STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075278	A. Building B. Wing	08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Hartford Health & Rehabilitation Center	130 Loomis Dr West Hartford, CT 06107

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 0584 Level of Harm - Potential for minimal harm Residents Affected - Some	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. (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 0584 Level of Harm - Potential for minimal harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of facility documentation, and interviews for 4 of 5 residents (Resident #4, Resident # 72, Resident #92, and Resident #124) reviewed for environmental concerns, the facility failed to ensure a safe, clean, comfortable, and homelike environment. The findings included: Resident #4 was admitted on [DATE] and diagnoses included paraplegia, and seizure disorder. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #4 was cognitively intact and required the assistance of 2 or more helpers for toilet hygiene and transfers. Observations on 8/20/25 at 12:18 PM Resident #4's lunch tray was placed on bedside tray table that had worn and chipped edges, on 8/25/25 at 11:43AM Resident #4 had personal items on the bedside tray table with worn and chipped edges, and on 8/26/25 at 11:35 AM Resident #4 had personal items on the bedside table with worn and chipped edges. Interview with Licensed Practical Nurse (LPN) # 7 on 8/26/25 at 11:50 AM identified she was not aware Resident #4's bedside tray table had chipped and worn edges. She further identified that the maintenance department has a logbook at the nurse's desk and any items that need to be fixed or repaired in resident's rooms on the unit, should be written in the book. Review of the maintenance book, dated March 2025 through August 2025 on the Harmony unit on 8/26/25 at 11:55 AM, identified Resident #4's bedside tray table was not included.Interview with Certified Nurse Aid (CNA) NA #8 on 8/26/25 at 12:05 PM identified that she was not aware of Resident #4's bedside tray tables condition of chipped and worn edges. She further identified Resident #4 had this bedside tray table since she returned from the hospital 2 weeks ago, and the condition of the bedside tray table should have been written in the unit maintenance book. Interview with the Infection Preventionist on 8/26/25 at 12:13 PM identified that he performs environmental rounds monthly and generally conducts them alone and sometimes a member of housekeeping will join him. He checks 4 resident rooms and 2 resident bathrooms per unit every month. Further identified that he was not aware of Resident #4's bedside tray table condition with chipped and worn edges and that he would replace with a newer condition one. Subsequent to surveyor inquiry, on 8/26/25 at 2:49 PM Resident #4's bedside tray table was replaced. Resident #72 was admitted on [DATE] and diagnoses included anxiety disorder and depression. The quarterly MDS assessment dated [DATE] identified Resident #72 was moderately cognitively impaired and had impairments on both sides of lower legs and used a wheelchair for mobility. Observations on 8/28/25 at 2:20 PM and on 8/29/25 at 10:29 AM identified Resident #72's wall under the television in his/her room was marked with deep scratch marks in the wall and wallpaper. Interview with the Infection Preventionist on 8/28/25 at 2:25 PM identified the wallpaper in resident's rooms is old and peels and the Administrator wants to replace it throughout the building Interview with NA #9 on 8/29/25 at 10:29 AM identified that Resident #72's wheelchair hit and scraped the wall under the television and peeled off the wallpaper. Further identified, NA #9 did not write Resident #72's wall condition in the maintenance book on the Reflection unit. Resident #92 was admitted on [DATE] and diagnoses included cerebral infarction (stroke) and Parkinson's disease. The quarterly MDS assessment dated [DATE] identified Resident # 92 was severely cognitively impaired and required the assistance of 2 or more helpers with toilet hygiene, lower body dressing and transfers. Observations on 8/28/25 at 2:22 PM and on 8/29/25 at 10:36 AM, identified a medium to larger size portion of wallpaper on the wall behind Resident #92's head of bed peeling off. Interview with LPN #8 on 8/29/25 at 10:36 AM identified the peeling wallpaper behind Resident #92's head of bed was caused when bed was moved. Further identified, the peeling wallpaper in Resident #92's room was not written in the maintenance book on the Reflections unit. Review of the Reflections unit maintenance book from March 2025 thorough August 2025 on 8/29/25 at 10:40 AM identified Resident #72's damaged wall under the television and Resident #92's peeling wallpaper behind the head of bed was not written in the book.Resident #124 was admitted on [DATE] and diagnoses included anxiety disorder, depression, and paranoid personality disorder. The quarterly MDS assessment dated [DATE] identified Resident #124 was moderately cognitively impaired and required the assistance of 2 or more helpers with toilet hygiene, lower body dressing and transfers. Observations on 8/28/25 at 2:23 PM and on 8/29/25 at 9:08 AM identified the wall under the window in Resident#124's window had a large section of wallpaper peeled off and missing. Interview with NA #7 on 8/29/25 at 9:10 AM identified that the large section of peeled off wallpaper under Resident #124's window occurred a year ago when another resident who was in the same room and same bed as Resident #124, peeled off the large section of wallpaper. Further identified, NA #7 did not write the condition of Resident

