

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 12/23/2024
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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</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** 48950</p> <p>Based on observations, clinical record review, review of facility policy, and interviews for 1 resident, (Resident #63) reviewed for dignity, the facility failed to ensure Residents #63 was treated in a dignified manner while services were provided. The findings include.</p> <p>Resident #63's diagnoses include spinal stenosis, anxiety and depression.</p> <p>The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #63 was cognitively intact with no impairment, independent with eating, dependent with toileting, and maximal assist for bathing, transfers, and personal hygiene.</p> <p>Review of the Resident Council minutes from 10/2024 identified that residents had concerns regarding distractions, such as ear buds and cell phones, used by nursing staff.</p> <p>Interview with Resident #63 on 12/19/24 at 11:08 AM identified LPN #6 was performing the medication pass during the evening on 12/18/24 and was on her cell phone arguing with someone. LPN #6 had her ear buds in and was swearing at the person she was on the phone with while in Resident #63's room. Resident #63 indicated that it was inappropriate and that the residents should not be exposed to that kind of behavior from staff while providing care to residents.</p> <p>The Director of Nursing Service (DNS) was immediately notified by the surveyor of Resident #63's statements on 12/19/24.</p> <p>Review of the investigation performed by the facility identified LPN #6 was talking on her phone, using inappropriate language and had her earbuds in place which was witnessed by all the staff members working on the unit on 12/18/24. Also identified was that education was provided to LPN #6 regarding customer service, cell phone usage while working to include using ear buds, and appropriate conduct while working.</p> <p>Interview with the Administrator on 12/20/24 at 2:30 PM identified that LPN #6 was an agency nurse, and the agency was called and informed that LPN #6 was no longer welcome to work at the facility.</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	If continuation sheet Page 1 of 27

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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>Note: The nursing home is disputing this citation.</p>	<p>An interview with LPN #6 on 12/23/24 at 10:03 AM identified she was on her cell phone with her earbuds in arguing with someone, using inappropriate language, while on the facility unit such as the medication room, hallway and nurse's unit. LPN #6 further identified that it was not appropriate for her to be on her phone while working and she should not have been using foul language on the unit.</p> <p>Review of the Cell Phones and Other Personal Electronic Devices policy identified that while in the workplace during work hours, workers are expected to focus on work first and foremost. Further identified was not to be engaging in personal conversations. Employees may use devices while they are not working. Devices may be used in the following designated areas during non-working times: lunchrooms, grounds, and offices. Employees are expected to be considerate of others, keep phone volume low or on vibrate, and modulate their conversation voice volume.</p>		

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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Honor the resident's right to organize and participate in resident/family groups in the facility.</p> <p>48950</p> <p>Based on review of facility Resident Council meeting minutes (formal records documenting discussions to address concerns and collaborations on facility-related matters affecting the residents), interviews, and facility policy, the facility failed to adequately respond to resident grievances. The findings include:</p> <ol style="list-style-type: none"> 1. Review of Resident Council minutes dated September 2024 identified the following concerns: <ol style="list-style-type: none"> A. Several concerns related to the number of agency staff (temporary healthcare workers hired through an agency to fill vacancies) in the building and agency staff not introducing themselves. 2. Review of the Resident Council meeting minutes dated October 2024 identified the following: <ol style="list-style-type: none"> A. Several concerns related to the number of agency staff in the building and lack of staff overall, concerns with overall care and staff knowledge of individual resident needs. B. Concerns regarding distractions such as earbuds and cell phones being used by staff. 3. Review of Resident Council meeting minutes dated November 2024 identified the following: <ol style="list-style-type: none"> A. Several concerns related to the number of agency staff in the building and lack of overall staff. <p>The Recreation Director provided signed copies of Resident Council minutes for the months of September, October and November of 2024 which included handwritten notes by the Administrator regarding concerns that were addressed. The copies failed to identify that the concerns related to the nursing staff were addressed.</p> <p>During the Resident Council meeting on 12/19/24 at 11:00 AM several residents were in attendance and stated that staff were using cell phones while on duty, that too many agency staff were in the building and that the agency staff were not aware of the resident ' s individual needs. Several residents present for the Resident Council meeting further identified concerns related to the lack of facility response to grievances and to concerns voiced during the Resident Council meetings.</p> <p>Interview on 12/19/24 at 11:35 AM with the Recreation Director identified that grievances are forwarded to the respective departments identified in the grievance, and to the Administrator. The Recreation Director identified that once reviewed, the Administrator signed and returned the grievance to the Recreation Director.</p> <p>(continued on next page)</p>		

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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Interview with the Administrator on 12/20/24 at 2:00 PM identified that she addressed concerns with agency staff not introducing themselves, but was unable to provide documentation of the follow up. She further identified that she had addressed nursing staffing concerns and that she would look into the nursing concerns. The Administrator identified that the Director of Nursing Services (DNS) would be responsible for follow up from the Resident Council meeting minutes regarding nursing issues, and that the facility would be changing the process for follow up of Resident Council meetings subsequent to the current process being ineffective.</p> <p>Interview on 12/23/24 at 8:44 AM with the DNS identified that concerns with agency staff had been brought to her attention, the facility continued to on board new staff, and no follow up was done with the recent Resident Council concerns due to a Covid-19 outbreak. The DNS further identified that the facility was changing the process for following up with grievances.</p> <p>Subsequent to surveyor request of the grievance policy, the policy was provided 7 days later.</p> <p>Review of the facility Grievance policy identified that any grievances filed should be completed with seven days and that records regarding grievances shall be retained at the facility for at least 3 years.</p>

