

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  01/13/2025
NAME OF PROVIDER OR SUPPLIER  Meriden Health and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0550</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51102</b></p> <p>Based on observations, interviews, and clinical record review for 1 of 2 sampled residents, (Resident #41), reviewed for dignity, the facility failed to return personal laundry, in a timely manner, to ensure the availability of street clothes to maintain a dignified appearance. The findings include:</p> <p>Resident #41's diagnoses included congestive obstructive pulmonary disease, muscle weakness, and peripheral vascular disease.</p> <p>The quarterly Minimum Data Set assessment dated [DATE] identified Resident #41 was cognitively intact, independent for toileting and ambulation, and required partial/moderate assistance for upper and lower body dressing.</p> <p>The Resident Care Plan dated 12/10/24 identified Resident #41 required assistance with Activities of Daily Living (ADL's) due to decreased strength and endurance. Interventions included set up for upper and lower body dressing and partial/moderate assistance for personal hygiene.</p> <p>The Nurse Aide (NA) Resident Care Card identified Resident #41 required assistance of 1 staff for dressing.</p> <p>Observation and interview with Resident #41 on 1/6/25 at 11:11 AM identified Resident #41 sitting in the lounge with a visitor. Resident #41 was dressed in a hospital gown (with 2 small orange stains on the front) and jeans. Resident #41 stated his/her personal clothing had been sent to the laundry, he/she was wearing the hospital gown because his/her laundry had not been done in a while and he/she would have preferred to have been dressed in his/her own street clothes. Further, when Resident #41 had notified the nursing staff, he/she was told that if there was time, staff would look to see if they could find any of the residents clothing. Resident #41 was unable to recall the last time he/she received clothing from the Laundry Department.</p> <p>Observation on 1/7/25 at 11:07 AM identified Resident #41 walking in the hallway wearing jeans and a hospital gown (with 2 small orange stains on the front) with his/her back exposed.</p> <p>Interview with NA #1 on 1/8/25 at 7:25 AM identified laundry for Resident #41's floor was done on Mondays.</p> <p>(continued on next page)</p>

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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<p>F 0550</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Interview with the Director of Laundry on 1/8/25 at 8:11 AM identified personal laundry was washed in the facility once a week or more frequently according to resident needs. Additionally, Resident #41's laundry had last been washed on Monday December 30, 2024, because the responsible staff member had been off this past Monday, January 6, 2025 (resident personal laundry was not collected), so the next laundry day would have been Monday January 13, 2025.</p> <p>Subsequent to surveyor inquiry Resident #41 received his/her laundry and was appropriately dressed in his/her own street clothes.</p> <p>Review of the Environmental Services and Laundry Policy directed, in part, that it was the facility policy to maintain an adequate supply of clean personal clothing for each resident at all times.</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 51182</p> <p>Based on record review, staff interviews, and review of facility policy for 3 of 24 residents (Resident #1, #41, and #46) reviewed for Advanced Directives, the facility failed to complete an Advance Directive form upon admission. The findings include:</p> <p>1. Resident #1's diagnoses included chronic obstructive pulmonary disease, Erb's Paralysis, and hypertension.</p> <p>The Resident Care Plan dated 11/22/24 identified Resident #1 had an Advanced Directive in place as a full Code (to be resuscitated).</p> <p>A nurse practitioner note dated 11/22/24 directed Resident #1 to be a full code</p> <p>A social services note dated 11/26/24 identified that Resident #1 was a full code.</p> <p>The admission Minimum Data Set assessment dated [DATE] identified Resident #1 was cognitively intact, required moderate assistance with personal hygiene, and utilized a manual wheelchair for mobilization.</p> <p>An interview with the Medical Records Coordinator on 1/8/25 at 10:34 AM identified the facility failed to complete a signed Advanced Directive form for Resident #41. She further noted Resident #1 would be contacted on 1/8/25 by the social worker to obtain a signed Advanced Directive form. The Medical Records Coordinator was unable to identify why the Advanced Directive form had not been completed.</p> <p>An interview with the Director of Social Services on 1/8/25 at 10:58 AM identified that she was responsible for obtaining and scanning Advanced Directive forms into a resident's EMR (Electronic Medical Record). The Director of Social Services further indicated she was responsible for ongoing communication with residents to ensure their code status reflected their wishes. The Director of Social Services identified that she had communicated with Resident #1 on 1/8/24 and his/her wishes were a code status of Do Not Resuscitate (DNR), not a full code. Subsequent to Surveyor inquiry, a signed Advanced Directive form for Resident #1 was obtained reflecting his/her DNR status and the code status in the EMR was changed from full code to DNR.