STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075296	A. Building B. Wing	05/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ark Healthcare & Rehabilitation at Branford Hills	189 Alps Road Branford, CT 06405

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** Based on review of the clinical record, facility documentation, facility policy, police reports, forensic laboratory findings and interviews for one (1) of two (2) residents (Resident #3) reviewed for abuse, the facility failed to protect a cognitively impaired, non-verbal resident from sexual abuse by another resident. Resident #3 lacked the cognitive ability to consent to sexual activity and forensic DNA testing confirmed the presence of Resident #2's DNA on Resident #3's oral and genital swabs. The findings include:1. Resident #3 was admitted with diagnoses that included congenital malformation syndrome predominantly affecting facial appearance, dementia, aphasia, intellectual developmental disability, dysphagia, autistic disorder, and speech disturbance. Resident #3 had a Power of Attorney (POA) for care.The annual MDS dated [DATE] identified Resident #3 had short-term and long-term memory impairment (not capable of completing a brief interview for mental status exam), severely impaired cognitive skills for daily decision making, dependent on staff for all activities of daily living (ADL's), required moderate assistance with transfers, and required supervision with ambulation.The Resident Care Plan (RCP) dated 6/25/2025 identified Resident #3 needed staff assistance with ADL's related to dementia, aphasia and autism. Interventions included an assist of one for ADL's and no male caregivers. The RCP identified Resident #3 had decreased communication skills related to aphasia, dementia and autism.2. Resident #2 was admitted with diagnoses that included Parkinson's, dementia without behavioral disturbances, heart failure, insomnia, difficulty walking, adjustment disorder, and need for assistance with personal care.A physician's order dated 4/30/2025 directed to administer Melatonin 3 mg at bedtime. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had intact cognition (Brief Interview for Mental Status (BIMS) score of 15) without behaviors or the presence of wandering, required supervision with transfers, dressing, and ambulation.The Resident Care Plan (RCP) dated 6/4/2025 identified Resident #2 had insomnia, may have difficulty sleeping at night with interventions that directed to be aware of any adverse side effects of sleep medications, keep room at Resident #2's preference: darkness/light and temperature as able, provide a quiet and restful environment at night, provide medication to help with sleep at night per MD orders, try not to awaken me during the night unless necessary, and medications adjusted per MD orders last on 4/30/2025.3.Review of the Reportable Event form, completed by the ADNS, on 7/21/25 at 2:00 AM identified that staff reported seeing Resident #2 exit Resident #3's room wearing underwear. There was a small amount of blood noted in Resident #3's brief, the physician was notified and ordered to send Resident #3 to the emergency department (ED) for an evaluation.a. Review of Resident #3's medical record identified the following:The nurse's note by RN #1 (nursing supervisor) dated 7/21/2025 at 3:44 A.M. identified staff informed him that Resident #2 existed Resident #3's room. RN #1 indicated that Resident #3 was awake in bed, non-verbal, and mood was stable. Upon assessment, Resident #3 had one leg out of his/her pajama pants, observed tinged colored blood to Resident #3's genital area, and on the edges of the underwear. RN #1 indicated Resident #3 had no scratches, or visible injuries, and Resident #3 did not exhibit signs of pain.The nurse's note by LPN #1 dated 7/21/2025 at 9:31 A.M. identified he was on the East side of the unit at (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 0600 Level of Harm - Actual harm Residents Affected - Few	about 1:15 A.M. preparing to start a medication pass when NA #1 pointed to Resident #2 who was on his/her knees halfway to his/her room, then stood up, and ran to his/her room. LPN #1 followed Resident #2 to his/her room and asked why he/she was outside of Resident #3's room and Resident #2 could not explain. LPN #1 called RN #1 and both residents were examined.The nurse's note by the former ADNS dated 7/21/2025 at 6:46 A.M. identified that MD #1 and Resident #3's POA were notified regarding the alleged incident. The ADNS identified the police were onsite and Resident #3's POA agreed with transferring Resident #3 to the ED for further evaluation and a Sexual Assault Nurse Exam (SANE) kit.Review of ED notes dated 7/21/2025 identified Resident #3 presented in the ED for a possible sexual assault. The facility noted blood to Resident #3's brief and it was unknown when the last menstrual period occurred. Resident #3 was non-verbal. Resident #3 still menstruated and per family Resident #3 was menstruating from 5/24/2025 to 5/30/2025, but unsure about June. Resident #3 tolerated the evidence collection well but was unable to obtain nail clippings. The physical examination that was conducted identified Resident #3 had a small green, yellow area of bruising on the right knee and a genitalia exam was conducted. Resident #3 has