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

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility policy review and interview for 1 of 3 residents (Resident #16) reviewed for Advanced Directives, the facility failed to ensure the physician's orders accurately reflected the resident/responsible party's documented wishes. The findings include: Resident # 16's diagnosis included heart failure and chronic obstructive pulmonary disease (COPD). The admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #16 had severe cognitive impairment. A physician's order dated [DATE] directed Full Code status (provide Cardiopulmonary Resuscitation). The care plan dated [DATE] indicated the Advanced Directive code status was Full Code or (Do Not Resuscitate (DNR) and to provide Cardiopulmonary Resuscitation (CPR) or not, based on the responsible party wishes. Resident #16's Advanced Directive Communication Form indicated on [DATE] a conference with the Conservator of Person (COP) indicated not wanting Cardiopulmonary Resuscitation or Do Not Intubation (DNI), and the physician signed the form on [DATE]. A physician's order dated [DATE] directed Do Not Resuscitate (DNR). On [DATE] at 10:29 AM, an interview and clinical record review with the nursing supervisor, Registered Nurse (RN #3) identified the physician's order for Advanced Directives dated [DATE] indicated Do Not Resuscitate (DNR), Resident #16's signed Advanced Directive paperwork which indicated DNR, DNI. RN #3 indicated the paperwork was not transcribed correctly for writing the physician's order and she/he would correct the order immediately. The facility policy labeled Advanced Directives indicated the resident/responsible party's advanced directive wishes will be incorporated into treatment care and services. Once the advanced directive form is completed by the resident or responsible party the physician will sign the form and a physician's order will be obtained.

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observations and staff interviews for 1 of 2 residents (Resident #154) reviewed for environment, the facility failed to ensure housekeeping staff reported a soiled privacy curtain for cleaning and replacement. The findings include: An observation on 2/05/2026 at 11:01 AM identified Resident #154's bedside curtain opened fully between the two beds in the room. At the level of the tray table behind the curtain on Resident #154's side an approximate 2-3 feet long and 1-foot-high soiled area noted at the middle of the privacy curtain.An observation on 2/11/2026 at 10:14 AM identified Housekeeper #1 working in Resident #154's room with the door to the room open and the privacy curtain between the beds was still noted to have a soiled area noted on 2/05/2026 at 11:01 AM (6 days ago).Once Housekeeper #1 exited Resident # 154's room on 2/11/2026 at 10:18 AM an interview was attempted. However, she/he indicated the need to contact the housekeeping supervisor and in Spanish asked Houskeeper #2 to do so.An interview and observation on 2/11/2026 at 10:22 AM with the Housekeeping Supervisor indicated privacy curtains are to be removed, replaced with a clean curtain, and the soiled curtains sent to be laundered on a schedule for complete room cleaning called room of the day and daily any soiled curtains are added to a list by the housekeeper on duty, given to the housekeeping supervisor who would have the privacy curtain removed and replaced. The Housekeeping Supervisor provided a handwritten list given to him/her 2 days prior by Housekeeper #1 which indicated resident rooms with privacy curtains needing replacement due to soiled area. Several rooms noted privacy curtains with soiled areas were on the list except Resident #154's. The Housekeeping Supervisor indicated all the privacy curtains on the list and Resident #154's would be changed immediately, and housekeeping staff would be re-educated on the process.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, review of facility policies and staff interviews for 1 of 4 residents (Resident #103), the facility failed to consistently conduct completed weekly pressure wound assessments that included wound measurements within accordance with facility practice. The findings included: Resident #103 ?s diagnoses included End-Stage Renal Disease (ESRD), pressure ulcer of the sacral region, gastroparesis, nausea with vomiting, metabolic encephalopathy, type 2 diabetes mellitus with diabetic neuropathy, Peripheral Vascular Disease (PVD), and chronic systolic Congestive Heart Failure (CHF).A Resident Care Plan (RCP) dated 6/11/24 identified Resident #103 was at risk for skin breakdown related to inability to respond to pressure-related discomfort, impaired mobility, bowel and bladder incontinence, and the presence of a wound. Interventions included encouraging frequent repositioning, assisting with repositioning every 2 hours, and using pressure-relieving devices.A quarterly MDS assessment dated [DATE] identified Resident #103 had a Stage 3 pressure ulcer and remained