STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075295	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meriden Health and Rehab	360 Broad Street, Ste 1 Meriden, CT 06450

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50059 Based on clinical record reviews, facility documentation, facility policy and interviews for one (1) of three (3) sampled resident (Resident #1) who were reviewed for a change in condition, the facility failed to conduct a complete and accurate assessment when the resident was unresponsive. The findings include: Resident #1's diagnoses included Alzheimer's, heart failure, and respiratory failure. The Resident Care Plan dated [DATE] identified an alteration in respiratory status and congestive heart failure. Interventions included to document changes in gait, restlessness, air hunger, and lethargy. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of 0 indicating Resident #1 rarely or never made decisions regarding tasks of daily life and required substantial assistance with activities of daily living. An Advanced Practice Registered Nurse (APRN) progress note dated [DATE] identified Resident #1's advanced directives directed full code status and allow resuscitation. A nurse's note dated [DATE] at 12:32AM identified the Nursing Supervisor was called by the charge nurse who reported Resident #1 looked pale and was not responding normally. Upon assessment Resident #1 became unresponsive for only a few seconds and 911 was called while attempting to obtain vital signs. Resident #1 was exhibiting shallow respirations and then first Emergency medical services arrived, assessed Resident #1 to have an oxygenation level of 62%, placed a non-rebreather mask on at 15 liters of oxygen on Resident #1. The Emergency Medical Services Record dated [DATE] at 12:51AM identified a 911 call was dispatched on [DATE] at 12:42AM and arrived at the facility on [DATE] at 12:48AM after a first team of responders. The report indicated Resident #1 was seated in a wheelchair, unresponsive, an oxygen mask was in place, the first responders attempted to obtain blood pressure, Resident #1 had a weak pulse, some eye movement and pain response prior to their arrival. Upon EMS assessment there were no palpable pulses or heart sounds, pupils were 4 and non-reactive, Resident #1 was immediately transferred onto the stretcher, Cardio-pulmonary Resuscitation (CPR) was initiated and Resident #1 was transferred to the hospital. (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
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The hospital Emergency Department note dated [DATE] identified on arrival at the facility the first responders identified Resident #1 had weak and thready pulses and when the second team arrived Resident #1 had agonal respirations and loss of pulses. In an interview with the 11PM-7AM Nursing Supervisor, Registered Nurse (RN) #1, on [DATE] at 12:34 PM she stated Resident #1 had an unwitnessed fall earlier in the evening, vital signs and neuro checks were obtained throughout the ,d+[DATE]PM shift with no reported changes in the resident's status. RN #1 explained she was called to the memory care unit by the 11PM-7AM charge nurse, Licensed Practical Nurse (LPN) #2, just after midnight on [DATE] to assess Resident #1 who was pale and not acting normal. RN #1 identified she observed Resident #1 sitting in a wheelchair and stated the resident was unresponsive for a few seconds but had a weak pulse. RN #1 stated she called 911, observed Resident #1 was again unresponsive, she attempted to obtain vital signs, and although Resident #1 was a full code, she did not access the crash cart, the AED (Automated External Defibrillator, is a portable medical device used to analyze a person's heart rhythm and deliver an electric shock to restore a normal heartbeat in cases of sudden cardiac arrest), or begin CPR. RN #1 stated the fire department arrived, found Resident #1's oxygen level to be 62%, and administered oxygen via a non-rebreather mask. RN #1 stated when the ambulance arrived, they placed the resident on a cardiac monitor, transferred Resident #1 onto the stretcher, initiated CPR, and transferred Resident #1 to the hospital. RN #1 stated everything happened so fast she could not identify why she had not immediately place oxygen on Resident #1, access with the AED or initiate CPR. Interview with the Director of Nurses (DON) on [DATE] at 1:15 PM identified each unit has an AED and crash cart that should be brought to a resident that has a change in condition, becomes unresponsive, and/or vital signs are difficult to assess until Emergency Medical Services (EMS) arrives. The DON stated staff have been reeducated on change in resident condition, accessing the crash cart, and use of the AED. Although attempted an interview with LPN #2, Nurse Aides #4 and #5 were unsuccessful. Review of the Policy Acute Condition Changes, Assessment and Recognition, dated [DATE] identified Direct care staff will be trained in recognizing subtle but significant changes in the residents, i.e. changes in skin color and condition, the nurse will assess and document vital signs, neurological status, level of consciousness, onset, duration and severity.