

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075159	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2025
NAME OF PROVIDER OR SUPPLIER Norwalk Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 23 Prospect Avenue Norwalk, CT 06850	

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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for one (1) of three (3) residents (Resident #3) reviewed for abuse, the facility failed to ensure adequate supervision was provided to prevent sexual abuse. The findings include:</p> <p>a. Resident #2 had diagnoses that included vascular dementia, psychotic disturbance, mood disturbance, aphasia, and anxiety.</p> <p>The quarterly [NAME] Data Set (MDS) dated [DATE] identified Resident #2 had a Brief Mental Interview for Mental Status (BIMS) of eight (8) indicative of moderately impaired cognition, with the presence of verbal behaviors directed towards others, was continent of bowel and bladder, independent with ADLs, bed mobility, transfers, and ambulation.</p> <p>The Resident Care Plan dated 2/19/2025 identified Resident #2 had behaviors of sexual expression and desire with interventions that directed to encourage Resident #2 to talk about h/her feelings, missing h/her significant other, as well as feelings h/she may have for any of the male or female residents on h/her unit, and psychology consult as needed.</p> <p>b. Resident #3 had diagnoses that included anxiety, depression, and dementia.</p> <p>The quarterly MDS dated [DATE] identified Resident #3 had a Brief Interview for Mental Status (BIMS) score of ten (10) indicative of moderately impaired cognition, was frequently incontinent of bowel and bladder, required supervision with ambulation, set-up for ADLs, and was independent with bed mobility and transfers.</p> <p>The Resident Care Plan dated 2/18/2025 identified Resident #3 was at risk of being a victim of abuse, neglect, and/or mistreatment, sexual risk due to congregate living with interventions that directed to advise Resident #3 to seek out staff if having difficulty with others, assess medical status and provide appropriate care, and counsel resident to avoid contact with the aggressor.</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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A nurse's note dated 2/22/2025 at 5:22 A.M. (late entry) by Registered Nurse (RN) #2 identified she was notified by Licensed Practical Nurse (LPN) #2 that an incident occurred on the unit. RN #2 identified LPN #2 reported that Nurse Aide (NA) #1 observed Resident #2 in Resident #3's room, Resident #2 was lying on top of Resident #3 with h/her pants down and Resident #2's diaper was shifted to the side. RN #2 identified that NA #1 believed that Resident #2 and Resident #3 were having intercourse. RN #2 indicated that Resident #3 was escorted back to h/her room. RN #2 identified during an interview with Resident #3 h/she stated, we were having sex. RN #2 indicated she and LPN #2 assessed Resident #3, and no signs of trauma were observed. RN #2 indicated interviews with Resident #2 and Resident #3 were completed and both residents stated that the sexual act was consensual. RN #2 identified Resident #3 was transferred to the hospital for further evaluation and Resident #2 was on a one-to-one observation.</p> <p>Review of the facility's accident and incident report dated 2/22/2025 at 6:33 A.M. identified on 2/22/2025 at approximately 4:30 A.M. NA #1 observed Resident #2 lying in the bed with Resident #3, Resident #3 did not have h/her pants on, Resident #2 's johnny coat was slightly pulled up, and h/her brief was opened. Resident #3 verbalized h/she gave consent to Resident #2 to have sex with h/her. Resident #3's Power of Attorney was notified and h/she mentioned that h/she was aware that Resident #2 and Resident #3 liked each other. Resident #2 was placed on one-to-one monitoring and Resident #3 was transferred to the hospital for further evaluation.</p> <p>The facility's investigation summary dated 2/25/2025 identified both Resident #2 and Resident #3 had a diagnosis of dementia and Resident #3's Power of Attorney knew that Resident #2 and Resident #3 liked each other. Per an interview with Resident #3 h/she stated that h/she gave permission to Resident #2 to touch h/her and they had sex. Per an interview with Resident #2 h/she verbalized that h/she was not doing anything, that nothing happened between h/her and Resident #3. The summary indicated the facility could not substantiate any wrongdoing, and the facility initiated education on Dementia and sexual desires, and how to care for residents who are expressing needs of sexual encounters.</p> <p>Interview with LPN #2 on 3/18/2025 at 9:00 A.M. identified that the 11:00 P.M. to 7:00 A.M. shift staff are assigned break times at the start of the shift, to ensure when a staff member takes a break there are always two staff on the unit. LPN #2 identified on 2/22/2025 at approximately 4:00 A.M. she was going on her break and told NA #1 who was sitting in a chair in the doorway of the dining room and that if she needed anything she would be in the unit break room. LPN #2 identified although she did not see NA #2 on the unit before she left for break, she assumed NA #2 was on the unit in a resident's room. LPN #2 identified at approximately 4:30 A.M., towards the end of her break, NA #1 came to her to report that Resident #2 and Resident #3 may have had sexual intercourse because she observed Resident #2 in Resident #3's room, Resident #2 had h/her pants off lying on top of Resident #3, and Resident #3's brief was undone and opened. LPN #2 indicated NA #1 immediately separated the residents and Resident #2 was back in h/her room. LPN #2 indicated she immediately went down to assess Resident #3 who stated h/she gave Resident #2 permission, and that they were having sex. LPN #2 identified Resident #2 was placed on one-to-one monitoring and Resident #3 was sent out to the hospital. LPN #2 identified after the incident she became aware that when NA #1 found Resident #2 in Resident #3's room, NA #1 was alone on the unit, because she (LPN #2) and NA #2 were on break at the same time. LPN #2 identified she should have ensured NA #2 was on the unit prior to taking her break and not assumed NA #2 was in a resident's room.