

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075396	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2026
NAME OF PROVIDER OR SUPPLIER Cherry Brook Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interviews, and facility documentation/policies for one (1) of three (3) residents (Resident #4) reviewed for accidents, the facility failed to initiate appropriate fall prevention interventions (toileting plan/schedule) and failed to implement an established care plan intervention (gripper socks) for a resident with progressive incontinence patterns who was at high risk for falls. The findings included: Resident #4 was admitted to the facility in February of 2025 and had diagnoses that included dementia, cerebral infarction, and difficulty in walking. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #4 had severely impaired cognition (Brief Mental Interview for Mental Status (BIMS) score of 3), was dependent with toileting hygiene and bathing, required substantial assistance with ambulation, was occasionally incontinent of urine, and utilized a wheelchair. The Resident Care Plan (RCP) dated 6/12/25 identified Resident #4 was at risk for falls secondary to an impaired sense of balance and unsteady gait. Interventions included to apply gripper socks while in bed. The RCP did not identify goals and interventions for incontinence care or a toileting plan/schedule. a. The Accident and Incident report (A&I) dated 7/4/25 at 3:30 AM identified Resident #4 sustained an unwitnessed fall, was found lying on the bathroom floor, and sustained a skin tear to the left elbow. b. The A&I by LPN #3 dated 8/6/25 at 2:20 PM identified Resident #4 sustained an unwitnessed fall, was found lying on the floor in his/her room with the wheelchair tipped over and reported a headache and pain to the right side, hip, and back. c. The A&I by LPN #3 dated 9/8/25 at 8:15 PM identified Resident #4 sustained an unwitnessed fall due to ambulating without assistance. Resident #4 was found next to his/her bed and sustained no injuries. d. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #4 had severely impaired cognition (Brief Mental Interview for Mental Status (BIMS) of 3), required substantial assistance with toileting hygiene, personal hygiene, and ambulation, utilized a wheelchair, and was frequently incontinent of bowel and bladder. Review of the RCP dated 9/24/25 identified Resident #4 was at risk for falls secondary to an impaired sense of balance and unsteady gait. Interventions directed to apply gripper socks while in bed, instruct Resident #4 to ask for assistance prior to attempting to transfer or ambulate, offer toileting during second rounds, and to offer bathroom frequently when in bedside chair. The RCP did not identify goals and adequate interventions for incontinence care or a toileting plan/schedule. The A&I by RN #7 dated 11/19/25 at 11:45 PM identified Resident #4 sustained an unwitnessed fall and was found under the sink in his/her bathroom, sustained a right elbow and low back skin tear, and reported right rib pain. Initial x-rays resulted negative; however, Resident #4 was transported to the hospital on [DATE] for a high pain level (10 out of 10) to the right side and back. The Certified Nurse's Aide Care Card (care card) (used to identify a resident's specific care needs) dated 11/20/25 identified Resident #4 was continent of bowel and bladder. The toileting plan section of the care card directed a transfer status rather than a toileting plan to provide</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 075396
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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>an assist of one for toilet transfers with use of a rolling walker or grab bar. The care card directed to ensure non-skid socks were in place. e.The comprehensive Minimum Data Set (MDS) assessment dated [DATE] identified Resident #4 had severely impaired cognition (Brief Mental Interview for Mental Status (BIMS) of 3), required supervision with toileting, substantial assistance with transfers, utilized a wheelchair, was frequently incontinent of urine.The Resident Care Plan (RCP) dated 12/9/25 identified Resident #4 was at risk for falls secondary to impaired sense of balance and unsteady gait and was incontinent of bowel and bladder. Interventions directed to apply gripper socks while in bed, to check placement of gripper socks at the beginning of the 11:00 PM to 7:00 AM shift, observe for non-verbal cues of needing to use the bathroom, observe for signs of redness or inflammation and apply barrier if indicated, to provide privacy and a brief. The RCP did not identify a toileting