STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075348	A. Building B. Wing	04/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advanced Center for Nursing & Rehabilitation	169 Davenport Avenue New Haven, CT 06519

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46046 Based on observations, clinical record review and interviews for one observed resident (Resident #618), the facility failed to ensure the call bell was within reach. The findings include: Resident #618's diagnoses included Cerebral Vascular Accident (CVA) with Right hemiparesis (weakness or paralysis of one side of the body), history of falls, and dementia. Physician order dated 2/8/2022 directed to transfer Resident #618 with a mechanical lift and two (2) staff assistance. The Resident Care Plan (RCP) dated 2/8/2022 identified Resident #618 was at risk for falls related to impaired mobility and poor safety awareness. Interventions directed to remind Resident #618 to use the call bell to request assistance. The admission Minimum Data Set assessment dated [DATE] identified Resident #618 had moderate cognitive impairment, required extensive assistance with bed mobility, and had no limited range of motion of the upper extremities. Observation on 3/29/2022 at 12 PM identified Resident #618 was lying in bed and the call bell was not within reach. The call bell was observed on Resident #618's right side (side with weakness) and above a folded wheelchair located next to the bed. Interview with LPN #2 at the time of the observation identified Resident #618 could not reach the call bell. LPN #2 indicated that rehab staff must have left it out of reach and indicated the bell should be within the resident's reach. LPN #2 moved the call bell to within reach of Resident #618. Observation on 4/1/2022 at 10:30 AM identified Resident #681 was sitting in a wheelchair on the left side of the bed in his/her room facing toward the foot of the bed (bed was on the resident's right side). The call bell was attached to the side rail on the left side of the bed (on the right side of the resident). Interview with Resident #618 at the time of the observation identified he/she was unable to reach the call bell due to weakness of his/her right arm. Interview and observation with RN #1 on 4/1/2022 at 10:32 AM, identified Resident #618 was unable to reach the call bell, and moved the call bell to within Resident #618's reach. RN #1 indicated the call bell should be within reach of a resident and did not know why it was not within reach. Subsequent to surveyor inquiry, the RCP was updated on 4/1/2022 to direct placement of the call bell on Resident #618's left side. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No facility policy was provided for surveyor review.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20740 Based on review of the clinical record, facility policy review and interviews for one of three residents (Resident #119) reviewed for a pressure ulcer (R#119), the facility failed to ensure the responsible party notified timely when a wound was identified. The findings include: Resident #119 had diagnoses that included a sacral pressure ulcer. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #119 had no pressure ulcer and used pressure relieving devices in his/her chair and bed. Review of the clinical record identified on 3/11/2022 staff observed a new facility acquired pressure ulcer on Resident #119's coccyx (stage 2). The wound measured 3.5 centimeters (cm) by 5.0 cm by 0.2 cm. Review of the clinical record failed to identify Resident #119's responsible party was notified of the new pressure ulcer identified on 3/11/2022. Nurse's note written by RN #3/ICN dated 3/14/2022 at 1:32 PM indicated Resident #119's responsible party (Person #1) was upset that the facility had not notified him/her of the new wound prior to 3/14/2022. The RN #3 informed the Person #1 that moving forward he would keep Person #1 updated of any changes in the wound status or treatments. The Resident Care Plan (RCP) updated on 3/25/2022 identified a problem with a pressure ulcer. Interventions directed to provide wound treatments as ordered. Interview and review of the clinical record with the Regional Nurse (RN#1) on 3/31/2022 at 2:15 PM identified Resident #119's responsible party should have been notified on 3/11/2022 when the wound was identified. He indicated that he would have expected the ICN to update Person#1 when the wound was found. Review of the facility Reporting a Change in Condition Policy, directed in part, that the facility must immediately inform the resident, the resident's physician, and if known, the resident's legal representative or an interested family when there is a significant change in the resident's physical, mental, or psychosocial status. Repeated attempts will be made to reach the family until successful.