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview MD #2 (psychiatrist) on 3/18/2025 at 10:20 A.M. identified following the sexual encounter between Resident #2 and Resident #3 she was asked by the facility to urgently see Resident #3 to evaluate h/her capacity to consent. MD #2 identified Resident #3 lacked the capacity to consent to sexual activity and relationships.</p> <p>Interview with RN #2 on 3/18/2025 at 10:55 AM identified prior to 2/22/2025 that she was not aware of any episodes, sexual in nature, between Resident #2 and Resident #3. RN #2 identified by the time she went to Resident #3's room, the residents were already separated. RN #2 identified she and LPN #2 assessed Resident #3's genital areas and no injuries or abnormalities were noted. RN #2 indicated Resident #3 stated it was consensual and that h/her gave Resident #2 permission, and Resident #2 stated that they were both consenting adults. RN #2 identified Resident #2 was placed on one-to-one monitoring and Resident #3 was transferred to the hospital.</p> <p>Interview with NA #1 on 3/18/2025 at 11:31 A.M. identified on 2/22/2025 at approximately 3:50 A.M., she was seated in a chair in the doorway of the dining room, unable to visualize the unit hallway. NA #1 identified LPN #2 told her she was taking a break and to call her if she needed anything. NA #1 identified, although she did not see NA #2, she thought NA #2 was on the unit when LPN #2 went on break. NA #1 identified on 2/22/2025 at approximately 4:20 A.M. when she went to start rounds alone, Resident #2 was not in h/her room. NA #1 identified while was looking for Resident #2 she noticed that Resident #3's room door was closed. NA #1 identified when she opened Resident #3's room door she observed Resident #2 with h/her pants off lying on top of Resident #3 with a johnny coat on. NA #1 identified she directed Resident #2 to get off Resident #3 and when Resident #3 got up she observed Resident #3's legs wide open with h/her brief opened and pushed to the side. NA #1 indicated she directed Resident #2 back to h/her room, then went to get LPN #2, and reported what happened. NA #1 identified that after the incident, NA #2 returned to the unit and identified she had been on break.</p> <p>Interview with NA #2 on 3/19/2025 at 11:00 A.M. identified on 2/22/2025 at approximately 3:50 A.M. when she went on her scheduled break NA #1 and LPN #2 were on the unit. NA #2 identified between 4:15 A.M. and 4:30 A.M. when she returned from her break NA #1, LPN #2, and RN #2 told her that Resident #2 was found lying on top of Resident #3 in h/her room. NA #2 identified on the 11:00 P.M. to 7:00 A.M. shift when a staff member goes on break it is one staff per break time because there always has to be two staff members on the unit.</p> <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interviews with Director of Nurses (DNS) on 3/18/2025 at 12:00 P.M. and on 3/19/2025 at 11:10 A.M. identified on 2/22/2025 at approximately 4:15 A.M. NA #1 observed Resident #2 lying on top of Resident #3 without h/her pants on and not wearing a brief, Resident #3 was on h/her back lying in the bed with a johnny coat, with h/her brief opened and pushed to the side exposing h/her genital area. The DNS indicated the residents were immediately separated by NA #1, Resident #2 was placed on one-to-one monitoring, and Resident #3 was sent to the hospital for further evaluation. The DNS indicated following the incident Resident #2 continued to deny any type of sexual activity occurred and remained on one-to-one monitoring until h/she was discharged per h/her request. The DNS identified at that start of each shift staff discuss break times with each other, break times are then assigned so that only one staff member is on break at a time to ensure that there are always two staff on the unit. The DNS identified her expectations are prior to the staff taking a break the charge nurse should ensure that there are two other staff on the unit and the 11:00 P.M. to 7:00 A.M. staff should not be in the dining room unless they are on a break. The DNS identified on 2/22/2025 that there should have been two staff on the unit when the sexual encounter happened between Resident #2 and Resident #3 and NA #1 should not have been sitting in the doorway of the dining room where she was unable to observe the unit or the residents.</p> <p>Review of the facility's reporting and investigation of resident abuse/neglect, or mistreatment policy dated 11/2016, in part; identified that the purpose of the policy is to ensure every resident has the right to free from abuse, neglect, misappropriation of resident property and exploitation.</p>		