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	05/22/2025

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 - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, facility documentation, facility policy, and interviews for one (1) of three (3) sampled residents (Resident #2) who were reviewed for changes made in their medication regimen, the facility failed to review, reconcile, and transcribe physician orders when the resident returned from a consulting physician's appointment. The findings include: Resident #2's diagnoses included neurofibromatosis (tumors affecting the brain, spinal cord, and nerves), elevated blood pressure, and pain. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #2 was alert and oriented to person, place, time, and situation. The hospital Discharge summary dated [DATE] directed to administer (a medication for nerve pain) Gabapentin 300 milligrams (mg) capsule, one (1) capsule three (3) times a day and (a corticosteroid medication) Dexamethasone 4mg every eight (8) hours. Review of the Medication Administration Record (MAR) identified the medications from the hospital discharge summary were reconciled and transcribed onto the MAR. The consultation form dated 4/2/25 identified a physician's order for Gabapentin 300mg two (2) times a day and Gabapentin 600mg once a day in the evening and to continue the Dexamethasone 4mg every eight (8) hours, will begin to slow wean in two (2) weeks once the Koselugo, a medication to treat neurofibromatosis, is restarted. Review of the Medication Administration Record (MAR) from 4/2/25 through 4/23/25 failed to reflect documentation that the consulting physician's orders were transcribed onto the MAR. The consultation form dated 4/23/25 identified a physician's order to increase the Gabapentin to 600 mg three (3) times a day, to slow wean the steroid Dexamethasone from 4mg to 2mg every eight (8) hours for two (2) weeks, and to apply a Lidoderm patch 5% place one (1) patch over twelve (12) hours onto the skin every twenty-four (24) hours, remove and discard patch within twelve (12) hours. Review of the April and May 2025 Medication Administration Records (MAR) failed to reflect that the changes in medications made by the consulting physician had been reviewed, reconciled, and transcribed onto the MAR. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Director of Nursing (DON) on 5/19/25 at 9:30 AM identified that when a resident returns from an appointment with physician orders, the orders are reviewed and reconciled by the Advanced Practice Registered Nurse, and then the supervisor, charge nurse, or unit manager transcribes the orders into the Electronic Health record. The DON indicated if a resident returns without a consultation form, it is the responsibility of the charge nurse, supervisor, or unit manager to call the provider's office to verify if any changes were made to the care plan. The DON stated that she was not aware that orders had not been reconciled and transcribed until notified by the hospital and an investigation was conducted. Interview with the consulting physician, an Oncologist (MD #1), on 5/21/25 at 1:30 PM identified Resident #2 was seen in his office on 4/23/25. MD #1 indicated he made changes to the medication regimen and dictated the changes into the consultation note. MD #1 identified the facility did not send a consultation form, so he offered to print a copy of the consultation with the medication changes to send back to the facility, but the staff person who accompanied Resident #2 said the facility would get the orders off the computer and a paper copy was not necessary. In a follow-up interview on 5/22/25 at 9:45 AM the DON could not explain why orders placed on the consultation forms dated 4/2/25 and 4/23/25 were not reviewed, reconciled, and transcribed. The DON identified she could not explain why the staff person did not bring back a copy of the orders, but the supervisor, charge nurse, or unit manager should have followed up and called the physician's office to inquire about orders. Review of the Transcription policy dated 1/2/24 identified that Orders can be written in the electronic health record or obtained over the phone, secured messaging system, verbally, and/or from discharge and transfer paperwork from the hospital, physicians' office visit, or the consultant's recommendations, and transcribed by the Registered Nurse, Licensed Practical Nurse, or Unit Manger. Review of facility documentation identified the facility implemented an action plan: *The licensed staff were educated on receiving accurately transcribing new orders from consultation sheet after appointment and updating the resident/responsible party should medication not be available to start as ordered. *Audits will be conducted on residents with outside provider consults to ensure accuracy of new recommendations/orders over the last thirty (30) days. *The director of Nursing will audit residents with outside appointments twice weekly for accuracy of new recommendations/orders from consults times four (4) weeks then monthly times three (3) or until substantial compliance is achieved. *Audits will be reviewed at monthly Quality Assurance meetings. Based on review of facility documentation, past non-compliance was identified on 5/9/25.