</p> <p>2. Resident #41's diagnoses included heart failure, neurogenic bladder, and chronic obstructive pulmonary disease.</p> <p>The Resident Care Plan dated 8/26/24 identified Resident #41 was a full code and his/her wish regarding cardiopulmonary resuscitation should be respected in the event of cardiac/respiratory arrest.</p> <p>The quarterly Minimum Data Set assessment dated [DATE] identified Resident #41 had intact cognition, required moderate assistance with personal hygiene, and was independent with sit to stand position changes.</p> <p>(continued on next page)</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A nurse practitioner note dated 9/9/24 directed Resident #41 to be a full code.</p> <p>An interview with the Medical Records Coordinator on 1/8/25 at 10:34 AM identified the facility failed to complete a signed Advanced Directive form for Resident #41. She further noted Resident #41 was conserved and the social worker would call the conservator on 1/8/25 to obtain a signed Advanced Directive form. The Medical Records Coordinator was unable to identify why the Advanced Directive form had not been completed.</p> <p>3. Resident #46's diagnoses included neurocognitive disorder, chronic obstructive pulmonary disease, and hypertension.</p> <p>A Physician order dated 7/23/24 directed Resident #46 was a full code.</p> <p>The Resident Care Plan dated 8/10/24 identified Resident #46 was a full code and requested cardiopulmonary resuscitation to be performed in the event of cardiac/respiratory arrest.</p> <p>The quarterly Minimum Data Set assessment dated [DATE] identified Resident #46 had severe cognitive impairment, was dependent with personal hygiene, and mobilized with a manual wheelchair.</p> <p>An interview on 1/7/25 at 10:38 AM with Licensed Practical Nurse (LPN) #4 and LPN #6 identified Advanced Directive forms were obtained from residents on admission and the nurse supervisor verified that the information on the Advanced Directive form matched the Advanced Directive information listed in the Electronic Medical Record (EMR). LPN #4 and LPN #6 failed to locate Resident #46's signed Advanced Directive form.</p> <p>An interview on 1/7/25 at 10:47 AM with RN #4 identified Resident #46 should have had a signed Advanced Directive form within his/her chart. RN #6 failed to locate Resident #46's signed Advanced Directive form. RN #6 was unable to identify why a signed Advanced Directive form was not in Resident #46's chart.</p> <p>An interview on 1/7/25 at 11:15 AM with the Medical Records Coordinator identified Resident #46 should have a signed Advanced Directive form within his/her chart. The Medical Records Coordinator failed to locate Resident #46's signed Advanced Directive form.</p> <p>A subsequent interview with RN #4 identified a signed Advanced Directive form was never obtained from Resident #46. She stated it was the responsibility of all staff to ensure the Advanced Directive was obtained and was unable to identify why the form was not completed. Subsequent to Surveyor inquiry, RN #4 reached out to Resident #46's lawyer and Power of Attorney (POA) to initiate the process of obtaining a signed Advanced Directive. RN #4 noted that the status of full code in Resident #46's EMR matched the verbal code status given to her by the POA.</p> <p>Review of the Advanced Directives Policy identified that upon admission, every resident should be offered the opportunity to formulate an Advanced Directive. Information on whether a resident has an advanced directive will be displayed prominently within a resident's medical record. Written information will include a description of the facility's policies to implement Advanced Directives and applicable state law.</p>		

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<p>F 0582</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 51182</p> <p>Based on review of the clinical record, facility policy, and interviews for 2 of 3 residents (Resident #306, and Resident #307) reviewed for beneficiary notification, the facility failed to ensure the Notice of Medicare Non-coverage (NOMNC) form was provided prior to a planned discharge. The findings include:</p> <p>1. Resident #306's diagnoses included rhabdomyolysis, human immunodeficiency virus disease, and hypertension.</p> <p>The discharge Minimum Data Set assessment dated [DATE] identified Resident #306 was cognitively intact and the discharge date to home was 8/16/24.</p> <p>A nurses note dated 8/16/24 at 1:07 PM identified that Resident #306's family member was informed of all discharge instructions.</p> <p>Resident #306's clinical record failed to indicate a NOMNC notice had been provided.</p> <p>2. Resident #307's diagnoses included spinal stenosis, hypertension, and hypothyroidism.</p> <p>The discharge Minimum Data Set assessment dated [DATE] identified Resident #307 was cognitively intact, and the discharge date to home with was 11/29/24.</p> <p>Resident #307's clinical record failed to indicate a NOMNC notice had been provided.