

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 02/10/2025
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 0550</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 a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #1) reviewed for accidents, the facility failed to follow act on a request for a room change timely. The findings include:</p> <p>Resident #1's diagnoses included surgical aftercare and Parkinson's disease. The nursing admission assessment dated [DATE] identified Resident #1 was alert, verbal with unclear speech, was inattentive, and agitated. The Resident Care Plan (RCP) dated 1/15/2025 identified an ADL deficit related to recent hospitalization. Interventions directed assist of one (1) for ADLs, toilet transfers and tasks using rolling walker.</p> <p>Record review identified Resident #1 had a family member identified as a Power of Attorney (POA) for financial and care decisions.</p> <p>Social work progress note dated 1/15/2025 indicated resident had A Brief Interview for Mental Status (BIMS) on 1/15/2025 indicated a score of six out of fifteen, indicative of severe cognitive impairment.</p> <p>The nurse's note dated 1/16/2025 identified that the family requested a room change due to roommate continuously talking in the middle of the night. Resident stated, I cannot sleep, and I am getting anxious. The note further identified the Supervisor was aware.</p> <p>Record review failed to identify Resident #1's room was changed, or the request for a room change was addressed.</p> <p>Review of social work progress note dated 1/22/2025 identified the Resident Care Conference (RCC) meeting was held with Resident #1, the POA, and family members present and reviewed discharge planning.</p> <p>Record review identified Resident #1 was discharged from the facility on 1/27/2025.</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview, clinical record review, and facility documentation review on 2/10/2025 at 11:01 AM with SW #1 identified she was not aware of a family request on 1/16/2025 for a room change. SW #1 stated during a RCC meeting held on 1/22/2025, the family requested a room change. SW #1 stated she did not know why a room change was requested, and the focus of the RCC was discharge planning. SW #1 stated the family did not make any additional requests for a room change and indicated if the initial request for a room change was made on 1/16/2025, the request should have been addressed at that time. Interview failed to identify why a room change was not acted upon, to include if a room was available for a room change, prior to Resident #1's discharge.</p> <p>On 2/10/2025 at 12:26 PM interview, review of clinical record, and facility documentation review with DNS identified that he was not aware of any room change requests until he spoke with the POA on 1/27/2025 (the day of discharge). The DNS stated room changes should be discussed in morning meeting, and a room change for Resident #1 should have been discussed on 1/17/2025, to include if a room was available. The DNS stated he was off on 1/17/2025 and was unable to explain why the requested room change was not acted upon.</p> <p>Review of facility Resident Rights and Advanced Directives Policy directed in part, employees will respect resident and patient's rights. The Policy further directed residents have the right to receive quality care and services with reasonable accommodation of your individual needs and preferences.</p>