no signs of trauma, no obvious signs of lacerations, abrasions, or injuries noted.b. Review of Resident #2's medical record identified the following:The nurse's note by RN #1 dated 7/21/2025 at 3:58 A.M. identified he was called to the unit by the NA who observed Resident #2 coming out of Resident #3's room and upon arrival Resident #2 was already in bed. RN #1 indicated he asked Resident #2 what he/she was doing in another residents room and Resident #2 was unable to explain. Upon assessment, Resident #2 had no blood on his/her hands, clothing, or genital area. Resident #2 was placed on one-to-one monitoring.The nurse's note by the former ADNS dated 7/21/2025 at 6:55 A.M. identified it was reported to her that Resident #2 was seen exiting Resident #3's room wearing only underwear. The ADNS indicated Resident #2 offered no explanation to why he/she was in Resident #3's room and an investigation was initiated.The nurse's note by RN #1 dated 7/21/2025 at 7:55 A.M. identified Resident #2 was observed on his/her knees holding on to the handrail a few minutes after the alleged incident happened at 2:00 A.M. RN #1 indicated Resident #2 denied pain, no shortening of limbs noted, ROM per normal, no external or internal rotation noted, and Resident #2 denied hitting his/her head.The psychiatric assessment dated [DATE] identified Resident #2 was seen following the alleged incident. Per staff Resident #2 was found leaving another resident's room. Resident #2 reported accidently entering another resident's room while looking for the dining room at night.Review of the facility frequent checks documentation identified Resident #2 was placed on one-to-one monitoring from 7/21/25 to 7/29/25, then was decreased to every 15-minute checks. On 10/16/25 at 7:45 AM Resident #2 was placed back on one-to-one observation until discharge from the facility on 3/31/26.The psychiatric assessment dated [DATE] identified Resident #2 was referred to psych to assess mood and cognition post alleged incident. Resident #2 stated he/she woke up and accidentally walked into another room but quickly stepped out of the room. It further identified cognitively, Resident #2 exhibited mild to moderate neurocognitive deficits as evidenced by his/her Brief Cognitive Assessment Tool (BCAT) score of 28/50.c. Interview with NA #1 on 7/23/2025 identified on 7/21/25 she worked 3:00 P.M. to 11:00 P.M. shift and 11:00 P.M. to 7:00 A.M. shift. NA #1 last changed Resident #3's brief at approximately 10:45 P.M. and she did not see any blood. NA #1 indicated she had last seen Resident #2 at approximately 12:30 A.M. asleep in his/her bed. NA #1 identified as she was starting the 2:00 A.M. rounds she observed Resident #2 exiting Resident #3's room. NA #1 identified Resident #2 was wearing just a t-shirt and underwear and when she asked Resident #2 what he/she was doing in the room he/she did not respond, paused, looked at her, and then knelt holding on to the handrails in the hallway. NA #1 indicated she yelled out to LPN #1 for assistance. NA #1 identified Resident #2 then rushed back towards his/her room with LPN #1 following him/her. NA #1 identified she went in to check on Resident #3, noted that Resident #3's right leg was out of his/her pajama's pants, and when she removed the brief, she observed blood on the inner edges of the brief and notified LPN #1.Interview with LPN #1 on 7/23/2025 identified on 7/21/2025 he completed (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	rounds between 11:10 P.M. to 11:20 P.M. and observed Resident #2 in bed. LPN #1 identified he was in the hallway preparing to administer medications when NA #1 yelled for him. LPN #1 indicated he ran over and observed Resident #2 in the hallway outside of Resident #3's kneeling down holding onto the railing. LPN #1 indicated Resident #2 stood up and started rushing down to his/her room, LPN #1 followed Resident #2 into his/her room, and Resident #2 got into bed. LPN #1 indicated he asked Resident #2 what he/she was doing but Resident #2 did not respond. LPN #1 indicated he remained in the room with Resident #2, called RN #1 on the phone, and RN #1 came to the room. LPN #1 indicated he and RN #1 examined Resident #2 from head-to-toe including checking Resident #2's hands, genital area, and clothing for any blood or moisture. LPN #1 indicated there was no blood or body fluids on Resident #2. Resident #2's clothing was clean and dry, and there was no evidence of a sexual encounter. LPN #1 identified that he noted blood on Resident #3's brief. LPN #1 identified immediately following the incident Resident #2 was placed on one-to-one monitoring.Interview with RN #1 on 7/23/2025 identified on 7/21/2025 he was notified by LPN #1 that Resident #2 was observed coming out of Resident #1's room wearing just underwear. RN #1 indicated he obtained permission from Resident #2 to conduct a body assessment then he and LPN #1 performed a Head-to-Toe assessment on Resident #2 which including checking nails and clothing. RN #1 indicated Resident #3 was calm, lying in bed on his/her back and in no apparent distress. RN #1 indicated Resident #3 was wearing a pajama top, pajama pants, and his/her right leg was out of the pant leg, with the left leg still in the pant leg. RN #1 identified Resident #3's pull-up was intact, not ripped or torn but he observed