STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075307	A. Building B. Wing	08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chestelm Health and Rehabilitation Center	534 Town St Moodus, CT 06469

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**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 had a new medication ordered for a change in condition and there was a noted medication interaction identified by the pharmacy, the facility failed inquiry the pharmacy why the medication had not been available and to notify the provider for six (6) days. The findings include: Resident #1's diagnoses included constipation, failure to thrive, and aphasia following cerebral infarction (a stroke resulting in damage to areas of the brain responsible for language). The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of fourteen (14) out of fifteen (15) indicating slight memory recall deficits, was dependent on staff for toileting and was always incontinent of bowel and bladder. The Resident Care Plan (RCP) dated 6/18/25 identified Resident #1 was at risk for constipation related to a history of constipation, impaired mobility, opiate use (narcotic pain medication) and a history of an ileus (a disruption of the normal propulsion of the intestine caused by lack of peristalsis or mechanical obstruction). Interventions directed to observe for signs of constipation, record the amount and characteristics of each bowel movement, follow the bowel protocol per policy and administer laxatives as ordered. The nurse's note dated 7/4/25 at 12:51 PM identified Resident #1 was noted with a moderate amount of bright red blood from the rectum, no external hemorrhoids were observed and the resident denied any pain to the area. The note identified the on-call provider was notified, and a new order was obtained for hydrocortisone suppositories twice daily for seven (7) days for a question of internal hemorrhoids. A physician's order dated 7/4/25 directed to insert one (1) hydrocortisone acetate rectal suppository 25 milligrams (mg) rectally every evening and night shift for seven (7) days for hemorrhoids. The nurse's note dated 7/4/25 identified an order note reported a drug protocol alert/warning was triggered. The note identified the interaction was with the Aspirin 81 milligrams. Review of the nurse's notes dated 7/4/25 through 7/10/25 failed to identify a provider was notified of the drug interaction until 7/10/25. Review of the July 2025 Treatment Administration Record (TAR) identified the hydrocortisone acetate suppository was not administered on the night shift from 7/4/25 through 7/10/25 because it was not available and was not administered on the evening shift on 7/5/25, 7/6/25 and 7/8/25. The TAR identified the hydrocortisone acetate suppository was administered on the evening shift on 7/7/25, 7/9/25 and 7/10/25. Review of the nurse's notes dated 7/4/25 through 7/10/25 failed to identify a provider was notified of the missed doses and the hydrocortisone acetate suppository was not available. An order administration note dated 7/10/25 at 6:07 AM identified the Advanced Practice Registered Nurse (APRN #1) was updated and directed the pharmacy to dispatch the hydrocortisone acetate suppository despite the allergy/drug interaction. The nurse's note dated 7/11/25 at 4:47 AM identified Resident #1 was noted with a moderate amount of rectal bleeding in the brief but denied any pain or discomfort, personal care was then provided, and no active bleeding occurred at that time. The note identified the on-call provider was notified of the incident, but no new orders were obtained. The nurse's note dated 7/11/25 at 8:49 AM identified Resident #1 was observed with worsening dark red rectal bleeding, expelling a large blood clot from the rectum, nausea, and upper right abdominal discomfort, the on-call provider was notified, and an order was obtained to transfer Resident #1 to the Emergency Department (ED) for evaluation. Review of the Bowel Movement Report identified Resident #1 had a medium bowel movement on 7/8/25, a medium bowel movement on 7/9/25, a large bowel movement on 7/10/25 and a large bowel movement on 7/11/25. The hospital Discharge summary dated [DATE] identified on 7/11/25 Resident #1 presented to the ED with a lower GI bleed and bright red blood from the rectum due to severe constipation requiring urgent disimpassion in the Operating Room (OR) on 7/11/25. The summary identified Resident #1 remained stable with no further signs of bleeding and was transferred back to the facility on 7/15/25. Interview with APRN #1 on 8/13/25 at 11:17 AM identified a provider should be notified for each scheduled medication that is not administered to a resident, reporting if the hydrocortisone acetate suppository was not available from the pharmacy and had he been notified, he would have held the hydrocortisone acetate suppository and ordered an alternative medication pending the arrival of the originally ordered hydrocortisone acetate suppository. APRN #1 reported he met with Resident #1 on 7/7/25 per request of the facility staff and no one mentioned to him at that time the hydrocortisone acetate suppositories had still not been received from the pharmacy or that there was an issue with the order. APRN #1 reported with the level of stool impaction that was noted on the hospital documentation, he did not believe

