STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075017	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montowese Center for Health & Rehabilitation	163 Quinnipiac Avenue North Haven, CT 06473

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16837 Based on review of clinical records, review of facility documentation, and interviews with facility staff for 7 of 7 residents self-administering medication (Resident #'s 54, 55, 56, 57, 58, 59, and 60), the facility failed to conduct a medication self-administration assessment in accordance with facility policy. The findings include: 1. Resident #54 was admitted to the facility on [DATE] with diagnoses that included weakness, peripheral vascular disease, essential hypertension, and acquired absence of the left leg above the knee. A self-administration assessment dated [DATE] indicated the resident was only administering Flonase. Physician orders dated 4/16/24 directed Methadone HCL 5 milligrams (mg), 50 mg daily for opioid dependence. A MDS assessment dated [DATE] identified the resident had a BIMS of 15. During an interview with the Nursing Supervisor on 5/3/24 at 5:00 A.M., s/he identified the nurse assigned to Resident #54 provides the Methadone to the resident at 6:00 A.M. and the resident self-administers the medication. Further interview and review of the clinical record, failed to identify a resident assessment was conducted to ensure the resident was appropriate to self-administer his/her medication. 2. Resident #55 was admitted to the facility on [DATE] with diagnoses that included weakness, type 2 diabetes mellitus with a foot ulcer, acquired absence of the right toes, and personal history of pulmonary embolism. Physician orders dated 4/18/24 directed Methadone HCL 5 milligrams (mg), 5 mg three times daily for pain management. A self-administration assessment dated [DATE] indicated the resident did not desire to self-administer his/her medications. A MDS assessment dated [DATE] identified the resident had a BIMS of 15. (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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Nursing Supervisor on 5/3/24 at 5:00 A.M., s/he identified the nurse assigned to Resident #55 provides the Methadone to the resident at 6:00 A.M. and the resident self-administers the medication. Further interview and review of the clinical record, failed to identify a resident assessment was conducted to ensure the resident was appropriate to self-administer his/her medication. 3. Resident #56 was admitted to the facility on [DATE] with diagnoses that included cellulitis of the right lower limb, opioid dependence, peripheral vascular disease, and hypothyroidism. A self-administration assessment dated [DATE] identified the assessment was in progress, however, had not been completed. A MDS assessment dated [DATE] identified the resident had a BIMS of 15. Physician orders dated 4/16/24 directed Methadone HCL 5 milligrams (mg) per 5 milliliters (ml), 8ml one time a day for opioid dependence. During an interview with the Nursing Supervisor on 5/3/24 at 5:00 A.M., s/he identified the nurse assigned to Resident #56 provides the Methadone to the resident at 6:00 A.M. and the resident self-administers the medication. Further interview and review of the clinical record, failed to identify a resident assessment was conducted to ensure the resident was appropriate to self-administer his/her medication. 4. Resident #57 was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus, aftercare following a joint replacement, opioid use, traumatic pneumothorax, and contusion of the lung. A MDS assessment dated [DATE] identified the resident had a BIMS of 15. A self-administration assessment dated [DATE] indicated the resident did not desire to self-administer his/her medications. Physician orders dated 3/10/24 directed Methadone HCL 5 milligrams (mg) per 5 milliliters (ml), 75 mg one time a day for opioid dependence. During an interview with the Nursing Supervisor on 5/3/24 at 5:00 A.M., s/he identified the nurse assigned to Resident #57 provides the Methadone to the resident at 6:00 A.M. and the resident self-administers the medication. Further interview and review of the clinical record, failed to identify a resident assessment was conducted to ensure the resident was appropriate to self-administer his/her medication. 5. Resident #58 was admitted to the facility on [DATE] with diagnoses that included toxic encephalopathy, bipolar disorder, repeat falls, hypotension, and idiopathic peripheral autonomic neuropathy. A self-administration assessment dated [DATE] indicated the resident did not desire to self-administer his/her medications. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Physician orders dated 4/16/24 directed Methadone HCL 5 milligrams (mg) per 5 milliliters (ml), 30 mg one time a day for opioid dependence. A MDS assessment dated [DATE] identified the resident had a BIMS of 13. During an interview with the Nursing Supervisor on 5/3/24 at 5:00 A.M., s/he identified the nurse assigned to Resident #58 provides the Methadone to the resident at 6:00 A.M. and the resident self-administers the medication. Further interview and review of the clinical record, failed to identify a resident assessment was conducted to ensure the resident was appropriate to self-administer his/her medication. 6. Resident #59 was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus, chronic kidney disease, hypothyroidism, and opioid dependence. A self-administration assessment dated [DATE] identified the assessment was in progress, however, had not been completed. Physician orders dated 1/17/24 directed Methadone HCL 5 milligrams (mg) per 5 milliliters (ml), 10 ml one time a day for analgesics-opioid. A MDS assessment dated [DATE] identified the resident had a BIMS of 8. During an interview with the Nursing Supervisor on 5/3/24 at 5:00 A.M., s/he identified the nurse assigned to Resident #59 provides the Methadone to the resident at 6:00 A.M. and the resident self-administers the medication. Further interview and review of the clinical record, failed to identify a resident assessment was conducted to ensure the resident was appropriate to self-administer his/her medication. 7. Resident #60 was admitted to the facility on [DATE] with diagnoses that included dehiscence of an amputation stump, asthma, essential hypertension, and opioid dependence. A self-administration assessment dated [DATE] indicated the resident did not desire to self-administer his/her medications. A MDS assessment dated [DATE] identified the resident had a BIMS of 13. Physician orders dated 4/16/24 directed Methadone HCL 5 milligrams (mg) per 5 milliliters (ml), 50 mg one time a day for opioid dependence. During an interview with the Nursing Supervisor on 5/3/24 at 5:00 A.M., s/he identified the nurse assigned to Resident #60 provides the Methadone to the resident at 6:00 A.M. and the resident self-administers the medication. Further interview and review of the clinical record, failed to identify a resident assessment was conducted to ensure the resident was appropriate to self-administer his/her medication. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy and procedure for Self-Administration of Medication indicated if a resident elects to self-administer his/her own medications, an evaluation of their cognitive, physical, and visual ability to perform this task is conducted to ensure accurate and safe medication management.

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 16647 Based on observations and interview the faciity failed to ensure recent survey activites were accessbile to residents and the public. The findings include: Observations during tour of the facility on 4/18/2024 at 8:00 AM identified a note taped on the counter of the reception desk that read Please see the Receptionist for Connecticut's Department of Public Health Annual Survey, which is now available for review. Interview with the Director of Nurses (DNS) at 9:30 AM identified that the Survey results are to be available to all and no one should have to ask for the survey results. Further observation identified that the DNS removed the sign from the counter at the receptionist desk. Observations on 4/24/2024 at 8:30, 10:00 AM and 2:00 PM and on 4/25/2024 at 8:00 AM and 2:05 PM identified that the survey results were located on the wall on the receptionist desk. Further observations identified that the results were covered by folders.

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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** 16647 Based on clinical record review and interview for 2 of 2 residents (R# 5 and Resident #13) that had an increase in weight or had a change of condition, the facility failed to notify the physican of a weight gain or the responsbile person of the change in condition. The findings include: 1. Resident #5 was admitted to the facility on [DATE] with diagnoses that included congestive heart failure (CHF), hypoxemia, weakness, low back pain and hypothyroidism. Physician orders dated 10/10/19 directed a daily weight and notify the APRN/MD of an increase of 2 pounds in a day or 5 pounds in a week. Subsequent orders dated 10/21/19 and 10/23/19 directed a fluid restriction of 1500 milliliters (ml) daily and a fluid restriction of 1500 ml daily with 11-7 shift: 340 ml, 7-3 shift: 340 ml, and on the 3-11 shift: 630 ml. An assessment dated [DATE] identified a cognitive impairment, required extensive assistance with transfers, continent of bowel function and occasional urinary incontinence. A corresponding care plan dated 10/11/19 and revised on 11/18/19 identified the resident had congestive heart failure/history of heart failure with interventions that included, early signs of CHF may include fatigue and weight gain, fluid overload may cause swelling of legs, ankles, fluid in the lungs, shortness of breath, and increased heart rate of respiratory rate. An additional intervention included monitoring weights as ordered. In addition, the care plan indicated the resident is at risk for dehydration related to medication with an intervention that included to monitor intake and output as indicated. Review of the weight record identifed a weight of 234.6 pounds on 10/12/19, 234.4 pounds on 10/13/19, and 236.4 pounds on 10/14/19 (2 pound weight gain). Further review identified a weight of 236 pounds on 10/16/19 and a weight of 240.2 pouunds on 10/17/19 (4.2 pound increase) and a 2.4 pound increase from 10/20/19-10/21/19. Review of progress notes dated 10/19/19 identified the family was expressing concerns about wheezing and swelling. APRN progress notes 10/20/19 and 10/25/19 identified the resident had 2-3 plus pitting edema in the lower extremities. Although weights were ordered daily, review of the clinical record failed to identify weights were obtained on 10/26, 10/27 and 10/28/19. S/he further stated the plan of care was not followed and the physician was not notified of the 2 pound weight gain from 10/13/19-10/14/19, a 4.4 pound increase from 10/16/19-10/17/19 and the 2.4 pound increase from 10/20/19-10/21/19. 2. Resident #13 was admitted to the facility on [DATE] with diagnoses that included hemiplegia, hemiparesis, osteomyelitis, cognitive communication deficit and pharyngeal dysphagia. A MDS assessment dated /15/2024 identified a BIMS of 03 (cognitive impairment). (continued on next page)

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	075017	A. Building B. Wing	05/23/2024

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the clinical record and progress notes from 1/14/2021 -1/29/2021 identified that R#13 had a noted change in condition as follows: a. On 1/20/22, the APRN documented that the resident had lost 13.40 pounds over a period of two months. b. On 1/20/22, the dietician documented a Weight Warning with a weight loss of 14 pounds in two months. c. On 1/22/22, the APRN documented an initial visit for fatigue, the symptoms had been gradual; and d. On 1/25/22, the APRN documented that the present illness was constipation for a duration of three days. Further review of the progress notes dated 1/27/22 identified the social worker went into the resident's room to notify him/her that the MDS significant change was to be completed. Upon entering the resident's room, the resident was noted to be across the bed moving a lot, and when the social worker presented the reason for the visit, the resident was inattentive with disorganized thoughts, and leaned toward the base of the bed almost falling out of bed. The resident's behavior was reported to nursing. On 1/29/22, the physician ordered Baclofen 5 mg three times a day and an Xray of the right hip and knees to rule out Heterotrophic ossification. Further review of the clinical record failed to identify the responsible person was notified about the changes with the resident. Interview and review of the clinical record with RN#4 on 5/2/2024 at 10:45 AM identified that with a BIMS of 03, the family and/or responsible person should have been notified.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16837 Based on review of the clinical records, review of facility documentation, review of policy and procedures and interview with facility staff for 11 of 12 residents reviewed for medication administration omissions or delays in administration (Resident #'s 3, 44, 45, 46, 47, 48, 49, 50, 52, 53 and #40) which had the potential for neglect, the facility failed to complete required reporting documentation, investigate why such omissions or delays occurred and take any corrective action, and failed to report to the state survey agency in accordance with the policy and procedures. The findings include: 1. Resident #3 was admitted to the facility on [DATE] with diagnoses that included malignant neoplasm of the meninges and the brain, epilepsy with intractable status epilepticus, type 2 diabetes, hypothyroidism, essential primary hypertension, heart failure, and atrial fibrillation. Physician orders dated 1/15/23 directed Cyanocobalamin, 1000 micrograms daily (indicated for low hematocrit). A nursing progress note dated and timed 1/28/23, 10:43 P.M., indicated the resident's daughter had called and reported the resident did not receive his/her medications timely and was taking the resident out of this place. A subsequent supervisor nursing progress note dated and timed 1/28/23, 11:20 P.M. indicated the resident and family made the decision to transfer out of the facility against medical advice. The note further identified the facility was short two nurses and the resident appeared to be upset about a few issues she had observed. Review of the medication administration record dated 1/28/23 and the corresponding medication administration audit report identified the following: Although Cyanocobalamin, 1000 micrograms was scheduled to be administered daily at 7:30 A.M., review of the medication administration record failed to identify the medication was administered on 1/28/23. 2. Resident #44 was admitted to the facility on [DATE] with diagnoses that included endocarditis, weakness, diabetes mellitus, hypertension, and congestive heart failure. Review of the physician orders dated 1/6/23 directed Amiodarone HCL, 200 milligrams (mg) one time a day for hypertension; Apixaban, 5 mg every 12 hours for mitral valve disease; Bumex, 2 mg one time a day for congestive heart failure; Colchicine, 0.6 mg one time a day for gout; Protonix delayed release, 20 mg one time a day for gastrointestinal reflux disease; and Tradjenta, 5 mg in the morning for diabetes. Although review of Resident 44's clinical record identified Amiodarone HCL 200 mg, Apixaban 5 mg, Bumex 2 mg, Colchicine 0.6 mg, Protonix delayed release 20 mg, and Tradjenta 5 mg were scheduled to be administered on 1/28/23 at 9:00 A.M., further review of the medication administration audit report identified the 9:00 A.M. doses were administered at 11:37 A.M. (1 hour and 37 minutes outside of the permitted administration window) (continued on next page)