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<p>F 0625</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48950</p> <p>Based on review of the clinical record, facility policy, and interviews for 2 of 2 sampled residents (Resident #14 and Resident #36) reviewed for hospitalization s, the facility failed to provide the required notification of a bed hold to the resident and the resident representative. The findings include:</p> <p>1. Resident #14 was admitted to the facility in September of 2024 and had diagnoses that included chronic obstructive pulmonary disease (COPD), diabetes, and Covid-19.</p> <p>The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #14 was moderately cognitively impaired (Brief Interview for Mental Status (BIMS) score of 9), required substantial/maximal assistance with oral hygiene and bed mobility, and was dependent for transfers.</p> <p>The Resident Care Plan (RCP) dated 10/1/2024 identified Resident #14 was at risk for complications of diabetes. Interventions included to monitor for signs of hypoglycemia (low blood sugar) which may include clammy skin, shallow respirations, and mental status changes. The RCP failed to identify Resident #14 was at risk for respiratory/pulmonary complications related to a diagnosis of COPD and a new diagnosis for COVID-19.</p> <p>An MDS Medicare progress note dated 11/25/2024 at 12:53 PM identified a Notice of Medicare Non-Coverage was received from the insurance company with a last covered day of 11/27/2024 and Resident #14's family member was appealing the notice with the insurance care management company.</p> <p>A progress note by APRN #2 dated 11/26/2024 at 1:11 PM identified she had spoken to Resident #14's family member regarding Resident #14's decline in condition with a new diagnosis of pneumonia in addition to COVID-19 and the family member was in agreement with transfer of Resident #14 to the hospital.</p> <p>Review of a nursing progress note dated 11/26/2024 at 1:57 PM identified Resident #14 was seen by APRN #2 for abnormal lung sounds, low oxygen saturation of 88% on 3 liters of oxygen, and an overall worsening condition following a positive test for COVID-19 on 11/25/2024. The progress note further identified per provider order, Resident #14 was sent to the hospital emergency room for evaluation, the family member was updated by phone, and Resident #14 left the facility at 1:50 PM transported by ambulance. The progress note failed to identify the resident/family member had been notified of the bed hold policy upon transfer of Resident #14 to the hospital.</p> <p>A provider order dated 11/26/2024 directed to send Resident #14 to the hospital emergency room for evaluation related to worsening pulmonary status.</p> <p>(continued on next page)</p>

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<p>F 0625</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Review of facility documentation and interview with Social Worker #2 on 12/20/2024 at 11:45 AM identified the social work office did not have record of a bed hold policy being given to Resident #14 on 11/26/2024 and his/her name was not on the November list of discharged residents, but Resident #14's name was on the monthly report of discharged residents sent to the Ombudsman. Social Worker #2 stated the bed hold policies they keep are copies given to the social work office by the receptionists who maintain the official binder of discharged residents with signed bed hold policies.</p> <p>Review of facility documentation and interview with Reception #1 on 12/23/2024 at 2:00 PM identified reception maintains a binder of signed bed hold policies for discharged residents at the front desk, the policies are organized by month and date of discharge. The October 2024, November 2024, and December 2024 lists in the binder were reviewed with Reception #1 and Resident #14's name was not identified as listed in the binder as discharged on [DATE] and no bed hold policy for Resident #14 was located within the binder. Reception #1 was unable to identify why Resident #14 was not listed in the binder and stated it is the responsibility of reception to follow-up if a bed hold is missing and reception was notified the resident was discharged to the hospital. Reception #1 further identified the bed hold policies are provided to reception by the nursing staff, but reception does not put the discharged resident name into the book until confirmation that the resident has been out of the facility for greater than or equal to 24 hours and reception does not always get notified that a resident has been admitted to the hospital after discharge.</p> <p>2. Resident #36's diagnoses included leukemia, pneumonia, coronary artery disease, and hypertension.</p> <p>The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #36 was cognitively intact, required set up for eating, dependent for bathing, dressing, personal hygiene, and transfers.</p> <p>Review of the Nursing progress note dated 10/21/24 at 3:41 identified that Resident #36 was having chest pain. The Advance Practice Registered Nurse directed for Resident #36 to be transferred to the emergency room , Resident #36 was subsequently admitted to the hospital.</p> <p>The home discharge MDS dated [DATE] identified that Resident #36 was admitted to the hospital.</p> <p>Interview and review of facility documentation on 12/19/24 at 2:51 PM with the Social Service Director identified that he could not find the Notice of Emergency Transfer to a Hospital that the resident/family was notified of the bed hold policy. Further identified was the lack of a copy of a certified mail notification was sent. The Social Service Director knew the facility policy and was unsure of why this was not done other than being an oversight.</p> <p>Review of the Bed Reservation policy identified that the facility must inform residents and their family/responsible party, at the time of admission, and upon transfer to a hospital of the conditions under which the resident's nursing home bed will be reserved. The Policy for the Reservation of beds: Notification to Residents, is provided via the Resident services and Information Directory upon admission. It is also sent with the resident upon emergency transfer to the hospital and via mail to the responsible party at the time the resident is transferred to the hospital.</p> <p>51183</p>		

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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>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** 51183</p> <p>Based on review of the clinical record, facility policy and interview for the only sampled resident (Resident #3) reviewed for trauma informed care, the facility failed to develop a comprehensive care plan for a resident with post-traumatic stress disorder (PTSD). The findings include:</p> <p>Resident #3 was admitted to the facility in November of 2017 and had diagnoses that included cerebral palsy, PTSD, and major depressive disorder.</p> <p>The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #3 was moderately cognitively impaired (Brief Interview for Mental Status (BIMS) score of 11), had PTSD as an active diagnosis, required setup or clean-up assistance with eating, substantial/maximal assistance with bed mobility and was dependent for transfers.</p> <p>The Resident Care Plan (RCP) dated 10/29/2024 identified Resident #3 had a history of accusatory behaviors related to a diagnosis of bipolar disorder, and traumatic history, and Resident #3 was uncomfortable with male care givers but was comfortable receiving medications from a male nurses. Interventions included no male nurse or caregiver for personal care and provide Resident #3 with support as needed. The RCP identified Resident #3 preferred not to have apple juice as it reminded him/her of a past trauma. Interventions included please do not give Resident #3 apple juice per his/her request and Resident #3 may have apples/apple sauce. The RCP further identified Resident #3 had potential for behavior problems of swearing, yelling out, banging wheelchair into closet and walls, and sobbing. Interventions included to decrease visual or auditory stressors, listen and be supportive, and monitor for triggering events and avoid them in the future. The RCP failed to identify Resident #3 had a diagnosis of PTSD related to childhood trauma, with interventions to include triggers that cause flashbacks or emotional responses of the past trauma.</p> <p>An interview and clinical record review with Social Worker #2 on 12/23/2024 at 12:15 PM identified the RCP did not contain a focus related to Resident #3's diagnosis of PTSD. Social Worker #2 stated she was aware of Resident #3's history of childhood trauma and triggers which caused flashbacks or emotional responses for Resident #3, but did not realize there was a diagnosis of PTSD until checking the clinical record subsequent to surveyor inquiry. Social Worker #2 indicated Resident #3 should have a RCP focus related to PTSD and that the Social Work department was responsible for entering these focuses into the RCP. Social Worker #2 could not identify why the focus was not entered into the RCP and stated Resident #3 was admitted prior to her starting employment.