

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075397	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/02/2024
NAME OF PROVIDER OR SUPPLIER New Haven Center for Nursing & Rehabilitation LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 181 Clifton Street New Haven, CT 06513	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation, and interviews, for one (1) of three (3) residents reviewed for abuse, (Resident #2), the facility failed to ensure that the resident was free from verbal abuse form a staff member.</p> <p>Resident #2 had a diagnosis of type 2 diabetes and a major depressive disorder. A quarterly Minimum Data Set, dated [DATE] identified that the resident had a Brief Interview for Mental Status (BIMS) of thirteen (13) indicative of intact cognition, was supervision with Acitivities of Daily Living (ADLs), and had no behaviors.</p> <p>A care plan dated [DATE] identified that the resident has a diagnosis of depression with interventions that directed to administer antidepressants as ordered and to monitor the residents mood for changes.</p> <p>Review of a reportable event form dated [DATE] identified the resident reported a staff member was verbally rude towards h/her, quoting the staff member as calling h/her ugly and that h/her significant other died just to get away from h/her.</p> <p>Interview with Registered Nurse (RN) #1 on [DATE] at 2:40 PM identified that on [DATE] Resident #2 came to his office and stated that NA #1 had told h/her that h/she was ugly and that h/her significant other died to get away from h/her. He identified that the roommate was a witness and gave the same statement.</p> <p>Interview with Resident #2 on [DATE] at 10:51 AM identified that NA#1 called h/her ugly, and stated, that is why your significant other died, to get away from you.</p> <p>Interview with Resident #3 (Resident #2's roommate at the time of the incident) on [DATE] at 11:20 AM identified that she overheard NA#1 call Resident #2 ugly and told her that her significant other died to get away from h/her.</p> <p>Interview with NA #1 on [DATE] at 2:00 PM identified that although she did care for Resident #2 on [DATE], she did not call the resident ugly or say anything about the resident's significant others death.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with the Administrator on [DATE] at 2:30 PM identified that the allegation of verbal abuse was substantiated because the resident and the resident's roommate's recollection of the incident were the same and did not deviate. NA #1 was terminated for verbal bause.</p> <p>Review of the abuse policy identified that the resident has the right to be free from abuse.</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, facility documentation, facility policy and interviews for one (1) of three (3) residents (Resident #1) reviewed for elopement, the facility failed to ensure that a resident who requires assistance and an assistive device with ambulation did not exit the facility without staff knowledge, resulting in the resident being found walking on the side of a roadway in the dark, nine (9) miles from the facility after he/she sustained a fall. These failures resulted in a finding of Immediate Jeopardy. The findings include:</p> <p>Resident #1's diagnoses included opiate dependence, acute infective endocarditis (an infection and inflammation of the inner lining of the heart valves and chambers), bacteremia (bacteria in the bloodstream), osteomyelitis (infection in the bone), and neuropathy (weakness, numbness and pain from nerve damage).</p> <p>The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Mental Interview for Mental Status (BIMS) of four (4) indicative of severely impaired cognition and required supervision assistance for transfers and ambulation. Additionally, the MDS identified that the resident had a history of falls and had Intravenous (IV) access and was receiving IV medications in the facility.</p> <p>Review of the admission Elopement Risk assessment dated [DATE] identified that Resident #1 was not at risk for elopement.</p> <p>The clinical record failed to identify Resident #1 had a Leave of Absence order (LOA).</p> <p>Review of the facility Reportable Event (RE) dated 10/16/24 identified that at 3:30 PM, it was reported that Resident #1, who was alert and oriented with forgetfulness and ambulated with a rolling walker, was seen outside walking down the street towards the bus stop. Staff then got in their cars and searched down the road where it had been reported that Resident #1 was observed walking. The RE reported that the resident was unable to be located so the facility then initiated their elopement protocol and notified the police. The resident was later found and sent to the hospital.</p> <p>Review of an Investigative police report dated 10/16/24 identified that the police department was called at 4:27 PM (54 minutes after the resident was noted to be missing by the facility and dispatched after a cognitively challenged resident was reported to be missing. The resident had last been seen at 3:13 PM after stating h/she was going to get a deck of cards.</p> <p>Review of Emergency Department (ED) note dated 10/16/24 identified that per Emergency Medical Services (EMS) Resident #1 reportedly walked between towns for four (4) hours. The resident was not dressed for the weather and was noted to be shivering. The resident reported he/she sustained a fall, striking his/her head at some point during the walk and was noted to have abrasions to his/her nose and tenderness along the nasal bone. The resident clearly confused, reported the year to be 1972. The resident was admitted to the hospital with a diagnosis of altered mental status.</p> <p>A nurse's note dated 10/22/24 at 1:28 PM identified that Resident #1 was readmitted to the facility at 12:00 PM.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Interview and review of surveillance footage with the Administrator on 11/26/24 at 11:14 AM identified that NA #1 left the facility through the main entrance. Two (2) people can be seen congregating at the front desk with the Receptionist and the Administrator is standing sideways in the center of the main entrance. Resident #1 is then seen walking directly behind the Administrator and exiting the main entrance.