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	05/05/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, interviews, and review of facility documentation and policies for one (1) of three (3) residents (Resident #1) reviewed for a change of condition, the facility failed to ensure the resident was evaluated upon return from a hospitalization. The findings included: Resident #1 was admitted to the facility in November of 2023 with diagnoses of transient ischemic attacks and cerebral infarction, alcoholic cirrhosis of the liver, and depression. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 was cognitively intact (Brief Interview for Mental Status (BIMS) score of 15) and was independent with toileting, dressing, bed mobility, and transfers. Review of the RCP dated 2/26/25 identified Resident #1 was on anticoagulant therapy related to a cerebral vascular accident with patent foramen ovale. Interventions directed to monitor/document/report as needed adverse reactions of anticoagulant therapy, including lethargy, loss of appetite, and sudden changes in mental status. A nursing note dated 4/7/25 at 5:15 PM identified Resident #1 returned to the facility following a hospitalization. The Therapy-Rehab/Activities of Daily Living Recommendation from Therapy to Nursing document identified Resident #1 required substantial assistance with toileting, dressing, bed mobility, and transfers. Review of provider notes identified Resident #1 was not evaluated by a provider, post hospitalization, until 4/12/25 (five days after Resident #1 was readmitted to the facility). Interview with the Director of Nursing on 5/5/25 at 2:50 PM identified the facility follows the Public Health Code for residents being admitted (as well as readmitted) to the facility, which directs residents to be evaluated by a physician within forty-eight (48) hours of admission to the facility. The DNS further indicated readmissions following a hospitalization could be evaluated by either a physician or advanced practice registered nurse (APRN) and was unable to identify why Resident #1 was not evaluated by either until 4/12/25. Review of the Public Health Code directs a comprehensive medical history and medical examination shall be completed for each patient within forty-eight (48) hours of admission.

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