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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. (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interviews, and review of facility policy for 1 of 2 residents reviewed for discharge (Resident #146), the facility failed to allow a resident to return after a therapeutic leave, failed to involve the interdisciplinary team in the discharge, and failed to notify the appropriate state agency of a concern with a resident not returning from a leave of absence. The findings include: Resident #146 was admitted on [DATE] with diagnoses that included anxiety, heart failure, and dysphagia (swallowing difficulties). A physician's order dated 7/29/2025 directed that the resident may go on a leave of absence (LOA) with a responsible party, with medications if necessary. The Nursing wandering/elopement risk assessment dated [DATE] indicated that Resident #146 ambulated independently and was a low risk for elopement. The admission nursing assessment dated [DATE] identified that Resident #146 had adequate short and long-term memory and was oriented to person, place, and time. The nursing assessment further indicated that the resident's mood was passive and speech was intact. The nursing assessment also indicated that Resident #146 required supervision for toileting and hygiene, and required limited assistance for transfers, dressing, and locomotion. A social services note dated 8/1/2025 indicated that Resident #146 was cognitively intact and was going on an LOA during the weekend and that nursing was aware and agreed to the LOA. The social work note did not indicate that Resident #146 requested to be discharged , but instead identified that the resident had indicated they would be back in time for a meeting scheduled for 8/4/2025. Additionally, the social work note did not indicate that Resident #146 was informed of a bed-hold policy or an LOA policy. A nursing note dated 8/2/2025 at 8:20 AM identified that Resident #146 went on an LOA with Person #1 with all appropriate medications. The note further indicated that the resident had informed the nurse that they would return on 8/3/2025. A nursing note dated 8/3/2025 at 10:54 AM identified that Person #1 had called the nursing supervisor. The note indicated that Resident #146 was slurring their words, and the nurse was unable to understand their speech. The note further indicated that Person #1's speech was also slurred but understandable. The note identified that Person #1 indicated Resident #146 would not be able to return on 8/3/2025 but rather 8/4/2025. The note failed to identify follow-up with a medical provider or an appropriate state agency for a resident who had not returned from an LOA and was noted to be slurring their speech and unable to communicate, which was not the resident's baseline. A nursing note dated 8/3/2025 at 11:26 AM identified that Person #1 had indicated that they would bring Resident #146 back to the facility on 8/4/2025 at 8:00 AM. The note did not indicate that the nurse had spoken to Resident #146 or that Resident #146 had indicated they wanted to be discharged . A review of a facility Supervisor's Report for 8/3/2025 identified that Resident #146 was on LOA and would return on Monday (8/4/2025). A social services note dated 8/4/2025 at 5:00 PM identified that on 8/4/2025 at 8:45 AM, Person #1 had called the facility, indicating that Resident #146 was experiencing knee pain and difficulty ambulating and that the nursing supervisor had recommended that Person #1 take Resident #146 to the hospital for evaluation. The social services note further indicated that by the afternoon of 8/4/2025, Resident #146 had not returned and was unreachable by phone. A review of notes identified that, other than calling, the facility failed to take steps to ensure that Resident #146 remained safe and failed to notify the appropriate state agency of a resident who had not returned from an LOA and then became unreachable by phone. The social services note dated 8/4/2025 further indicated that Person #1 was eventually reached by phone and Person #1 indicated that they had not sought medical attention and that they were waiting for a friend to help take Resident #146 back to the facility. The social services note identified that Person #1 was informed by social services and the Administrator that Resident #146 was considered as discharged Against Medical Advice (AMA) due to not having returned at the agreed-upon time from an LOA. The social services note failed to identify that a medical provider was involved in the AMA discharge of Resident #146. The social services note also failed to identify that Resident #146 had expressed a desire to be discharged from the facility. A nursing note dated 8/4/2025 at 10:38 PM indicated that Resident #146's room was cleared of belongings by staff. A review of hospital records dated 8/5/2025 identified that Resident #146 was evaluated for knee pain and that the resident had recently been discharged from a skilled nursing facility. A review of the facility Release From Responsibility for LOA form identified that if a resident did not return by midnight without prior approval, it would be considered a discharge AMA and would not be permitted to return. The release form was signed by LPN #5, but did not contain a signature of Person #1 or Resident #146. On 8/27/2025 at 1:45 PM, an

