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	03/24/2025

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

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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 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** 44675 Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 3 residents (Resident #4) reviewed for care plans, the facility failed to create and implement a Resident Care Plan (RCP) for bowel incontinence and wounds per facility policy. The findings include: 1. Resident #4 was admitted to the facility with diagnoses that included pyelitis cystica (small cysts in the ureters) and pressure ulcer of the sacral region. The admission assessment dated [DATE] identified Resident #4 was not orientated to person, place, time and/or situation, was dependent on two or more staff for activities of daily living (ADL's), had right and left buttock unstageable pressure ulcers and was incontinent of stool. The Norton Scale for predicting risk of pressure ulcers dated 2/6/25 identified a score of six (6) indicating he/she was at high risk for developing pressure ulcers. The Wound Physician note dated 2/14/25 identified Resident #4 had an unstageable gluteal cleft wound measuring 6.5 centimeteres (cm) by 6 cm by .1 cm with 100% slough (non-viable tissue). The 5-day MDS dated [DATE] identified Resident #4 was at risk of developing pressure ulcers/injuries and had one (1) stage three (3) pressure ulcer. The RCP dated 3/4/25 identified wounds and enhanced barrier precautions (EBP). Interventions included to hang an EBP sign outside of the room, staff to wear gloves and gowns for high contact activities and hand hygiene before entering and leaving the room. The RCP failed to address Resident #4's incontinence, pressure ulcer risk and active sacral wound. Interview with the DNS on 3/20/25 at 2:22 PM identified Resident #4's pressure injury risk, current wound and incontinence should be addressed in the RCP. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the care plan, comprehensive person-centered policy directed that the comprehensive, person-centered care plan will incorporate identified problem areas, incorporate risk factors associated with identified problems, identify the professional services that are responsible for each element of care, aid in preventing or reducing decline in the resident's functional status and/or functional status, enhance the optimal functioning of the resident by focusing on a rehabilitative program in appliable and reflect current recognized standards of practice for problem areas and conditions.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44675 Based on review of the clinical record, facility documentation, facility policy and interviews for one (1) of three (3) residents (Resident #3) reviewed for admission orders and one (1) of (3) residents (Resident #7) reviewed for skin assessments, the facility failed to follow a provider's order directing to hold Levemir (long-acting insulin) for a blood sugar less than 80 and failed to ensure preventative weekly skin assessments (body audits/skin checks) were performed per provider order and facility protocol. The findings include: 1. Resident #3's diagnoses included type 2 diabetes mellitus, Parkinson's disease, anxiety disorder and depression. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #3 had moderately impaired cognition (Brief Mental Interview for Mental Status (BIMS) score of 12) and required supervision assistance with transfers and moderate assistance with bed mobility. The Resident Care Plan (RCP) dated 1/7/25 identified that Resident #3 had diabetes mellitus. Interventions included to monitor/document/report as needed any signs and symptoms of hypoglycemia to include sweating, tremors, increased heart rate (tachycardia), change in skin color, nervousness, confusion, slurred speech, lack of coordination and staggering gait and diabetes medication to be administered as ordered by physician and staff to monitor/document for side effects and effectiveness. A physician's order dated 3/2/25 directed to administer Levemir subcutaneous (under the skin) solution 100 units per milliliter (mL), inject 5 units subcutaneously one time a day for type 2 diabetes mellitus. Hold for a blood sugar less than 80. The Medication Administration Record (MAR) for March 2025 identified that Levemir 5u was administered at 9:00 AM on 3/3/35, 3/4/25 and 3/5/25. A Nurse's note dated 3/5/25 at 10:22 PM identified that RN #3 was notified Resident #3 was experiencing a change in condition, and was observed in bed leaning to the left, flailing his/her arms and legs around. The note identified that staff were unable to obtain a blood pressure due to Resident #3's movement, that Resident #3 was alert but unable to answer questions or produce any noise, and both pupils were nonresponsive to light. NP #1 was notified and directed RN #3 inquire with Resident #3 ' s family on transfer to the Emergency Department (ED) for evaluation. The note identified that Resident #3's family sent a relative to see Resident #3, and once the relative arrived, they demanded Resident #3 be sent to the ED. Emergency Medical Services (EMS) were called and Resident #3 was transferred to the ED for evaluation. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Prehospital Care Report (ambulance run sheet) dated 3/5/25 identified that EMS arrived at the facility at 6:30 PM and Resident #3 was observed in bed, moving around like he/she was in pain but unresponsive to commands and questions. The report identified LPN #4 stated she last saw Resident #3 around 4:00 PM and when she entered Resident #3's room around 6:00 PM, she found Resident #3 in the above-mentioned state, and stated Resident #3 was normally alert and oriented so this was not his/her normal behavior. The report identified that clinical paperwork was reviewed and identified Resident #3 had a diabetic history. LPN #4 was asked if she obtained Resident #3's blood sugar level, and she reported she had not. The report identified Resident #3's blood sugar was obtained with a result of 29, Resident #3 was administered a 250 mg bag of D10 (dextrose) in route to the hospital, responded well, and the involuntary body movements subsided. Review of the hospital ED note dated 3/5/25 at 7:24 PM identified that Resident #3 presented at the ED for hypoglycemia (low blood sugar) and was found to have a blood sugar of 29 (critically low level) by EMS and dextrose (sugar) was given on route to the hospital. The note identified that Resident #3 became more responsive and his/her sugar level improved. The note further identified that blood work and an ECG (electrocardiogram) were obtained and resulted within normal limits and Resident #3 was discharged back to the facility on [DATE]. Review of the clinical record failed to identify that blood sugars were obtained from 3/2/25 through 3/5/25 according to provider order instructions. Interview with LPN #1 on 3/19/25 at 12:35 PM identified that on 3/5/25 she administered Levemir insulin to Resident #3 without first obtaining his/her blood sugar although she knew obtaining a blood sugar was required. She further identified that she did not completely read the order. Interview with the DNS on 3/19/25 at 2:14 PM identified that a blood sugar should be taken obtained prior to insulin administration. She reported that LPN #1, #2 and #3 should have checked the Resident #3's blood sugar prior to administering the Levemir insulin on 3/3/25, 3/4/25 and 3/5/25 per the physician's order and then documented the result in the clinical record. Although attempted, interviews with LPN #2 and LPN #3 were not obtained. Review of the Insulin Administration policy (undated) directed, in part, that the type of insulin, dosage requirements, strength and method of administration must be verified before administration, to ensure that it corresponds with the order on the medication sheet and the physician's order. The nurse shall notify the Director of Nursing Services and Attending Physician of any discrepancies, before giving the insulin. Document the resident's blood glucose result, as ordered. Review of the Diabetes- Clinical Protocol policy (undated) directed, in part, that the risk for hypoglycemia should be considered in any treatment plan, as it is a significant and high-risk complication of treatment. For the resident receiving insulin who is well controlled: monitor blood glucose levels twice daily if on insulin. 2. Resident #7 was admitted to the facility with diagnoses that included osteomyelitis of the vertebra and sacral wound. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Admission assessment dated [DATE] identified Resident #7 was alert and orientated to person, place, time and/or situation, was dependent on two or more staff for personal hygiene, required maximal assist for toileting and had an unstageable right ankle pressure ulcer and a stage four (4) coccyx pressure ulcer. The Norton Scale for predicting risk of pressure ulcers dated 2/27/25 identified Resident #7 had a score of nine (9) indicating he/she was at high risk for developing pressure ulcers. A physician's order dated 2/27/25 directed body audit weekly on shower day, Thursday, during the 3:00 PM - 11:00 PM shift. The weekly skin assessment dated [DATE] identified Resident #7's skin was not clean and intact with treatments to a stage four (4) sacral wound and right heel. No new skin areas were noted at that time. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #7 was at risk of developing pressure ulcers/injuries and had one (1) stage three (3) pressure ulcer and (1) stage four (4) pressure ulcer. The Resident Care Plan dated 3/5/25 identified Resident #7 had potential/actual impairment to skin integrity with interventions that included to assist with turning and repositioning every two hours and as needed, to follow the facilities protocol for treatment of injury and weekly treatment documentation. The weekly skin assessment dated [DATE] identified Resident #7's skin was not clean and intact with treatments to a stage four (4) sacral wound and right heel. No new skin areas were noted at that time. The medical record failed to identify a weekly skin check was completed and documented for the week of 3/2/25 to 3/8/25. Interview with the DNS on 3/20/25 at 2:22 PM identified the facility does not have a preventative skin assessment policy. She identified that weekly skin assessments should be performed as ordered and on residents scheduled shower day. Although requested, the facility does not have a policy for weekly skin assessments. 48879

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. 48879 Based on review of personnel files for five (5) of five (5) Nurse Aides (NA #3, #4, #5, #6 and #7) and interviews, the facility failed to complete annual performance appraisals. The findings include: Review of the personnel file for NA #3 identified the last performance appraisal in NA #3's personnel file was dated 11/29/23 (16 months ago). NA #3's Date of Hire (DOH) was noted to be 3/21/2017. Review of the personnel file for NA #4 identified that there was not a past performance appraisal in NA #4's personnel file. NA #4's DOH was noted to be 11/20/2018. Review of the personnel file for NA #5 identified the last performance appraisal in NA #5's personnel file was dated 11/7/23 (16 months ago). NA #5's DOH was noted to be 6/7/1994. Review of the personnel file for NA #6 identified the last performance appraisal in NA #6's personnel file was dated 11/14/23 (16 months ago). NA #6's DOH was noted to be 4/24/2012. Review of the personnel file for NA #7 identified the last performance appraisal in NA #7's personnel file was dated 11/9/23 (16 months ago). NA #6's DOH was noted to be 6/7/2016. Interview and facility documentation review with the Director of Human Resources (HR) on 3/24/25 at 1:12 PM identified that he was unable to locate performance appraisals for NA #3, #5, #6 or #7 that were dated after 2023 and reported that he was unable to locate any performance appraisals for NA #4. He identified that he had been employed as HR for five (5) months, had not initiated or completed any performance appraisals in those five (5) months, and was unsure of the process. Interview with the Administrator and the DNS on 3/24/25 at 1:16 PM identified that performance appraisals are to be performed annually for all staff and that HR should be alerted when a staff member is due for an appraisal. Further identified was that HR was to compile staff appraisals to include staff names and appraisal due dates, then provide the appraisals to the DNS for the DNS to delegate to the nursing staff for completion. Although requested, a Performance Appraisals policy was not provided.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48879 Based on review of the clinical record, facility policy and interviews for one (1) of three (3) residents (Resident #2 and Resident #3) reviewed for abuse, the facility failed to ensure social services support was provided timely following a resident-to-resident altercation within the facility. The findings include: 1. Resident #1's diagnoses included Alzheimer's disease, dementia with behavioral disturbances, anxiety disorder and depression. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Mental Interview for Mental Status (BIMS) of zero (0) indicative of severely impaired cognition and was independent with bed mobility, transfers and ambulation. Additionally, it identified that Resident #1 did not exhibit physical or verbal behaviors directed towards others. Review of the facility Reportable Event (RE) dated 3/2/25 identified that at 2:00 PM, Nurse Aide (NA) #1 was ambulating Resident #2 out of the hallway bathroom to his/her wheelchair outside of the bathroom. The RE identified that Resident #1 was obstructing the wheelchair, so NA #1 requested that Resident #1 move aside, and then ambulated Resident #2 around Resident #1, Resident #1 then punched Resident #2 in the left cheek. The RE identified that Resident #1 was immediately removed from the area by staff, the provider was notified, the police were