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	04/14/2026

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 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 documentation, facility policy, and interviews for one of three residents (Resident #1) reviewed for abuse, the facility failed to notify the State Agency timely of an allegations of mistreatment. The findings include: Resident #1's diagnoses included heart failure, anxiety and depression. The Resident Care Plan (RCP) dated 12/3/2025 identified ADL self-care performance deficit. Interventions directed to encourage to discuss feelings about self-care deficit, encourage to participate to fullest extent in each interaction and to use call bell for assistance. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified that Resident #1 had a Brief Interview for Mental Status (BIMS) score of twelve out of fifteen, indicative of moderate cognitive impairment and was dependent with toilet hygiene, ADLs, transfers, manual wheelchair use, and partial/moderate assistance with bed mobility, and had no behaviors (no hallucinations or delusions) in the prior seven (7) days. Psychiatric APRN note dated 12/31/2025 indicated asked to see patient urgently via telehealth for eval. Resident #1 alleged a man I grew up with came in my room on a gurney and touched my ankle and leg. I think he was trying to rape me. No distress was noted during the exam. Resident #1 reported another resident, a man in his 40s with short black hair came into his/her room and touched his/her ankle which awoke him/her. Resident #1 states that he told her not to scream and began running his hand up his/her leg. Stated that this is someone he/she grew up with but cannot remember his name. Resident #1 also states he rolled in on a gurney. This is different than his/her original report. After complete evaluation, it appears patient most likely had a nightmare or delusion. Resident report eating and sleeping well. Significant confusion noted, and anxiety mild, but stable. Plan monitor behaviors for concerns, continue plan of care. Record review failed to identify a nursing note regarding the request for the psychiatric APRN to see Resident #1 for the allegation described by the APRN note dated 12/31/2025. Review of email sent to the Administrator from the Ombudsman, dated 3/10/2026 at 10:48 AM, requested information be provided to Resident #1's responsible party regarding the investigation on the 12/31/2025 statements on rape allegation. Further, the Ombudsman requested to be informed of the allegation. Review of social service typed note, provided by the Administrator, dated 12/31/2025 identified Resident #1 alleged a man she grew up with had come into his/her room at night and tried to rape him/her. Resident #1 stated they started touching his/her ankles and Resident #1 screamed. Review of social service typed note provided by the Administrator, dated 12/31/2025 identified she interviewed two (2) residents that resided on Resident #1's unit to ask if they had seen any males in the hallway or hear any screaming. Review of the State Agency Facility Licensing & Investigations Section (FLIS) system failed to identify the allegation of abuse was reported to the State Agency. Review of facility documentation failed to identify the facility completed an incident report for the allegation. Interview with the Acting/Interim DNS (DNS #2) and Administrator on 4/14/2026 at 12:45 PM identified the Administrator and DNS #2 were not sure if an allegation of abuse by Resident #1 on 12/31/2025 had an associated accident and investigation report or if the allegation was reported to the State Agency. DNS #2 stated he had only been covering as DNS for about three (3) weeks, and although he was aware of the allegation, he (continued on next page)

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated that he did not submit a reportable event for the allegation. The Administrator stated she was aware of the allegation, but she did not submit a reportable event. The Administrator stated that DNS #1 was no longer at the facility and she and DNS #2 would look for DNS #1's files for the investigation regarding the allegation made by Resident #1 on 12/31/2025. Interview and record review on 4/14/2026 at 11:53 AM with DNS #1 (former DNS) identified she was the facility DNS from March 2025 until March 2026, and she remembered Resident #1 and the allegation of abuse Resident #1 made on 12/31/2025. The DNS stated there was no facility investigation conducted. She stated that social services was involved and psychiatry services saw Resident #1. Administrator #2 was covering at the time of the allegation due to vacations, and Administrator #2 and RN #2 (corporate RN) determined Resident #1 was having a dream and at that time the facility decided not to report the allegation to the State Agency based on the psychiatric evaluation. On 4/14/20256 at 12:33 PM interview and record review with SW #1 identified she was notified that on 12/31/2025 after lunch, but was unsure of the time, that Resident #1 made an allegation of abuse/mistreatment. SW #1 stated she was advised to investigate and to notify the DNS of the results. Resident #1 told SW #1 that someone from his/her past had touched him/her, but did not say anything about a gurney, and she believed psych services saw the resident within an hour. SW #1 indicated after her investigation, she provided a written statement to the DNS. Interview on 4/14/2026 at 12:45 PM with acting DNS #2 and Administrator identified the Administrator did not know where Resident #1's 12/31/2025 investigation report was or if the facility even had one. The Administrator stated she was unaware if an incident report and investigation was completed, or if it was reported to the State Agency, and did not know if the facility had any staff statements or an incident