</p> <p>Review of the Comprehensive Care Plans policy identified comprehensive care plans are developed by the interdisciplinary team and include objectives to accommodate psychosocial needs, and care plans are evaluated and revised as needed but at least quarterly.</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>Note: The nursing home is disputing this citation.</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** 51183</p> <p>Based on review of the clinical record, review of facility policy, and interviews for one sampled resident (Resident #20) reviewed for weight loss, the facility failed to follow a dietician recommendation for a resident with known weight loss. The findings include:</p> <p>Resident #20 was admitted to the facility in May of 2022 with diagnoses which included dementia, diabetes, and abnormal weight loss.</p> <p>The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #20 was severely cognitively impaired (Brief Interview for Mental Status (BIMS) score of 3), required setup or clean-up assistance with eating, partial/moderate assistance with bed mobility and substantial/maximal assistance with bed/chair transfers.</p> <p>The Resident Care Plan (RCP) dated 11/6/2024 identified Resident #20 had potential for impaired nutrition related to dementia and was at risk for weight loss. Interventions included to allow Resident #20 adequate time to consume meals, assist with meals as needed, and monitor weight as needed.</p> <p>Review of the Weights and Vitals Summary report identified the following documented weights: 125.2 lbs. on 5/30/2024, 124.8 lbs. on 6/28/2024, 124.4 lbs. on 6/29/2024, 125.1 lbs. on 7/25/2024, 125 lbs. on 8/21/2024, 120.5 lbs. on 9/18/2024, 118.6 lbs. on 10/10/2024, 113.2 lbs. on 11/28/2024, 111.5 lbs. on 12/2/2024, and 111.5 lbs. on 12/5/2024. The report further identified a 9.44% severe weight loss from 8/21/2024 through 11/28/2024, and a 10.66% severe weight loss from 6/28/2024 through 12/2/2024.</p> <p>A late entry Nursing progress note dated 12/2/2024 at 7:43 PM identified the Advanced Practice Registered Nurse (APRN) was aware of Resident #14's weight loss and no new orders were given.</p> <p>A progress note by the Dietician dated 12/4/2024 at 11:09 AM identified Resident #20's weight was 111.5 pounds (lbs.) which reflected a 13.3 lbs. (10.7%) weight loss from 6/28/2024 through 12/2/2024. The progress note further identified Resident #20 would continue diet, supplements and weekly weights.</p> <p>Review of the clinical record failed to identify that weekly weights were ordered and completed as recommended by the dietician.</p> <p>Interview with the Dietician on 12/20/2024 at 2:53 PM identified she was unaware Resident #20 was not on weekly weights and still had a current order in place for monthly weights. The Dietician stated she sometimes enters orders into the electronic medical record (EMR) and other times she writes her recommendations on a Dietary Recommendation form which she then hands directly to the Nursing Supervisor. The Dietician stated she wrote a request for weekly weights on a Dietary Recommendation form on 12/4/2024 and gave the form to the Nursing Supervisor. She could not identify why the order was not changed.</p> <p>A progress note by the Dietician dated 12/21/2024 at 10:43 AM identified a new nutritional supplement order but failed to further address the need for weekly weights.</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>Note: The nursing home is disputing this citation.</p>	<p>Review of the Order Summary Report dated 12/23/2024 identified a provider order dated 10/9/2024 which directed to obtain a weight and vital signs monthly on Thursday every 4 weeks.</p> <p>The Order Summary Report failed to identify a new order for weekly weights.</p> <p>Interview and clinical record review with Registered Nurse (RN) #1 on 12/23/2024 at 9:43 AM identified she is responsible for entering the dietician's written recommendations into the EMR as soon as the form is handed to her and then discards the form. RN #1 was unable to recall receiving a recommendation for weekly weights and confirmed that this order was not in place in the EMR.</p> <p>Interview with APRN #2 on 12/23/2024 at 11:25 AM indicated she did not know if she was notified of a weight loss for Resident #20 and further indicated the care for Resident #20 was managed by MD #1. She identified that she addressed only urgent acute needs when MD #1 was unavailable.</p> <p>Attempts to interview MD #1 were unsuccessful.</p> <p>Although requested, facility policies for dietician assessments and dietician recommendations were not provided.</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50179</p> <p>Based on observations, review of the clinical record, facility policy and interviews for 1 of 2 residents (Resident #75) reviewed for bladder and bowel incontinence, the facility failed to follow the toileting plan and provide incontinence care as directed in the plan of care. The findings include:</p> <p>Resident #75 was admitted to the facility in November of 2023 with diagnoses which included Diffuse Traumatic Brain Injury, Aphasia, Dysphagia, Gastrostomy Tube status, Seizures, and Quadriplegia.</p> <p>The annual Minimum Data Set assessment dated [DATE] identified Resident #75 was severely cognitively impaired (Brief Interview for Mental Status (BIMS) score of 0) and required total assistance with eating, bathing, dressing, toileting and mobility. Resident #75 was always incontinent of bladder and bowel.</p> <p>The Resident Care Plan (RCP) dated 11/26/24 identified Resident #75 was incontinent of bowel and/or bladder with a history of urinary retention. Interventions included a maintenance toileting plan which instructed to toilet or provide use of bed pan before and after meals, at hour of sleep and as needed if able, that Resident #75 could raise hand to let staff know s/he needed to go to the bathroom and would shake leg for urgent bathroom use, observe nonverbal clues of needing to use the bathroom, provide incontinent care per incontinent episode and as needed, check every 2 hours for toileting needs.</p> <p>The Resident Care Card (RCC) (readily accessible document used by Nurse Aides (NA) to quickly reference key patient information) identified toileting: bladder continent/incontinent, bowel continent, assist of 2 staff to bathroom. The RCC failed to identify the toileting plan or to check for incontinence every 2 hours as identified in the RCP.</p> <p>Observation on 12/20/24 at 12:20 PM, identified NA #3 provided morning care for Resident #75 from 9:30 AM to 10:00 AM.</p> <p>Observation on 12/20/24 from 10:30 AM to 12 PM identified Resident #75 in the dining room and then assisted back to his/her room without the benefit of toileting or being checked for incontinence.</p> <p>Observation from 12 PM to 12:35 PM identified Resident #75 was in his/her room sitting in his/her wheelchair and no toileting or incontinence checks occurred. Person #1 arrived at 12:35 PM and checked Resident #75 for incontinence and identified that Resident #75's brief was saturated with urine. Person #1 asked Licensed Practical Nurse (LPN) #3 if an NA could change Resident #75, and Resident #75 was subsequently changed.</p> <p>Interview on 12/20/24 at 12:35 PM with NA #3 identified she usually tried to change Resident #75 twice before lunch but was unable to do this today because she was pulled to do other tasks on the unit.</p> <p>(continued on next page)</p>		