</p> <p>An interview with the Administrator on 1/13/25 at 10:58 AM identified that the MDS Coordinator was responsible for ensuring all residents receive a NOMNC form before a planned discharge. He further noted that Resident #306 and Resident #307 should have received a NOMNC form and did not. The Administrator was unable to identify why the residents did not receive a NOMNC form per the facility policy.</p> <p>The MDS Coordinator was unavailable for interview.</p> <p>The Notice of Medicare Non Coverage (NOMNC) Policy identified the Resident Care Coordinator is responsible for issuing the NOMNC to every resident, in person, at least two calendar days prior to discharge. If not delivered in person, the means of delivery along with date and time must be documented. The Resident Care Coordinator must ensure a resident understands the NOMNC and their appeal rights.</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 51102</p> <p>Based on observations, interviews, and record review for 1 of 2 residents (Resident #7) reviewed for activities, the facility failed to develop and implement a comprehensive individualized care plan related to resident activities of interest, and for the only sampled resident, (Resident #24), reviewed for edema, the facility failed to implement the Resident Care Plan to monitor the resident for Congestive Heart Failure (CHF). The findings include:</p> <p>1. Resident #7 was admitted to the facility in March 2022 with diagnoses that included mild cognitive impairment, anxiety disorder, and adjustment disorder with depressed mood.</p> <p>The annual Minimum Data Set (MDS) assessment dated [DATE] identified listening to music as an activity of importance.</p> <p>The quarterly MDS assessment dated [DATE] identified Resident #7 was severely cognitively impaired and required maximum assistance from staff for bed mobility and dressing, a mechanical lift for transfers, and set up assistance for meals.</p> <p>A Resident Care Plan (RCP) dated 6/5/24 identified a mood problem. Interventions included reviewing the activity calendar, encourage to identify activities of choice, and provide materials and supplies as needed. Although the RCP for mood indicated activities of choice, a RCP was never developed to identify a person centered, comprehensive problem with interventions related to Resident #7's preferred activities.</p> <p>Interview and review of the RCP with the Recreation Director on 1/8/25 at 11:05 AM failed to identify the RCP was comprehensive related to Resident #7's specific leisure activities or interests of listening to music (per the MDS dated [DATE]). The Recreation Director identified that the MDS Coordinator was responsible for developing an activity care plan including resident interests, and that no activity assessments had been completed from 6/1/24 through 1/6/25 identifying Resident #7's leisure interests.</p> <p>The Resident Care Card (directs the Nurse Aide in the physical and psychosocial care that was needed for residents) lacked the date initiated and did not identify Resident #7's interest in music.</p> <p>An interview and review of the RCP with LPN #3 (MDS Coordinator) on 1/9/25 at 11:15 AM failed to identify documentation of a comprehensive activity care plan that included Resident #7's leisure interests. LPN #3 was not able to locate an activity care plan and was not able to identify Resident #7's activities of interests based on her review of the care plan. LPN #3 indicated that the care plan was not comprehensive or individualized related to activities as it did not include music as an interest (per the MDS dated [DATE]).</p> <p>2. Resident #24's diagnoses included CHF, acute embolism and thrombosis of unspecified vein, and diabetes mellitus.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #24 was cognitively intact, independent for eating, and dependent on staff for toileting and transfers.</p> <p>The Resident Care Plan dated 12/31/24 identified Resident #24 had CHF. Interventions included to check breath sounds and to monitor/document for labored breathing, and the use of accessory muscles while breathing. Additionally, as needed monitor/document/report any signs or symptoms of CHF; dependent edema (swelling) of legs and feet, periorbital (around the eye) edema, shortness of breath upon exertion, cool skin, dry cough, distended neck veins, weakness, weight gain unrelated to intake, crackles and wheezes upon auscultation of the lungs, orthopnea (shortness of breath that occurs while laying down), weakness and or fatigue, increased heart rate, lethargy or disorientation.</p> <p>The physician's orders dated 12/18/24 did not include orders for monitoring/documenting for signs and symptoms of CHF.</p> <p>Observation of Resident #24 on 1/6/25 at 1:14 PM identified right hand edema swelling.</p> <p>Interview and record review with Registered Nurse (RN) #1 on 1/8/25 at 9:58 AM identified that it was the facility policy to monitor residents with CHF for edema and lung sounds but she was unable to identify how Resident #24 was being monitored or why monitoring was not identified as being performed. Review of the clinical record failed to identify any CHF monitoring or assessments for Resident #24.