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	06/04/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, facility documentation, facility policy, and interviews for one of three residents (Resident #2) reviewed for abuse or neglect, the facility failed to ensure the resident was free from physical abuse. The findings include: A. Resident #2 was admitted to the facility with diagnoses that included encephalopathy, heart failure and depression.] A significant change Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had severe cognitive impairment (Brief Interview for Mental Status (BIMS) score of 7), required maximal assistance for rolling side to side and was dependent for transfer and personal hygiene. A resident care plan (RCP) dated 3/22/2025 identified Resident #2 had major depression. The RCP directed supportive counseling and individual psychotherapy. B. Resident #3 was admitted to the facility with diagnoses that included dementia and hypertension. A quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #3 had severe cognitive impairment (Brief Interview for Mental Status (BIMS) score of 3) and was independent for bed mobility, transfer and ambulation. A resident care plan (RCP) dated 3/23/2025 identified Resident #3 exhibited behaviors as attempts to disassemble furniture, clog bathroom toilets and was at risk for elopement. Interventions included to redirect as needed, place wanderguard (device that alarms if resident leaves a designated area) on resident and notify MD of any changes in behavior. A facility reportable event form (RE form) dated 5/13/2025 identified a resident-to-resident event with injury. At 1:30 PM, Resident #3 was seen exiting Resident #2's room. Resident #2 reported Resident #3 hit him/her. Bruising to Resident #2's left facial side, mouth and left hand were observed. Both residents were sent to the hospital emergency department (ED) for evaluation. Resident #2 requested a room change upon return from the ED and was transferred to a private room on a different unit upon return. Resident #3 was evaluated and was cleared to return to the facility. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A hospital Discharge summary dated [DATE] identified that Resident #2 was evaluated after an assault at a nursing facility. Resident #2 reported that a man went into her/his room and hit her/him with a telephone multiple times to the left side of the face and as she/he shielded him/herself with the left hand, the left hand was also hit by the telephone. On exam, puncture wounds were noted to the left lower lip with a 0.5 centimeter (cm) laceration to the inner left lower lip with left lower lip edema and to the left upper outer lip, and tenderness was noted over the nasal bridge. The left thumb and index finger were noted to be swollen. Resident #2 was on a blood thinner. Resident #2 was alert and oriented to name, place, time and current event (times 4). A facility RE summary dated 5/15/2025 identified the event was found to be unprovoked. Medical work-up was conducted for Resident #3 and medication was adjusted (as needed Trazadone added). Resident #2's room was changed per resident request. Interview with NA # 7 on 6/4/2025 at 11:30 AM identified on 5/13/2025 she was sitting at the nurse's desk when she heard Resident #2 calling for help. As she stood up from the desk, she saw Resident #3 exiting Resident #2's room. NA #7 identified that upon entering the room, Resident #2 reported that a man went into the room and when Resident #2 asked what he was doing in the room, the man began to hit him/her with the phone. Resident #2 reported he/she never saw the man before. Interview and review of Resident #2's medical record with APRN # 4 on 6/4/2025 at 10:58 AM identified he evaluated Resident #2 after an attack by another resident who Resident #2 reported walked into his/her room and used a telephone to hit his/her face and left hand. Bruising and cuts were sustained to the left lip and bruising to the left side of face. Resident #2's left hand small finger was bruised secondary to shielding oneself to prevent Resident #3 from hitting his/her face. Resident #2 was in no acute distress but was visibly shaken due to the unprovoked attack. Resident #2 and Resident #3 were transferred to the hospital for further evaluation. Interview and review of the 5/13/2025 event investigative documents with the DNS on 6/4/2025 at 1:30 PM identified that review of camera footage confirmed the staff report that at approximately 1:30 PM on 5/13/2025, Resident #2 was calling out for help, and at that time, Resident #3 was observed exiting Resident #2's room. Staff immediately responded to Resident #2's calls for help and were observed entering Resident #2's room right after Resident #3 exited the room. The facility policy, Resident Abuse, Mistreatment, Neglect, Exploitation, Misappropriation, and Retaliation policy dated 9/16/2018, directed, in part, that it is the policy of the facility to ensure residents are free from abuse and mistreatment. Abuse was defined as the infliction of injury, unreasonable confinement, intimidation, punishment, or exploitation with resulting physical harm, pain, or mental anguish. Physical abuse was defined as the intentional infliction of physical pain, bodily harm, or physical coercion. The facility policy, Resident Rights dated 4/16/2018, directed in part that a Resident has the right to be free from verbal, sexual, physical or mental abuse.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation, facility policy, and interviews for one of three residents (Resident #1), reviewed for abuse or neglect, the facility failed to obtain vital signs according to provider order for a resident who required monitoring after a newly discontinued medication. The findings include: Resident #1 was admitted to the facility with diagnoses that included multiple sclerosis, functional quadriplegia (loss of function of the four limbs and torso), neurogenic bladder (lack of bladder control) and a pressure ulcer of the right buttock. A quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had moderate cognitive impairment (Brief Interview for Mental Status (BIMS) score of 9) and was dependent for bed mobility, transfer, and personal care. An APRN progress note dated 4/28/2025 identified Resident #1 was seen for chronic medical problems. Assessment and plan identified Resident #1 had intermittent hypotension with improved anemia. Blood pressure (BP) 90-100s systolic and metoprolol succinate (heart medication that treats blood pressure) 12.5 mg was discontinued. Monitor BP/Heart rate. A provider order dated 4/28/2025 directed to discontinue the metoprolol succinate and obtain vital signs every shift. Review of the medical record failed to identify recorded vital signs for the evening shift on 4/28/2025, 4/29/2025, 5/3/2025, 5/4/2025 and for both the day and evening shifts on 5/5/2025. Interview with LPN #3 on 6/3/2025 at 11:00 AM identified vital signs were obtained by the NAs, written on a worksheet and then the assigned nurse reviewed and entered the vital signs into the electronic medical record. LPN #3 did not know why Resident #1's vital signs were not recorded in the medical record as she was the nurse assigned to provide care for Resident #1 during the shifts identified with no recorded vital signs. She could not recall if she reviewed vital signs on those shifts. Interview with APRN #1 on 6/3/2025 at 1:02 PM identified she recalled Resident #1 had mildly low blood pressure and that the metoprolol had been discontinued. She identified that monitoring vital signs after the discontinuation of a medication was ordered to monitor for any changes. Interview with the DNS on 6/4/2025 at 1:30 PM identified that nurses should follow provider orders for all elements of the treatment plan including vital signs. She did not know why LPN #3 did not record vital signs for the shifts identified. Although requested, the facility did not provide a policy for obtaining vital signs.