</p> <p>Interview with NA #1 on 11/25/24 at 11:54 AM identified that she always looks behind her when exiting the facility, and she never saw the resident exit the facility on 10/16/24.</p> <p>Interview with Resident #5 on 11/25/24 at 12:35 PM identified that he/she was setting up for the card activity on 10/16/24 when he/she noticed that one card was missing. Resident #5 reported that Resident #1 stated that he/she had a deck of cards and would go get them at his/her house and would be back in ten (10) minutes, identifying that he/she assumed that Resident #1 was referring to his/her room at the facility. Resident #5 identified that a few minutes later he/she saw Resident #1 outside through the window, walking down the hill. Resident #5 identified that he/she reported the sighting to the Recreation Assistant, who reported that she didn't think the resident was supposed to be outside and she left the room.</p> <p>Interview with the Recreation Assistant (RA) on 11/25/24 at 12:27 PM identified that she arrived at the second-floor dining room a little after 3:00 PM and Resident #5 reported to her that Resident #1 was outside on the front lawn. She reported that she then went to talk with the Receptionist at the front entrance and ask if Resident #1 had a LOA form. The Receptionist reported that Resident #1 did not have an LOA, so she (RA) went back upstairs to notify the Recreation Director that Resident #5 reported that Resident #1 was outside. Then her and the Recreation Director searched Resident #1's room and the third floor, they could not locate Resident #1 so they notified the Administrator. The RA identified that from the time it was reported that Resident #1 was outside to when the Administrator was notified was close to five (5) minutes, but stated she did not check the clock, and it was no longer than ten (10) minutes.</p> <p>Interview with the Recreation Director on 11/26/24 at 10:18 AM identified that when the Recreation Assistant reported to her that Resident #5 identified Resident #1 was outside, she immediately searched the resident's room and then notified the Nursing Supervisor (RN #2) that the resident could not be located and then went downstairs and notified the Administrator in person. She identified that within five (5) minutes of her notifying the Administrator, a code purple (missing resident) was called staff were outside searching for Resident #1.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Interview with the Administrator on 11/26/24 at 9:59 AM identified that when viewing the camera surveillance from 10/16/24, NA #1 exited the front door and approximately thirty (30) seconds -while he (the Administrator) was near the front desk, Resident #1 was able to walk right behind him and out the door without the Receptionist or himself noticing. He identified that the front door had closed behind NA #1, at the time of the incident the locking mechanism would take 90 seconds to engage the lock of the door once the door was opened, so Resident #1 was able to exit the door before the lock was re-engaged. The Administrator identified that the Director of Recreation came to his office to notify him that she could not locate Resident #1 and had been seen outside He reported that he believed there was a ten (10) minute delay from when the Recreation Assistant was notified that Resident #1 was outside to when he was notified at around 3:30 PM, a code purple was called and the search for Resident #1 began. He identified that he expects the Receptionist to be able to monitor the front exit and multi-task with other tasks such as answering the phone. The Administrator further identified that the Assistant Director of Nursing Services called the police to report Resident #1 missing once he returned to the facility after searching on foot for Resident #1. He reported that ideally the police should have been contacted immediately, stating he was focused on finding the resident and that it did take too long to contact them.</p> <p>Interview with MD #1 (Medical Director) on 11/27/24 at 9:44 AM identified that it was his expectation that the facility notify the police immediately when it's identified that a resident is missing.</p> <p>Review of the Elopement policy dated 11/13/17 directed, in part, that upon admission all residents will be assessed by a registered nurse using the Elopement Observation on readmission, quarterly, annually and for any significant change in status and it will then be reviewed and care planned for by the interdisciplinary team. Should staff find that they cannot locate the resident, a Code Purple will be announced, and staff will immediately follow procedures for Code Purple.</p> <p>Review of the Code Purple procedure (undated) directed, in part, that for all missing residents a staff will page three times Code Purple identifying the unit and the resident's name. Staff will immediately search the interior of the facility including all shower rooms, bathrooms and staff areas. Staff members will be stationed at all exit doors to monitor for the resident while other staff members search the exterior of the facility. The police department will be contacted with the resident's information and facility staff members will be dispatched to begin a search of the community.</p> <p>Review of the Leave of Absence policy dated 9/16/18 directed, in part, that upon admission, residents that are mentally and physically capable may be given a physician's order for a therapeutic LOA if they are able to understand and follow all procedures involved with the LOA protocols. Any resident with intravenous (IV) access is not eligible for an LOA. Residents wishing to leave the building must notify their Charge Nurse and complete the form entitled, Release of Responsibility for Leave of Absence and complete the sign out log on their unit and at the security desk.</p>		