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	01/15/2025

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48879 Based on review of the clinical record, facility documentation, facility policy and interviews for one (1) of three (3) residents (Resident #1) reviewed for abuse, the facility failed to ensure the resident was free from sexual abuse. The findings include: 1. Resident #1 was admitted with diagnoses including malignant neoplasm of the brain, epilepsy with seizures, cognitive communication deficit and depression. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Mental Interview for Mental Status (BIMS) of two (2) indicative of severely impaired cognition and was dependent on staff for bed mobility and transfers. The Resident Care Plan (RCP) dated 12/26/24 identified that the resident had impaired cognition related to a brain mass with interventions that included to cue, orient, and supervise as needed. 2. Resident #2 was admitted with diagnoses including dementia with behavioral disturbances, anxiety disorder, sepsis and chronic kidney disease. The Admission assessment dated [DATE] identified that Resident #2 was alert and oriented to person and required supervision for ambulation. A psychiatric Advanced Practice Registered Nurse (APRN) note dated 12/24/24 identified Resident #2 was seen and assessed as a new referral to the facility, stating he/she was a poor historian, had poor immediate and remote memory and no concerns with mood or behaviors were reported by nursing or Resident #2. The note identified that no behaviors were noted during the evaluation, the resident had no history of psychotropic medication use and the resident was found not to be considered a danger to self or others. A nurse's note dated 12/27/24 at 6:47 AM identified that at approximately 4:40 AM Resident #2 was observed coming out of another resident's room. Licensed Practical Nurse (LPN) #1 instructed Nurse Aide (NA) #1 to check on the other resident and to then assist Resident #2 back to bed. LPN #1 was then called by NA # 1 to Resident #2's room and informed by NA #1 that she observed Resident #2 touching Resident #1 ' s genitalia.The note identified that LPN #1 then escorted the resident out of the room and seated Resident #2 in front of the nurse's station and RN #1 (11:00 PM to 7:00 AM nursing supervisor) was notified. (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

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 01/15/2025

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F 0600

Level of Harm - Actual harm

Residents Affected - Few

Review of facility Reportable Event (RE) identified that at 4:45 AM on 12/27/24, Resident #2 was observed by NA #1 standing over Resident #1 (roommate) with his/her hands touching Resident #1's genitalia. Resident #1's brief was noted to be open at the time of the incident. Resident #1 was noted by staff to be teary and identified that Resident #2 had touched him/her inappropriately. NA #1 immediately brought Resident #2 to his/her side of the room and yelled for assistance from LPN #1, who was out in the hallway. LPN #1 came into the room and assessed the situation and directed for Registered Nurse (RN) #1 to be called. Resident #1 was assessed by RN #1 and did not to not have any injuries. Resident #2 was immediately placed on a one-to-one observation and kept out of the room for the remainder of the shift. Resident #1 was placed on every fifteen (15) minute checks for his/her safety and comfort and The RE reported that both resident's were seen by psychiatric services and Resident #2 had a room change to a private room and has remained on one-to-one observation since the 12/27/24 incident.

A psychiatric Licensed Professional Counselor (LPC) note dated 12/27/24 at 10:12 AM identified Resident #2 was seen per request of the facility following an incident with the roommate (Resident #1) earlier that morning. It identified that the resident was unable to recall the year and the day, and a Brief Mental Interview for Mental Status (BIMS) was conducted reporting a seven (7) indicative of severely impaired cognition. The note reported that Resident #2 had no recollection of the event and had been relocated to a separate room.

Review of a psychiatric evaluation note dated 12/30/24 for Resident #1 identified that the resident was seen because of a resident to resident incident. When asked about the incident Resident #1 became teary eyed, however, indicated that he/she did not want to discuss it any further.

A psychiatric Advanced Practice Registered Nurse (APRN) note dated 12/31/24 identified that Resident #2 was seen for evaluation in his/her room, alongside a NA, as resident remained on one-to-one observation per facility protocol. The resident was noted to be confused, display poor recent and remote memory, poor insight and requiring consistent redirection. Recommendations included starting Risperidone (antipsychotic medication) 0.5 milligrams (mg) twice daily as well as remaining on one-to-one observation and providing redirection and supportive care. Additionally, the note identified that an Abnormal Involuntary Movement Scale (AIMS) was completed.