</p> <p>Interview with Medical Doctor (MD) #1 on 1/8/25 at 11:10 AM identified it was the facility policy to monitor weights and perform a nursing assessment on CHF residents. Additionally, he would expect nursing to be monitoring and assessing Resident #24 for lung sounds and edema and he would be adding orders to monitor for Resident #24's CHF.</p> <p>Subsequent to surveyor inquiry, review of the physician's orders dated 1/8/25 identified monitoring/assessments every shift as follows; to assess for peripheral edema, fluid restriction of 1500 milliliters (ml) in a 24-hour time period, monitor for dyspnea (shortness of breath), orthopnea, poor activity tolerance and cough, oxygen saturation, and lung assessment.</p> <p>Review of the Heart Failure-Protocol policy directed in part that the physician will monitor the progress of individuals with heart failure, including ongoing evaluation and documentation of signs, symptoms and condition changes.</p> <p>Review of the Care Plans, Comprehensive Person-Centered policy directed, in part, a comprehensive, person-centered care plan to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. Additionally, identifying problem areas and their risk factors/causes and developing interventions that are targeted and meaningful to the resident, are the endpoint of the interdisciplinary process.</p> <p>51756</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51102</b></p> <p>Based on interviews and record review for 1 of 3 residents (Resident #20) reviewed for accidents, the facility failed to complete a neurological assessment for a resident who had an unwitnessed fall with a head injury and for the only sampled resident, (Resident #54), reviewed for death, the facility failed to complete a comprehensive assessment at the time of pronouncement of death per professional standards of practice. The findings include:</p> <p>1. Resident #20's diagnosis included Parkinson's disease, diabetes mellitus, and hypertension.</p> <p>The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #20 was cognitively intact, set up for eating, needed partial/moderate assistance for transfers, and was independent for dressing.</p> <p>The Resident Care Plan in effect on [DATE] identified Resident #20 was at risk of falls due to Parkinson's disease and anemia. Interventions included monitor for and correct unsafe practices and monitor for changes in mobility.</p> <p>A nurses note dated [DATE] at 1:53 AM identified Resident #20 had an unwitnessed fall on [DATE] at 1:15 AM and indicated that neurological checks were initiated and within normal limits.</p> <p>Review of the Reportable Event form dated [DATE] identified that Resident #20 had an unwitnessed fall in his/her room, had a bump on their forehead, and the MD/APRN was notified.</p> <p>Review of the physician's order dated [DATE] directed to apply ice to the quarter sized right forehead bump every 6 hours for 20 minutes as tolerated for 24 hours.</p> <p>Review of the nurses notes and neurological check sheet from [DATE] at 1:53 AM through 8:00 AM (when the resident hospitalized ) and again from [DATE] at 11:00 PM (resident returned from the hospital) through [DATE] at 1:15 AM failed to identify any neurological checks had been performed or recorded. The neurological check sheet identified vital signs (temperature, pulse, respirations, and blood pressure) but lacked neurological signs which included pupillary reaction, hand grasps, and level of consciousness for the designated intervals (every 15 minutes for 2 hours, then every 30 minutes for 2 hours, then then every 60 minutes for 4 hours, then every 8 hours for 16 hours).</p> <p>Interview with the Director of Nurses (DNS) on [DATE] at 9:00 AM identified the facility policy for a resident with an unwitnessed fall and a head injury was to initiate neurological checks. Further, the charge nurse on the unit was responsible to ensure neuro checks were performed which included the assessment of equal hand grasps and pupil reaction, not just the vital signs. The DNS was unable to identify why the full neurological assessment had not been performed.</p> <p>Interview and review of the facility neurological check form on [DATE] at 9:00 AM with Licensed Practical Nurse (LPN) #2 identified that although vital signs had been taken, the facility policy included ensuring a complete neurological assessment was conducted following an unwitnessed fall with a head injury. LPN #2 was unable to explain why the entire neurological sign columns, which included pupillary reaction, hand grasps, and level of consciousness, remained blank.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Unwitnessed Fall Policy directed in part should the event involve a head injury, in addition to vital signs, neuro signs will be taken sequentially as follows: at the time of the event, every 15 minutes for 2 hours, every 30 minutes for 2 hours, every 60 minutes for 2 hours, then every shift for a completion of 72 hours.</p> <p>Review of The Neurological Assessment Policy directed in part that the assessment is indicated following an unwitnessed fall and subsequent to a fall with a suspected head injury. Furthermore, steps in the procedure included taking temperature, pulse, respirations and blood pressure, checking pupil reaction, determining motor ability and sensation to extremities.