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	03/11/2026

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

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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 - 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 review of the clinical record, facility documentation, facility policy, and interviews for 3 of 5 residents (Resident's #93, #23 and #99) reviewed for abuse, the facility failed to ensure Resident #93 was free from verbal and physical abuse by his/her roommate Resident #41, and failed to ensure Resident 23 and 99, who were roommates, were free from abuse from each other. The findings include: 1a. Resident #93 was admitted to the facility in May 2024 with diagnoses that included schizophrenia, psychosis, and adjustment disorder. The clinical record identified Resident #41 had a room change to Resident #93's room on 3/13/25. The care plan dated 4/28/25 identified Resident #93 had potential for impaired thought processes related to difficulty expressing him/herself. Interventions included communicating with the resident and his/her resident representative regarding his/her needs. The quarterly MDS dated [DATE] identified Resident #93 had intact cognition. A psychiatric supportive services note by SW #3 on 11/8/25 identified Resident #93 reported ongoing issues with his/her roommate. A nurse's note dated 11/10/25 at 7:52 PM by RN #5 (7:00 AM – 3:00 PM RN Supervisor) identified Resident #93 requested to be transferred to another room, the room transfer was completed, and Resident #93's representative was notified. b. Resident #41 was admitted to the facility in September 2004 with diagnoses that included schizophrenia, dementia, and anxiety disorder. The annual MDS dated [DATE] identified Resident #41 had moderately impaired cognition. A nurse's note dated 7/7/25 at 7:34 AM by LPN #5 (11:00 PM – 7:00 AM charge nurse) identified Resident #41 was observed at 5:00 AM having a verbal altercation with his/her roommate. LPN #5 identified the altercation occurred without a reason, and that Resident #41 continued with behaviors despite attempts at redirection, and that Resident #41 was observed yelling at other residents in the unit hallway. The note further identified that Resident #41 was observed by 3 facility staff kicking his/her roommate in the hallway. LPN #5 identified she notified her supervisor and that a referral to be seen by psychiatry in the morning had been placed. Review of Resident #41's care plan failed to identify a revision or interventions related to the resident-to-resident altercation documented by LPN #5 which occurred on 7/7/25. (continued on next page)

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F 0600

Level of Harm - Actual harm

Residents Affected - Few

A psychosocial evaluation note dated 7/7/25 identified that Resident #41 displayed rudeness towards his/her roommate and aggression towards staff overnight. The note further identified that individual psychotherapy would be provided 1 – 5 times monthly to reduce emotional symptoms.

A psychiatric evaluation note dated 7/8/25, by APRN #4, identified she was asked to see Resident #41 due to agitated behaviors per nursing. APRN #4 identified no signs of delusions, auditory or visual hallucinations, agitation or aggression. APRN #4 further identified no changes were recommended based on her evaluation.

A nurse's note dated 10/21/25 at 5:13 AM by LPN #5 identified Resident #41 was observed up all night yelling and screaming at his/her roommate for no reason. LPN #5 identified she attempted to redirect Resident #41 with no result.

Review of a Behavioral Health Visit Request/Follow Up Log identified a note on 10/21/25 which identified Resident #41 was up all night yelling at his/her roommate for no reason and accosting him/her for coughing.

A medical APRN note dated 10/31/25 identified Resident #41 during the visit, Resident #41 was mildly anxious, ambulating the hallway asking where is my roommate. The note further identified that staff reported Resident #41 had a recent escalation in behaviors that included yelling and screaming at his/her roommate during the night and being disruptive. The note also identified that redirection was not successful, and that Resident #41 was seen by the psychiatric provider with an increase of Risperdal ordered.

Review of a facility grievance form dated 11/12/25 (two days after the room change) identified Resident #93 requested a room change due to verbal abuse by his/her roommate. An undated letter addressed to the administrative office, which was attached to the grievance form was signed by Resident #93. The grievance form was completed by SW #1 (Social Work Director) and signed by Resident #93, SW #4, and the Administrator, and identified that the resident's room was changed and the resident reported that things were better following the change.

Review of the letter (attached to the grievance dated 11/12/25) written and signed by Resident #93 identified the following. Resident #41 abuses me verbally and has hit me a few times. I fight back and hopefully won't get violent and be in trouble for it. He/she does it every day when I enter the room or leave and when I go to my closet. He/she is a homosexual and I am not. I want a different room.

Interview with Resident #93 on 2/24/26 at 3:18 PM identified he/she had been in the same room with Resident #41 since March 2025. Resident #93 identified beginning sometime in the summer, Resident #41 began to make indirect romantic verbal advances towards him/her (Resident #93) that made him/her feel uncomfortable. Resident #93 identified once he/she rejected the advances, Resident #41 became more aggressive, and would intermittently yell at him/her for no reason. Resident #93 identified that over time, the yelling escalated from intermittent episodes to constant yelling overnight, and then occasionally included being hit or kicked by Resident #41. Resident #93 identified that by the time he/she had written the letter to the Administrator in November 2025, Resident #41 was yelling overnight several times a week, and anytime Resident #93 attempted to access his/her closet, which was located near the door and Resident #41's bed, Resident #41 would approach from behind and shove Resident #93 into the closet door. Resident #93 identified that he/she had reported the incidents several times to multiple nursing staff, but they had instructed Resident #93 to tell Resident #41 he/she did not want to talk and to stop the behavior. Resident #93 identified he/she
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F 0600

Level of Harm - Actual harm

Residents Affected - Few

tried but that only made Resident #41's behavior worse. Resident #93 identified that he/she would often sit in the hallway to avoid Resident #41 and only go in his/her room as necessary, but it did not help and the behaviors continued. Resident #93 reported he/she feared Resident #41 and did not feel safe while in the same room with him/her and so he/she wrote a letter to the Administrator and asked for a room change. Resident #93 identified no staff had ever offered to move him/her to another room prior to the letter, and after the room change, a staff member who he/she could not remember, followed up once to make sure the new room was working out.

Interview with SW #1 on 2/26/26 at 9:05 AM identified she began working at the facility on 11/10/25 and was shadowing SW #4 for the first few days. SW #1 identified that SW #4 had outstanding grievances that needed to be completed and to help SW #4 out, she completed the grievance form for Resident #93's request for a room change but did not address the issue herself. SW #1 was unable to identify if Resident #93's allegation of abuse was addressed outside of his/her request for a room change and reiterated that it was SW #4's responsibility.

Interview with the Administrator on 2/26/26 at 9:07 AM identified she received a letter from Resident #93 related to a room change but didn't read the letter from Resident #93 because she could not read the handwriting. The Administrator directed SW #4 to address it as a grievance and she did not make any attempt to discuss or review the letter with Resident #93, and was unaware that the letter, addressed to her, included allegations of daily verbal and physical abuse by Resident #41. The Administrator further identified she was unaware of the incidents documented in Resident #41's clinical record related to verbal and physical altercation with Resident #93 on 7/7/25 or verbal altercation on 10/21/25.

