STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075348	A. Building B. Wing	03/19/2026

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 - 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 review of the clinical record, facility documentation/policy, and interviews for two (2) of three (3) residents (Resident #2 and Resident #14) reviewed for neglect, the facility failed to ensure nail care was performed for a dependent resident (Resident #2) with a contracted hand, failed to implement effective interventions when the resident resisted care, and failed to report ongoing care concerns to the provider for further evaluation, resulting in overgrown, unkempt fingernails and a left fourth finger infection requiring surgical intervention (incision and drainage); and failed to ensure bathing care was provided for a cognitively impaired resident (Resident #14) and failed to identify, report, and address ongoing gaps in care delivery, resulting in poor hygiene requiring hand soaks to remove fecal matter from underneath the fingernails. The findings included:1.Resident #2 was admitted to the facility in February of 2022 with diagnoses which included Type 2 diabetes mellitus with diabetic autonomic neuropathy, contracture of the left hand, and schizoaffective disorder, bipolar type. The significant change Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 moderately cognitively impaired (Brief Mental Interview for Mental Status (BIMS) of 9) and dependent with toileting, bathing, and lower body dressing. The Resident Care Plan (RCP) dated 12/18/25 identified the resident exhibited behaviors as evidenced by refusals of care with staff at times. Interventions directed to re-approach the resident at another time, monitor changes in mood/behavior, and report to the medical doctor. The hospital Discharge summary dated [DATE] identified Resident #2 had a principal diagnoses of septic shock due to Methicillin Sensitive Staphylococcus Aureus (MSSA), pneumonia, urinary tract infection, and hypoxic and hypercapnic respiratory failure. Resident #2 had a left fourth finger paronychial infection and chronic contracture which required nail removal, incision and drainage, with wound cultures growing MSSA and Staphlococcus Lugdunensis. Photographs of Resident #2's left contracted hand identified fingernails that were overgrown and unkempt with notation Resident #2 was unable to passively extend any of the left upper extremity digits at the distal interphalangeal, proximal interphalangeal, and metacarpal phalangeal joints but was able to flex and extend his/her left thumb. Resident #2 was continued on Cefazolin (antibiotic) with local wound care soaks and cleared for discharge.Interview with LPN #1, on 3/10/26 at 11:45 AM identified nail care was performed on shower days or as needed and was typically performed by the NAs. LPN #1 further indicated he/she was not informed Resident #2 had nail care issues during January of 2026. Interview with NA #1 on 3/10/26 at 12:02 PM identified Resident #2 would have his/her nail care done on bath days, which occurred during the 3:00 PM to 11:00 PM shift. NA #1 indicated Resident #2 had nail care issues and staff had difficulty trying to open his/her left hand to perform care. NA #1 identified Resident #2 demonstrated resistance to left hand care, responding in pain when contact was made and pulling away when attempts to open the hand occurred. NA #1 indicated he/she was limited in what areas of the hand he/she could clean.Interview with APRN #1 on 3/10/26 at 1:26 PM identified he/she was not informed of Resident #2's nail care issues until after the 1/24/26 to 2/6/26 hospitalization, however, APRN #1 was aware of Resident #2's resistance to staff touching/opening the left hand. APRN #1 indicated he/she should have been informed of Resident #2's resistance to nail (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 0600 Level of Harm - Actual harm Residents Affected - Few	care, and had Resident #2 received regular nail care, the nail infection identified during the January of 2026 hospitalization could have been prevented. Interview with LPN #2 on 3/10/26 at 3:13 PM identified nail care was an on-going issue for Resident #2 and she first observed Resident #2's untrimmed nails prior to January of 2026 when Resident #2 was transferred to the nursing unit she was assigned. LPN #2 identified having difficulty visualizing the nails on his/her left hand due to the contracture. LPN #2 further indicated Resident #2 would resist having his/her left hand cleaned or opened, so LPN #2 was unable to assess the condition of his/her nails and did not inform the nursing supervisor or provider that Resident #2's nail care was not being performed because she believed the issue was common knowledge.Interview with NA #2 on 3/10/26 at 3:31 PM identified Resident #2 would refuse nail care to the left hand, would pull his/her hand away, and only allowed NA #2 to trim the left thumb and left fifth digit fingernails at times. NA #2 further indicated Resident #2, even when reapproached, would infrequently allow him/her to clean the upper surface of his/her left hand. However, he/she was sometimes able to slide a thin washcloth through the underside of his/her contracted fingers, which NA #2 indicated had a strong foul odor following the cleaning. NA #2 identified he/she informed LPN #2 of the issue with performing Resident #2's nail care.Interview with the Director of Nursing Services (DNS) on 3/11/26 at 1:26 PM identified he/she was unaware of difficulties performing Resident #2's nail care, hence no alternative nail care treatments were offered. The DNS identified facility practice was to perform nail care on shower days and as needed, and if unable to perform initially, NAs were to reattempt and/or revisit the task. If unsuccessful, the nurse was to be informed and attempt to complete the task. If still unable to complete the task, the nurse supervisor/DNS/provider were to be informed of the issue. The DNS further indicated a referral to physiatry and/or physical therapy/occupational therapy could have provided additional insight/intervention on how to address the concern.2. Resident #14?s diagnoses included vascular dementia without behavioral disturbances and adult failure to thrive.