report. DNS #2 stated he did not know if the facility had any staff statements or an incident report. The Administrator stated DNS #1 left recently and she did not know where anything was, and both the Administrator and DNS #2 indicated they did not know if there were accident and incident reports and where they were stored. On 4/14/2026 at 1:11 PM, interview with DNS #2 and the Administrator identified the Administrator stated they were notified of the allegation when they received an email from the Ombudsman during March 2026 that indicated a family member had notified the Ombudsman of the allegation. The Administrator had a soft file in her office regarding the allegation, and DNS #2 had a separate soft file in his office regarding the allegation. Review of the soft files identified statements were included that were dated 12/31/2025. The Administrator stated she directed DNS #1 to notify the State Agency, and she was aware that DNS #1 did not notify the State Agency. The Administrator stated she discussed the matter with the Regional Administrator #2 and RN #2 (corporate), and that DNS #1 had characterized the incident as a non-reportable allegation involving contact with the resident's ankle. The Administrator stated a meeting was held on 3/11/2026 with the Regional Administrator #2 and RN #2 with direction given to DNS #1 to report the allegation. The Administrator stated she directed DNS #1 to notify the State Agency, and she was aware that DNS #1 did not notify the State Agency. The Administrator stated DNS #1 resigned on 3/23/2026 and although DNS #2 assumed the role at that time, the State Agency was not notified of the allegation that the facility was aware of on 12/31/2025. The Administrator stated the allegation should have been reported within the two (2) hours after the facility became aware, in accordance with facility policy. Review of the State Agency Facility Licensing & Investigations Section (FLIS) system identified the State Agency was notified of the allegation on 4/14/2026 at 7:19 PM. Review of facility Abuse, Neglect and Exploitation Policy directed in part. Abuse means willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain or mental anguish. An alleged violation is a situation or occurrence that is observed or reported by staff, resident, relative, visitor or others. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies within specified time frames: immediately, but not later than 2 hours after the allegation is made.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for one of three residents (Resident #1) reviewed for abuse, the facility failed to ensure a thorough investigation was completed timely after an allegation of mistreatment. The findings include: Based on review of the clinical record, facility documentation, facility policy, and interviews for one of three residents (Resident #1) reviewed for abuse, the facility failed to ensure a thorough investigation was completed timely after an allegation of mistreatment. The findings include: Resident #1's diagnoses included heart failure, anxiety and depression. The Resident Care Plan (RCP) dated 12/3/2025 identified ADL self-care performance deficit. Interventions directed to encourage to discuss feelings about self-care deficit, encourage to participate to fullest extent in each interaction and to use call bell for assistance. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified that Resident #1 had a Brief Interview for Mental Status (BIMS) score of twelve out of fifteen, indicative of moderate cognitive impairment and was dependent with toilet hygiene, ADLs, transfers, manual wheelchair use, and partial/moderate assistance with bed mobility, and had no behaviors (no hallucinations or delusions) in the prior seven (7) days. Psychiatric APRN note dated 12/31/2025 indicated asked to see patient urgently via telehealth for eval. Resident #1 alleged a man I grew up with came in my room on a gurney and touched my ankle and leg. I think he was trying to rape me. No distress was noted during the exam. Resident #1 reported another resident, a man in his 40s with short black hair came into his/her room and touched his/her ankle which awoke him/her. Resident #1 states that he told her not to scream and began running his hand up his/her leg. Stated that this is someone he/she grew up with but cannot remember his name. Resident #1 also states he rolled in on a gurney. This is different than his/her original report. After complete evaluation, it appears patient most likely had a nightmare or delusion. Resident report eating and sleeping well. Significant confusion noted, and anxiety mild, but stable. Plan monitor behaviors for concerns, continue plan of care. Record review failed to identify a nursing note regarding the request for the psychiatric APRN to see Resident #1 for the allegation described by the APRN note dated 12/31/2025. Review of email sent to the Administrator from the Ombudsman, dated 3/10/2026 at 10:48 AM, requested information be provided to Resident #1's responsible party regarding the investigation on the 12/31/2025 statements on rape allegation. Further, the Ombudsman requested to be informed of the allegation. Review of social service typed note dated 12/31/2025 identified Resident #1 alleged a man she grew up with had come into his/her room at night and tried to rape him/her. Resident #1 stated they started touching his/her ankles and Resident #1 screamed. Review of social service typed note dated 12/31/2025 identified she interviewed two (2) residents that resided on Resident #1's unit to ask if they had seen any males in the hallway or hear any screaming. Review of facility documentation failed to identify the facility completed an incident report and investigation for the allegation. Interview and record review on 4/14/2026 at 11:53 AM with DNS #1 (former DNS) indicated she was the