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	08/20/2025

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

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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 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. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**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 (Residents #1) reviewed for medication administration, the facility failed to ensure the physician/APRN was notified timely when medications were not administered in accordance with orders, and for two (2) of three (3) residents (Resident #14 and Resident #16) reviewed for medication administration, the facility failed to notify the physician/APRN timely when medications were not available for administration in accordance with physician orders. The findings include: The findings include:Based on clinical record review, facility documentation review, facility policy review and interviews for one of three residents (Residents #1) reviewed for medication administration, the facility failed to ensure the physician/APRN was notified timely when medications were not administered in accordance with orders, and for two (2) of three (3) residents (Resident #14 and Resident #16) reviewed for medication administration, the facility failed to notify the physician/APRN timely when medications were not available for administration in accordance with physician orders. The findings include: The findings include: 1. Resident #1 was admitted with diagnoses that included chronic pain syndrome, opioid dependance, osteomyelitis of the vertebra (back bone infection), and bacteremia (blood infection). A hospital Discharge summary dated [DATE] identified Resident #1 was discharged on Cefazolin (antibiotic) two (2) grams (gms) per fifty (50) milliliters (mls) intravenous (IV) solution every eight (8) hours, to stop on July 16, 2025. A physician order dated 6/20/2025 directed to administer Cefazolin two (2) gms per 50 mls IV every 8 hours, at 6:00 AM, 2:00 PM and 10:00 PM. Nursing admission assessment identified Resident #1 was alert and oriented. The Resident Care Plan (RCP) dated 6/21/2025 identified Resident #1 had an infection. Interventions directed to administer medication as per MD orders. An admission Minimum Data Set (MDS) dated [DATE] identified Resident #1 had a Brief Mental Interview for Mental Status (BIMS) of fifteen (15) and was alert and oriented, and experienced pain frequently in the last five (5) days. Medical record review of the Medication Administration Record (MAR) identified LPN #12 documented on 6/21 and 6/22/2025 that Resident #1 did not receive did not receive the Cefazolin two (2) gms on 6/21 and 6/22/2025 at 2 PM in accordance with physician orders. The MAR indicated Resident #1 was unavailable as he/she was out of the facility on leave of absence (LOA). Review of the facility grievance form dated 6/23/2025 identified Resident #1 reported he/she had missed medications. Interview with LPN #12 on 8/12/2025 at 9:39 AM identified she was the charge nurse for Resident #1 on 6/21/2025 from 7:00 AM to 7:00 PM, and on 6/22/2025 from 7:00 AM to 300 PM. LPN #12 stated Resident #1 was transferred to the hospital on 6/21 and 6/22/2025 about 10 AM to receive Methadone, and she did not remember when Resident #1 returned to the facility. LPN #12 stated she did not administer the Cefazolin two (2) gms on 6/21 and 6/22/2025 at 2 PM as ordered because Resident #1 was not in the facility. LPN #12 further stated that she did not notify the APRN the doses were omitted, and calls to the on-call physician/APRN were usually done by the supervisor. LPN #12 indicated she did not notify the supervisor the Cefazolin was omitted because she thought the supervisor already knew because Resident #1 was out of the building. Interview with RN #3 and medical record review on 8/11/2025 at 12:15 PM identified she was the supervisor on 6/21/2025 from 7:00 AM to 7:00 PM and she was aware Resident #1 was transferred to the hospital for medication was she saw Resident #1 in the facility about 5:30 PM. RN #3 stated that Resident #1 had informed her that he/she would be going back to the hospital on 6/22/2025 for an additional dose of medication. RN #3 stated she was not notified the Cefazolin was not administered at 2 PM, and if a medication is omitted the nurse should notify the supervisor. RN #3 further stated if she had known about the missed doses of Cefazolin, she would have notified the APRN. Interview with RN #2 on 8/12/2025 at 10:10 AM identified she was the supervisor on 6/22/2025 from 7:00 AM to 7:00 PM and she did not remember if the charge nurse notified her of any missed/omitted medications. RN #2 stated if she was notified, she would have notified the APRN. Interview and medical record review with APRN # 1 on 8/12/2025 at 10:42 AM identified he saw Resident #1 on 6/23/2025 and he was not aware the Cefazolin due to be administered on 6/21 and 6/22/2025 at 2 PM were not administered as ordered. APRN #1 stated he would have expected to be notified, and if he was notified, he would have called the Infectious Disease consultant to determine if the treatment plan needed to be adjusted. Interview with the DON on 8/13/2025 at 10:13 AM identified that if a Resident missed an antibiotic dose, the APRN should be notified. The DON stated the supervisor, APRN and herself should have been notified and she did not know why it was not done. The facility policy Change of