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #14 had severely impaired cognition (Brief Interview for Mental Status (BIMS) score of 3), required substantial assistance for eating, partial assistance for bed mobility and transfers and supervision assistance for ambulation.The Resident Care Plan (RCP) dated 10/01/25 identified Resident #14 required assistance with functional Activities of Daily Living (ADLs). Interventions included assistance with showering every Monday on the 3:00 PM to 11:00 PM shift.Review of the Point of Care History for December 2025 identified Resident #14 received a shower on 12/5/25 at 3:44 PM and a complete bed bath on 12/7/25 at 11:31 AM but failed to identify Resident #14 received a shower or bed bath at least weekly between 12/8/25 and 12/20/25 or between 12/24/25 and 12/31/25.A Grievance/Concern Form dated 1/6/26 identified on 1/6/26 Resident #14 was noted with feces under his/her nails that required Resident #14's hands to be soaked to a bowl of soapy warm water to remove. It identified staff was educated regarding daily nail/foot care.Review of the Point of Care History for January 2026 identified Resident #14 received a partial bed bath on 1/10/26 at 5:17 AM but failed to identify Resident #14 received a shower or bed bath at least weekly between 1/1/26 and 1/9/26 or between 1/21/26 through 1/27/26.Review of the Point of Care History for March 2026 identified Resident #14 received a partial bed bath on 3/5/26 at 2:07 PM but failed to identify Resident #14 received a shower or bed bath at least weekly between 3/6/26 and 3/13/26.Review of the clinical record from 12/1/25 through 3/15/26 failed to identify Resident #14 refused a shower or bed bath.Interview with the DNS on 3/19/26 at 12:45 PM identified each resident should be provided with either a shower or a complete bed bath at least weekly. She identified the clinical record did not reflect Resident #14 received a shower or bed bath the week leading up to the grievance.Review of the Bathing and Grooming Care policy dated 1/19/18 directed, in part, rooms are assigned to either a day or evening shift to enable those residents to be provided with at least a weekly shower. Nail care, facial hair care and skin care is provided as a standard of care with bathing and grooming.The Resident Abuse, Mistreatment, Neglect, Exploitation, Misappropriation of Resident Property, and Retaliation policy directed it was the policy of the facility (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	to ensure residents were free from abuse, mistreatment, neglect, exploitation, misappropriation of property, and retaliation and defined neglect as the failure of the facility, its employees or service providers to provide goods or services to a resident that were necessary to attain or maintain their highest practicable level of physical, mental, and psychosocial well-being.

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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 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, interviews, and review of facility documentation and policy for seven (7) of nine (9) residents (Resident #1, #3, #4, #7, #8, #9, and #13) reviewed for discharge, the facility failed to provide timely notification to the ombudsman when residents were discharged and/or planned for discharge from the facility. The findings included:1.Resident #1 was admitted to the facility in October of 2025 and had diagnoses which included Type 2 diabetes mellitus with foot ulcer, chronic osteomyelitis of the right foot and ankle, and cellulitis of the right lower limb.A physician's order dated [DATE] identified an independent leave of absence (LOA) was granted.The LOA Notification Form dated [DATE] at 9:36 AM identified Resident #1 left the faciity on an LOA and planned to return at 11:00 AM on [DATE].A nurse's note by RN #1 on [DATE] at 1:53 PM identified he/she called Resident #1 and Resident #1 indicated he/she would return the following morning ([DATE]). RN #1 further indicated the physician was updated Resident #1 would miss medications due to the overnight LOA. Interview with the Director of Nursing Services (DNS) on [DATE] at 10:23 AM identified Resident #1 was found sleeping on a park bench, intoxicated, and hypothermic upon arrival to the emergency department (ED). The DNS further indicated despite lifesaving measures, Resident #1 expired while in the ED the afternoon of [DATE].Although the facility provided an Admit/Discharge Report dated [DATE] to [DATE] which indicated Resident #1 was on hospital leave [DATE], the facility was unable to provide evidence that a discharge notice was uploaded to the Aging and Disability Services application portal. 2.Resident #3 was admitted to the facility in January of 2026 and had diagnoses which included acute osteomyelitis of the right ankle and foot, peripheral vascular disease, and gas gangrene.A social service's note by Social Worker (SW) #2 dated [DATE] at 4:41 PM identified Resident #3 planned on staying at the facility short term, planned to return to his/her residence in the community, and a seventy-two (72) hour meeting was conducted on [DATE] with Resident #3's daughter, son-in-law, therapy, and Director of Nursing Services (DNS) in attendance.The Notice of Intent to discharge date d [DATE] identified a thirty (30) day notice was provided to Resident #3 as he/she no longer needed the services of the facility due to improved health and the facility was planning to discharge him/her to the previous home address.A social service's note by SW #2 on [DATE] at 3:00 PM identified Resident #3 was discharged on [DATE].The New Discharge Notification File Confirmation email identified Resident #3's discharge notice was uploaded to the Aging and Disability Services application portal on [DATE] at 10:30 AM (twelve (12) days after the Notice of Intent to discharge was given to Resident #3).3.Resident #4 was admitted to the facility in October of 2023 and had diagnoses which included Type 2 Diabetes Mellitus with diabetic peripheral angiopathy with gangrene, coronary artery disease, and renal insufficiency. A social service's note by SW #3 on [DATE] at 3:49 PM identified Resident #4 was provided diabetic education regarding preferred meal regimen along with lifestyle changes to maintain normal ranges once discharged home.The Notice of Intent to discharge date d [DATE] identified a thirty (30) day notice was provided to Resident #4 as his/her application for Money Follows the Person was accepted, and the team found him/her housing.A social service's note by SW #2 dated [DATE] at 4:34 PM identified Resident #4 was successfully discharged from the facility at approximately 12:15 PM. The New Discharge Notification File Confirmation email identified Resident #4's discharge was uploaded to Aging and Disability Services application portal on [DATE] at 2:28 PM (twenty-three (23) days after the Notice of Intent to Discharge was given to Resident #4).4.Resident #7 was admitted to the facility in October of 2025 and had diagnoses which included Type 2 diabetes mellitus, anxiety disorder, and chronic obstructive pulmonary disease. A social service's note by SW #1 on [DATE] at 10:03 AM identified he/she spoke with Resident #7 and Resident #7's family as they were working on cleaning the resident's apartment in the community as Resident #7 was adamant about returning (continued on next page)

