| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 075017 | A. Building<br>B. Wing | 01/27/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Montowese Center for Health & Rehabilitation | 163 Quinnipiac Avenue<br>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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>**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 #1) who were reviewed for medication administration, the facility failed to ensure the charge nurse notified the supervisor when a medication was not available for administration. The findings include:Resident #1's diagnoses included epilepsy, anoxic brain injury and meningioma (brain tumor). The Resident Care Plan dated 11/10/25 identified Resident #1 had a history of seizure disorder. Interventions directed to give seizure medication as ordered, seizure precautions, monitor for adverse drug reaction and side effects, monitor for seizure activity. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 had short-and-long term memory recall deficits, was dependent on staff to perform activities of daily living and received anticonvulsant medication. A physician's order dated 1/15/26 directed to administer Brivaracetam oral tablet (a medication used to treat seizure disorder) 100 milligrams (mg) tablet by mouth two (2) times a day for seizures. The Controlled Substance Disposition Record dated 1/15/26 identified the facility had received twenty (20) tablets of Brivaracetam 100 mg from the pharmacy and on 1/20/26 at 8:00 AM there were ten (10) tablets remaining. The nurse's note dated 1/20/26 at 8:29 PM identified the Brivaracetam was not available to administer to Resident #1. The nurse's note failed to reflect documentation the nursing supervisor, provider and pharmacy were contacted regarding the Brivaracetam not being available. The nurse's note dated 1/21/26 at 3:18AM identified Resident #1 had seizure activity lasting two (2) minute, the provider was notified, and Resident #1 returned to baseline. The provider's note dated 1/21/26 at 2:03 AM identified Resident #1 was seen via telemedicine post two (2) minute seizure activity, Resident #1 will remain at the facility, and the primary care provider will follow up in the morning of 1/21/26. The nurse's note dated 1/21/26 identified Resident #1 was transferred to the hospital at 11:34 AM for sudden onset of right extremity paralysis. The hospital Discharge summary dated [DATE] identified Resident #1 was admitted on [DATE] for altered mental and initially was evaluated for a stroke, however neurology felt the event was a breakthrough seizure. The summary indicated Resident #1 was discharged with the following recommendations: increase the dose of antiseizure medication oxcarbazepine from 300 mg twice a day to 400 mg twice a day and the Brivaracetam dose will remain 100 mg twice a day. The hospital bloodwork results dated 1/21/26 identified the Brivaracetam level was 2.1 (normal level range 0.2-2.0) and the oxcarbazepine was 7.9 (normal range 3.0-35.0). The provider's note dated 1/23/26 identified Resident #1 was re-admitted to the facility. Interview with the 3-11PM charge nurse, Licensed Practical Nurse (LPN) #1, on 1/27/26 at 11:55 AM identified on 1/20/26 she could not find Resident #1's Brivaracetam in the medication cart for the scheduled 8:30 PM dose. LPN #1 explained the facility policy was when a medication was not available, the charge nurse was to notify the nursing supervisor who could then contact the provider for further instructions. LPN #1 identified although she did contact the supervisor during the shift, she did not inform the supervisor<br><br>(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 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | about Resident #1 missing the evening dose of Brivaracetam and stated she should have informed the supervisor. Interview with the 3-11PM nursing supervisor, Registered Nurse (RN) #1, on 1/27/26 at 12:14 PM identified on 1/20/26 LPN #1 did not report to her Resident #1 missed the scheduled evening dose of Brivaracetam. Interview with RN #2 on 1/27/26 at 12:57 PM identified on 1/21/26 after Resident #1 was sent to the hospital for seizure activity and stroke-like symptoms, she reviewed Resident #1's clinical record and found that on 1/20/26 LPN #1 did not report to the supervisor that she did not have the Brivaracetam for the evening dose. RN #2 indicated the facility policy was if a medication was not administered or not available, the charge nurse was to inform the supervisor so that the supervisor could contact the pharmacy and provider to get further instructions. Interview and clinical record review with the Director of Nursing (DON) on 1/27/26 at 1:07 PM identified on 1/21/26 she was notified Resident #1 had missed his/her 8:30 PM scheduled dose of Brivaracetam on 1/20/26. The DON indicated the nurse's note dated 1/20/26 failed to reflect documentation the supervisor and/or provider were notified. The DON identified facility policy directs if a medication was unavailable for the regular scheduled dose, the charge nurse was to notify the supervisor who can then notify the provider and pharmacy. The DON identified LPN #1 stated she spoke with the supervisor about another issue but failed to inform her of the missed dose of Brivaracetam on 1/20/26. Review of the clinical policy titled Medication Pass Policy, last revised 9/23/24, directed, in part that medications are administered safely and timely per the physician's order. Review of the facility policy titled Unavailable Medication Policy, last revised 10/2024, directed, in part if a medication is unavailable for any reason, the facility shall act promptly to notify the pharmacy and the appropriate practitioners to obtain a new medication supply order. The facility identified the deficient practice and developed an immediate action plan on January 21, 2026:Education was initiated for licensed nursing staff on the fiver rights of medication administration, high alert medications such as anticoagulants, insulin and opioids and physician notification.Random weekly audits will be conducted on medication pass audits to be completed weekly by supervisors.Random audits of medication omissions will be conducted weekly for four (4) weeks, then every month for three (3) months or until substantial compliance is achieved.Audit results will be reviewed monthly at QAPI (Quality Assurance Performance Improvement) meeting.Results will be reviewed at the next QAPI meeting.Completion date: January 26, 2026 |