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	04/14/2025

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #1) reviewed for resident rights, the facility failed to ensure the physician/APRN was notified timely of critical x-ray results. The findings include: Resident #1's diagnoses included multiple sclerosis, obstructive and reflux uropathy, and constipation. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of fifteen out of fifteen (15/15), indicative of cognitively intact and required assistance with ADLs (activities of daily living). The Resident Care Plan (RCP) dated 1/14/2025 identified Resident #1 was at risk for constipation related to a history of constipation, pain medication use, and decreased mobility. Interventions directed to administer medications as ordered, bowel protocol when indicated, and observe for signs and symptoms of constipation or extended abdomen that may indicate constipation. APRN #1 progress note dated 1/27/2025 at 8:45 AM identified Resident #1 was seen for follow-up on loose stools and abdominal x-ray. Nursing reported Resident #1 had a small amount of loose stools over the weekend and had a STAT (immediate) abdominal x-ray to rule out obstruction which showed a severe colonic ileus, moderate stool in colon, and no obstruction or free air. Resident #1 without nausea/vomiting. Resident #1 denied abdominal pain and tenderness. Hypoactive (reduced frequency) bowel sounds noted on auscultation (listening). Abdomen was soft and nondistended, and Resident #1 was nontoxic appearing. New order for clear liquids only if tolerated, continue GlycoLax (laxative) 17 grams (g) BID (twice a day), hold all stimulant laxatives and enemas, repeat abdominal x-ray, and monitor bowel sounds and abdominal status daily. Physician order dated 1/27/2025 directed a KUB (kidneys, ureters and bladder x-ray). Review of the Radiology Results Report dated 1/27/2025 with a time noted of 7:08 PM identified Resident #1's KUB results indicated there was a coffee bean shaped gas shadow in the lower abdomen. Suspicious for partial sigmoid volvulus (sigmoid portion of the colon twists). Follow-up was suggested. Nursing note dated 1/27/2025 at 10:58 PM (3 hours and 50 minutes after the results report was dated) identified Resident #1 continued on clear liquid diet, pending KUB results. Nursing note dated 1/28/2025 at 6:07 AM (10 hours and 59 minutes after the results report was dated) identified KUB results were pending. (continued on next page)

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

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing note dated 1/28/2025 at 8:41 indicated Resident #1 was transferred to the hospital per physician order due to abdominal x-ray results. Record review identified although the KUB results were dated 1/27/2025 at 7:08 PM, record review failed to identify the facility staff accessed the results in the Electronic Medical Record (EMR) on 1/27 and 1/28/2025 prior to 8:41 AM. Interview with Customer Service Agent (CSA #1) on 4/14/2025 at 12:00 PM identified the Radiology Team faxed the results of Resident #1's Abdomen x-ray results to the facility on 1/27/2025 at 7:56 PM. Additionally, the results were available in the facility EMR on 1/27/2025 at 7:57 PM. The results were identified as critical findings positive. CSA #1 identified the Radiology Team called the facility on 1/28/2025 at 3:31 AM (7 hours and 34 minutes after the results were first available to the facility), but there was no answer and a voicemail was left. On 1/28/2025 at 4:14 AM (8 hours and 17 minutes after the results were first available to the facility), the Radiology Team spoke to RN #2, to confirm the results and faxed over the results again. Interview with RN #1 on 4/14/2025 at 12:40 PM identified she worked on the 3:00 PM to 11:00 PM shift as the RN Supervisor. RN #1 indicated that if any resident had pending lab work or radiologic testing performed, the results will be faxed to the facility, and it is the RN Supervisor's responsibility to review any new faxes that come in during the shift. RN #1 stated she checks the fax machine at least at the beginning and the end of her shift. RN #1 identified she did not recall reviewing a fax report regarding Resident #1's x-ray results on 1/27/2025. RN #1 stated it was possible she missed the document, as the fax machine can have hundreds of papers/paperwork coming out, due to either receiving new admissions, pharmacy paperwork, critical lab paperwork, etc. RN #1 stated if she did receive the results, she would have notified the physician and written a nursing note to reflect that she had done so. Interview with RN #2 on 4/14/2025 at 12:55 PM identified she was the supervisor from 11:00 PM to 7:00 AM (night shift) on 1/28/2025 and she checks the fax machine multiple times a night, every time she walks in the office and during rounds. RN #2 stated she spoke with the Radiology Team regarding the x-ray results for Resident #1 and stated the Radiology Team indicated that they would fax over the results. RN #2 indicated the results did not come prior to the end of her shift (7 AM) and she did not report the concerns to the physician, since she did not receive the printed report/results from the Radiology Team. RN #2 stated she did not want to call the provider without having any documentation of the results, as the provider will also need clarification as to what exactly the results were and how to treat the resident accordingly. Interview with the DON on 4/14/2025 at 1:20 PM identified although the x-ray results were dated 1/27/2025 at 7:08 PM, and RN #2 was notified verbally of the results on 1/28/2025 at 4:14 AM, the physician/APRN was not notified of the results until after 7 AM. The DON stated on 1/27/2025 there was only one (1) new resident admission, and the supervisors were responsible for checking the fax machine for results during their shift. The interview failed to identify why the physician/APRN was not notified timely. Although attempted, interview with MD #1 was unable to be obtained during the survey. (continued on next page)