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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 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview and record review with LPN #3 identified Resident #75 should have been checked, changed and toileted before lunch. LPN #3 did not know why Resident #75 was not checked for incontinence and toileted before lunch and indicated NA #3 should have toileted Resident #75 prior to starting other tasks.</p> <p>Observation on 12/23/24 at 9:15 AM identified Resident #75 was receiving morning care.</p> <p>Observation on 12/23/24 from 9:30 AM to 11:04 AM identified Resident #75 was sitting in his/her wheelchair at the nurse's station.</p> <p>Observation on 12/23/24 from 11:04 AM to 11:28 AM identified Resident #75 was sitting in his/her wheelchair in the lounge with visitors. Resident #75 was then assisted back to his/her room by his/her visitors.</p> <p>Observation on 12/23/24 At 12:10 PM identified NA #7 assisted Resident #75 into the dining room without the benefit of providing incontinent care or toileting.</p> <p>Interview on 12/23/24 at 12:10 PM with NA #7 (temporary agency NA) identified that she was unaware that Resident #75 was to be checked for incontinence and toileted prior to lunch because no one at the facility communicated this information to her and she was unaware that the RCC was available for reference in Resident #75 's closet.</p> <p>Interview on 12/23/24 at 12:12 PM with LPN #8 (temporary agency LPN) identified that she was unaware that Resident #75 should have been toileted and checked for incontinence before lunch.</p> <p>Interview on 12/23/24 at 12:20 PM with Director of Nursing (DNS) identified agency NA's and nurses should utilize and follow the RCP and RCC to identify how to care for the residents. Additionally, she did not know why the nurse and NA did not know what the RCP or RCC instructed for toileting or incontinence care.</p> <p>Review of the Incontinence Care policy directed, in part, residents who are incontinent of bowel or bladder or who need assistance in hygiene after toileting will receive incontinence care.</p> <p>Although requested, a facility policy for toileting was not provided.</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50179</p> <p>Based on observations, review of the clinical record, facility policy and interviews for the only sampled resident (Resident # 75) reviewed for activities, the facility failed to ensure aspiration precautions were maintained during pleasure eating. The findings include:</p> <p>Resident #75 was admitted to the facility in November of 2023 with diagnoses which included Diffuse Traumatic Brain Injury (TBI), Aphasia, Dysphagia, Gastrostomy Tube status, Seizures, and Quadriplegia.</p> <p>A physician's order dated 2/9/24 directed to provide pureed food including a magic cup and honey thick liquids, by teaspoon only, and with strict aspiration precautions for oral pleasure.</p> <p>The annual Minimum Data Set assessment dated [DATE] identified Resident #75 was severely cognitively impaired (Brief Interview for Mental Status (BIMS) score of 0) and required total assistance with eating, bathing, dressing, toileting and mobility. Resident #75 had a feeding tube.</p> <p>The Resident Care Plan dated 11/26/24 identified Resident #75 was at elevated risk for aspiration in the setting of TBI, Dysphagia and Gastrostomy tube status. Interventions included to always maintain at least 30 degrees head elevation, pleasure food: pureed consistency 3 to 4 ounces once per day, recline 10-15 degrees head elevation in wheelchair for feeding positioning, only feed if alert and awake, may have honey thick liquids by teaspoon only with strict aspiration precautions for pleasure.</p> <p>Observation on 12/19/24 at 12:01 PM, identified NA #4 feeding Resident #75 yogurt in the dining room with Resident #75's chair reclined to 30 degrees. LPN #5 repositioned Resident #75's wheelchair to recline 10-15 degrees and educated NA #4 that Resident #75 was on strict aspiration precautions.</p> <p>Interview and record review with LPN #5 on 12/19/24 at 12:05 PM identified Resident #75 as an aspiration risk with associated interventions to prevent aspiration. LPN #5 did not know why NA #4 was feeding Resident #75 in a reclined position.</p> <p>Review of the Aspiration Precautions policy directed, in part, aspiration precautions will be utilized to reduce the risk of aspiration of food or liquid into a resident's lungs. A resident with significant risk of aspiration which is not completely controlled by current diet modifications will require aspiration precautions by the interdisciplinary team. Resident's needing aspiration precautions will be individualized. Any signs or symptoms of aspiration such as increased temperature, abnormal lung sounds, increased coughing will be further assessed and the physician notified.</p>		

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<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide care or services that was trauma informed and/or culturally competent.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51183</p> <p>Based on review of the clinical record, facility documentation, facility policy and interviews for the only sampled resident (Resident #3) reviewed for trauma informed care, the facility failed to provide trauma-informed care to minimize triggers and/or re-traumatization for a resident with post-traumatic stress disorder (PTSD). The findings include:</p> <p>Resident #3 was admitted to the facility in November of 2017 with diagnoses which included cerebral palsy, PTSD, and bipolar disorder.</p> <p>The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #3 was moderately cognitively impaired (Brief Interview for Mental Status (BIMS) score of 11), had PTSD as an active diagnosis, required setup or clean-up assistance with eating, substantial/maximal assistance with bed mobility and was dependent for transfers.</p> <p>The Resident Care Plan (RCP) dated 10/29/2024 identified Resident #3 was uncomfortable with male care givers and preferred to not have male Nurse Aides (NA) but was comfortable receiving medications from male nurses. Interventions included no male NA 's and Resident #3 requested female nursing staff for treatments or procedures requiring exposure. The RCP identified Resident #3 preferred not to have apple juice as it reminded him/her of a past trauma. Interventions included to not give Resident #3 apple juice per his/her request and Resident #3 may have apples/apple sauce. The RCP further identified Resident #3 had potential for behavior problems of swearing, yelling out, banging his/her wheelchair into the closet and walls, and sobbing. Interventions included to monitor for triggering events and avoid them in the future.</p> <p>A Clinical Social Worker progress note dated 11/5/2024 at 5:21 PM identified Resident #3 expressed he/she was having difficulty with agency and per diem staff because they didn't understand him/her and that emotional support was provided.</p> <p>A Clinical Social Worker progress note dated 12/17/2024 at 4:20 PM identified Resident #3 expressed sadness related to recent feeding struggles, expressed how these struggles related to past childhood traumas and that emotional support was provided.</p> <p>Interview with Resident #3 on 12/18/2024 at 11:23 AM identified he/she was given apple juice or spicy food at times, which triggered memories of past trauma. Resident #3 stated he/she would like staff to be more aware of his/her triggers to avoid memories of childhood trauma.</p> <p>Review of the Resident Care Card (RCC) on 12/19/2024 at 12:09 PM (located on the inside Resident #3's closet door) identified Resident #3 was to have no male NA 's and no apple juice.</p> <p>A progress note by APRN #1 dated 12/19/2024 at 5:13 PM identified Resident #3's history of childhood trauma continued with dissociative episodes and flashbacks to childhood trauma events and there were no new orders.</p> <p>(continued on next page)</p>		

