

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075348	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/22/2025
NAME OF PROVIDER OR SUPPLIER  Advanced Center for Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on clinical record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #3) reviewed for accidents, the facility failed to ensure that the medical provider was notified timely of a change in condition. The findings include:</p> <p>Resident #3 was admitted with diagnoses that included dementia and chronic obstructive respiratory disease (COPD). A quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident # 3 was alert and oriented (Brief Interview for Mental Status (BIMS) score of 14), and was independent with mobility and ambulation. The Resident Care Plan (RCP) dated 7/19/2023 identified Resident #3 had altered respiratory status due to COPD. The RCP directed to assess for changed in respiratory status and advise MD and administer oxygen as ordered.</p> <p>A nursing note dated 11/21/2023 at 3:13 PM identified that Resident #1 was alert and responsive, and was observed with shortness of breath (SOB) and oxygen (O2) saturation was 88 percent (%) on room air (normal 90% and above). Resident's baseline recorded oxygen saturation was 92 to 95 % on room air (RA). A breathing treatment was provided with fair effect, oxygen was applied with oxygen saturation increased to 90%. Resident #3 was assessed by the APRN and new orders were obtained for nasal O2 at two (2) liters (l). No further signs of respiratory distress were noted, and blood pressure was 156/86, temperature 97.1, and pulse was 86.</p> <p>A nursing note by LPN #4 dated 11/22/2023 at 4:46 AM identified Resident #3 had a change in mental status; Resident #3 was alert, confused and hallucinated at times. Resident #3 stated that there was a man in his/her room trying to attack him/her. O2 saturation was 84 % to 85 % on RA. A breathing treatment was administered and oxygen were applied with pulse oximetry to 95%, and noted other vital signs were stable. Resident #3 was out of bed at times, ambulating in the room and talking to self. Plan for continued monitoring.</p> <p>A nursing note dated 11/22/2023 at 2:53 PM identified Resident #3 was noncompliant with use of ordered O2 at two (2) l via nasal cannula. Oxygen saturation was 85% on RA. Resident #3 was encouraged to keep oxygen on as oxygen saturation increased to 90% while wearing oxygen. Resident #3 refused activities of daily living (ADLs) and refused assistance to change soiled clothes.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075348	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/22/2025
NAME OF PROVIDER OR SUPPLIER  Advanced Center for Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview and review of medical record with LPN #4 on 4/16/2024 at 2:48 PM identified she cared for Resident #3 on the 11:00 PM to 7:30 AM shifts (overnight to next day) on 11/20/2023, 11/21/2023 and 11/22/2023. She could not recall if she had notified the supervisor for the change in mental status that she observed on 11/22/2023, but stated that she would have documented in her nursing note if she had notified the supervisor.</p> <p>Interview and review of the medical record with RN #2, nursing supervisor on the 11:00 PM to 7:30 AM shifts on 11/21/2023 and 11/22/2023 (overnight into the next day) on 4/16/2025 at 10:41 AM identified she was never notified of any changes in mental status, problems with oxygen administration or respiratory changes. RN #2 stated she would have assessed Resident #3 and documented the assessments if she was notified, and she would have notified the on-call APRN for any next steps. She did not know why the LPN #4 did not contact her.</p> <p>Interview and medical record review with the DON on 4/17/2025 at 12:46 PM identified that the change in mental status identified on 11/22/2023 at 4:46 AM was a significant change in condition. The DON stated the supervisor, and the on-call provider should have been contacted/notified and she did not know why the APRN or physician were not contacted/notified.</p> <p>Interview and medical record review with the Medical Director on 4/22/2025 at 9:55 AM identified that LPN #4 should have notified the supervisor for the mental status change in condition. Further, when Resident #3 was hallucinating, a call to the physician or APRN should have been completed to notify and then the physician or APRN could determine if any changes to the treatment plan were needed.</p> <p>The facility Change in Condition Policy dated 1/30/2025 directed in part, every resident's change in condition is reported to the physician. The facility must immediately consult the resident's physician when there is a significant change in the resident's physical, mental, or psychosocial status.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075348	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/22/2025