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	075017	A. Building B. Wing	05/23/2024

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Resident #45 was admitted to the facility on [DATE] with diabetes mellitus, hypothyroidism, weakness, congestive heart failure, depression and spinal stenosis. Review of the physician orders dated 1/26/23 directed Aspirin, 81 milligrams (mg) one time a day as a blood thinner; Brillanta, 90 mg two times a day as a blood thinner; Bumex, 4 mg one time a day as a water pill; Carvedilol, 3.125 mg two times a day for the heart and blood pressure; Duloxetine capsule delayed release, 60 mg one time a day for depression; Farxiga, 10 mg one time day for diabetes; Gabapentin, 300 mg two times a day for nerve pain; Humalog insulin, inject 12 units with meals related to diabetes mellitus; Prednisone, 5 mg one time a day for corticosteroid; Sacubitril-Valsartan, 24-26 mg two times a day related to congestive heart failure and Spironolactone, 12.5 mg one time a day as a water pill. Although review of Resident 45's clinical record identified Aspirin, 81 mg; Brillanta, 90 mg; Bumex, 4 mg; Carvedilol, 3.125 mg; Duloxetine capsule delayed release, 60 mg; Farxiga, 10 mg; Gabapentin, 300 mg; Gabapentin, 300 mg; Sacubitril-Valsartan, 24-26 mg; and Spironolactone, 12.5 mg, were scheduled to be administered on 1/28/23 at 9:00 A.M., review of the corresponding medication administration audit report identified the medications had not been administered. Further review identified that Humalog insulin, 12 units which were ordered for administration with meals had not been administered at 7:30 A.M. and 12:30 P.M. on 1/28/23. 4. Resident #46 was admitted to the facility on [DATE] with diagnoses that included anemia, dysphagia, esophagitis, hypertension, and a gastrointestinal bleed with a gastric tube for enteral nutrition. Physician orders dated 1/12/23 directed Escitalopram Oxalate, 10 milligrams (mg) via the gastric tube one time a day for depression; Esomeprazole Magnesium Packet, 20 mg, via gastric tube two times a day for gastro esophageal reflux disease; and Metoprolol Tartrate, 50 mg via the gastric tube, two times a day for hypertension. A subsequent physician order dated 1/13/23 directed to flush the gastric tube with 150 milliliters (ml) of water every 4 hours and Aspirin, 81 mg one time a day. Although review of Resident 46's clinical record identified Escitalopram Oxalate, 10 mg, Esomeprazole Magnesium Packet, 20 mg, Metoprolol Tartrate, 50 mg, and Aspirin 81 mg were scheduled to be administered on 1/28/23 at 9:00 A.M. via the gastric tube, review of the corresponding medication administration audit report identified the medications had not been administered. 5. Resident #47 was admitted to the facility on [DATE] with diagnoses that included a right hip replacement, hypertension, anemia, and sarcoidosis. Physician orders dated 12/14/22 directed Vitamin C, 1000 mg every day; Fluticasone Propionate Suspension 50 micrograms, 2 sprays in each nostril one time a day; and Famotidine, 20 mg one time a day for heartburn. Although review of Resident 47's clinical record identified Vitamin C, 1000 mg, Fluticasone Propionate Suspension 50 micrograms, 2 sprays and Famotidine, 20 mg were scheduled to be administered on 1/28/23 at 10:00 A.M., review of the corresponding medication administration audit report identified the medications had not been administered. (continued on next page)

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	075017	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. Resident #48 was admitted to the facility on [DATE] with diagnoses that included osteoarthritis, left knee replacement, tremors, peripheral vascular disease, atrial fibrillation, and hypertension. Physician orders dated 1/27/23 directed Acetaminophen, 975 mg every 8 hours for pain, Apbcaban, 2.5 mg two times a day for anticoagulant; Meloxicam, 15 mg one time a day for pain; and Metoprolol, 50 mg two times a day for hypertension. Although review of Resident 48's clinical record identified Apbcaban, 2.5 mg, Meloxicam, 15 mg, and Metoprolol, 50 mg were scheduled to be administered on 1/28/23 at 9:00 A.M., review of the corresponding medication administration audit report identified the medications had been administered at 11:44 A.M. (1 hour and 44 minutes outside of the permitted administration window). Further review identified Acetaminophen 975 mg was not administered as scheduled at 2:00 P.M. 7. Resident #49 was admitted to the facility on [DATE] with diagnoses that included acute respiratory failure, chronic obstructive pulmonary disease, atrial fibrillation, hypertension, congestive heart failure and secondary malignant neoplasm of the breast. Physician orders dated 1/24/23 directed Anastrozole, 1 mg one time a day for breast cancer; Cyanocobalamin, 1000 micrograms one time a day for Vitamin D deficiency; Docusate Sodium 100 mg every day for constipation; Ferrous Sulfate, 325 mg three times day for iron deficiency; Losartan Potassium, 25 mg one time a day for hypertension; Multivitamin, one tab for preventative maintenance; Omeprazole, 40 mg daily for gastroesophageal reflux disease; Oxybutynin Chloride ER, 5 mg daily for preventative maintenance; Toprol XL ER, 25 mg daily for hypertension; Trelegy Ellipta, 100-62.5-25 micrograms aerosol powder, one puff into lungs daily; Vitamin C, 500 mg daily for preventative maintenance; and Xarelto, 20 mg daily for atrial fibrillation. Although review of Resident 49's clinical record identified Anastrozole, 1 mg; Cyanocobalamin, 1000 micrograms; Docusate Sodium 100 mg; Ferrous Sulfate, 325 mg; Losartan Potassium, 25 mg; Multivitamin, one tab; Omeprazole, 40 mg; Oxybutynin Chloride ER, 5 mg; Toprol XL ER, 25 mg; Trelegy Ellipta, 100-62.5-25 micrograms aerosol powder; Vitamin C, 500 mg; and Xarelto, 20 mg; were scheduled to be administered on 1/28/23 at 9:00 A.M., review of the corresponding medication administration audit report identified the medications had been administered between 11:31 A.M. - 11:35 A.M. (1 hour and 31-35 minutes outside of the permitted administration window). 8. Resident #50 was admitted to the facility on [DATE] with diagnoses that included radiculopathy, hallucinations, spinal stenosis, low back pain and depression. Physician orders dated 7/27/22 directed Divalprox Sodium Delayed Release 250 mg daily as part of 750 mg dose for depression and Divalprox Sodium Delayed Release 500 mg daily as part of 750 mg dose for depression. Although review of Resident 45's clinical record identified Divalprox Sodium Delayed Release, 750 mg was scheduled to be administered on 1/28/23 at 9:00 A.M., review of the corresponding medication administration audit report identified the medications had not been administered. (continued on next page)

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	075017	A. Building B. Wing	05/23/2024

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9. Resident #52 was admitted to the facility on [DATE] with diagnoses that included ischemic cardiomyopathy, major depressive disorder, post-traumatic stress disorder, atherosclerotic heart disease, and non-ST elevation myocardial infarction. Physician orders dated 11/27/22 directed Carvedilol 25 mg, two times a day for heart failure. Further physician orders dated 11/28/22 directed Corlaner, 5mg two times a day for heart failure; Eliquis 5 mg daily for a blood thinner; Entresto 49-51 mg two times a day for non-ST elevation and cardiomyopathy; Farxiga 10mg daily for type 2 diabetes mellitus; Lactobacillus, one tablet for loose stools; Lexapro 20 mg daily for major depressive disorder; Miralax 17 grams daily for constipation; Neurontin 100 mg with meals for nerve pain; and Spironolactone 12.5 mg daily for heart failure. Additional physician orders dated 12/15/22 and 1/10/23 directed a Lidocaine patch 4%, 2 patches to the upper back one time a day for pain and Keppra 250 mg two times a day related to syncope and collapse. Although review of Resident 52's clinical record identified Carvedilol 25 mg, Corlaner, 5mg, Eliquis 5 mg, Entresto 49-51 mg, Farxiga 10mg, Lactobacillus, one tablet, Lexapro 20 mg, Miralax 17 grams, Spironolactone 12.5 mg, Lidocaine patch 4%, and Keppra 250 mg were scheduled to be administered on 1/28/23 at 9:00 A.M., review of the corresponding medication administration audit report identified the medications had been administered between 11:18 A.M. - 11:24 A.M. (1 hour and 18-24 minutes outside of the permitted administration window). Further review identified Neurontin 100 mg scheduled for 8:30 A.M. was not administered until 11:18 A.M. (1 hours and 48 minutes outside of the permitted administration window) and the 12:30 P.M. was not administered. 10. Resident #53 was readmitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease, heart failure, chronic kidney disease, hypertension, and type 2 diabetes mellitus. Review of the physician orders dated 1/20/23 directed Amiodipine, 10 mg daily in the morning for hypertension; Ascorbic Acid, 500 mg daily in the morning for vitamins; Benztropine Mesylate, 1 mg two times a day for involuntary movements; Budesonide-Formoterol Fumarate Inhalation, 160-4.5 micrograms 2 puffs, 2 times a day for wheezing; Buspirone HCL, 10 mg- 2 tabs, 2 times a day for anxiety; Cholecalciferol 25 micrograms in the morning for a vitamin supplement; Cyanocobalamin, 1000 micrograms in the morning for Vitamin B12; Cymbalta, 30 mg in the morning for depression; Famotidine, 20 mg in the morning for stomach ulcers; Hydrochlorothiazide, 25 mg in the morning for hypertension; Januvia, 25 mg daily for antidiabetics; Pantoprazole Sodium, 40 mg two times a day for acid reflux; Spiriva Respimat Inhalation, 2.5 micrograms inhalation in the morning for asthma and Vitamin E, 400 units two times day for vitamin supplement. Although review of Resident 53's clinical record identified Amiodipine, 10 mg; Ascorbic Acid, 500 mg; Benztropine Mesylate, 1 mg; Budesonide-Formoterol Fumarate Inhalation, 160-4.5 micrograms 2 puffs; Buspirone HCL, 10 mg- 2 tabs; Cholecalciferol 25 micrograms; Cyanocobalamin, 1000 micrograms; Cymbalta, 30 mg; Famotidine, 20 mg; Hydrochlorothiazide, 25 mg; Januvia, 25 mg; Pantoprazole Sodium, 40 mg; Spiriva Respimat Inhalation, 2.5 micrograms and Vitamin E, 400 units had not been administered. 11 Resident #40 was admitted to the facility on [DATE] with diagnoses that included hemiplegia and hemiparesis following a cerebral infarction, type 2 diabetes mellitus with diabetic neuropathy, and adjustment disorder with depressed mood. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075017	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montowese Center for Health & Rehabilitation	163 Quinnipiac Avenue North Haven, CT 06473

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physician order dated 10/24/23 directed Semglee Subcutaneous Solution Pen injector 100 Units/Milliliter, inject 40 units subcutaneously at bedtime for diabetes. A nursing progress note dated 10/30/23 identified the resident was yelling for his/her medications to be administered. Attempts to redirect were unsuccessful and the progress note annotated the supervisor requested the nurse administer the medications now. The note further identified while the nurse was administering the medication, it was immediately realized that an error in administration occurred. Instead of administering Semglee 40 units as ordered on 10/24/23, Novolog 40 units was administered. Further review of the progress note identified the APRN was notified, and blood sugars were monitored. A subsequent progress note identified Resident # 40 called the emergency response system and requested to be transferred to the hospital. The facility policy and procedure for Oral Medication Administration dated June 2015 directed in part, verify that the medication is being administered at the proper time, in the prescribed dose and by the correct route. The facility policy and procedure for Medication Error Reporting directed in part; A medication error is any reportable event that may cause or lead to inappropriate medication use, which the medication is in the control of the health care professional. The procedure further indicated a medication error report is to be completed immediately after an error is discovered to ensure proper resident/patient follow up. During an interview and review of the clinical records for Resident #'s 3, 44, 45, 46, 47, 48, 49, 50, 52, 53 and #40 with the Regional Nurse on 5/8/24 at 12:05 P.M., s/he stated that the policy for medication administration was not followed, and residents did not receive their medication in accordance with the standard of care or the physician orders. Further review identified that medication error reports had been started, although not completed, and investigations in to the cause had not been done. During an interview with the Medical Director on 5/23/24 at 1:30 P.M., s/he stated the medications that were omitted or delayed in administering could have had potentially harmful effects to the involved residents and their plan of care and management of medical conditions.

