STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075366	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hamden Rehabilitation & Healthcare Center	1270 Sherman Ave Hamden, CT 06514

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 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 clinical record review, facility documents and staff interview for 1 of 3 residents (Residents #71) reviewed for abuse, the facility failed to ensure staff documented clinical findings of the resident's condition for 2 shifts during the 72-hour post fall period. The findings include: Resident #7's diagnoses included Alzheimer's disease, cervical vertebrae fracture and history of back pain. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #71 as severely cognitively impairment, required partial to moderate assistance with a walker for transfer and ambulation, noted no falls since admission, had a fall in the last month and fall with a fracture in the last 6 months. The care plan dated 5/08/2025 indicated Resident #71 was at risk for falls due to a history of falls weakness impaired mobility and safety awareness. Interventions included: to ensure resident is positioned in the center of the bed during rounds, encourage not to get up alone, ensure resident is wearing nonskid socks, explain all tasks, encourage use of the call bell and to place commonly used items within reach. A progress note dated 8/2/2025 at 10:49 AM indicated the Registered Nurse supervisor was called to the unit and noted Resident #71 lying on his/her right side on the floor, the resident was able to move all extremities without complaints of pain and no injuries noted. The Advanced Practice Registered Nurse (APRN) was notified, and no new orders were obtained at that time. The progress notes dated 8/02/2025at 12:36 PM written by the charge nurse on duty identified Resident #71had an unwitnessed fall reported to him/her at 8:36 AM. The resident was noted on the floor at the entrance to the bathroom verbally denying pain, once the resident was cleared upon standing. The resident complained of some back pain and received Tylenol as scheduled for back pain with some positive effect and the RN supervisor was updated. Vital signs and neurological checks were initiated after the fall and Resident #71 required constant redirection and reminders not to get up on her/his own. A nursing progress note written by the 7-3 PM supervisor on 8/02/2025 at 3:17 PM identified Resident #71 was noted grimacing from pain of the lower right back and hip area and to the left swollen ankle. The APRN was notified with new orders for portable x-rays and noted family member had been updated. A nursing note dated 8/02/2025 at 5:16 PM indicated the x-rays had been completed at 4:45 PM and Resident #71 had tolerated the procedure well. At 9:36 PM results of the left ankle and the lumbo-sacral spine noted osteoarthritis. A nursing progress notes dated 8/02 2026 at 9:40 PM indicated Resident #71 had no signs of discomfort, bedtime care was completed and vital signs, including neurological signs were within normal limits. The next nursing progress note was entered on 8/03/2025 at 8:29 PM (no 11-7 AM shift or 7-3 PM shift notes on 8/03/2025). A nursing progress note dated 8/04/2025 at 4:09 PM indicated it was day 2 post fall and the resident voiced no signs or symptoms of distress or discomfort and appears to be sleeping. The 8/04/2025 Occupational Therapy progress note dated 11:00 AM indicated Resident #71 had been at physical therapy, had difficulty bearing weight when standing, and complained of left hip pain. The note indicated (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
	075366	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hamden Rehabilitation & Healthcare Center	1270 Sherman Ave Hamden, CT 06514

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the session was stopped and the supervisor was updated. A nursing note dated 8/04/2025 at 1:10 PM written by the nursing supervisor indicated she/he observed the same complaint upon examination and the APRN was notified and an order for a left hip x-ray was obtained. A nursing note written on 8/04/2025 at 7:47 PM indicated the left hip x-ray results were obtained and noted a left hip fracture. A physician's order from the APRN was obtained to send Resident #71 to the hospital for further evaluation and treatment. A later note written at 8:03 PM indicated the resident left for the hospital at 8:00 PM with 2 ambulance attendants. An interview with the Director of Nursing Services on 2/11/2026 from 10:45 AM through 11:06 AM indicated documentation after a fall should occur every shift for 3 days and the clinical record noted missing documentation which she/he would follow up on. On 2/11/2026 at 12:02 PM identified although the DNS was unable to provide the documentation missing from the clinical record on the 2 shifts for 8/03/2025 for 11-7 AM and the 7-3 PM shift s/he was able to provide the shift-to-shift nursing report sheet (not part of the clinical record) and the neurological documentation sheet including vital signs, neurological and comfort status during the 2 shifts. The facility policy labeled Falls Management notes once the resident had been identified stable, neurological signs for an unwitnessed fall where the resident is a poor historian will be documented on the neurological flow sheet for 72 hours. In addition, documentation is required for 72 hours to assess latent injuries.