

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075017	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/30/2024
NAME OF PROVIDER OR SUPPLIER  Montowese Center for Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50094</p> <p>Based on clinical record review, facility documentation, and staff interview for one of three residents (Resident #1) reviewed for accidents, the facility failed to ensure the residents rights were honored by limiting Leave of Absence (LOA) due to contraband. The findings include:</p> <p>Resident #1 was admitted during 10/2023 with diagnoses that included Traumatic Brain Injury (TBI), paraplegia (paralysis of the lower body), and cognitive communication deficit. The quarterly [NAME] Data Set (MDS) dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of 15 indicating the resident had no cognitive impairment and required substantial assistance for transfers. The Resident Care Plan dated 7/22/2024 identified Resident #1 had short term memory loss and a mobility deficit. Interventions directed to assistance with transfers using a slide board, and to use simple direction communication and verbal cues.</p> <p>Physician order dated 8/31/2024 directed no LOAs.</p> <p>Interview with record review with the DNS on 9/30/2024 at 12:16 PM identified Resident #1 had physician orders upon admission for no LOAs due to his/her medical condition. The DNS further stated Resident #1 currently had physician orders for no LOA order because he/she was found with contraband in the facility, and because of the contraband, no LOAs were allowed. The DNS stated on 8/15/2024 Resident #1 was found with an empty lighter and an 2nd lighter, and on 8/29 and 8/30/2024 Resident #1 was found with vape pens, a lighter and a marijuana vape pen. The DNS stated she had a conversation with the Medical Director and new orders were obtained for LOA for medical appointments only.</p> <p>Interview with MD #1 on 9/30/2024 at 3 PM identified Resident #1 was restricted to go on LOA for his/her safety and the safety of the other residents in the facility due to the resident bringing lighters and vapes back to the facility after multiple conversations about not bringing the items into the facility.</p> <p>Review of the facility Non-Smoking Policy and Agreement dated 5/2023, directed in part, the facility does not permit any cigarettes, cigars, pipes, vape pens, bowls, or bong. The Policy further directed no marijuana or other combustible substance were permitted. Violation of the policy will result in a 30-day notice of eviction from the facility.</p> <p>(continued on next page)</p>

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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility Resident Smoking Protocol, signed by Resident #1's representative on 10/18/2023, directed in part, residents are not allowed to have cigarettes, matches, or lighters in their possession. The Protocol further directed residents who do not abide by the protocols may have their smoking privileges revoked and may be given a discharge notice.</p> <p>Review of facility Safe Unsupervised LOA Policy dated March of 2023, directed in part, any resident found to be participating in potentially dangerous behavior while on LOA will be reviewed by the IDT (interdisciplinary team) and the physician may determine what change may need to be made to the physician orders and plan of care.</p> <p>Facility Leave of Absence (LOA) Policy dated December 2015, directed in part, nursing staff will obtain an order for LOA with responsible party for a resident on admission.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50094</p> <p>Based on record review, facility documentation, and staff interview for one of three residents (Resident #1) reviewed for accidents, the facility failed to ensure the resident was transferred in accordance with physician orders. The findings include:</p> <p>Resident #1 had diagnoses that included Traumatic Brain Injury (TBI), paraplegia (paralysis of the lower body), and cognitive communication deficit. The quarterly [NAME] Data Set (MDS) dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of 15 indicating the resident had no cognitive impairment and required substantial assistance for transfers. The Resident Care Plan dated 7/22/2024 identified Resident #1 had short term memory loss and a mobility deficit. Interventions directed to assistance with transfers using a slide board, and to use simple direction communication and verbal cues.</p> <p>Physician order dated 8/31/2024 directed minimal assist with slide board transfers and assist with bilateral lower extremity positioning.</p> <p>Nursing note dated 9/6/2024 at 5:05 PM identified reception requested assistance getting Resident #1 into a vehicle that the resident hired to transport him/her to a family outing. Upon arrival the resident stated he/she attempted to get into the vehicle and heard a pop but did not have any discomfort. The nurse requested the resident remain in the facility to allow for an x-ray to be completed but the resident refused. An assessment was completed that identified the bilateral lower extremities were equal in length, no obvious deformity was noted visually or through palpation.</p> <p>Nursing note dated 9/6/2024 at 9:49 PM identified Resident #1 returned from leave of Absence (LOA) around 9:45 PM.</p> <p>Interview and record review with Receptionist #1 on 9/30/2024 at 11:16 AM identified he was a NA at the facility about two (2) years ago. Receptionist #1 stated on 9/6/2024 he and the uber driver attempted to assist Resident #1 into the uber driver's vehicle for an LOA. The uber driver was pushing from the side and Receptionist #1 was assisting from the bottom of the resident. A pop was then heard, and the resident was lowered back into the wheelchair. Receptionist #1 further indicated that he did not know the transfer status of the resident, he had not transferred Resident #1 before and stated the reason he transferred Resident #1 was because the resident asked him to. Receptionist #1 then stated a slide board was available but did not use it because the seat was too high for the transfer (going uphill), and he should not have attempted to transfer Resident #1.</p> <p>Interview and record review with PT #1 on 9/30/2024 at 12:02 PM identified Resident #1 required assistance of one (1) perform for transfers with a sliding board. PT #1 stated to use a sliding board the transfer needs to be from a higher level to a lower-level surface or to a same height surface.</p> <p>Interview and record review with the DNS and ADNS on 9/30/2024 at 12:16 PM identified Receptionist #1 had worked at the facility several years ago as a NA. The DNS was unable to provide documentation when Receptionist #1 last worked as a NA or when competencies for resident transfers were last completed. The DNS stated Receptionist #1 should not have transferred the resident and should have called nursing to complete the transfer.</p>		