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Form Approved OMB
No. 0938-0391

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	03/24/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #2) reviewed for medication administration, the facility failed to notify the physician regarding the resident not receiving his/her medication for two (2) days. The findings include: Resident #2's diagnoses included dementia, prostate cancer, schizophrenia, diabetes mellitus, seizures, and encephalopathy. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had a Brief Interview for Mental Status (BIMS) score of five out of fifteen (3/15), indicative of severely impaired cognition and was dependent with ADLs (activities of daily living). Physician order dated 8/27/2024 directed to administer Abiraterone (antineoplastic) 1000 milligrams (mg) every day at 8:30 PM. The Resident Care Plan (RCP) dated 10/10/2024 identified Resident #2 had an alteration in health maintenance related to physical and psychological conditions. Interventions directed to administer medications as ordered and to update the APRN/MD as needed. A nursing note dated 10/3/2024 at 9:35 PM written by LPN #6 identified the pharmacy was called for Abiraterone 1000 mg at bedtime and the pharmacy indicated it was a special medication being delivered to the family only. Person #4 was notified and said he/she will follow up tomorrow (10/4/2024) to make sure the medication is delivered, and the supervisor was updated. A nursing note dated 10/6/2024 at 11:31 PM written by LPN #6 identified the facility was still waiting for family to supply Abiraterone, and the supervisor was updated. Review of the Medication Administration Record (MAR) for October 2024 identified on 10/5 and 10/6/2024, LPN #6 documented Abiraterone 1000 mg was not administered, with a comment indicating the medication was on order. Clinical record review failed to identify a physician or APRN was notified regarding Resident #2 not receiving the scheduled medication on 10/5 and 10/6/2024. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LPN #6 on 3/24/2025 at 3:40 PM identified Resident #2's family (Person #4) would bring his/her Abiraterone to the facility, and the nursing staff would always remind Person #4 when the medication supply was low. LPN #6 indicated on 10/3/2024, Resident #2's Abiraterone was getting low, and he called the pharmacy for a refill. The pharmacy indicated that the medication is sent to the family and not the facility. LPN #6 then notified Person #4 of the low supply and requested Person #4 to bring the Abiraterone to the facility at their earliest convenience. LPN #6 stated he did not administer the Abiraterone on 10/5 and 10/6/2024 as scheduled, and he did not notify the physician/APRN. LPN #6 stated he notified the nursing supervisor of the missing Abiraterone and the supervisor would be responsible to notify the physician/APRN. Although requested, the facility was unable to provide information regarding who the nursing Supervisor was on 10/5 and 10/6/2024. Interview with APRN #3 on 3/24/2025 at 2:25 PM identified she was not notified Resident #2 did not receive the ordered Abiraterone on 10/5 and 10/6/2025. APRN #3 indicated if she was notified, she would have notified Resident #2's oncology team or instructed the nursing team to call the oncology team for further instructions regarding missing the scheduled medication. Interview with the DON on 3/24/2025 at 3:55 PM identified she expected the nursing team to notify the physician/APRN when a resident does not receive their scheduled medication. Although the interview identified the nurses should have notified the provider that Resident #2 did not receive the ordered Abiraterone on 10/5 and 10/6/2025, interview failed to identify why the provider was not notified.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #2) reviewed for medication administration, the facility failed to ensure a medication provided by the family for facility staff to administer was verified/confirmed to be the drug ordered by the physician and failed to ensure the contents of each container have been verified by a licensed pharmacist in accordance with facility policy. The findings include: Resident #2's diagnoses included dementia, prostate cancer, schizophrenia, diabetes mellitus, seizures, and encephalopathy. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had a Brief Interview for Mental Status (BIMS) score of five out of fifteen (3/15), indicative of severely impaired cognition and was dependent with ADLs (activities of daily living). Physician order dated 8/27/2024 directed to administer Abiraterone (antineoplastic) 1000 milligrams (mg) every day at 8:30 PM. The Resident Care Plan (RCP) dated 10/10/2024 identified Resident #2 had an alteration in health maintenance related to physical and psychological conditions. Interventions directed to administer medications as ordered and to update the APRN/MD as needed. A nursing note dated 10/3/2024 at 9:35 PM written by LPN #6 identified the pharmacy was called for Abiraterone 1000 mg at bedtime and the pharmacy indicated it was a special medication being delivered to the family only. Person #4 was notified and said he/she will follow up tomorrow (10/4/2024) to make sure the medication is delivered, and the supervisor was updated Interview with LPN #6 on 3/24/2025 at 3:40 PM identified Resident #2's family (Person #4) would bring his/her Abiraterone to the facility. Record review failed to identify any indication of how the nursing staff verified the Abiraterone prior to administration to Resident #2, or the process staff followed when Resident #2's Abiraterone was delivered to the facility by the family (Person #4). Interview with Pharmacist #1 (from the facility contracted pharmacy) on 3/24/2025 at 12:00 PM identified Resident #2's Abiraterone was dispensed/provided by the facility pharmacy as of 10/31/2024. Pharmacist #1 indicated prior to 10/31/2024, the Abiraterone was noted to be dispensed by another pharmacy (outpatient pharmacy), and was unable to provide information regarding the other pharmacy. Further, Pharmacist #1 stated the facility pharmacy made a one-time delivery of the Abiraterone 30-day supply to the facility on [DATE]. Interview failed to identify why the drug was not ordered from the pharmacy prior to 10/30/2024. Interview with Pharmacy Technician #1 (PharmT #1), from the outpatient pharmacy providing the Abiraterone prior to 10/30/2024, on 3/24/2025 at 1:00 PM identified the Abiraterone was dispensed to Resident #2's home address. PharmT #1 identified she reviewed notes from October 2024 and stated the notes indicated Person #4 picked up the Abiraterone at the dispensing pharmacy to bring to facility. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with DON on 3/24/2025 at 3:55 PM identified specialty medications can be brought in by the family if the facility pharmacy does not offer the medication. The DON stated the main reasons the facility pharmacy would not provide medication was if it was not available at the pharmacy or the pharmacy had refused. Interview failed to identify why the facility contracted pharmacy did not supply the medication, and if the contracted pharmacy was unable to obtain the Abiraterone. The DON stated the facility process to accept medications from a family included verifying the medication, which would include the drug description/looks with a website. Once the nursing team verifies a medication brought from outside the facility, then the nursing staff can administer the medication. The DON was unable to provide a website utilized by nursing to verify the medication, and was unable to provide documentation that the drug provided by the family was verified to be Abiraterone. Further, the DON was unable to provide the medication in question and stated the drug had been destroyed by the facility after the resident was discharged from the facility. Review of the facility Medication Brought in by Family Policy dated 2/16/2018 directed in part, the facility shall ordinarily not permit residents and families to bring medications into the facility. Residents and families must report to the nursing staff any medications that they want to bring or have brought into the facility. The facility discourages the use of medications brought in from outside and will inform residents and families of that policy as well as applicable laws and regulations. If a medication is not otherwise available and/or it is determined to be essential to the resident's life, health, safety, or well-being to be able to take a medication brought in from the outside, the DON and nursing staff, with support of the Attending Physician and Consultant Pharmacist, shall check to ensure that: the medications have been ordered by the resident's Attending Physician, and documented on the physician's order sheet; the contents of each container are labeled in accordance with established policies; and the contents of each container have been verified by a licensed pharmacist.