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	10/02/2025

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 - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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
	075348	A. Building B. Wing	10/02/2025

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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 0580 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, facility policy and interviews for one (1) of three (3) sampled residents (Resident #2) who were reviewed for a change in condition, the facility failed to notify the provider at the time Resident #2 reported shortness of breath until three (3) hours later. The findings include:Resident #2's diagnoses included acute respiratory failure with hypercapnia (excess carbon dioxide in the bloodstream), Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure (CHF) and dependence on supplemental oxygen. A physician's order dated [DATE] directed to administer continuous oxygen at three (3) liters per minute via nasal cannula for a diagnosis of COPD. The order noted the oxygen may be removed for brief periods. Interventions per the Resident Care Plan dated [DATE] directed to provide supplemental oxygen per physician's order, monitor for signs and symptoms of respiratory distress and report to the provider, and to check oxygen saturation levels as needed and report abnormal values to the provider. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #2 had a Brief Interview for Mental Status (BIMS) score of fourteen (14) out of fifteen (15) indicating Resident #2 had no memory recall deficits, was alert and oriented to person, place, and required supervision assistance with personal care and transfers. The late entry nurse's note dated [DATE] at 2:37 PM identified at 10:40 AM the 7AM-3PM nursing supervisor, Registered Nurse (RN) #1, had walked onto the unit to see the charge nurse, Licensed Practical Nurse (LPN) #1, when a nurse aide, Nurse Aide (NA) #1, yelled out Resident #2 was calling out for help, stating he/she could not breathe. The note indicated the Nurse Practitioner (NP) was on the unit, immediately assessed Resident #2 and ordered staff to call 911. The note identified Resident #2 was noted to be sitting in a chair, breathing heavily using accessory muscles, RN #1 requested staff to bring a portable oxygen tank and Resident #2 was switched from the concentrator via nasal cannula to the portable tank and a non-rebreather mask at fifteen (15) liters per minute was applied. The note indicated Resident #2 was transferred to bed, became unresponsive, Cardiopulmonary Resuscitation (CPR) was initiated by RN #1 and the NP, at approximately 10:45 AM, Emergency Medical Services (EMS) arrived and took over the CPR and despite continued CPR efforts, Resident #2 was pronounced deceased at 11:15 AM. Interviews with three (3) nurse aides, Nurse Aide (NA) #1, #2 and #3, on [DATE] identified on [DATE], around 7:45 AM, Resident #2 started complaining of shortness of breath (SOB), so they notified the charge nurse, Licensed Practical Nurse (LPN) #1 immediately. NA #2 reported Resident #2 continued to complain of SOB, so she notified LPN #1 again around 9:00 AM. They identified that after 10:00 AM (10:40 AM) Resident #2 started yelling for help and stating he/she could not breathe. NA #1 explained she yelled for help to LPN #1 and RN #1 who were down the hallway near the nurse's station and RN #1 ran into the room. Interview with the 7AM-3PM charge nurse, LPN #1, on [DATE] at 9:39 AM identified on [DATE], the 11PM-7AM charge nurse, LPN #3, had notified her in report Resident #2's oxygen concentrator was not functioning, and he/she was utilizing portable oxygen. LPN #1 stated the nurse aides had notified her shortly after the start of the shift that Resident #2 was short of breath and although she directed them to bring two (2) portable tanks into Resident #2's room she did not check on or assess Resident #2. LPN #1 explained that she should have taken Resident #2's vital signs, assessed Resident #2 and then notified the provider and the nursing supervisor but she did not. Interview with the 7AM-3PM nursing supervisor, RN #1, on [DATE] at 12:15 PM identified on [DATE] she was rounding on Resident #2's unit around 9:20 AM, and LPN #1 had not reported any issues, stating she had asked LPN #1 if she needed anything and LPN #1 reported she did not. RN #1 explained at 10:40 AM she was by the nurse's station with LPN #1 when NA #1 yelled to them Resident #2 could not breathe and needed help. RN #1 identified she ran down to the room, followed by the Nurse Practitioner (NP) and Resident #2 was noted to be sitting in the wheelchair, with the nasal cannula attached to the oxygen concentrator gasping and using accessory muscles to breathe. RN #1 stated prior to 10:40 AM, LPN #1 did not notify her Resident #2 was having shortness of breath, there were issues with Resident #2's concentrator and portable oxygen tanks were being used. RN #1 identified LPN #1 reported to her she did not conduct a respiratory assessment or take vital signs or oxygen saturation levels that shift. RN #1 identified had LPN #1 notified her immediately of Resident#2's change in condition at 7:45 AM, she would have assessed Resident #2, notified the provider and transferred Resident #2 to the Emergency Department, as Resident #2 had a history of respiratory exacerbations. Interview with the Nurse Practitioner, NP, on [DATE] at 10:44 AM identified he was not aware Resident #2 had been reporting shortness of breath since