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<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Interview with APRN #1 on 12/20/2024 at 11:50 AM identified she was familiar with Resident #3 having PTSD, and her main trigger of apple juice but was not aware of a trigger for Resident #3 related to hot sauce or spicy foods. APRN #1 was not able to identify any recommendations given to staff to help manage or prevent trauma triggers for Resident #3.</p> <p>Interview with Social Worker #2 on 12/23/2024 at 12:15 PM identified Resident #3 had a diagnosis of PTSD and had childhood trauma triggers related to apple juice, hot sauce, men, and new/different beds. Social Worker #2 stated the most recent incident of Resident #3 being triggered was when a staff member brought a bottle of hot sauce into the dining room for use on their own food, and Resident #3 saw the bottle of hot sauce and subsequently expressed distress. Social Worker #2 indicated there are periodic generalized in-services related to PTSD provided to staff. She further identified the in-services are an opportunity for improvement because they are not resident-centered, and indicated she was unsure of how to educate staff specifically on Resident #3's triggers. Social Worker #2 stated regular facility staff were aware of Resident #3's history of trauma but utilizing agency nursing staff complicated the continuity of communication because they do not consistently follow the RCP or RCC.</p> <p>Observation on 12/20/2024 at 12:35 PM identified Resident #3 was in the dining room finishing his/her lunch meal. Pureed food identified by the diet slip was almost completely consumed. Resident #3 was eating vanilla ice cream. The diet slip accompanying the meal listed the entree as chicken fricassee, the vegetable as [NAME] blend vegetables, the dessert as lactose free vanilla ice cream w/ toppings, and extra items as 1 right curved utensil, 1 hiwall plate, and 1 [NAME] anti-spill cup. The diet slip failed to identify Resident #3 ' s dietary preferences for no apple juice, no hot sauce, and no spicy foods.</p> <p>Subsequent to surveyor inquiry, a progress note by Social Worker #2 dated 12/23/2024 at 1:37 PM identified a new RCP focus was added to address Resident #3's PTSD diagnosis.</p> <p>Interview with the Dietary Menu Clerk on 12/23/2024 at 1:45 PM identified resident preferences are usually listed on the bottom of dietary slips. She further identified that when nursing staff enter dietary orders in the electronic medical record with preferences, the order will carry over to the system used to print the dietary slips. The Dietary Menu Clerk identified foods that were triggers for Resident #3 and indicated she did not think to add these foods to the diet slip so that they were visible to all staff assisting in the dining room or passing trays.</p> <p>Subsequent to surveyor inquiry, printed diet slips dated 12/23/2024 included instructions at the bottom for: no apple juice; no tomato sauce; no hot sauce/spicy foods.</p> <p>Although requested, a facility policy for trauma informed care was not provided due to absence of a facility policy.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>50179</p> <p>Based on observations, review of facility documentation, facility policy and interviews the facility failed to maintain completed shift change reconciliation records for controlled drugs and failed to periodically reconcile the facility inventory of controlled drugs. The findings include:</p> <p>Review of the Apple Gate South medication cart on 12/18/24 at 9:41AM identified the Count Sheets for Narcotics and Sedatives form (the controlled drug reconciliation form that on-coming and off-going nurses complete to ensure controlled drugs were counted) were missing signatures on the following dates:</p> <ul style="list-style-type: none"> a. 11/19/24: off-going b. 11/26/24 on-coming and off-going c. 11/27/24 on-coming and off-going d. 12/6/24 on-coming e. 12/7/24 on-coming f. 12/8/24 off-going and on-coming g. 12/11/24 off-going h. 12/16/24 on-coming and off-going i. 12/17/24 off-going j. 12/18/24 on-coming, off-going, on-coming and off-going k. 12/19/24 on-coming, off-going and off-going. <p>Interview with LPN #2 on 12/18/24 at 9:41 AM indicated that upon completion of the Count Sheet for Narcotics and Sedatives, the sheets were placed in the Director of Nursing's (DNS) document bin.</p> <p>Interview and record review with the RN supervisor (RN #1) on 12/19/24 at 11:25 AM identified blanks on the Count Sheets for Narcotics and Sedatives form. RN #1 indicated she was not aware of the blanks and that no one monitors whether the forms are complete or have blanks. The completed Count Sheets for Narcotics and Sedatives forms are placed in the DNS document bin when completed.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with the DNS on 12/20/24 at 9:30 AM identified she tried to follow up with nurses to complete the missing signatures on the Count Sheets for Narcotic and Sedatives forms but was unsuccessful. The DNS indicated she completed twice monthly audits of random medication carts but failed to provide documentation of the audits. When asked how diversion of narcotics would be identified, the DNS stated, no comment.</p> <p>Review of the Storage of Controlled Substance policy directed, in part, medications classified by the Drug Enforcement Administration (DEA) as controlled substances are subject to special handling, storage, disposal and recordkeeping in the facility in accordance with federal, state, and other applicable laws and regulations. The Director of Nursing, in collaboration with the consultant pharmacist, maintains the facility's compliance with federal and state laws and regulations in the handling of controlled substances. At each shift change, or when keys are transferred, a physical inventory of all controlled substances including refrigerated items, is conducted by 2 licensed personnel and is documented. Controlled substance inventory is regularly reconciled to the Medication Administration Record and documented on a control count sheet or similar form or in accordance with facility policy.</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50179</p> <p>Based on observation, review of the clinical record, facility documentation, facility policy and interviews for 1 of 3 residents reviewed for facility medication administration, the facility failed to maintain a medication error rate of less than 5% (omission of 3 medications out of 35 opportunities resulting in a medication error rate of 8.57%). The findings include:</p> <p>Resident #16 was admitted to the facility in November of 2024 with diagnoses that included fracture of thoracic vertebrae 9-10, thrombocytopenia, and severe protein calorie malnutrition.</p> <p>The admission Minimum Data Set assessment dated [DATE] identified Resident #16 was cognitively intact (Brief Interview for Mental Status (BIMS) score of 13) and required set up assistance with eating, oral hygiene, personal hygiene, substantial maximum assistance to dependence with dressing, toileting and mobility.</p> <p>The Resident Care Plan dated 11/26/24 identified Resident #16 had potential for impaired nutritional status due to anemia, myelodysplastic syndrome, low body mass index and dysphagia. Interventions included to monitor labs as ordered, monitor weight as needed, monitor percentage consumed of solids and fluids and provide vitamins as ordered.</p> <p>Physician's orders dated 12/17/24 directed to administer Prevagen capsule 10 milligrams (mg), in the morning for memory supplement, Quercetin tablet 50 mg in the morning for supplement, and [NAME] cartilage capsule 500 mg in the morning for supplement.</p> <p>Observation and review of the Medication Administration Record (MAR) with LPN #2 identified on 12/18/24 at 9:41 AM, Prevagen, Quercetin and [NAME] cartilage were not administered as directed.</p> <p>Interview with LPN #2 on 12/19/24 at 10:50 AM identified that Resident #16's family member was providing the Prevagen, Quercetin and [NAME] cartilage from home. LPN #2 indicated she called the family member on 12/18/24 to remind them to bring in the medications, but the medications were still not available. LPN #2 indicated she notified the supervisor of the medication omission, but did not notify the provider.</p> <p>Interview and review of the MAR and progress notes with RN #1 on 12/19/24 at 11:25 AM identified that Resident #16's Prevagen, Quercetin and [NAME] Cartilage had been omitted because they were unavailable. RN #1 further indicated that LPN #2 notified her of the omissions but failed to add a progress note notifying the provider of the omission. RN #1 indicated she would notify the provider and request the Prevagen, Quercetin and [NAME] cartilage be placed on hold until the medications were brought in by the family.