

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  01/09/2025
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 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to organize and participate in resident/family groups in the facility.</p> <p>Based on review of facility documentation, facility policy, and interviews, the facility failed to address the resident's grievances for lengthy wait times times to call light response identified during several resident council meetings. The findings include:</p> <p>A review of the Resident Council Meeting Minutes dated 9/26/24 identified residents had concerns with call bells not being answered in a timely manner. The residents stated the call bell issues on the second shift are ongoing but understand audits are being conducted and are helping with the issue. The residents appreciate the ongoing audits and staff education the DNS is working on to resolve the issues.</p> <p>A review of the Resident Council Meeting Minutes dated 10/27/24 identified residents (unidentified residents) had concerns with call bells not being answered in a timely manner. The residents state the call bell issues on the second shift are ongoing but understand audits are being conducted and are helping with the issue. The residents appreciate the ongoing audits and staff education the DNS is working on to resolve the issues.</p> <p>A review of the Resident Council Meeting Minutes dated 11/27/24 identified residents had concerns with call bells not being answered in a timely manner. The residents state the call bell issues on the second shift are ongoing but understand audits are being conducted and are helping with the issue. The residents appreciate the ongoing audits and staff education the DNS is working on to resolve the issues.</p> <p>A review of the Resident Council Meeting Minutes dated 12/26/24 identified residents had concerns with call bells not being answered in a timely manner. The residents state the call bell issues on the second shift are ongoing but understand audits are being conducted and are helping with the issue. The residents appreciate the ongoing audits and staff education the DNS is working on to resolve the issues.</p> <p>An interview with DNS on 1/8/25 at 3:00 P.M. identified he was aware during the resident council meetings unidentified residents voiced concerns that their call lights were not being responded to in a timely manner. The DNS indicated audits were being conducted to ensure call lights were responded to in a timely manner. The DNS was unable to provide documentation to reflect that the facility addressed and acted upon the residents' grievances regarding lengthy wait times for call bell response. The DNS identified although the audits had been done during rounding, he could not locate them. The DNS identified staff had not been provided with education on answering call lights in a timely manner.</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
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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Subsequent to surveyor inquiry, the DNS identified on 1/8/25 he initiated staff education on answering call lights and call light audits were implemented.</p> <p>Review of facility call light policy dated 7/2015 identified the purpose is to respond to resident's request and needs as quickly as possible.</p> <p>Although requested, a facility resident council policy was not provided.</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on review of the clinical record, facility documentation, facility policy, and interviews for one (1) of three (3) residents (Resident #1) reviewed for change in condition, the facility failed to ensure the physician was notified when the resident experienced a change in condition. The findings include:</p> <p>Resident #1 had diagnoses that included type 2 diabetes mellitus and thrombocytopenia.</p> <p>The care plan dated 10/26/24 identified Resident #1 requires assistance with bathing, dressing, hygiene, and with assist of two (2) staff members.</p> <p>The admission MDS dated [DATE] identified Resident #1 had Brief Interview for Mental Status score of fifteen (15) indicative of intact cognition and assistance with ADL's.</p> <p>A nurse's note dated 11/26/24 at 6:18 P.M. written by LPN #3 identified Resident #1 was complaining that h/she caught h/her family members cold. LPN #3 identified Resident #1 is complaining of feeling very malaise, body aches, chills, and no appetite, the note further identified that Resident #1's had a rasping low voice. LPN #3 indicated Resident #1 is currently fever free, vital signs stable, and the complaints were put in the APRN's book for review.</p> <p>Review of APRN #2's note dated 11/29/24 (3 days later) at 9:00 A.M. identified Resident #1 was seen at the family's request for complaints of oral pain and possible thrush (a fungal infection in the mouth). APRN #2 identified Resident #1 reports oral discomfort and some difficulty swallowing. APRN #2 identified Resident #1's oral examination revealed thick white coating to lateral aspects of tongue. APRN #2 identified Resident #1 has candidal stomatitis as evidence by oral examination reveals evidence of thrush.</p> <p>The physician's order dated 11/29/24 directed to administer nystatin (anti-fungal medication) mouth/throat suspension 100000 unit/milliliter swish and swallow 5 milliliters every 6 hours for 14 days.