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	10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, observations, review of facility policy and interviews for one (1) of three (3) sampled residents (Resident #3) reviewed for supplemental oxygen usage, the facility failed to develop a care plan to address Resident #3's need for oxygen use. The findings include:Resident #3's diagnoses included acute respiratory failure with hypoxia (low levels of oxygen in the body tissues), Chronic Obstructive Pulmonary Disease (COPD) and anxiety disorder. A physician's order dated 9/19/22 directed to administer oxygen via a nasal cannula or non-rebreather at two (2) to three (3) liters per minute every shift as needed for Shortness of Breath (SOB) to maintain an oxygen saturation level greater than 92 percent. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #3 had a Brief Interview for Mental Status (BIMS) score of fifteen (15) out of fifteen (15) indicating Resident #3 was alert and oriented to person, place, and time, was independent with activities of daily living, and utilized oxygen therapy. Observations of Resident #3 on 9/24/25 at 12:49 PM identified an oxygen concentrator to be running and set at three (3) liters via the nasal cannula. Review of the clinical record on 9/25/25 and 9/26/25 failed to identify a Resident Care Plan (RCP) that addressed Resident #3's respiratory diagnoses and oxygen utilization. Upon further review, on 9/29/25, a care plan was developed and interventions implemented. Interview with the Regional Nurse, Licensed Practical Nurse (LPN) #5, on 9/30/25 at 9:25 AM identified a care plan should have been in place identifying Resident #3's respiratory diagnoses and oxygen utilization. LPN #5 explained the Interdisciplinary Team was responsible for reviewing and revising care plans and he was unsure why a care plan was not in place. Review of the Comprehensive Care-Planning policy dated 1/30/25 directed, in part, that the Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The comprehensive person-centered care plan will include measurable objectives and timeframes, describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being, incorporates identified problem areas and risk factors associated with identified problems, reflects treatment goals, timetables and objectives in measurable outcomes, identifies the professional services that are responsible for each element of care and reflects currently recognized standards of practice for problem areas and conditions. Identifying problem areas and their causes, and developing interventions that are targeted and meaningful to the resident, are the endpoint of an interdisciplinary process. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' condition change. The IDT must review and update the care plan when there's been a significant change in the resident's condition, when the resident has been readmitted to the facility from a hospital stay and at least quarterly, in conjunction with the required quarterly MDS assessment.