Interview with RN #5 (7:00 AM – 3:00 PM supervisor) on 2/26/26 at 10:55 AM identified he assisted with Resident #93's room change but was not sure why Resident #93 had made the request. RN #5 identified based on his recollection, Resident #93 had approached him sometime during the day on 11/10/25 to request the room change. RN #5 identified he was unsure who he spoke to about the issue. RN #5 identified that he was not aware of Resident #93's grievance or the allegations of abuse by Resident #41 or yelling overnight by Resident #41, and that he was not aware of any issues between the residents. RN #5 identified that when Resident #93 was moving his/her belongings to the new room on 11/10/25, he did recall Resident #41 asking him where his/her roommate was going and said (I love my roommate).

Interview with NA #3 on 2/26/26 at 11:43 AM identified that she worked on the 11:00 PM – 7:00 AM shift but did not recall being assigned to Resident #41 and Resident #93's unit. NA #3 identified that while she was not assigned to the residents, it was common knowledge with the nursing staff throughout the facility that Resident #41 would confront Resident #93 with aggressive behaviors on a regular basis. NA #3 identified she never saw Resident #41 become physical with Resident #93 on 7/7/25 but did witness on multiple occasions Resident #41 yelling at Resident #93 overnight, and witnessed Resident #41 go directly into Resident #93's face and yell on multiple occasions. NA #3 identified it was very hard to redirect Resident #41 away from Resident #93 and to deescalate the behaviors. NA #3 also identified that while she did not observe Resident #41 attempt to hit or kick Resident #93, Resident #41 had attempted to hit her in the past but stopped before actually striking her. NA #3 identified that Resident #41 was verbally abusive to Resident #93, and the behavior had gone on for several months in 2025. NA #3 also indicated that Resident #93 had reported to her she was afraid of Resident #41. NA #3 identified Resident #41 felt disrespected because Resident #93 would not speak with him/her, and that caused Resident #41 to escalate and begin yelling. NA #3 identified that she reported behaviors to the unit charge nurse but was unable to provide any specifics
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F 0600 Level of Harm - Actual harm Residents Affected - Few	on the nurse or when she reported the issues. NA #3 reported that staff at the facility would attempt to redirect Resident #41 but a room change was not attempted prior to 11/10/25. NA #3 indicated she was not aware of any other interventions to protect Resident #93, and that she never observed Resident #93 being aggressive or instigating any altercations with Resident #41. NA #3 also identified that it was the longstanding culture of the nursing staff, including the nurse aides and licensed nurses, to ignore Resident #41's behaviors and not address the issues, which was likely why Resident #93 had to self-request the room change. Interview with SW #3 on 2/26/25 at 12:17 PM identified that Resident #93 had reported issues with Resident #41, however the issues were that Resident #93 found Resident #41 to be annoying. SW #3 identified Resident #93 reported Resident #41 was loud and she had a hard time sleeping because of this, but did not report any physical abuse, safety or inappropriate behavior. Interview with APRN #4 on 2/26/26 at 1:26 PM identified that she was not aware of any issues related to Resident #41 and Resident #93, including any issues related to physical or verbal altercations. Interview with the DNS on 2/26/26 at 1:42 PM identified that she had been the DNS of the facility since March 2025. The DNS identified that she was not aware of any issues between Resident #41 and Resident #93, was not aware of the incidents on 7/7/25 or 10/21/25, and was not aware of the letter written by Resident #93 to the Administrative office in November 2025 which alleged daily abuse by Resident #41, and was not aware why Resident #93 requested a room change. The DNS identified that following the incident on 7/7/25, the residents should have been placed in separate rooms for safety and if Resident #41 did not respond to redirection, the resident should have been sent to the hospital for psychiatric evaluation. The DNS also identified that the medical and psychiatric providers should have been notified of every incident between the residents as well as the resident representatives, and that social work should have been involved. Interview with LPN #5 on 2/27/26 at 6:38 AM identified there had been an ongoing issue between Resident #41 and Resident #93 for several months in 2025. LPN #5 identified she observed that Resident #41 wanted to be close friends with Resident #93, but Resident #93 was not interested in any friendship or interactions with Resident #41. LPN #5 identified that Resident #41 responded to the rejection by becoming angry and aggressive towards Resident #93, and Resident #41 appeared to fixate on Resident #93 and would often ask where Resident #93 was when he/she left the room. LPN #5 identified that the staff were aware of the issues between Resident #41 and Resident #93, and that it regularly occurred during the evening and overnight shifts, but that she was the only nurse who would document Resident #41's behaviors towards Resident #93 as other nursing staff did not want their names associated with the incidents. LPN #5 identified that on 7/7/25, she observed Resident #41 kick and slap Resident #93 while he/she was in the hallway. LPN #5 could not recall who the other 3 staff were who were present during the incident. LPN #5 identified that she, along with the 3 staff, separated Resident #41 and Resident #93 following the incident. LPN #5 identified she notified the RN supervisor of the incident. LPN #5 indicated it may have been RN #5 (7:00 AM – 3:00 PM RN Supervisor) or RN #6, a prior 11:00 PM – 7:00 AM supervisor who is no longer employed at the facility. LPN #5 identified that she recalled assessing Resident #93 following the incident but did not document. LPN #5 identified that she put a request in the Behavioral Health Visit Request/Follow Up Log for Resident #41 to be seen following the incident, and no further action was taken on her part. LPN #5 also identified she was present for the incident on 10/21/25, and Resident #41 was yelling all night at Resident #93 and did not respond to any redirection by staff. LPN #5 identified she was unsure if she notified the supervisor, but that she placed another request in the Behavioral Health (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Visit Request/ Follow Up Log for Resident #41 to be seen. LPN #5 identified she had repeatedly notified the DNS and prior Administrator of the issues with Resident #41 and Resident #93, and they were aware of the incidents between the residents. LPN #5 also identified that she would often place requests in the Behavioral Health Visit Request/Follow Up Log when Resident #41 would have behaviors overnight and would attempt to redirect Resident #41, but this often did not work. LPN #5 was unable to identify any additional interventions related to Resident #41 and Resident #93, or why she failed to document any incidents or subsequent assessments in Resident #93's clinical record. Interview with the Medical Director on 3/11/26 at 10:56 AM and review of Resident #93's clinical record, grievance, and letter requesting a room change identified that he was recently notified by the DNS at a medical director meeting that Resident #41 and Resident #93 were placed in separate rooms, but he was not made aware of the specific issues that prompted the room change. In review of the nurses note dated 7/7/25 with the Medical Director he identified he had not been notified that Resident #41 had yelled at and kicked Resident #93 and he was not aware that Resident #41 had also slapped Resident #93, which was ascertained during a staff interview. The Medical Director identified he was not aware of any additional incidents, including the 10/21/25 verbal altercation, or the letter written by Resident #93 and given to the Administrator on 11/10/25 which alleged daily verbal and physical abuse by Resident #41. The Medical Director identified first and foremost, he would expect all staff to keep the residents safe and this would include a room change separating Resident #41 and Resident #93 immediately following the incident on 7/7/25. The Medical Director also identified Resident #41 and Resident #93 should have had physical assessments by a medical provider to determine if they were harmed as a result of the incidents, and to determine if there was a medical cause for Resident #41's behavior. The Medical Director identified that an accident and incident investigation should have been completed, the state agency should