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prepare residents for a safe transfer or discharge from the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16837 Based on review of the clinical record, review of facility documentation, review of facility policy and procedures and interviews with facility staff, for two of two residents reviewed for discharge planning (Resident #21 and #26) the facility failed to provide a safe and comprehensive discharge plan that included education to caregivers regarding the discharged resident's level of support that would be needed and provided upon discharge from the facility or provide the resident with the appropriate medication. The findings include: 1. Resident #21 was admitted to the facility on [DATE] with diagnoses that included a cerebral vascular accident, myocardial infarction, falls, anemia, weakness, Covid 19, major depression, and post-traumatic stress disorder. A physician's order dated 6/20/20 directed to plan for discharge. A MDS assessment dated [DATE] indicated a BIMS of 15 and the resident required minimal to extensive assistance with dressing and transfers. The discharge Minimum Data Set assessment dated [DATE] identified Resident #21 was cognitively intact, required limited to minimal assistance of 1 person with dressing, transfers and toileting and was continent of bladder and bowel function. A corresponding Resident Care Plan (RCP) identified the resident was at risk for falls with 6 falls noted from 8/18/19-9/18/20. Additionally, the RCP identified a potential for discharge to an appropriate setting with appropriate services. Interventions included discharge planning meetings as needed, involve the family with resident's permission, order recommended adaptive equipment as needed and referrals to agencies for home care as appropriate. A discharge planning follow up note dated 9/9/20, 3:35 P.M. indicated a call was placed to Resident #21's friend who agreed that s/he will be available to help Resident #21 when s/he moves into a new apartment until supportive services take effect and a voicemail was left for another friend waiting for a return call, however, the note failed to identify information was provided to the friend regarding the resident's care needs and level of support that would be required to ensure a safe discharge. A nurse practitioner progress note dated 9/24/20 identified that Resident #21 arranged for an apartment out of state and s/he feels ready for discharge and reports having a supportive daughter and friends in such state. The discharge packet dated 9/24/20 sent with Resident #21 included an inter-agency patient referral report(W-10) which indicated Resident #21's diagnosis, diet, activity level, code status, referrals made to agencies and the brochures with contact numbers for those agencies, face sheet listing demographic information, Medication list with last given medications indicated, and the level of care needed with activities of daily living. A case management note dated 9/25/20 at 9:38 A.M. identified, in part, Resident #21 was discharged to a new residence, a handicap apartment out of state with a referral for services made to a local home care agency in ssuch state. (continued on next page)

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A case management note dated 9/28/20 at 12:58 P.M. indicated the Resident's family called and were unaware the resident had been discharged and had concerns about the discharge. Further review of the clinical record identified documentation from Hospital #1 dated 10/5/20 which identified, in part, Resident #21 is alert and oriented, calm and is discussing his/her homelessness and has no ideas of friends or family or resources to use. The note further identified Resident #21 called his/her friend today and s/he declined to help him/her. Documentation indicated Resident #21 was a one-person minimal assist for most activities of daily living. Interview with Hospital #1's Case Manager on 4/23/24 at 11:17 at A.M. via Zoom identified Resident #21 arrived at Hospital #1's emergency room (ER) by ambulance from a family member's house where s/he was staying. During the interview, it was reported that Resident #21 had a change in condition in her psychosocial condition and the family called 911. Resident #21 was evaluated in the ER and determined to be stable. Further interview with Hospital #1's Case Manager at that time identified Resident #21 was determined to not have a good sense of his/her own limitations and subsequently was transferred to another CT LTC facility by Hospital #1. Review of the Discharge Planning policy and procedure directed, in part, the interdisciplinary plans will be developed to provide sufficient preparation, orientation and education to residents and/or family members/next of kin, to ensure a safe and orderly discharge to home or a lesser level of care. The facility failed to provide verbal education and/or written documentation of the level of support that would be needed and provided by the friend out of state. 2. Resident #26 was admitted to the facility on [DATE] with diagnoses that included difficulty walking, type 2 diabetes mellitus, essential hypertension, and abdominal pain. A MDS assessment dated [DATE] identified the resident had a BIMS of 15 and required limited to extensive assistance with activities of daily living. Review of progress notes from 1/6/22-1/10/22 identified discharge planning arrangements were being made with Resident #26 being discharged to home with services in place. A discharge progress note dated 1/10/22 indicated Resident #26 was discharged to home with the family establishing private care at home. The note further identified all medications will be given to the resident upon discharge. Interview with Person #6 on 5/6/24 at 3:30 P.M. identified that medications were sent with Resident #26. S/he further stated the discharge packet included medications that did not belong to Resident # 26 but rather Resident #61. Person #6 further stated at the time, the facility was notified of the error. Person # 6 provided photographs of the medication cards that belonged to Resident #61 that had been part of the discharge packet for Resident #26. Durng an interview with the Regional Nurse on 5/9/24 at 11:00 A.M. s/he identified she did not have any awareness of this situation.

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16647 Based on clinical record review and interview for 1 resident (R#10) reviewed as a new admission to the facility, the facility failed to have the orders signed timely. The findings include: Resident # 10 was admitted to the facility on [DATE] with diagnoses that included metabolic encephalopathy, syncope and collapse, anemia, acute kidney failure and basal cell carcinoma of skin of left upper limb. Review of the Order Summary Report from 10/1/2022 -10/31/2022 failed to identify that the physician had approved the orders and signed the orders. Review of the clinical record identified one Progress Note *NEW* dated 10/13/2022 Facility Discharge, Late Entry APRN Progress Notes. Further review of the clinical record failed to identify admission documentation completed by the physician and/or APRN. Interview and review of the clinical record with RN#4 on 5/2/2024 at 10:45 AM failed to identify admission documentation completed by the physician and/or the APRN within forty eight hours of the residents admission to the facility.

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	075017	A. Building B. Wing	05/23/2024

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16837 Based on review of the clinical record, review of the policy and procedure, and interview with facility staff for one resident reviewed for falls (Resident #6), the facility failed to ensure the fall risk assessment was done at admission in accordance with the policy and procedures. The findings include: Resident # 6 was admitted to the facility on [DATE] with diagnoses that included weakness, systemic lupus, and a history of falls with a recent Cervical 1, 2 and 3 fracture. A resident care plan dated 5/24/21 identified a risk for falls with interventions that included, do not leave in the bathroom unattended, place call light within reach and orient to surroundings. Review of facility documentation dated 6/3/21identified the resident was found on the floor of his/her room at 7:30 P.M. The facility investigation indicated the resident had been last checked at 6:00 P.M. and concluded the resident had independently transferred out of bed. Further review of facility documentation identified an initial fall risk assessment was not completed at admission. During an interview and review of the clinical record with [NAME] Nurse #1 on 5/8/24 at 12:00 P.M. s/he stated a fall risk assessment should have been done on admission. Review of the facility policy and procedures for fall management identifed in part, a fall risk assessment will be conducted on each resident upon admission.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16647 Based on review of the clinical record, review of facility policy and procedures and interview with facility staff for 2 of 4 residents (Resident #19 and 36) reviewed for non-pressure skin conditions, the facility failed to follow physician orders, failed to document weekly skin assessments for the right 2nd toe and left 4th toe and failed to ensure assistance was provided to ensure the resident had access to his/her scheduled follow up appointment. The findings include: 1. Resident # 19 was admitted on [DATE] with diagnoses which included COVID-19, End Stage Renal Disease (ESRD), atherosclerotic heart disease of native coronary artery, and hypertension. The hospital discharge summary dated 4/27/20 identified a necrosis to the 4th right toe and an ulceration to the 4th left toe. The discharge summary further noted a pressure injury to the coccyx (no measurement noted) A nursing admission assessment dated [DATE], 10:55 P.M. identified an open area to the coccyx which measured 0.25 centimeters (cm) by 0.25 cm and an area on the right second toe with a 0.5x0.5 eschar. Review of physician orders dated 4/27/20 directed facility staff to complete weekly wound documentation. Although a subsequent APRN progress note dated 4/28/20 identified Resident #19 had an opening to the left 4th toe measuring 0.8cm by 08.cm it was not further identified in later progress notes or nursing evaluations. The Resident Care Plan dated 4/28/20 identified Resident #19 had a wound infection to the toe, had an opening on the left 4th toe, coccyx pressure injury, an eschar on the 2nd toe of the right foot, and a superficial abrasion to the right 2nd and 3rd toe. Interventions included administer antibiotics as ordered, administer treatment to toe as ordered, monitor for signs and symptoms of healing and or deterioration and report to MD, offload heels, elevate extremities, and skin checks per facility protocol. Review of the progress notes and weekly nursing evaluations from 4/29/24 until 6/22/20 failed to show weekly wound documentation of the left 4th toe, right 2nd toe, and right 3rd toe had been completed. Interview and review of the clincial record with the Corporate Wound Nurse on 4/18/24 at 12:10 P.M. identified wound measurements were not documented or tracked weekly for the right 2nd toe, right 3rd toe, and left 4th toe and that it would be his/her expectation that the nursing staff would document wound measurements weekly. The Corporate Wound Nurse further indicated s/he believes the wound documentation in the electronic health record is inaccurate. Review of facility policy for Non-Pressure Wound Assessment identified a Registered Nurse assessment is required weekly for all wounds (pressure and non-pressure) and upon identification of any new wounds. (continued on next page)

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	075017	A. Building B. Wing	05/23/2024