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based of review of the clinical record, facility documents, interviews, and facility policy, for 1 of 3 residents, (#106) reviewed for Pressure Ulcer the facility failed to ensure staff updated a care plan to accurately reflect the resident status. The findings include: Resident #106's diagnosis includes pressure ulcer of the sacral region and quadriplegia. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #106 had one unstageable pressure ulcer. The care plans dated April 2025 indicated Resident #106 was at risk for pressure ulcers due to impaired mobility, incontinence of bowels and requiring assistance with positional changes. Interventions in place included in part to follow pressure ulcer prevention guidelines, provide a pressure redistributing bed support surface and seating surface devices, provide treatments as ordered, utilize a skin protectant/moisture barrier with incontinent care and to evaluate skin condition daily during care and report any abnormalities to the nurse. The care plan also indicated Resident #106 had an unstageable pressure ulcer of the sacrum with one intervention to provide the wound clinic service as ordered. A physician's order dated 06/23/2025 at 11:47 AM directed to apply PICO wound therapy to the sacral pressure ulcer through 06/30/2025. The care plan indicating Resident #106 had an unstageable pressure ulcer was updated with an intervention to use the PICO wound therapy machine as ordered. A nursing progress note dated 06/26/2025 at 12:18 PM indicated the PICO wound therapy had been in place during the early morning but loosened as the day progressed. New orders were obtained to discontinue the PICO treatment and a new treatment order was obtained. A physician's order dated 06/26/2025 at 11:57 AM directed to discontinue the PICO treatment. The quarterly MDS dated [DATE] indicated Resident #106 had one stage 4 pressure ulcer that was not present on admission. The care plans continued to indicate Resident #106 was at risk for pressure ulcer with no change in the interventions and also indicated Resident #106 had an unstageable pressure ulcer with the interventions of providing the wound clinic service and to provide PICO therapy. An interview, clinical record review, and facility electronic document review on 08/25/2025 at 11:28 AM with RN #1, the facility wound nurse, indicated Resident #106's wound treatments changed over time as the wound evolved and the use of the PICO wound therapy only lasted for 3-4 days as it could not handle the amount of wound drainage. As a result, a larger Wound Vac therapy machine was ordered and implemented but the resident did not like it and it was discontinued. RN #1 further indicated s/he was responsible for updating the care plans for residents with pressure ulcers and the current care plan was not up to date as it indicated Resident #106 had an unstageable pressure ulcer, when actually the pressure ulcer was a stage 4. In addition, the intervention to apply the PICO wound therapy remained in the care plan but had been discontinued on 06/26/2025 (60 days ago). RN #1 further indicated resident #106's preference to not limit his/her time out of bed and to reposition despite recommendations to do so, were not reflected in the care plan. RN #1 indicated turning and repositioning was not part of the care plan and documentation was not required by the Nurse Aides as it was expected as part of the care for all residents. The facility policy labeled pressure ulcer prevention and management indicated in part an individualized care plan would be developed for residents with pressures ulcers including, wound care orders, pain management strategies, nutritional support and interventions. The facility policy labeled Turning and Repositioning indicated in part all residents at risk for skin breakdown will be turned and repositioned at least every 2 hours during the day and every 3 hours overnight or as ordered by the practitioner and documented in the resident's individualized care plan. The policy further indicated certified nurse aides and the nursing staff are responsible for turning and repositioning and the licensed nurse is responsible for monitoring compliance and updating the care plan as necessary. _____