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	08/20/2025

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. (continued on next page)

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	075348	A. Building B. Wing	08/20/2025

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation review, facility policy review and interviews for three sampled residents (Residents #1, #12, and #13) reviewed for medication administration, the facility failed to ensure the resident was free from misappropriate of resident property. The findings include:Based on clinical record review, facility documentation review, facility policy review and interviews for three sampled residents (Residents #1, #12, and #13) reviewed for medication administration, the facility failed to ensure the resident was free from misappropriate of resident property. The findings include:A. Resident #1 was admitted with diagnoses that included chronic pain syndrome, opioid dependance, osteomyelitis of the vertebra (back bone infection), and bacteremia (blood infection). The Resident Care Plan (RCP) dated 6/21/2025 identified Resident #1 had pain. Interventions directed to administer pain medication as ordered. An admission Minimum Data Set (MDS) dated [DATE] identified Resident #1 had a Brief Mental Interview for Mental Status (BIMS) of fifteen (15) and was alert and oriented, and experienced pain frequently in the last five (5) days. A physician order dated 6/24/2025 directed to administer Hydromorphone (narcotic pain medication) three (3), two (2) milligram (mg) tablets for six (6) mg total by mouth every three (3) hours as needed for moderate pain. A physician order dated 6/24/2025 directed to administer Hydromorphone eight (8) mg tablets by mouth every three (3) hours as needed for moderate pain. 1. Review of the Medication Administration Record (MAR) and the Controlled Substance Distribution Record (CSDR) #1428681 identified thirty (30) tablets of Hydromorphone eight (8) mg were received by the facility from the pharmacy on 6/24/2025, with eight (8) tablets remaining. The Hydromorphone CSDR sheet identified one (1) tablet was signed out to indicate administered to Resident #1, but was not signed as administered to Resident #1 on the MAR on the following dates: 6/24/2025 at 10:00 AM by LPN #1 6/24/2025 at 3:40 PM by LPN #1 6/25/2025 at 2:00 AM by LPN #4 6/25/2025 at 6:00 AM by LPN #1 6/25/2025 at 9:00 AM by LPN #1 6/25/2025 at 12:00 PM by LPN #1 6/28/2025 at 8:00 AM by LPN #1 6/28/2025 at 12:00 PM by LPN #1 6/28/2025 at 6:00 PM by LPN #3 6/29/2025 at 8:00 AM by LPN #1 6/29/2025 at 11:00 AM by LPN #1 6/29/2025 at 6:00 PM by LPN #3 Reconciliation of CSDR #1428681 to Resident #1's June 2025 MAR identified that 30 tablets were received with eight (8) doses remaining. Twenty-two (22) doses of Hydromorphone 8 mg were signed out on CDSR #1428681 and only ten (10) doses were documented as administered to Resident #1; twelve (12) doses were unaccounted for (not documented in the MAR/medical record as administered to Resident #1. 2. A review of Resident #1's MAR and CSDR 1428756, identified thirty (30) tablets of Hydromorphone 2 mg were received by the facility from the pharmacy on 6/25/2025 with eleven (11) doses remaining. Four (4) tablets were signed out on the CSDR but were not signed as administered to Resident #1 on the June MAR on the following dates: 6/25/2025 at 11:00 AM by LPN #1 6/27/2025 at 12:00 PM by LPN #2, additional review identified one (1) additional tablet was documented as wasted without the signature of another nurse as a witness to the destroyed medication. 6/28/2025 at 5:30 PM by LPN #1 6/29/2025 at 10:30 PM by LPN #3 with 3 tablets signed out; MD order was for 4 tablets. Reconciliation of CSDR #1428756 to Resident #1's June MAR identified that 30 tablets were received with eleven doses remaining. Seventeen (17) doses (4 tablets on each day listed above plus one additional on 6/27/2025) were signed out on CDSR #1428756 to identify they were removed the from narcotic drawer, and all of the doses listed above were not documented as administered (not documented in the MAR/medical record to indicate they were administered to Resident #1). B. Resident #12 was admitted with diagnoses that included endocarditis and post traumatic stress syndrome. A physician order dated 6/30/2025 directed to administer Hydromorphone eight (8) mg tablets by mouth every four (4) hours as needed for pain. The RCP dated 7/1/2025 identified Resident #12 was at risk for pain. Interventions directed to administer pain medication as ordered. An admission MDS dated [DATE] identified Resident #12 was alert and oriented (BIMS 15), and experienced pain frequently in the last five (5) days. Review of Resident #12's MAR with the CSDR #1442827 identified thirty (30) tablets of Hydromorphone eight (8) mg was received by the facility on 7/1/2025 and on 7/8/2025, a CSDR #1418161 identified that the facility received an additional twenty-eight tablets (28) of the same medication (total of 58 tablets). One (1) tablet of the eight (8) milligram (mg) tablets was signed out for a dosage of eight (8) mg on the CSDR but not signed on the MAR as administered to Resident #1 on the following dates: 7/2/2025 at 1:00 AM by LPN #5 7/2/2025 at 12:30 PM by LPN #6 7/3/2025 at 12:30 AM by LPN #7 7/4/2025 at 5:00 AM by LPN #7 7/5/2025 at 12:00 AM by LPN #3 7/5/2025 at 5:00 AM by LPN #3 7/5/2025 at 8:00 PM by LPN #6