have been notified immediately following the incidents, and psychiatric follow-up should have been provided. Further, the residents care plans should have been updated and a root cause analysis should have been done to determine the cause of the incident. The Medical Director identified that the facility had open beds, and if the residents had been separated following 7/7/25, the incident on 10/21/25 and allegations identified by Resident #93 in the letter to the Administrator would not have occurred. The Medical Director also identified that it was completely unacceptable to make a note in a resident's chart regarding any verbal or physical altercation and not do anything else. The Medical Director identified at a minimum, the residents should have been separated and assessed to ensure they were safe. Although attempted, an interview with RN #6 and SW #4 was not obtained. The facility policy on Abuse, Neglect and Exploitation directed that abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain or mental anguish. The policy also directed an alleged violation was a situation or occurrence observed or reported by staff, resident, relative, or others but had not yet investigated and if verified, could be an indication of noncompliance of federal requirements with abuse. The policy further directed mental abuse included, but was not limited to, humiliation, harassment, threats of punishment, or deprivation, and physical abuse included, but was not limited to, hitting, slapping, punching, biting, and kicking. The policy also identified that possible indicators of abuse included but were not limited to resident reports of abuse, verbal abuse of a resident overheard, physical abuse of a resident observed, and psychological abuse of a resident observed. The policy further identified that an immediate investigation was warranted when suspicion of abuse or reports of abuse occur. The policy also identified that the facility would make efforts to ensure all residents were protected from physical (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	and psychosocial harm as well as additional abuse during and after an investigation. Examples included but were not limited to responding immediately to protect the alleged victim and the integrity of the investigation, examining the alleged victim for any sign of injury including a physical exam or psychosocial assessment, increased supervision of the alleged victim and residents, room changes if necessary to protect the resident from the alleged perpetrator, protection from retaliation, provide emotional support and counseling to the resident during and after the investigation if needed, and revision of the residence care plan if the residents medical, nursing, physical, mental, or psychosocial needs change as a result of an incident of abuse. The policy also directed that reporting of all alleged violations to the Administrator, state agency, Adult Protective Services and all other required agencies including law enforcement when applicable, should be done immediately but not later than two hours after an allegation was made, if the events that cause the allegation involve abuse. 2a. Resident #99 was admitted to the facility in December 2022 with diagnoses that included schizoaffective disorder and dementia. Review of the facility census identified Resident #99 was moved to Resident #23's room effective 3/12/25. The quarterly MDS dated [DATE] identified Resident #99 was moderately cognitively impaired and independent with bed mobility, transfers and ambulation. The care plan dated 10/19/25 identified Resident #99 had an actual mood problem related to dementia, schizoaffective disorder and anxiety. Interventions included monitoring mood, provide supportive psychotherapy and administer medications as ordered. A social service note dated 2/9/26 at 6:12 PM identified Resident #99 requested a room change due to roommate compatibility. A voice message was left for the responsible party with awaiting call back. A social service note dated 2/11/26 identified the requested room change would not take effect as intended because the proposed new roommate's representative was not in agreement. b. Resident #23 was admitted to the facility in March 2022 with diagnoses that included cerebral infarction (stroke)and major depressive disorder with mood disturbances. The annual MDS dated [DATE] identified Resident #23 was cognitively intact and required one person assist with bed mobility, two person assist with transfers and utilized a motorized wheelchair. The care plan dated 10/19/25 identified Resident #23 had a mood problem related to major depressive disorder with interventions that included psychiatric consultation for behavioral concerns and supportive services. A social service note dated 2/9/26 identified Resident #23 reported not getting along with his/her roommate and requested the roommate be moved. A social service note dated 2/11/26 identified the requested room change would not take effect as intended because the proposed new roommate's representative was not in agreement. Resident #23 was referred to psychiatry for support. Social services plan was to follow up as needed and education (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	was provided to both residents. Review of the clinical record and facility documentation failed to identify the circumstances leading up to the room change request. Interview with Resident #99 on 2/24/26 at 8:26 AM identified he/she had frequent altercations with Resident #23 who often cursed at him/her and keeps the TV too loud. Resident #99 indicated in recent days, while in their room, Resident #23 yelled the F word at him/her. In response, Resident #99 grabbed Resident #23's leg momentarily. Resident #23 informed Resident #99 he/she would be reporting the assault, but he/she had heard nothing further. The frequent altercations have left Resident #99 feeling anxious and upset, often not wanting to stay in his/her room and subsequently the resident has made requests for placement at an alternate facility. Resident #99 further identified he/she had also been making repeated requests for a room change with nothing being done to honor his/her request. Interview with Resident #23 on 2/24/26 at 8:36 AM identified he/she did not get along with Resident #99. Resident #23 indicated an altercation over the TV volume had taken place between the two residents on 2/22/26 in their room at approximately 2:30 AM. Resident #23 said the F word to Resident #99 who in response, grabbed Resident #23's right foot with both hands. Resident #23 told Resident #99 that he/she was going to report him/her for assault. Resident #23 did eventually report the incident to NA #4, but no further action was taken. Interview with the Director of Social Services on 2/24/26 at 8:46 AM identified Resident #23 and Resident #99 were roommates who did not get along. Resident #99 complained Resident #23 kept the TV too loud and Resident #23 complained about Resident #99's perfume. On 2/9/26, Resident #99 had called Resident #23 the B word. Both residents were socially separated following the altercation and seen by psychiatry. Referrals have been made for Resident #99 to be transferred to an alternate facility which was under review. The Director of Social Services further indicated she would have to refer to the facility's policies for abuse to determine any further required procedures. Interview with NA #4 on 2/24/26 at 10:17 AM identified while the resident-to-resident incident that occurred on 2/22/26 was not reported to her, it was known that Resident #23 and Resident #99 did not get along. NA #4 had observed the two residents yelling at each other, with Resident #23 often swearing at Resident #99. These incidents were reported to the nurse who did their best to separate the two residents. Interview with LPN #8 on 2/24/26 at 2:24 PM identified she was routinely assigned to Resident #23 and 99's unit during the 7:00 AM to 3:00 PM shift. LPN #8 indicated Resident #23 and Resident #99 frequently got in verbal altercations. Resident #99 would call Resident #23 the B word and Resident #23 would say the F word to Resident #99. LPN #8 separated the two residents and reported the incidents to the Director of Social Services in recent weeks. Interview with NA #7 on 2/24/26 at 2:28 PM identified she was routinely assigned to Resident #23 and 99's unit during the 7:00 AM to 3:00 PM shift and has heard Resident #99 call Resident #23 the B word, and Resident #23 say the F word to Resident #99. Subsequent interview with the Director of Social Services on 2/24/26 at 2:50 PM identified for any allegation of resident-to-resident mistreatment, both residents were to be placed on 1:1 supervision until cleared by psychiatry, the physician and responsible party were to be notified, and the incident (continued on next page)