</p> <p>2. Resident # 54's diagnoses included chronic obstructive pulmonary disease, hyperlipidemia and dementia.</p> <p>The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #54 was severely cognitively impaired, and was dependent on staff for eating, toileting and transfers.</p> <p>The Resident Care Plan dated [DATE] identified Resident #54 had a terminal prognosis and was active with hospice. Interventions included assessing resident coping strategies and respect resident wishes.</p> <p>The physician's order dated [DATE] directed for Resident #54 's advance directives to be Do Not Resuscitate/Registered Nurse may Pronounce (DNR/RNP).</p> <p>A nurses note written by Registered Nurse (RN) #3 dated [DATE] at 1:04 PM identified that she was notified of Resident #54's the lack of a pulse. RN #3 indicated that she assessed Resident #54 which indicated that vital signs were completed and there was no pulse. RN#3's assessment failed to identify which vital signs had been assessed.</p> <p>An interview and record review on [DATE] at 9:41 AM with RN #3 identified that she pronounced Resident #54 as deceased on [DATE]. RN #3 stated this was her first time performing a Registered Nurse Pronouncement of death. RN #3 was unaware of the facility policy or what assessment needed to be performed prior to the pronouncement of death stating only that her assessment of Resident #54 was the lack of a pulse.</p> <p>An interview with the Administrator on [DATE] at 9:51 AM identified the facility policy was to include all vital signs (in addition to the pulse) and an assessment of the resident which should include, in part, lung sounds, and pupillary reaction. The Administrator was unable to identify why the RN Pronouncement note failed to include a complete assessment per the facility policy.</p> <p>Review of the Registered Nurse Pronouncement policy directed, in part, that the facility shall allow Registered Nurses to pronounce a resident as deceased in accordance with Connecticut state laws and regulations. Additionally, Determination of Death means observation and assessment that a person has ceased bodily functions irreversibly including but not limited to the following: pulse, respirations, heartbeat, and pupillary reaction.</p>

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide activities to meet all resident's needs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51756</b></p> <p>Based on observations, review of the clinical record, facility policy, and interviews for 1 of 2 sampled residents reviewed for activities (Resident #7), the facility failed to provide activities of interest. The findings include:</p> <p>Resident #7 diagnosis included mild cognitive impairment, anxiety disorder, and adjustment disorder with depressed mood.</p> <p>The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #7 enjoyed listening to music as an activity of importance.</p> <p>The quarterly MDS dated [DATE] identified Resident #7 was severely cognitively impaired and required maximum assistance from staff for bed mobility and dressing, mechanical lift for transfers, and set up for meals.</p> <p>The Resident Care Plan (RCP) dated 6/5/24 identified a mood problem. Interventions included reviewing the activity calendar, encourage to identify activities of choice and provide materials and supplies as needed. The RCP failed to identify Resident #7's interest in music (per the MDS dated [DATE]) or any other interests.</p> <p>The Resident Care Card (directs the Nurse Aide in the physical and psychosocial care that was needed for residents) lacked the date initiated and did not identify Resident #7's interest in music or any other interests.</p> <p>A physician's order dated 12/11/24 directed to document each shift on the behavior monitoring form the intervention of music/activity but the behavior monitoring form failed to identify music was offered to Resident #7.</p> <p>A review of the Recreation Participation Record for December 2024 identified Resident #7 received in 1 to 1 visits 27 days. Additionally, Resident #7 only attended tv/movie/music 3 times, and a social 2 times for the entire month.</p> <p>The Recreation Participation Record from 1/1/25 through 1/8/25, identified Resident #7 received a 1 to 1 visit on 1 day, received Reiki 1 day, and participated in a social tea on 1 day.</p> <p>Observation on 1/7/25 at 9:30 AM identified Resident #7 lying in bed wearing a hospital gown, his/her eyes were closed, and the curtain was pulled between him/her and the roommate. No active stimulation (TV or radio) was noted.</p> <p>(continued on next page)</p>

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  01/13/2025
NAME OF PROVIDER OR SUPPLIER  Meriden Health and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  360 Broad Street, Ste 1 Meriden, CT 06450	