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	10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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	10/02/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, facility policy and interviews for one (1) of three (3) sampled residents (Resident #2) reviewed for supplemental oxygen, the facility failed to assess the resident when staff reported Resident #2 was experiencing shortness of breath. The findings include:Resident #2's diagnoses included acute respiratory failure with hypercapnia (excess carbon dioxide in the bloodstream), Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure (CHF) and dependence on supplemental oxygen. A physician's order dated [DATE] directed to administer continuous oxygen at three (3) liters per minute via nasal cannula for a diagnosis of COPD. The order noted the oxygen may be removed for brief periods. Interventions per the Resident Care Plan dated [DATE] directed to provide supplemental oxygen per physician's order, monitor for signs and symptoms of respiratory distress and report to the provider, and to check oxygen saturation levels as needed and report abnormal values to the provider. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #2 had a Brief Interview for Mental Status (BIMS) score of fourteen (14) out of fifteen (15) indicating Resident #2 had no memory recall deficits, was alert and oriented to person, place, and time, and required supervision assistance with personal care and transfers. The late entry nurse's note dated [DATE] at 2:37 PM identified at 10:40 AM the 7AM-3PM nursing supervisor, Registered Nurse (RN) #1, had walked onto the unit to see the charge nurse, Licensed Practical Nurse (LPN) #1, when a nurse aide, Nurse Aide (NA) #1, yelled out Resident #2 was calling out for help, stating he/she could not breathe. The note indicated the Nurse Practitioner (NP) was on the unit, immediately assessed Resident #2 and ordered staff to call 911. The note identified Resident #2 was noted to be sitting in a chair, breathing heavily using accessory muscles. The note indicated Resident #2 was transferred to bed, became unresponsive, Cardiopulmonary Resuscitation (CPR) was initiated by RN #1 and the NP, at approximately 10:45 AM, Emergency Medical Services (EMS) arrived and took over the CPR and despite continued CPR efforts, Resident #2 was pronounced deceased at 11:15 AM. Interviews with three (3) nurse aides, Nurse Aide (NA) #1, #2 and #3, on [DATE] identified on [DATE], around 7:45 AM, Resident #2 started complaining of shortness of breath (SOB), so they notified the charge nurse, Licensed Practical Nurse (LPN) #1 immediately. The nurse aides identified they did not observe LPN #1 enter Resident #2's room at the time they notified her. NA #2 reported Resident #2 continued to complain of SOB, so she notified LPN #1 again around 9:00 AM and did not observe LPN #1 enter Resident #2's room at that time. The nurse aides identified after 10:00 AM (10:40 AM) Resident #2 started yelling for help, stating he/she could not breathe. NA #1 explained she yelled for help to LPN #1 and RN #1 who were down the hallway near the nurse's station and RN #1 ran into the room. Interview with the 7AM-3PM charge nurse, LPN #1, on [DATE] at 9:39 AM identified on [DATE], the 11PM-7AM charge nurse, LPN #3, had notified her in report Resident #2's oxygen concentrator was not functioning, and he/she was utilizing portable oxygen. LPN #1 stated the nurse aides had notified her shortly after the start of the shift that Resident #2 was short of breath and although she directed them to bring two (2) portable tanks into Resident #2's room she did not check on or assess Resident #2. LPN #1 explained that she should have taken Resident #2's vital signs, assessed Resident #2 and then notified the provider and the nursing supervisor but she did not. Interview with the 7AM-3PM nursing supervisor, RN #1, on [DATE] at 12:15 PM identified on [DATE] she was rounding on Resident #2's unit around 9:20 AM, and LPN #1 had not reported any issues, stating she had asked LPN #1 if she needed anything and LPN #1 reported she did not. RN #1 explained at 10:40 AM she was by the nurse's station with LPN #1 when NA #1 yelled to them Resident #2 could not breathe and needed help. RN #1 identified she ran down to the room, followed by the Nurse Practitioner (NP) and Resident #2 was noted to be sitting in the wheelchair, with the nasal cannula attached to the oxygen concentrator gasping and using accessory muscles to breathe. RN #1 stated prior to 10:40 AM, LPN #1 did not notify her Resident #2 was having shortness of breath, there were issues with Resident #2's concentrator and portable oxygen tanks were being used. RN #1 identified LPN #1 reported to her she did not conduct a respiratory assessment or take vital signs or oxygen saturation levels that shift. RN #1 identified had LPN #1 notified her immediately of Resident#2's change in condition at 7:45 AM, she would have assessed Resident #2, notified the provider and transferred Resident #2 to the Emergency Department, as Resident #2 had a history of respiratory exacerbations. Interview with the Administrator on [DATE] at 11:17 AM identified LPN #1 should have attended to Resident #2 immediately after staff notified her Resident #2 could not breathe and then notified

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	10/02/2025

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 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Provide safe and appropriate respiratory care for a resident when needed. (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	10/02/2025