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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 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility documentation and interviews, the facility failed to ensure accurate staffing data was entered in the Payroll Based Journal (PBJ) during FY Quarter 4 2025 (July1 -[DATE]). The findings include: Review of the PBJ Staffing Data Report dated FY Quarter 4 2025 (July1 -[DATE]) identified that the facility triggered for a one star staffing rating, no RN hours on the following dates: 9/19/25, 9/20/25, 9/22/25, 9/23/25, 9/24/25, 9/25/25, 9/26/25, 9/27/25, 9/29/25, and 9/30/25, and failure to have licensed nurse coverage 24 hours/day on the following dates: 9/19/25, 9/20/25, 9/22/25, 9/23/25, 9/24/25, 9/25/25, 9/26/25, 9/27/25, 9/29/25, and 9/30/25. Review of the Daily Staffing documents dated: 9/19/25, 9/20/25, 9/22/25, 9/23/25, 9/24/25, 9/25/25, 9/26/25, 9/27/25, 9/29/25, and 9/30/25 identified the facility did have RN coverage and licensed nurse coverage 24 hours a day. Interview with the Regional Administrator/Director on 2/27/26 at 12:30 PM identified that the PBJ data submitted for FY Quarter 4 was completed by the previous owner, and that she could not speak to the process for PBJ data submission, nor its accuracy, completed by the facility prior to the change of ownership (11/1/25). The Payroll Based Journal policy directs that the facility is to electronically submit timely to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. The responsibilities for data submission include the Administrator, HR director, and Director of Nursing to be responsible for verifying the accuracy of the staffing data that is submitted to CMS using various facility audit forms and/or payroll vendor reports.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, facility documentation, facility policy and interviews for 3 of 3 residents, (Resident #12, 69 and 79) reviewed for activities of daily living (ADL) and who were unable to care for themselves, the facility failed provide basic care including bathing and toileting between 7:00 AM - 12:00 PM after the nurse aide assigned to provide care was reassigned and that information was not communicated to other staff. The findings include:1. Resident 12 was admitted to the facility in August 2025 with diagnoses that included stroke and dementia.The quarterly MDS dated [DATE] identified Resident #7 was severely cognitively impaired, required two person assist with bed mobility, transfers and toileting needs, was incontinent of bowel and bladder, was at risk for the development of pressure ulcers and had no unhealed pressure ulcer.The care plan dated 12/3/25 identified Resident #12 had a potential or actual skin integrity impairment and potential problem with urinary incontinence related to benign prostatic hyperplasia, BPH (enlarged prostate that can contribute to urinary frequency). Interventions included turning and repositioning four times during the shift and providing care after each incontinent episode. 2. Resident #69 was admitted to the facility in January 2024 with diagnoses that included spondylosis (degenerative spine disease) and difficulty walking.The annual MDS dated [DATE] identified Resident #69 was cognitively intact and required one person assist with bed mobility, transfers, bathing and toileting needs, was frequently incontinent, was at risk for the development of pressure ulcers and had no unhealed pressure ulcer.The care plan dated 1/11/26 identified Resident #69 was at risk for complications related to incontinence, history of urinary tract infections, an ADL deficit and impaired skin integrity. Interventions included checking every two hours and assisting with toileting as needed, provide assist of one with bathing dressing/ toileting needs and encourage resident to reposition four times each shift. 3. Resident #79 was admitted to the facility in December 2025 with diagnoses that included Parkinson's disease and stroke.The admission MDS dated [DATE] identified Resident #79 was moderately cognitively intact, required one person assist with bed mobility, transfers, and toileting, was incontinent of bladder and bowel, was at risk for the development of pressure ulcers and had no unhealed pressure ulcers.The care plan dated 12/30/25 identified Resident #79 was at risk for skin breakdown and incontinent. Interventions included providing two person assist for toileting and checking for incontinence routinely and as needed.Interview with LPN #1 on 2/27/26 at 11:50 AM identified NA #13 began her assignment at 7:00 AM and left the facility at 10:00 AM without completing her resident assignments and without informing her. This resulted in several residents not receiving assistance with bathing and incontinent care. LPN #1 indicated she was just learning this information and was adjusting the nurse aide assignments accordingly. LPN #6 was not previously informed that NA #13 would be leaving the facility at 10:00 AM.Observation and facility documentation review with the Administrator and RN #2 on 2/27/26 at 1:00 PM identified 3 of 8 residents, Resident #12, 69 and 79, who had been assigned to NA #13, were still in bed, in johnny coats and wet with urine.Interview with RN #5 on 2/27/26 at 1:19 PM identified he was the assigned nursing supervisor during the 7:00 AM to 3:00 PM shift. RN #5 indicated that a resident who was scheduled for a medical appointment in the community did not have a staff member assigned to go with the resident when transportation arrived just prior to 10:00 AM. RN #5 decided in the moment, to re-assign NA #13 to accompany the resident to the medical appointment but did not to notify LPN #6 of the change.Interview with NA #8 at 2/27/26 1:45 PM identified she assisted the night shift aide in incontinent care at 6:30 AM for Resident #79, but provided no other care for him/her, Resident #12 or Resident #69 until re-assigned after 12:00 PM.Interviews with NA #9 and NA #19 on 2/27/26 at 2:00 PM identified they had not provided any care to Resident #12, Resident #69 or Resident #79 prior to being assigned to do so at 12:00 PM,.Interview with RN #2 on 2/27/26 at 1:57 PM identified she would expect the nursing supervisor to notify the charge nurse if a nurse aide was removed from an (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	assignment so adjustments could be made to ensure all residents receive the necessary care.Interview with NA #13 on 2/27/26 at 3:30 PM identified she was assigned the ?float' assignment consisting of 8 residents. NA #13 provided morning care to 5 of the 8 residents but confirmed she did not provide any incontinent or bathing assistance to Resident #12, Resident #69 and Resident #79 before being re-assigned. NA #13 indicated she was informed by RN #5 at 10:00 AM to accompany another resident on a medical appointment and left immediately thereafter without first notifying the charge nurse or letting anyone know about the status of her assignment. NA #13 had no previous knowledge that she would be reassigned to go to an appointment with another resident until 10:00 AM.Subsequent to Resident #12, 69 and 79 not receiving care due to NA #13's reassignment, a quality assurance performance improvement (QAPI) plan was initiated with immediate review of staffing schedules and patient assignments, staff reassignment to ensure all residents had nurse aide coverage and the wound nurse immediately completed skin assessments which identified no new skin integrity issues. A plan for ongoing surveillance was implemented to review staffing, verify nurse aide assignments each shift and notify the DNS/Administrator of gaps with the DNS/designee to review daily staffing sheets for 30 days.Review of the facility policy for ADL care directed the facility to provide appropriate treatment and services to ensure ADL needs are met daily. Each resident's physical functioning will be assessed, the assistance needed will be included in the care plan and utilized when providing care.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility documentation, facility policy, facility assessment, and interviews, for 5 of 5 nurse aides (NA #8, 15, 16, 17, and 18) and 2 of 2 licensed nurses (LPN #5 and #8), reviewed for sufficient and competent nurse staffing, the facility failed to ensure the staff had demonstrated competencies necessary to care for resident's needs, from the last standard survey ([DATE]) through the change of ownership of the facility on [DATE]. The findings include: Review of NA #8's personnel file identified that he/she was hired in [DATE]. The personnel file failed to identify documentation that annual competencies had been demonstrated from the last standard survey [DATE]. After the facility changed ownership on [DATE], NA #8 completed an in-service on the 2026-2027 mandatory education on [DATE]. Review of NA #15's personnel file identified that he/she was hired in [DATE]. The personnel file failed to identify documentation that annual competencies had been demonstrated from the last standard survey [DATE]. After the facility changed ownership on [DATE], NA #15 completed an in-service on the 2026-2027 mandatory education on [DATE]. Review of NA #16's personnel file identified that he/she was hired in [DATE]. The personnel file failed to identify documentation that annual competencies had been demonstrated from the last standard survey [DATE]. After the facility changed ownership on [DATE], NA #16 completed an in-service on the 2026-2027 mandatory education on [DATE]. Review of NA #17's personnel