STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075393	A. Building B. Wing	01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bel-Air Manor Nursing & Rehabilitation Center	256 New Britain Avenue Newington, CT 06111

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 - Minimal harm or potential for 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** 49021 Based on clinical record reviews, review of facility policies and procedures, review of facility documentation, and interviews for one (1) of two (2) sampled residents (Resident #2) who were reviewed for an allegation of resident-to-resident sexual abuse, the facility failed to ensure Resident #2 was free from inappropriate touching by another resident. The findings include: Resident #1's diagnoses included depression and hemiplegia. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 was alert and oriented to person, place and time, had no memory deficits and was independent with self-propelling the wheelchair. Resident #2's diagnoses included unspecified dementia, and anxiety disorder. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #2 rarely or never made decisions regarding tasks of daily life and required supervision or touching assistance with most Activities of Daily Living (ADLs). The nursing progress note dated 1/8/25 identified Resident #1 was observed on the video camera entering another resident's room (Resident #2), kissing Resident #2 on the mouth and touching Resident 2's breast. The Facility Reported Incident form dated 1/8/25 identified Resident #1 was seen on video on 1/8/25 at 10:30 AM kissing Resident #2 with a hand on Resident #2's breast. The report indicated Resident #2's spouse, Person #1, witnessed the incident on the video camera that was located in Resident #2's room, which was utilized for the purpose of virtual visitation between Resident #2 and the spouse and informed the facility. (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 - Minimal harm or potential for actual harm Residents Affected - Few	The investigation identified Resident #1 was observed on video to have entered Resident #2's room, kiss Resident #2 on the mouth, and place a hand on Resident #2's breast. The investigation indicated Resident #1 was alert and orientated at the time of the incident, Resident #2 was alert to self only with baseline confusion and Resident #2 did not have the capacity to consent to sexual contact with Resident #1. Resident #1 was immediately placed on one-to-one (1:1) supervision, Resident #2 sent to the emergency department for further evaluation, a police investigation was initiated, psychiatric evaluations of both Resident #1 and Resident #2 were conducted, and Resident #1 was moved to another room on a different unit. The social services progress note dated 1/8/25 identified the Social Worker spoke privately with Resident #1 to assess resident's understanding of consent and boundaries following Resident #1 being observed kissing another resident. The note indicated Resident #1 expressed feeling bad for engaging in an inappropriate interaction. Interview with Resident #1 on 1/22/25 at 12:35 PM identified Resident #2 was seated in a chair located by the door to Resident #2's room, he/she self-propelled the wheelchair to Resident #2's room, kissed Resident #2 on the lips, and touched Resident #2's breast. Resident #1 identified he/she initiated the physical contact with Resident #2 and expressed he/she should not have done it. Interview and review of the facility reported incident with the Director of Nursing (DON) on 1/22/25 identified Resident #1, who was alert and orientated, was observed on video to have entered Resident #2's room, go over to Resident #2, kiss Resident #2 on the mouth, and place his/her right hand on Resident #2 so it went across Resident #2's chest. The DON identified although Resident #2 was observed to be smiling following the incident and no distress or physical harm was noted, the allegation of sexual abuse was substantiated because Resident #2 had cognitive impairments and was not able to consent to sexual contact with Resident #1. The DON identified Person #1 shared the video footage with her and the Administrator on 1/8/25 at 10:30 AM. The DON indicated prior to the incident, in November 2024, Resident #2 was observed by staff to lean over and peck Resident #1 on the cheek. The DON identified there was no harm or distress to either resident, social services followed up with both Resident #1 and Resident #2. The DON identified facility policy only permitted consenting adults to engage in sexual expression with each other. Review of facility Abuse Prevention Policies and Procedures dated 11/25/16 directed abuse of any kind, including sexual abuse, was prohibited. Review of the facility [NAME] of Rights directed each resident had the right to be free from abuse and residents must not be subject to abuse by anyone, including other residents.