plan/schedule. The Fall Investigation Report by RN #4 dated 12/20/25 at 4:15 AM identified Resident #4 fell out of bed while attempting to use a urinal and was not wearing gripper socks.Interview with NA #4 on 1/22/26 at 10:58 AM identified he/she was seated outside Resident #4's room on 12/20/25 during the 11:00 PM to 7:00 AM shift when Resident #4 fell to the floor. NA #4 indicated Resident #4 explained he/she was sitting on the edge of the bed with both feet on the floor, attempting to position the urinal for use, when he/she lost balance and fell. NA #4 further identified Resident #4 was not wearing gripper socks at the time of the fall and that he/she was unaware Resident #4 was to have gripper socks on while in bed and checked for placement on the 11 PM to 7 AM shift.Interview with the Director of Nursing Services (DNS) on 1/22/26 at 11:33 AM identified Resident #4 should have had a toileting plan/schedule due to severe cognitive impairment and identified incontinence patterns. The DNS identified NAs were trained to review care cards at the start of each shift because updates/changes to the level of care could occur at any time and would be updated on the care card.Interview with NA #5 on 1/22/26 at 2:34 PM identified he/she was assigned to provide care for Resident #4 during the 3 PM to 11 PM shift on 12/19/25. NA #5 identified he/she provided personal care and assisted Resident #4 to bed. NA #5 identified he/she applied regular socks and was unaware that Resident #4 required gripper socks while in bed.The Falls Management policy directed the facility would utilize all resident/patient related information made available upon admission and ongoing to determine resident/patient at risk for fall status and that the interdisciplinary team would develop, initiate, and implement an appropriate individualized care plan based on the fall risk evaluation score.The Urinary Incontinence policy directed each resident would have a urinary assessment on admission, readmission, and with a significant change in continence. The policy further indicates changes in continence status would be monitored and that the bladder assessment, once completed, would determine the type of toileting plan based on the score. Although requested, the facility did not have a Resident Care Card policy to provide. The Comprehensive Care Plan policy directed the facility was committed to providing residents with all necessary care and services to enable them to achieve the highest quality of life, that care plans were oriented toward preventing avoidable decline in clinical functional levels, maintaining a specific level of functioning, and that the Comprehensive Care Plan included measurable objectives and timelines to accommodate preferences, special medical, nursing and psychosocial needs identified.</p>		

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<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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interviews, and review of facility documentation and policies for one (1) of three (3) residents (Resident #4) reviewed for accidents, the facility failed to perform a Bowel and Bladder Assessment upon readmission to the facility, in accordance with facility policy. The findings included: Resident #4 was admitted to the facility in February of 2025 and had diagnoses that included dementia, cerebral infarction, and difficulty in walking. The Bladder and Bowel assessment dated [DATE] identified Resident #4 was continent of bowel and the bladder section indicated non applicable. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #4 had severely impaired cognition (Brief Mental Interview for Mental Status (BIMS) of 3), required substantial assistance with toileting hygiene, personal hygiene, and ambulation, utilized a wheelchair, and was frequently incontinent of bowel and bladder. The Resident Care Plan (RCP) dated 9/24/25 failed to identify Resident #4's continence status. A hospital discharge summary identified Resident #1 was hospitalized from [DATE] to 11/27/25. A nurse's note by RN #6 dated 11/27/25 at 12:57 PM identified Resident #1 returned from the hospital. Review of the clinical record failed to identify a Bowel and Bladder Assessment was performed upon readmission to the facility after the 11/22/25 to 11/27/25 hospitalization. Interview with the Director of Nursing Services (DNS) on 1/22/26 at 11:33 AM identified a Bowel and Bladder Assessment should have been completed following Resident #4's readmission to the facility on [DATE] according to facility policy. The Urinary Incontinence policy directed each resident was to have a urinary assessment upon admission, readmission, and with a significant change of continence.