file identified that he/she was hired in [DATE]. The personnel file failed to identify documentation that annual competencies had been demonstrated from the last standard survey [DATE]. After the facility changed ownership on [DATE], NA #17 completed an in-service on the 2026-2027 mandatory education on [DATE]. Review of NA #18's personnel file identified that he/she was hired in [DATE]. The personnel file failed to identify documentation that annual competencies had been demonstrated from the last standard survey [DATE]. After the facility changed ownership on [DATE], NA #18 completed an in-service on the 2026-2027 mandatory education on [DATE]. Review of LPN #5's personnel file identified that he/she was hired in February 2024. The personnel file failed to identify documentation that annual competencies had been demonstrated in 2025. After the facility changed ownership on [DATE], LPN #5 completed an in-service on the 2026-2027 mandatory education on [DATE]. Review of LPN #8's personnel file identified that he/she was hired in [DATE]. The personnel file failed to identify documentation that annual competencies had been demonstrated in 2025. After the facility changed ownership on [DATE], LPN #8 completed an in-service on the 2026-2027 mandatory education on [DATE]. Interview with the MDS Coordinator/Interim Staff Development and Infection Control Nurse (LPN #6) on [DATE] at 1:48 PM identified that when she began her employment at the facility in [DATE], there was no documentation of nursing staff education or competency evaluations available under the prior owner. LPN #6 indicated that, in collaboration with the IDT and regional team, a mandatory in-service/competency fair was initiated and implemented, for all nursing staff; additionally monthly and as needed education had been implemented including education on droplet precautions and PPE during the facility's influenza and Covid-19 outbreaks in 12/25 and 1/26. Interview with the DNS on [DATE] at 3:07 PM identified that she had worked at the facility since [DATE] and while the annual mandatory education packet was provided to staff by Human Resources, in 2025, they were unable to locate the documentation of the education, as the prior owner had removed/taken the documentation for nursing staff education. The DNS indicated that under the prior owner, she would provide education to staff on things that were new to the facility, and she would make observations of staff during care, but there was no formal process for evaluating licensed nurse or nurse aides for competencies. The DNS further indicated that under the new facility ownership, a mandatory education and skills fair (2026-2027 Mandatory Inservice) had already been implemented for nursing staff, which included education provided by the regional team, staff (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	development, and RNs from sister facilities, as well as hands-on return demonstrations, of licensed nurses and nurse aides, for competency evaluation. Interview with the Human Resources Director on [DATE] at 8:25 AM identified that she was unable to locate any nurse staffing educational or competency documentation from 2025, prior to the change of ownership. The Competency Evaluation policy directs the facility to evaluate each employee to ensure they meet appropriate competencies and skills for performing their job. Initial competency is evaluated during the orientation process, an employee remains on orientation until all competencies are verified and subsequent and/or annual competency is evaluated at a frequency determined by the facility assessment, evaluation of training program, and/or job performance evaluations. The Nursing Services and Sufficient Staff policy directs that the facility must ensure licensed nurses have specific competencies and skill sets necessary to care for the resident's needs as identified through the resident assessments and described in the plan of care, and the facility must ensure that nurse aides are able to demonstrate competency and skills and techniques necessary to care for resident's needs, as identified through resident assessments and as described in the plan of care. Although requested the Facility Assessment (prior to the Facility Assessment updated on [DATE]) was not available for review. The Facility assessment dated [DATE] directs the facility must have sufficient training with the appropriate competencies and skill sets to provide nursing and appropriate related services to assure resident safety and maintain the highest practicable physical, mental and psychosocial well-being of each resident determined by the resident assessments and individual plans of care considering the number, acuity and diagnosis of the facility's resident population. The facility provides staff training/education and competencies that are necessary to provide care and support needed for the resident population. The training/education and competency/skill sets are generally provided upon hire, during monthly in-servicing/training, annual in-service/training, whenever an area of concern is identified, or new areas are identified based on resident diagnosis and/or clinical condition. The facility provides training on topics and competencies that include but are not limited to: resident rights and facility responsibilities, abuse, neglect, and exploitation including reporting procedures and fear of retaliation, Elder Justice Act, customer service, HIPAA, bloodborne pathogens, sexual harassment, MSDS, OSHA, emergency preparedness, elopement, values and standards, workplace violence, CPR/abdominal thrust, pain, falls, body mechanics, fire safety, care/management for people with dementia, person centered care, and behavioral health training.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility documentation, facility policy, and interviews, the facility failed to ensure 5 of 5 nurse aides (NA #8, 15, 16, 17, and 18) received a performance evaluation at least once every 12 months, from the last standard survey (3/12/24) through 2/24/26. The findings include: Review of NA #8's personnel file identified that he/she was hired in August 202. The personnel file failed to identify documentation that an annual performance evaluation was completed from 3/12/24 through 2/24/26. Review of NA #15's personnel file identified that he/she was hired in October 2018. The personnel file failed to identify documentation that an annual performance evaluation was completed from 3/12/24 through 2/24/26.Review of NA #16's personnel file identified that he/she was hired in September 2007. The personnel file failed to identify documentation that an annual performance evaluation was completed from 3/12/24 through 2/24/26.Review of NA #17's personnel file identified that he/she was hired in [NAME] 2004. The personnel file failed to identify documentation that an annual performance evaluation was completed from 3/12/24 through 2/24/26.Review of NA #18's personnel file identified that he/she was hired in October 2018. The personnel file and failed to identify documentation that an annual performance evaluation was completed from 3/12/24 through 2/24/26.Interview with the DNS on 2/27/26 at 8:48 AM identified that performance evaluations for all nursing staff, including nurse aides, had been completed in 2025, but they were unable to locate the evaluations after the change of ownership. The DNS identified that the 2025 process for completing annual performance evaluations was that the DNS evaluated the RN supervisors, the RN supervisors evaluated the charge nurses, and the charge nurses evaluated the nurse aides; the completed evaluations were placed in the employee's personnel file with Human Resources (HR). The DNS further identified that the prior company had taken most of the HR files. The DNS identified that since the change of ownership (10/2025) the new company has started the process for completing annual evaluations, but they have not yet implemented it. The Evaluation Process policy directs the facility to review the work performance of employees with a formal written evaluation. The following procedure will be followed for employee performance evaluations: at the end of each month, the human resource department will notify the department manager of evaluations due for the following month, performance evaluations will be used in determining any promotions, demotions, transfers, terminations, salary/wage adjustments etc. Evaluation forms are to be returned to the manager at least one week prior to the employees appraisal date whenever possible, the manager/supervisor is to complete the employee evaluation form, after the evaluation has been reviewed by the administrator, the manager/supervisor will meet with the employee to review and discuss the evaluation, once the evaluation review is complete, the employee and manager should sign the evaluation form. Original evaluation tools are to be forwarded to the Human Resource department to be processed and placed in the appropriate personnel file. The In-Service Training Program, Nurse Aide policy directs all nurse aides shall participate in regularly scheduled in service training classes. The facility will complete a performance review of nurse aides at least every 12 months. In-servicing will be based on the outcome of the annual performance reviews, addressing weaknesses identified in the reviews.