notified, and Resident #1 was placed on one-to-one observation until Emergency Medical Services (EMS) arrived and transported Resident #1 to the Emergency Department (ED) for evaluation. The Resident Care Plan (RCP) dated 3/3/25 identified that Resident #1 was involved in a resident-to-resident altercation where he/she struck out at another resident. Interventions included investigating per facility policy, following the plan of care as outlined, reporting the incident to the Department of Public Health (DPH), local police department, Administrator and Director of Nursing Services (DNS), reporting the incident to the family/responsible party and the provider, obtaining vital signs per policy, providing psychiatric service follow-up as indicated and observing for any signs and symptoms of mental distress, increased anxiety or changes in mood and reporting to the provider. A nurse's note dated 3/3/25 at 11:48 AM identified that Resident #1 returned to the facility from the hospital and that social services conducted an evaluation. Review of social services notes from 3/2/25 through 3/5/25 for Resident #1 failed to identify social services documentation. 2. Resident #2's diagnoses included Alzheimer's disease (a progressive dementia that destroys memory and other mental functions), dementia and anxiety disorder. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had a Staff Assessment for Mental Status identifying both short-term and long-term memory problems indicative of moderately impaired cognition and required substantial assistance with transfers and ambulation. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility Reportable Event (RE) dated 3/2/25 identified that at 2:00 PM, Resident #2 was ambulating out of the hall bathroom accompanied by Nurse Aide (NA) #1 and Resident #1 was noted to be standing in front of Resident #2's wheelchair. NA #1 requested that Resident #1 move aside and then started to ambulate Resident #2 around Resident #1, then Resident #1 punched Resident #2 in the left cheek. The RE identified both residents were immediately separated, the provider was notified, the police were notified, and an assessment was completed on Resident #2 indicating no injuries or skin abnormalities. The Resident Care Plan (RCP) dated 3/3/25 identified that Resident #2 was involved in a resident-to-resident altercation where he/she was struck by another resident. Interventions included investigating per facility policy, following the plan of care as outlined, reporting the incident to the Department of Public Health (DPH), local police department, Administrator and Director of Nursing Services (DNS), reporting the incident to the family/responsible party and the provider, obtaining vital signs per policy, providing psychiatric service follow-up as indicated and observing for any signs and symptoms of mental distress, increased anxiety or changes in mood and reporting to the provider. Review of social service notes from 3/2/25 through 3/5/25 for Resident #1 failed to identify social services documentation. Interview with the DNS and the Administrator on 3/20/25 at 2:03 PM identified that for all resident-to-resident abuse incidents within the facility, the Director of Social Services (SW #1) is to meet with each resident involved as soon as possible and then follow up with the residents involved for 72-hours following the incident, documenting all encounters in the clinical record. Interview with SW #1 on 3/20/25 at 2:20 PM identified that social services is responsible for following up with all residents involved in resident-to-resident abuse incidents within the next business day, but ideally as soon as possible. She identified that social services is then responsible for following up daily for 72-hours after the initial encounter to offer support and document all encounters in the clinical record. SW #1 identified that she was responsible for providing social services support for Resident #1 and Resident #2 after the 3/2/25 incident, and although there was a nurse's note dated 3/3/25 identifying that she met with Resident #1 following the incident, she did not document in the clinical record or follow-up with Resident #1 thereafter. SW #1 could not recall if she met with Resident #2 following the incident, but stated she should have and that there should have been consistent documentation for 72-hours following the incident. Review of the Reporting Abuse to Facility Management policy dated April 2024 directed, in part, that the facility does not condone resident abuse by anyone. Unless the resident requests otherwise, the social service representative will give the Administrator and Director of Nursing Services a written report of his/her findings.