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**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) reviewed for constipation, the facility failed to ensure an abdominal assessment was conducted and continued monitoring following an incident of rectal bleeding. The findings include: Resident #1's diagnoses included constipation, failure to thrive, aphasia following cerebral infarction (a stroke resulting in damage to areas of the brain responsible for language) and atrial fibrillation (an irregular heart rate). The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of fourteen (14) indicating no memory recall deficits, was dependent on staff for toileting and was always incontinent of bowel and bladder. The Resident Care Plan dated 6/18/25 identified Resident #1 was at risk for constipation related to a history of constipation, impaired mobility, opiate use (narcotic pain medication) and a history of an ileus (a disruption of the normal propulsion of the intestine caused by lack of peristalsis or mechanical obstruction). Interventions directed to observe for signs of constipation, record the amount and characteristics of each bowel movement, follow the bowel protocol per policy and administer laxatives as ordered. The nurse's note dated 7/4/25 at 12:51 PM identified Resident #1 was noted with a moderate amount of bright red blood from the rectum, no external hemorrhoids were observed, and Resident #1 denied any pain to the area. The note identified the on-call provider was notified, and a new order was obtained for hydrocortisone suppositories twice daily for seven (7) days for a question of internal hemorrhoids. The note failed to identify a Gastrointestinal (GI) assessment was performed to include an abdominal assessment, the inspection, auscultation, and light palpation of the abdomen to identify visible abnormalities; bowel sounds and softness/tenderness A physician's order dated 7/4/25 directed to insert one (1) hydrocortisone acetate rectal suppository 25 milligrams (mg) rectally every evening and night shift for seven (7) days for hemorrhoids. Review of the July 2025 Treatment Administration Record (TAR) identified that the hydrocortisone acetate suppository was not administered on the night shift from 7/4/25 through 7/10/25 because it was not available and was not administered on the evening shift on 7/5/25, 7/6/25 and 7/8/25. The TAR identified the hydrocortisone acetate suppository was administered on the evening shift on 7/7/25, 7/9/25 and 7/10/25. Review of nurse's notes from 7/4/25 through 7/11/25 failed to reflect documentation a Gastrointestinal (GI) assessment was performed to include an abdominal assessment, the inspection, auscultation, and light palpation of the abdomen to identify visible abnormalities; bowel sounds and softness/tenderness The nurse's note dated 7/11/25 at 4:47 AM identified Resident #1 was noted with a moderate amount of rectal bleeding in the brief but denied any pain or discomfort, so personal care was then provided, and no active bleeding occurred at that time. The note identified the on-call provider was notified of the incident, but no new orders were obtained. The third eye health note dated 7/11/25 at 5:48 AM identified Resident #1 with know hemorrhoids had a formed stool last night after an enema. This morning the brief had more stool along with several blood smears, not currently bleeding, Resident #1 had pain last night related to difficulty evacuating stool and the brief was seen by the provider on the video. The note failed to identify a gastrointestinal assessment was performed. The nurse's note dated 7/11/25 at 8:49 AM identified Resident #1 was observed with worsening dark red rectal bleeding, nausea and upper right abdominal discomfort, and the on-call Advanced Practice Registered Nurse (APRN) was notified, and while speaking with the provider, Resident #1 was observed expelling a large blood clot from the rectum so an order was obtained to transfer Resident #1 to the Emergency Department (ED) for evaluation, Resident #1 was transported via Emergency Medical Services (EMS) at 7:44 AM. The hospital Discharge summary dated [DATE] identified on 7/11/25 Resident #1 presented to the ED with a lower GI bleed and bright red blood from the rectum due to severe constipation requiring an urgent disimpassion in the Operating Room (OR) on 7/11/25. The summary identified Resident #1 remained stable with no further signs of bleeding and was transferred back to the facility on 7/15/25. Interview with APRN #1 on 8/13/25 at 11:17 AM identified although Resident #1 should have received the hydrocortisone acetate suppository the level of stool impaction that was noted on the hospital documentation, he did not believe the hydrocortisone acetate suppository, would have made a significant difference in relieving the impaction or preventing Resident #1's hospitalization. APRN #1 identified on 7/4/25, Registered Nurse (RN) #2 should have been aware Resident #1 had a history of constipation, should have performed a full GI assessment to include bowel sounds and an abdominal assessment and should have communicated all of the information to the on-call when Resident #1 had the