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	home by the end of the month and made Resident #7 aware he/she would receive limited services with his/her insurance. The Notice of Intent to discharge date d [DATE] identified a thirty (30) day notice was provided to Resident #7 as he/she no longer needed the services of the facility due to improved health and the resident/writer/family helped facilitate a safe discharge back to his/her apartment set for Friday, [DATE]. A social service's note by SW #1 dated [DATE] at 4:37 PM identified Resident #7 was discharged back to his/her apartment.The New Discharge Notification File Confirmation email identified Resident #7's discharge was uploaded to Aging and Disability Services application portal on [DATE] at 9:47 AM (one (1) day after the Notice of Intent to Discharge was given to Resident #7 but four (4) days after Resident #7 informed the facility of his desire to be discharged from the facility and the facility uploading the notification.5.Resident #8 was admitted to the facility in January of 2025 and had diagnoses which included Type 2 diabetes mellitus, depression, and Multiple Sclerosis.The Notice of Intent to discharge date d [DATE] identified a thirty (30) day notice was provided to Resident #8 as he/she no longer needed the services of the facility due to improved health.The New Discharge Notification File Confirmation email identified Resident #8's discharge was uploaded to Aging and Disability Services application portal on [DATE] at 12:13 PM, twelve (12) days after Resident #7 was given the Notice of Intent to Discharge.A social service's noted by SW #2 on [DATE] at 2:18 PM identified Resident #8 was successfully discharged from the facility on [DATE].6.Resident #9 was admitted to the facility in September of 2025 and had diagnoses which included heart failure, chronic obstructive pulmonary disease, and respiratory failure. A social service's note by SW #1 on [DATE] at 3:18 PM identified a meeting was held with Resident #9, therapy, and family per request and that a discharge date of [DATE] was decided upon.The Notice of Intent to discharge date d [DATE] identified a thirty (30) day notice was provided to Resident #9 as he/she no longer needed the services of the facility due to improved health and per family choice, family/resident had a discharge meeting and would like him/her to return back to his/her apartment.A social service's note by SW #1 dated [DATE] at 2:50 PM identified Resident #9 was discharged home.The New Discharge Notification File Confirmation email identified Resident #9's discharge was uploaded to Aging and Disability Services application portal on [DATE] at 3:14 PM, six (6) days after the Notice of Intent to Discharge was given to Resident #7.7.Resident #13 was admitted to the facility in October of 2024 and had diagnoses which included schizoaffective disorder, anxiety disorder, and Type 2 diabetes mellitus.A social service's note by SW #1 dated [DATE] at 1:14 PM identified a discharge meeting was held with Resident #13 and Money Follows the Person (MFP) as Resident #13 would be discharged to his/her new apartment on [DATE] and SW #1 had started a safe transition for Resident #13 in the community.The Notice of Intent to discharge date d [DATE] identified a thirty (30) day notice was provided to Resident #13 as his/her application for MFP was accepted and he/she provided housing. A social service's note by SW #2 dated [DATE] at 4:46 PM identified Resident #13 was discharged from the facility. The New Discharge Notification File Confirmation email identified Resident #13's discharge notice was uploaded to Aging and Disability Services application portal on [DATE] at 2:22 PM (thirty-seven (37) days after the Notice of Intent to discharge was given to Resident #13).Interview with SW #1 on [DATE] at 12:57 PM identified Resident #1's discharge was not reported to the Aging and Disability Services application portal as he/she considered him/her a transfer rather than a discharge to the hospital and would not have notified the ombudsman of a transfer. SW #1 further indicated the timeframe required to upload discharge notices to the Aging and Disability Services application portal varied, and that there was no specific date or timeframe the discharge notice was to be created and uploaded into the portal by. Interview with the DNS on [DATE] at 10:01 AM failed to identify when the facility was to inform/upload the notice of discharge into the Aging and Disability Services application portal. The Transfer/Discharge policy dated [DATE] identified before the facility transfers the resident, the facility must notify the resident and their representative of the transfer or discharge, the reason for the move in writing in a language the resident understands, and the regional long term care ombudsman should be notified by the long term (continued on next page)

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	care portal (Aging and Disability Services application portal).The Centers for Medicare Services Transfer and Discharge Documentation Regulation directed the facility must provide notice of discharge to the resident and resident representative along with a copy of the notice to the Office of the State LTC Ombudsman at least 30 days prior to the discharge or as soon as possible, and the copy of the notice to the ombudsman must be sent at the same time notice is provided to the resident and resident representative.