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. a. Resident #36 was admitted on [DATE] with a re-admitted [DATE] with diagnoses of cellulitis of right lower limb, chronic venous hypertension with ulcer and inflammation of right lower extremity, fistula of intestine, anemia, chronic viral hepatitis c, hypertension, and opioid dependence. An admission [NAME] Data Set (MDS) assessment dated [DATE] indicated Resident #36 had intact cognition, required set-up, or clean up assistance with oral hygiene, and required supervision or touching assistance with upper body dressing, and personal hygiene. The hospital discharge summary dated 12/18/23 identified Resident #36 had future appointments on 1/12/24 and on 1/16/24 for gastrointestinal surgery follow up. The resident care plan dated 12/19/23 identified Resident #36 had an alteration in gastrointestinal status related to colocutaneous fistula, venous statis ulcer of the right lower leg. Interventions included monitoring, documenting, and reporting signs and symptoms of infection, weekly treatment documentation, and notifying the provider of significant abnormalities. Interview with the facility scheduler on 5/2/24 at 12:40 PM identified Resident #36's appointment on 1/12/24 was a telehealth appointment and that the resident was going to use their personal phone to attend the appointment. The scheduler further stated that Resident #36's appointment on 1/16/24 was cancelled due to inclement weather and only attempted once to reschedule the appointment but never received a call back and did not try again. However, the facility failed to provide documentation that the resident was going to use their personal device to attend the appointment and failed to provide documentation that an attempt was made to reschedule the resident's appointment. Although the hospital discharge summary dated 12/18/23 identified Resident #36 had future appointments on 1/12/24 and on 1/16/24 for gastrointestinal surgery follow up, review of the clinical record failed to identify documentation regarding the follow up appointments, specifically, missed the appointments due to inclement weather or information related to rescheduling the follow up appointments. Review of the Policy for Outside Appointments identified it is the unit secretary's responsibility to schedule all appointments. b. Further review of progress notes from 1/5/24-1/19/24 identified chronic non healing wounds to bilateral lower extremities, with a progress note dated 1/16/24 which indicated the right lower extremity wound was saturated with a large amount of malodorous, bright green, purulent drainage. Physician orders dated 2/1/24 directed to cleanse right lower leg with normal saline and pat dry. Apply xeroform followed by hydrofera blue followed by abdominal pad, kerlix wrap, and ace wrap daily and as needed. Review of the clinical record with the Director of Nursing (DNS) and RN #4 (former DNS) failed to identify wound care treatments were being completed from 21/24-2/15/24. Interview and review of the clinical record with RN #4 and RN #6 on 5/2/24 at 1:48 PM identified it is an expectation that wound care treatments are being documented and it is the nurse's responsibility to document that wound care treatments are being completed and could not verify wound care treatments had been completed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Nursing Documentation Policy dated February 2016 identified the treatment type and resident/patient response, if appropriate should be documented and may also be recorded on the treatment Kardex if permitted at the facility, instead of in narrative notes. Based on review of the clinical records, review of facility documentation, review of policy and procedures and interview with facility staff for 5 of 12 residents (Resident #'s 3, 44, 47, 48, and 49) reviewed for medication administration, the facility failed to administer medications in accordance with physician/advanced practice registered nurse orders to ensure medications were administered timely. The findings include: 1. Resident #3 was admitted to the facility on [DATE] with diagnoses that included malignant neoplasm of the meninges and the brain, epilepsy with intractable status epilepticus, type 2 diabetes, hypothyroidism, essential primary hypertension, heart failure, and atrial fibrillation. Physician orders dated 1/15/23 directed Cyanocobalamin, 1000 micrograms daily (indicated for low hematocrit). A nursing progress note dated and timed 1/28/23, 10:43 P.M., indicated the resident's daughter had called and reported the resident did not receive her medications timely and was taking the resident out of this place. A subsequent supervisor nursing progress note dated and timed 1/28/23, 11:20 P.M. indicated the resident and family made the decision to transfer out of the facility against medical advice. The note further identified the facility was short two nurses and the resident appeared to be upset about a few issues she had observed. Review of the medication administration record dated 1/28/23 and the corresponding medication administration audit report identified the following: Although Cyanocobalamin, 1000 micrograms was scheduled to be administered daily at 7:30 A.M., review of the medication administration record failed to identify the medication was administered on 1/28/23. 2. Resident #44 was admitted to the facility on [DATE] with diagnoses that included endocarditis, weakness, diabetes mellitus, hypertension, and congestive heart failure. Review of the physician orders dated 1/6/23 directed Amiodarone HCL, 200 milligrams (mg) one time a day for hypertension; Apixaban, 5 mg every 12 hours for mitral valve disease; Bumex, 2 mg one time a day for congestive heart failure; Colchicine, 0.6 mg one time a day for gout; Protonix delayed release, 20 mg one time a day for gastrointestinal reflux disease; and Tradjenta, 5 mg in the morning for diabetes. Although review of Resident 44's clinical record identified Amiodarone HCL 200 mg, Apixaban 5 mg, Bumex 2 mg, Colchicine 0.6 mg, Protonix delayed release 20 mg, and Tradjenta 5 mg were scheduled to be administered on 1/28/23 at 9:00 A.M., further review of the medication administration audit report identified the 9:00 A.M. doses were administered at 11:37 A.M. (1 hour and 37 minutes outside of the permitted administration window) 3. Resident #47 was admitted to the facility on [DATE] with diagnoses that included a right hip replacement, hypertension, anemia, and sarcoidosis. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Physician orders dated 12/14/22 directed Vitamin C, 1000 mg every day; Fluticasone Propionate Suspension 50 micrograms, 2 sprays in each nostril one time a day; and Famotidine, 20 mg one time a day for heartburn. Although review of Resident 47's clinical record identified Vitamin C, 1000 mg, Fluticasone Propionate Suspension 50 micrograms, 2 sprays and Famotidine, 20 mg were scheduled to be administered on 1/28/23 at 10:00 A.M., review of the corresponding medication administration audit report identified the medications had not been administered. 4 Resident #48 was admitted to the facility on [DATE] with diagnoses that included osteoarthritis, left knee replacement, tremors, peripheral vascular disease, atrial fibrillation, and hypertension. Physician orders dated 1/27/23 directed Acetaminophen, 975 mg every 8 hours for pain, Apbcaban, 2.5 mg two times a day for anticoagulant; Meloxicam, 15 mg one time a day for pain; and Metoprolol, 50 mg two times a day for hypertension. Although review of Resident 48's clinical record identified Apbcaban, 2.5 mg, Meloxicam, 15 mg, and Metoprolol, 50 mg were scheduled to be administered on 1/28/23 at 9:00 A.M., review of the corresponding medication administration audit report identified the medications had been administered at 11:44 A.M. (1 hour and 44 minutes outside of the permitted administration window). Further review identified Acetaminophen 975 mg was not administered as scheduled at 2:00 P.M. 5. Resident #49 was admitted to the facility on [DATE] with diagnoses that included acute respiratory failure, chronic obstructive pulmonary disease, atrial fibrillation, hypertension, congestive heart failure and secondary malignant neoplasm of the breast. Physician orders dated 1/24/23 directed Anastrozole, 1 mg one time a day for breast cancer; Cyanocobalamin, 1000 micrograms one time a day for Vitamin D deficiency; Docusate Sodium 100 mg every day for constipation; Ferrous Sulfate, 325 mg three times day for iron deficiency; Losartan Potassium, 25 mg one time a day for hypertension; Multivitamin, one tab for preventative maintenance; Omeprazole, 40 mg daily for gastroesophageal reflux disease; Oxybutynin Chloride ER, 5 mg daily for preventative maintenance; Toprol XL ER, 25 mg daily for hypertension; Trelegy Ellipta, 100-62.5-25 micrograms aerosol powder, one puff into lungs daily; Vitamin C, 500 mg daily for preventative maintenance; and Xarelto, 20 mg daily for atrial fibrillation. Although review of Resident 49's clinical record identified Anastrozole, 1 mg; Cyanocobalamin, 1000 micrograms; Docusate Sodium 100 mg; Ferrous Sulfate, 325 mg; Losartan Potassium, 25 mg; Multivitamin, one tab; Omeprazole, 40 mg; Oxybutynin Chloride ER, 5 mg; Toprol XL ER, 25 mg; Trelegy Ellipta, 100-62.5-25 micrograms aerosol powder; Vitamin C, 500 mg; and Xarelto, 20 mg; were scheduled to be administered on 1/28/23 at 9:00 A.M., review of the corresponding medication administration audit report identified the medications had been administered between 11:31 A.M. - 11:35 A.M. (1 hour and 31-35 minutes outside of the permitted administration window). The facility policy and procedure for Oral Medication Administration dated June 2015 directed in part, Verify that the medication is being administered at the proper time, in the prescribed dose and by the correct route. (continued on next page)

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	075017	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and review of the clinical records for Resident #'s 3, 44, 47, 48, and 49 with the Regional Nurse on 5/8/24 at 12:05 P.M., she stated that the policy for medication administration was not followed and residents did not receive their medication in accordance with the standard of care or the physician orders. 29050 Based on clinical record review, review of facility documentation, review of facility policy and procedures, and interviews with facility staff for one sampled resident reviewed for medication errors related to transcription of orders (Resident #25), the facility failed to timely and accurately complete medication reconciliation on admission/readmission and prior to medication administration to identify medication discrepancies. The findings include: Resident #25's diagnoses included mechanical aortic valve replacement. a. Review of the hospital Inter-Agency Referral Report (W10) dated 8/16/23 identified orders that included Warfarin commonly known as Coumadin (anticoagulant) 4 milligram (mg) 1 tablet (4mg total) by mouth daily and Warfarin 5 mg 1 tablet (5mg total) by mouth daily. Further review identified an asterisk (*) next to each Warfarin order to identify a warning that this list has 2 medications that are the same as other medications prescribed for you. Read the directions carefully and ask your doctor or other care provider to review them with you. Review of the hospital Recently Administered Medications Prior to Discharge list identified that Warfarin 5 mg was last administered on 8/13/23 and Warfarin 4 mg was last administered on 8/15/23. Other hospital discharge instructions directed to continue home regimen of Warfarin as listed because the resident had mechanical valve and goal of INR (blood test used to monitor clotting for proper Warfarin dosing) was in 2.5 to 3.0 range. The hospital Discharge Summary dated 8/16/23 identified the resident's home regimen was Warfarin 4 mg Monday, Wednesday, Friday and Warfarin 5 mg the other days. Further review identified that on the day of discharge the residents INR was in therapeutic range. The Discharge Summary further directed to continue medications which have not changed. The details included Warfarin 4 mg 1 tablet (4mg total) by mouth daily and Warfarin 5 mg 1 tablet (5mg total) by mouth daily. The warning identified potential duplicate medications were found and directed to please discuss with provider. The facility Admission/Readmission form dated 8/16/23 identified Resident #25 was oriented, able to respond appropriately and required staff assistance with ambulation. A physician's order transcribed by RN #1 and dated 8/16/23 at 3:51 PM directed to administer Warfarin 4 mg by mouth daily and Warfarin 5 mg by mouth daily. Review of e-MAR identified on 8/16/23 at 5:29 PM, Resident #25 received both Warfarin 4 mg and Warfarin 5 mg for total dose of 9 mg. Review of Reportable Event Form and investigation dated 8/16/23 identified in the evening of Resident #25's admission, the resident received 9 mg of Warfarin in error. However, he/she was supposed to receive only 4 mg of Warfarin. APRN #3 was notified, ordered blood work and to hold the medication. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's clinical record identified a new order dated 8/17/23 for Warfarin 4mg 1 tablet daily and to repeat bloodwork. Interview with RN #2 on 4/17/24 at 3:20 PM identified that to prevent possible medication errors, the medication reconciliation process for any new admission or re-admission includes review of hospital Inter-Agency Referral Report and hospital Discharge Summary, also review of medications that the resident was taking at home to ensure that there were no discrepancies and to check when the medications were administered last while at the hospital. Lastly, a second nurse check is performed. RN #2 further identified if any concerns were identified, she would call the doctor or the hospital for clarifications and directions and then transcribe the correct medication orders. RN #2 stated she was unaware how the error occurred. Interview with LPN #1 on 4/18/24 at 12:01 PM identified that on 8/16/23 Resident #25 received Warfarin 9 mg in error instead of 4 mg as per hospital schedule. LPN #1 further identified she was notified of the medication error after RN #1 reviewed both the hospital Inter-Agency Referral Report and the hospital Discharge Summary and noted that the resident was on alternating dose of Warfarin 4 mg and 5 mg and the 9 mg total daily dose was transcribed in error by RN #1. Interview with APRN #3 on 4/18/24 at 12:20 PM identified although she was unable to recall that incident, she would expect the nursing supervisor (RN #1) to review all available hospital documentation, especially Inter-Agency Referral Report and Discharge Summary before calling her to verify hospital orders. APRN #3 further identified that if notified that the resident was alternating Warfarin 4 mg and 5 mg dose while at home, last dose received at the hospital was Warfarin 4 mg and total dose to be administered was not identified as 9 mg. She would consider both doses written separately a duplicate entry because there was no direction to administer a total dose of 9 mg, therefore an error. Although attempted, an interview with RN #1 was not obtained. Review of facility documentation identified to ensure accurate transcription of Warfarin for residents on admission and readmissions, on 8/17/23 and 8/18/23 nursing staff have been educated on Coumadin Admission Alert steps to take to ensure that Warfarin orders were accurately transcribed to avoid medication errors. b. Review of clinical record identified Resident #25 was discharged to the hospital on 9/15/23 for a surgical procedure to improve swallowing function. Review of a hospital pharmacy consult dated 9/16/23 identified hospital Warfarin dosing, for INR to be 2.5 to 3.5. The resident was on Lovenox bridge therapy. Recent Warfarin dosing reviewed, and recommendations directed to keep dose at 4 mg every Monday, Friday and 5 mg all other days, per anticoagulation clinic note on 8/31/23. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of hospital Discharge Medications and Orders dated 9/17/23 directed to continue taking Warfarin 4 mg total by mouth daily and Warfarin 5 mg total by mouth daily. Further review identified asterisk (*) next to each Warfarin order with warning that this list has medications that are the same as other medications prescribed and to read the directions carefully and ask the doctor or other care provider to review them. Review of the hospital Recently Administered Medications Prior to Discharge list identified that Warfarin 5 mg was last administered on 9/16/23. Special instructions directed to continue Lovenox (anticoagulant) shots while on Warfarin until therapeutic PT (blood test to evaluate blood clotting)/INR was reached. The hospital Discharge Summary dated 9/17/23 directed to continue Warfarin 4 mg 1 tablet (4mg total) daily and Warfarin 5 mg 1 tablet (5mg total) daily with warning. The warning identified potential duplicate medications were found and directed to please discuss with provider. Resident #25 was readmitted to the facility on [DATE] at 2:14 PM, on call APRN was notified and the residents medications were verified. A physician's order dated 9/17/23 directed to administer Warfarin 4 mg 1 tablet by mouth daily and Warfarin 5 mg 1 tablet by mouth daily with start date 9/18/23. Review of pharmacy Medication Regimen Review dated 9/18/23 identified Resident #25 with two orders for Warfarin. One order was for Warfarin 4 mg daily to be given at 9 AM and the other order was for Warfarin 5 mg daily to be given at 10 AM. Consultant Pharmacist Recommendations directed to evaluate apparent duplication in therapy and consider consolidating doses or discontinuing one order, if appropriate. Further review identified undated signed physician/prescriber response that the order was changed. The nurse's note dated 9/18/23 by LPN #2 identified APRN #3 was notified to verify Warfarin schedule orders. Two orders were in place, one for 4 mg and one for 5 mg. Per APRN #3, medication was not to be administered at that time and ordered STAT (immediately) PT/INR. APRN will order proper dosing upon receiving blood work results. A physician order dated 9/18/23 directed STAT PT/INR and to notify APRN with results for Coumadin dose. The order failed to direct to hold or discontinue Warfarin doses 4 mg and 5 mg transcribed to be administered at 9 AM and 10 AM daily. A physician order dated 9/18/23 directed to administer Warfarin 3 mg (for PT/INR 16.1/1.5) by mouth in the afternoon until 9/20/23 and repeat INR on 9/20/23. Review of e-MAR identified on 9/19/23, Resident #25 received Warfarin 4 mg at 9:00 AM and Warfarin 5 mg at 10:00 AM. The resident received an additional dose of Warfarin 3 mg at 6:00 PM for a total dose of 12 mg. Further review identified on the day of the error Resident #25 was scheduled to only receive Warfarin 3 mg 1 tablet by mouth in the afternoon. The nurse's note dated 9/20/23 identified APRN #3 was called with blood work results (PT/INR 19.8/1.9). APRN #3 ordered to hold Warfarin and repeat PT/INR on 9/22/23. Review of e-MAR identified on 9/25/23 Resident #25 was restarted on Warfarin 3 mg and continued to receive Lovenox injections daily with blood work monitoring. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and Resident #25's clinical record review with APRN #1 on 4/18/24 at 1:26 PM identified on 9/19/23 the resident received incorrect dose of Warfarin (12 mg total), he/she was supposed to receive only 3 mg of Warfarin as ordered. Further review identified that LPN #2 should have written an order to hold or to discontinue the previous Warfarin order dated 9/17/23 that was also transcribed incorrectly (wrong dose/time). APRN #1 further identified, some residents may be very sensitive to Warfarin changes and mistakes may result in problems. APRN #1 identified her expectation was that the nursing staff review the resident's complete medication regimen at the time of admission and transcribe the physician orders accurately to ensure that correct medication dose was given. Interview with DNS on 4/18/24 at 2:14 PM identified she was new in the position. DNS failed to provide documentation that Coumadin Admission Alert steps were implemented to ensure that Warfarin error did not reoccur. Interview and hospital Warfarin Therapy Instructions review with hospital Pharmacist #1 on 4/23/24 at 10:54 AM identified Resident #25 was not receiving 9 mg total dosing of Warfarin while at the hospital. The resident was on alternate dose of 4 mg to 5 mg of Warfarin and doses were based on blood work results and Lovenox use. The hospital Pharmacist #1 confirmed Warfarin 9 mg orders should not have been entered for Resident #25 on admission and readmission to the facility. Inaccurate increase dose of Warfarin may be potential for bleeding. Although attempted, an interview with LPN #2 was not obtained. Review Resident #25's clinical record identified inaccurate Warfarin doses were transcribed on both admission and readmission from the hospital and Warfarin orders were not implemented correctly. The facility Nursing policy identified Medication Reconciliation refers to the process of verifying that the resident's current medication list matches the physician's orders for the purposes of providing the correct medications to the resident at all points throughout his or her stay. The policy further directed to during admission process to compare orders to hospital records, etc. and to obtain clarification orders as needed. The facility Physician's Orders Transcription policy identified all written physician's orders or telephone physician's orders must be duly noted and accurately transcribed by licensed nursing staff.