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	08/20/2025

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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. (continued on next page)

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	075348	A. Building B. Wing	08/20/2025

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on clinical record review, facility documentation review, facility policy review and interviews for three sampled residents (Residents #1, 12, and 13) reviewed for medication administration, the facility failed to ensure services provided met professional standards to include controls of narcotic medications as per facility policy. The findings include:Based on clinical record review, facility documentation review, facility policy review and interviews for three sampled residents (Residents #1, 12, and 13) reviewed for medication administration, the facility failed to ensure services provided met professional standards to include controls of narcotic medications as per facility policy. The findings include: Although requested, the facility was unable to provide the facility monthly or bi-monthly audits of controlled substances as per facility policy for June or July 2025 and indicated any audits could not be located at time of survey. Interview and documentation review with the DON on 8/13/2025 at 10:13 AM identified that staff signed Hydromorphone medication out on the Controlled Substance Distribution Record (CSDR) to indicate the drug was removed from the controlled/narcotic box on the following dates:Resident #1: 6/24, 6/25, 6/27, 6/28 and 6/29.Resident #12: 7/2, 7/3, 7/4, 7/5, 7/6, 7/7, 7/10, 7/11, 7/13 and 7/14.Resident #13: 7/21, 7/23, 7/26, 7/27, 8/4 and 8/9. Further interview identified the controlled drug was wasted/destroyed on 6/27/2025, and medication was signed out on the CSDR sheets on 7/26 and 7/27/2025 when there were no physician orders.The DON was unable to provide documentation in the resident's medical records and Medication Administration Records (MAR) that the residents received the medication on the dates signed out on the CSDR. The DON stated nurses should sign the MAR to indicate when it is administered, and she did not know why it was not done on the dates listed. The DON further stated for narcotics/controlled medication, if there was a need to waste a pill for any reason; another nurse other than the nurse who originally pulled the medication needed sign accordingly on the CSDR sheet as a witness to the destruction. Further, the DON stated a controlled medication should not have been signed out on the CSDR if there was no physician order for the medication, and she did not know why the medication was signed out.The DON stated the facility conducted monthly narcotic control audits to verify the count matched the CSDR but was unable to explain how the audits were actually conducted. The DON indicated the audits were conducted by the prior ADNS who no longer worked at the facility, and she was unable to provide documentation of any audits that were conducted. She stated any policy exceptions such as a lack of a second signature at the time of a narcotic pill waste should be observed through the audit process and addressed at that time. The DON stated spot checks were also done on a sample of residents MARs to verify that the nurses were documenting administration but did not include if that spot check also compared the MAR to the CSDR. She did not know why the ADNS had not identified any issues during the audits and indicated she could not produce the audits conducted for June or July 2025, as requested for review during the survey. She continued that a copy of the original CDSR sheets and the completed CDSRs are maintained in the medical records office. The DON further stated that discontinued controlled drugs are maintained on the units, secured under double lock until such time they are collected by nursing leadership and destroyed as per policy. Please reference F602. Interview and observation on 8/13/2025 at 4:15 PM with the Administrator completed CDSR sheets were stacked by date and alphabet on a desk in the medical record office, to the left of the door. Observation identified multiple large stacks of white and yellow papers bundled together. Each bundle had a bright pink paper on top of the bundle and was