NAME OF PROVIDER OR SUPPLIER  Advanced Center for Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<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> Based on clinical record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #2), reviewed for accidents, the facility failed to ensure the care plan was revised timely after a fall. The findings include:</p> <p>Resident #2 was admitted with diagnoses that included traumatic brain hemorrhage and Schizophrenia. An annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had severely impaired cognition and required extensive assistance for bed mobility and assistance for transfers into a wheelchair. The Resident Care Plan (RCP) dated 5/3/2023 identified Resident #2 was at risk for falls due to a history of falls and cognitive impairment. Interventions directed to remind Resident to use the call bell to request assistance before getting out of bed and to toilet promptly.</p> <p>A facility incident report dated 5/31/2023 at 10:50 AM identified Resident #2 had an unwitnessed fall and was observed on the floor by housekeeping. Resident #2 had no injuries.</p> <p>A nursing note dated 5/31/2023 at 11:42 AM by LPN #2 identified Resident #2 missed the floor mats when he/she fell, and the bedside table was also on the floor. Resident #2 denied any pain.</p> <p>Record review failed to identify an intervention was entered into the care plan to prevent a re-occurrence.</p> <p>Interview and record review with LPN #1 on 4/16/2025 at 2:56 PM identified she was the charge nurse on 5/31/2023 during the 3:00 to 11:00 PM shift when Resident #2 fell. LPN #1 stated Resident #2 had no injuries, she could not recall any other details, and she did not know if the care plan was updated.</p> <p>Interview and review of facility written statement dated 5/31/2023 with NA #3 on 4/17/2025 at 1:00 PM identified she had regularly cared for Resident #2 and recalled that Resident #2 was impulsive, which had led to Resident #2's falls.</p> <p>Interview and record review with the DON on 4/17/2025 at 2:00 PM identified although Resident #2 had a fall risk care plan, the DON was unable to provide documentation that the care plan had been updated after the fall on 5/31/2023. The DON stated she would have expected the nursing staff to complete the facility incident investigation form that would have identified findings related to the fall, and then to update the care plan to prevent future falls. The DON stated she did not know why the care plan was not updated.</p> <p>LPN #2 was not available for interview during the survey.</p> <p>The facility Fall Prevention Policy dated 1/19/2018 directed in part, to initiate interventions to prevent falls and reduce the risk of injury from a fall, and to implement interventions according to the resident's assessment.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075348	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/22/2025
NAME OF PROVIDER OR SUPPLIER  Advanced Center for Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility Comprehensive Care-Planning Policy dated 9/16/2018 directed in part, care plans are revised as the resident's condition changed. The care plan must be updated if there was a significant change in the residents' condition and the desired outcome is not met.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075348	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/22/2025
NAME OF PROVIDER OR SUPPLIER  Advanced Center for Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<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**</b> Based on clinical record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #2), reviewed for accidents, the facility failed to ensure neurological assessments were completed timely after an unwitnessed fall in accordance with facility Monitoring guidelines. The findings include:</p> <p>Resident #2 was admitted with diagnoses that included traumatic brain hemorrhage and Schizophrenia. An annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had severely impaired cognition and required extensive assistance for bed mobility and assistance for transfers into a wheelchair. The Resident Care Plan (RCP) dated 5/3/2023 identified Resident #2 was at risk for falls due to a history of falls and cognitive impairment. Interventions directed to remind Resident to use the call bell to request assistance before getting out of bed and to toilet promptly.</p> <p>A facility incident report dated 5/31/2023 at 10:50 AM identified Resident #2 had an unwitnessed fall and was observed on the floor by housekeeping. Resident #2 had no injuries.</p> <p>A nursing note dated 5/31/2023 at 11:42 AM by LPN #2 identified Resident #2 was assessed on the floor. Further, the note indicated Resident #2 missed the floor mats when he/she fell, and the bedside table was also on the floor. Resident #2 denied any pain.</p> <p>Nursing note dated 5/31/2023 at 12:27 PM, written by RN #8 identified she completed an assessment after a housekeeper observed Resident #2 on the floor. Vital signs were within normal limits, Resident #2 denied pain, no adverse effect was noted, and Resident #2 was assisted back to bed. Plan to continue to monitor.</p> <p>Nursing note dated 5/31/2023 at 9:19 PM identified neuro checks in place.