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **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 #14) reviewed for significant weight loss, the facility failed to ensure the comprehensive assessment accurately reflected the resident's significant weight loss greater than ten (10) percent (%) in the last six (6) months at the time of the assessment. The findings include: Resident #14?s diagnoses included vascular dementia without behavioral disturbances and adult failure to thrive.A weight of 122.0 pounds (lbs) was obtained on 5/13/25.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #14 had severely impaired cognition (Brief Interview for Mental Status (BIMS) score of 3), required setup assistance for eating and was independent for bed mobility, transfers and ambulation.The Resident Care Plan (RCP) dated 6/10/25 identified Resident #14 was at risk for malnutrition related to a history of adult failure to thrive, altered nutrition related bloodwork, body mass index less than 23 and significant weight changes. Interventions included assessing intakes, bloodwork and weights, monitoring weight for significant changes and encouraging and monitoring meal, snack and medication pass intakes. A weight of 108.6 lbs was obtained on 11/16/25 signifying a 13.4 lb (10.984%) weight loss in six (6) months compared to the 5/13/25 weight.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #14 had severely impaired cognition (Brief Interview for Mental Status (BIMS) score of 3), required substantial assistance for eating and bed mobility and was dependent on staff for transfers. The MDS did not identify Resident #14 had a weight loss of 5% or more in the last month or a loss of 10% or more in the last six (6) months.Interview with the Registered Dietician (RD) on 3/19/26 at 10:59 AM identified she was responsible for completing Section K (Swallowing and Nutritional Status) of the MDS. The RD acknowledged that Section K of the 12/4/25 MDS for Resident #14 was coded incorrectly. She reported she used an incorrect baseline weight and failed to calculate the resident's weight change using the appropriate six (6) month look-back period from the Assessment Reference Date. The RD stated that based on the 5/13/25 weight of 122.0 lbs and the 11/16/25 weight of 108.6 lbs, Resident #14 experienced a weight loss greater than ten (10) percent (%) in six (6) months, and the MDS should have identified a significant weight loss.Interview with the DON on 3/19/26 at 12:45 PM identified the MDS should accurately reflect a resident's care for all sections, including Swallowing and Nutritional status. The DON stated Resident #14's MDS dated [DATE] did not accurately reflect Resident #14's significant weight loss of more than 10%.Although requested, a policy on Comprehensive Assessments was not provided.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, interviews, and facility documentation/policy for one (1) of three (3) residents (Resident #1) reviewed for a leave of absence (LOA), the facility failed to update the Resident Care Plan (RCP) to include directives for the management of the residents independent LOA in accordance with facility policy and for one (1) of three (3) residents (Resident #2) reviewed for activities of daily living, the facility failed to implement interventions related to physician notification for refusal of contracture care. The findings included:Resident #1 was admitted to the facility in October of 2025 and had diagnoses which included Type 2 diabetes mellitus, chronic osteomyelitis of the right foot and ankle, and cellulitis of the right lower limb.The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 was cognitively intact (Brief Interview for Mental Status (BIMS) score of 15) and utilized a walker and wheelchair for mobility.The RCP dated 10/10/25 identified Resident #1 had a history or active diagnosis of substance abuse. Interventions directed to seek support from family and friends to support treatment once the resident returned to the community.A physician's order dated 12/8/25 identified an independent LOA.Review of the RCP failed to include goals of care related to Resident #1's independent LOA. Interview with the Director of Nursing Services on 3/10/26 at 10:15 PM identified goals and interventions for residents with active LOA orders should be implemented into the RCP once the LOA order was approved. Review of the LOA policy dated 11/1/25 identified the facility supports the residents? rights to participate in community activities and family events by allowing temporary LOAs in accordance with the resident's care plan, physician orders, and applicable state and federal regulations.Review of the Comprehensive Care Planning policy identified that a comprehensive, person-centered care plan that included measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs was developed and implemented for each resident. 2. Resident #2 was admitted to the facility in February 2022 with diagnoses which included Type 2 diabetes mellitus with diabetic autonomic neuropathy, contracture of the left hand, and schizoaffective disorder, bipolar type. The significant change Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 moderately cognitively impaired (Brief Mental Interview for Mental Status (BIMS) of 9) and dependent with toileting, bathing, and lower body dressing. The Resident Care Plan (RCP) dated 12/18/25 identified the resident exhibited behaviors as evidenced by refusals of care with staff at times. Interventions directed to re-approach the resident at another time, monitor changes in mood/behavior, and report to the medical doctor. Interview with NA #1 on 3/10/26 at 12:02 PM identified Resident #2 would have his/her nail care done on bath days, which occurred during the 3:00 PM to 11:00 PM shift. Interview with LPN #2 on 3/10/26 at 3:13 PM identified nail care was an on-going issue for Resident #2 and she first observed Resident #2's untrimmed nails prior to January of 2026 when Resident #2 was transferred to the nursing unit she was assigned. LPN #2 identified having difficulty visualizing the nails on his/her left hand due to the contracture. LPN #2 further indicated Resident #2 would resist having his/her left hand cleaned or opened, so LPN #2 was unable to assess the condition of his/her nails and did not inform the nursing supervisor or provider that Resident #2's nail care was not being performed because she believed the issue was common knowledge.Interview with the Director of Nursing Services (DNS) on 3/11/26 at 1:26 PM identified he/she was unaware of difficulties performing Resident #2's nail care, hence no alternative nail care treatments were offered. The DNS identified facility practice was to perform nail care on shower days and as needed, and if unable to perform initially, NAs were to reattempt and/or revisit the task. If unsuccessful, the nurse was to be informed and attempt to complete the task. If still unable to complete the task, the nurse supervisor/DNS/provider were to be informed of the issue.Review of the Comprehensive Care Planning policy identified that a comprehensive, person-centered care plan that included measurable (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	objectives and timetables to meet the resident's physical, psychosocial, and functional needs was developed and implemented for each resident. The policy further identified care plan interventions were chosen only after careful data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem area and their causes, and relevant clinical decision making.