at risk for further skin breakdown, noted pressure-relieving devices and nutritional interventions were in place.A nursing progress note dated 12/14/24 documented Resident #103 returned from a hospital admission with redness noted on her/his coccyx. A subsequent nursing progress note dated 12/16/24 documented the resident returned to the hospital from a specialized treatment due to hypotension and lethargy.The RCP dated 12/19/24 directed weekly wound measurements to the coccyx and treatment as ordered.A nursing progress note dated 12/19/24 documented Resident #103 returned from hospitalization with an open sacral wound measuring 1.5 Centimeter (CM) x 0.5 CM x 0.5 CM.A quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #103 was severely cognitively impaired; required set-up assistance with eating and oral hygiene; required substantial to maximum assistance with toileting, showering, and dressing; and required partial to moderate assistance with transfers. The MDS further identified the resident was receiving specialized treatment, was at risk for pressure ulcers, and had one unstageable pressure ulcer and noted pressure-relieving devices and treatment interventions in place.The clinical record identified that although nursing staff documented wound treatments frequently, staff failed to complete weekly wound measurements as ordered for 1 of 2 expected weeks in December 2024.A review of the clinical record from January 2025 through November 2025 identified documentation of wound treatment. However, the clinical identified staff failed to document weekly wound measurements as required for the following: 3 of 5 weeks in January 2025, 4 of 4 weeks in February 2025; 4 of 4 weeks in March 2025, 3 of 5 weeks in April 2025, 3 of 4 weeks in May 2025, 2 of 4 weeks in June 2025, 4 of 5 weeks in July 2025, 3 of 4 weeks in August 2025, 3 of 4 weeks in September 2025, 5 of 5 weeks in October 2025 and 2 of 4 weeks in November of 2025.Further review of the clinical record from December 2025 through February 13, 2026, identified staff failed to document weekly wound measurements for: 4 of 4 weeks in December 2025, 5 of 5 weeks in January 2025 and 1 of 2 weeks to date in February 2026.On 2/11/26 at 9:57 AM, the Director of Nursing Services (DNS) identified she/he expects staff to measure resident wounds weekly. The DNS reported that Resident #103 was frequently absent from the facility on Fridays during scheduled wound rounds for her/his specialized treatment appointment. The DNS identified that a registered nurse should complete wound measurements when the resident is absent during wound rounds and indicated she could not identify a reason why the measurements were not completed. The DNS identified licensed nurses have been trained to complete wound measurements.On 2/11/26 at 12:35 PM Licensed Practical Nurse (LPN #3) (wound care nurse) identified wound measurements are expected to be completed weekly during Friday wound rounds. LPN #3 further indicated any licensed nurse performing a dressing change could and should complete wound measurements if they are not completed during wound rounds. LPN #3 further indicated staff received training in completing wound measurements.Review of facility policy, Prevention & (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Management of Pressure Injuries, directed that pressure injuries are assessed and documented at least weekly and with any significant change until resolved. The policy directed documentation of wound measurements in centimeters (length, width, depth, undermining, and tunneling) and required a weekly RN assessment for all wounds in accordance with policy.The facility failed to ensure that Resident #103 received weekly wound assessments and measurements in accordance with facility practice and policy.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation of the environment and staff interviews, the facility failed to ensure an electric wheelchair was not obstructing an exit and failed to ensure staff used the appropriate location for charging the electric wheelchair battery per facility practice. The findings include: On 2/05/2026 at 10:35 AM observation identified the facility fire alarm sounding and an electric wheelchair noted parked at the open lounge area at the end of the resident unit hall next to a coffee table. The wheelchair was noted obstructing the facility emergency exit. The electric wheelchair was also noted to be plugged into the wall outlet in the common lounge area, recharging. Further observations identified no attempts by staff to remove the chair were made during the fire alarm. Once the fire alarm ended and it was safe to resume usual duties. An interview with LPN #2 at 10:40 AM indicated the chair belonged to a resident on the unit and must have been placed there by the prior shift. The Maintenance Director arrived at the common lounge area on the unit at 10:42 AM and after surveyor inquiry indicated the electric wheelchair was not allowing egress (a path for exit out of the building). The Maintenance Director further indicated the location and policy procedure for charging electric wheelchairs would have to be taken up by the nursing department, but s/he would have the wheelchair moved immediately. An interview with the Director of Nursing Services (DNS) on 2/10/2026 at 10:10 AM indicated a fire safety policy regarding the exit doors existed but even though a separate room exist for charging electric wheelchairs there was no policy 02/05/2026 10:35 AM fire drill electric w/c obstructing exit and plugged into a common area no residents at this time. pictures taken