labeled drug sheets 2025. Bundles were further labeled as Jan to June A -G, H - Z. Additional bundles had pale green paper on the top of each bundle labeled 2025. The bundles were stacked as high as standard 3-ring facility notebooks that were upright next to them (approximately 11.5 to 12 inches high). The initial CDSR signed facility receipt of narcotics from the pharmacy were in notebooks (by unit location) behind the stacks of completed CDSRs. There were no audit results or documentation of audits completed observed in the medical records area. Interview failed to identify a process with a tracking system for current audits of controlled medications in the facility. The facility Controlled Substance Handing Policy, dated 1/19/2018, directed in part, directed monthly audits that monitor for discrepancies in counts, unexplained wastage and patterns of high usage. Additionally, the policy directed that a controlled substance accountability records and audit records should be kept on file for period no less than five (5) years and that discontinued controlled drugs are returned to the nursing office after the count was verified.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation review, facility policy review and interviews for three of six residents (Residents #1, Resident #14 and Resident #16) reviewed for medication administration, the facility failed to ensure medications were available and administered in accordance with physician orders. The findings include: Based on clinical record review, facility documentation review, facility policy review and interviews for three of six residents (Residents #1, Resident #14 and Resident #16) reviewed for medication administration, the facility failed to ensure medications were available and administered in accordance with physician orders. The findings include: 1. Resident #1 was admitted with diagnoses that included chronic pain syndrome, opioid dependance, osteomyelitis of the vertebra (back bone infection), and bacteremia (blood infection). A hospital Discharge summary dated [DATE] identified Resident #1 was discharged on Cefazolin (antibiotic) two (2) grams (gms) per fifty (50) milliliters (mls) intravenous (IV) solution every eight (8) hours, to stop on July 16, 2025. A physician order dated 6/20/2025 directed to administer Cefazolin two (2) gms per 50 mls IV every 8 hours, at 6:00 AM, 2:00 PM and 10:00 PM. Nursing admission assessment identified Resident #1 was alert and oriented. The Resident Care Plan (RCP) dated 6/21/2025 identified Resident #1 had an infection. Interventions directed to administer medication as per MD orders and report to APRN/MD as needed. Medical record review of the Medication Administration Record (MAR) identified LPN #12 documented on 6/21 and 6/22/2025 that Resident #1 did not receive did not receive the Cefazolin two (2) gms on 6/21 and 6/22/2025 at 2 PM in accordance with physician orders. The MAR indicated Resident #1 was unavailable as he/she was out of the facility on leave of absence (LOA). Review of the facility grievance form dated 6/23/2025 identified Resident #1 reported he/she had missed medications. Interview with LPN #12 on 8/12/2025 at 9:39 AM identified she was the charge nurse for Resident #1 on 6/21/2025 from 7:00 AM to 7:00 PM, and on 6/22/2025 from 7:00 AM to 300 PM. LPN #12 stated Resident #1 was transferred to the hospital on 6/21 and 6/22/2025 at about 10 AM to receive another medication and she did not administer the Cefazolin two (2) gms at 2 PM as ordered because Resident #1 had not returned from the hospital at the scheduled 2 PM time. Further, she did not notify the nursing supervisor because she thought the supervisor knew Resident #1 was at the hospital, and she did not notify the physician or APRN because she thought the supervisor would do that. Interview with RN #3 and medical record review on 8/11/2025 at 12:15 PM identified she was the supervisor on 6/21/2025 from 7:00 AM to 7:00 PM. RN #3 stated she was aware Resident #1 was transferred to the hospital for medication in the morning, she was not aware he/she did not receive the scheduled Cefazolin. RN #3 stated if a medication is omitted, the nurse should notify the supervisor. RN #3 further stated if she had known about the missed dose of Cefazolin, she would have notified the APRN. (continued on next page)