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation/policy, and interviews for two (2) of three (3) residents (Resident #2 and Resident #14) reviewed for activities of daily living, the facility failed to provide necessary assistance with personal hygiene, including hand and nail care for a dependent resident with a contracted hand (Resident #2), and bathing care for a cognitively impaired resident (Resident #14), and failed to implement effective interventions when care was resisted, resulting in poor hygiene, including overgrown, unkempt fingernails with compromised skin integrity and the need for hand soaks to remove fecal matter from underneath the fingernails. The findings included:1.Resident #2 was admitted to the facility in February of 2022 with diagnoses which included Type 2 diabetes mellitus with diabetic autonomic neuropathy, contracture of the left hand, and schizoaffective disorder, bipolar type. The significant change Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 moderately cognitively impaired (Brief Mental Interview for Mental Status (BIMS) of 9) and dependent with toileting, bathing, and lower body dressing. The Resident Care Plan (RCP) dated 12/18/25 identified the resident exhibited behaviors as evidenced by refusals of care with staff at times. Interventions directed to re-approach the resident at another time, monitor changes in mood/behavior, and report to the medical doctor. The hospital Discharge summary dated [DATE] identified Resident #2 had a principal diagnoses of septic shock due to Methicillin Sensitive Staphylococcus Aureus (MSSA), pneumonia, urinary tract infection, and hypoxic and hypercapnic respiratory failure. Resident #2 had a left fourth finger paronychial infection and chronic contracture which required nail removal, incision and drainage, with wound cultures growing MSSA and Staphlococcus Lugdunensis. Photographs of Resident #2's left contracted hand identified fingernails that were overgrown and unkempt with notation Resident #2 was unable to passively extend any of the left upper extremity digits at the distal interphalangeal, proximal interphalangeal, and metacarpal phalangeal joints but was able to flex and extend his/her left thumb. Resident #2 was continued on Cefazolin (antibiotic) with local wound care soaks and cleared for discharge.Interview with LPN #1, on 3/10/26 at 11:45 AM identified nail care was performed on shower days or as needed and was typically performed by the NAs. LPN #1 further indicated he/she was not informed Resident #2 had nail care issues during January of 2026. Interview with NA #1 on 3/10/26 at 12:02 PM identified Resident #2 would have his/her nail care done on bath days, which occurred during the 3:00 PM to 11:00 PM shift. NA #1 indicated Resident #2 had nail care issues and staff had difficulty trying to open his/her left hand to perform care. NA #1 identified Resident #2 demonstrated resistance to left hand care, responding in pain when contact was made and pulling away when attempts to open the hand occurred. NA #1 indicated he/she was limited in what areas of the hand he/she could clean.Interview with APRN #1 on 3/10/26 at 1:26 PM identified he/she was not informed of Resident #2's nail care issues until after the 1/24/26 to 2/6/26 hospitalization, however, APRN #1 was aware of Resident #2's resistance to staff touching/opening the left hand. APRN #1 indicated he/she should have been informed of Resident #2's resistance to nail care, and had Resident #2 received regular nail care, the nail infection identified during the January of 2026 hospitalization could have been prevented. Interview with LPN #2 on 3/10/26 at 3:13 PM identified nail care was an on-going issue for Resident #2 and she first observed Resident #2's untrimmed nails prior to January of 2026 when Resident #2 was transferred to the nursing unit she was assigned. LPN #2 identified having difficulty visualizing the nails on his/her left hand due to the contracture. LPN #2 further indicated Resident #2 would resist having his/her left hand cleaned or opened, so LPN #2 was unable to assess the condition of his/her nails and did not inform the nursing supervisor or provider that Resident #2's nail care was not being performed because she believed the issue was common knowledge.Interview with NA #2 on 3/10/26 at 3:31 PM identified Resident #2 would refuse nail care to the left hand, would pull his/her hand away, and only allowed NA #2 to trim the left thumb and left fifth digit fingernails at (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	times. NA #2 further indicated Resident #2, even when reapproached, would infrequently allow him/her to clean the upper surface of his/her left hand. However, he/she was sometimes able to slide a thin washcloth through the underside of his/her contracted fingers, which NA #2 indicated had a strong foul odor following the cleaning. NA #2 identified he/she informed LPN #2 of the issue with performing Resident #2's nail care.Interview with the Director of Nursing Services (DNS) on 3/11/26 at 1:26 PM identified he/she was unaware of difficulties performing Resident #2's nail care, hence no alternative nail care treatments were offered. The DNS identified facility practice was to perform nail care on shower days and as needed, and if unable to perform initially, NAs were to reattempt and/or revisit the task. If unsuccessful, the nurse was to be informed and attempt to complete the task. If still unable to complete the task, the nurse supervisor/DNS/provider were to be informed of the issue. The DNS further indicated a referral to physiatry and/or physical therapy/occupational therapy could have provided additional insight/intervention on how to address the concern.2. Resident #14?s diagnoses included vascular dementia without behavioral disturbances and adult failure to thrive.