify documentation that nurse aides completed no less than 12 hours, per year, of in-servicing and failed to identify dementia management training was completed.Facility documentation review and interview with the DNS and the Staff Development Nurse (RN #1) on 6/3/25 at 11:45 AM identified that the facility's prior Staff Development Nurse left the facility in August of 2024. RN #1 indicated that the staff development position wasn't filled, and sometime around October or November of 2024, she and the DNS took on the role of educating the nursing staff. The DNS indicated that the facility provided competency evaluations and education, on the following topics upon hire and annually: body mechanics, falls, fear of retaliation, fires safety, HIPPA, infection control, Covid-19, personal protective equipment (PPE), abuse, neglect, misappropriation, resident rights, workplace violence, codes, black out take out, hazardous materials, QAPI, and emergency preparedness. The DNS further indicated that staff in-services and competency evaluations were on-going and completed on an as needed basis, but they did not always document when training was completed; additionally supportive services had also come to the facility to provide staff education. RN #1 identified that she was unaware that nurse aides required no less than 12 hours of in-servicing, per year, and that she would estimate that the nurse aides had completed approximately 8 hours of training, in 2024. The DNS also identified that she was unaware that nurse aides required no less than 12 hours of in-servicing, per year. The DNS further indicated that the prior Staff Development Nurse did not leave a lot of records for in-servicing or competencies that had been completed. RN #1 indicated that while annual in-servicing was completed by approximately 80% of nursing staff, dementia education was not provided, in 2024 or to date in 2025. The DNS identified that she and RN #1 got the majority of the nursing staff caught up with the mandatory annual education, but dementia in-serving had fallen through the cracks. The DNS identified that she would implement a system for tracking nurse aide in-servicing hours and ensure documentation was completed for all in-services and competency evaluations. The DNS further identified that the nursing staff would be provided dementia management training.The facility's In-servicing of Nursing Assistants policy directs that all nurse aides receive regular, structured in-service education that is relevant, competency-based, and compliant with federal and state regulations to promote quality care delivery. The facility shall implement and maintain an in-service education program for nursing assistants that: includes at least 12 hours of in-service training per calendar year, addresses identified knowledge and skills deficit, and includes topics relevant to the nurse aide role and resident care, including areas such as infection control, resident rights, abuse prevention, dementia care, communication techniques, and proper body mechanics.The facility's Dementia Care Management policy directs all staff shall receive dementia-specific training upon hire and annually thereafter. Training shall include techniques for effective communication with cognitively impaired residents, de-escalation, and non-pharmacologic behavior management strategies, and recognition of abuse, neglect, and exploitation.The facility's Dementia Education policy directs that all staff working in long-term care facilities receive comprehensive training on dementia care to provide high quality, person-centered support for residents living with dementia. The training aims to enhance staff knowledge, improve communication skills, and promote a compassionate, safe, and dignified environment for residents. Staff should complete dementia training upon hire, annually, and refresher courses or additional training sessions will be provided as needed.