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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** 16647 16837 Based on review of the clinical records, staff interviews, and facility policy for 2 of 4 residents (Resident #19 and #28) reviewed for skin conditions related to pressure, the facility failed to follow physician orders, failed to document weekly skin assessments for a pressure ulcer noted on the coccyx and failed to follow the policy on the prevention and management of pressure ulcers. The findings include: 1. Resident # 19 was admitted on [DATE] with diagnoses which included COVID-19, end stage renal disease (ESRD), atherosclerotic heart disease of native coronary artery, and hypertension. The hospital discharge summary dated 4/27/20 identified a necrosis to the 4th right toe and an ulceration to the 4th left toe. The discharge summary further noted a pressure injury to the coccyx (no measurement noted) Review of physician orders dated 4/27/20 directed facility staff to do weekly wound documentation and hemodialysis three times a week A nursing admission assessment dated [DATE], 10:55 P.M. identified an open area to the coccyx which measured 0.25 centimeters (cm) by 0.25 cm and an area on the right second toe with a 0.5 cm x 0.5 cm eschar. The Resident Care Plan dated 4/28/20 identified Resident #19 had a wound infection to the toe, had an opening on the left 4th toe, a coccyx pressure injury, had an eschar on 2nd toe of the right foot, and a superficial abrasion on the right 2nd and 3rd toe. Interventions included to administer antibiotics as ordered, administer treatment to toe as ordered, monitor for signs and symptoms of healing and/or deterioration and report to the MD, offload heels, elevate extremities, and skin checks per facility protocol. Review of the progress notes and weekly nursing evaluations from 4/29/24 until 6/22/20 failed to show weekly wound documentation of the pressure injury to the coccyx had been completed. Interview and review of the clinical record with the Corporate Wound Nurse on 4/18/24 at 12:45 P.M identified wound measurements were not documented or tracked weekly for the coccyx and that it was his/her expectation that the nursing staff would document wound measurements weekly. The Corporate Wound Nurse further stated s/he believes the wound documentation in the electronic health record is inaccurate. Review of the facility policy on Prevention and Management of Pressure Injuries identified pressure injuries are assessed and documented at least weekly and with a significant change in the wound until it is resolved. (continued on next page)

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	075017	A. Building B. Wing	05/23/2024

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #28 was admitted to the facility on [DATE] with diagnoses that included a right hip fracture with titanic trochanteric nail, osteoarthritis, benign prostatic hyperplasia with lower urinary tract symptoms and a surgical wound of the right hip. Review of the Admission/Readmission V2 assessment dated [DATE] Functional Ability document identified that the resident required assist of two for toileting. transfers, ambulation, and bed mobility. Review of the Norton Plus V2 skin assessment dated [DATE] identified the resident with a score of 13, which is a moderate risk for development of pressure ulcers. Review of the Physician orders dated 10/7/2019 directed to apply foam dressing to bilateral buttock every day for a stage one pressure ulcer, Norton Plus skin assessment upon admission and weekly times four, specialty air mattress on the bed checking placement and function every shift, and a wound consult. Further review identified a physician order dated 10/16/2019 which directed Triad to the coccyx and buttock wounds, cover with calcium alginate and bordered foam dressing daily. Review of the care plan 10/7/2019 identified that the resident had a diagnosis of arthritis with the potential for pain and decreased mobility. Interventions included assist with position changes to achieve optimal comfort as needed and use care with repositioning. The care plan further indicated the resident is at risk for skin breakdown with interventions that included inspect skin for redness, irritation, and breakdown; offer turning and positioning approximately every two hours and as needed; pressure reducing cushion/mattress as needed; toilet and incontinent care as needed; treatments as ordered and weekly skin inspections. Review of LPN #1's progress notes dated 10/11/2019 and 10/13/2019 directed to encourage to turn and reposition, identified that a foam dressing was applied to buttocks/sacrum and turn/reposition off boney areas to distribute pressure. A subsequent progress note dated 10/15/2019 by APRN #1 identified new open areas on bilateral buttocks with surrounding erythema, not blanchable, ulcers are open with scant yellow drainage, no odor, and seen by the wound nurse. Although review of the Documentation Survey Report from 10/6/2019 through 10/16/2019 indicated the resident required limited assistance to total dependence for bed mobility, further review of the clinical record failed to identify documentation that the resident was offered turning and positioning approximately every two hours and/or that the resident was turned and positioned every two hours and as needed. Interview and review of the clinical record with the DNS on 4/23/2024 at 11:00 AM failed to identify documentation that the resident was offered and/or turned and positioned every two hours and as needed. According to the Policy for Prevention and Management of Pressure Injuries, 2nd Edition 2014: Residents with pressure injuries and those at risk for skin breakdown are identified, assessed, and provided appropriate treatment to encourage healing and/or maintenance of skin integrity. Care plans are developed based on individual resident's goals and decisions for treatment. Ongoing monitoring and evaluation are provided to ensure optimal resident outcomes.

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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** 16837 Based on review of the clinical records, staff interviews, and review of facility policyand procvedures for 7 of 7 sampled residents (Resident # 1. 5, 9, 18, 23, 29, and 42) reviewed for nutrition and hydration, the facility failed to monitor weights or monitor intake and output in accordance with physician orders. The findings include: 1. Resident # 1 was admitted to the facility on [DATE] with diagnoses that included, type 2 diabetes mellitus, infection of the skin and renal dialysis. A minimum data set (MDS) assessment dated [DATE] identified a BIMS of 15 and the resident can make decisions related to tasks of daily living. The MDS assessment further identified the resident as receiving dialysis. A corresponding care plan which was initiated on 4/29/21 identified a potential for impaired nutrition due to requiring hemodialysis with interventions that included a fluid restriction of 1500 milliliters (ml) per day and to monitor intake. Review of physician orders dated 5/5/21 directed a 1500 milliliter (ml) fluid restriction daily with 200 ml on the day, evening, and night shifts with 900 ml reserved for dietary trays. Review of intake and output documentation from 5/1/21-8/2/21 (93 days) identified that intake had not been monitored on the day or the evening shift. During an interview with the Director of Nurses on 4/17/24 at 2:54PM, s/he stated that the physician orders should be followed, and the expectation is that intake should have been monitored on all three shifts. Review of the intake and output monitoring policy indicated in part that intake and output will be monitored per physician orders. 2. Resident #5 was admitted to the facility on [DATE] with diagnoses that included congestive heart failure (CHF), hypoxemia, weakness, low back pain and hypothyroidism. Physician orders dated 10/10/19 directed a daily weight and notify the APRN/MD of an increase of 2 pounds in a day or 5 pounds in a week. Subsequent orders dated 10/21/19 and 10/23/19 directed a fluid restriction of 1500 milliliters (ml) daily and a fluid restriction of 1500 ml daily with 11-7 shift: 340 ml, 7-3 shift: 340 ml, and on the 3-11 shift: 630 ml. An assessment dated [DATE] identified a cognitive impairment, required extensive assistance with transfers, continent of bowel function and occasional urinary incontinence. (continued on next page)

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	075017	A. Building B. Wing	05/23/2024

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A corresponding care plan dated 10/11/19 and revised on 11/18/19 identified the resident had congestive heart failure/history of heart failure with interventions that included, early signs of CHF may include fatigue and weight gain, fluid overload may cause swelling of legs, ankles, fluid in the lungs, shortness of breath, and increased heart rate of respiratory rate. An additional intervention included monitoring weights as ordered. In addition, the care plan indicated the resident is at risk for dehydration related to medication with an intervention that included to monitor intake and output as indicated. Review of progress notes dated 10/19/19 identified the family was expressing concerns about wheezing and swelling. APRN progress notes 10/20/19 and 10/25/19 identified the resident had 2-3 plus pitting edema in the lower extremities. Review of the clinical record and interview with Regional Nurse #1 on 5/9/24 at 10:30 A.M. failed to identify that intake and output had been monitored from 10/10/19-11/1/19 (20 days-60 shifts). Although weights were ordered daily, review of the clinical record failed to identify weights were obtained on 10/26, 10/27/ and 10/28/19. S/he further stated the plan of care was not followed. Review of the policy and procedure for fluid restriction, dated April 2015, directed in part to maintain accurate intake and output. Review of the policy and procedure for weights indicated weights are documented in the resident's clincal record or weight book. 3. Resident #9 was readmitted on [DATE] with diagnoses that included urosepsis, acute kidney injury, chronic kidney disease, congestive heart failure and was readmitted with a Foley catheter. A physician's order dated 1/30/19 directed to monitor Intake and Output (I & O) every shift for 72 hours upon admission/readmission, and document on the intake and output paper flowsheet. The baseline(electronic) care plan dated 1/30/19 indicated that intake and output was an intervention for foley catheter monitoring. Although review of the progress note dated 1/31/19 -2/5/19 identified urine output was tracked, review of the intake and output monitoring during that time frame failed to identify intake was monitored. Interview with Director of Nursing Services and Administrator on 4/17/24 at 2:45PM identified the night nurse's responsibilities include initiating a new intake I & O document for each resident who is being monitored for I & O, for the upcoming day. S/he further stated I do not know why this was not done and the intake and output sheets are blank. Further, s/he stated that the expectation was that Resident #9 would be placed on Intake and output because of his diagnosis, Foley catheter and IV antibiotics and the I & O was monitored in accordance with physician orders. Review of the urinary catheter insertion policy directed, in part, to document output on Intake and Output record. 4. Resident #18 was admitted to the facility on [DATE] with diagnoses that included congestive heart failure, atrial fibrillation, bradycardia, and chronic obstructive pulmonary disease. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Physician orders dated 5/11/19 directed to monitor intake and output every shift for 72 hours and to documents on the intake and output flow sheet. In addition, physician orders dated 5/16/19 directed a 1200 milliliter (ml) fluid restriction daily and daily weights as part of the congestive heart failure protocol. Review of a resident care plan dated 5/13/19 indicated the resident had a diagnosis of congestive heart failure and was at risk for dehydration. Interventions included monitoring weights as directed and monitoring intake and output as indicated. Review of progress notes from 5/15/19-5/18/19 identified the resident continued to gain weight with a weight gain of 8 pounds noted since admission. Further review of the progress notes during this time identified multiple changes to the resident's cardiac medication. Review of the Resident Care Plan failed to identify a 1200 ml fluid restriction. Further, review of the Nurse Aide Care Card failed to identify a 1200 ml fluid restriction and/or that intake and output should be monitored. Review of the clinical record with the Regional Nurse on 5/9/24 at 10:00 A.M. failed to identify intake and output had been monitored and/or that the fluid restriction had been communicated to the nurse aide providing supportive care to the resident. Review of the Fluid Restriction policy and procedure dated April 2015 directed to maintain accurate intake and output. 5.Resident #23 was admitted on [DATE] with diagnoses which included acute kidney failure, type 2 diabetes, essential hypertension, and heart failure. A quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #23 was independent for eating, required setup or clean-up assistance for oral hygiene, and required substantial/maximal assistance for upper body dressing. A Resident Care Plan (RCP) dated 9/5/23 identified Resident #23 had acute kidney failure and was receiving diuretic therapy. Interventions included fluids as ordered (restrict or give as ordered), monitor changes in mental status, administered diuretic as ordered and monitor for side effects and effectiveness. Physician orders dated 8/28/23 at 6:02 AM and 9/13/23 at 1:44 PM directed weights 3 times a week, notify provider of weight gain greater than 5 pounds in 1 week and directed obtaining post void residual (PVR) every shift and notify provider if residual is greater than 200 milliliters. Further physician orders dated 9/13/23 at 1:44 PM directed strict intake and output for 3 days. Review of the progress notes identified a late entry Advanced Practice Registered Nurse (APRN) note for 9/13/23 and was created and entered on 9/18/23. The APRN note indicated that Resident #23 had a significant Acute Kidney Injury (AKI) and new orders for holding Lasix for 3 days, bladder scan for post void residual (PVR) every shift, notify provider if PVR is greater than 200 milliliters, strict intake and output documentation for 3 days, new order to place peripheral intravenous catheter (PIV), and run D5 1/2NS at 75 milliliters an hour for 2 liters. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075017	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montowese Center for Health & Rehabilitation	163 Quinnipiac Avenue North Haven, CT 06473