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48879 Based on review of the clinical record, facility documentation, facility policy and interviews for one (1) of three (3) residents (Resident #3) reviewed for medication errors, the facility failed to prevent a significant medication error by failing to accurately transcribe Providers order's and verify Provider's orders for a resident readmitted to the facility. This failure resulted in the finding of Immediate Jeopardy. The findings include: Resident #3 was admitted to the facility in September of 2024 with diagnoses including type 2 diabetes mellitus, Parkinson's disease, anxiety disorder and depression. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #3 had moderately impaired cognition (Brief Mental Interview for Mental Status (BIMS) score of 12) and required supervision assistance with transfers and moderate assistance with bed mobility. The Resident Care Plan (RCP) dated 1/7/25 identified that Resident #3 had diabetes mellitus. Interventions included to monitor/document/report as needed any signs and symptoms of hypoglycemia to include sweating, tremors, increased heart rate (tachycardia), change in skin color, nervousness, confusion, slurred speech, lack of coordination and staggering gait and diabetes medication to be administered as ordered by physician and staff to monitor/document for side effects and effectiveness. Review of facility Reportable Event (RE) dated 3/6/25 identified a medication transcription error upon readmission to the facility, from the hospital, on 3/2/25. The report identified that Levemir insulin 5 units was renewed (mechanism within the electronic medical record (EMR) which allows the selection of previously discontinued orders to be reactivated, as previously ordered, but with a current start date. The discontinued order section of the EMR contains a select all option, which will renew all previously discontinued orders within the EMR, if selected) within the EMR, but not listed as an active order on hospital discharge documents and was not ordered by the readmitting provider (NP #1). Review of the hospital discharge documents dated 3/2/25 identified Resident #3 was admitted to the hospital from 2/25/25 through 3/2/25 and contained no documentation that Levemir insulin was administered throughout the hospital admission or should be started upon discharge. Medications that the discharge documents identified as stopped, during the hospital admission, included tradjenta (oral anti-diabetic medication) 5 milligrams (mg) tablet, metformin (oral anti-diabetic medication) 1000 mg tablet, and metformin 500 mg tablet. A physician's order dated 3/2/25 directed to administer Levemir insulin subcutaneous (under the skin) solution 100 units (u) per milliliter (mL), inject 5 units subcutaneously one time a day for type 2 diabetes mellitus and to hold for a blood sugar less than 80. Review of the facility Medication Administration Record (MAR) for March 2025 identified an order for Levemir insulin 5u daily was administered at 9:00 AM on 3/3/25 (by LPN #3), 3/4/25 (by LPN #2), and 3/5/25 (by LPN #1). (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Further review of the clinical record identified that an order directing Levemir insulin subcutaneous solution 100 u per mL, inject 5 units subcutaneously one time a day for type 2 diabetes mellitus and to hold for a blood sugar less than 80, was initially ordered at the facility on 3/27/24 and was discontinued at the facility on 5/16/24. Review of the MAR for March 2025 identified an order for tradjenta 5 mg once daily had a start date of 10/10/24 and was administered at 5:00 PM on 3/2/25 (by LPN #4) and subsequently discontinued at 5:45 PM. Review of the MAR for March 2025 identified an order for metformin 500 mg twice daily had a start date of 10/10/24 and was administered at 5:00 PM on 3/2/25 (by LPN #4) and subsequently discontinued at 5:45 PM. Review of the Order Audit Report for Resident #3 identified the DNS discontinued the tradjenta 5 mg and metformin 500 mg orders on 3/2/25 at 5:45 PM, after the medications were administered at 5:00 PM. Review of Nurse Practitioner (NP) visit notes dated 3/3/25 and 3/4/25 failed to identify the four (4) transcription errors. Review of the clinical record failed to identify that blood sugars were obtained from 3/2/25 through 3/5/25. A Nurse's note dated 3/5/25 at 10:22 PM identified that RN #3 was notified Resident #3 was experiencing a change in condition, and was observed in bed leaning to the left, flailing his/her arms and legs around. The note identified that staff were unable to obtain a blood pressure due to Resident #3's movement, that Resident #3 was alert but unable to answer questions or produce any noise, and both pupils were nonresponsive to light. NP #1 was