</p> <p>Interview with LPN #3 on 1/8/25 at 1:48 P.M. identified on 11/26/24 Resident #1 complained of malaise, body aches, chills, no appetite, reported h/she thinks h/she caught a cold from h/her granddaughter, and Resident #1 had a low raspy voice. LPN #3 identified on 11/26/24 Resident #1 had a white coating on the tongue, possibly the start of oral thrush which caused Resident #1 to have a low raspy voice and no appetite. LPN #3 identified she did not notify the MD or APRN on 11/26/24 when Resident #1 had a change in condition. LPN #3 indicated she put a note in the APRN book then LPN #3 was off for a few days, and she thought the APRN had seen Resident #1 the next day. LPN #3 further identified that she did not include the white patches she observed in the residents mouth because she had written it in the APRN book.</p> <p>Interview with APRN #2 on 1/8/25 at 2:45 P.M. identified on 11/29/24 per Resident #1's family's request she had seen Resident #1 for concerns of oral thrush. APRN #2 identified LPN #3 did not notify her or the on-call APRN on 11/26/24 when Resident #1 had a change in condition. APRN #2 identified LPN #3 should have called the on-call APRN on 11/26/24 to report Resident #1's change in condition.</p> <p>(continued on next page)</p>

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview and review of the APRN book with the DNS on 1/8/25 at 3:00 P.M. identified on 11/26/24 LPN #3 did not document in the APRN book that Resident #1 complained of malaise, body aches, chills, no appetite, and Resident #1 had the start of oral thrush. The DNS identified on 11/26/24 LPN #3 should have notified the APRN by phone that Resident #1 had a change in condition. The DNS identified it is his expectation that when a resident has any change in condition the MD or APRN are notified at the time of the change in condition.</p> <p>Review of facility notification change in condition policy dated 8/2017, in part; identified the purpose is to ensure that every resident's change in condition is reported to the physician.</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on review of the clinical record, facility documentation, facility policy, and interviews for one (1) of three (3) residents (Resident #2) reviewed for abuse, the facility failed to provide adequate supervision to prevent sexual abuse. The findings include:</p> <p>1. Resident #2 had diagnoses that included dementia, adjustment disorder, and dysthymic disorder.</p> <p>The care plan dated 12/9/24 identified Resident #2 has a consensual friendly relationship with another resident (Resident #3) that has been approved by the family with interventions that directed per family Resident #3 okay to spend time with Resident #2, sit with resident, kiss on cheek, hold hands, yellow tape was placed at Resident #2's room threshold as a reminder for male resident (Resident #2) not to enter the room unaccompanied, and social services to follow up to ensure residents are abiding by guidelines set forth by family.</p> <p>Review of SW #2's (psych) note dated 12/16/24 at 12:40 P.M. identified asked to assess Resident #2's cognition and judgement related to relationship with another male Resident #3. SW #2 identified Resident #2 is alert, pleasant, and very confused. SW #2 identified utilizing the Brief Cognitive Assessment Tool (BCAT) Resident #2 scored a four (4) suggestive of dementia or severe cognitive impairment. SW #2 identified for Resident #2 she will add a diagnosis of dementia. SW #2 indicated in the matter of Resident #2's relationship with Resident #3 the opposite sex staff will continue to monitor concerns related to Resident #2's poor judgment and confused thoughts.</p> <p>The annual MDS dated [DATE] identified Resident #2 had a Brief Interview for Mental Status (BIMS) score of ten (10) indicative of moderately impaired cognition, was continent of bowel, frequently incontinent of bladder, independent with transfers, bed mobility, and ambulation with use of a device.</p> <p>A nurse's note dated 12/22/24 at 7:21 P.M. written by LPN #4 identified APRN #1 reported that Resident #2 who is in a well-established relationship with another male resident (Resident #3) was being touched on h/her private area by Resident #2. LPN #4 identified after the incident Resident #3 went back to h/her room and has not been seen back on Resident #2's unit. LPN #4 identified Resident #2 denies any pain or discomfort. LPN #4 indicated RN #3 (supervisor) and DNS were updated.</p> <p>2. Resident #3 had diagnoses that included dementia, anxiety, hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side, and major depressive disorder. The care plan dated 12/9/24 identified Resident #3 has a consensual friendly relationship with another resident (Resident #2) that was approved by family with interventions that directed per family Resident #3 okay to spend time with Resident #2, sit with resident, kiss on cheek, hold hands, and social services to follow up to ensure residents are abiding by guidelines set forth by family.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of SW #2's (psych) note dated 12/16/24 at 12:42 P.M. asked to assess Resident #3's cognition and judgement related to relationship with Resident #2. SW #2 identified Resident #3 is alert, logical with observed forgetfulness. SW #2 identified throughout assessment Resident #3 was suspicious with little cooperation. SW #2 identified utilizing the BCAT Resident #3 scored a fifteen (15) suggestive of dementia or severe cognitive impairment. SW #2 identified based on the score it is indicative that Resident #3 has issues with cognition/judgement and the diagnosis of dementia added for Resident #3. SW #2 indicated in the matter of the relationship Resident #3 and Resident #2's relationship the opposite sex staff will continue to monitor concerns related to Resident #3's judgment and confused thoughts.