STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075396	A. Building B. Wing	08/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cherry Brook Health Care Center	102 Dyer Avenue Canton, CT 06019

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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 0609 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 record review, facility documentation review, and staff interviews for one of three residents (Resident #1) reviewed for abuse, the facility failed to ensure staff reported an allegation of mistreatment timely. The findings include:Based on record review, facility documentation review, and staff interviews for one of three residents (Resident #1) reviewed for abuse, the facility failed to ensure staff reported an allegation of mistreatment timely. The findings include: Resident #1 had a diagnosis of Traumatic Brain Injury (TBI), dysphagia (difficulty swallowing) aphasia (inability to communicate. The quarterly Minimum Data Set (MDS) dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of 0 indicating severely impaired cognition, no swallowing difficulties, and required setting up for feeding. The Resident Care Plan (RCP) dated 6/24/2025 identified a potential for impaired nutrition due to dysphagia. Interventions directed to allow resident time to consume meals, use calm approach, and assist with meals as needed. Facility reportable event dated 7/28/2025 at 12 PM identified Resident #1 had severe cognitive impairment, and Nurse Aide (NA) #1 reported hearing NA #2 tell Resident #1, keep it up and I won't feed you on Monday either. Facility documentation identified Resident #1 was interviewed and was unable to respond, and the facility initiated an investigation. Written statement from NA #2 dated 7/29/2025 identified she never told any residents that she would not feed them. Facility summary dated 7/31/2025 identified Resident #1 required total assistance for eating, and Resident #1 was unable to communicate what occurred. NA #1 provided a written statement that she heard NA #2 make the alleged comments, and NA #2 denied the allegation and her employment was terminated. Psychiatric provider note dated 8/7/2025 identified Resident #1 was seen for an allegation of abuse and had no recollection of the incident with no change in mood or behaviors noted. Interview with NA #1 on 8/18/2025 at 11:32 AM identified she was working on 7/25/2025 and about 7 or 8 PM, NA #2 asked for help to provide care to Resident #1. NA #1 stated when she entered the room, Resident #1 was upset and combative. NA #1 she would try to calm the resident, and NA #2 then stated to Resident #1, if you keep it up, I will not feed you again Monday. NA #1 stated she then asked NA #2 to leave the room and NA #1 then provided care for Resident #1. NA #1 indicated she asked Resident #1 if he/she was hungry and he/she nodded yes, and she provided food for Resident #1 (ate 100%). NA #1 stated she notified LPN #1 and did not know if LPN #1 reported the incident; NA #1 notified the DNS on 7/28/2025 (3 days after the incident). Interview with LPN #1 on 8/18/2025 at 12:14 PM identified on 7/25/2025 after dinner, NA #1 informed her that she observed NA #2 tell Resident #1 if you keep it up, I won't feed you again Monday. LPN #1 stated she did not report the incident to anyone else, and she told NA #1 to report it to the DNS or Administrator. LPN #1 stated later in the shift she asked NA #1 if she reported the incident, and NA #1 stated she would report it on 7/26/2025 (the next day). LPN #1 stated she should have reported the allegation when NA #1 reported it, but she wanted NA #1 to report it herself. Interview and record review with the DNS and Administrator on 8/18/2025 at 1PM identified the DNS was notified of the allegation on 7/28/2025 about 12 PM. Interview failed to identify why the allegation was not reported immediately, and stated staff should have reported it immediately and the DNS would have then notified the State Agency within two (2) hours. Review of facility Abuse, Neglect and Crimes Committed Against Residents Policy dated 6/22/22 directed in part, residents have the right to be free from abuse. The Policy further directed any suspicion of abuse, neglect (allegations of abuse) must be reported immediately.