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	09/18/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 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 clinical record review, observations, facility documentation review, facility policy review, and interviews for two of three residents (Resident #2 and Resident #7) reviewed for accidents, the facility failed to provide adequate supervision to ensure the residents were free from mistreatment, and failed to protect a roommate when placed in a room with a resident with known behaviors of pushing a resident out of bed. The findings include:a. Resident #1's diagnoses included dementia, schizoaffective, liver failure, and brain lesion. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a BIMS score of zero out of fifteen, indicative of severe cognitive impairment, required supervision or touching assist with transfers and ambulation, and was on hospice services. The Resident Care Plan (RCP) dated 6/21/2025 identified impaired thought processes due to schizoaffective disorder and wandering behaviors. Interventions directed assist as needed, and staff must be present on the unit during the evening shift to redirect when wandering, and to assist to common areas or room. Record review identified Resident #1 had no roommate. b. Resident #7's diagnoses included dementia, depression and diabetes. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had a BIMS score of zero out of fifteen, indicative of severe cognitive impairment, and was dependent with ADLs. The RCP identified an alteration in ADLs with interventions that directed to provide assistance with ADLs as indicated, and mechanical lift for transfers. Facility reportable event dated 8/9/2025 at 9:30 PM identified Resident #1 entered Resident #7's, went to window bed and pushed resident off his/her bed. Review of witness statement identified Resident #1 was witnessed pushing Resident #7 off his/her bed and no injuries were identified. The care plan was for Resident #1 was updated for a potential to be physically aggressive. Interventions directed to monitor for behaviors, document observed behavior and attempted interventions, administer medications as ordered, notify appropriate parties and social services follow up as indicated. Facility reportable event summary dated 8/16/2025 identified the corrective action directed increased staff presence on the unit, particularly in the evenings when Resident #1's wandering is most frequent, and to redirect to common areas for safety. Interview, review of the clinical record and facility documentation on 9/18/2025 at 1:02 PM with the Administrator and DNS identified Resident #1 had wandering behaviors and on 8/9/2025 he/she entered Resident #7's room and pulled/pushed Resident #7 off his/her bed. Resident #1 had no injuries, and Resident #1 sustained a skin tear due to the incident. Interview identified Resident #1 should not have pulled/pushed Resident #7 out of his/her bed, and Resident #1's RCP was updated to direct additional staff on the unit to monitor behaviors and wandering. c. Resident #1's diagnoses included dementia, schizoaffective, and liver failure. Record review identified Resident #1 was receiving hospice services. The Resident Care Plan (RCP) dated 8/10/2025 identified impaired thought processes due to schizoaffective disorder and wandering behaviors, and hospice services. Interventions directed hospice care, assist as needed, supervise as needed, and staff must be present on the unit during the evening shift to redirect when wandering, and to assist to common areas or room. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a BIMS score of zero out of fifteen, indicative of severe cognitive impairment, required supervision or touching assist with transfers and ambulation, and was on hospice services. d. Resident #2's diagnoses included dementia. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had a BIMS score of zero out of fifteen, indicative of severe cognitive impairment, and was dependent for ADL care and wheelchair mobility. The RCP dated 7/15/2025 identified alteration in functional mobility and ADLs due to impaired cognition due to dementia, and brain lesion. Interventions directed to provide personal hygiene, provide maximal assistance with transfers and mobility in wheelchair, and provide hospice services. Record reviews identified Resident #1 and Resident #2 were roommates. Facility reportable event dated 8/29/2025 at 4:15 PM Resident #1 pulled Resident #2 off his/her bed, both residents were observed on the floor, and both residents were transferred to the hospital for evaluation. Resident #1 returned from the hospital with a discharge summary that identified a CT scan of the head was performed. Resident #1's CT scan results identified a subacute right subdural hematoma (collection of blood on the right side of the brain) with a 4 millimeter (mm) of right to left subfalcine herniation (shift of the brain). The report further identified Resident #1 (returned from the hospital) was placed on one-to-one (1:1) observation. Nursing note for Resident #2 dated 8/29/2025 at 4:40 PM identified Resident #2 was noted laying on the floor at bedside with linen on floor under resident. No injuries were identified, and