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documents, interviews and facility policy for 1 of 2 residents (#126) reviewed for Accidents/Fall the facility staff failed to complete a comprehensive post fall investigation with injury, failed to provide ongoing documentation regarding the left knee condition post fall and failed to obtain a treatment order for the injury for 5 days. The findings include: Resident #126's diagnosis included non-pressure ulcer of part of the right foot and type 2 diabetes.The admission Minimum Data Set assessment (MDS) dated [DATE] indicated in part Resident #126 had mild cognitive impairment, was receiving occupational and physical therapy and had no history of falls prior to admission or at the facility. The care plan dated August 2025 indicated Resident #126 was at risk for falls due to impaired gait, balance medications with known risk and at risk for falls and for falls with serious injuries. The interventions included evaluation by physical and occupational therapy, to keep the call bell within reach, bed in low position and to provide safety precautions for falls. A facility Reportable Event form dated 08/18/2025 indicated at 12:30 PM Resident #126 had slipped and sat on the floor during a therapy session in the Rehab Gym sustaining a skin tear to the right knee. The report indicated the fall was witnessed and two statements were obtained from the treating occupational assistant (OT#1) and a physical therapist (PT #2). The report further indicated after the Registered Nurse assessed the resident; Resident #126 was assisted off the floor via a mechanical lift device and 2 persons assistance. The report further indicted the resident indicated while trying to step forward while the parallel bars s/he slipped. A Medical note dated 08/18/2025 at 12:33 PM completed by Advanced Practice Registered Nurse (APRN) #1 indicated in part s/he was asked to see Resident #126 who had a witnessed fall during therapy on exam a skin tear was noted to the right knee with full range of motion and no visible deformities and indicated to continue with post fall assessment per facility guidelines and inform provider with abnormal findings from baseline assessment. A nursing note dated 08/18/2025 at 07:15 PM indicated the writer and the APRN(NP) had been called to the therapy department, and the Nurse Practitioner found the resident on the floor in therapy with a right knee skin tear. The note indicated a xeroform dressing followed by a clean dry dressing was applied and the responsible party was notified of the fall. No further nursing notes address the fall or the left knee skin tear until 08/21/2025. The fall care plan was updated with the addition of Resident #126 being lowered to the floor in therapy and a new intervention to continue therapy was added. A nursing note dated 08/21/2025 at 08:06 AM indicated the wound nurse was to see Resident #126 this day. A Wound/Ostomy APRN Consultation (APRN #2) note dated 08/21/2025 indicated in part following resident regarding right foot surgical wound and initial assessment of Resident #126's abrasion to the left knee measuring 2.5x1.5 (cm) that was clean and pink with scant drainage and no odor. Recommendations at that time were to continue treatment to the right foot per the surgeon's orders and to cleanse the left knee wound with normal saline, apply xeroform, followed by foam dressing on Monday Wednesday and Friday and as needed. A physician's order dated 08/24/2025 at 02:47 PM directed to provide wound care to the left knee abrasion every Monday, Wednesday and Friday by rinsing with normal saline, applying xeroform followed by a foam dressing on the 7-3 shift. An interview, record review, and facility document review with the Assistant Director of Nursing (ADNS) and the Director of Nursing (DNS) on 08/29/2025 at 10:24 AM indicated no post fall monitoring had been documented in the nurses' notes as expected for a fall with head injury but would have nursing look for the documentation included in the accident/incident packet used as a backup to the electronic charting. On 08/29/2025 at 10:44 AM further review of the records and documents with the DNS and the ADNS lacked investigation of surrounding circumstances of the fall and the DNS called PT #2 to attend the interview. PT #2 indicated Resident #126 had nonskid socks and a hard-soled bootie at the time of the fall further indicating s/he felt the resident may have been tired as had exercises earlier in the morning and the resident was asked by the OT assistant #1 if the resident was tired but Resident #126 wanted to continue. PT #2 indicated therapy had used a slide board out of bed for 3 days once felt better stand pivot transfer with therapy and continued a mechanical lift transfer with Nursing. On 08/29/2025 at 12:15 PM the ADNS indicated the facility had no post fall policy and verified no treatment orders were obtained for the left knee skin tear on 08/18/2025 but orders were written on 08/24/2025(6 days later). On 08/29/2025 at 1:00PM interview and record review with RN #1 the Infection Preventionist/wound nurse, indicated the wound APRN had evaluated and treated Resident #126 on Friday 08/21/2025 and the recommendations written by the APRN were sent to the facility over the weekend and