</p> <p>A nurse's note dated 12/19/24 at 12:02 PM identified the Advanced Practice Registered Nurse (APRN) was made aware of the unavailable medications and the medications were placed on hold until provided by the family.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Ordering Medications from the Pharmacy policy directed, in part, medication orders are written on a physician order form, telephone order sheet or reorder form provided by the pharmacy, written in the chart by the physician, or entered into the facility's Electronic Health Record (EHR) system and transmitted to the pharmacy. When calling, faxing, sending electronically medication orders for a newly readmitted resident, the pharmacy is also given all allergies and diagnosis to facilitate generation of a patient profile and permit initial medication use assessment.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>50179</p> <p>Based on observations, review of facility documentation, facility policy and interviews, the facility failed to store discontinued controlled drugs in a separately locked permanently affixed compartment, and failed to have a system to limit access to controlled drugs. The findings include:</p> <p>Observation on 12/19/24 at 12:20 PM identified the DNS office door was open without any staff present within the office.</p> <p>Interview with the DNS on 12/20/24 at 9:30 AM identified the discontinued controlled drugs were kept in a cabinet drawer in her office until destroyed.</p> <p>Observation on 12/20/24 at 2:15 PM identified the DNS office door was open without any staff present in the office.</p> <p>Interview on 12/20/24 at 2:20 PM with the DNS identified the keys to both locks of the discontinued controlled drugs cabinet drawer were located in her unlocked desk drawer and that she normally kept the keys stored in that drawer.</p> <p>Observation on 12/20/24 at 2:20 PM with the DNS identified the desk drawer containing the keys to the discontinued controlled drugs cabinet drawer was unlocked.</p> <p>Observation on 12/20/24 at 2:22 PM of the cabinet drawer containing discontinued controlled drugs identified the following controlled drugs to include blister packs, patches and liquids:</p> <p>(continued on next page)</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Oxycodone IR 5 milligram (mg) tabs quantity 57 tabs, Hydromorphone 2 mg tabs quantity 1 tab, Oxycodone-APAP 5-325 mg tab quantity 46 tabs, Tramadol 25 mg tab quantity 1 tab, Tramadol 25 mg tab quantity 12 tabs, Oxycodone IR 5 mg tab (1/2 tab = 2.5 mg) quantity 20(1/2 tabs), Tramadol 50 mg tab quantity 19 tabs, Oxycodone IR 5 mg tab quantity 30 tabs, Oxycodone IR 5 mg tab quantity 17 tabs, Amphetamine salt combo 10 mg tab quantity 9 tabs, Tramadol 50 mg tab quantity 21 tabs, Tramadol 50 mg (1/2=25 mg) tab quantity 59 (1/2 tabs), Lorazepam 0.5 mg tab quantity 52 tabs, Tramadol 50 mg tab quantity 10 tabs, Tramadol 25 mg tab quantity 27 tabs. Hydromorphone 4 mg tab quantity 25 tabs, Hydromorphone 2 mg tab quantity 29 tabs, Tramadol 25 mg tab quantity 27 tabs, Pregabalin 150 mg cap quantity 60 caps, Oxycodone IR 5 mg tab quantity 30 tabs, Lorazepam 0.5mg tab quantity 2 tabs, Hydromorphone 2 mg tab quantity 22 tabs, Diazepam 2 mg tab quantity 30 tabs, Tramadol 50 mg tab quantity 30 tabs, Diazepam 2 mg tab quantity 11 tabs, Hydromorphone 2 mg tab quantity 30 tabs, Alprazolam 0.25 mg tab quantity 20 tabs, Oxycodone IR 5 mg tab quantity 45 tabs, Oxycodone IR 5 mg tab quantity 27 tabs, Morphine Sulfate ER 15 mg tab quantity 35 tabs, Oxycodone IR 5 mg tab quantity 6 tabs, Hydromorphone 2 mg tab quantity 7 tabs, Tramadol 50 mg tabs quantity 22 tabs, Diazepam 5 mg tab quantity 86 tabs, Alprazolam 0.25 mg tab quantity 7 tabs, Alprazolam 0.25 mg tab quantity 36 tabs, Oxycodone- APAP 5-325 mg tab quantity 19 tabs, Oxycodone IR 5 mg tab quantity 4 tabs, Lorazepam 2 mg tab quantity 90 tabs, Lorazepam 2mg tab quantity 55 tabs, Tramadol 50 mg tab quantity 28 tabs, Clonazepam 0.5 mg quantity 21 tabs, Oxycodone IR 5 mg quantity 5 tabs, Lorazepam 0.5 mg tab quantity 29 tabs, Lorazepam 0.5 mg tab quantity 9 tabs, Oxycodone IR 5 mg tab quantity 15 tabs, Hydromorphone 2 mg tab quantity 59 tabs, Hydromorphone 2 mg tab quantity 16 tabs, Oxycodone IR 5 mg quantity 28 tabs, Tramadol 50 mg tab quantity 38 tabs, Tramadol 25 mg tab quantity 60 tabs, Zolpidem 5 mg tab quantity 1 tab, Alprazolam 0.5 mg tab quantity 17 tabs, Morphine 20 mg /milliliters(ml) quantity 25.25 ml, Lacosamide 10mg /ml quantity 20 ml, Lorazepam 2 mg/ml quantity 24.75 ml, Fentanyl patch 25 microgram /hour quantity 3 patches, Lorazepam 2mg /ml quantity 0 ml, Morphine Sulfate 100mg /5ml (20mg /ml) quantity 7 ml, Lorazepam 2 mg /ml quantity 28 ml, Lorazepam 2 mg /ml quantity 28.50 ml, Morphine 20 mg /ml quantity 30 ml, Hydromorphone 1 mg/ml quantity 6 ml, Morphine 20 mg/ml quantity 19 ml, Lorazepam 2mg /ml quantity 22 ml, Lorazepam 2mg /ml quantity 27 ml, Morphine Sulfate 100mg /5 ml quantity 29.75 ml.</p> <p>All 67 controlled drugs were reconciled by the DNS and RN #1, and the quantities matched the controlled drug disposition records.</p> <p>Subsequent to surveyor inquiry, observation on 12/23/24 at 9:24 AM identified a new file cabinet was permanently affixed to the wall with a double lock. The new file cabinet contained the facility discontinued controlled drugs.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the Storage of Controlled Substance policy dated revision 8/2020 directed, in part, medications classified by the Drug Enforcement Administration (DEA) as controlled substances are subject to special handling, storage, disposal and recordkeeping in the facility in accordance with federal, state, and other applicable laws and regulations. The Director of Nursing, in collaboration with the consultant pharmacist, maintains the facility's compliance with federal and state laws and regulations in the handling of controlled substances. Only authorized licensed nursing and pharmacy personnel have access to controlled substances. Schedule 2 through 5 medications and other medications subject to abuse or diversion are stored in either a permanently affixed, double locked compartment separate from other medications or in accordance with state regulations. The access system to controlled medications is not the same as the access system for other medications. If a key system is used, the medications nurse on duty maintains possession of the key to controlled substances storage areas. Back up keys to all medication storage areas, including those for controlled substances, are kept by the Director of Nursing or designee. A controlled substance accountability record is prepared by the pharmacy/facility for all schedule 2, 3, 4 and 5 medications, including those in the emergency supply. At each shift change, or when keys are transferred, a physical inventory of all controlled substances including refrigerated items, is conducted by 2 licensed personnel and is documented. Controlled substance inventory is regularly reconciled to the Medication Administration Record and documented on a control count sheet or similar form or in accordance with facility policy. Controlled substances remaining in the facility after the order has been discontinued or the resident has been discharged are retained in the facility in a securely locked area with restricted access until destroyed in accordance with facility policy and state regulations. Accountability records for discontinued controlled substances are maintained with the unused supply until it is destroyed or disposed of and then stored for 5 years or as required by applicable law or regulation. The consultant pharmacy or designee routinely monitors controlled substance storage, records, and expiration dates during routine medication storage inspections.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50167</p> <p>Based on observations, staff interviews, and review of facility documentation, the facility failed to ensure open food items were dated and labeled. The findings include:</p> <p>Tour of the Dietary Department on [DATE] at 10:05 AM with the Kitchen Manager identified the following:</p> <p>a. The walk-in refrigerator was noted to contain an opened 1-pound bag of cheddar cheese (that was ,d+[DATE] full), an opened 1-gallon container of mayonnaise (that was ,d+[DATE] full), and an opened bag of 7 croissants with no open date or expiration date identified.