Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075295	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2026

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. Based on a review of clinical records, facility documentation, and facility policies, and interviews for one sampled resident (Resident #1)reviewed for a change in condition, the facility failed to ensure staff activated emergency medical services timely after a change in condition was identified and after directed by the APRN, resulting in a delay of transport to the hospital by forty-one (41) minutes. The findings include: Resident #1 was admitted to the facility with diagnoses that included multiple sclerosis (MS), paraplegia (partial or complete loss of movement in the lower half of the body including both legs), dementia and depression. A quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 2/14/2026 identified Resident # 1 had a Brief Interview for Mental Status (BIMS) score of 13, alert and oriented and was dependent for personal hygiene, bed mobility and transfer. A resident care plan (RCP) dated 12/12/2025 identified Resident #1 had anemia, and took medications for depression, hypertension and pain. Interventions included to monitor for changes in condition, behavior changes not usual to the person and to observe for side effects of pain medication to include new onset of confusion. An APRN progress note dated 2/24/2026 at 9:32 PM identified via audio/visual (AV) technology at 9:00 PM that she was notified Resident #1 had an acute altered mental status with word finding difficulty and was dysthartic (slow, weak and uncoordinated speech). Emergency medical services (EMS) had been activated for hospital transfer. Via the AN system with LPN #1 in attendance, the APRN observed that Resident #1's vital signs were stable and Resident #1 was not in acute distress. The APRN identified that this was an acute/new problem and that Resident #1's condition was critical. She questioned a MS flare up or possible stroke agreeing with transfer to the hospital and to notify her when Resident #1 returned after hospital evaluation. A nursing note dated 2/24/2026 at 11:15 PM identified Resident #1 was transferred to the hospital for altered mental status, post treatment for urinary tract infection and poor appetite. The APRN was notified and ordered to transfer to hospital for evaluation. Resident #1 left the facility at 10:30 PM. Vital signs were: Temperature 98.7 (normal 98.6), Heart rate 71, Blood pressure 124/76 with no distress noted, and the responsible party was notified. Interview with LPN #1 on 4/9/2026 at 10:52 AM identified she was the 3:00 PM to 11:00 PM shift nurse for Resident #1 and LPN #2 was the day shift nurse for Resident #1 on 2/24/2026. LPN #1 stated she notified the supervisor, RN #1, and RN #1 evaluated Resident #1 and noted Resident #1 to be back at his/her baseline. At approximately 7:00 PM, LPN #1 asked LPN #2 (who was working on another unit) to concur that Resident #1's mental status had worsened, and LPN #2 agreed that Resident #1's current mental status was a change from the day shift. LPN #1 then notified the responsible party and called EMS and the on-call APRN. The on-call APRN agreed that EMS should be called, and LPN #1 could not recall the specific time of when she made the calls to the APRN and EMS. Interview failed to identify why the APRN visit was documented at 9:32 PM and EMS was called at 10:13 PM (41 minutes later). Review of Emergency Medical Services (EMS) run sheet dated 2/24/2026 identified EMS dispatch was notified (call received) at 10:13 PM (41 minutes after the APRN note). When EMS arrived at Resident #1 at 10:28 PM they observed Resident #1 lying in bed obtunded (sluggish) and only responsive to painful stimuli. The EMS report identified an initial Blood Pressure (BP) was 50 systolic, and intravenous (IV) fluids and Narcan (medication to counteract pain medication) were administered with improved mental (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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	075295	A. Building B. Wing	04/09/2026

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	status and BP. EMS transported Resident #1 to the hospital at 10:53 PM. Interview with LPN #2 on 4/9/2026 at 11:21 AM identified she saw Resident #1 at 7:00 PM when LPN #1 asked her to see Resident #1. LPN #2 stated she noted a change in Resident #1's mental status since the 7:00 AM to 3:00 PM shift. Resident #1 was more confused and was having difficulty finding the words to communicate effectively. LPN #2 stated she returned the Resident #1's unit about 8:30 PM to assist LPN #1 with the AV device to call the APRN, and left the unit about 8:45 PM. Interview with RN #1 on 4/9/2026 at 12:34 PM identified she was the nursing supervisor on 2/24/2026 during 3:00 to 11:00 PM shift. RN #1 stated LPN #1 had notified her on 2/24/2026 early in the shift that Resident #1 had mental status changes with stable vital signs and was requesting Resident #1 be transferred to the hospital. RN #1 stated she evaluated Resident #1 and identified he/she was back to baseline. RN #1 stated later in the shift (she was unclear of the time), LPN #1 contacted her again concerning Resident #1's change in mental status and EMS was notified. RN #1 could not recall if she or LPN #1 had made the call to EMS. Interview failed to identify why the APRN visit was documented at 9:32 PM and EMS was called at 10:13 PM (41 minutes later). Interview with the DON on 4/9/2025 at 2:35 PM identified once it is determined that a resident should be sent to the hospital emergently, EMS should be activated. The DON stated she expected that once the floor nurse notified the supervisor of a significant change in condition, both the floor nurse and the supervisor would be with the resident as the supervisor would be assessing the resident. Once the determination to transfer was identified, either the supervisor or floor nurse should activate EMS by dialing 911. Interview failed to identify why the APRN visit was documented at 9:32 PM and EMS was not called until 10:13 PM (41 minutes later). The facility Change in Condition Reporting Policy dated August 2025, directed in part, when there is a significant change in condition, there should be timely recognition and communication of the change.