

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/27/2026
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)		
F 0573 Level of Harm - Potential for minimal harm Residents Affected - Some	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, review of the clinical record, review of facility documentation and review of facility policy for 1 of 3 sampled residents (Resident #99) reviewed for pressure ulcers, the facility failed to ensure Resident #99's resident representative was provided copies of medical record upon request. The findings include: Resident #99 was admitted to the facility in December 2025 with diagnoses that included contusion of the left front wall thorax (chest), acute embolism (blockage of blood vessel that has traveled in blood stream) and thrombosis (blood clot) of deep veins of right lower extremity, and dementia with severe anxiety. A hospital Discharge summary dated [DATE] identified Resident #99 was severely cognitively impaired and required moderate assistance of one staff member for washing, dressing, and toileting and required assistance of 2 staff members for transfers and ambulation with a rolling walker, minimal assistance with bed mobility and cueing for meals (there was not a Nursing admission Assessment or Minimum Data Set assessment completed for Resident #99 when admitted to the facility). The Resident Care Plan (RCP) dated 12/2/25 identified nutrition as an area of focus with interventions that included allowing adequate time to consume meals, assisting with meals as needed, monitoring labs, intake and output, monitoring weights as needed, providing diet as ordered and snacks as desired, speech therapy, inspect skin for redness, irritation or breakdown, pressure reducing cushion and mattress. Physician orders dated 12/3/25 directed assistance of 1 staff member for ambulation and bed mobility, physical, occupational, and speech therapy evaluation and treatment as indicated. Provide a no added salt diet with regular consistency and med pass (protein supplement) 120 milliliter (ml) once a day for nutritional needs. Social Worker (SW) #1's notes dated 12/10/26 noted information was provided to Person #1 and Person #2 regarding the last covered insurance day and discharge due to Resident #99's cognitive impairments. Psychiatric progress notes dated 12/4/26 by a Physician's Assistant indicated that Resident #99 had severe cognitive impairment with anxiety and depressed mood. Resident #99 was forgetful, confused and disoriented to place and time on situational exam. Nursing notes dated 12/12/26 indicated that Person #1 signed discharge paperwork for Resident #99 as he/she could not comprehend information provided for discharge. Interview with Person #1 on 7/27/26 at 8:15 AM indicated that requests had been made several times for a copy of Resident #99's medical records. Person #1 stated that she had spoken to the Administrator and emails had gone back and forth but still had not received copies of the medical record. Person #1 stated that the facility was just giving the run around. Person #1 indicated that Person #2 who was the resident representative for Resident #99 even requested copies of Resident #99's medical record per the Administrator's directive and still no copies had been sent. Interview with Person #2 on 7/27/26 at 12:15 PM indicated that she had spoken to Person #1 about Resident #99's medical records and that the facility wanted Person #2 to (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 075396	Facility ID: 075396 If continuation sheet Page 1 of 2

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/27/2026
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)		
F 0573 Level of Harm - Potential for minimal harm Residents Affected - Some	give consent. Person #2 indicated that she had told the facility to send the medical records for Resident #99 and she believed she had sent them written consent. Person #2 indicated that she did not know why it was taking so long to get the medical records as the request started in December 2025 even before Resident #99 was discharged . A review of email correspondence between Person #1 and the Administrator noted emails on 4/24/26, 5/7/26, 5/11/26, and 5/18/26. All emails were about Person #1's formal requests for the entire medical record for Resident #99. The Administrator's responses to Person #1, was either Person #2 or Resident #99 needed to send a signed consent in order for medical records to be released as Resident #99 was considered his/her own person. Even though Resident #99's BIMS score was 7 (severely cognitively impaired) and other documents pertaining to Resident #99 such as Beneficiary Notice and discharge paperwork were provided to Person #1 or Person #2. Otherwise, provide documentation that Person #1 was power of attorney for Resident #99. On 5/7/26 Person #1 provided a document titled, Document Concerning Health Care Instruction Combined Form. The form addressed, Living Will, Appointment of Health Care Representative, Designation of Conservator of Person, Anatomical Gift and Health Insurance Portability and Accountability Act (HIPPA) Release authority. In section of Health Care Representative, the document indicated that Person #1 and Person #2 had the authority to request and receive any information, verbal, or written, regarding my personal affairs or my physical or mental health, including medical and hospital records, and to execute any release or other documentation that may be required to obtain information. This document was in effect if attending physician determined that Resident #99 is unable to understand and appreciate the nature and consequences of health care decisions and to communicate any informed decisions. Interview with the Administrator on 7/27/26 at 1:00 PM indicated that the medical record for Resident #99 had not been sent because the information provided by Person #1 was a Living Will and was only in effect if Resident #99 was deemed incapacitated despite that Resident #99 was severely cognitively impaired and all other documents had been provided to Person #1 and Person #2 for their signatures. The Medical Records policy dated 12/4/25, directed, in part, under Connecticut General Statutes 19a-490b and 19a-550(b)(9), residents, their authorized health agents, conservators, or power of attorney may review and copy all medical records in the facility's possession upon written request by a complete and authorized form. A medical record form must be completed in its entirety and signed by a person legally eligible to release the records. When form is completed, it is returned to the facility. The maximum charge is \$0.65 a page for most records.		