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (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 0842 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 record review, facility documentation review, and staff interviews for one of three residents (Resident #1) reviewed for abuse, the facility failed to ensure the medical record was complete and accurate to include support visits made after an allegation of mistreatment. The findings include:Based on record review, facility documentation review, and staff interviews for one of three residents (Resident #1) reviewed for abuse, the facility failed to ensure the medical record was complete and accurate to include support visits made after an allegation of mistreatment. The findings include: Resident #1 had a diagnosis of Traumatic Brain Injury (TBI), dysphagia (difficulty swallowing) aphasia (inability to communicate. The quarterly Minimum Data Set (MDS) dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of 0 indicating severely impaired cognition, no swallowing difficulties, and required setting up for feeding. The Resident Care Plan (RCP) dated 6/24/2025 identified a potential for impaired nutrition due to dysphagia. Interventions directed to allow resident time to consume meals, use calm approach, and assist with meals as needed. Facility reportable event dated 7/28/2025 at 12 PM identified Resident #1 had severe cognitive impairment, and Nurse Aide (NA) #1 reported hearing NA #2 tell Resident #1, keep it up and I won't feed you on Monday either. Facility documentation identified Resident #1 was interviewed and was unable to respond, and the facility initiated an investigation. Written statement from NA #2 dated 7/29/2025 identified she never told any residents that she would not feed them. Facility summary dated 7/31/2025 identified Resident #1 required total assistance for eating, and Resident #1 was unable to communicate what occurred. NA #1 provided a written statement that she heard NA #2 make the alleged comments, and NA #2 denied the allegation and her employment was terminated. Psychiatric provider note dated 8/7/2025 identified Resident #1 was seen for an allegation of abuse and had no recollection of the incident with no change in mood or behaviors noted. Record review failed to identify any social service support visits, or any nursing support visits were provided prior to 8/7/2025 (7 days after the incident). Interview with NA #1 on 8/18/2025 at 11:32 AM identified she was working on 7/25/2025 and about 7 or 8 PM, NA #2 asked for help to provide care to Resident #1. NA #1 stated when she entered the room, Resident #1 was upset and combative. NA #1 she would try to calm the resident, and NA #2 then stated to Resident #1, if you keep it up, I will not feed you again Monday. NA #1 stated she then asked NA #2 to leave the room and NA #1 then provided care for Resident #1. NA #1 indicated she asked Resident #1 if he/she was hungry and he/she nodded yes, and she provided food for Resident #1 (ate 100%). NA #1 stated she notified LPN #1 and did not know if LPN #1 reported the incident; NA #1 notified the DNS on 7/28/2025 (3 days after the incident). Interview with LPN #1 on 8/18/2025 at 12:14 PM identified on 7/25/2025 after dinner, NA #1 informed her that she observed NA #2 tell Resident #1 if you keep it up, I won't feed you again Monday. LPN #1 stated she did not report the incident to anyone else, and she told NA #1 to report it to the DNS or Administrator. Interview and record review with Social Worker (SW) #1 on 8/18/2025 at 2:20 PM identified he saw Resident #1 on 7/28/2025, the day the DNS was notified. SW #1 stated he did not write a SW note in the electronic medical record (EMR). SW #1 stated he writes some of his notes in a Microsoft Word document and places it in the hard (paper) copy chart. Social Worker #1 stated he does not always write a note in the EMR because it was faster to write notes in Microsoft Word, print it, and place it in the paper chart if he was running behind. Review of note identified the paper had no date, no resident name, and no SW signature. SW stated staff would know it was his note because it is my note and says Social Services. Further, SW #1 stated if staff were unsure, they could ask him if it was his note. SW #1 stated he would await direction from the State Agency if his documentation was not sufficient. Interview and record review with the DNS and Administrator on 8/18/2025 at 1 PM identified the DNS assessed Resident #1 on 7/28/2025 after the allegation was made and Resident #1 had no distress noted. Further, the DNS stated she did not write a nursing note regarding her assessment/support visit in the EMS, and stated she should have. Interview identified SW is supposed to document in the EMR, and sometimes they write notes that are not in the EMR, but best practice would be to write in the EMR. Interview identified the Administrator and DNS expected staff to include a date and signature on any resident documentation, and any paper documentation was required to have the resident's name on the paper. Review of SW #1's note identified the note was incomplete documentation because it lacked any resident name, a date, and a staff member's signature. Review of Nursing Documentation policy dated 7/1/2025 directed in part, licensed nursing personnel were to document information related to the resident's condition