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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 documentation that post void residuals were being tracked on 9/13/23, 9/14/23, 9/15/23, failed to identify weights were being documented 3 times a week, and failed to monitor intake and output. The facility policy on Intake and Output Monitoring identified intake and output will be monitored as indicated by the resident's hydration status, risk for dehydration, and/or per physician's order. 6. Resident #29's was admitted to the facility on [DATE] with diagnoses that included end stage renal disease, chronic kidney disease, arteriovenous fistula, chronic obstructive pulmonary disease, emphysema, deep vein thrombosis, and anemia. A physician's order dated 1/17/20 directed to monitor intake and output every shift for 72 hours upon admission or readmission and document on the intake and output paper flowsheet. Additionally, review of physician orders dated 1/19/20 directed a fluid restriction of 1500 milliliters per day: 200 milliliters on 11-7 shift, 200 milliliters on 7-3 shift and 900 milliliters on 3-11 shift, every shift document intake and output on the initake and output (I + O) sheet. The Resident Care Plan dated 1/20/20 identified Resident #29 received hemodialysis for end stage renal disease, had a central line for hemodialysis and a newly placed arteriovenous fistula in his/her left upper arm. Resident #29 was receiving hemodialysis on Monday, Wednesday and Friday. Interventions included to monitor intake and output, symptoms of shock may include hypotension, orthostatic blood pressure changes, weak or absent peripheral pulses or changes in mental status. Although the medication administration records identified that I + O had been monitored from 2/19/20-2/25/20 in accordance with the fluid restriction as ordered by the physician, review of the clinical record identified that I + O documentation was missing with the exception of a flow sheet dated 1/23/20 which indicated a 1500 milliliter per 24 hour restriction, however had 0 noted on the 11-7 shift for both intake and output, with the remaining shifts not recorded. In an interview and clinical record review with the Director of Nursing Services #2 on 5/2/24 at 11:00AM, the clinical record failed to reflect documentation for completed intake and output on the paper flowsheet from 2/17/20-2/25/20 (22 shifts). Review of the Hemodialysis and Fluid restriction policy dated April 2015 directed, in part, if a resident is placed on a fluid restriction, monitor intake. Allocate fluids to be given by nursing and dietary with amounts per shift and maintain accurate intake and output. 7. Resident #42 was admitted to the facility on [DATE] with diagnoses that included neuromuscular dysfunction of the bladder, retention of urine, and acute kidney failure. A MDS assessment dated [DATE] indicated the resident had a cognitive impairment, had an indwelling urinary catheter, was incontinent of bowel function and had an enteral feeding tube for nutrition. A physician order dated 4/26/24 directed intake and output every shift every day related to the catheter and a feeding tube. The order further directed to document intake and output on the paper flow sheet every shift. (continued on next page)

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	075017	A. Building B. Wing	05/23/2024

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and review of the clinical record, specifically intake and output documents with the Nursing Supervisor on 5/3/24 at 5:00A.M. identified that from 4/23/24- 5/2/24, documentation of intake and output was missing on 23 of the 30 shifts.

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	075017	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16837 Based on review of the clinical record, review of the facility policy and procedure, and interviews for 1 resident reviewed for pain management (Resident #11) , the facility failed to identify and intervene timely for complaints of pain. The findings include: Resident #11 was admitted to the facility on [DATE] with diagnoses that included acute respiratory failure with hypoxia, influenza, pneumonia, osteoarthritis of right shoulder and a right artificial shoulder joint. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #11 as cognitively intact and required limited assistance with bathing and dressing and transfer and ambulation happened only once or twice. The MDS further identified the resident reported the presence of pain almost constantly, the level of pain makes it hard to sleep at night and the pain limits day to day activities. The Resident Care Plan dated 12/6/22 and revised 1/3/23 identified Resident #11 had pain and the potential for pain related to chronic shoulder pain. Interventions included to administer pain medication as ordered, assess characteristics of pain, location, severity on a scale of 0-10, assist with position changes as needed, and discuss with resident #11 the need to request pain medication before the pain becomes severe. Review of progress notes dated 12/9/22 indicated the resident was seen at the request of nursing for pain with a recommendation for Tylenol 1000 milligrams every 8 hours and to continue to monitor. A physician's order dated 12/9/22 directed Tylenol 1000 milligrams every 8 hours for pain for 10 days and to hold Tylenol 325 milligrams 650 milligrams orally every 4 hours as needed for mild pain for pain scale of 1-4 not to exceed 3 grams in 24 hours. A nurse's note dated 12/10/22 at 11:24 PM identified in part, that the scheduled Tylenol does not work for him. The Medication administration record (MAR) indicated on 12/10/22 a level 5 at 7:30 AM, a level 5 at 3:30 PM, a level 3 at 11:30 PM and at 2:00 PM a level 7 and at 10PM a level 6. Additionally, a physician's order dated 12/13/22 directed a Lidocaine patch 4%, apply 1 patch to right shoulder on for 12 hours off for 12 hours. Interview with Director of Nursing Services on 4/29/24 at 12:21PM identified that if a resident reported a level 7 pain, the expectation would be to give an as needed medication, wait an hour and if no relief, contact the provider. If there was no available as needed medication, then the provider should be contacted. The clinical record failed to reflect documentation that the provider was contacted prior to 12/13/22 after identifying a pain level of 7. (continued on next page)

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	075017	A. Building B. Wing	05/23/2024

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the pain management policy dated April 2015 directed, in part, when a new onset of worsening pain is identified, a pain evaluation is completed, as well as a physical evaluation and notification of the physician.

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	075017	A. Building B. Wing	05/23/2024

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 16837 Based on review of clinical records for 8 of 8 residents who experienced singficant medication errors (Resident #'s 24, 25, 45, 46, 50, 52, 53, and 40) and review of facility documentation, the facility failed to ensure sufficient staffing on 1/28/23 between 7:00 AM - 11:30 AM to meet the resident's needs. The findings include: Review of the daily census dated 1/28/23 identified a census of 107 residents. Review of the staffing dated 1/28/23 for the 7:00 AM - 3:00 PM shift identified although there were 3 nurses and 1 nursing supervisor assigned to the facility, significant medications were either late or omitted for 8 residents.

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	075017	A. Building B. Wing	05/23/2024

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 16837 Based on review of 2 of 2 personnel files, the facility failed to complete performance appraisals in accordance with the facility policy. The findings include: Review of the personnel files identified the following: 1. Registered Nurse #8 had an effective employment date of 9/29/22. Further review failed to identify a performance review had been completed since the date of hire. 2. Registered Nurse (RN) #9 had an effective employment date of 9/29/22. Further review failed to identify a performance review had been completed since the date of hire. Interview and review of the personnel files with the Chief Administrative Officer on 5/5/24 identified the personnel files for RN # 8 and RN #9 were lacking performance appraisals since the effective date of hire and in accordance with the facility policy and procedure. Review of the Performance Appraisals policy directed in part, Department heads and supervisors will complete performance appraisals upon the following occasions: a. By the end of the first three months of employment; b. Prior to the anniversary date of employment; c. Six months after the employee is transferred or promoted to a new job.

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	075017	A. Building B. Wing	05/23/2024

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16837 Based on review of the clinical records, review of facility documentation, review of policy and procedures and interviews with facility staff for 8 of 12 residents (Resident #'s 24, 25, 45, 46, 50, 52, 53, and 40) reviewed for medication administration which resulted in medication errors, the facility failed to administer medications in accordance with physician/advanced practice registered nurse orders to ensure residents were free from significant errors. The findings include: 1. Resident #24's was admitted to the facility on [DATE] with diagnoses that included cellulitis, atrial fibrillation. congestive heart failure (CHF) and lymphedema. A physician's order dated 6/23/21 directed Eliquis tablet 5 milligrams by mouth two times a day for atrial fibrillation and Lasix Tablet 40 milligrams, by mouth two times a day for congestive heart failure. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #24 as cognitively intact and required extensive assistance with bathing and dressing. The Resident Care Plan dated 6/24/21 with a revision on 7/10/21 identified the resident had an altered cardiovascular status related to CHF, hypertension, and atrial fibrillation. Interventions included administering cardiac medications as ordered by the physician, monitoring and documenting side effects and reporting adverse reactions to the physician as needed. Review of the medication administration audit report indicated that on 6/26/21 Eliquis, 5 milligrams scheduled for 9:00 A.M. was administered at 10:34 A.M. (34 minutes outside of permitted window) and the scheduled second dose was not given. Additionally, further review of the medication administration audit report indicated on 6/26/21 Lasix, 40 milligrams scheduled for 9:00 A.M. and 2:00 P.M. was administered at 3:09 P. M. both the 9:00AM dose and the 2:00PM dose. During an interview with the Regional Nurse on 5/8/24 at 12:07 P.M. s/he identified that there is a pattern of missing medications and late medications. The facility policy and procedure for Oral Medication Administration dated June 2015 directed in part, verify that the medication is being administered at the proper time, in the prescribed dose and by the correct route. 2. Resident #25's diagnoses included mechanical aortic valve replacement. (continued on next page)

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	075017	A. Building B. Wing	05/23/2024

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. Review of the hospital Inter-Agency Referral Report (W10) dated 8/16/23 identified orders that included Warfarin commonly known as Coumadin (anticoagulant) 4 milligram (mg) 1 tablet (4mg total) by mouth daily and Warfarin 5 mg 1 tablet (5mg total) by mouth daily. Further review identified an asterisk (*) next to each Warfarin order to identify a warning that this list has 2 medications that are the same as other medications prescribed for you. Read the directions carefully and ask your doctor or other care provider to review them with you. Review of the hospital Recently Administered Medications Prior to Discharge list identified that Warfarin 5 mg was last administered on 8/13/23 and Warfarin 4 mg was last administered on 8/15/23. Other hospital discharge instructions directed to continue home regimen of Warfarin as listed because the resident had mechanical valve and goal of INR (blood test used to monitor clotting for proper Warfarin dosing) was in 2.5 to 3.0 range. The hospital Discharge Summary dated 8/16/23 identified the resident's home regimen was Warfarin 4 mg Monday, Wednesday, Friday, and Warfarin 5 mg the other days. Further review identified that on the day of discharge the residents INR was in therapeutic range. The Discharge Summary further directed to continue medications which have not changed. The details included Warfarin 4 mg 1 tablet (4mg total) by mouth daily and Warfarin 5 mg 1 tablet (5mg total) by mouth daily. The warning identified potential duplicate medications were found and directed to please discuss with provider. The facility Admission/Readmission form dated 8/16/23 identified Resident #25 was oriented, able to respond appropriately and required staff assistance with ambulation. A physician's order transcribed by RN #1 and dated 8/16/23 at 3:51 PM directed to administer Warfarin 4 mg by mouth daily and Warfarin 5 mg by mouth daily. Review of e-MAR identified on 8/16/23 at 5:29 PM, Resident #25 received both Warfarin 4 mg and Warfarin 5 mg for total dose of 9 mg. Review of Reportable Event Form and investigation dated 8/16/23 identified in the evening of Resident #25's admission, the resident received 9 mg of Warfarin in error. However, he/she was supposed to receive only 4 mg of Warfarin. APRN #3 was notified, ordered blood work and to hold the medication. Review of the resident's clinical record identified a new order dated 8/17/23 for Warfarin 4mg 1 tablet daily and to repeat bloodwork. Interview with RN #2 on 4/17/24 at 3:20 PM identified that to prevent possible medication errors, the medication reconciliation process for any new admission or re-admission includes review of hospital Inter-Agency Referral Report and hospital Discharge Summary, also review of medications that the resident was taking at home to ensure that there were no discrepancies and to check when the medications were administered last while at the hospital. Lastly, a second nurse check is performed. RN #2 further identified if any concerns were identified, she would call the doctor or the hospital for clarifications and directions and then transcribe the correct medication orders. RN #2 stated she was unaware how the error occurred. (continued on next page)