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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 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 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review observation, review of policy and interviews for 1 of 3 residents (Resident# 6) reviewed for pressure, the facility failed to ensure staff completed hand hygiene between donning and doffing gloves and failed to ensure staff utilized a cleansing solution (normal saline) that had not expired. The findings include: Resident #6 diagnosis included pressure ulcers and dementia. The care plan dated [DATE] indicated Resident #6 was at risk for alteration in skin integrity due to decreased mobility and had a history of pressure ulcers. Interventions included providing treatments as ordered. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #6 was severely cognitive impairment and at risk for pressure ulcer noted with one unstageable pressure ulcer. On [DATE] from 11:50 AM through 12:20 PM an observation of a dressing change to Resident #6's right outer foot and interview with LPN #1 identified LPN #1collecting the items required to complete the dressing change prior to start of the observation. The bedside table was cleansed with an antibacterial wipe, clean paper towels were placed on the table with a small bottle of clear liquid, clean 4x4 dressings and a kerlix wrap. LPN #1 had a black marker and was noted writing on a small paper/tape and removed the top of the small bottle of clear liquid. LPN #1 applied a pair of non-sterile gloves. A nurse aide was in attendance to assist with turning and positioning Resident #6, once positioned, LPN #6 removed the dressing from Resident #6's right foot and placed it in the trash then removed the pair of gloves and donned a clean pair without the benefit of hand hygiene while reaching for a 4x4 dressing. Surveyor intervened and reminded LPN #1 of hand hygiene needed to be performed after removing (doffing) gloves. LPN #1 removed the gloves washed his/her hands and applied a clean pair of gloves and a 4x4 dressing and placed it on top of the solution bottle with one hand and with the other turned the bottle over slightly to pour liquid onto the dressing, cleansed the closed scabbed area of the outer right foot with the solution on the 4x4 then applied a kerlix wrap dressing. Resident #6 was repositioned by the nurse aide at the conclusion of the dressing change. LPN #1 then removed all the dressing items and paper towels and placed them in the trash except the small bottle of clear liquid which appeared at a distance to be over 3/4 full. LPN #1 removed the gloves and conducted hand hygiene the small bottle was brought to the cart outside the room. When asked to see the bottle it was noted to be a bottle of normal saline and to have a handwritten date in black marker on the cap indicating [DATE] (opened 13 days ago) and a manufactures' date of expiration stamped on the cap. LPN #1 indicated the marker date was when the bottle was opened and indicated the open bottle would be good to use until the manufacturers expiration date (2027). LPN#1 further indicated she/he was not sure if there was a facility policy related to how long an open bottle of normal saline could be used. On [DATE] at 12:50 PM an interview with the Infection Preventionist/wound nurse LPN #3 indicated hand hygiene should be completed before and after applying and removing gloves. LPN #3 indicated the saline bottles were good for 24 hours, but she/he would look to see if the manufacturer had a recommendation. LPN #3 indicated about a month ago the facility was no longer able to purchase normal saline in a spray bottle which had a longer shelf life and the small bottles of normal saline were purchased for use. LPN #3 was unaware of any training of staff regarding the transition from one form of saline to use of the new saline product. An interview and observation with Director of Nursing Services on [DATE] from 1:10 PM- 1:24 PM indicated the bottle of normal saline used during the earlier dressing change was discarded and the right foot dressing change was completed again under observation for proper hand hygiene and dressing change practice. The DNS indicated a new bottle of saline was used then discarded and pointed out on the bottle label in small writing with a notation for 1 time use. The DNS indicated no training had been provided regarding the use of a new product for wound care.