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observation, review of the clinical record, facility documentation, facility policy and interview the facility failed to ensure its medication error rate was not 5 percent or greater. The findings include. During the recertification survey 2/24/26 - 2/27/26 the survey team observed 5 residents during medication administration with 35 opportunities for errors. There were 3 observed medication errors making the medication error rate 8.57%. 1. Resident #19 was admitted to the facility in October 2020, diagnosis included with diagnoses that included hypothyroidism.Physician's order dated 2/21/26 directed to administer Levothyroxine 112mcg daily, Vitamin C 500mg daily, Vitamin D 25mg daily, and Ferrous Sulfate Oral Solution 300 (60 Fe) mg/ml give 5ml daily.a. Observation during medication administration on 2/26/26 at 10:04 AM identified that LPN #4 administered Levothyroxine 112mcg, Vitamin C 500mg, Iron (Ferrous Sulfate) tablet 325mg/65mg (medication error), and Vitamin D 25mg. b. Review of the Levothyroxine blister pack on 2/26/26 (used by LPN #6 to administer the Levothyroxine) identified the following directions from the pharmacy.Take this medication at least 4 hours before taking Antacids, Iron or Vitamin/Mineral Supplements. Take this medicine on an empty stomach preferably 1/2 to 1 hour before breakfast. Interview with RN #2 on 2/26/26 at 2:00 PM identified that the Levothyroxine should be administered at 6:30 AM. Subsequent to surveyor inquiry on 2/26/26 the administration time of the Levothyroxine was changed to daily at 6:00 AM, and a TSH and Iron level were ordered. 2. Observation on 2/27/26 at 9:24 AM identified LPN #10 administered medications to Resident #111 however, omitted the administration of the physician ordered Cholecalciferol 1000units. The medication administration policy identified medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Compare medication source (bubble pack, vial, etc.) with MAR to verify resident name, medication name, form, dose, route, and time. Administer medication as ordered and in accordance with manufacturer specifications. Medications requiring administration on an empty stomach include Levothyroxine.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observation, review of facility policy, and interviews, for 4 of 4 medication carts, the facility failed to maintain medication carts in a clean and sanitary manner. The findings include:a. Observation of the medication cart on Center South on 2/25/26 at 1:30 PM with DNS, RN #2 (Vice President of Clinical Operations), and LPN #1 identified an accumulation of loose medication pills and/or blister pack back covers at the bottom of fifth drawer. Interview on 2/25/26 at 1:30 PM with LPN #1 indicated she was not aware of the loose medication pills and/or blister pack back covers at bottom of medication drawer. LPN #1 indicated it is the responsibility of all the nurses to keep the medication cart clean at all times. b. Observation of the medication cart on Center North on 2/25/26 at 1:59 PM with DNS, RN #2 (Vice President of Clinical Operations) and LPN # 2 identified an accumulation of loose medication pills and/or blister pack back covers at the bottom of fifth drawer. Interview on 2/25/26 at 1:59 PM with LPN #2 indicated she was not aware of the loose medication pills and/or blister pack back covers at bottom of medication drawer. LPN #2 indicated it is the responsibility of all the nurses to keep the medication cart clean at all times and after themselves. c. Observation of the medication cart on North on 2/25/26 at 2:05 PM with DNS, RN #2 (Vice President of Clinical Operations) LPN #3 identified an accumulation of loose medication pills and/or blister pack back covers at the bottom of fifth drawer. Interview on 2/25/26 at 2:05 PM with LPN #3 indicated she was not aware of the loose medication pills and/or blister pack back covers at bottom of medication drawer. LPN #3 indicated it is the responsibility of all the nurses to keep the medication cart clean at all times. d. Observation of the medication cart on South on 2/25/26 at 2:10 PM with DNS, RN #2 (Vice President of Clinical Operations) and LPN #4 identified an accumulation of loose medication pills and/or blister pack back covers at the bottom of fifth drawer. Interview on 2/25/26 at 2:10 PM with LPN #4 indicated she was not aware of the loose medication pills and/or blister pack back covers at bottom of medication drawer. LPN #4 indicated it is the responsibility of all the nurses to keep the medication cart clean at all times.Interview on 2/25/26 at 2:15 PM with the DNS identified she was not aware the medication carts were not being cleaned. The DNS indicated the expectation of the facility is that all nurses clean the medication carts at the end of their shift and/or the medication carts are clean at all times. The DNS indicated education and in-service will be given to the nursing staff.Review of the facility storage of medications policy identified the facility shall store all drugs and biologicals in a safe, secure, and orderly manner. The nursing staff shall be responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation review of facility documentation, facility policy and interviews, the facility failed to ensure resident designated water pitches were clean and sanitized routinely. The findings include:Interview with Resident #23 on 2/24/26 at 8:36 AM identified water pitchers were not routinely cleaned and instead, reused daily. Resident #23 had previously complained to staff (unidentified), but the practice continued.Observation on 2/24/26 at 8:36 AM identified an ice cooler on a utility cart at the end of the hall, with no clean water pitchers. Various staff lifted the lid using an ice scooper inside to obtain ice to fill water pitchers before returning to a resident room, with one staff member filling three unmarked water pitchers before heading down the hall towards the resident rooms.Observation on 2/25/26 at 7:04 AM identified the ice cooler at the end of the hall, no clean pitchers.Observation on 2/25/26 at 9:34 AM identified a staff member scooping ice into a water pitcher and returning to a resident room.Observation on 2/26/25 at 10:25 AM identified the ice cooler at the end of the hall, no clean water pitchers.Interview with NA #6 on 2/26/25 at 10:25 AM identified water pitchers were not washed often and that nurse aides must ask. When requesting replacement water pitchers, staff were told there were not enough.Interview with Dietary Aide #1 on 2/26/26 at 10:50 AM identified she routinely operated the dishwasher beginning at 6:00 AM as part of her assignment. Dietary Aide #1 indicated the nurse aides working the 11:00 PM - 7:00 AM shift previously would bring the water pitchers to the kitchen in the morning for cleaning; however, this process had not occurred in the past five months. Instead, water pitches were only cleaned when requested but not routinely.Interview with the Food Service Director (FSD) on 2/26/26 at 10:52 AM identified both nursing staff and dietary staff shared responsibility to ensure residents receive clean water pitchers daily. The FSD indicated there had been shortages of water pitchers and lids, so water pitchers were not changed out routinely adding he had to obtain lids from central supply as early as the preceding day. Instead, existing water pitchers were cleaned if nursing staff made the request.Observation of the storage cabinet where the water pitchers were stored identified approximately 20 water pitchers were stacked in the cabinet with lids stacked to the side.Further interview and tour of central supply with the FSD in the food service storage area and central supply identified one box (100 count each) of water pitchers with lids. One box was opened with an undetermined amount. While the FSD indicated he obtained lids form the open box, he was unable to explain why the new water pitches were not being utilized.Interview and review of facility documentation with Central Supply Staff #1 on 2/26/26 at 11:02 AM identified she assumed central supply responsibilities in November 2025. At that time, she was informed there was a shortage of water pitchers and ordered one box (100 pieces). Central Supply Staff #1 was unable to account for any water pitchers ordered and stored separately.Review of supply order invoices identified the following:Order invoice dated 11/21/25 included one box (100 count) of water pitchers and lids with a shipping date of 11/24/25.A second supply order invoice dated 11/25/25 included one box (100 count) of water pitchers and lids with a shipping date of 11/26/25.A third supply order invoice dated 12/25/25 included one box (48 count) of water pitchers and lids.Interview with the Administrator on 2/26/26 11:07 AM identified clean water pitchers were provided to the residents on a weekly basis. The Administrator indicated she was aware of a shortage November 2025 and directed staff to obtain additional water pitchers. The Administration further identified that while audits were conducted to ensure residents were receiving clean water pitchers, she was unable to provide documentation of such.Interview with Resident #48 on 2/26/26 at 2:06 PM identified his/her water pitcher was replaced/cleaned when requested, not done on a routine basis.Interview with Resident #5 on 2/26/26 at 2:10 PM also identified his/her water pitcher was replaced/cleaned when requested, not done on a routine basis.Interview with NA #2 on 02/27/2026 at 6:30 AM identified she routinely worked the 11:00 PM to 7:00 AM shift. NA #2 indicated water pitchers were cleaned/replaced upon resident request and not completed (continued on next page)