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	075017	A. Building B. Wing	05/23/2024

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with LPN #1 on 4/18/24 at 12:01 PM identified that on 8/16/23 Resident #25 received Warfarin 9 mg in error instead of 4 mg as per hospital schedule. LPN #1 further identified she was notified of the medication error after RN #1 reviewed both the hospital Inter-Agency Referral Report and the hospital Discharge Summary and noted that the resident was on alternating dose of Warfarin 4 mg and 5 mg and the 9 mg total daily dose was transcribed in error by RN #1. Interview with APRN #3 on 4/18/24 at 12:20 PM identified although she was unable to recall that incident, she would expect the nursing supervisor (RN #1) to review all available hospital documentation, especially Inter-Agency Referral Report and Discharge Summary before calling her to verify hospital orders. APRN #3 further identified that if notified that the resident was alternating Warfarin 4 mg and 5 mg dose while at home, last dose received at the hospital was Warfarin 4 mg and total dose to be administered was not identified as 9 mg. She would consider both doses written separately a duplicate entry because there was no direction to administer a total dose of 9 mg, therefore an error. Although attempted, an interview with RN #1 was not obtained. Review of facility documentation identified to ensure accurate transcription of Warfarin for residents on admission and readmissions, on 8/17/23 and 8/18/23 nursing staff have been educated on Coumadin Admission Alert steps to take to ensure that Warfarin orders were accurately transcribed to avoid medication errors. b. Review of clinical record identified Resident #25 was discharged to the hospital on 9/15/23 for a surgical procedure to improve swallowing function. Review of a hospital pharmacy consult dated 9/16/23 identified hospital Warfarin dosing, for INR to be 2.5 to 3.5. The resident was on Lovenox bridge therapy. Recent Warfarin dosing reviewed, and recommendations directed to keep dose at 4 mg every Monday, Friday, and 5 mg all other days, per anticoagulation clinic note on 8/31/23. Review of hospital Discharge Medications and Orders dated 9/17/23 directed to continue taking Warfarin 4 mg total by mouth daily and Warfarin 5 mg total by mouth daily. Further review identified asterisk (*) next to each Warfarin order with warning that this list has medications that are the same as other medications prescribed and to read the directions carefully and ask the doctor or other care provider to review them. Review of the hospital Recently Administered Medications Prior to Discharge list identified that Warfarin 5 mg was last administered on 9/16/23. Special instructions directed to continue Lovenox (anticoagulant) shots while on Warfarin until therapeutic PT (blood test to evaluate blood clotting)/INR was reached. The hospital Discharge Summary dated 9/17/23 directed to continue Warfarin 4 mg 1 tablet (4mg total) daily and Warfarin 5 mg 1 tablet (5mg total) daily with warning. The warning identified potential duplicate medications were found and directed to please discuss with provider. Resident #25 was readmitted to the facility on [DATE] at 2:14 PM, on call APRN was notified and the residents' medications were verified. A physician's order dated 9/17/23 directed to administer Warfarin 4 mg 1 tablet by mouth daily and Warfarin 5 mg 1 tablet by mouth daily with start date 9/18/23. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of pharmacy Medication Regimen Review dated 9/18/23 identified Resident #25 with two orders for Warfarin. One order was for Warfarin 4 mg daily to be given at 9 AM and the other order was for Warfarin 5 mg daily to be given at 10 AM. Consultant Pharmacist Recommendations directed to evaluate apparent duplication in therapy and consider consolidating doses or discontinuing one order, if appropriate. Further review identified undated signed physician/prescriber response that the order was changed. The nurse's note dated 9/18/23 by LPN #2 identified APRN #3 was notified to verify Warfarin schedule orders. Two orders were in place, one for 4 mg and one for 5 mg. Per APRN #3, medication was not to be administered at that time and ordered STAT (immediately) PT/INR. APRN will order proper dosing upon receiving blood work results. A physician order dated 9/18/23 directed STAT PT/INR and to notify APRN with results for Coumadin dose. The order failed to direct to hold or discontinue Warfarin doses 4 mg and 5 mg transcribed to be administered at 9 AM and 10 AM daily. A physician order dated 9/18/23 directed to administer Warfarin 3 mg (for PT/INR 16.1/1.5) by mouth in the afternoon until 9/20/23 and repeat INR on 9/20/23. Review of e-MAR identified on 9/19/23, Resident #25 received Warfarin 4 mg at 9:00 AM and Warfarin 5 mg at 10:00 AM. The resident received an additional dose of Warfarin 3 mg at 6:00 PM for a total dose of 12 mg. Further review identified on the day of the error Resident #25 was scheduled to only receive Warfarin 3 mg 1 tablet by mouth in the afternoon. The nurse's note dated 9/20/23 identified APRN #3 was called with blood work results (PT/INR 19.8/1.9). APRN #3 ordered to hold Warfarin and repeat PT/INR on 9/22/23. Review of e-MAR identified on 9/25/23 Resident #25 was restarted on Warfarin 3 mg and continued to receive Lovenox injections daily with blood work monitoring. Interview and Resident #25's clinical record review with APRN #1 on 4/18/24 at 1:26 PM identified on 9/19/23 the resident received incorrect dose of Warfarin (12 mg total), he/she was supposed to receive only 3 mg of Warfarin as ordered. Further review identified that LPN #2 should have written an order to hold or to discontinue the previous Warfarin order dated 9/17/23 that was also transcribed incorrectly (wrong dose/time). APRN #1 further identified, some residents may be very sensitive to Warfarin changes and mistakes may result in problems. APRN #1 identified her expectation was that the nursing staff review the resident's complete medication regimen at the time of admission and transcribe the physician orders accurately to ensure that correct medication dose was given. Interview with DNS on 4/18/24 at 2:14 PM identified she was new in the position. DNS failed to provide documentation that Coumadin Admission Alert steps were implemented to ensure that Warfarin error did not reoccur. (continued on next page)

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	075017	A. Building B. Wing	05/23/2024

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview and hospital Warfarin Therapy Instructions review with hospital Pharmacist #1 on 4/23/24 at 10:54 AM identified Resident #25 was not receiving 9 mg total dosing of Warfarin while at the hospital. The resident was on alternate dose of 4 mg to 5 mg of Warfarin and doses were based on blood work results and Lovenox use. The hospital Pharmacist #1 confirmed Warfarin 9 mg orders should not have been entered for Resident #25 on admission and readmission to the facility. Inaccurate increase dose of Warfarin may be potential for bleeding. Although attempted, an interview with LPN #2 was not obtained. Review Resident #25's clinical record identified inaccurate Warfarin doses were transcribed on both admission and readmission from the hospital and Warfarin orders were not implemented correctly. The facility Nursing policy identified Medication Reconciliation refers to the process of verifying that the resident's current medication list matches the physician's orders for the purposes of providing the correct medications to the resident at all points throughout his or her stay. The policy further directed to during admission process to compare orders to hospital records, etc. and to obtain clarification orders as needed. The facility Physician's Orders Transcription policy identified all written physician's orders or telephone physician's orders must be duly noted and accurately transcribed by licensed nursing staff. 3. Resident #45 was admitted to the facility on [DATE] with diabetes mellitus, hypothyroidism, weakness, congestive heart failure, depression and spinal stenosis. Review of the physician orders dated 1/26/23 directed Aspirin, 81 milligrams (mg) one time a day as a blood thinner; Brillanta, 90 mg two times a day as a blood thinner; Bumex, 4 mg one time a day as a water pill; Carvedilol, 3.125 mg two times a day for the heart and blood pressure; Duloxetine capsule delayed release, 60 mg one time a day for depression; Farxiga, 10 mg one time day for diabetes; Gabapentin, 300 mg two times a day for nerve pain; Humalog insulin, inject 12 units with meals related to diabetes mellitus; Prednisone, 5 mg one time a day for corticosteroid; Sacubitril-Valsartan, 24-26 mg two times a day related to congestive heart failure and Spironolactone, 12.5 mg one time a day as a water pill. Although review of Resident 45's clinical record identified Aspirin, 81 mg; Brillanta, 90 mg; Bumex, 4 mg; Carvedilol, 3.125 mg; Duloxetine capsule delayed release, 60 mg; Farxiga, 10 mg; Gabapentin, 300 mg; Gabapentin, 300 mg; Sacubitril-Valsartan, 24-26 mg; and Spironolactone, 12.5 mg, were scheduled to be administered on 1/28/23 at 9:00 A.M., review of the corresponding medication administration audit report identified the medications had not been administered. Further review identified that Humalog insulin, 12 units which were ordered for administration with meals had not been administered at 7:30 A.M. and 12:30 P.M. on 1/28/23. 4. Resident #46 was admitted to the facility on [DATE] with diagnoses that included anemia, dysphagia, esophagitis, hypertension, and a gastrointestinal bleed with a gastric tube for enteral nutrition. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075017	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montowese Center for Health & Rehabilitation	163 Quinnipiac Avenue North Haven, CT 06473

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Physician orders dated 1/12/23 directed Escitalopram Oxalate, 10 milligrams (mg) via the gastric tube one time a day for depression; Esomeprazole Magnesium Packet, 20 mg, via gastric tube two times a day for gastro esophageal reflux disease; and Metoprolol Tartrate, 50 mg via the gastric tube, two times a day for hypertension. A subsequent physician order dated 1/13/23 directed to flush the gastric tube with 150 milliliters (ml) of water every 4 hours and Aspirin, 81 mg one time a day. Although review of Resident 46's clinical record identified Escitalopram Oxalate, 10 mg, Esomeprazole Magnesium Packet, 20 mg, Metoprolol Tartrate, 50 mg, and Aspirin 81 mg were scheduled to be administered on 1/28/23 at 9:00 A.M. via the gastric tube, review of the corresponding medication administration audit report identified the medications had not been administered. 5. Resident #50 was admitted to the facility on [DATE] with diagnoses that included radiculopathy, hallucinations, spinal stenosis, low back pain and depression. Physician orders dated 7/27/22 directed Divalprox Sodium Delayed Release 250 mg daily as part of 750 mg dose for depression and Divalprox Sodium Delayed Release 500 mg daily as part of 750 mg dose for depression. Although review of Resident 45's clinical record identified Divalprox Sodium Delayed Release, 750 mg was scheduled to be administered on 1/28/23 at 9:00 A.M., review of the corresponding medication administration audit report identified the medications had not been administered. 6. Resident #52 was admitted to the facility on [DATE] with diagnoses that included ischemic cardiomyopathy, major depressive disorder, post-traumatic stress disorder, atherosclerotic heart disease, and non-ST elevation myocardial infarction. Physician orders dated 11/27/22 directed Carvedilol 25 mg, two times a day for heart failure. Further physician orders dated 11/28/22 directed Corlaner, 5mg two times a day for heart failure; Eliquis 5 mg daily for a blood thinner; Entresto 49-51 mg two times a day for non-ST elevation and cardiomyopathy; Farxiga 10mg daily for type 2 diabetes mellitus; Lactobacillus, one tablet for loose stools; Lexapro 20 mg daily for major depressive disorder; Miralax 17 grams daily for constipation; Neurontin 100 mg with meals for nerve pain; and Spironolactone 12.5 mg daily for heart failure. Additional physician orders dated 12/15/22 and 1/10/23 directed a Lidocaine patch 4%, 2 patches to the upper back one time a day for pain and Keppra 250 mg two times a day related to syncope and collapse. Although review of Resident 52's clinical record identified Carvedilol 25 mg, Corlaner, 5mg, Eliquis 5 mg, Entresto 49-51 mg, Farxiga 10mg, Lactobacillus, one tablet, Lexapro 20 mg, Miralax 17 grams, Spironolactone 12.5 mg, Lidocaine patch 4%, and Keppra 250 mg were scheduled to be administered on 1/28/23 at 9:00 A.M., review of the corresponding medication administration audit report identified the medications had been administered between 11:18 A.M. - 11:24 A.M. (1 hour and 18-24 minutes outside of the permitted administration window). Further review identified Neurontin 100 mg scheduled for 8:30 A.M. was not administered until 11:18 A.M. (1 hours and 48 minutes outside of the permitted administration window) and the 12:30 P.M. was not administered. 7. Resident #53 was readmitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease, heart failure, chronic kidney disease, hypertension, and type 2 diabetes mellitus. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075017	A. Building B. Wing	05/23/2024

