STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075348	A. Building B. Wing	03/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advanced Center for Nursing & Rehabilitation	169 Davenport Avenue New Haven, CT 06519

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, facility documentation, facility policy, and interviews for one (1) of three (3) sampled residents (Resident #1) reviewed for pressure ulcers, the facility failed to ensure the treatment plans recommended by the wound care physician were entered into the clinical record and implemented. The findings include: Resident #1's diagnoses included pressure ulcer, diabetes mellitus, malnutrition, peripheral vascular disease, and dementia. The Resident Care Plan dated 1/12/25 identified a potential for skin impairment related to poor physical condition. Interventions directed to apply barrier cream, turn and reposition every two (2) hours, and weekly skin checks. The admission Minimum Data Set assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status score of three (3) out of fifteen (15) indicating Resident #1 rarely or never made decisions regarding tasks of daily living, had an altered level of consciousness, required staff assistance for personal care and activities of daily living, had no documented pressure ulcers, and prevention directed a pressure reducing device for the bed. A physician's order dated 2/12/25 directed to document a Braden Scale assessment weekly times four (4) weeks on shower day and which shift, (change based on shower day) shower day every Monday 7AM-3PM shift. The nurse's note dated 2/12/25 at 9:07 PM identified Resident #1 was re-admitted from an acute care facility and a skin check was completed with no open areas noted. Review of the February 2025 Treatment Administration Record (TAR) identified a readmission skin check was completed on 2/12/25. The TAR failed to reflect documentation a weekly skin assessment was conducted on 2/17/25 and although a body audit was signed off on 2/23/25 and 2/24/25 the clinical record failed to identify the appearance of Resident #1's skin. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Wound Physician's progress note dated 2/27/25 identified Resident #1 was seen for an initial evaluation and treatment recommendation regarding a pressure ulcer to the sacrum and deep tissue injury to the right heel. The note indicated Resident #1 had a non-stageable sacral pressure ulcer measuring 12.5 centimeters (cm) length by 7.4 cm width, by 0.3 cm depth, with moderate serous exudate and 100% slough. The treatment recommendation directed to cleanse the sacral area with 0.25% Dakin's solution, apply Medihoney, cover with a dry, clean dressing, and change dressing every shift, with added recommendations to address preventative wound healing directed at turning and repositioning every two (2) hours, off-load pressure areas, foam boots, and a low-pressure air mattress. Review of the February and March 2025 TARs identified the specialized air mattress and pressure relieving boots that the wound doctor recommended on 2/27/25 had not been initiated and the sacral wound treatment recommended on 2/27/25 was not initiated until 3/4/25 (five (5) days later). Review of the clinical record identified Resident #1 was transferred to the hospital on 3/6/25 for evaluation and treatment of the sacral wound. The Medical Director's note dated 3/17/25 identified Resident #1 had developed a viral skin eruption, presumed to be herpes related that involved the groin, perineum, and sacrum, staff had reported blisters in this area which subsequently ruptured and created a large area of skin alteration. Interview with the Wound Care Physician, MD #1, on 3/17/25 at 10:45 AM identified he was consulted on 2/27/25 to evaluate a blister on Resident #1's genital. MD #1 stated when he rolled Resident #1 on his/her side to evaluate a concern of another blister on the anus, he observed a non-stageable pressure ulcer on Resident#1's sacrum, with intact slough that he did not remove as to avoid opening the area. MD #1 stated he ordered treatment for the sacral wound and preventative measures. Interview with the Infection Prevention and Wound Nurse, Registered Nurse (RN) #1, on 3/17/25 at 1:10 PM identified she receives the recommendations from the wound care consultant the day of the evaluation and enters them into the Electronic Health Record (EHR) and receives a wound treatment report every Monday. RN #1 could not explain why the recommendations made on 2/27/25 had been entered into the record until 3/4/25. RN #1 stated the Treatment Administration Record and Care Plan are updated when new orders are entered. Interview and observations with the Director of Nurses (DON) on 3/17/25 at 2:20 PM identified Resident #1's bed did not have a specialty mattress in place as recommended by the wound team on 2/27/25. The DON stated she could not identify why the air mattress had not been applied to as they are kept within the facility. Review of the Pressure Ulcer Identification Policy dated 1/18/18 identified, the purpose of this procedure is to provide clinical information associated with risk factors and the implementation of interventions that are consistent with the residents' needs. Goals, and professional standard of practice.