STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075410	A. Building B. Wing	03/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aaron Manor Nursing & Rehabilitation	3 South Wig Hill Rd Chester, CT 06412

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility policy and interviews for one (1) of three (3) residents (Resident #2) reviewed for abuse, the facility failed to ensure the State Agency was notified timely of an allegation of abuse. The findings include: Resident #2's diagnoses included adjustment disorder (an emotional or behavioral reaction to a stressful event or change in a person's life), anxiety disorder and chronic pain disorder. The Resident Care Plan (RCP) dated 4/23/24 identified that Resident #2 is at risk for constipation due to decreased mobility and pain management with interventions that included to administer scheduled and/or as needed medications for constipation, review medication side effects and discuss concerns or complications with the provider if indicated and provider to evaluate drug regimen if indicated. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had a Brief Mental Interview for Mental Status (BIMS) of fifteen (15) indicative of intact cognition and required moderate assistance with personal hygiene, transfers and ambulation. Additionally, it identified that the only behavior exhibited was rejection of care. A physician's order dated 6/8/24 and transcribed by RN #2 at 10:02 AM directed to administer Hemorrhoidal Rectal Ointment 0.25-14-74.9 %, insert one application rectally every six (6) hours as needed for hemorrhoidal inflammation. Interview with RN #2 on 3/11/25 at 11:56 AM identified that Resident #2 on 6/8/24 alleged that NA #1 applied hemorrhoidal ointment, and while doing so stuck his finger into the resident's anus. He reported that that he believed that Resident #2 had made several allegations against staff members while residing at the facility, so it was plausible that the allegation was made, and he just couldn't remember. He identified that for all allegations of abuse, he immediately reports the allegations to the Administrator and the DNS and immediately removes the accused staff member from the unit and sends them home. He reported that he would not document anything until he was directed to do so by the Administrator or DNS. Review of nurse's notes dated 6/1/24 through 6/30/24 failed to identify any incidents or allegations regarding Resident #2, or any notes from RN #2 regarding the need for hemorrhoidal ointment. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the State Agency Reportable Events website on 3/11/25 failed to identify the allegation of abuse was reported to the State Agency. Interview with Administrator #2 on 3/11/25 at 12:07 PM identified that on 6/8/24 she was made aware that Resident #2 was alleging that a Nurse Aide (NA #1) applied hemorrhoid ointment to the resident and stuck his finger up the resident's anus, reporting that it was an abuse allegation and it should have been reported to the State Agency, but she was unsure if it had been. She identified that she obtained statements and an investigation was initiated, stating that they unsubstantiated the allegation but she could not recall why. Interview with the DNS on 3/11/25 at 2:16 PM identified that she was not employed at the facility at the time of the 6/8/24 abuse allegation regarding Resident #2 but stated that if a resident reported that a staff member put their finger up their anus/rectum, the staff member should have been sent home immediately pending investigation, the allegation should have been reported to the State Agency immediately and an investigation should have been initiated. Additionally, she identified that an investigation on the 6/8/24 allegation of abuse regarding Resident #2 was not located. Although attempted, interviews with NA #1 and RN #4 (previous interim DNS) were not obtained. Review of the Abuse Prevention policy (undated) directed, in part, that the facility will not condone any form of resident abuse or neglect, and all personnel is to report any signs and symptoms of abuse/neglect to their supervisor or to the Director of Nursing Services immediately. Abuse is the willful infliction of injury, unreasonable confinement intimidation, or punishment with resulting physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse. Physical abuse includes, but is not limited to, hitting, slapping, punching, biting and kicking. Any allegation or incident of abuse will be reported immediately but no later than two (2) hours of the allegation or occurrence to the Department of Public Health (DPH).