blood on the edges of the pull-up. RN #1 indicated Resident #3 had no bruises, no redness, or marks on his/her skin, and Resident #3's skin was intact. RN #1 indicated he notified the ADNS and DNS, called the police, and initiated an investigation. RN #1 identified Resident #3 was sent out to the hospital for further evaluation and Resident #2 remained on one-to-one monitoring.Interview with the DNS on 7/23/2025 identified on 7/21/2025 at approximately 2:00 A.M. RN #1 reported Resident #2 was observed exiting Resident #3's room wearing underwear. The DNS indicated she arrived at the facility approximately 15 minutes after RN #1 notified her. The DNS indicated shortly after she arrived the Administrator, ADNS, and [NAME] President of clinical services arrived to the facility. The DNS indicated that Resident #3's brief was labeled in a clear bag and was intact and she observed smears of what appeared to be old blood on the pull-up. The DNS indicated when Resident #2 was asked by staff and the police officers what he/she was doing Resident #2 reported he/she was going to the kitchen to get a drink and some food, entered Resident #3's room where he saw two residents sleeping, realized he/she mistakenly went into the wrong room, and left the room quickly. The DNS identified that Resident #3 was transferred to the ED for further evaluation. The DNS identified Resident #3 returned to the facility, according to the hospital documentation Resident #3 had no trauma, lacerations, or injuries, but the evidence collected was sent to the lab for testing. The DNS indicated that prior this incident Resident #2 did not wander, did not exhibit any type of sexual behaviors, was not intrusive, did not invade others space, touch, or kiss other residents or staff. The DNS identified Resident #2 had a room change to a new unit, was placed on one-to-one monitoring, and psych was following both residents at that time. The DNS identified she spoke to Police Officer #1 several times and their investigation was ongoing. The DNS indicated the results of the lab testing could take up to 3 months and once she received the results and the police report she would send them to the State Agency.d. Review of the Police Report dated 8/22/25 identified the police officer received an email containing State Forensic Lab results from the sexual assault kit that was previously submitted. It identified Resident #2's DNA was detected in the kit and the lab requested an elimination swab from any known suspects from the nursing home. On 8/28/26 the police officer reported to the nursing home for a DNA sample from Resident #2.Review of the Police Report dated 12/18/25 identified the police officer received the lab results from Resident #2's DNA. Resident #2's DNA was found on Resident #3's oral swabs and genital swabs. The officer then applied for an arrest warrant for Resident #2 for sexual assault.Review of the Police Report dated 2/3/26 identified on (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	2/2/26 the police officer returned to the nursing home to determine Resident #2's cognitive ability due to the diagnosis of dementia.Review of the Police Report dated 3/19/26 identified on 3/17/26 he emailed the Administrator of the nursing home and advised him the case was being closed.Although multiple attempts were made, a follow up interview with LPN #1 and NA #1 were not obtained.Interview with the DNS on 5/19/26 at 1:00 PM identified the facility did not have a policy for sexual relations. He identified the procedure would be resident specific. The residents would need to be alert and orientated.Interview with the [NAME] President of Clinical Operations on 5/19/26 at 12:55 PM identified she was involved with the investigation for the event that occurred on 7/21/25 with Resident #2 and Resident #3. After the alleged event, Resident #2 was placed on one-to-one monitoring until 7/29/25 and on every 15-minute checks from 7/29/25 to 10/16/25. She identified Resident #2 transitioned back to one-to-one monitoring on 10/16/25 after the police returned to the facility for DNA samples. She identified the police officer had come to the facility on 2/3/26 to review Resident #2's cognition. She identified the police officer would not share specific information due to the active investigation and did not want to compromise the case. However, the police did identify there was a hit on Resident #2's DNA. The facility received a letter in March of 2026 that identified the case was closed and no charges were being pursued. She identified Resident #3 would not have been able to consent to sexual activity.Interview with the Administrator on 5/19/26 at 2:00 PM identified he received notification from the police department in March of 2026 that the investigation was closed and no charges were being pursued. He identified he was not notified that there was a positive match for Resident #2's DNA.Review of the Resident's Rights policy directed that residents have the right to be free from verbal, sexual, physical or mental abuse.Review of the Abuse/Resident policy directed that abuse or mistreatment of any kind toward a resident is strictly prohibited. The policy defined sexual abuse to include but no limit, sexual harassment, sexual coercion or sexual assault. This included any unwanted touch between residents.