STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075397	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Haven Center for Nursing & Rehabilitation LLC	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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, interviews, and review of facility documents and policies for one of three residents (Resident #1) reviewed for accidents, the facility failed to ensure staff notified the physician/medical director and facility administration timely when a resident failed to return to the facility as scheduled following a leave of absence, and for one of three residents reviewed for accidents, the facility failed to notify the provider that the resident's evening medications were missed. The findings included:Resident #1 had diagnoses that included cerebral infarction, chronic obstructive pulmonary disease, and adjustment disorder. Record review identified Person #1 was noted as Resident #1's responsible party. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #11 had a Brief Mental Interview for Mental Status (BIMS) score of eleven (11), indicating the resident had moderate cognitive impairment, required set-up assistance with personal hygiene and supervision with transfers and ambulation. Physician order dated 8/13/2025 directed Leave of Absence (LOA) with rollator (walker). The Resident Care Plan (RCP) dated 8/28/2025 identified Resident #1 was at risk for pain and had a potential for altered thought processes and difficulty adjusting to situations. Interventions directed to administer medications as ordered, and evaluation of the effectiveness of current psychotropic medications. Review of a Leave of Absence Notification form dated 9/8/2025 identified Resident #1 left on a LOA at 10:30 AM and planned to return at 6:00 PM the same day. a. Review of the nursing note dated 9/8/2025 at 8:56 PM identified Resident #1 was still out on LOA. The note further indicated Resident #1 was responsible for him/herself, and that the supervisor was aware. Nursing note dated 9/9/2025 at 12:00 AM identified a call was placed to Resident #1's responsible party/Person #1, to inquire about the resident's whereabouts, and reached a recording that indicated Person #1's phone was out of service. Nursing note dated 9/9/2025 at 3:50 AM identified Resident #1 was returned to the facility (nine (9) hours and fifty (50) minutes after his/her expected time of return) by a Good Samaritan and was alert and verbal. Resident #1 was informed he/she would need to go to the hospital to be assessed, and Resident #1 agreed and stated he/she had back and knee pain as well. Interview with the Director of Nursing Services (DNS) on 9/9/2025 at 10:18 AM identified Resident #1 signed out of the facility at 10:30 AM on 9/8/2025 with the understanding that he/she was to return to the facility by 6:00 PM that evening. The DNS stated staff had called Resident #1's responsible party and two (2) local hospitals in an attempt to verify Resident #1's whereabouts. The DNS stated she was not notified by staff that Resident #1 did not return to the facility as scheduled; when she arrived to work on 9/9/2025 she was notified Resident #1 did not return to the facility as scheduled and had returned at 3:50 AM (9 hours and 50 minutes late). The DNS stated she and the Administrator should have been notified, and the local police and the resident's physician should have been notified that Resident #1 was missing, and staff did not know where he/she was. Interview failed to identify why notifications were not completed. Interview with Physician #1 on 9/17/2025 at 1:28 PM identified he would want to be notified if Resident #1 did not return timely from a LOA and that either he, the on-call physician, or Nurse Practitioner should be notified when a resident does not return timely from a leave of absence. Review of the Leave of Absence policy dated 2/3/2025 directed in part, if a resident does not return to the facility within one (1) hour of the expected return time, the registered nurse supervisor would notify the Director of Nursing Services/Assistant Director of Nursing Services, the Nurse Practitioner/Medical Director, responsible party, and the Administrator. b. Review of the Medication Administration Report (MAR) dated 9/8/2025 identified Resident #1 did not receive scheduled Furosemide (diuretic used to treat swelling) 40 milligrams at 9:00 PM, Gabapentin (used to treat pain) 800 milligrams at 9:00 PM, Quetiapine (Seroquel, antipsychotic used to treat mood) 50 milligrams at 7:00 PM, and Eliquis (anticoagulant/blood thinner) 5 milligrams, at 9:00 PM. Interview with LPN #1 on 9/15/2025 at 1:09 PM identified he/she failed to contact Resident #1's physician or APRN to notify them that Resident #1 missed scheduled medication. LPN #1 stated she did notify the charge nurse that the resident had missed his/her evening medications as he/she did not return from his/her LOA when scheduled to return. Interview with MD #1 on 9/10/2025 at 1:07 PM identified that although the facility provided him with resident updates during morning report, MD #1 stated he expected staff to notify him within one (1) to two (2) hours after a resident's medications were missed. MD #1 stated he, the on-call physician, or the Nurse Practitioner should be notified when a resident does not return timely from a leave of absence so that decisions could be made regarding any missed medications. Review of the Medication Administration policy directed staff to notify the provider, supervisor, Director of