notified and directed RN #3 inquire with Resident #3 ' s family on transfer to the Emergency Department (ED) for evaluation. The note identified that Resident #3's family sent a relative to see Resident #3, and once the relative arrived, they demanded Resident #3 be sent to the ED. Emergency Medical Services (EMS) were called and Resident #3 was transferred to the ED for evaluation. Review of the Prehospital Care Report (ambulance run sheet) dated 3/5/25 identified that EMS arrived at the facility at 6:30 PM and Resident #3 was observed in bed, moving around like he/she was in pain but unresponsive to commands and questions. The report identified LPN #4 stated she last saw Resident #3 around 4:00 PM and when she entered Resident #3's room around 6:00 PM, she found Resident #3 in the above-mentioned state, and stated Resident #3 was normally alert and oriented so this was not his/her normal behavior. The report identified that clinical paperwork was reviewed and identified Resident #3 had a diabetic history. LPN #4 was asked if she obtained Resident #3's blood sugar level, and she reported she had not. The report identified Resident #3's blood sugar was obtained with a result of 29, Resident #3 was administered a 250 mg bag of D10 (dextrose) in route to the hospital, responded well, and the involuntary body movements subsided. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the hospital ED note dated 3/5/25 at 7:24 PM identified that Resident #3 presented at the ED for hypoglycemia (low blood sugar) and was found to have a blood sugar of 29 (critically low level) by EMS and dextrose (sugar) was given on route to the hospital. The note identified that Resident #3 became more responsive and his/her sugar level improved. The note further identified that blood work and an ECG (electrocardiogram) were obtained and resulted within normal limits and Resident #3 was discharged back to the facility on [DATE]. Review of RN #2's statement dated 3/6/25 identified that, as an agency nurse, she was instructed for the readmission process, to discontinue all medication orders and then renew the medication orders so the pharmacy was alerted that the resident returned to the facility. The statement identified RN #2 renewed all of Resident #3's previously discontinued medication orders during the readmission process, including the Levemir insulin. Interview with RN #2 on 3/19/25 at 11:49 AM identified she was the nursing supervisor on 3/2/25 responsible for readmitting Resident #3 to the facility. RN #2 identified the DNS instructed her to discontinue all active EMR orders from prior to the hospitalization and then renew all of the discontinued EMR orders. RN #2 reported that after discontinuing and renewing all of the EMR orders, she reviewed the hospital discharge documents with NP #1 and entered new orders subsequent to the hospitalization . RN #2 identified that she then signed and activated all of the orders without the benefit of verifying the orders she was signing and activating for accuracy. She identified that she inadvertently renewed previously discontinued EMR orders to include Levemir insulin which was discontinued nearly a year prior to the hospitalization and tradjenta, metformin and Seroquel orders which were to be stopped according to the hospital discharge documents. RN #2 identified that she should have verified the orders before signing and activating them to ensure accuracy. Interview with NP #1 on 3/19/25 at 12:02 PM identified that when there is a new admission, the RN Supervisor sends her a copy of the discharge documents and medication list which she reviews and approves as appropriate. She identified that on 3/2/25, the hospital discharge documents directed to stop tradjenta, metformin and Seroquel and further identified RN #2 never reported an order for Levemir insulin. She identified when she saw Resident #3 on 3/3/25 and 3/4/25 she did not review the active medication list in the EMR as she should have. She identified that Resident #3 receiving Levemir insulin was a significant medication error, which could have led to seizures and/or death if EMS did not arrive when they did. NP #1 identified that a third shift nurse is supposed to verify the orders for accuracy, which did not occur, and could have identified the error. NP #1 identified that for all residents who are administered insulin, a standard of practice and facility policy, is that a blood sugar is obtained prior to administration, and the Levemir insulin order directed to hold the Levemir insulin for a blood sugar less than 80, which could have prevented the hypoglycemic episode. Interview with LPN #1 on 3/19/25 at 12:35 PM identified that on 3/5/25 she administered Levemir insulin to Resident #3 without first obtaining his/her blood sugar although she knew obtaining a blood sugar was required. She further identified that she did not completely read the order. Interview with RN #3 (Nursing Supervisor) on 3/19/25 at 1:20 PM identified that on 3/5/25 between 6:00 PM and 7:00 PM, LPN #4 reported Resident #3 was unresponsive. RN #3 indicated she assessed Resident #3 and thought he/she may have had a stroke, then further indicated she should have obtained a blood sugar but did not think to do so. (continued on next page)