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interviews, and facility documentation/policies for one (1) of three (3) residents (Resident #5) reviewed for falls, the facility failed to provide adequate supervision for a hospice resident suffering from terminal agitation who sustained several falls within a 24-hour period resulting in injury. The findings included: Resident #5 was admitted to the facility in December of 2025 with diagnoses which included chronic obstructive pulmonary disease (COPD), malignant neoplasm of the lung, anxiety disorder, depression and was admitted to hospice care on 12/19/25. The Nursing admission assessment dated [DATE] identified Resident #5 was oriented to person, drowsy, and confused and required maximal assistance with toileting, personal hygiene, and rolling from side to side. The Nursing admission Assessment failed to identify Resident #5 was assessed for ambulation. The Resident Care Plan (RCP) dated 12/20/25 identified Resident #5 was at risk for falls secondary to being newly admitted to the facility and having cognitive impairment. Interventions directed to leave urinal at bedside. The Certified Nurse Aide Care Card (care card) (used to identify a resident's specific care needs) dated 12/23/25 identified Resident #5 required an assist of one (1) with transfers and was able to ambulate without an assistive device. The Accident and Incident report (A&I) by RN #7 on 12/23/25 at 12:00 AM identified Resident #5 sustained an unwitnessed fall, was found scooting on his/her buttocks near his/her bed and was able to get him/herself up. The A&I identified gripper socks while in bed was added as a post fall intervention. The A&I by RN #7 on 12/23/25 at 3:00 AM identified Resident #5 sustained an unwitnessed fall while seated in his/her wheelchair at the nurse's station when a loud thump was heard and Resident #5 was observed seated on the floor. The A&I identified an intervention for frequent checks was added as a post fall intervention. A nursing note by APRN #1 dated 12/23/25 at 10:30 AM identified Resident #5 was experiencing increased agitation with falls that occurred the prior night (at 12:00 AM and 3:00 AM), appeared to be actively transitioning (the active dying phase in which physical and neurological changes occur as the body begins to shut down), and that the agitation experienced the prior day was likely related to terminal agitation. Review of the clinical record failed to identify new interventions or treatment related to terminal agitation. The A&I by RN #5 on 12/23/25 at 5:00 PM identified Resident #5 sustained an unwitnessed fall, was observed on the floor by the window side of his/her bed, and sustained skin tears to the left elbow and right forearm. The A&I identified placement of the call light within reach was added as a post fall intervention. The A&I by LPN #5 on 12/23/25 at 9:00 PM identified Resident #5 sustained an unwitnessed fall and was observed on the floor. The A&I identified an intervention for bed in low position was added to the RCP as a post fall intervention. The A&I by RN #4 on 12/24/25 at 3:30 AM identified Resident #5 was observed on the floor, hitting his/her head on the floor, and that bleeding was noted from his/her head. A nursing note by RN #3 dated 12/24/25 at 5:22 AM identified Resident #5 fell and upon entering his/her room, Resident #5 was lying face down in a pool of blood and repeatedly striking his/her head. While pressure was applied to his/her lateral head, Resident #5 continued to strike his/her head onto the floor and proceeded to strike all four limbs onto the floor. Emergency Medical Services (EMS) arrived, and Resident #5 was transferred to the hospital. Interview with APRN #1 on 1/23/26 at 1:48 PM identified terminal agitation could occur at the beginning of the dying process and presented as increased anxiety/agitation. APRN #1 further indicated Resident #5 came to the facility extremely anxious and that at the end-of-life, terminal agitation was common and resulted in abnormal and unpredictable behaviors. Interview with RN #2 (hospice nurse) on 1/27/26 at 11:44 AM identified he/she received a call from RN #5 at 5:55 PM on 12/23/25 and was informed Resident #5 fell out of bed at</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>5:00 PM and was administered two (2) 10 milligram (mg) doses of Morphine at 4:00 PM and 5:00 PM, one dose of Haldol at 5:21 PM, and was resting comfortably at the time of the call. No new medication orders were given at that time. RN #2 identified receiving another call from RN #5 on 12/23/25 at 9:20 PM and was