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	075348	A. Building B. Wing	08/20/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with RN #2 on 8/12/2025 at 10:10 AM identified she was the supervisor on 6/22/2025 from 7:00 AM to 7:00 PM and she did not remember if the charge nurse notified her of any missed/omitted medications. RN #2 stated if she was notified, she would have notified the APRN. Interview and medical record review with APRN # 1 on 8/12/2025 at 10:42 AM identified he saw Resident #1 on 6/23/2025 and he was not aware the Cefazolin due to be administered on 6/21 and 6/22/2025 at 2 PM were not administered as ordered. APRN #1 stated he would have expected to be notified, and if he was notified, he would have called the Infectious Disease consultant to determine if the treatment plan needed to be adjusted. Interview with the DON on 8/13/2025 at 10:13 AM identified that if a Resident missed an antibiotic dose, the APRN should be notified. The DON stated the supervisor, APRN and herself should have been notified and she did not know why it was not done. 2. Resident #14 was admitted to the facility with diagnoses that history of substance use disorder. Review of the hospital Discharge summary dated [DATE] identified Resident #14 was to continue taking the medication of Methadone (used to treat Opioid Use Disorder) 115 milligrams (mg) daily. admission nursing note dated 8/6/2025 at 9:18 PM identified Resident #14 alert and oriented. A physician order dated 8/6/2025 directed Methadone 115 mg oral once a day at 6:00 AM. Review of the August 2025 Medication Administration Record (MAR) identified LPN #16 signed that Methadone 115 mg oral at 6:00 AM was not administered, as ordered, at the facility on 8/7, 8/8, 8/9 and 8/10/2025 because the drug was unavailable. Record review failed to identify why the prescribed Methadone was not available in the facility. Nursing note written by RN #2 dated 8/9/2025 (Saturday) at 10:39 AM identified the APRN was notified the Methadone was unavailable, and new orders were obtained to transfer Resident #14 to the hospital to receive the ordered Methadone on 8/9 and also on 8/10/2025 (Sunday), and then to follow up with the Methadone clinic on 8/11/2025. The note further indicated Resident #14 was transferred to the hospital. Nursing note dated 8/9/2025 at 6:10 PM identified Resident #14 returned from the hospital following Methadone administration in the emergency room. Plan to return to the hospital on 8/10/2025 for another dose. Record review identified Resident #14 was transferred to the hospital on 8/10/2025. Review of the hospital emergency department note dated 8/10/2025 identified Resident #14’s diagnosis was Methadone withdrawal, and was administered Methadone 100 mg. Record review identified Resident #14 returned to the facility on 8/10/2025. (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	APRN #1 note dated 8/11/2025 at 10:18 AM identified Resident #14 missed ordered doses of Methadone on 8/7 and 8/8, and then was sent to the hospital and received correction doses at the hospital after missing additional doses of Methadone on 8/9 and 8/10/2025. Interview with RN #3 on 8/20/2025 at 12:40 PM identified she was the RN supervisor on 8/7, 8/8 and 8/9/2025, and stated she was not notified that Methadone was not available for Resident #14, as prescribed. RN #3 stated if she was notified, she would have notified the provider and made arrangements for the resident to obtain the Methadone. RN #3 stated when a resident is admitted on Methadone, the hospital sends a dose and then the facility schedules visits with the Methadone clinic. Further, the facility has a nurse that obtains the required Methadone for residents from the Methadone clinic. Interview with RN #2 on 8/20/2025 at 1:56 PM identified she was notified on 8/9/2025 (Saturday) that the Methadone was not available for Resident #14 on 8/9/2025, and she notified the APRN and transferred Resident #14 to the hospital to obtain the Methadone. RN #2 stated the Methadone nurse is responsible to obtain the prescribed Methadone from the clinic and transport it to the facility for residents. Interview with LPN #15 on 8/20/2025 at 2:20 PM identified she was the facility Methadone nurse (obtains the Methadone from the clinic for residents on weekdays) and she was not aware that Resident #14 did not have his/her prescribed Methadone available on 8/7, 8/8 and 8/9/2025. LPN #15 stated if she was aware, she would have obtained the Methadone. LPN #15 stated the facility process for admissions from the hospital with Methadone ordered is for the hospital to send a dose of Methadone with the patient on a weekday, and if it were a weekend, then the hospital sends a three day supply. LPN #15 stated Resident #14 was transferred to the hospital on 8/9/2025 after missing prescribed doses of Methadone on 8/7 and 8/8/2025. Interview with APRN #1 on 8/20/2025 at 2:00 PM identified medications should be administered in accordance with physician/APRN orders. APRN #1 stated he was not notified on 8/7 and 8/8/2025 that Resident #14 did not receive his/her prescribed Methadone. Further, after two (2) missed doses of Methadone, the resident should be transferred to the hospital because withdrawals can begin around day three (3) of missing Methadone. Interview with the DNS on 8/20/2025 at 2:30 PM identified Resident #14 should have received his/her Methadone as ordered. The DNS stated residents admitted on Methadone should come from the hospital with a dose of Methadone, and then the facility would obtain subsequent doses from the Methadone clinic. The DON was unable to identify if Resident #14 was admitted from the hospital with any doses of Methadone, and why subsequent doses were not obtained timely from the Methadone clinic. 3. Resident #16 was admitted to the facility with diagnoses that included opioid abuse. A physician order dated 5/23/2025 directed Methadone 75 mg oral once a day at 6:00 AM. The Resident Care Plan (RCP) dated 5/23/2025 identified Resident #16 received Methadone for maintenance for a history of substance use disorder. Interventions directed to maintain required contacts/sessions with outside Methadone agency as needed and provide resident with Methadone as ordered. The admission MDS dated [DATE] identified Resident #16 had a Brief Mental Interview for Mental Status (BIMS) of fifteen (15) indicative of intact cognition and was receiving an opioid. (continued on next page)