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #14 had severely impaired cognition (Brief Interview for Mental Status (BIMS) score of 3), required substantial assistance for eating, partial assistance for bed mobility and transfers and supervision assistance for ambulation.The Resident Care Plan (RCP) dated 10/01/25 identified Resident #14 required assistance with functional Activities of Daily Living (ADLs). Interventions included assistance with showering every Monday on the 3:00 PM to 11:00 PM shift.Review of the Point of Care History for December 2025 identified Resident #14 received a shower on 12/5/25 at 3:44 PM and a complete bed bath on 12/7/25 at 11:31 AM but failed to identify Resident #14 received a shower or bed bath at least weekly between 12/8/25 and 12/20/25 or between 12/24/25 and 12/31/25.A Grievance/Concern Form dated 1/6/26 identified on 1/6/26 Resident #14 was noted with feces under his/her nails that required Resident #14's hands to be soaked to a bowl of soapy warm water to remove. It identified staff was educated regarding daily nail/foot care.Review of the Point of Care History for January 2026 identified Resident #14 received a partial bed bath on 1/10/26 at 5:17 AM but failed to identify Resident #14 received a shower or bed bath at least weekly between 1/1/26 and 1/9/26 or between 1/21/26 through 1/27/26.Review of the Point of Care History for March 2026 identified Resident #14 received a partial bed bath on 3/5/26 at 2:07 PM but failed to identify Resident #14 received a shower or bed bath at least weekly between 3/6/26 and 3/13/26.Review of the clinical record from 12/1/25 through 3/15/26 failed to identify Resident #14 refused a shower or bed bath.Interview with the DNS on 3/19/26 at 12:45 PM identified each resident should be provided with either a shower or a complete bed bath at least weekly. She identified the clinical record did not reflect Resident #14 received a shower or bed bath the week leading up to the grievance.The Activities of Daily Living policy identified residents who were unable to carry out activities of daily living independently would receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. The policy further directed, if residents with cognitive impairment or dementia resisted care, staff would attempt to identify the underlying cause of the problem, not assume the resident was refusing or declining care, and that approaching the resident in a different way, at a different time, or having another staff member speak with the resident may be appropriate.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation/policy, and interviews for three (3) of three (3) residents (Residents #2, #14, and #18) reviewed for significant weight loss, the facility failed to ensure adequate nutritional monitoring and intervention to prevent significant weight loss by failing to obtain weights per policy and physician orders, failing to obtain timely re-weights following significant changes, and failing to consistently document and evaluate meal intake to guide care resulting in an inability to identify and respond to nutritional decline and contributed to continued weight loss, and for Resident #14, malnutrition. The findings include:1. Resident #14?s diagnoses included vascular dementia without behavioral disturbances and adult failure to thrive.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #14 had severely impaired cognition (Brief Interview for Mental Status (BIMS) score of 3), required setup assistance for eating and was independent for bed mobility, transfers and ambulation.The Resident Care Plan (RCP) dated 6/10/25 identified Resident #14 was at risk for malnutrition related to a history of adult failure to thrive, altered nutrition related bloodwork, body mass index less than 23 and significant weight changes. Interventions included assessing intakes, bloodwork and weights, monitoring weight for significant changes and encouraging and monitoring meal, snack and medication pass intakes.A weight dated 6/9/25 identified a weight of 119.3 pounds (lbs).Review of physician orders dated 7/1/25 through 3/19/26 failed to identify an order to obtain weights.Review of the clinical record failed to identify weights were obtained from 6/10/25 through 7/10/25.The facility census identified Resident #14 was admitted to the hospital from [DATE] through 8/22/25.A readmission Nutrition assessment dated [DATE] at 9:53 AM identified Resident #14 had poor to fair intake and was consuming fifty (50) % of meals or less upon return from the hospital on 8/22/25. The assessment identified that a weight had not been obtained and an updated weight was requested to further assess current weight trends.A weight dated 9/10/25 (19 days after readmission to the facility) identified a weight of 117.3 lbs.Review of the clinical record identified no additional weights were obtained from 9/11/25 through 9/19/25.The facility census identified Resident #14 was admitted to the hospital from [DATE] through 9/30/25A weight dated 10/9/25 (9- days after readmission to the facility) identified a weight of 114.1 lbs. A weight dated 11/12/25 identified a weight of 108.6 lbs. A Weight Change Nutrition assessment dated [DATE] at 3:46 PM identified Resident #14 had a weight of 108.6 lbs on 11/16/25 and had a significant undesirable/unplanned weight loss of ten (10) % for the prior six (6) months related to decreased by mouth intake and a dementia related decline.The facility census identified Resident #14 was admitted to the hospital from [DATE] through 12/14/25.A weight dated 12/16/25 (2 days after readmission to the facility) identified a weight of 95.9 lbs (weight loss of 12.7 lbs (11.694%) in one month). A Readmission/Weight Change Nutrition assessment dated [DATE] at 4:25 PM identified Resident #14 had a significant undesirable/unplanned weight loss consuming less than twenty-five (25) % to fifty (50) % and met the criteria for severe malnutrition related to inadequate by mouth intake. Recommendations included continuing the current plan of care.A re-weight of 106.6 lbs was obtained on 1/15/26 (30-days after the 12/16/25 weight of 95.9 lbs was obtained) which was an increase of 10.7 lbs (11.157%) in one month.A Monthly Weight Change Nutrition assessment dated [DATE] at 12:42 PM identified Resident #14's 1/15/26 weight was a significant beneficial/desired weight gain over the prior month, suspected a potential outlier for the 12/16/25 weight and gradual improvement in by mouth intake was reported by the staff.A re-weight of 104.4 lbs was obtained on 2/4/26 (20-days after the 1/15/26 weight of 106.6 lbs was obtained).Review of the clinical record from 8/22/25 through 2/3/26 failed to identify that additional weights were obtained or that Resident #14 refused the readmission weights on 8/22/25, 9/30/25 or 12/14/25 or re-weights