informed Resident #5 again fell out of bed, was banging his/her head on the floor, and stated he/she wanted to die. RN #2 indicated he/she was told there was blood on the floor but the facility was unable to identify the source of bleeding. Resident #5 was assisted to bed, given oxygen at three (3) liters via nasal cannula, was administered ten (10) mg of morphine at 8:30 PM and 9:11 PM, and at the time of the call, was agitated and confused. RN #2 identified she called the hospice provider and a new order for Haldol (which modified the existing order of two (2) milligrams every six (6) hours to one (1) to two (2) milligrams every four (4) hours) was obtained and reported to the facility at 10:19 PM, at which time RN #2 reported Resident #5 was resting comfortably in bed. Interview with RN #5 on 1/27/26 at 3:05 PM identified he/she requested 1:1 supervision for Resident #5 during the 3:00 PM to 11:00 PM shift on 12/23/25 due to falls earlier that day, but the request was denied by the ADNS who informed RN #5 there was not enough staff. RN #5 indicated that staff contributed a portion of their shift to monitor Resident #5 more closely. RN #5 identified he/she was informed that Resident #5 was hitting his/her head on the floor following the 9:00 PM fall and that frank blood was observed on the floor. RN #5 identified that despite performing a full head to toe assessment, she was unable to identify the source of bleeding. RN #5 further identified Resident #5 verbally indicated he/she wanted to die, that the on-call APRN was informed of Resident #5's 9:00 PM fall, but did not recall reporting Resident #5 was hitting his/her head on the floor following the fall and saying he/she wanted to die. Interview with LPN #4 on 1/27/26 at 10:06 AM identified he/she worked the 11:00 PM to 7:00 AM shift on 12/23/25 to 12/24/25. LPN #4 identified that while doing rounds, he/she found Resident #5 on the floor of his/her room repeatedly striking his/her head on the floor. Interview with the DNS on 1/27/26 at 3:24 PM identified Resident #5 was not assigned 1:1 supervision the night of 12/23/25 and further indicated he/she was not made aware of the fall or self-harm incident that occurred on 12/23/25 at 9:00 PM. Interview with MD #1 on 1/27/26 at 3:51 PM identified the facility should have been able to manage and treat Resident #5 at the facility, which would have required 1:1 supervision, psychological review for the verbalized suicidal ideation, and a medication review. However, it would not have been realistic to perform these assessments and reviews at 9:00 PM and the best course of action would have been to send Resident #5 to the hospital after the 9:00 pm fall incident if 1:1 supervision was not possible at the facility. The Falls Management policy directed the facility would utilize all resident/patient related information made available upon admission and ongoing to determine resident/patient at risk for fall status and that the interdisciplinary team would develop, initiate, and implement an appropriate individualized care plan based on the fall risk evaluation score.</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interviews, and facility documentation/policies for one (1) of three (3) sampled residents (Resident #1) reviewed for accidents, the facility failed to follow physician orders which directed the assistance of two (2) staff for bed mobility which resulted in a dislocation of the left shoulder, and for one (1) of three (3) residents (Resident #4) reviewed for accidents, the facility failed provide adequate supervision by failing to initiate appropriate fall prevention interventions (toileting plan/schedule) and failing to implement an established care plan intervention (gripper socks) for a resident with progressive incontinence patters who was at high risk for falls. The findings included:1.Resident #1's diagnoses included hemiplegia and hemiparesis after cerebral infarct affecting the left, non-dominant side. A Nurse's note dated 12/11/25 at 10:13 PM identified Resident #1 was alert and oriented times four. A Physician's admission Assessment note dated 12/12/25 at 11:30 AM identified Resident #1 was chair bound, had left sided weakness with no ability to move the left upper or left lower extremity. The physician's order dated 12/12/25 directed an assist of two (2) with bed mobility. The Resident Care Plan dated 12/12/25 identified Resident #1 had decreased functional mobility and was at risk of falls due to hemiplegia and hemiparesis of the left, non-dominant side. Interventions directed assistance of two (2) with bed mobility and transfers in and out of the bed and chair. The Nurse Aid Care