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 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for one (1) of three (3) sampled residents (Resident #2) reviewed for supplemental oxygen, the facility failed to assess the resident and notify the provider when Resident #2 experienced Shortness of Breath (SOB) related to the facility's lack of oxygen concentrators and emergency tank supplies. The facility failed to ensure continuous, functioning supplemental oxygen and failed to provide timely, appropriate intervention for Resident #2's acute respiratory distress, resulting in Resident #2's condition deteriorating to acute respiratory arrest, ultimately leading to death. The failures resulted in the finding of Immediate Jeopardy. The findings include: Resident #2's diagnoses included acute respiratory failure with hypercapnia (excess carbon dioxide in the bloodstream), Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure (CHF) and dependence on supplemental oxygen. A physician's order dated [DATE] directed to administer continuous oxygen at 3.0 liters per minute via nasal cannula for a diagnosis of COPD. The order noted the oxygen may be removed for brief periods. Interventions per the Resident Care Plan dated [DATE] directed to provide supplemental oxygen per physician's order, monitor for signs and symptoms of respiratory distress and report to the provider, and to check oxygen saturation levels as needed and report abnormal values to the provider. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #2 had a Brief Interview for Mental Status (BIMS) score of fourteen (14) out of fifteen (15) indicating Resident #2 had no memory recall deficits, was alert and oriented to person, place, and required supervision assistance with personal care and transfers. The late entry nurse's note dated [DATE] at 2:37 PM identified at 10:40 AM the 7AM-3PM Nursing Supervisor, Registered Nurse (RN) #1, had walked onto the unit to see the charge nurse, Licensed Practical Nurse (LPN) #1, when a nurse aide, Nurse Aide (NA) #1, yelled out Resident #2 was calling out for help, stating he/she could not breathe. The note indicated the Nurse Practitioner (NP) was on the unit, immediately assessed Resident #2 and ordered staff to call 911. The note identified Resident #2 was noted to be sitting in a chair, breathing heavily using accessory muscles, RN #1 requested staff to bring a portable oxygen tank and Resident #2 was switched from the concentrator via nasal cannula to the portable tank and a non-rebreather mask at fifteen (15) liters per minute was applied. The note indicated Resident #2 was transferred to bed, became unresponsive, Cardiopulmonary Resuscitation (CPR) was initiated by RN #1 and the NP, at approximately 10:45 AM, Emergency Medical Services (EMS) arrived and took over the CPR and despite continued CPR efforts, Resident #2 was pronounced deceased at 11:15 AM. Review of the clinical record failed to identify Resident #2's vital signs and oxygen saturation levels were obtained from [DATE] through [DATE]. The clinical record indicated there were no orders to obtain vital signs and oxygen saturation levels. Interview with LPN #4 on [DATE] at 11:13 AM identified on [DATE] she worked the 3-11PM shift. LPN #4 indicated when she switched Resident #2 from the oxygen concentrator to a portable oxygen cylinder, she did not check the oxygen concentrator for functioning, and she did not document Resident #2's oxygen saturation level after she switched the oxygen sources. LPN #4 identified she did not personally speak with the 3-11PM nursing supervisor, RN #3, during her shift regarding Resident #2 because she thought RN #3 was already aware Resident #2 needed a new oxygen concentrator. Interview with the 3-11PM nursing supervisor, RN #3, on [DATE] at 11:18 AM identified LPN #4 did not notify her nor was she aware Resident #2 had been receiving oxygen via the portable oxygen tanks instead of the concentrator throughout the 3-11PM shift on [DATE] and had she been made aware she would have assessed Resident #2, checked the oxygen concentrator for function, and located a functioning concentrator within the facility. Interview with LPN #3 on [DATE] at 1:33 PM identified when she arrived for her 11PM-7AM shift on [DATE] into [DATE], LPN #4 reported to her that Resident #2's oxygen concentrator was not working, and Resident #2 was on bottled oxygen. LPN #3 stated although she should have, she did not look for an oxygen concentrator or check Resident #2's oxygen saturation level throughout the shift. LPN #3 indicated she also did not notify the 11PM-7AM nursing supervisor, RN #2, that Resident #2 was utilizing bottled oxygen or that the concentrator was not working, stating she assumed RN #2 was already aware. Interview with RN #2 on [DATE] at 1:40 PM identified that she was not aware Resident #2's concentrator was not functioning or that Resident #2 was utilizing bottled oxygen starting on the 3-11PM shift. RN #2 identified neither the 3-11PM nursing supervisor, RN #3, nor the 11PM-7AM charge nurse, LPN #3, had notified her of an issue with the concentrator. RN #2 reported had she been notified, she would have ensured Resident #2 had a functioning