following the significant loss/gain on 12/16/25 and 1/15/26.Meal percentage documentation from 9/1/25 through 1/31/26 identified that only seventy-four (74) out of four hundred fifty-nine (459) meal percentages (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	were recorded (16%).2. Resident #2?s diagnoses included severe protein calorie malnutrition, adult failure to thrive, type II diabetes mellitus and stage 3 pressure ulcer (full thickness skin loss that extends through the skin into deeper tissue and fat but doesn't reach muscle, tendon or bone).The significant change in status MDS assessment dated [DATE] identified Resident #2 had moderately impaired cognition (Brief Interview for Mental Status (BIMS) score of 9), required partial assistance with eating, substantial assistance with bed mobility and was dependent on staff for transfers. The MDS identified Resident #2 had a weight loss of 5% or more over the last month or a loss of 10% or more over the last six (6) months and was not on a physician-prescribed weight-loss regimen.The Resident Care Plan (RCP) dated 10/01/25 identified Resident #2 was at increased risk for alterations in nutritional status secondary to the potential for weight loss/gain and a history of significant weight loss. Interventions included monitoring weight for significant changes and encouraging and monitoring by mouth intake at meals, snacks and medication pass.Review of physician's orders dated 10/1/25 through 3/19/26 failed to identify an order to obtain weights.Review of the clinical record identified the following weights were obtained: 112.8 pounds (lbs) on 11/10/25, 108.6 lbs on 1/7/26 and 107.1 lbs on 2/6/26 and failed to identify a weight was obtained in December 2025.Review of the clinical record from 11/11/25 through 1/6/26 failed to identify any additional weights were obtained or that Resident #2 refused the December 2025 weight.Meal percentage documentation from 9/1/25 through 1/31/26 identified that only forty-two (42) out of two hundred seventy (270) meal percentages were recorded (15%).3. Resident #18 ?s diagnoses included malignant neoplasm of the gallbladder (rare, aggressive cancer of the gallbladder), acute on chronic right heart failure (when the heart's right ventricle is too weak to pump blood to the lungs leading to fluid overload and significant fatigue) and Acute Immunodeficiency Virus (a virus that attacks the body's immune system making it hard to fight other infections and diseases).A physician's order dated 4/4/25 directed to obtain a weekly weight on Mondays at 6:00 AM.The annual MDS assessment dated [DATE] identified Resident #18 had intact cognition (Brief Interview for Mental Status (BIMS) score of 15), required setup assistance for eating and was independent with bed mobility, transfers and ambulation. The MDS identified Resident #18 had a weight loss of 5% or more in the last month or a loss of 10% or more in the last six (6) months and was not on a physician-prescribed weight-loss regimen.The Resident Care Plan (RCP) dated 10/15/25 identified Resident #18 was at increased risk for alterations in nutritional status secondary to the potential for weight loss/gain. Interventions included monitoring weight for significant changes and encouraging and monitoring by mouth intake at meals, snacks and medication pass.Review of the clinical record identified the following weights were obtained: 219.6 lbs on 10/3/25, 222.8 lbs on 10/7/25, 223.0 lbs on 11/3/25, 231.0 lbs on 12/8/25, 233.1 lbs on 12/29/25, 228.1 lbs on 1/5/26 and 228.1 lbs on 1/6/26.Review of the clinical record failed to identify that weights were obtained or that Resident #18 refused weights from 10/8/25 through 11/2/25, 11/4/25 through 12/7/25, 10/13/25 through 10/27/25, 11/10/25 through 12/1/25, and 12/15/25 through 12/22/25.The facility census identified Resident #18 was admitted to the hospital from [DATE] through 1/10/26.Review of the clinical record from 1/10/26 through 2/3/26 failed to identify that weekly weights were obtained from 1/12/26 through 2/2/26 per physician's order or that Resident #18 refused the weights.A weight of 219.1 was obtained on 2/4/26, 25 days after Resident #18's readmission to the facility.Meal percentage documentation from 10/1/25 through 2/28/26 identified only two hundred sixty-nine (269) out of four hundred fifty-three (453) meals were recorded for Resident #18 (59.38%).Interview with the Registered Dietician (RD) on 3/17/26 at 2:14 PM identified all residents (except those on hospice) should have an order for weights and be weighed at least monthly. She reported that a weight should be obtained within 24 to 48 hours of readmission to the facility and any resident with a weight change of five (5) % or more should be reweighed within (2) days and she should be notified. She identified all weights should be documented in the clinical record. The RD identified that she reviewed readmissions, ordered weights (weekly, monthly, etc.) and re-weights for residents who triggered for significant weight loss. She identified that if weights were not obtained or reweights were required, (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	she would follow up with staff to ensure they were done and further indicated she was inconsistent with the follow up. She identified that when a resident had a significant weight loss, she was unable to review meal documentation over a period of time because it was incomplete, therefore, she was unable to obtain a clear picture of the resident's intake. She identified that despite the incomplete documentation affecting a resident's assessment and plan of care, she had not reported the issue to the DNS or provider. The RD identified that it was best practice to obtain weights more frequently for residents who had a significant weight loss, and she was responsible for making recommendations to the provider but did not recommend more frequent weight monitoring for Resident #14.Interview with the DON on 3/19/26 at 12:45 PM identified Residents #2 and #14 should have had physician's orders to direct the frequency and schedule for obtaining weights, especially for residents with weight loss/gain, and reported she was unaware residents were missing weight orders. She identified nursing staff was responsible for entering weight orders on admission/readmission and if directed by a provider. She identified the RD should closely monitor weights for residents with significant weight loss, ensure orders were in place, ensure weights were obtained and notify nursing of any issues. She identified the RD should make recommendations on how often weights are obtained and collaborate with the provider on preventing weight loss. The DNS reported Residents #2, #14 and #18 should