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility Change in a Resident's Condition or Status Policy dated 4/2024 identified the facility will promptly notify the resident, his/her attending physician, of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.). The nurse will notify the resident's attending physician or physician on-call when there has been a(an): significant change in the resident's physical condition; need to transfer the resident to a hospital.

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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** Based on clinical record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #1) reviewed for resident rights, the facility failed to ensure staff accessed x-ray results timely for a resident with a possible small bowel obstruction. The findings include: Resident #1's diagnoses included multiple sclerosis, obstructive and reflux uropathy, and constipation. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of fifteen out of fifteen (15/15), indicative of cognitively intact and required assistance with ADLs (activities of daily living). The Resident Care Plan (RCP) dated 1/14/2025 identified Resident #1 was at risk for constipation related to a history of constipation, pain medication use, and decreased mobility. Interventions directed to administer medications as ordered, bowel protocol when indicated, and observe for signs and symptoms of constipation or extended abdomen that may indicate constipation. A nursing note dated 1/26/2025 at 12:11 PM written by RN #3 identified Resident #1 received bowel regimen with watery discharge. Denied abdominal pain, positive bowel sounds in all quadrants and abdomen was non-distended. APRN #1 was notified and new orders obtained for a KUB (x-ray of the kidneys, ureters, and bladder) to rule out constipation and small bowel obstruction. Review of the Radiology Results Report dated 1/26/2025 at 6:59 PM identified Resident #1's KUB results identified a severe colonic ileus (inability of the colon to move contents forward) with moderate stool in the colon. There was no obstruction or free air. APRN #1 progress note dated 1/27/2025 at 8:45 AM identified Resident #1 was seen for follow-up on loose stools and abdominal x-ray. Nursing reported Resident #1 had a small amount of loose stools over the weekend and had a STAT (immediate) abdominal x-ray to rule out obstruction which showed a severe colonic ileus, moderate stool in colon, and no obstruction or free air. Resident #1 without nausea/vomiting. Resident #1 denied abdominal pain and tenderness. Hypoactive (reduced frequency) bowel sounds noted on auscultation (listening). Abdomen was soft and nondistended, and Resident #1 was nontoxic appearing. New order for clear liquids only if tolerated, continue GlycoLax (laxative) 17 grams (g) BID (twice a day), hold all stimulant laxatives and enemas, repeat abdominal x-ray, and monitor bowel sounds and abdominal status daily. Physician order dated 1/27/2025 directed to repeat the KUB. Review of the Radiology Results Report dated 1/27/2025 at 7:08 PM identified Resident #1's KUB results indicated there was a coffee bean shaped gas shadow in the lower abdomen. Suspicious for partial sigmoid volvulus (sigmoid portion of the colon twists). Follow-up was suggested. Nursing note dated 1/27/2025 at 10:58 PM (3 hours and 50 minutes after the results report was available) identified Resident #1 continued on clear liquid diet, pending KUB results. Nursing note dated 1/28/2025 at 6:07 AM (10 hours and 59 minutes after the results report was available) identified KUB results were pending. (continued on next page)

