STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075373	A. Building B. Wing	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cheshire House Health Care Facility & Rehab Center	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)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, review of facility documentation, and interviews for one (1) of three (3) sampled residents (Resident #4) who were recent admissions, the facility failed to accurately review the hospital discharge summary and address the pharmaceutical recommendations. The findings include: Resident #4's diagnoses included aftercare following joint replacement, type 2 diabetes, hypertension, and hyperlipemia. The hospital Discharge summary dated [DATE] identified Resident #4 was admitted to the hospital for right total hip replacement. The summary indicated Resident #4 diagnoses included hyperlipidemia and was discharged with a medication recommendation of Atorvastatin 10 milligrams (mg) nightly. The summary did not identify Resident #4 had a diagnosis of migraine headaches A physician's order dated 6/18/22 and signed by the provider on 6/20/22 directed to administer Atogepant tablet (a medication used to treat migraine headaches) 10 mg by mouth one (1) time a day for hyperlipidemia. The admission evaluation signed on 6/19/22 indicated that all active medication orders had been reviewed and were accurate from the Inter-Agency Referral Form, W-10. The pharmacy medication regimen review dated 6/20/22 identified Resident #14 was a new admission, and this was the initial review. The medication regimen review identified a concern related to the indication for the Atogepant, elevated lipids. Review of the interim physician order form and provider progress notes from 6/20/22 through 6/29/22 failed to identify documentation that the 6/20/22 pharmacy medication review concern was reviewed or addressed by an Advanced Practice Registered Nurse (APRN) or physician. The provider's progress note dated 6/25/22 at 6:38 PM included a full medication list, including the Atogepant. The provider progress note dated 6/27/22 at 2:12 PM indicated Resident #4's medications had been reviewed in the EMR (Electronic Medical Record). Interview with the Director of Nursing (DON) on 3/3/26 at 1:25 PM identified that upon arrival of a new admission, it was the responsibility of the nursing supervisor to enter the new admission orders and the entered orders are reviewed by a Registered Nurse (RN) on the next shift. The DON explained that the chart of the new admission was brought to morning report to review the orders, the pharmacy does a medication review within a few days of the admission, and the admission orders were reviewed by an APRN or physician within forty-eight (48) hours. Interview with Resident #4's attending physician, MD #1, on 3/3/26 at 1:53 PM identified that admission orders are reconciled by a nurse and then reviewed, changed as clinically appropriate and signed by the physician. MD #1 indicated the pharmacy would notify the facility of contraindications or if a medication was not appropriate. Interview with a pharmacist, Person #1, on 3/3/26 at 2:43 PM identified if a medication was noted during review to be ordered with an incorrect clinical indication a request to clarify would be initiated. Person #1 identified the clinical indication for Atogepant was migraine headaches. Person #1 identified there was clinical indication for Atogepant to be ordered for hyperlipidemia. Although attempted, a call was not returned by RN #1. Review of the facility Medication Verification policy dated 2/13/15 directed, in part, that complete lists of the resident's current medications are compiled and reviewed upon admission. Further, it directs to review the admission orders from the W-10 or Interagency Referral Form. Review of the facility Medication Regimen Review Policy dated 11/28/17 (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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	instructs, in part, irregularities that do not require urgent action, the attending physician within the next visit shall document the following in the resident's medical record: a. The irregularity has been reviewed; and b. What if, any, action has been/should be taken to address it. c. If no change to the medication, the attending must document the rationale for not making any change to the medication.