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	10/02/2025

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, clinical record reviews, facility policy and interviews, the facility failed to ensure a medication cart located in the hallway was locked and medication was secured to prevent unauthorized access. The findings include:Observations on the D1 unit on 9/25/25 at 10:17 AM identified a medication cart in the hallway to the left of the nurse's station, pushed up against the left side of the hall, about one-third of the way down. The medication cart was noted to be unlocked with the cart keys located on the top of the cart, as well as an open bottle of docusate sodium (stool softener), a glucometer, a bottle of glucometer test strips, five (5) empty blister packs of medication, six (6) pre-poured cups of water without covers, an orange cover to an insulin syringe and a cell phone. Upon further observations a resident was noted to walk by the cart and the charge nurse, Licensed Practical Nurse (LPN) #2, was noted to emerge from a resident's room, in which the door had been closed at 10:19 AM. Interview and observations of the medication cart with LPN #2 on 9/25/25 at 10:19 AM identified that although she should not have left any of the above items on the top of the cart with the cart unlocked and unsecured, she needed to attend to a resident quickly and she did not request the assistance of other staff although she was aware that she left the cart unlocked with the cart keys on top. Interview with the 7AM-3PM nursing supervisor, Registered Nurse (RN) #1, on 9/25/25 at 12:42 PM identified LPN #2 should not have left items on top of the cart, including the cart keys when the cart was unattended and the medication cart should be locked at all times when the nurse steps away from it. Review of the Medication Cart Management policy (undated) directed, in part, that medication carts shall be maintained in a clean, organized, locked and secured manner at all times. Medication carts are considered extensions of the facility's medication storage area and must comply with all security, sanitation and documentation requirements. Carts must remain locked when unattended, even for brief intervals. Keys are to remain in the possession of the assigned nurse. No food, drink, personal items or unrelated supplies may be stored on or in the cart.

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	10/02/2025

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. Based on clinical record reviews, facility documentation, facility policy and interviews for two (2) of twenty-one (21) randomly selected residents (Residents #5 and #11), the facility failed to ensure blood work was obtained per the physician's order. The findings include:1. Resident #5's diagnoses included pneumonia, acute and chronic respiratory failure with hypoxia (low levels of oxygen in body tissues), Congestive Heart Failure (CHF), anemia (low levels of healthy red blood cells to carry oxygen throughout the body), generalized edema (severe buildup of fluid in the tissues of several parts of the body) and hypocalcemia (low calcium levels in the blood). A physician's order dated 9/10/25 directed on 9/12/25 to obtain a Basic Metabolic Panel (BMP) and a Complete Blood Count (CBC) with differential. Review of Resident #5's clinical record failed to identify the blood work was obtained or Resident #5 had refused the blood work. A new physician's order dated 9/25/25 directed to obtain a Comprehensive Metabolic Panel (CMP) and a CBC with differential on 9/26/25 and there were no significant abnormalities. 2. Resident #11's diagnoses included alcohol abuse, hypothyroidism (a condition where the thyroid gland doesn't produce enough thyroid hormone) and peripheral vascular disease (narrowing of blood vessels due to deposit buildups which reduces blood flow to the limbs). A physician's order dated 8/30/25 directed on 9/3/25 to obtain a BMP and a CBC with differential. Review of Resident #11's clinical record failed to identify the blood work was obtained or that Resident #11 refused the blood work. Interview with the Regional Nurse, Licensed Practical Nurse (LPN) #5, on 9/30/25 at 12:05 PM identified he was unable to locate documentation the blood work was obtained for Residents #5 and #11, explaining the blood work should have been obtained per the physician's order or the provider should have been notified and rescheduled to a different date with a new physician's order. Interview with the Nurse Practitioner (NP) on 10/2/25 at 11:22 AM identified that he was unaware the bloodwork was not obtained per the physician's orders for both Residents #5 and #11, explaining the physician's orders should have been followed or he should have been notified the bloodwork was not obtained so he could have placed a new order. The NP identified that nursing staff should have documented in the clinical record why the bloodwork was not obtained, provider notification and any follow-up orders. Review of the Laboratory and Blood Work Services policy dated 01/19/18 directed, in part, that the facility is to ensure that laboratory and bloodwork services are provided in accordance with physician's orders, resident rights, federal regulations and Connecticut Public Health code standards. All bloodwork will be obtained and processed in a manner that ensures resident safety, accuracy, timeliness and professional standards of quality. Results will be returned to the ordering physician and entered into the resident's medical record. Nursing staff must promptly review results, notify the physician of abnormal or critical values and document the notification.