facility DNS from March 2025 until March 2026, and she recalled Resident #1 and the allegation of abuse on 12/31/2025. The DNS stated there was no facility investigation completed. Social services was involved, psychiatry services saw the resident, and it was determined by Administrator #2 (filling in for current Administrator at the time) and RN #2 (corporate) that the resident was having a dream. On 4/14/2026 at 1:11 PM, interview with DNS #2 and the Administrator identified the Administrator stated they were notified of the allegation when they received an email from the Ombudsman during March 2026 that indicated a family member had notified the Ombudsman of the allegation. The Administrator had a soft file in her office regarding the allegation, and DNS #2 had a separate soft file in his office regarding the allegation. Review of the soft files identified one (1) file had six (6) staff statements were included that were dated 12/31/2025. The statements had staff names written on the top in the same handwriting. Two (2) staff statements had no staff names, and none of the (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	statements were signed. The other soft file had thirteen (13) staff statements dated 12/31/2025 with names on the top of the page similar to the first soft file, and none of the statements were signed. Interview failed to identify a facility incident report was completed with a thorough investigation to include a review of the documents, statements, and social services and psychiatry notes. The Administrator indicated an incident report and investigation should have been completed. Interview failed to identify why a thorough investigation was not completed, including staff statements with names and signatures. The facility Accident and Incidents Policy dated 10/27/2025 directed that an incident was any occurrence or situation that is not consistent with the routine care of a resident or with the routine operation of the organization. Review of facility Abuse, Neglect and Exploitation Policy directed in part, abuse means willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain or mental anguish. Investigation of alleged abuse, neglect and exploitation: an immediate investigation is warranted: identifying and interviewing all involved persons, including the alleged victim, others who might have knowledge of the allegations, providing complete and thorough documentation of the investigation.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for one of three residents (Resident #1) reviewed for abuse, the facility failed to ensure social service support visits were provided timely after an allegation of abuse. The findings include: Resident # 1's diagnoses included heart failure, anxiety and depression. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified that Resident #1 had a Brief Interview for Mental Status (BIMS) score of twelve out of fifteen, indicative of moderate cognitive impairment and was dependent with toilet hygiene, ADLs, transfers, manual wheelchair use, and partial/moderate assistance with bed mobility, and had no behaviors (no hallucinations or delusions) in the prior seven (7) days. Psychiatric APRN note dated 12/31/2025 indicated asked to see patient urgently via telehealth for eval. Resident #1 alleged a man I grew up with came in my room on a gurney and touched my ankle and leg. I think he was trying to rape me. No distress was noted during the exam. Resident #1 reported another resident, a man in his 40s with short black hair came into his/her room and touched his/her ankle which awoke him/her. Resident #1 states that he told her not to scream and began running his hand up his/her leg. Stated that this is someone he/she grew up with but cannot remember his name. Resident #1 also states he rolled in on a gurney. This is different than his/her original report. After complete evaluation, it appears patient most likely had a nightmare or delusion. Resident report eating and sleeping well. Significant confusion noted, and anxiety mild, but stable. Plan monitor behaviors for concerns, continue plan of care. Further review identified the RCP was updated on 12/31/2025 to indicate Resident #1 had a history of a trauma that occurred during childhood. Interventions directed social service one to one (1:1) visits as needed for support and reassurance, encourage family involvement and support, encourage verbalization of feelings, and offer psych services as needed. Record review identified that the last social service note was dated 12/23/2025; there were no SS notes related to the 12/31/2025 allegation of mistreatment, or the delusion documented by the psychiatric APRN. Interview and record review on 4/14/2026 at 10:47 AM with SW #1 identified the facility received an email from the Ombudsmen on 12/31/2025 that alleged Resident #1 was raped. The DNS requested SW #1 speak with the resident and Resident #1 told her that it was someone in his/her past. SW #1 stated she did not write a SS note, and she did not provide any additional follow-up or support visits to Resident #1 regarding the incident. Although SW #1 was aware of the allegation, interview failed to identify why the SW visit was additional support visits were not provided. Interview and record review on 4/14/2026 at 12:45 PM with DNS #2 and the Administrator identified social services saw Resident #1 on 12/31/2025 after the allegation was made. Interview identified the last social service note was dated 12/23/2025, and that the social worker interviewed Resident #1 and provided a statement related to the allegation. Interview failed to identify why the SW visit was additional support visits were not provided. Review of facility Abuse, Neglect and Exploitation Policy directed in part, to provide emotional support and counseling to the resident during and after the investigation, as needed.