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	routinely.Review of the facility policy for Food and Nutrition Policies and Procedures directed that water pitchers be collected at the bedside by nursing, a minimum of one time weekly and delivered to the Food and Nutrition Service employees. Pitchers and tumblers are to be sanitized in the dish machine, returned to nursing stations and distributed/stored until needed.

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	075011	A. Building B. Wing	03/11/2026

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. Based on review of facility documentation, facility policies, and interviews, the facility failed to ensure an antibiotic stewardship program was in place that included a standardized tool for infection surveillance and a system for periodic review, from the last standard survey (3/12/24) through the change of ownership (11/1/25). The findings include: Review of the Antibiotic Stewardship binder with documentation dated 3/1/25 through 2/23/26 failed to identify, that from 3/1/25 through 10/31/25, the facility was using a standardized tool when assessing residents for infection and failed to identify that a feedback system was in place for educating prescribing practitioners on their antibiotic utilization patterns and facility infection rates. Review of November 2025, December 2025, and January 2026 (February 2026 in process) Monthly Infection Reports identified infection surveillance, broken down by body systems and percentages rates, was being tracked. During an interview with the MDS Coordinator/Interim Staff Development and Infection Control Nurse (LPN #6) and the Regional Clinical Leader on 2/26/26 at 11:00 AM, LPN #6 identified that she began working at the facility in November 2025, and when she arrived there was no standardized tool in place for infection surveillance, and subsequent to the change of ownership, the facility began utilizing McGeer criteria for infection surveillance. LPN #6 further indicated that there was no documentation available, from the prior owner, that periodic review and reporting on antibiotic surveillance and infection surveillance to appropriate members of the interdisciplinary team such as the medical providers and nursing staff, had occurred nor was there documentation of education being provided to nursing staff about antibiotic stewardship, prior to the change of ownership. LPN #6 identified that during the December 2025 Medical Staff meeting, the monthly infection reports were reviewed, and the reports will be reviewed again at the upcoming March Medical Staff Meeting. The Regional Clinical Leader indicated that there was no data available from the previous owner (prior to 11/1/25) to include in the statistical analysis, but it was their goal to have monthly infection rate and antibiotic usage data reviewed, then build up to quarterly, and then yearly for the IDT review. Interview with the DNS on 2/26/26 at 3:07 PM identified that she was hired in March 2025, and that from her time of hire until the change of ownership (11/1/25), the facility was without a full-time Infection Control Nurse (ICN), and that the prior owner oversaw the Infection Control Program. The DNS indicated that there was no documentation available that the facility had used a standardized tool for infection surveillance, and that during Medical Staff meetings, infection and antibiotic surveillance data was not reported on to the IDT. The DNS identified that during the Medical Staff Meetings, active infections would be reported, but antibiotic reconciliation and provider antibiotic ordering data were not presented, and the prior owner would report that the ICN position was open and that the facility was actively trying to hire an ICN. The Antibiotic Stewardship policy directs the purpose of the antibiotic stewardship program is to monitor the use of antibiotics in the residents. Orientation, training, and education of staff will emphasize the importance of antibiotic stewardship and will include how inappropriate use of antibiotics affects individual residents and the overall community. The Infection Prevention and Control Committee (IPCC) policy directs that the objectives of the infection prevention and control program were to: assist in the development and implementation of written policies and procedures for prevention and control of infections among residents and personnel, provide the facility guidelines for a safe and sanitary environment, review, establish and monitor environmental infection control approaches, develop isolation precaution protocols, identify situations that may result in employees exposure to blood, bodily fluids, or other potentially infectious materials, help develop an effective employee health program, develop infection prevention and control orientation and in service training programs for all levels of facility personnel, develop policies and procedures for the surveillance and monitoring of infection control practices, and review and help monitor the medical waste management plan. The IPCC will advise administration about ensuring that records are maintained to document the following, in part, in-service training records and findings made during surveillance of antibiotic usage (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	patterns. The IPCC shall meet whenever necessary, or its functions will be covered by the QAPI committee, at least monthly overtime. Committee meetings will cover at least: Directives from health department, surveillance reports of infections or infectious in communicable diseases, surveillance reports of antibiotic usage and antibiotic susceptibility patterns, policy reviews and revisions, current infection control/prevention concerns, environmental infection control concerns, changes in regulations, antibiotic utilization patterns, and emergence of antibiotic resistant organisms, measures to prevent infections or exposures in the future, and in- service training program.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on review of facility documentation, facility policy and interviews, the facility failed to designate an infection preventionist (IP) at least part time to monitor the facility infection control program. The findings include:Review of the facility infection control program identified there no designated IP.Interview and facility documentation review with the Administrator on 2/24/26 at 2:03 PM identified that no designated IP had been assigned since 1/19/23. Various staff had intermittently assisted, including LPN #6, employed since November 2025 and the DNS who was recently certified on 2/7/26. The Administrator indicated there were ongoing efforts to recruit for the position; however, facility documentation identified the position had been posted on just one occasion, 10/22/25. The Administrator further identified a candidate was hired for the position and was anticipated to begin on 3/4/26. The Administrator was unable to provide documentation through schedules or punch records demonstrating designated time for the management infection control program or LPN #6's oversight.Review of the policy for Infection Preventionist directed the facility to employ one or more qualified individuals with the responsibility for implementing the facility's infection prevention and control program (IPCP). The individual is designated by the facility to be responsible for the IPCP, qualified by education, training in infection control and prevention, have experience or certification, must be employed at least part time, with the amount of time determined by the facility assessment and needs for its IPCP.Review of the facility assessment identified the facility maintained an IP and IPCP with no formal hours detailed.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility documentation, facility policy, facility assessment, and interviews, the facility failed to ensure 5 of 5 nurse aides (NA #8, 15, 16, 17, and 18) reviewed for sufficient and competent nurse staffing, completed the minimum required 12-hours of in-service education, annually, from the last standard survey (3/12/24) through the change of ownership (11/1/25). The findings include: Review of NA #8's personnel file identified that he/she was hired in August 2021. The personnel file failed to identify documentation that the minimum required 12-hours of in-service education had been completed between the last standard survey, 3/12/24 and 1/31/26, 22 months. Review of NA #15's personnel file identified that he/she was hired in October 2018. The personnel file failed to identify documentation that the minimum required 12-hours of in-service education had been completed between the last standard survey, 3/12/24 and 12/29/25, 21 months. Review of NA #16's personnel file identified that he/she was hired in September 2007. The personnel file failed to identify documentation that the minimum required 12-hours of in-service education had been completed between the last standard survey, 3/12/24 and 1/4/26, 21 months. Review of NA #17's personnel file identified that he/she was hired in July 2004. The personnel file failed to identify documentation that the minimum required 12-hours of in-service education had been completed between the last standard survey, 3/12/24 and 1/30/26, 22 months. Review of NA #18's personnel file identified that he/she was hired in October 2018. The personnel file failed to identify documentation that the minimum required 12-hours of in-service education had been completed between the last standard survey, 3/12/24 and 1/31/26, 22 months. Interview with the MDS Coordinator/Interim Staff Development and Infection Control Nurse (LPN #6) on 2/26/26 at 1:48 PM identified that when she began her employment at the facility in November 2025, there was no documentation of nursing staff education available, and she could not speak to how many hours of in-service education the nurse aides had received, under the prior owner. LPN #6 indicated that, in collaboration with the IDT and regional team, a mandatory in-service was initiated, for all nursing staff which covered educational topics such as: resident rights, HIPAA, dignity and privacy, abuse, retaliation, cultural diversity, customer service, pain, dementia, hand hygiene, quality and environmental grounds, infection control/prevention, precautions in MDROs, personal protective equipment, occupational exposure to TB, bloodborne pathogens, elopement, fall prevention, abdominal thrusts/Heimlich, hazardous materials, lockout/tag out, fire prevention, electrical safety, emergency preparedness, active shooter, workplace violence, sexual harassment, corporate compliance, agronomics and body mechanics, antibiotic stewardship, and COVID-19, which she estimated to account for 2-3 hours of education. Additionally, in-person education had also been provided and documented when opportunities had been identified, from November 2025 through February 2026. Interview with the DNS on 2/26/26 at 3:07 PM identified that she had worked at the facility since March 2025 and while an annual mandatory education packet was provided to staff by Human Resources, in 2025, they were unable to locate the binder for in-servicing education documentation, as the prior owner had removed the binder and documentation of the nursing staff education, and she was unable to identify if nurse aides had received 12 hours of in-service education. The DNS further indicated that under the new facility ownership, a mandatory education and skills fair (2026 - 2027 Mandatory Inservice) had already been implemented for nursing staff, which included education provided by the regional team, staff development, and RNs from sister facilities. Interview with the Human Resources Director on 2/27/26 at 8:25 AM identified that she was unable to locate nurse staff education documentation from 2025, prior to the change of ownership. The In-Service Training Program, Nurse Aide policy directs all nurse aides shall participate in regularly scheduled in-service training classes. The facility will complete a performance review of nurse aides at least every 12 months. In-service training will be based on the (continued on next page)