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	10/02/2025

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. (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	10/02/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, observations, facility policies and interviews for three (3) of seven (7) sampled residents (Residents #3, #4 and #5) who required supplemental oxygen use via a concentrator, the facility failed to ensure the oxygen tubing was changed every seven (7) days per facility policy. The findings include:1. Resident 3's diagnoses included acute respiratory failure with hypoxia (low levels of oxygen in the body tissues), Chronic Obstructive Pulmonary Disease (COPD) and anxiety disorder. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #3 had a Brief Mental Interview for Mental Status (BIMS) score of fifteen (15) out of fifteen (15) indicating Resident #3 was alert and oriented to person, place and time. A physician's order dated 9/19/22 directed to administer oxygen via a nasal cannula or non-rebreather at two (2) to three (3) liters per minute every shift as needed for Shortness of Breath (SOB) to maintain an oxygen saturation level greater than 92 percent and to change and date the oxygen tubing once daily on Sunday on the 11PM-7AM shift. Observations of Resident #3 on 9/24/25 at 12:49 PM identified the oxygen concentrator to be running and set at three (3) liters, and the oxygen tubing label was dated 9/14/25 (10-days prior). Observations of Resident #3 with the Director of Nursing (DON) on 9/24/25 at 1:12 PM identified the oxygen concentrator to be running and set at three (3) liters, and the oxygen tubing label was dated 9/14/25 (10-days prior). Review of the September 2025 Treatment Administration Record (TAR) identified although the oxygen tubing was dated 9/14/25 on observations, the treatment was signed off as changed on 9/21/25 by the 11PM-7AM charge nurse, Licensed Practical Nurse (LPN) #1. 2. Resident #4's diagnoses included pneumonia, heart failure, COPD and anxiety disorder. A physician's order dated 4/11/25 directed to administer oxygen via a nasal cannula at three (3) liters per minute continuously every shift. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #4 had a Brief Interview for Mental Status (BIMS) score of eleven (11) out of fifteen (15) indicating Resident #4 had some memory recall deficits. Review of the active physician's orders failed to identify an order to change and date the oxygen tubing weekly. Observations of Resident #4 and interview with the DON on 9/24/25 at 1:12 PM identified the oxygen concentrator to be running and set to three (3) liters, and the oxygen tubing was labeled 9/14/25. The DON identified that the oxygen tubing should have been changed on 9/21/25 for both Residents #3 and #4 by the 11PM-7AM nurse for infection control purposes. 3. Resident #5's diagnoses included acute and chronic respiratory failure with hypoxia, Congestive Heart Failure (CHF), COPD and dependence on supplemental oxygen. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #5 had a Brief Interview for Mental Status (BIMS) score of fourteen (14) out of fifteen (15) indicating Resident #5 was alert and oriented to person, place and time. A physician's order dated 9/10/25 directed to titrate the oxygen down to room air every shift to maintain oxygen saturation greater than 95 %. A provider's note dated 9/23/25 at 5:36 PM identified Resident #5 utilized oxygen at four (4) four liters. Upon further review, the active physician's orders failed to identify an order to change and date the oxygen tubing weekly. Observations of Resident #5 and interview with the DON on 9/24/25 at 1:47 PM identified the oxygen concentrator running and set at four (4) four liters and the oxygen tubing label was dated 9/7/25 (17-days prior). The DON identified that the oxygen tubing should have been changed weekly by the 11PM-7AM nurse for infection control purposes and the tubing had not been changed for greater than two (2) weeks. Interview with the Regional Nurse, Licensed Practical nurse (LPN) #5, on 9/30/25 at 9:25 AM identified the nursing staff are expected to change the oxygen tubing weekly on the 11PM-7AM shift per their policy and for infection control purposes, and the nurses should never sign off orders prior to completing/administering the medication or treatment. LPN #5 indicated residents who utilize oxygen should have had a physician's order directing to change the oxygen tubing weekly. Review of the Oxygen Tubing policy dated 01/19/18 directed, in part, that the facility will provide and maintain oxygen tubing in a manner consistent with manufacturer guidelines, infection prevention standards and resident care needs. Oxygen tubing will be changed, labeled, stored and disposed of in accordance with regulatory requirements and facility protocols. Standard nasal cannula/tubing will be changed every seven (7) days or sooner if visibly soiled, contaminated, or per manufacturer instructions. Tubing change dates will be documented in the resident's medical record.