Interview with NA #1 on 1/15/25 at 10:14 AM identified that just prior to 5:00 AM on 12/27/24, LPN #1 and herself witnessed Resident #2 walking out of another resident's room and then into his/her room, stating she had never seen the resident wander before, so she went to check on the resident and see what Resident #2 had been doing in the room. She reported that when she entered the room, the resident was resting with his/her eyes closed and the blankets covering the resident were smooth and untouched, so she exited the room and went into Resident #2's room to check on him/her. She identified that when she entered, Resident #1 was wearing a johnny with the sheets uncovered, his/her brief was opened, and Resident #2 was standing over Resident #1 touching his/her genitalia. NA #1 reported that she immediately walked Resident #2 to his/her side of the room, and he/she stated that he/she was trying to help Resident #1. NA #1 reported that she yelled for LPN #1 who came right away to witness how Resident #1 was left. She reported that Resident #1 was teary and nodded yes when asked by LPN #1 if Resident #2 touched him/her inappropriately. She identified that LPN #1 and herself escorted Resident #2 to the nurse's station and RN #1 (nursing supervisor) was notified. She reported that Resident #2 remained at the nursing station for the remainder of the shift, accompanied by NA #2 and other staff while they did their charting.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Interview with LPN #1 on 1/15/25 at 10:47 AM identified on 12/27/24 a little before 5:00 AM she was in the hall going to check on another resident when she observed Resident #2 coming out of the room across the hall from his/her room, so she directed NA #1 to go check on the resident. She reported that NA #1 came back to her and reported that nothing appeared disturbed, and the resident was sleeping so she was going to check on Resident #2. LPN #1 identified that a few minutes later, she heard NA #1 yelling for her from Resident #2's room and when she entered, NA #1 was standing next to Resident #2 who was already back in his/her bed and Resident #1 was laying in his/her bed with the sheet down and the brief pushed over, and his/her genitalia was exposed. NA #1 reported to her that she observed Resident #2 standing over Resident #1 touching his/her genitalia. LPN #1 identified that she asked Resident #1 if Resident #2 had touched him/her inappropriately and he/she had tears in their eyes and nodded his/her head yes. She reported that she then escorted Resident #2 to the nurse's station and notified RN #1 (nursing supervisor) of the incident. She reported that Resident #2 was placed on a one-to-one and remained at the nurse's station for the remainder of the shift. LPN #1 identified that she never observed the resident wandering prior to or following the incident on 12/27/24. Interview with RN #1 on 1/15/25 at 11:08 AM identified that when LPN #1 notified her of the incident on 12/27/24, she ensured resident was immediately placed on a one-to-one observation, reporting that Resident #2 sat at the nurse's station surrounded by staff until they were able to set up a new room for the resident. She identified that the resident was not left alone at any point, stating she called the ADNS who came in to assist with staffing and paperwork. She reported that staff also did frequent checks on Resident #1 to ensure his/her safety following the incident identifying that he/she had been crying and visibly upset. RN #1 reported that she does frequent rounds on the 11:00 PM to 7:00 AM shift and stated that she had never witnessed Resident #2 wandering and no staff had ever reported any wandering behaviors to her prior to the 12/27/24 incident. Interview with the DNS and ADNS on 1/15/24 at 1:39 PM identified that they had never observed or been alerted by staff that Resident #2 had been wandering in and out of other residents' rooms prior to the 12/27/24 incident. They identified that although the resident had a change in condition and has not been ambulating recently due to a gout flare up, there are no current plans to discontinue the one-to-one staff observation of Resident #2. They identified that the resident is still being followed closely by psych services and the family was hopeful that the confusion would clear, and the resident could be discharged home, but that the confusion has not yet subsided so the future is unclear if he/she may become long-term. Additionally, they reported that they initiated an immediate Plan of Correction to include a Quality Assurance and Performance Improvement (QAPI), staff education on wandering, abuse, close observation monitoring and resident behavior audits subsequent to the event. Review of the Abuse policy dated 01/2023 directed, in part, that each resident has the right to be free from abuse. Sexual abuse is defined as non-consensual sexual contact of any type with a resident. Sexual abuse includes but is not limited to sexual harassment, sexual coercion, or sexual assault. Staff training should include appropriate interventions to deal with aggressive and/or catastrophic reactions of residents, what constitutes abuse, that abuse allegations require immediate action and how to identify residents who have the potential for becoming victims of abuse. The facility will continue to provide individualized care plans that identify risk factors of residents as well as plans for protecting their rights. After the incident occurs the interdisciplinary team will update the person-centered care plan with appropriate interventions.