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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. 20740 Based on observations, review of facility policy, facility documentation review, and interviews for on one of seven nursing unit shower rooms (S-3 Unit), reviewed for environment, the facility failed to ensure that the shower room was maintained in a clean, comfortable home-like manner and/or free from disrepair. The findings included: Observation of the shower room on the S-3 unit on 3/29/22 at 12:38 PM was identified as having cracked and missing tiles on the shower room floor. The wall-mounted heater had areas of rust and was dislodged from the wall on its upper right side. The walls surrounding the heater were noted to have rust-colored stains and the baseboard below the heater observed to have a black grime-like coating on the top edges. The ceiling in the shower room was observed with numerous rust-colored specks. Interview and observation of the S-3 shower room on 4/4/22 at 3:20 PM with the Director of Maintenance (DOM) identified the cracked and missing tiles should be replaced, the heater should be securely attached to the wall, and the rust-colored areas and black colored areas should be cleaned. The DOM indicated that he would repair the identified concerns. No facility policy was provided for surveyor review.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20740 Based on clinical record review and staff interviews for one of four residents reviewed for nutrition (Resident #119) and for one of two residents reviewed for indwelling catheters (Resident #119), the facility failed to ensure intake and output were monitored for a resident with a feeding tube and a Foley catheter. The findings included: Resident #119's diagnoses included hydronephrosis with renal and ureteral calculous obstruction, indwelling urinary catheter, left flank percutaneous nephrostomy drain, sepsis due to pseudomonas, adult failure to thrive, urinary retention, benign prostate hypertrophy (BPH) and gastric-tube insertion A quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #119 had moderate cognitive impairment for decision-making skills, was always incontinent of urine and received 51% or more total calories via feeding tube. The Resident Care Plan (RCP) dated 3/25/22 and on 3/27/22 identified an indwelling catheter and a feeding tube as the problems. Interventions directed to monitor intake and output, monitor weights, and maintain aspiration precautions. Review of the paper and electronic clinical records failed to identify Resident #119 s intake and output was monitored from 2/1 through 4/1/2022, and although Resident #119 had a feeding tube and a Foley catheter, the review failed to identify staff obtained a physician's order for intake and output monitoring. During an interview, clinical record review, and a written request for intake and output documentation, with Regional RN #1 on 4/1/2022 at 10:48 AM the Regional RN #1 was unable to provide documentation for intake and output for Resident #119. RN #1 indicated that intake and output should have been monitored, and he did not know why it was not completed. During an interview and clinical record review with the Registered Dietitian (RD) on 4/4/2022 at 10:43 AM, the RD was unable to provide documentation that Resident #119's intake and output was monitored. RD indicated that although the facility did not document the intake and output, she relies on her formulas to ensure the resident was receiving enough tube feeding to support his/her nutritional status. Interview and clinical record review on 4/4/2022 at 9:25 AM with MD #1 identified that Resident #119 had a tube feeding and a foley catheter. MD #1 indicated that he would expect the facility to monitor Resident #119's intake and output. No facility policy was provided for surveyor review. According to Lippincott procedures - Intake and Output Measurements dated May 2020, directed in part, that intake and output measurement should be recorded on a 24-hour intake and output record, and the total intake and output should be calculated and recorded at the end of the 24-hour shift. Intake and output assessments helps monitor the patient's response to treatment.