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	10/02/2025

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. (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	10/02/2025

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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 0908 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 reviews, observations, facility documentation, facility policies and interviews for two (2) of seven (7) sampled residents (Residents #6 and #7) who required supplemental oxygen usage via a concentrator, the facility failed to ensure the oxygen concentrators were inspected annually for function and safety. The findings include:1. Resident #6's diagnoses included Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure (CHF), Shortness of Breath (SOB) and anxiety disorder. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #6 had a Brief Interview for Mental Status (BIMS) score of seven (7) out of fifteen (15) indicating Resident rarely or never made decisions regarding tasks of daily life. A physician's order for 8/1/25 through 9/26/25 directed to administer oxygen via nasal cannula at two (2) liters per minute every shift to maintain oxygen saturation greater than 91 percent (%) and to prevent hypoxia (low levels of oxygen in the body's tissues). Observations with the Director of Nursing (DON) on 9/24/25 at 12:30 PM identified Resident #6 was receiving oxygen via the oxygen concentrator. A sticker on the oxygen concentrator identified the concentrator had last been inspected on 4/2024 and was due for inspection on 4/2025, indicating the inspection was five (5) months overdue. 2. Resident #7's diagnoses included chronic respiratory failure with hypoxia (low levels of oxygen in body tissues), COPD, CHF, emphysema (a progressive lung disease that causes shortness of breath) and anxiety disorder. A physician's order dated 8/15/25 directed to administer humidified oxygen at five (5) liters per minute via nasal cannula continuously every shift. The annual Minimum Data Set assessment dated [DATE] identified Resident #7 had a Brief Interview for Mental Status (BIMS) score of fourteen (14) out of fifteen (15) indicating Resident #7 was alert and oriented to person, place and time. Observations with the DON on 9/24/25 at 1:40 PM identified Resident #7 was receiving oxygen via the oxygen concentrator. A sticker on the oxygen concentrator identified the concentrator had last been inspected on 4/2024 and was due for inspection on 4/2025, indicating the inspection was five (5) months overdue. Upon further observations, the filter on the side of the concentrator was noted with a thick covering of dust. Observations and interview with the Administrator on 9/24/25 at 3:25 PM identified a sticker on both Resident #6 and Resident #7's oxygen concentrators identified the concentrators had last been inspected on 4/2024 and were next due for inspection on 4/2025. The Administrator identified the facility owns the concentrators, which are to be inspected annually by an outside company, and she was unaware there were concentrators that were overdue for inspection and the maintenance staff were responsible for cleaning the filters. Interview with Person #2 (the oxygen concentrator servicing vendor) on 9/26/25 at 11:59 AM identified 2025 was the first year they serviced the facility. Person #2 explained they were not given a list of how many concentrators were in the building or where the concentrators were located, stating they went room to room and completed biomed testing (ensuring the units were functioning and there was no electrical leakage issues) of all the units they were able to locate. Person #2 identified if units have been observed recently that have not been inspected since 2024, they were not accessible to them at the time of their visit. Person #2 indicated they are not contracted to clean the filters on the concentrator units, and it is recommended the inside filters are replaced every two (2) years and the outside filters are cleaned every two (2) to three (3) weeks. Interview with the Director of Environmental Services on 9/26/25 at 12:11 PM identified although the concentrators are required to be serviced annually, he did not do a walk through with the vendor at the time the vendor was in the facility. The Director of Environmental Services explained he would have the company come back to the facility and he would do a walk through with them to ensure all units were up to date with annual service. The Director of Environmental Services identified maintenance checks the filters weekly for debris and housekeeping was responsible for monitoring the oxygen concentrators filters daily when they clean the room and will notify maintenance of the need to be cleaned. The Director of Environmental Services identified he was unsure why the filter on Resident #7's concentrator was noted with thick dust. Review of the Fire Safety and Prevention policy dated 1/19/18 directed, in part, to ensure that any cleaning, repair or filling of oxygen equipment is performed by qualified, properly trained staff. All personnel must report observations of malfunctioning equipment and supplies and any unusual incidents. Although requested, policies on servicing of and cleaning oxygen concentrators were not provided.