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, and a review of facility policy for the only resident reviewed for antibiotic therapy (Resident #9), the facility failed to ensure that licensed staff administered saline and heparin intravenous flushes as per policy and the standard of care. The findings include: Resident #9 was admitted on [DATE] with diagnoses that included infection of an artificial hip joint and an open wound on the hip area. The admission MDS assessment, dated 7/20/2025, identified that Resident #9 was cognitively intact; however, it failed to note that Resident #9 had an intravenous catheter. A physician's orders dated 7/14/2025 directed the use of a central line (a long intravenous catheter inserted into a large vein with the tip ending near the heart that allows for long-term delivery of medications and fluids) for intermittent infusions. The orders also directed to flush the central line (a process of administering a solution through the catheter to clear out blood, prevent clots, and maintain the central line's patency). The order directed that flushing should be with 10 mL of saline before the medication is administered; after the medication has been administered, the central line should be flushed with 10 mL of saline and then 5 mL of heparin 10 units/mL (a fast-acting blood thinner). A physician's order dated 7/31/2025 directed to administer Vancomycin (an antibiotic) 1.5 grams in 250 milliliters (mL) of 0.9% sodium chloride intravenously (IV) daily at 9:00 AM. On 8/21/2025 at 11:15 AM, LPN#5 was observed disconnecting Vancomycin from Resident #9's central line, flushing the central line with a blue-colored syringe, followed by flushing the same port of the central line with a white colored syringe. An interview with LPN#5 on 8/21/2025 at 11:20 AM identified that LPN#5 had flushed Resident #9's central line first with 5 mL of Heparin 10 units/mL, followed by 10 mL of 0.9% saline solution. LPN#5 indicated that heparin was used to prevent the central line from developing clots that could occlude the catheter. A record review and follow-up interview with LPN #5 at 3:30 PM indicated that the facility used the SASH protocol, which stood for Saline, Antibiotic, Saline, Heparin. A review of Resident #9's orders with LPN#5 identified an order directing to flush the central line after a medication with saline and then heparin. LPN#5 indicated that she was not sure why she had flushed with heparin first and then saline and indicated she may have misread the order on the computer. On 5/21/2025 at 3:59 PM, an interview with the DNS indicated that the facility uses the acronym SASH to remind staff how and when to flush central lines. The DNS indicated that SASH stood for Saline, Antibiotic, Saline, Heparin, and did not know why LPN#5 may have flushed with heparin first and then saline. A review of the facility policies for IV management contained a chart titled Vascular Access Device Flushing and Maintenance Chart, which indicated that for central lines being used for intermittent medication administration, 10mL of saline would be used to flush the catheter after medication administration and then with 5mL of heparin. _____

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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** Based on observation, review of the clinical record, interviews, and review of the facility policy for the only resident reviewed for Respiratory Care, (#145) the facility failed to ensure respiratory equipment settings were obtained and reflected in the physician orders. The findings include: Resident #145's diagnosis included obstructive sleep apnea. The admission Minimum dataset assessment (MDS) dated [DATE] indicated Resident #145 was cognitively intact but failed to indicate Resident #145 was utilizing a Cpap (Continuous Positive Airway Pressure) a non-invasive mechanical respirator. A physician's order dated 08/19/2025 at 07:20 PM directed Cpap settings- on at 9:00PM (bedtime) and off at 07:00 AM. An observation 08/20/2025 at 11:40 AM found Resident #140 with a C-pap machine at the bedside, a medical device that provides a continuous flow of air pressure while an individual is sleeping used in treating sleep apnea. An interview, clinical record and facility policy review on 08/29/2025 at 10:50 AM with the ADNS and the DNS found Resident #145's Cpap order lacking the machine settings and did not know why the settings were not obtained and entered into the physician order. Subsequent to surveyor inquiry, a physician's order dated 08/29/2025 at 11:56 AM was entered into Resident #145's clinical record and directed to provide Cpap at 19. 2 pressure setting on at 9:00PM (HS) and off at 7:00AM. The facility policy labeled C-pap indicated in part a physician's order would include the settings, flow liter for oxygen (if used) and the time period to wear it.