</p> <p>b. The walk-in freezer was noted to contain an opened 3-pound bag of French fries (that was ,d+[DATE] full), an opened bag of 2 fish filets, and an opened 3-pound bag of potato tots (that was ,d+[DATE] full) with no open date or expiration date identified.</p> <p>c. The dry storage room was noted to contain an opened 3-pound bag of elbow noodles (that was ,d+[DATE] full), an opened 3-pound bag of tri-color macaroni noodles (that was ,d+[DATE] full), an opened 5-pound bag of taco seasoning (that was ,d+[DATE] full), and an opened 1-pound bag of pearled barley (that was ,d+[DATE] full) with no open date or expiration date identified.</p> <p>Interview with the Kitchen Manager at that time identified the staff member who opened the food items was responsible to label the food item with a date when opened, as well as when the items should have been discarded or expired. He further identified that it was his responsibility to do spot checks weekly in the refrigerator, freezer and dry storage room to ensure open food items were dated and labeled and it was not done. He indicated he was not aware of a policy on labeling and dating open food items.</p> <p>Interview with the Administrator on [DATE] at 2:00 PM identified there was no Facility or Corporate Policy on Date Marking or Labeling Open Food items.</p>		

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<p>F 0868</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>48950</p> <p>Have the Quality Assessment and Assurance group have the required members and meet at least quarterly</p> <p>Based on facility documentation review, facility policy review and interviews, the facility failed to perform quarterly Quality Assurance meetings and failed to ensure Quality Assurance meetings consisted of the minimum required members to maintain an effective and comprehensive Quality Assurance and Performance Improvement (QAPI) program. The findings include:</p> <ol style="list-style-type: none"> 1. Review of the attendance record for the Quality Assurance Review meeting provided by the administrator failed to show that a Quality Assurance meeting was completed for September 2024. <p>Interview with the administrator on 12/18/24 at 1:03 PM identified there was no QAPI meeting held since 6/2024. The administrator was unable to provide QAPI meeting minutes (official records of discussions, decisions, and actions taken during QAPI meetings) for the 6/2024 QAPI meeting and produced, only, a sign in sheet. The administrator identified she began working in the facility in 9/2024 as an interim administrator up until 3 weeks prior to the current date when she accepted the role permanently. She identified the previous administrator oriented her to the position and instructed her to hold quarterly QAPI meetings and indicated a QAPI meeting should have been held in 9/2024. The administrator further identified she had not held a QAPI meeting because she was trying to keep the building going subsequent staff turnover. The administrator identified she did not have a future QAPI meeting scheduled as of the current date.</p> <ol style="list-style-type: none"> 2. The attendance sheet for the quarterly QAPI meetings were reviewed for 3/2023, 6/2023, 9/2023, 12/2023, 3/2024, and 6/2024 and failed to identify that the Infection Preventionist and 2 other staff members were in attendance during the QAPI meetings. <p>On 12/23/24 at 2:44 PM an Interview with the Administrator and the Director of Nursing (DNS) during a review of the QAPI meeting agenda and criteria, the Administrator identified that a QAPI meeting had not been completed since 6/20/24 and indicated that she lost sight of it and thought it had been done in September. The Administrator further identified that she had just began working at the facility in September of 2024 and she was not aware that the Infection Preventionist and 2 other staff members were required to be in attendance.</p> <p>The Facility policy for Quality Assurance Performance Improvement dated 4/2015 indicated the governing body/and/or administration of the nursing home develops a culture that involves leadership seeking input from facility staff, residents, and their families and /or representative. The governing body assures adequate resources exist to conduct QAPI efforts. This includes designating one or more persons to be accountable for QAPI; developing leadership and facility-wide training on QAPI; and ensuring staff time, equipment, and technical training as needed. The governing body should foster a culture where QAPI is a priority by ensuring that policies are developed to sustain QAPI despite changes in personnel and turnover.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48950</p> <p>Based on observations, review of the clinical record, facility documentation, facility policy and interviews for 1 of 1 resident (Resident #1) observed on facility tour, 10 of 32 residents (Resident #5, Resident #12, Resident #20, Resident #32, Resident #36, Resident #51, Resident #53, Resident #67, Resident #70, and Resident #244) reviewed for Enhanced Barrier Precautions (EBP) and 1 of 2 residents (Resident #242) reviewed for Transmission Based Precautions (TBP), the facility facility failed to properly store a urinary containment bag and failed to initiate and maintain EBP per the Center of Disease Control (CDC) guidelines for residents with a history of Multiple Drug Resistant Organisms (MDROs) and failed to utilize personal protective equipment (PPE) while assisting a resident requiring EBP and failed to maintain TBP while assisting a resident with a positive COVID-19 diagnosis and failed to maintain a clean and sanitary environment. The findings include:</p> <p>1. Resident #1's diagnoses included paraplegia, multiple sclerosis, and neuromuscular dysfunction of the bladder.</p> <p>The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 was cognitively intact and was a set up for meals, and personal hygiene, also dependent for toileting, bathing, dressing and transfers. Further, identified was Resident #1 had a urostomy.</p> <p>The Resident Care Plan (RCP) dated 10/22/24 identified a urinary containment bag with interventions which directed to place the urinary containment bag in a basin on the floor and to provide education to Resident #1 on infection control measures.</p> <p>Observation on 12/17/24 at 10:32 AM identified of the urinary containment bag on the floor under Resident #1's bed, no basin in place.</p> <p>Observation on 12/18/24 at 10:19 AM identified the urinary containment bag on the floor under Resident #1's bed, no basin in place.</p> <p>Observation on 12/20/24 at 10:41 AM identified the urinary containment bag on the floor under the bed, no basin in place.</p> <p>Interview with Nurse Aid (NA) #2 on 12/20/24 at 10:41 AM identified that she provided care for Resident #1 previously, and she was familiar with his/her care. NA #2 provided the NA Care Card which was in Resident #1 ' s closet. NA #2 stated she was not aware of any specific instructions regarding Resident #1's urinary containment bag but stated it should not be on the floor.</p> <p>Review of the NA Care Card on 12/20/24 at 10:45 AM did not identify care instructions for the urinary containment bag.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 12/20/24 at 10:46 AM with Licensed Practical Nurse (LPN) #1 identified she did not know of specific instructions regarding Resident #1 ' s urinary containment bag. LPN #1 reviewed the NA Care Card and indicated there was nothing specific noted on the NA Care Card regarding the urinary containment bag. LPN #1 reviewed the RCP and identified Resident #1 ' s urinary containment bag with an intervention for the containment bag to be placed in a basin while the resident was in bed. LPN #1 further identified that she was unsure how this intervention would be communicated to staff if it was not on the NA Care Card. LPN #1 identified that the urinary containment bag should not be on the floor.