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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** 20740 Based on observations, clinical record review, facility policy review and interviews for one of three residents reviewed for a pressure ulcer (Resident #119), the facility failed to ensure a wound treatment was provided in a clean manner with supplies placed on a clean surface. The findings included: Resident #119 had diagnoses that included a sacral pressure ulcer. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #119 had no pressure ulcer and used pressure relieving devices in his/her chair and bed. Review of the clinical record identified a facility acquired pressure ulcer was identified on 3/11/2022 on Resident #119's coccyx (stage 3). The Resident Care Plan (RCP) updated on 3/25/2022 identified a problem with a pressure ulcer. Interventions directed to provide wound treatments as ordered. Observation on 3/31/2022 at 11:20 AM of RN #3/ICN performing a wound treatment for Resident #119 identified RN #3 was observed setting up treatment supplies (i.e., 1-large sterile package of a foam border dressing, one tube of Santyl ointment, a small stack of clean 4x4 gauze, 1-sterile package of calcium alginate gloves 1-sterile packet of a cotton tip swab applicator, and 1-small bottle of 0.9% NS) on Resident #119's cluttered and uncleaned bedside nightstand without the benefit of cleaning it's surface or providing a clean barrier for the treatment supplies. RN #3 was then observed to remove Resident #119's old dressing. RN #3 performed hand hygiene and applied gloves prior to picking up treatment supplies from the uncleaned bedside nightstand to use to cleanse Resident #119's wound. Subsequent to surveyor's intervention and inquiry, the treatment was suspended. RN #3 was then observed to set up treatment supplies on a clean drape or barrier before resuming Resident #119's wound care. Interview and clinical record review with Regional RN #1 on 3/31/2022 at 1:15 PM identified RN #3 should not have put treatment supplies on an unclean surface, and he would have expected the treatment supplies to have been setup on a clean surface prior to initiation of the treatment. Review of facility Dressing Changes Policy, directed in part, to assemble dressing supplies on a clean surface.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20740 Based on clinical record review, facility policy review and interviews for two of four residents (Resident #23 and #119), the facility failed to ensure a significant weight loss was addressed timely and the facility failed to ensure a reweight was obtained timely for a resident identified with a weight loss. The findings include: 1. Resident #23 was admitted with diagnoses that included dementia and diabetes. A quarterly Minimum data set (MDS) dated [DATE] identified Resident #23 had severe cognitive impairment and was independent with staff set up to eat. The Resident Care Plan (RCP) dated 12/16/2021 identified Resident #23 had an increased risk for alteration in nutritional status. Interventions directed to provide supplements and to monitor weight trends. Review of Resident #23's weights identified the following: on 1/5 was 125.1 pounds (lbs), on 2/1 was 100.2 lbs which identified a loss of 24.9 lbs, and weight on 2/7/2022 was recorded as 103.7 lbs. A Dietician note dated 2/10/2022 at 11:58 AM identified Resident #23 had a significant weight loss, with a reweigh requested to rule out any error and confirm a weight loss trend. Recommendations included to encourage intake and to trail a supplement (Boost Plus). A Dietician weight loss assessment note dated 2/14/2022 (13 days after the weight loss was identified) at 12:19 PM indicated that a significant weight loss was reviewed with the APRN. Resident #23's current weight was 104.1 lbs. A nursing progress note dated 2/14/2022 at 8:22 PM identified that APRN was notified of Resident #23's recent weight loss with new orders obtained, and a message left to family. A physician's order dated 2/14/2022 directed to obtain an abdominal ultrasound due to weight loss and to provide Boost Plus 8 ounces twice a day (order obtained 4 days after the dietician recommendation for Boost Plus supplement). An APRN progress note dated 2/15/2022 at 6:27 PM identified Resident #23 was seen for evaluation of a significant weight loss (14 days after the weight loss was identified) with his/her current weight at 103.7 lbs, confirmed with a reweigh. Labs, abdominal ultrasound, speech and occupational therapy evals and to start Remeron 15 milligrams (mg) nightly (an appetite stimulant). A Speech therapy progress note dated 2/16/2022 at 11:01 AM identified that a consistency downgrade to chopped was recommended for Resident #23. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and clinical record review with LPN #3 on 4/1/2022 at 11 AM identified that if a Resident weight is obtained that is very different than the previous weight, a reweigh is completed to confirm, usually right after the first weight is obtained. Or when the nurse reviews weights obtained during the shift and identifies a discrepancy, she would direct staff to obtain a reweight and then notify the dietician. LPN #3 indicated that although Resident #23 had a reweight obtained on 2/7/2022 to confirm the weight loss identified on 2/1/2022, she indicated that the reweight should have been obtained on 2/1/2022. LPN #3 indicated that she did not know why the reweight was not obtained on 2/1/2022, and although she could not recall if she had notified the APRN and Dietician of the confirmed weight loss on 2/7/2022, she indicated the APRN and Dietician should have been notified when the weight loss was confirmed. Interview with the Dietician on 4/1/2022 at 3 PM identified although she could not remember if she was notified of the weight loss on 2/1/2022, if she was notified, she would have requested a reweigh at that time, completed an evaluation, and followed up with the APRN. Interview with Corporate RN #1 on 4/2/2022 at 9 AM identified that if a significant weight loss is identified the staff are expected to do an immediate re-weigh to confirm the resident's weight. If the weight loss was confirmed, then staff should notify the physician/APRN and the dietician at the time of recording the weight and it was the nurse's responsibility. RN #1 indicated a significant weight loss was identified for Resident #23 on 2/1/2022, and he did not know why a reweight was not obtained timely (before 2/7/2022) and indicated the weight should have been obtained on 2/1/2022. Further, he did not know if the APRN and Dietician were notified timely, and why the physician's order for the Boost Plus supplement was not obtained until four (4) days after the dietician recommended the supplement, and 13 days after the weight loss was identified. He indicated the physician/APRN and dietician should have been notified when the weight loss was identified, and the supplement orders obtained on 2/10/2022 when the Dietician made the recommendation. Review of facility Weight Policy dated 8/1/2021 directed in part, that any Resident displaying weight changes if 5 pounds or more will be reweighed within 24 hours by the assigned NA/designee or nurse. Any Resident displaying a significant change in weight of greater than or equal to 5 lbs. gain/loss in one month will be reported to the Registered Dietician in writing. 2. Resident #119 had diagnoses that included adult failure to thrive and a sacral pressure ulcer. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #119 had moderate cognitive impairment and received 51% or more total calories via feeding tube. A review of Resident #119's weights for February 2022 and March 2022 identified that on 2/7/22, the resident weighed 190 lbs. and 182 lbs. on 3/1/22. Further review of the clinical record failed to identify a reweight was obtained on 3/1/2022 to verify the accuracy of the weight of 182 lbs. to confirm if Resident #119 sustained an eight-pound weight loss. Physician orders dated 3/4/22 directed to obtain a re-weight. The RCP updated on 3/25 and on 3/27/2022 identified indwelling catheter and feeding tube as the problems. Interventions directed to monitor intake and output, monitor weights, and maintain aspiration precautions. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the clinical record failed to identify a reweight was obtained to confirm the loss identified on 3/1/2022. Interview and clinical record review on 4/4/2022 at 10:43 AM with the registered dietitian (RD) regarding a reweight identified she did not request staff obtain a reweight to confirm the weight obtained on 3/1/2022 because in her opinion, Resident #119's weight was stable. The RD further indicated based on the facility policy, she should have requested a reweight be obtained. Review of the facility Weight Policy, directed in part, any resident with weight changes of 5 or more pounds will be re-weighed within 24 hours by the assigned nurse aide/designee and nurse. 41223

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46046 Based on observation, clinical record review, policy review, and interviews for one of two residents (Resident #616) reviewed for respiratory care, the facility failed to ensure oxygen tubing was changed timely. The findings include: Resident #616 had diagnoses that included COPD. Physician's order dated 2/3/2022 directed oxygen at three (3) liters per minute via nasal cannula, and to change the oxygen tubing every week (on Saturday) during the 11-7 shift. The Resident Care Plan dated 2/3/2022 identified an alteration in respiratory status. Interventions directed to administer oxygen as ordered and maintain oxygen equipment at bedside. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #616 was alert and oriented, and required use of oxygen. Observation and interview with RN #1 on 4/1/2022 at 9:35 AM identified Resident #616 was wearing oxygen and the tubing was dated 3/20/2022 (13 days prior to the observation). RN #1 indicated the tubing should be changed weekly. Review of the facility Oxygen Tubing Policy directed in part, tubing and supplies are changed weekly on 11-7 every Saturday and as needed and should be dated with last date changed.