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	08/20/2025

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

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the MAR for August 2025 identified Resident #16 did not receive Methadone 75 mg oral at 6:00 AM on 8/12/2025; LPN #16 documented the Methadone was unavailable. Record review failed to identify why Resident #16’s prescribed Methadone was not available for administration. Interview and record review on 8/20/2025 at 12:40 PM with RN #3 identified she was the supervisor on 8/12/2025 (11 PM to 7 AM on 8/12/2025) when Resident #16’s Methadone was due to be administered at 6 AM. RN #3 stated she was not aware the Methadone was not administered as ordered, and failed to identify why the Methadone was unavailable. Although attempted, an interview with LPN #16 was not obtained during survey. Interview with APRN #1 on 8/20/25 at 2:00 PM identified the Methadone should have been administered as ordered. Interview with the DNS on 8/20/2025 at 2:30 PM identified Resident #16 should have received his/her Methadone as ordered. The DNS was unable to explain why the Methadone was not available in the facility for administration as ordered. Review of the Methadone Maintenance policy dated 9/16/2020 directed in part, to provide continued access to Methadone. The Policy further directed, after admission to the facility, a licensed nurse will retrieve the resident’s Methadone bottles for administration until the resident’s next scheduled clinic day. Review of the Change of Condition policy dated 1/30/2025 directed in part, that the LPN is to administer provider ordered medications as indicated