

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075373	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/20/2024
NAME OF PROVIDER OR SUPPLIER Cheshire House Health Care Facility & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3396 E Main Street Waterbury, CT 06705	

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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50059</p> <p>Based on clinical record reviews, facility documentation and policies and interviews for five (5) of seven (7) sampled residents (Residents #2, # 3, #4, and #5) who were reviewed for the misappropriation of personal property, the facility failed to ensure the residents' controlled medications and the controlled disposition sheets were not removed from the facility by a licensed nurse. The findings include:</p> <ol style="list-style-type: none"> Resident #2's diagnoses included fracture of right femur, anxiety, and joint replacement. <p>The admission Minimum Data Set assessment dated [DATE] identified Resident #2 was alert and oriented to person, place, and time and received pain medication.</p> <p>The Resident Care Plan dated [DATE] identified Resident #2 was at risk of pain. Interventions directed to monitor for pain and administer medications as ordered.</p> <p>A physician's order dated [DATE] directed to administer Oxycodone 10 milligrams (mg) every six (6) hours as needed for pain.</p> <ol style="list-style-type: none"> Resident #3's diagnoses included low back pain, muscle weakness, and difficulty walking. <p>The admission Minimum Data Set assessment dated [DATE] identified Resident #3 was alert and oriented to person, place, and time and received pain medication.</p> <p>The Resident Care Plan dated [DATE] identified Resident #3 was at risk of pain. Interventions directed to monitor for pain and administer medications as ordered.</p> <p>A physician's order dated [DATE] directed to administer Dilaudid 2mg every six (6) hours as needed for moderate pain and Dilaudid 4mg every six (6) hours as needed for severe pain.</p> <ol style="list-style-type: none"> Resident #4's diagnoses included intermittent claudication of lower extremities (poor blood flow causing pain or discomfort) and peripheral vascular disease. <p>The quarterly Minimum Data Set assessment dated [DATE] identified Resident #4 was alert and oriented to person, place, and time and received pain medication.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075373	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/20/2024
NAME OF PROVIDER OR SUPPLIER Cheshire House Health Care Facility & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3396 E Main Street Waterbury, CT 06705	
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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Resident Care Plan dated [DATE] identified Resident #4 was at risk of pain. Interventions directed to monitor for pain and administer medications as ordered.</p> <p>A physician's order dated [DATE] directed to administer Oxycodone 5mg tablet give two (2) tablets every three (3) hours as needed for moderate pain and Oxycodone 5mg tablets give three (3) tablets every three (3) hours as needed for severe pain.</p> <p>4. Resident #5's diagnoses included muscle weakness, multiple myeloma (blood cancer), and anxiety.</p> <p>The admission Minimum Data Set assessment dated [DATE] identified Resident #5 was alert and oriented to person, place, and time and received pain medication.</p> <p>The Resident Care Plan dated [DATE] identified Resident #5 was at risk of pain. Interventions directed to monitor for pain and administer medications as ordered.</p> <p>A physician's order dated [DATE] directed to administer Oxycodone 5mg one (1) tablet every six (6) hours as needed for moderate pain.</p> <p>5. Resident #6's diagnoses included right ankle pain, left ankle fracture, and muscle weakness.</p> <p>A physician's order dated [DATE] directed to administer Oxycodone 5mg one (1) tablet every four (4) hours as needed for moderate pain and Oxycodone 10mg every four (4) hours as needed for severe pain.</p> <p>The Resident Care Plan dated [DATE] identified Resident #6 was at risk of pain. Interventions directed to monitor for pain and administer medications as ordered.</p> <p>The admission Minimum Data Set assessment dated [DATE] identified Resident #6 was alert and oriented to person, place, and time and received pain medication.</p> <p>The Facility Reported Incident form dated [DATE] at 11:47 AM identified on [DATE] a charge nurse reported to the Director of Nursing (DON) that a resident's Oxycodone was not available in the medication cart and the controlled substance disposition record was missing. An audit of the narcotics was conducted which revealed one (1) narcotic and the controlled substance disposition record was missing. Upon further investigation and continued audits identified the blister pack of Oxycodone 5mg tablets and the controlled substance disposition record was missing for Resident #2, the blister pack of Dilaudid 4 mg tablets and the controlled substance disposition record was missing for Resident #3, the blister pack of Oxycodone 10mg tablets and the controlled substance disposition record was missing for Resident #4, the blister pack of Oxycodone 5mg tablets and the controlled substance disposition record was missing for Resident #5, and the blister pack of Oxycodone 5mg tablet and the controlled substance disposition record was missing for Resident #6. The report indicated the Department of Consumer Protection, the Drug Enforcement Division (DCP) was notified and oversaw the investigation.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075373	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/20/2024
NAME OF PROVIDER OR SUPPLIER Cheshire House Health Care Facility & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3396 E Main Street Waterbury, CT 06705	
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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview with the Director of Nursing (DON) on [DATE] at 9:25 AM identified a 7AM-3PM charge nurse, Licensed Practical Nurse (LPN) #1, reported on [DATE] during the shift-to-shift narcotic count with the 11PM-7AM nurse, a bubble pack of Oxycodone tablets and the corresponding controlled substance disposition record for Resident #4 was noted to be missing. The DON stated that after LPN #1 brought to his attention the Oxycodone 5mg tablet and the controlled substance disposition record for Resident #4 was missing, he looked for the medication in the medication carts and where he stores expired and discontinued medications, and he could not locate them. The DON stated he continued his investigation and identified four (4) more residents' controlled medications and the controlled substance disposition records were missing. The DON stated that he contacted the Department of Consumer Protection, the Drug Enforcement Division (DCP) on [DATE] who took control of directing the investigation. The DON identified the Licensed Practical Nurse who removed the controlled medications from the facility, was terminated from employment on [DATE].</p> <p>Review of the abuse policy [DATE] identified Misappropriation of resident property is defined as the patterned or deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075373	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/20/2024
NAME OF PROVIDER OR SUPPLIER Cheshire House Health Care Facility & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3396 E Main Street Waterbury, CT 06705	

