STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075011	A. Building B. Wing	06/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Windsor	581 Poquonock Ave Windsor, CT 06095

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, facility documentation, facility policies and interviews for one (1) of three (3) sampled residents (Resident #1) who required set-up assistance from staff with personal hygiene and toileting, the facility failed to ensure a staff member did not verbalize profanity towards the resident. The findings include: Resident #1's diagnoses included vascular dementia, anxiety, depression, and coronary vascular accident with right sided weakness. The annual Minimum Data Set assessment dated [DATE] identified Resident #1 had no memory recall deficits, was oriented to person, place, time, and situation, required supervision from staff for toileting, personal hygiene, bed mobility, transfers and self-propelled while in a wheelchair. The Resident Care Plan dated 5/9/25 identified Resident #1 had a self-care deficit and was hard of hearing. Interventions directed to assist with care as needed, ensure resident was aware of staff presence before providing care, and use facial expressions to convey emotional tones. The nurse's note dated 5/31/25 at 8:50 AM identified during the morning medication pass, the 7AM-3PM charge nurse witnessed a nurse aide get into a verbal altercation with Resident #1. The nurse aide stated to Resident #1 You don't want me to be your f***ing aide, so get the f*** away from me. The note indicated Resident #1 did not hear what was stated by the nurse aide. The note identified Resident #1 was immediately removed from the area and brought to his/her room, the nurse aide was removed from the floor and the Nursing Supervisor was notified of the incident immediately. The nurse's note dated 5/31/25 at 10:52 AM identified during a discussion with the police Resident #1 verbalized I did not hear anything. The summary report dated 6/4/25 identified although Resident #1 did not hear the comment or appeared to be affected by the remark, the nurse aide was terminated. Interview with a 7AM-3PM nurse aide, Nurse Aide (NA) #1, on 6/9/25 at 12:35 PM identified on 5/31/25 while she was seated at the nurse's station, she witnessed Resident #1 approach another nurse aide, NA #3, who was seated in the lounge adjacent to the nurse's station. NA #1 stated she heard Resident #1 ask NA #3 who his/her nurse aide was and then heard NA #3 use profanity towards Resident #1 and told Resident #1 to get away from him/her. NA #1 identified NA #3 exited the lounge area walking past Resident #1 and NA #3 continued to curse as she walked down the hall. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the 7AM-3PM charge nurse, Licensed Practical Nurse (LPN) #1, on 6/9/25 at 1:05 PM identified on 5/31/25 she was standing in the hallway close to the lounge area when she heard NA #3 say to Resident #1 You don't want me to be your f***ing aide, so get the f*** away from me. LPN #1 stated she immediately removed Resident #1 from the situation and contacted the Nursing Supervisor. Interview with NA #2 on 6/9/25 at 1:15 PM identified on 5/31/25 she was also seated at the nurse's station and witnessed NA #3 use profanity towards Resident #1 while telling the resident to get away from her. Interview with the Director of Nursing on 6/9/25 at 2:30 PM identified the facility conducted its own internal investigation and terminated NA #3 for verbal abuse. Interview with NA #3 on 6/9/25 at 2:45 PM identified she was wrong because she made statements using profanity around the resident. Review of the facility policy for Abuse, Neglect, and Exploitation, directed in part, the facility maintains a zero-tolerance for any form of abuse. The policy further identified verbal abuse includes oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents, or within their hearing distance regardless of the residents' age, ability to comprehend, or disability. Review of facility documentation identified that a Plan of Correction was initiated immediately and included: Staff training in Abuse Education. Random audits of residents for allegations of abuse three (3) times per month to ensure residents are not subjected to any type of abuse. Audits to be reviewed at the monthly QAPI meetings. The Administrator and Director of Nursing are responsible for the plan. Compliance as of 6/2/25 The plan of correction was reviewed on 6/9/25 and the facility met all components for past non-compliance.