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interviews and facility policy the facility failed to ensure 2 out of 3 ice machines were maintained in a sanitary manner. The findings include:An observation on 08/21/2025 at 11:36 AM of the interior of the Unit 1 ice machine found a buildup of a black substance on the inner edges of the ice machine. The log fixed to the machine labeled Ice Machine Cleaning Schedule had columns for every month to indicate the date cleaned a check off for removal of the ice, one for cleaning, and another for sanitizing and a column to indicate who completed the work. The last date entered was 06/22/2025. Another labeled affixed to the ice machine was from the mechanical service provider, indicating annual cleaning, sanitization and cleared drains was completed on 03/13/2025. Observation of the ice machines located on Unit 1 and Unit 2 and interviews on 08/29/2025 at 2:40 PM with the Physical Plant Director and the Regional Director of Environmental Services found a buildup of a black substance inside the ice machine located where the machine makes the ice. Each machine had a tag indicating maintenance was provided yearly by an outside service and a check off list with initials was attached to each machine indicating monthly cleaning had been performed. The unit 2 ice machine indicated it had been cleaned 07/2025 and the unit one ice machine had been cleaned on 8/23/2025. The Regional Environmental Services Director indicated housekeeping was responsible to clean the ice machines located on the units and the black build up was unacceptable. The Regional Director of Environmental Services provided the facility policy for cleaning the ice machines and indicated the housekeeping staff would be educated regarding the procedure for cleaning the ice machine and was unable to locate any previous training provided for this task.The facility policy labeled Ice Machine Maintenance, indicated the facility ice machines are maintained in a clean and sanitary condition to prevent contamination and reduce the risk of infection to residents, staff and visitors. The policy indicated Environmental staff conduct a visual inspection daily of the ice machines to ensure they are clean from spills, debris, or visible mold; monthly Environmental services would perform a basic cleaning of external surfaces using an approved disinfectant and drain lines would be checked for leaks and buildup; annually, the ice machine would be emptied, thoroughly cleaned and sanitized according to the manufacturer's instructions. ----

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075278	A. Building B. Wing	08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Hartford Health & Rehabilitation Center	130 Loomis Dr West Hartford, CT 06107

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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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, interviews, and facility policy review, for 1of 2 residents reviewed for Hospice (#140) the facility did not ensure receipt of renewal orders and plan of care for a specialized service and the facility failed to initiate an end-of-life care plan. The findings include: Resident #140's diagnosis included unspecified Dementia with behavioral disturbance. The admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #140 had severe cognitive impairment and was receiving Hospice care. The care plan dated 04/25/2025 indicated Resident #140's Advanced Directive was Do not resuscitate, do not intubate and do not hospitalize due to terminal illness and to provide comfort care. The sole intervention was to honor the residents 'and family's wishes. The quarterly MDS assessment dated [DATE] indicated Resident #140 was receiving Hospice care.The care plan dated July 2025 indicated Resident #140's Advanced Directive was do not resuscitate, do not intubate and do not hospitalize due to terminal illness and to provide comfort care. With the sole intervention to honor the residents' and family's wishes. No revisions to the Advanced Directives care plan were made including coordination of services provided by the Hospice provider and the facility related to end of life care (95 days after admission on Hospice services). An interview and record review with the social worker on 08/28/2025 at 10:40 AM indicated s/he was unable to locate an End of Life(Hospice) care plan in the resident's medical record indicating it was the responsibility of the social worker to initiate a Hospice/end of life care plan and did not know why s/he did not initiate one. The Social Worker indicated s/he would start a care plan and have the interdisciplinary team review and revision as needed. The social worker also indicated the Hospice provider was not routinely invited to participate in the Hospice residents care plan meeting and none were invited to Resident #147's care plan meetings. On 08/28/2025, subject to surveyor inquiry, Social Worker #1 initiated a Terminal Condition care plan (137 days after admission on Hospice) with interventions including to assist with Hospice services through the designated provider, honor code status (Advanced Directives) discuss prognosis with family, resident and the physician, and resident #140 to attain psychological and spiritual ease before death. On 08/28/2025 at 11:10 AM an interview and record review with the ADNS found no 90-day re-certification paperwork after 04/26/2025 and would contact the business office manager and medical records.An interview on 