STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075390	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beacon Brook Center for Health & Rehabilitation	89 Weid Drive Naugatuck, CT 06770

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, facility documentation, and staff interviews for one of three residents (Resident #1) reviewed for abuse, the facility failed to ensure supervision was provided in accordance with the resident plan of care, to prevent a resident incident. The findings include: Resident #1 had a diagnosis of dementia, major depressive disorder, anxiety, and cognitive communication deficit. The quarterly Minimum Data Set (MDS) dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of three (3), indicating severely impaired cognition, and was independent with ambulation. The Resident Care Plan (RCP) dated 5/20/2025 identified the family approved a relationship with Resident #2. Interventions directed staff to supervise Resident #1 when resident visits Resident #2. Resident #2 had a diagnosis of dementia, anxiety, depression, and cognitive communication deficit. The quarterly MDS dated [DATE] identified Resident #2 had a BIMS of three (3), indicating severely impaired cognition, and was independent with ambulation. The RCP dated 5/15/2025 identified the family approved a relationship with Resident #1. Interventions directed social services visits as indicated and directed every 15-minute checks. Facility reportable event dated 5/14/2025 at 9:50 AM identified NA #2 observed Resident #1 and #2 sitting on a couch next to each other and Resident #2 commented to Resident #1 you will never look as good as you used to. Resident #1 became upset and attempted to stand to move away. Resident #2 grabbed Resident #1's arm and stated he/she was not going anywhere. Resident #2 was placed on one-to-one (1:1) observation and transferred to the hospital for evaluation. Facility summary dated 5/19/2025 identified when Resident #1 had attempted to walk away from the couch, Resident #2 held onto Resident #1's arm. Resident #1 was assessed with no injuries identified. Resident #2 returned from the hospital with no new orders. The residents both resided on the same floor, and after the incident, Resident #2 was moved to another floor. 1. The nursing note dated 6/13/2025 at 10:55 PM identified a NA observed Resident #1 in bed with another resident, and both residents had no clothes on. When the nurse observed both residents in the room, they were fully dressed. An assessment was completed for Resident #1, no injuries were noted and no signs of bruising or swelling to the peri area was noted, and the resident denied discomfort. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility reportable event incident report dated 6/13/2025 at 10:35 PM identified Resident #1 was observed lying in Resident #2's bed with Resident #2 without clothing on. Resident #1 had a BIMS of four (4) and Resident #2 had a BIMS of three (3), both indicated severe cognitive impairment. The residents were separated, an assessment was completed for Resident #1 and identified no injuries, and then the residents were dressed. Both residents yelled at staff to leave them alone because they are adults and should be able to lay down in bed together. Both residents were placed on 1:1 observation. The facility investigation identified NA #1 was completing unit rounds and had observed Residents #1 and #2 sitting together in Resident #2's room with the door open. NA #1 then went to provide care for a resident located about four (4) doors down. Approximately 15 to 20 minutes later, NA #1 left the other resident room and walked down the hall to check on Residents #1 and #2 and observed the door to Resident #2's room was closed. NA #1 knocked on the door, entered the room, and observed Residents #1 and 2 in Resident #2's bed without wearing any clothing. NA #1 separated the residents and directed them to get dressed. Nursing note dated 6/13/2025 at 11:09 PM identified Resident #2 refused a body assessment. Record review identified although Resident #1's care plan directed to supervise Resident #1 when he/she visited with Resident #2, and staff were aware the residents were together on 6/13/2025, review failed to identify that supervision was provided timely in accordance with the plan of care when the residents were observed together in the room on 6/13/2025. Interview and record review with RN #1 on 6/26/2025 at 12:11 PM identified she was called to Resident #2's room around 8:45 PM because NA #1 had reported Resident #1 and Resident #2 were found in bed together naked. Upon arriving in the room, both residents were dressed after directed by staff. An assessment was completed for Resident #1, and no injuries were noted. Resident #2 refused an assessment and stated he/she was fine. RN #1 then called the Director of Nursing (DON) and notified the required parties. RN #1 stated the residents were supposed to have constant supervision when they were together, and she did not know why NA #1 did not supervise the residents. RN #1 stated NA #1 should have stayed with the residents when she observed them alone in Resident #2's room. Interview with NA #1 on 6/26/2025 at 12:48 PM identified she first saw Resident #1 and Resident #2 together in the hallway at 8 PM and when she checked on the residents again, she found them in Resident #2's room around 8:25 PM. At that time both residents were fully clothed and were sitting on the bed. NA #1 then went to provide care for another resident and when she returned to check on the residents 20 minutes later, she observed them both in Resident #2's room, laying on the bed without any clothes on. NA #1 stated she did not witness either resident harm the other and did not witness any sexual acts being performed. NA #1 stated Residents #1 and #2 were supposed to be supervised when they were together and she thought they were supposed to be checked on every 15-minutes when they are together per the care plan. Interview and record review with the Administrator and Assistant Director of Nursing (ADNS) on 6/26/2025 at 1:22 PM identified RN #1/supervisor notified them that Resident #1 and Resident #2 were found in bed with no clothes on on 6/13/2025. Interview identified the resident assessments identified no injuries and staff indicated they did not observe any sexual acts were observed. The ADNS and Administrator indicated Residents #1 and #2 were allowed to be together in Resident #2's room, but they should have been supervised when they were together. Interview identified although NA #1 had checked on the residents, interview failed to identify why supervision was not provided, in accordance with the plan of care. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Baseline/Comprehensive Person-Centered Care Plan policy dated March 2023 directed in part, all clinical department heads are responsible to ensure implementation of the resident care plans.