Card (summary of a resident's daily care needs and instructions used by staff to provide care) dated 12/12/25 directed an assist of 2 with bed mobility. The Nurse's note dated 12/15/25 at 2:15 PM identified RN #2 (the 7 AM to 3 PM Nursing Supervisor), was notified Resident #1 complained of shoulder pain and stated he/she heard a pop while being transferred by a nurse aide (NA). The Advanced Practice Registered Nurse (APRN) was notified and directed an x-ray of the left shoulder. Pain medication was administered. The Nurse's note dated 12/16/25 at 12:34 PM identified Resident #1 denied pain. A Physician's progress note dated 12/16/25 at 1:00 PM identified Resident #1 complained of left shoulder, arm, and hand pain. Resident #1 had intact sensation but no active movement to the left upper extremity at baseline. Resident #1 had a small area of greenish- yellow ecchymosis on the left hand. The x-ray identified a normal left humerus with an anterior dislocation of the left shoulder. Resident #1 was sent to the Emergency Department (ED) for further evaluation. Review of the facility's summary report dated 12/18/25 identified Resident #1 complained of left arm pain when NA #1 was moving Resident #1 in bed on 12/15/25. Initially an x-ray was ordered but was discontinued by the APRN because Resident #1 no longer complained of pain and was unable to give a clear report of what happened when interviewed by the nursing supervisor. The APRN followed up with Resident #1 on 12/16/25 for evaluation of the left upper extremity pain and based on symptoms re-ordered the x-ray. NA #1 was subsequently provided with education regarding safe body mechanics and following the plan of care. An interview with LPN #1 on 1/14/26 at 11:00 AM identified that on 12/15/25 NA #1 reported that when he assisted Resident #1 with the bedpan, he pulled Resident #1's arm while moving him/her in bed. LPN #1 spoke with Resident #1 who reported the incident occurred that morning and further identified he/she heard a pop when NA #1 was moving him/her in bed. An interview with the Director of Nursing (DON) on 1/14/26 at 11:45 AM identified when she interviewed NA #1, he identified he moved Resident #1 in bed without assistance. The DON identified that provider orders directed assistance of two (2) staff members for bed mobility. Interview with NA #1 on 1/14/26 at 12:00 PM identified on 12/15/25 he was in a rush and Resident #1 wanted a boost up in bed to eat breakfast. NA #1 was alone and stood at the head of Resident #1's bead, grabbed the right side of the transfer sheet that was under Resident #1 with his right hand and grabbed Resident #1's left</p> <p>(continued on next page)</p>		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	<p>shoulder with his left hand and pulled Resident #1 up in the bed. NA #1 further identified he was aware Resident #1 was supposed to be moved by two (2) people while in bed. Although requested, the facility was unable to provide a transfer policy. 2. Resident #4 was admitted to the facility in February of 2025 and had diagnoses that included dementia, cerebral infarction, and difficulty in walking. The Bladder and Bowel assessment dated [DATE] identified Resident #4 was continent of bowel and the bladder section indicated non applicable. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #4 had severely impaired cognition (Brief Mental Interview for Mental Status (BIMS) score of 3), was dependent with toileting hygiene and bathing, required substantial assistance with ambulation, was occasionally incontinent of urine, and utilized a wheelchair. The Resident Care Plan (RCP) dated 6/12/25 identified Resident #4 was at risk for falls secondary to an impaired sense of balance and unsteady gait. Interventions directed to apply gripper socks while in bed, instruct Resident #4 to ask for assistance prior to attempting to transfer or ambulate, place call bell within reach, and orient to surroundings. The RCP did not identify goals and interventions for incontinence care or a toileting plan/schedule. a. The Accident and Incident report (A&I) dated 7/4/25 at 3:30 AM identified Resident #4 sustained an unwitnessed fall, was found lying on the bathroom floor, and sustained a skin tear to the left elbow. b. The A&I by LPN #3 dated 8/6/25 at 2:20 PM identified Resident #4 sustained an unwitnessed fall, was found lying on the floor in his/her room with the wheelchair tipped over and reported a headache and pain to the right side, hip, and back. c. The A&I by LPN #3 dated 9/8/25 at 8:15 PM identified Resident #4 sustained an unwitnessed fall due to ambulating without assistance. Resident #4 was found next to his/her bed and sustained no injuries. d. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #4 had severely impaired cognition (Brief Mental Interview for Mental Status (BIMS) of 3), required substantial assistance with toileting hygiene, personal hygiene, and ambulation, utilized a wheelchair, and was frequently incontinent of bowel and bladder. Review of the RCP dated 9/24/25 identified Resident #4 was at risk for falls secondary to an impaired sense of balance and unsteady gait. Interventions directed to apply gripper socks while in bed, instruct Resident #4 to ask for assistance prior to attempting to transfer or ambulate, offer toileting during second rounds, and to offer bathroom frequently when in bedside chair. The RCP did not identify goals and adequate interventions for incontinence care or a toileting plan/schedule. The A&I by RN #7 dated 11/19/25 at 11:45 PM identified Resident #4 sustained an unwitnessed fall and was found under the sink in his/her bathroom, sustained a right elbow and low back skin tear, and reported right rib pain. Initial x-rays resulted negative; however, Resident #4 was transported to the hospital on [DATE] for a high pain level (10 out of 10) to the right side and back. The Certified Nurse's Aide Care Card (care card) (used to identify a resident's specific care needs) dated 11/20/25 identified Resident #4 was continent of bowel and bladder. The toileting plan section of the care card directed a transfer status rather than a toiling plan to provide an assist of one for toilet transfers with use of a rolling walker or grab bar. The care card directed to ensure non-skid socks were in place. A nurse's note by RN #6 on 11/27/26 at 12:57 PM identified Resident #4 was readmitted to the facility and had fractures to ribs 8-11. Review of the clinical record failed to identify a Bowel and Bladder assessment was performed upon readmission to the facility according to facility policy. e. The comprehensive Minimum Data Set (MDS) assessment dated [DATE] identified Resident #4 had severely impaired cognition (Brief Mental Interview for Mental Status (BIMS) of 3), required supervision with toileting, substantial assistance with transfers, utilized a wheelchair, was frequently incontinent of urine. The Resident Care Plan (RCP) dated 12/9/25 identified Resident #4 was at risk for falls secondary to impaired sense of balance and unsteady gait and was incontinent</p> <p>(continued on next page)</p>		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	<p>of bowel and bladder. Interventions directed to apply gripper socks while in bed, to check placement of gripper socks at the beginning of the 11:00 PM to 7:00 AM shift, observe for non-verbal cues of needing to use the bathroom, observe for signs of redness or inflammation and apply barrier if indicated, to provide privacy and a brief. The RCP did not identify a toileting plan/schedule. The Fall Investigation Report by RN #4 dated 12/20/25 at 4:15 AM identified Resident #4 fell out of bed while attempting to use a urinal and was not wearing gripper socks. A Nursing Post Event progress note by RN #7 dated 12/20/25 at 5:11 AM identified Resident #4 sustained an unwitnessed fall out of bed and stated was trying to use the urinal and I don't know what happened, sustained a 2.5 centimeter (cm) skin tear to his/her head with a hematoma, and a bruise to the outer lower leg. The on-call provider was contacted and ordered Resident #4 to be transported to the hospital for further evaluation. A nursing note by RN #2 dated 12/21/25 at 8:55 AM identified Resident #4 returned from the hospital after receiving 2 staples for a 3 cm by 2.5 cm head laceration and additionally sustained an 11 cm by 8 cm bruise to the right elbow area from the fall. Interview with NA #4 on 1/22/26 at 10:58 AM identified he/she was seated outside Resident #4's room on 12/20/25 during the 11:00 PM to 7:00 AM shift when Resident #4 fell to the floor. NA #4 indicated Resident #4 explained he/she was sitting on the edge of the bed with both feet on the floor, attempting to position the urinal for use, when he/she lost balance and fell. NA #4 further identified Resident #4 was not wearing gripper socks at the time of the fall and that he/she was unaware Resident #4 was to have gripper socks on while in bed and checked for placement on the 11 PM to 7 AM shift. Interview with the Director of Nursing Services (DNS) on 1/22/26 at 11:33 AM identified Resident #4 should have had a toileting plan/schedule due to severe cognitive impairment and identified incontinence patterns. The DNS was unable to identify why the facility failed to implement a toileting plan/schedule despite Resident #4 