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility policy and interviews for one (1) of three (3) residents (Resident #2) reviewed for abuse, the facility failed to remove the accused staff member immediately once the allegation of abuse was made. The findings include: Resident #2's diagnoses included adjustment disorder (an emotional or behavioral reaction to a stressful event or change in a person's life), anxiety disorder and chronic pain disorder. The Resident Care Plan (RCP) dated 4/23/24 identified that Resident #2 is at risk for constipation due to decreased mobility and pain management. Interventions included administering scheduled and/or as needed medications for constipation, review medication side effects and discuss concerns or complications with the provider if indicated and provider to evaluate drug regimen if indicated. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had a Brief Mental Interview for Mental Status (BIMS) of fifteen (15) indicative of intact cognition and required moderate assistance with personal hygiene, transfers and ambulation. Additionally, it identified that the only behavior exhibited was rejection of care. A physician's order dated 6/8/24 and transcribed by RN #2 at 10:02 AM directed to administer Hemorrhoidal Rectal Ointment 0.25-14-74.9 %, insert one application rectally every six (6) hours as needed for hemorrhoidal inflammation. Review of nurse's notes dated 6/1/24 through 6/30/24 failed to identify any incidents or allegations regarding Resident #2, or any notes from RN #2 regarding the need for hemorrhoidal ointment. Review of NA#1's time card dated 6/8/24 (day of the allegation) identified that NA#1 punched in for work at 7:03 AM and did not punch out unitl 3:09 PM, completing the 7:00 AM to 3:00 PM shift. Interview with RN #2 on 3/11/25 at 11:56 AM identified that he was unsure if he was notified of an abuse allegation made by Resident #2 on 6/8/24 alleging that NA #1 applied hemorrhoidal ointment to the resident and while doing so stuck his finger into the resident's anus. He identified that for all allegations of abuse, he immediately reports the allegations to the Administrator and the DNS and immediately removes the accused staff member from the unit and sends them home, RN #2 reported that following an allegation of abuse, the accused staff member would be removed from the facility immediately, however he could not recall if he had sent NA #1 home on 6/8/24. Interview with Administrator #2 on 3/11/25 at 12:07 PM identified that on 6/8/24 she was made aware that Resident #2 was alleging that a Nurse Aide (NA #1) applied hemorrhoid ointment to the resident and stuck his finger up the resident's anus, reporting that it was an abuse allegation and the staff member should have been removed immediately, but could not recall if that had happened. Interview with the DNS on 3/11/25 at 2:16 PM identified that she was not employed at the facility at the time of the 6/8/24 abuse allegation regarding Resident #2 but stated that if a resident reported that a staff member put their finger up their anus/rectum, the staff member should have been sent home immediately pending investigation. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Although attempted, interviews with NA #1 and RN #4 (previous interim DNS) were not obtained. Review of the Abuse Prevention policy (undated) directed, in part, that the facility will not condone any form of resident abuse or neglect, and all personnel is to report any signs and symptoms of abuse/neglect to their supervisor or to the Director of Nursing Services immediately. During abuse investigations, residents will be protected from harm and any employee accused of participating in an alleged abuse will be subjected to suspension during the course of the investigation.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility policy and interviews for one (1) of three (3) residents (Resident #2) reviewed for abuse, the facility failed to have documentation that an investigation was completed for an allegation of abuse. The findings include: Resident #2's diagnoses included adjustment disorder (an emotional or behavioral reaction to a stressful event or change in a person's life), anxiety disorder and chronic pain disorder. The Resident Care Plan (RCP) dated 4/23/24 identified that Resident #2 is at risk for constipation due to decreased mobility and pain management with interventions that included administering scheduled and/or as needed medications for constipation, review medication side effects and discuss concerns or complications with the provider if indicated and provider to evaluate drug regimen if indicated. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had a Brief Mental Interview for Mental Status (BIMS) of fifteen (15) indicative of intact cognition and required moderate assistance with personal hygiene, transfers and ambulation. Additionally, it identified that the only behavior exhibited was rejection of care. A physician's order dated 6/8/24 and transcribed by RN #2 at 10:02 AM directed to administer Hemorrhoidal Rectal Ointment 0.25-14-74.9 %, insert one application rectally every six (6) hours as needed for hemorrhoidal inflammation. Interview with RN #2 on 3/11/25 at 11:56 AM identified that he was unsure if he was notified of an abuse allegation made by Resident #2 on 6/8/24 alleging that NA #1 applied hemorrhoidal ointment and while doing so stuck his finger into the resident's anus. He reported that he believed that Resident #2 had made several allegations against staff members while residing at the facility, so it was plausible that the allegation was made, and he just couldn't remember. He identified that for all allegations of abuse, he immediately reports the allegations to the Administrator and the DNS and immediately removes the accused staff member from the unit and sends them home. He reported that he would not document anything until he was directed to do so by the Administrator or DNS. Review of nurse's notes dated 6/1/24 through 6/30/24 failed to identify any incidents or allegations regarding Resident #2, or any notes from RN #2 regarding the need for hemorrhoidal ointment. Interview with Administrator #2 on 3/11/25 at 12:07 PM identified that on 6/8/24 she was made aware that Resident #2 was alleging that a Nurse Aide (NA #1) applied hemorrhoid ointment to the resident and stuck his finger up the resident's anus, She identified that she obtained statements and an investigation was initiated, stating that they unsubstantiated the allegation but she could not recall why. Additionally, she identified that the investigation should be available in the facility for review and she was unsure why it could not be located, stating it should have been in either the DNS or Social Worker #1's office. Although attempted, interviews with NA #1 and RN #4 (previous interim DNS) were not obtained. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Abuse Prevention policy (undated) directed, in part, that the facility will not condone any form of resident abuse or neglect, and all personnel is to report any signs and symptoms of abuse/neglect to their supervisor or to the Director of Nursing Services immediately. All reports of resident abuse shall be promptly and thoroughly investigated by facility management. The individual conducting the investigation will interview staff members (on all applicable shifts) who have had contact with the resident during the period of the alleged incident, interview other residents to whom the accused employee provides care or services when indicated and review all events leading up to the alleged incident.