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the physician orders dated 1/20/23 directed Amiodipine, 10 mg daily in the morning for hypertension; Ascorbic Acid, 500 mg daily in the morning for vitamins; Benztropine Mesylate, 1 mg two times a day for involuntary movements; Budesonide-Formoterol Fumarate Inhalation, 160-4.5 micrograms 2 puffs, 2 times a day for wheezing; Buspirone HCL, 10 mg- 2 tabs, 2 times a day for anxiety; Cholecalciferol 25 micrograms in the morning for a vitamin supplement; Cyanocobalamin, 1000 micrograms in the morning for Vitamin B12; Cymbalta, 30 mg in the morning for depression; Famotidine, 20 mg in the morning for stomach ulcers; Hydrochlorothiazide, 25 mg in the morning for hypertension; Januvia, 25 mg daily for antidiabetics; Pantoprazole Sodium, 40 mg two times a day for acid reflux; Spiriva Respimat Inhalation, 2.5 micrograms inhalation in the morning for asthma and Vitamin E, 400 units two times day for vitamin supplement. Although review of Resident 53's clinical record identified Amiodipine, 10 mg; Ascorbic Acid, 500 mg; Benztropine Mesylate, 1 mg; Budesonide-Formoterol Fumarate Inhalation, 160-4.5 micrograms 2 puffs; Buspirone HCL, 10 mg- 2 tabs; Cholecalciferol 25 micrograms; Cyanocobalamin, 1000 micrograms; Cymbalta, 30 mg; Famotidine, 20 mg; Hydrochlorothiazide, 25 mg; Januvia, 25 mg; Pantoprazole Sodium, 40 mg; Spiriva Respimat Inhalation, 2.5 micrograms and Vitamin E, 400 units had not been administered. 8. Resident #40 was admitted to the facility on [DATE] with diagnoses that included hemiplegia and hemiparesis following a cerebral infarction, type 2 diabetes mellitus with diabetic neuropathy, and adjustment disorder with depressed mood. A physician order dated 10/24/23 directed Semglee Subcutaneous Solution Pen injector 100 Units/Milliliter, inject 40 units subcutaneously at bedtime for diabetes. A nursing progress note dated 10/30/23 identified the resident was yelling for his medications to be administered. Attempts to redirect were unsuccessful and the progress note annotated the supervisor request the nurse administer the medications now. The note further identified while the nurse was administering the medication, it was immediately realized that an error in administration occurred. Instead of administering Semglee 40 units as ordered on 10/24/23, Novolog 40 units was administered. Further review of the progress note identified the APRN was notified, and blood sugars were monitored. A subsequent progress note identified Resident # 40 called the emergency response system and requested to be transferred to the hospital. The facility policy and procedure for Oral Medication Administration dated June 2015 directed in part, verify that the medication is being administered at the proper time, in the prescribed dose and by the correct route. During an interview and review of the clinical records for Resident #'s 45, 46, 50, 52, 53, and 40 with the Regional Nurse on 5/8/24 at 12:05 P.M., she stated that the policy for medication administration was not followed, and residents did not receive their medication in accordance with the standard of care or the physician orders. During an interview with the Medical Director on 5/23/24 at 1:30 P.M., s/he stated the medications that were omitted or delayed in administering could have had potentially harmful effects to the involved residents and their plan of care and management of medical conditions.

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	075017	A. Building B. Wing	05/23/2024

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Montowese Center for Health & Rehabilitation	163 Quinnipiac Avenue North Haven, CT 06473

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16837 Based on clinical record review, review of facility documentation, review of facility policy and procedures, and staff interviews for one sampled resident (Resident #12) reviewed for hydration, the facility failed to ensure a laboratory test was obtained iin accordance with physician orders. The findings include: Resident #12 was admitted to the facility on [DATE] with diagnoses of anemia, dementia, atrial fibrillation, and hypertension. A Resident Care Plan dated 12/29/20 identified the resident was a fall/safety risk, had a diagnosis of anemia, expereinced an ADL decline, and had a COVID-19 infection. Interventions included transmission-based precautions, vital signs as indicated, reduce and/or eliminate out of room activity unless medically indicated, grooming and dressing, monitor for complications, and encourage to use the call light. Physician orders dated 1/8/21 directed a repeat Basic Metabolic Panel (BMP) was to be obtainied. Review of the clinical record with the DON (Director of Nursing) on 5/9/24 at 3:30 P.M. verified the facility failed to identify laboratory results were completed as ordered. Subsequent to surveyor inquiry, the DON was unable to locate any additional documentation verifying the laboratory test was performed. Interview with Registered Nurse (RN) #5 on 5/7/24 at 3:45 PM indicated that Resident #12's laboratory order for 1/8/21 should have been drawn and that it is the nursing supervisor's responsibility to ensure labs are drawn. RN #5 further indicated that it would be her expectation for nurses to follow physician orders but cannot speak as to why it was not done. Review of the Diagnostic Services Policy identified all laboratory, radiological and other diagnostic services are performed only on the order of a physician.

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	075017	A. Building B. Wing	05/23/2024

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F 0775 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep complete, dated laboratory records in the resident's record. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16837 Based on clinical record review, staff interviews, and facility policy for 1 sampled resident (Resident #12) reviewed for hydration, the facility failed to ensure Resident #12's laboratory results were available in the resident's medical record. The findings include: Resident #12 was admitted to the facility on [DATE] with diagnoses of anemia, dementia, atrial fibrillation, and hypertension. An initial Resident Care Plan (RCP) dated 12/29/20 identified the resident was a fall/safety risk, and had anemia, an ADL decline, and a COVID-19 infection. Interventions included transmission-based precautions, vital signs as indicated, reduce and/ or eliminate out of room activity unless medically indicated, grooming and dressing, monitor for complications, and encourage to use call light. An admission Minimum Data Set (MDS) dated for 12/30/20 identified Resident #12 did not have intact cognition and required set up or clean up assistance for eating and oral hygiene. Additionally, the resident required partial/moderate assistance for toileting and lower body dressing. Review of physician orders dated 12/30/20 and 1/11/21 directed laboratory work, a complete blood count with a basal metabolic panel to be completed on 12/31/20 and 1/12/21. Upon review of the clinical record with the Director of Nursing, the facility failed to identify laboratory results were filed in Resident #12's medical record pursuant to the 12/30/20 and 1/11/21 physician orders. Interview with Registered Nurse (RN) #5 indicated that Resident #12's laboratory results should be in the resident's medical record but cannot speak as to why they are not there. Review of the facility policy and procedure for Nursing Documentation identified all resident record forms are kept in the resident's medical record.

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	075017	A. Building B. Wing	05/23/2024

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16837 Based on review of the clinical record, review of facility documentation and interview with facility staff for one sampled resident (Resident #18) who had a diagnostic test ordered, the facility failed to obtain the test in accordance with provider orders. The findings include: Resident #18 was admitted to the facility on [DATE] with diagnoses that included congestive heart failure, atrial fibrillation, bradycardia, difficulty walking, and chronic obstructive pulmonary disease. A fall risk assessment dated [DATE] identified a score of 6, with a score of 10 or greater representing a high risk for falls. A resident care plan dated 5/12/19 identified the resident was at risk for falls secondary to being newly admitted to the nursing home. Interventions included a bed alarm, chair alarm, gripper socks while in bed, and placing the call bell in reach. Review of a progress note dated 5/12/19 indicated the resident had an unwitnessed fall. The progress note identified the patient reported s/he hit her head, and vital signs and neurological checks were within normal limits. A subsequent progress note dated 5/13/19 indicated periorbital ecchymosis (bruising around the eyes) was noted around both eyes. Further, a APRN progress noted dated 5/16/19 indicated bruising with a plan to obtain a head cat scan without contrast to rule out hemorrhage related to the fall over the weekend. Although an APRN order dated 5/16/19 directed a head cat scan without contrast to rule out hemorrhage, review of the clinical record and interview with the Regional Nurse on 5/9/24 at 10:30 A.M., failed to identify the cat scan had been obtained. During further interview at that time, the Regional Nurse indicated provider orders should be followed. Review of the Diagnostic Services Policy identified all laboratory, radiological and other diagnostic services are performed only on the order of a physician.

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	075017	A. Building B. Wing	05/23/2024

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16837 Based on review of the clinical record, facility policy and interview for 1 of 1 resident (Resident #24) reviewed for dietary preferences, the facility failed to conduct an initial nutritional assessment in accordance with the policy and procedures and/or to assess and establish menu preferences for the resident reviewed. The findings include: Resident #24 was admitted to the facility on [DATE] with diagnoses which included cellulitis, Congestive Heart Failure (CHF), and atrial fibrillation. A physician's order dated 6/23/2021 directed a low fat, low sodium regular consistency texture, with thin liquids consistency diet. In addition, orders dated 6/23/21 directed to obtain a weight on admission and for 4 consecutive weeks post admission then reassess. The admission Minimum Data Set assessment dated [DATE] identified Resident #24 as cognitively intact and required extensive assistance with bathing and dressing. While the resident care plan dated 7/10/21 identified the resident is on a therapeutic diet with interventions that included to monitor labs as ordered, monitor weight as needed, obtain and update preferences as needed and provide a diet, review of the clinical record failed to identify a nutritional assessment had been completed which would have included resident preferences. Although physician orders directed a weight on admission and for 4 consecutive weeks post admission, a weight was noted to be completed on 6/23/21 only. In an interview and review of the clinical record with the Director of Nursing Services on 5/9/24 at 9:00AM, the clinical record failed to reflect documentation of a nutrition assessment, or that resident preferences were completed in accordance with the policy and procedure. Review of the Food First Nutrition policy dated August 2015 directed, in part, the resident will be assessed by a registered dietitian or registered diet technician within 7 days.

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	075017	A. Building B. Wing	05/23/2024

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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** 16837 Based on review of the clinical record, staff interviews, and review of facility policy for 1 of 4 residents (Resident #19) reviewed for wounds, the facility failed to document weekly skin assessments for the coccyx, right 2nd toe and left 4th toe, and failed to provide accurate documentation in the electronic health record. The findings include: Resident #19 was admitted on [DATE] with diagnoses which included COVID-19, End Stage Renal Disease (ESRD), atherosclerotic heart disease of native coronary artery, and hypertension. The hospital discharge summary dated 4/27/20 identified a necrosis to the 4th, right toe and an ulceration to the 4th left toe. The discharge summary further noted a pressure injury to the coccyx (no measurement noted). A nursing admission assessment dated [DATE] at 10:55 P.M. identified an open area to the coccyx which measured 0.25 centimeters (cm) by 0.25 cm and an area on the right second toe with a 0.5 cm x 0.5 cm eschar. A subsequent APRN progress note dated 4/28/20 identified Resident #19 had an opening to the left 4th toe measuring 0.8cm by 0.8 cm, however, review of the clinical record failed to identify any further reference to the left 4th toe in later progress notes or nursing evaluations. Review of physician orders dated 4/27/20 directed facility staff to do weekly wound documentation. The initial Resident Care Plan dated 4/28/20 identified Resident #19 had a wound infection to the toe, had an opening on the left 4th toe, coccyx pressure injury, an eschar on the 2nd toe of the right foot, and superficial abrasions on the right 2nd and 3rd toes. Interventions included administering antibiotics as ordered, administering treatment to toe as ordered, monitor for signs and symptoms of healing and or deterioration and report to MD, offload heels, elevate extremities, and skin checks per facility protocol. An admission Minimum Data Set (MDS) dated [DATE] identified Resident #19 was moderately cognitively impaired, required partial/moderate assistance with toileting hygiene, upper body dressing, and substantial/maximal assistance with showering and lower body dressing. The MDS further identified the resident was at risk for developing pressure ulcers/injuries Review of the progress notes and weekly nursing evaluations from 4/29/24 until 6/22/20 failed to show weekly wound documentation of the left 4th toe, right 2nd toe, right 3rd toe, and coccyx had been completed. Review of the progress notes and weekly nursing evaluations since admission to the facility failed to identify an accurate assessment of Resident #19's clinical progress and changes in his/her condition specific to the resident's risk and/or current altered skin integrity. (continued on next page)

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	075017	A. Building B. Wing	05/23/2024

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Corporate Wound Nurse on 4/18/24 at 12:10 PM identified wound measurements were not documented or tracked weekly for the coccyx, right 2nd toe, right 3rd toe, and left 4th toe and that it would be his/her expectation that the nursing staff would document wound measurements weekly. The Corporate Wound Nurse went further to state s/he believes the wound documentation in the electronic health record was inaccurate. Review of the Nursing Documentation dated February 2016 identified notes should be clear, concise, and not subject to misinterpretation.

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	075017	A. Building B. Wing	05/23/2024

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 16837 Based on observations and interview with facility staff, the facility failed to ensure a safe environment. The findings include: Observations on 4/17, 4/18, and 4/19/24 throughout the days identified the pool area in the facility rehabilitation gym was unsecured. Observations identified the rehabilitation gym to be very busy on all days. Addtionally, the pool was noted to be drained with an approximate 4-5 foot drop to the bottom of the pool. Subsequent to surveyor interview with the Maintenance Director on 4/19/24 at 11:30 A.M., the area was noted to be secured throughout the remaining days of the inspection activities.