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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	Nursing note dated 1/28/2025 at 8:41 (12 hours and 44 minutes after the x-ray report was available) indicated Resident #1 was transferred to the hospital per physician order due to abdominal x-ray results. Record review identified although the KUB results were dated 1/27/2025 at 7:08 PM, record review failed to identify the facility staff accessed the results in the Electronic Medical Record (EMR) on 1/27 and 1/28/2025 prior to 8:41 AM. Interview with Customer Service Agent (CSA #1) on 4/14/2025 at 12:00 PM identified the Radiology Team faxed the results of Resident #1's Abdomen x-ray results to the facility on 1/27/2025 at 7:56 PM. Additionally, the results were available in the facility EMR on 1/27/2025 at 7:57 PM. The results were identified as critical findings positive, but CSA #1 identified the computer system does not have a confirmation system to indicate the facility reviewed the results. CSA #1 identified the Radiology Team called the facility on 1/28/2025 at 3:31 AM (7 hours and 34 minutes after the results were first available to the facility), but there was no answer and a voicemail was left. On 1/28/2025 at 4:14 AM (8 hours and 17 minutes after the results were first available to the facility), the Radiology Team spoke to RN #2, to confirm the results and faxed over the results again. Interview with RN #1 on 4/14/2025 at 12:40 PM identified she worked on the 3:00 PM to 11:00 PM shift as the RN Supervisor. RN #1 indicated that if any resident had pending lab work or radiologic testing performed, the results will be faxed to the facility, and there generally are no calls by the lab or radiology provider. RN #1 indicated it is the RN Supervisor's responsibility to review any new faxes that come in during the shift, and although she there was no frequency as to how many times a supervisor checks the fax machine, she checks at least at the beginning and the end of the shift. RN #1 identified she did not recall reviewing a fax report regarding Resident #1's x-ray results on 1/27/2025. RN #1 stated it was possible she missed the document, as the fax machine can have hundreds of papers/paperwork coming out, due to either receiving new admissions, pharmacy paperwork, critical lab paperwork, etc. RN #1 stated if she did receive the results, she would have notified the physician and written a nursing note to reflect that she had done so. Interview with RN #2 on 4/14/2025 at 12:55 PM identified she was the supervisor from 11:00 PM to 7:00 AM (night shift) on 1/28/2025 and she checks the fax machine multiple times a night, every time she walks in the office and during rounds. RN #2 spoke with the Radiology Team regarding the x-ray results for Resident #1 and stated the Radiology Team indicated that they would fax over the results. RN #2 indicated the results did not come prior to the end of her shift (7 AM). RN #2 stated she did not report the concerns to the physician, since she did not receive the printed report/results from the Radiology Team. RN #2 stated she did not want to call the provider without having any documentation of the results, as the provider will also need clarification as to what exactly the results were and how to treat the resident accordingly. (continued on next page)

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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	Interview with the DON on 4/14/2025 at 1:20 PM identified radiology results appear in the resident's EMR results tab, which would show any testing/imaging performed. The DON stated the EMR does not have a confirmation notification or alert of a new result, that would notify staff of any new results that were posted in the system. The DON stated service providers, such as Radiology, notify the facility by faxing results or by a phone call. Interview identified although the x-ray results were dated 1/27/2025 at 7:08 PM, the DNS was unable to provide documentation the staff accessed the results on 1/27/2025. Further, the interview identified although RN #2 was notified verbally of the results on 1/28/2025 at 4:14 AM, the physician/APRN was not notified of the results until after 7 AM. The DON stated on 1/27/2025 there was only one (1) new resident admission, and the supervisors were responsible for checking the fax machine for results during their shift. The interview failed to identify why the results were not accessed timely.