</p> <p>Subsequent to surveyor inquiry, the NA Care Card was updated for Resident #1's urinary containment bag to be placed in a basin.</p> <p>Review of the Urine Drainage Bags Policy identified that urinary drainage bags are to be hung in a privacy bag on the bed.</p> <p>2. Resident #5, Resident #12, Resident #32, Resident #36, Resident #53, Resident #67, and Resident #244 had a history of Extended Spectrum Beta Lactamases (ESBL).</p> <p>Resident #32 had a history of ESBL and Vancomycin Resistant Enterococci (VRE).</p> <p>Resident #20 and Resident #51 had a history of Methicillin Resistant Staphylococcus Aureus (MRSA).</p> <p>Resident #70 had a history of Clostridium Difficile (C. Diff.).</p> <p>Review of the History vs Active MDRO list compared to the EBP list provided by the Infection Control Nurse identified that residents with active MDRO ' s or a history of MDRO ' s were not on EBP.</p> <p>Interview and review of the MDRO list, EBP list and current CDC guidelines with LPN #4 on 12/19/24 at 12:33 PM identified that residents identified to have a history of an MDRO should be placed on EBP.</p> <p>Center for Disease Control (CDC) guidelines identified April 1, 2024: Implementation of Enhanced Barrier Precautions (EBP) in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms. Multidrug-resistant Organism (MDRO): bacteria or fungi resistant to multiple antimicrobials and colonization identifies a germ is found on or in the body but is not causing infection. Many nursing home residents are unknowingly colonized with an MDRO, especially residents with risk factors like indwelling medical devices or wounds. Residents who have an MDRO can develop serious infections, remain colonized for long time periods, and spread MDROs to others. EBP are indicated for nursing home residents with any of the following: Infection or colonization with an MDRO when Contact Precautions do not otherwise apply, wounds and/or indwelling medical devices. EBP is not limited to outbreaks or specific MDROs.</p> <p>3. Observation on 12/23/24 at 9:12 AM identified signage outside of Resident #75 ' s room directing EBP and PPE was stocked outside of the room. NA #7 was observed finishing morning care for Resident #75 without the benefit of using PPE.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 12/23/24 at 9:12 AM with NA #7 identified she was aware of the signage outside of Resident #75 ' s room but indicated she was unaware of which resident was on EBP. NA #7 identified she was unaware of the Resident Care Card (readily accessible document used by NA ' s to quickly reference key patient information) which was located inside Resident #75 ' s closet. NA #7 indicated she provided morning care without using PPE.</p> <p>Review of facility policy titled Enhanced Barrier Precautions, directed in part, the facility will implement enhanced barrier precautions for preventing transmission of novel or targeted multidrug-resistant organisms (MDRO). Novel or targeted MDROs are organisms that are resistant to all, or most antibiotics tested , are uncommon in a geographical area, or have special genes that allow them to spread their resistance to other germs. Additional epidemiologically important MDROs may include but are not limited to: MRSA, ESBL, VRE. Enhanced barrier precautions require the use of gowns and gloves for certain residents during specific high contact resident care activities in which there is an increased risk for transmission of multi-drug-resistant organisms. High contact resident care activities include bathing/showering, providing hygiene, dressing, transferring, linen changes, toileting, device care and wound care.</p> <p>4. Observation on 12/20/24 at 12:09 PM identified signage outside of Resident #242 ' s room instructing contact and droplet precautions. NA #10 was observed entering Resident #242 ' s room to answer the call light but wore a surgical mask rather than an N95 mask as instructed by the signage outside the room. N95 masks were available in the PPE cart outside the room. Resident #242 was on contact and droplet precautions due to Covid-19.</p> <p>Interview with NA #10 on 12/20/24 at 12:09 PM identified that the sign posted outside of Resident #242's room identified that Resident #242 was on contact and droplet precautions and NA #10 should have worn an N95 mask rather than a surgical mask.</p> <p>Review of facility policy titled Transmission Based Precautions, directed in part, Transmission based precautions will be employed for known or suspected infections for which there are active symptoms, and the route of transmission is known. The transmission-based categories used in this facility are Droplet precautions and Contact precautions.</p> <p>5. Observation on 12/17/24 at 11:20 AM, in the 3rd floor shower room, identified 2 commode buckets on the floor in a shower stall.</p> <p>Observation on 12/17/24 at 11:29 AM in room [ROOM NUMBER] identified 2 unlabeled wash basins on the bathroom floor.</p> <p>Observation on 12/17/24 at 11:29 AM in room [ROOM NUMBER] identified 2 unlabeled wash basins on the bathroom floor. 1 of the wash basins contained an unlabeled bed pan.</p> <p>Observation on 12/17/24 at 11:29 AM in room [ROOM NUMBER] identified a wash basin on the bathroom floor and a urine containment bag (leg bag) draped over a railing located above the trash can. The trash can contained soiled wipes with a brown substance laying over the edge of the trash can.</p> <p>Observation on 12/19/24 at 10:47 AM in room [ROOM NUMBER] identified 2 unlabeled wash basins on the bathroom floor.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 12/19/24 at 10:47 AM in room [ROOM NUMBER] identified 2 unlabeled wash basins on the bathroom floor. 1 of the wash basins contained an unlabeled bedpan and the other wash basin was placed on top of a 2nd unlabeled bed pan.</p> <p>Observation on 12/19/24 at 10:47 AM In room [ROOM NUMBER] identified unlabeled wash basins were on the bathroom floor, a urine containment bag (leg bag) was hanging over the railing located above the trash can. The trash can was 3/4 full and contained soiled wipes with a brown substance and odor of feces.</p> <p>Observation on 12/19/24 at 11:51 AM of the 3rd floor shower room identified 3 commode buckets on the floor and wet linens draped over a railing. The shower stall floor was noted to be wet and a strong smell of urine was noted inside the shower stall.</p> <p>Observation on 12/20/24 at 10:18 AM of the 3rd floor shower room with LPN #4 and the Director of Nursing (DNS) identified 2 commode buckets and a wet used washcloth on the floor in the shower stall and 3 disposable razors on the countertop. LPN # 4 discarded the razors in a sharps container.</p> <p>Observation on 12/20/24 at 10:18 AM with LPN #4 and the Director of Nursing (DNS) in room [ROOM NUMBER] with LPN #4 and the Director of Nursing (DNS) identified wash basins were on the floor in the bathroom.</p> <p>Observation on 12/20/24 at 10:18 AM with LPN #4 and the Director of Nursing (DNS) in room [ROOM NUMBER] identified wash basins containing a bedpan were on the bathroom floor.</p> <p>Observation on 12/20/24 at 10:18 AM with LPN #4 and the Director of Nursing (DNS) in room [ROOM NUMBER] identified a urine containment bag (leg bag) was draped over the railing in the bathroom. Additionally, a foul odor of urine was identified. LPN #4 discarded the urine containment bag in the trash can.</p> <p>Interview with the DNS on 12/20/24 at 10:18 AM identified that the NA's should label the personal care items and the staff should perform auditing and rounding on the units. Additionally, the DNS stated no comment when the surveyor inquired why this was not done.</p> <p>Review of the facility policy titled General Infection Control Nursing Policies directed, in part, all resident personal items will be appropriately labeled with resident name and stored in the bedside stands or other designated resident storage areas and cleaned and disinfected as indicated. All resident common areas will be maintained in a clean and orderly manner and will be free of obvious hazards such as fall hazards, chemical hazards, etc.</p> <p>50179</p>		