</p> <p>Nursing note dated 6/1/2023 at 6:22 AM identified neuros wnl (within normal limits).</p> <p>Nursing note dated 6/2 at 10:29 PM identified neuro checks in place.</p> <p>Review of the facility Post A &amp; I Monitoring Sheet dated 5/31/2013 directed to complete an initial assessment, then every shift for 72 hours. The sheet directed to check vital signs (blood pressure, pulse, respirations, temperature), range of motion, level of consciousness, vision, weakness, headache, and pain. Additional review of the sheet identified the assessments was completed on 5/31/2023 at 10:50 PM, 11:05 PM and 11:15 PM. The remainder of the sheet was blank (missing the every shift for 72 hours; missing 9 assessments).</p> <p>Although record review identified neurological (neuro) assessments were completed during 3 to 11 PM shift on 5/31, the 11 PM to 7 AM shift on 6/1, and the 3 to 11 PM shift on 6/2/2023, review failed to identify any additional neurological checks were completed between the fall on 5/31 and 6/22/2023. Record review identified assessments were not documented to reflect completed for seven (7) of the required shifts per the Monitoring Sheet directions.</p> <p>LPN #2 was not available for interview during the survey.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075348	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/22/2025
NAME OF PROVIDER OR SUPPLIER  Advanced Center for Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview and record review with LPN #1 on 4/16/2025 at 2:56 PM identified she was the charge nurse on 5/31/2023 during the 3:00 to 11:00 PM shift when Resident #2 fell. LPN #1 stated Resident #2 had no injuries. Interview failed to identify any information regarding an RN assessment or neurological assessments.</p> <p>Interview and record review with the DON on 4/17/2025 at 2:00 PM identified neurological assessments should be completed on the shift of a fall, and every shift for 72 hours. Although neurological assessments were documented on the shift of the fall and on one (1) shift during 6/1 and 6/2/2023, the DON was unable to provide documentation that the neurological assessments were completed in accordance with facility policy as listed on the Post A &amp; I Monitoring Sheet. The DON stated the assessments should have been completed, and she did not know why staff did not complete the assessments as required.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075348	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/22/2025
NAME OF PROVIDER OR SUPPLIER  Advanced Center for Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0712</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that the resident and his/her doctor meet face-to-face at all required visits.</p> <p>Deficiency Text Not Available</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075348	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/22/2025
NAME OF PROVIDER OR SUPPLIER  Advanced Center for Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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**</b> Based on a review of clinical records, facility documentation, facility policies, and interviews with one of three residents (Resident #3) reviewed for accidents, the facility failed to ensure the medical record was complete and accurate to include timely documentation of a medical evaluation. The findings include:</p> <p>Resident #3 was admitted with diagnoses that included dementia and chronic obstructive respiratory disease (COPD). A quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident # 3 was alert and oriented (Brief Interview for Mental Status (BIMS) score of 14), and was independent with mobility and ambulation. The Resident Care Plan (RCP) dated 7/19/2023 identified Resident #3 had altered respiratory status due to COPD. The RCP directed to assess for changed in respiratory status and advise MD and administer oxygen as ordered.</p> <p>A nursing note dated 11/21/2023 at 3:13 PM identified that Resident #1 was alert and responsive, and was observed with shortness of breath (SOB) and oxygen (O2) saturation was 88 percent (%) on room air (normal 90% and above). Resident's baseline recorded oxygen saturation was 92 to 95 % on room air (RA). A breathing treatment was provided with fair effect, oxygen was applied with oxygen saturation increased to 90%. Resident #3 was assessed by the APRN, and new orders were obtained for nasal O2 at two (2) liters (l). No further signs of respiratory distress were noted, and blood pressure was 156/86, temperature 97.1, and pulse was 86.</p> <p>Record review failed to identify an APRN assessment dated [DATE].</p> <p>An interview with the APRN was not obtained during the survey.</p> <p>Interview and record review with the Medical Director on 4/22/2025 at 9:55 AM identified that if the APRN assessed Resident #3 on 11/21/2023, the assessment should have been documented in the medical record.</p> <p>The facility policy Physician Services/Visits dated 1/1/2023 directed in part that a progress note must be written signed and dated for each visit.</p>		