Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 02/18/2026
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)
F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, review of facility documentation, and interviews for one (1) of three (3) sampled residents (Resident #1) who were admitted for short term rehabilitation, the facility failed to implement and document an ongoing discharge plan for a resident to ensure a safe and effective transition back into the community. The findings include:Resident #1's diagnoses included bacteremia, intraspinal abscess and granuloma, and anxiety disorder. The admission history and physical summary dated 11/24/25 identified Resident #1 had unstable housing, was admitted to the long-term care facility for short term rehabilitation following hospital discharge on [DATE]. The social service admission note dated 11/28/25 at 11:23 AM identified Resident #1 was seen for admission to the facility. The note indicted prior to hospitalization in November 2025 Resident #1 was living at a friend's house, discharge plans were discussed and Resident #1 reported he/she would go back to the friend's house if no other housing options were available. The note identified a referral would be made to Money Follows the Person for housing reports and social service would provide support. The admission Minimum Data Set assessment dated [DATE] identified Resident #1 had no memory recall deficits, was alert and oriented to person, place, and time and the overall goal established was for discharge back into the community. The Resident Care Plan dated 12/15/25 identified Resident #1 was admitted for short-term rehabilitation and would be safely discharged back into the community. Interventions included the social worker will utilize community resources to ensure a safe discharge, the social worker will prepare the resident and family for discharge back into the community, the interdisciplinary care plan team will work together to discharge resident at the appropriate time, the social worker and resident's insurance company will work together to provide resident with all of the equipment and services that will be needed, and the social worker will involve the resident and family in the discharge planning process. The Level of Care Screen completed by Maximus dated 12/22/26 identified Resident #1's level of care was reviewed on 12/21/26, the approved length of stay was sixty (60) days effective 12/23/25, and the end date was 2/21/26. The rationale identified based on the submitted information received, short term care was appropriate for sixty (60) days and the long-term care facility should continue to assist with discharge planning for appropriate community and support services. The supportive care psychological services progress note dated 1/13/26 identified Resident #1 was seen to assist Resident #1 in managing anxiety related to potential early discharge and interpersonal conflict while residing in the nursing facility. The plan was to continue to address the discharge-related anxiety. The Advanced Practice Registered Nurse progress note dated 1/15/26 at 12:00 PM indicated Resident #1 completed the course of intravenous (IV) antibiotics, remained stable with no new reported symptoms, and Resident #1 was preparing for discharge to home later in the week, pending final coordination. The Transition of Care/Discharge Summary document dated 1/15/26 identified Resident #1 had an anticipated discharge date for 1/16/26 and the identified discharge (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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	075397	A. Building B. Wing	02/18/2026

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

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	location was back into the community. Review of the social service notes from the initial admission note dated 11/28/25 through 1/15/26 failed to reflect documentation social service had been working with Resident #1 regarding discharge back into the community. Interview with Social Worker #1 on 2/18/26 at 10:30 AM identified she was the person responsible for documenting discharge planning in the resident's record. Social Worker #1 identified the interdisciplinary team discussed discharge planning for Resident #1 the week of 1/16/26 and determined Resident #1 was appropriate for discharge. Social Worker #1 identified she then met with Resident #1 during that week to discuss the anticipated discharge on [DATE]. Social Worker #1 identified it was indicated Resident #1 needed housing resources and she encouraged Resident #1 to call family and friends, as well as provided 211 as a resource for Resident #1 to call. Social Worker #1 identified Resident #1 was to discharge back to the community although there was no identified set location for Resident #1 to discharge to upon being medically cleared and an anticipated discharge date of 1/16/26 set. Review of the clinical record with Social Worker #1 on 2/18/26 at 10:30 AM failed to reflect documentation of the interdisciplinary team's collaboration, referrals and resources provided for post-discharge needs, failed to reflect documentation of discharge readiness and Resident #1's participation in the discharge planning process. Social Worker #1 indicated she did document the discharge planning process in the electronic system under progress notes, however there must have been a glitch in the system because the notes were not in the record. Social Worker #1 identified facility policy was for documentation related to discharge planning to be completed and remain part of the clinical record. Interview with Resident #1 on 2/18/26 at 12:00 PM identified he/she was told by the facility he/she was ready for discharge on a Monday in January and asked if he/she was able to be discharged by that Friday. Resident #1 identified he/she needed to secure housing, was informed by Social Worker #1 if he/she was unable to find housing, then he/she could call 211 for assistance. Resident #1 identified he/she felt there was no ongoing assistance from the facility to secure housing upon discharge and no discussion on aftercare. Review of the facility Discharge Planning policy dated 1/1/25 directed, in part, discharge planning beings at admission and continued until the resident leaves the facility, and during stay (ongoing) the interdisciplinary team will review discharge progress weekly for short stay residents, update care plan as condition changes, and document progress notes regarding discharge readiness. It was further indicated a discharge meeting occurred for short term residents within 72 hours and weekly, and documentation must include participants, readiness for discharge, services arranged, and teaching provided.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observations, review of facility documentation, and interviews for two (2) of three (3) sampled residents (Residents #1 and #4) who were reviewed for functioning call lights, the facility failed to ensure the call light indicator illuminated above the room door in the hallway when activated. The findings include: During a tour of the third floor on 2/17/25 at 2:40 PM, observations identified when Resident #4 activated the call bell while the surveyor was present, the visual indicator light outside the room above the door did not illuminate. Resident #4 indicated his/her call bell often did not work properly and facility staff had just come a day ago to fix it. Observations on 2/17/26 at 2:41 PM identified when Resident #1's call bell was activated, the call light indicator did not illuminate outside the room above the door. Observations and interview with the charge nurse, Licensed Practical Nurse (LPN) #1, on 2/17/26 at 2:43 PM identified when the call bell for Resident #4 was pressed, the call light indicator did not illuminate above the room door. LPN #1 identified although the indicator light was not illuminated above the door, the audible signal and visual light at the nurses' station was activated, which allowed staff to determine what wing a call bell light was activated so it was considered functional. Interview with the Director of Nursing (DON) on 2/17/26 at 3:30 PM identified the expectation was for the call light indicator above a room door to illuminate when activated and the call bell had been pressed. The DON identified she would inform maintenance to look into it. Interview with the Administrator on 2/18/26 at 10:15 AM identified although routine environmental rounds and testing of the call bell system were conducted, there was no specific timeframe for how often the rounds and testing were conducted. Although requested, no documentation on routine environmental rounds and testing of the call bell system was provided. Review of the facility maintenance log from December 2025 through February through 2026 failed to identify documentation of repair requests for Residents #1 and #4. Review of the facility Call Bell policy dated 1/1/24 directed staff will be made aware of the call bell being activated by the buzzer ringing at the nurses' station and the light above the room being lit and identified if a call bell is found to be defective a hand bell will be provided.