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	03/24/2025

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with LPN #4 on 3/19/25 at 2:34 PM identified that on 3/2/25, RN #2 notified her Resident #3's readmission orders were complete and she (LPN #4) administered all medications reflected on the EMR. LPN #4 identified no one instructed her to verify the readmission orders. LPN #4 identified that on 3/5/25, sometime after dinner, Resident #3 had a change in condition, she immediately notified RN #3, and they attempted to obtain vital signs but were unsuccessful due to Resident #3's uncontrolled body movements. She identified she was unaware Resident #3 received Levemir insulin since readmission to the facility, but was aware that Resident #3 was diabetic and received oral anti diabetic medications. LPN #4 identified she did not think to check Resident #3 ' s blood sugar when the change in condition was identified. Interview with the DNS on 3/19/25 at 2:14 PM identified that RN #2 should have verified the readmission orders for Resident #3 prior to activating them, should have instructed LPN #4 (3:00 PM to 11:00 PM charge nurse on 3/2/25) to verify the orders and LPN #5 should have verified the readmission orders on third shift (11:00 PM to 7:00 AM). The DNS identified that LPN #1, LPN #2 and LPN #3 should have obtained Resident #3 ' s blood sugar prior to administering the Levemir insulin on 3/3/25, 3/4/25 and 3/5/25 according to the provider's order instructions and that LPN #4 or RN #3 should have checked Resident #3 ' s blood sugar on 3/5/25 when a change in condition was identified. Although attempted, interviews with MD #1, LPN #2 , LPN #3 and LPN #5 were not obtained. Review of the Agency Orientation Acknowledgement packet provided by the DNS identified a table of contents including policies, in part, for Care Plans/Resident Care Cards, Documentation and paper/EMR plan of care. The packet failed to identify the admission/readmission process to include order transcription and medication reconciliation. The Agency Orientation Acknowledgement was manually signed by RN #2 on 5/17/24 and electronically signed by RN #3 on 3/5/25 at 12:36 AM. Review of the Insulin Administration policy (undated) directed, in part, that the type of insulin, dosage requirements, strength and method of administration must be verified before administration, to ensure that it corresponds with the order on the medication sheet and the physician's order. The nurse shall notify the Director of Nursing Services and Attending Physician of any discrepancies, before giving the insulin. Document the resident's blood glucose result, as ordered. Review of the Diabetes- Clinical Protocol policy (undated) directed, in part, that the risk for hypoglycemia should be considered in any treatment plan, as it is a significant and high-risk complication of treatment. For the resident receiving insulin who is well controlled: monitor blood glucose levels twice daily if on insulin. Review of the Adverse Consequences and Medication Errors policy (undated) directed, in part, that the interdisciplinary team monitors medication usage in order to prevent and detect medication-related problems such as adverse drug reactions and side effects. Review of the Telephone/Verbal orders policy (undated) directed, in part, that orders must be entered by the person receiving the orders and telephone orders must be countersigned by the physician during his or her next visit. (continued on next page)

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	03/24/2025

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

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Although requested, policies on Medication Transcription and Medication Reconciliation were not provided. The Immediate Jeopardy template was presented to the Administrator by the State Agency on 3/20/25 at 1:30 PM. The facility immediately initiated a removal plan which included ensuring Resident #3 was receiving all medications according to Provider order, education for all nursing staff to include medication reconciliation and diabetes management, auditing of all residents prescribed insulin and auditing of all readmission orders. The removal plan was verified and accepted by the State Agency during an on-site visit on 3/20/25 at 5:21 PM and the Immediate Jeopardy was removed.