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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** 20740 Based on observations, review of the clinical record, facility policy and procedures and interviews for one of three residents reviewed for a pressure ulcer (R#119), the facility failed to ensure the clinical record was maintained in a complete and accurate manner to include accurate dates weekly skin checks were completed. The findings include: R#119's diagnoses included a sacral pressure ulcer, indwelling urinary catheter, left flank percutaneous nephrostomy drain, adult failure to thrive, and gastric-tube insertion. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #119 had moderate cognitive impairment and required staff assistance for ADLs. The Resident Care Plan (RCP) dated on 2/2/2022 identified a problem with pressure ulcer. Interventions directed to report any changes to skin to APRN/MD as necessary and perform weekly skin checks. Physician monthly orders for March 2022 directed body audits weekly on shower days, edit day based on shower days once a day on Wednesday, 7:00 A.M. - 3:00 P.M. Clinical record review identified Resident #119's shower days were Wednesdays. Review of the electronic Treatment Administration Record (TAR) identified the TAR was signed to indicate the weekly skin check for March 2022 were signed off as completed on Wednesdays, 3/2 and 3/9/2022 (Resident #119's shower). Review of the paper weekly body skin check sheets identified the paper forms were completed on Tuesdays, 3/1 and 3/8/2022. The review identified an inaccuracy between the electronic TAR and the paper forms completed. interview and review of the clinical record (electronic and paper) on 3/31/2022 at 1:15 PM with RN #1 identified weekly skin checks are completed on the resident's assigned shower days. RN #1 indicated the dates on the paper forms, and the electronic TAR should match (have the same dates) and he did not know why they did not match (RN #1 was unable to identify which days the skin checks were completed). No facility policy was provided for surveyor review.

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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** 20740 Based on observations, clinical record review, facility policy review and interviews for one of two residents (Resident #188) reviewed for tracheostomy care, the facility failed to ensure supplies were stored appropriately and not stored on the floor, and for facility Infection Control Review, the facility failed to ensure facility infections were tracked and expired IV supplies were removed from staff access timely. The findings include: 1. Resident #188 had diagnoses that included a terminal condition of the larynx. The quarterly MDS assessment dated [DATE] identified Resident #188 was alert and oriented and had a tracheostomy. The RCP dated [DATE] identified an alteration in respiratory sttus. Interventions directed to assess for changes in respiratory status and maintain oxygen and suction equipment at bedside. Observation on [DATE] at 11:17 AM identified Resident #188's personal belongings including trach dressings and supplies were located inside and on top of a clear see-through plastic bag which was sitting on the floor of the resident's room. Interview with Resident #188 at the time of the observation identified he/she had just had a room change and could offer no further explanation for the reason the bag was on the floor. Additional intermittent observations on ,d+[DATE], ,d+[DATE] and [DATE] identified Resident #188's personal belongings including trach dressings and supplies continued to be located inside and on top of a clear see-through plastic bag which was located on the floor of the resident's room. Interview and observation with RN #3/ICN on [DATE] at 1:40 PM identified Resident #188's personal belongings including trach dressings and supplies continued to be located inside and on top of a clear see-through plastic bag which was located on the floor of the resident's room. RN #3 indicated the items should not be located on the floor. Subsequent to surveyor's inquiry, RN #3 was removed the plastic bag containing the items off the floor. No facility policy was provided for surveyor review. 2. Interview and review of the facility Infection Control program with RN #1 on [DATE] at 10:54 AM identified RN #1 was unable to locate any monthly and/or quarterly tracking for facility infection control from ,d+[DATE] through ,d+[DATE]. RN #1 indicated that tracking of facility infections should be maintained. No facility policy was provided for surveyor review. 3. Interview and review of facility IV emergency box supplies with RN #1 on [DATE] at 9:30 AM identified the following supplies were past their expiration date: two (2) Normal Saline Solution (NACL Flush, two (2) Heparin lock flushes, seven (7) IV start and tubing supplies outdated to 2021, one (1) 1000 milliliter (ml) bag of Normal Saline was open and not in the original protective wrapping, a zip-lock clear plastic bag with a pharmacy label contained two (2) unwrapped IV solutions. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075348	A. Building B. Wing	04/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advanced Center for Nursing & Rehabilitation	169 Davenport Avenue New Haven, CT 06519

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility IV Supplies Policy dated [DATE] directed in part, the infection preventionist will maintain IV supplies in an emergency kit in the Supervisors office. Interview with pharmacist #1 on [DATE] at 1:13 PM identified the facility was responsible to remove expired IV supplies from the IV emergency supply box. Pharmacist #1 indicated that an IV solution that was not stored in it's protective packaging was good for 30 days. 46046