08/28/25 at 11:45 AM with the Financial Director (Business office manager) indicated s/he did not have any certification paperwork and the ADNS had contacted the Hospice service provider to request them. On 08/29/2025 subject to surveyor inquiry, Hospice Certification Renewal orders with plans of care (142 days after Resident #147 was admitted on Hospice services) for Resident #140 were received by the facility from the Hospice provider for 2 certification periods, 04/27/2025- 07/25/2025 and 07/26/2025-09/23/2025.The facility policy labeled Policy for Care of Hospice Residents contracted with an Outside Agency indicted in part the facility aims to provide compassionate coordinated care to hospice residents. The policy further indicated that the facility would develop a comprehensive care plan in collaboration with the hospice agency incorporating input from the resident and the family including pain management, symptom control, emotional support, and any other hospice-related services. _____ _____

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075278	A. Building B. Wing	08/29/2025

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on facility record review and staff interviews, the facility did not maintain records of monthly water flushes according to the facility water management plan. The findings include: An environmental assessment completed by a contractor and dated 4/9/2018 identified risk areas for opportunistic pathogens and recommended mitigation steps. Areas that were at risk included showers, tubs, faucet taps, and eye wash stations. Recommendations included flushing any uncommonly used tubs, showers, and faucets for 3 to 5 minutes, and the process was documented and kept in the service records section of the water management program. Additionally, the water management plan indicated that eyewash stations should be flushed monthly. An environmental annual inspection dated 4/21/2021 from a contractor identified recommendations that included using all aspects of the facility assessment mitigation plan, establishing a flushing program, and documenting all water-related tasks, such as preventative maintenance, routine, and emergency events. A review of yearly Exposure Control/Water Plan meeting minutes dated 1/7/2025 identified that the water plan/legionnaires prevention plan was in process and that testing had been completed for 2024. A further review of the facility's water management plan identified that the facility gets the water tested for opportunistic pathogens. The last two tests were on 4/15/2024 and 4/21/2025, both of which were negative for the presence of opportunistic pathogens. On 8/26/2025 at 1:00 PM, a review of facility documents for water management with the Director of Physical Plant identified that the last documented water flushing was on 12/18/2023. The Director of Physical Plant indicated that he was unsure why the flushing was not documented but indicated that he knows he has performed them and may have forgotten to return to the office to document the flushing because his additional responsibilities. The Director of Physical Plant identified that the flushing included flushing the water storage tanks, random resident rooms, showers, and sinks, including sinks in the dirty utility rooms of the resident units. Additionally, tubs were part of the flushing, but most of the tubs had been removed, except for one resident unit that has a hydro tub. The Director of Physical Plant indicated that the last time he performed flushing was on 7/21/2025 after he returned from vacation. For eye wash stations, the Director of Physical Plant indicated he has started using tags that hang from the eye wash station to document the flushing; however, he indicated that he plans on putting tags on the tubs and sinks that are flushed but has not started using tags for the tubs or sinks yet. The Director of Physical Plant indicated that he was on an extended leave from 9/20/2024 to 12/2025, where he came on and off to work. The Director indicated that the Special Projects Supervisor was covering for him during his leave of absence. On 8/6/2025 at 1:23 PM, an interview with the Special Projects Supervisor indicated that he was covering for the Director of Physical Plant when the Director had been out on extended leave. The Special Projects Supervisor indicated he recalled flushing the tub in the resident shower area but did not recall flushing sinks in the soiled utility rooms. Additionally, the Director of Physical Plant indicated he did not recall having to document any of the flushing performed. On 8/6/2025 at 2:00 PM, an interview with the Administrator identified that the 4/21/2021 recommendations from the contractor were the last recommendations received. Additionally, the Administrator indicated that during the Exposure Control/Water Plan meeting, the water plan is reviewed as well as testing, but that reviewing the flushing documentation is not part of the meeting. A review of the Water Management Plan Policy identified that a water management plan should be adopted and implemented but did not identify specific preventative measures to prevent the growth of opportunistic pathogens.