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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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, interviews, and review of facility documents and policies for one (1) of three (3) residents (Resident #1) reviewed for discharge, the facility failed to provide and document sufficient preparation and orientation to the resident to ensure a safe and orderly transfer or discharge from the facility after a thirty-day discharge notice was given. The findings included: Resident #1 had diagnoses that included cerebral infarction, chronic obstructive pulmonary disease, and adjustment disorder. Record review identified Person #1 was noted as Resident #1's responsible party. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #11 had a Brief Mental Interview for Mental Status (BIMS) score of eleven (11), indicating the resident had moderate cognitive impairment, required set-up assistance with personal hygiene and supervision with transfers and ambulation. The Resident Care Plan (RCP) dated [DATE] identified Resident #1 was a short term stay admission. Interventions directed the Social Worker will utilize community resources to ensure a safe discharge, will prepare Resident #1 for discharge, the interdisciplinary care plan team will work together to discharge Resident #1 at the appropriate time, the Social Worker will, at the resident request, contact other facilities for a more appropriate placement, and will involve Resident #1 in the discharge planning Review of Resident #1's 30-Day Notice of discharge date d [DATE] identified a discharge was scheduled for [DATE] to a sister facility due to the resident being a danger to him/herself and others in the nursing facility. Review of Social Worker's note dated [DATE] at 10:48 AM identified Resident #1 was issued a thirty (30) day discharge notice (30-day notice) due to issues in complying with facility policies and that Resident #1 had refused to transfer to a sister facility. Review of the Social Worker's note dated [DATE] at 12:35 PM identified the resident was in agreement with the transfer. Interview with the Social Worker on [DATE] at 9:15 AM identified Resident #1 was given a 30-day discharge notice on [DATE] due to non-compliance with the facility smoking policy; Resident #1 would smoke in front of the building in the parking lot while awaiting transportation. The Social Worker stated the facility made a referral for transfer to a sister facility, but stated they were notified the resident's insurance would not pay for the stay at the alternate facility, and she was now unsure if the resident would be transferred. The Social Worker stated she had not done any additional planning for the discharge and was unsure where Resident #1 would go when the thirty (30) day notice expired on [DATE]. The Social Worker stated she had not talked with Resident #1 about his/her plans. Interview with the Director of Nursing Services (DNS) on [DATE] at 9:24 AM identified she was aware the 30-day discharge notice was given but was unsure as to the reason why. The DNS further stated residents with planned discharges and 30-day notice discharges were discussed during daily morning meeting and referred to a white board located in the conference room, however Resident #1's name was not included on the board. The DNS stated she was not aware if Resident #1 was appealing the discharge, and she was not aware if the Ombudsman was informed of the 30-day discharge notice. Interview with the Administrator on [DATE] at 9:24 AM identified he was new in the facility and was not aware a 30-day discharge notice was given. The Administrator stated he was not aware that Resident #1 was being transferred due to non-compliance with the smoking policy. Interview with the MDS Coordinator on [DATE] at 10:01AM identified Resident #1 would need to be removed from his HMO insurance plan for the sister facility to accept his/her transfer. The MDS Coordinator stated she had escalated the issue for coverage at another facility with the insurance company and had not received any updates regarding coverage. The MDS Coordinator stated she did not follow-up further regarding the insurance. Interview on [DATE] at 10:10 AM with the MDS Coordinator, Social Worker, and the Admissions Coordinator at the sister facility that Resident #1 was referred to for potential admission identified the Admissions Coordinator had not received a referral for a potential admission to the facility. The Social Worker the stated technically, a referral was not sent to the sister facility/. The Social Worker stated she had sent the other facility a notice because although Resident #1's insurance covered this facility it would not cover the new facility. The Social Worker then stated Resident #1 was covered by Medicaid insurance, and coverage should not be a problem. The Social Worker further stated she had not made any plans for a safe discharge (19 days after the notice was given) when the 30-day notice was due to expire on [DATE]. Interview with Resident #1 on [DATE] at 12:41 PM identified Resident #1 believed the facility was transferring him/her to another facility on [DATE]. Resident #1 stated the facility had not provided him/her with