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	06/26/2025

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, review of facility documentation, facility policies, and interviews for one (1) of three (3) sampled residents (Resident #1) who was a new admission and had a history of fall prior to admission, the facility failed to develop a baseline admission care plan that addressed Resident #1's risk for fall until after Resident #1 sustained a fall on 3/16/25 (eighteen (18) days after admission). Resident #1's diagnoses included metabolic encephalopathy, osteoarthritis, osteomyelitis, low back pain, muscle weakness, history of falls and difficulty in walking. The admission fall risk assessment dated [DATE] identified Resident #1 was at a moderate risk for falls. The assessment indicated Resident #1 was confined to a chair, was unable to independently come to a standing position and utilized an assistive device e.g. cane, walker, etc. The admission Nursing assessment dated [DATE] identified Resident #1 was oriented to person, place, time, and situation, was incontinent of bowel and bladder and required extensive assistance with bed mobility and toileting and supervision for transfers. Review of the clinical record failed to reflect documentation a baseline Resident Care Plan was developed within the first forty-eight (48) hours of admission that addressed Resident #1's history of falls prior to admission. The Resident Care Plan dated 3/16/25 identified Resident #1's risk for falls was developed after Resident #1 sustained an unwitnessed fall. The nurse's note dated 3/16/25 at 7:04 PM identified Resident #1 had an unwitnessed fall, Resident #1 was found on the floor, Resident #1 stated he/she slid forward out of the wheelchair and onto the floor. The note indicated Resident #1 complain of bilateral hip and right shoulder pain, the on-call Advanced Practice Registered Nurse was updated and directed to send Resident #1 to the Emergency Department for an evaluation. The nurse's note dated 3/17/25 at 2:58 AM identified Resident #1 returned from the Emergency Department and all images were negative for fractures. (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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and clinical record review with the Director of Nursing (DON) on 6/26/25 at 11:31 AM identified upon admission Resident #1 was identified as a moderate risk for falls. The DON identified it would be her expectation that an admission baseline care plan would have been put in place for a resident identified as a moderate risk for falls. The DON identified the Minimum Data Set nurse is primarily responsible for controlling the care plan, but all members of the team should be checking to ensure it is complete.

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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** Based on clinical record reviews, review of facility documentation, facility policies, and interviews for one (1) of three (3) sampled residents (Resident #2) who had a history of falls, the facility failed to implement the care plan intervention to have mats on each side of the bed for safety. The findings include: Resident #2's diagnosis included dementia, hemiplegia and hemiparesis (one sided weakness) following cerebral infarction (stroke) affecting the left side, muscle weakness, and difficulty walking. The admission Minimum Data Set (MDS) dated [DATE] identified Resident #2 rarely or never made decisions regarding tasks of daily life, was incontinent of bowel and bladder, and required total staff assistance with bed mobility, and transfers and toileting. The Resident Care Plan dated 2/14/25 identified Resident #2 was a high risk for falls. Interventions directed to anticipate and meet the resident's needs, ensure the call light is within reach and encourage the resident to use it for assistance as needed, bed in low position, body pillows to both sides of bed, floor mats to each side of bed, perimeter cover for air mattress, follow facility fall protocol, and monitor for and correct unsafe practices if observed. The nurse's note dated 3/22/25 at 1:17 PM identified at 11:00 AM Resident#2 was found lying on the left side of the bed on the floor mat, the bed was in the low position, Resident #2 denied any pain and was assisted back to bed. The nurse's note dated 3/23/25 at 4:02 PM identified at 3:00 PM Resident #2 was found on the floor on his/her left side, yelling after an unwitnessed fall. The note identified Resident #2 was agitated, complained of pain to the right knee and there was a raised area to the left temple, the Advanced Practice Registered Nurse was notified, and an order was obtained to send Resident #2 to the Emergency Department. The note failed to reflect documentation the floor mats were in place at the time of the fall. The Reportable Event Form and Interdisciplinary Accident /Incident assessment dated [DATE] failed to reflect documentation the floor mats were in place at the time of the fall. The hospital record dated 3/24/25 identified Resident #2's family informed the hospital case manager they did not want Resident #2 to return the facility, and referrals were sent to other long term care facilities. The hospital note dated 3/31/25 identified Resident #2 was medically cleared and was transferred to another long-term care facility closer to the family. Interview with the Infection Control Nurse, Registered Nurse (RN) #2, on 6/26/25 at 11:22 AM identified at the time of Resident #2's fall on 3/23/25, Resident #2 was combative and the floor mats were not in place by each side of the bed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and clinical record review with the Director of Nursing (DON) on 6/26/25 at 11:41 AM identified Resident #2 did have a care plan in place that directed to place floor mats on the floor on both sides of the bed. The DON identified it was the responsibility of the staff to ensure that all interventions are implemented. The DON identified she was not made aware that the floor mats were not in place at the time of her investigation. Review of the facility policy titled Falls-Clinical Protocol, undated, directed, in part, as part of the initial assessment, the physician will help identify individuals with a history of falls and risk factors for subsequent falling. Review of the facility policy titled Care Plans, Comprehensive Person-Centered, revised 5/23/22, directed, in part, a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident. Additionally, the policy directed the interdisciplinary team, in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident and care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The policy further directed, the care plan will incorporate identified problem areas and incorporate risk factors associated with identified problems. The policy directed, in part, identifying problem areas and their risk factors/causes and developing interventions that are targeted and meaningful to the resident and the comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required comprehensive assessment (MDS).