sustaining three (3) falls related to toileting needs, two of which resulted in injury. The DNS further identified the facility should have performed a Bowel and Bladder assessment following the 11/22/25 to 11/27/25 hospitalization according to facility policy. The DNS identified NAs were trained to review care cards at the start of each shift because updates/changes to the level of care could occur at any time and would be updated on the care card. The DNS indicated NA #4 and NA #5 should have checked Resident #4's care card. Interview with NA #5 on 1/22/26 at 2:34 PM identified he/she was assigned to provide care for Resident #4 during the 3 PM to 11 PM shift on 12/19/25. NA #5 identified he/she provided personal care and assisted Resident #4 to bed. NA #5 identified he/she applied regular socks and was unaware that Resident #4 required gripper socks while in bed. The Falls Management policy directed the facility would utilize all resident/patient related information made available upon admission and ongoing to determine resident/patient at risk for fall status and that the interdisciplinary team would develop, initiate, and implement an appropriate individualized care plan based on the fall risk evaluation score. The Urinary Incontinence policy directed each resident would have a urinary assessment on admission, readmission, and with a significant change in continence. The policy further indicates changes in continence status would be monitored and that the bladder assessment, once completed, would determine the type of toileting plan based on the score. Although requested, the facility did not have a Resident Care Card policy to provide. The Comprehensive Care Plan policy directed the facility was committed to providing residents with all necessary care and services to enable them to achieve the highest quality of life, that care plans were oriented toward preventing avoidable decline in clinical functional levels, maintaining a specific level of functioning, and that the Comprehensive Care Plan included measurable objectives and timelines to accommodate preferences, special medical, nursing and psychosocial needs identified.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075396	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2026
NAME OF PROVIDER OR SUPPLIER Cherry Brook Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews, for two (2) of three (3) sampled residents reviewed for medication administration (Residents #2 and #3), the facility failed to ensure medications were administered in accordance with physician orders when Resident #2 received Lacosamide prescribed for Resident #3 instead of the ordered Tramadol. The findings include: Resident #2's diagnoses included Parkinson's Disease, dementia, and anxiety. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #2 had severe cognitive impairment (Brief Interview for Mental Status (BIMS) score of 5) and was dependent on staff for all care. The Resident Care Plan (RCP) dated 9/11/25 identified Resident #2 had a diagnosis of alcohol and polysubstance abuse. Interventions directed to monitor the resident's psychosocial status, provide support, and arrange psychiatric services as needed. A physician's order for Resident #2 dated 11/13/25 directed to administer Tramadol (pain medication) oral solution 5 milligrams (mg)/milliliters (ml) give 10 ml (50 mg) by mouth two (2) times per day. A physician's order for Resident #3 dated 12/30/25 directed to administer Lacosamide (anticonvulsant) oral solution 10 milligrams (mg)/milliliters (ml) give 20 ml (200 mg) two (2) times per day. The nurse's note dated 12/30/25 at 12:51 PM identified LPN #2 administered the incorrect medication to Resident #2 at 8:00 AM. Resident #2 was closely monitored and there were no noted side effects. The Facility Reported Incident form dated 12/30/25 identified Resident #2 was given the incorrect medication. The APRN directed to monitor the resident. An interview with the Director of Nursing (DON) on 1/14/26 at 1:50 PM identified she was aware of the medication error that occurred on 12/30/25. The DON reported LPN #2 was preparing to administer liquid Tramadol to Resident #2 but poured liquid Lacosamide prescribed for Resident #3. The DON identified both medications were controlled substances stored in a locked area and the medication bottles appeared similar. The DON further identified LPN #2 did not read the medication label prior to pouring the medication. Although attempted, an interview with LPN #2 was not obtained. Review of the Medication Administration policy directed to compare the medication label to the resident's Medication Administration Record.</p>		