</p> <p>The quarterly MDS dated [DATE] identified Resident #3 had a Brief Interview for Mental Status (BIMS) score of thirteen (13) indicative of intact cognition, was frequently incontinent of bowel and bladder, non-ambulatory, required touching assistance for transfers, independent with bed mobility and for locomotion with use of a wheelchair.</p> <p>A nurse's note dated 12/22/24 at 7:21 P.M. written by LPN #4 identified APRN #1 reported that Resident #2 who is in a well-established relationship with another male resident (Resident #3) was being touched on h/her private area by Resident #3. LPN #4 identified after the incident Resident #3 went back to h/her room and has not been seen back on Resident #2's unit. LPN #4 identified Resident #2 denies any pain or discomfort. LPN #4 indicated RN #3 (supervisor) and DNS were updated.</p> <p>A nurse's note dated 12/22/24 at 7:13 P.M. written by LPN #5 identified it was reported to him that Resident #3 was seen by APRN #1 touching Resident #2 in h/her genital area. LPN #5 indicated Resident #3 was redirected by staff and the residents were separated. LPN #5 indicated RN #3 (supervisor), and the DNS were notified. LPN #5 identified Resident #3 is sitting in h/her room in recliner and no further behaviors were observed.</p> <p>Review of the facility's accident and incident report dated 12/22/24 at 4:44 P.M. identified on 12/22/24 at approximately 2:45 P.M. APRN #1 heard moaning coming from Resident #2's room and when APRN #1 went to investigate the moaning she saw Resident #3 touching Resident #2's genital area. Neither Resident #2 nor Resident #3 are accusing the other of harm and both were mutually agreeable to the encounter. The facility's summary dated 12/28/24 identified both Resident #2 and Resident #3 have a diagnosis of dementia, Resident #2's daughter has power of attorney and has known of and approving of the relationship between Resident #2 and Resident #3, and when Resident #2's daughter was asked if she was okay with this encounter she is okay with Resident #2 and Resident #3 holding hands, hugging, kissing, but does not feel they should be performing sexual acts. In conclusion this was a mutually consensual interaction between Resident #2 and Resident #3 but did exceed what Resident #2's Power of Attorney had anticipated.</p> <p>Interview with APRN #1 on 1/9/25 at 9:55 A.M. identified on 12/22/24 at approximately 2:20 P.M. she heard a moaning coming from Resident #2's room and the door to Resident #2's room was open. APRN #1 identified when she entered Resident #2's room she observed Resident #3 sitting in h/her wheelchair fully dressed partially leaning on the bedside table with h/her hand on Resident #2's genital area. APRN #1 identified Resident #2 was sitting in h/her bedside chair with h/her upper body clothed, but h/her brief and pants were pulled down. APRN #1 identified as soon as the residents saw her standing there Resident #2 stood up and quickly pulled up h/her brief and pants while Resident #3 exited the room heading back to h/her room.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with LPN #4 on 1/9/25 at 8:45 A.M. identified that LPN #4 identified Resident #2, and Resident #3 were in a known established friendly relationship prior to 12/22/24, there had never been any type of sexual contact between Resident #2 and Resident #3 prior to 12/22/24. Resident # 3 knew he was not allowed in Resident #2's room and there was yellow tape at the door to remind h/her. LPN #4 identified on 12/22/24 she could not recall the exact time, but it was after 2:30 P.M. that APRN #1 notified her that Resident #2 had been touched on h/her private area by Resident #3, and after the incident Resident #3 went back to h/her room. LPN #4 identified Resident #2 denied any pain or discomfort. LPN #4 indicated from 12/22/24 at 2:30 P.M. to after 7 A.M. on 12/23/24 Resident #2 did not have any contact with Resident #3 and was on every 15 minute checks.</p> <p>Interview with RN #3 on 1/9/25 at 10:55 AM identified that there had never been any episodes of a sexual nature between Resident #2 and Resident #3, and Resident #3 was not allowed in Resident #2's room. On 12/22/24 by the time she came to Resident #2's room the residents were already separated. She assessed Resident #2's genital area and no injuries or abnormalities were identified.</p> <p>Interview with the DNS on 1/9/25 at 12:30 P.M. identified on 12/22/24 at approximately 2:20 P.M. APRN #1 observed Resident #2 sitting in the bedside chair with h/her pants and brief pulled down, Resident #3 seated in the wheelchair fully dressed partially leaning on the bedside table with h/her hand on Resident #2's genital area. The DNS identified prior to 12/22/24 Resident #2's power of attorney was aware of and approving of the consensual mutually agreed upon relationship between Resident #2 and Resident #3. The DNS identified Resident #2's power of attorney had previously given approval for Resident #2 and Resident #3 to hold hands, kiss, and hug. The DNS identified on 12/22/24 that the sexual encounter between Resident #2 and Resident #3 exceeded the approval that was provided by Resident #2's daughter who did not approve of any sexual acts or encounters. Subsequent to the event Resident #3 was placed on every fifteen minute checks and was seen by psychiatric services and denied any type of sexual activity. Resident #2 was seen by psychiatric services and did not recall the event.</p> <p>Review of the facility resident to resident abuse policy dated 11/25/2016; in part; identified the facility staff will monitor residents for inappropriate behaviors towards other residents.</p>		