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, observations, review of facility documentation, facility policies, and interviews for one (1) of three (3) sampled residents (Resident #1) who had an unwitnessed fall, the facility failed to ensure Resident #1's was not left alone on the floor while waiting for Emergency Medical Services (EMS) personnel arrived to transport Resident #1 to the Emergency Department. The findings include: Resident #1's diagnoses included metabolic encephalopathy, osteoarthritis, osteomyelitis, low back pain, muscle weakness, history of falls and difficulty in walking. The admission fall risk assessment dated [DATE] identified Resident #1 was at a moderate risk for falls. The assessment indicated Resident #1 was confined to a chair, was unable to independently come to a standing position and utilized an assistive device e.g. cane, walker, etc. The admission Nursing assessment dated [DATE] identified Resident #1 was oriented to person, place, time, and situation, was incontinent of bowel and bladder and required extensive assistance with bed mobility and toileting and supervision for transfers. The nurse's note dated 3/16/25 at 7:04 PM identified Resident #1 had an unwitnessed fall, Resident #1 was found on the floor, Resident #1 sated he/she slid forward out of the wheelchair and onto the floor. The note indicated Resident #1 complain of bilateral hip and right shoulder pain, the on-call Advanced Practice Registered Nurse was updated and directed to send Resident #1 to the Emergency Department for an evaluation. The Emergency Medical Sheet (EMS), the document from EMS that describes the details of the call to the facility, dated 3/16/25 at 6:40 PM identified Resident #1 was found alone in his/her room laying supine on the floor and Resident #1 stated that he/she slid out of his/her wheelchair while trying to make it to the bathroom. The nurse's note dated 3/17/25 at 2:58 AM identified Resident #1 returned from the Emergency Department and all images were negative for fractures. Interview and clinical record review with the Director of Nursing (DON) on 6/26/25 at 11:31 AM identified the facility did not have a policy in place at the time of the fall that addressed whether a staff member should stay with the resident while awaiting EMS arrival, but it was the expectation that a staff member would stay with a resident who had fallen. Review of the facility policy titled Resident Unwitnessed Falls, undated, directed in part if any question exists as the possibility of a fracture, or other serious condition per the initial Registered Nurse's (RN) assessment, the resident is not to be moved, they are to be made as comfortable as possible in their current locations until transported to an acute care setting for evaluation per physician order as needed by EMS personnel. Although attempted, interviews with the 3-11PM Nursing Supervisor and 3-11PM nurse aide were unable to be obtained.