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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>50059</p> <p>Based on clinical record reviews, facility documentation, and interviews for one (1) of three (3) sampled residents (Resident #1) who were new admissions, the facility failed to address the hospital's discharge recommendation for a treatment order. The findings include:</p> <p>Resident #1's diagnoses included left knee replacement, pain, and osteoarthritis.</p> <p>The hospital discharge summary dated 7/26/24 identified a discharge order for cryocuff, a type of cold compress, to the affected knee, recharge every four (4) hours and as needed.</p> <p>Review of the facility's admission orders dated 7/26/24 failed to reflect an order for the cryocuff or cold compress treatment.</p> <p>The nursing admission sheet dated 7/26/24 identified Resident #1 was alert and oriented to person, place and time and required partial to moderate assistance with activities of daily living.</p> <p>The Resident Care Plan dated 7/26/24 identified Resident #1 was at risk for pain. Interventions directed to monitor pain, use non-drug interventions as needed, and administer meds as needed.</p> <p>A physician's order dated 7/31/25 directed to apply ice to the left knee every hour, fifteen (15) minutes on, fifteen (15) minutes off, as needed for pain and/or swelling.</p> <p>Interview with Resident #1 on 11/19/24 at 4:00 PM identified he/she never received any ice to the left knee. Resident #1 stated when he/she asked about ice, the nurse would state there was no order for ice.</p> <p>Interview with the Director of Nursing (DON) on 11/20/24 at 2:20 PM identified the hospital discharge summary is reviewed and the attending physician or Advanced Practice Registered Nurse places the order. The DON could not identify why the order for the cryocuff that was on the hospital discharge summary had not been ordered upon admission to the facility.</p> <p>Although requested, a facility policy for transcribing was not provided.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075373	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/20/2024
NAME OF PROVIDER OR SUPPLIER Cheshire House Health Care Facility & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3396 E Main Street Waterbury, CT 06705	
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 0836</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards.</p> <p>50059</p> <p>Based on observations and interviews, the facility failed to ensure residents had an identification bracelet or other form of visible identification. The findings include:</p> <p>Observations on 11/20/24 at 1:00 PM identified three (3) of five (5) residents seated in wheelchairs in the common area and there was no visible form of identification on the resident. When Resident #10 and Resident #11 were questioned as to their name bands, both residents identified they had never worn an identification bracelet.</p> <p>Observations made on 11/20/24 of the facilities three (3) units and recreation area identified multiple residents without identification bracelets.</p> <p>Interview with the Director of Nursing (DON) on 11/20/24 at 1:20 PM identified the expectation was each resident was to have an identification bracelet. The DON stated the name bands were a means of resident identification for all nurses to perform medication administration. The DON identified instructions were given to the charge nurses on the units to audit residents for name bands and to ensure each resident had a visible form of identification.</p> <p>Review the Resident Name Band Audit dated 11/20/24 identified 52 residents out of the current census of 75 residents did not have an identification bracelet on or some other form of visible identification.</p> <p>Although requested, the facility did not have a policy for resident identification</p>		