any additional details after he/she received the 30-day discharge notice on [DATE] (19 days prior)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, interviews, and review of facility documents and policies for one of three residents (Resident #1) reviewed for accidents, the facility failed obtain a hospital discharge summary timely after a resident's readmission, and for one sampled resident (Resident #1) reviewed for leave of absence, the facility failed to ensure staff acted timely when a resident did not return as expected from a Leave of Absence, and failed to ensure staff were provided with a current facility policy that directed steps to follow when a resident did not return timely from a leave of absence. The findings include: Resident #1 had diagnoses that included cerebral infarction, chronic obstructive pulmonary disease, and adjustment disorder. Record review identified Person #1 was noted as Resident #1's responsible party. Hospital Discharge summary dated [DATE] identified Resident #1 reported use of Marijuana. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Mental Interview for Mental Status (BIMS) score of eleven (11), indicating the resident had moderate cognitive impairment, and required set-up assistance with personal hygiene and supervision with transfers and ambulation. Physician order dated 8/13/2025 directed Leave of Absence (LOA) with rollator (walker). The Resident Care Plan (RCP) dated 8/28/2025 identified Resident #1 was at risk for pain and had a potential for altered thought processes and difficulty adjusting to situations. Interventions directed to administer medications as ordered, and evaluation of the effectiveness of current psychotropic medications. 1. Review of the facility Reportable Event form dated 9/1/2025 at 8:00 AM identified Resident #1 had fallen earlier during the night, hit his/her head, and reported a 9/10 level of pain to his/her head, neck, and elbow. Resident #1 was transferred to the hospital for further evaluation. Review of RN #1's nursing note dated 9/1/2025 at 4:01 PM identified Resident #1 had returned from the hospital at 3:50 PM without paperwork and he/she was in stable condition. Record review failed to identify the hospital discharge paperwork was obtained after Resident #1's readmission to the facility on 9/1/2025 (14 days prior to record review). Interview with RN #2 on 9/9/2025 at 2:11 PM identified she was the nursing supervisor on 9/1/2025 during the 7 AM to 3 PM shift, when Resident #1 returned from the hospital. RN #2 stated she was aware that Resident #1 had returned from the hospital without hospital discharge paperwork and stated it was the responsibility of the 3 PM to 11 PM shift to follow up and obtain the missing hospital discharge summary. Interview and record review with the Director of Nursing Services (DNS) on 9/9/2025 at 1:07 PM identified the facility identified Resident #1 was sent to the hospital on the morning of 9/1/2025 after a fall with reported pain to his/her head, neck, and elbow, and he/she returned on the same day. Resident #1 returned without any hospital discharge paperwork to indicate what occurred at the hospital or if there were any new diagnoses or new treatments required. The DNS was unable to provide documentation that the facility obtained the discharge summary paperwork from the hospital and stated the facility policy was to review the hospital discharge summary upon readmission to the facility. The DNS stated it was the responsibility of the nursing supervisor to request the discharge summary if it was not sent with the resident. RN #1 was the supervisor who readmitted Resident #1 on 9/1/2025 and she should have requested the information from the hospital. The DNS stated the facility did not have Resident #1's discharge summary from his/her 9/1/2025 hospital visit, so it was not reviewed after Resident #1 was readmitted and she did not know why. Interview and record review with RN #1 on 9/9/2025 at 9:32 AM identified she was the supervisor when Resident #1 was readmitted from the hospital without the discharge summary. RN #1 stated she did not call the hospital to request Resident #1's discharge summary. RN #1 further indicated facility policy was to call the hospital and request the discharge paperwork if not returned with the resident. Interview failed to identify why RN #1 did not obtain the hospital discharge summary. Review of the facility Accident and Incident Policy dated 7/1/2025 directed in part, all hospital discharge paperwork must be reviewed within twenty-four (24) hours of the patient's return to the facility. 2. Review of a Leave of Absence Notification form dated 9/8/2025 identified Resident #1 left the faciity on an LOA at 10:30 AM and indicated on the form that he/she planned to return at 6:00 PM the same day. Review of the nursing note dated 9/8/2025 at 8:56 PM (2 hours and 56 minutes after the expected return time) identified Resident #1 was still out on LOA. The note further indicated Resident #1 was responsible for him/herself, and that the supervisor was aware. Nursing note dated 9/9/2025 at 12:00 AM identified a call was placed to Resident #1's emergency contact/Person #1, to inquire about the resident's whereabouts, and reached a recording that indicated Person #1's phone was out of service. Nursing note dated 9/9/2025 at 3:50 AM identified Resident #1 was returned to the facility