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation and interview with the Recreation Director on 1/8/25 at 11:00 AM identified a 1 to 1 visit in progress. The visit lasted less than 5 minutes and consisted of the Recreation Director telling the resident the day, of the week, the weather outside, and asked the resident (who had his/her eyes closed and appeared to be sleeping) if he/she would like to attend the program (but did not state what the program was). The Recreation Director identified although she was aware of Resident #7's interest in music, she did not provide any means of music because she had just started working at the facility in September 2024, and was attempting to catch up but noted a radio should have been in place.</p> <p>Interview with Licensed Practical Nurse (LPN) #3 (the MDS Coordinator) on 1/9/25 at 11:15 AM indicated that if there was a quarterly Activity Assessment completed it would have been used to identify music as an interest and assist in developing an activity specific Resident Care Plan.</p> <p>Subsequent to surveyor inquiry on 1/8/25, the Recreation Director provided a radio and played soft instrumental music for Resident #7.</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51182</b></p> <p>Based on observation, interviews, and review of facility policy, the facility failed to ensure resident identifiable information and resident medical records were stored in a secure location. The findings include:</p> <p>Observations on 1/9/25 at 2:28 PM in an unoccupied wing of the facility identified the following:</p> <ol style="list-style-type: none"> <li>1. In room [ROOM NUMBER], (unlocked), 9 bankers boxes were observed stored in a closet below a preventative fire suppression (sprinkler) device. The boxes contained resident medical records with personally identifiable information including name, date of birth, medical record number, and diagnoses. Additionally, a dead mouse was located within room [ROOM NUMBER] near the bankers boxes.</li> <li>2. In room [ROOM NUMBER], (unlocked), 3 bankers boxes containing resident records from 2020 and 2 bankers boxes containing yellow controlled substance disposition records (narcotic sheets), identifying the residents name as well as the prescribed medication, dated September of 2022 were stored below a preventative fire suppression device.</li> <li>3. In room [ROOM NUMBER], (locked), approximately 20 bankers boxes of mixed resident records, human resource records, and financial records were noted to be stored below preventative fire suppression devices.</li> <li>4. In room [ROOM NUMBER], (locked) approximately 50 bankers boxes of facility year end information, business office documentation, and resident rehabilitation therapy logs from 2019 were stored below preventative fire suppression devices.</li> </ol> <p>An interview with the Administrator on 1/9/25 at 2:28 PM identified he was aware the facility paperwork was being stored in the 4 rooms. He noted that the information was previously stored in out buildings, referred to as The Cottages, and was moved to the 4 unoccupied rooms within the facility when The Cottages were sold. The Administrator further indicated that he was aware the boxes contained Protected Personally Identifiable Information including Tax Identification Numbers and clinical records.</p> <p>The facility Records Retention Policy identified that records are to be maintained in a locked area that is not subject to hazards that could possibly damage or destroy the records stored therein. Hazards indicated within the policy included fire, flooding, and rodents or other pests.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>51867</p> <p>Based on observations, facility policy, and interviews during a tour of the laundry area, the facility failed to ensure clean laundry and hangers were stored under sanitary conditions according to infection control principles. The findings include:</p> <p>Observation and interview with Laundry Aide #1, the Administrator, Infection Preventionist, RN #2, and Maintenance Director, in the Laundry Department on 1/9/25 at 1:45 PM, located in a barn next to the facility on campus, identified in the soiled laundry area, a dirty laundry bin. The bin contained a bag of dirty, personal, resident laundry. Clean hangers were noted to be hanging from the edge of the dirty bin, as well as clean hangers stored under and next to a bag containing dirty resident laundry. More clean hangers were noted to be stored on top of a dirty item receptacle. Laundry Aide #1 identified the hangers were considered clean and ready for use to hang clean laundry. RN #2 indicated clean items should not be stored with dirty items.</p> <p>Observation and interview in the clean laundry area, identified a clean laundry bin filled with laundered rags for use in the kitchen. The rags were designated for cleaning and disinfecting kitchen surfaces. The clean linen bin was stored touching and next to a wall which had several broken and open areas of sheetrock including a large crack and a fist size hole. Additionally, there were three larger areas of missing sheetrock exposing insulation barrier, dust, debris, and dirt. The window along this same wall had plastic hung to cover the entire window secured with duct tape. This window also accommodated the dryer vent. The Administrator indicated that the area could use improvement.</p> <p>According to the facility policy, Environmental Services and Laundry, all clean laundry must be covered for transport back to the facility. Resident clothing is folded or pressed and hung, in the clean laundry area, for transfer to Resident's room and put away.</p>