have had weights obtained at least monthly or per physician's orders, as well as on readmission and with any significant change in weight from the previous recorded weight so that interventions could be implemented timely to prevent further weight loss. She identified admission weights, readmission weights and re-weights should be obtained within 24 hours and documented before the end of the shift. Further, she identified meal percentages should be recorded for every resident and if a resident refused a meal, the refusal should be documented and nursing should be notified. The DNS reported she was unaware meal percentages were not being documented consistently and identified the importance of the accuracy, especially for residents at risk of or with actual weight loss/gain.Review of the Weight policy (undated) directed, in part, it is the policy of the facility to weigh each resident on admission, then weekly for four (4) weeks, then monthly thereafter, unless otherwise ordered by the physician or interdisciplinary team. The facility will utilize a consistent procedure for monitoring weights and prevent unnecessary weight loss in the residents. Each resident will be weighed monthly by the tenth (10th) day of the month. New and re-admission residents' weight will be obtained within 24 hours of admission and the assigned NA, under the supervision of the licensed nurse or the Registered Dietician will obtain all resident weights. Any resident displaying a significant change in weight of greater than or equal to 5 percent (%) gain/loss in one month will be reported to the Registered Dietician and reweighed. The Registered Dietician will review the medical record or residents with significant weight changes (5% loss/gain in one month, 7.5% loss/gain in 3 months, 10% loss/gain in 6 months). Dietary interventions will be recommended as needed. All significant weight losses will be reported to the physician. Interventions that are initiated in response to a weight change will be reflected in the care plan. Residents with weight loss/gain will be further reviewed in the interdisciplinary meeting/risk meeting.Although requested, facility policies for significant weight loss and obtaining re-weights were not provided.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for two (2) of three (3) residents (Residents #2 and #14) reviewed for bathing and grooming, the facility failed to ensure the clinical record was complete and accurate to reflect the provision of required hygiene care, including weekly showers and/or bed baths, resulting in an inability to verify care delivery. The findings include:1. Resident #2?s diagnoses included severe protein calorie malnutrition, adult failure to thrive, type II diabetes mellitus and stage 3 pressure ulcer (full thickness skin loss that extends through the skin into deeper tissue and fat but does not reach muscle, tendon or bone). The significant change in status Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had moderately impaired cognition (Brief Interview for Mental Status (BIMS) score of 9), required partial assistance with eating, substantial assistance with bed mobility and was dependent on staff for transfers. The Resident Care Plan (RCP) dated 10/01/25 identified Resident #2 required assistance with functional Activities of Daily Living (ADLs). Interventions included total care for showering and grooming. Review of the Point of Care History for December 2025 identified Resident #2 received a shower on 12/8/25 at 3:51 PM and a partial bed bath on 12/17/25 at 7:30 PM, but failed to identify Resident #2 received a shower or bed bath at least weekly between 12/1/25 and 12/7/25 or between 12/18/25 and 12/31/25. Review of the Point of Care History for January 2026 identified Resident #2 received a partial bed bath on 1/1/26 at 10:51 PM but failed to identify Resident #2 received a shower or bed bath at least weekly between 1/2/26 and 1/11/26 or between 1/25/26 and 1/31/26. Review of the clinical record from 12/1/25 through 1/31/26 failed to identify Resident #2 refused a shower or bed bath. 2. Resident #14?s diagnoses included vascular dementia without behavioral disturbances and adult failure to thrive. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #14 had severely impaired cognition (Brief Interview for Mental Status (BIMS) score of 3), required substantial assistance for eating, partial assistance for bed mobility and transfers and supervision assistance for ambulation. The Resident Care Plan (RCP) dated 10/01/25 identified Resident #14 required assistance with functional Activities of Daily Living (ADLs). Interventions included assistance with showering every Monday on the 3:00 PM to 11:00 PM shift. Review of the Point of Care History for December 2025 identified Resident #14 received a shower on 12/5/25 at 3:44 PM and a complete bed bath on 12/7/25 at 11:31 AM but failed to identify Resident #14 received a shower or bed bath at least weekly between 12/8/25 and 12/20/25 or between 12/24/25 and 12/31/25. A Grievance/Concern Form dated 1/6/26 identified on 1/6/26 Resident #14 was noted with feces under his/her nails that required Resident #14's hands to be soaked to a bowl of soapy warm water to remove. It identified staff was educated regarding daily nail/foot care. Review of the Point of Care History for January 2026 identified Resident #14 received a partial bed bath on 1/10/26 at 5:17 AM but failed to identify Resident #14 received a shower or bed bath at least weekly between 1/1/26 and 1/9/26 or between 1/21/26 through 1/27/26. Review of the Point of Care History for March 2026 identified Resident #14 received a partial bed bath on 3/5/26 at 2:07 PM but failed to identify Resident #14 received a shower or bed bath at least weekly between 3/6/26 and 3/13/26. Review of the clinical record from 12/1/25 through 3/15/26 failed to identify Resident #14 refused a shower or bed bath. Interview with the DON on 3/19/26 at 12:45 PM identified each resident should be provided with either a shower or a complete bed bath at least weekly. She identified care should be documented in the clinical record before the end of the shift. She identified the clinical record did not reflect Resident #14 received a shower or bed bath the week leading up to the grievance. Review of the Bathing and Grooming Care policy dated 1/19/18 directed, in part, rooms are assigned to either a day or evening shift to enable those residents to be provided with at least a weekly shower. Nail care, facial hair care and skin care is provided as a standard of care with bathing (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and grooming. Although requested, facility policies for Nurse Aide documentation or Kardex/Care Card were not available.