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	outcome of the annual performance reviews, addressing weaknesses identified in the reviews. Annual in-services must ensure the continuing competence of nurse aides, be no less than 12-hours per employment year, address areas of weakness as determined by nurse aid performance reviews, address the special needs of the residents as determined by the facility staff, include training that addresses the care of residents, cognitive impairment, and include training and dementia management and abuse prevention. All training classes attended by employees shall be entered on their respective employees' record of in-service by the person designated by the supervisor and records shall be filed in the employee's personnel file. Although requested, the Facility Assessment (prior to the change in ownership; updated on 11/13/25) was not available. The Facility assessment dated [DATE] directs the facility requires in-service training for nurse-aides. In-service training must be sufficient to ensure the continuing competence of nurse aides but must be no less than 12 hours per year.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for 2 of 6 residents (Resident #16 and 110) reviewed for grievances, the facility failed to ensure the residents were treated in a respectful and dignified manner. The findings included: 1. Resident #16 was admitted to the facility in January 2026 with diagnoses that included muscle wasting and atrophy, dementia, history of falling, and congestive heart failure.The care plan dated 1/16/26 identified Resident #16 had a self-care performance deficit. Interventions included providing assistance in completing ADL tasks as needed, offer toileting every 2-3 hours while awake and staff to check for incontinence and assist with changes routinely and as needed.The resident grievance form dated 1/21/26 identified Resident #16 indicated he/she requested a blanket on 1/20/26 at 4:00 PM which was not provided until the following morning by another staff member. Resident #16 also indicated he/she requested a bedpan and was informed by staff that bedpans were not used at the facility. The resolution was staff education regarding customer service, social work support and weekly follow-up. The admission MDS dated [DATE] identified Resident #16 had intact cognition, was frequently incontinent of bowel and bladder, required supervision or touching assistance with roll left and right, and required partial/moderate assistance with toilet transfer.Review of the all-staff meeting form dated 1/23/26 identified the agenda included customer service and mutual respect in the workplace for colleagues, visitors, vendors, providers, and residents. Review of the in-service training sheet (no date or time) identified to reinforce professional conduct, respectful communication and compliance with facility expectations when interacting with residents, families, coworkers, and management. Customer service expectations: Maintain respectful, professional behavior at all times. Follow assigned duties and instructions as directed. Respond promptly and appropriately to requests. Control tone, language, and body language regardless of stress or disagreement.Review of the staff in-service sign-in forms failed to reflect documentation that NA #15, 21, 23, 24, LPN #7, and #13 had signed in-service sign-in forms or received the education. The facility could not verify attendance for these staff members. Review of the clinical record and facility documentation failed to reflect that the allegation made by Resident #16 regarding requesting a blanket and bedpan had been addressed or investigated.Interview with the DNS on 3/11/26 at 11:00 AM identified she was not aware that Resident #16 had requested a blanket on 1/20/26 at approximately 4:00 PM and had also requested a bedpan that was not provided during the shift. The DNS indicated she had not reviewed the resident grievance form dated 1/21/26 and had not investigated the allegations documented on the grievance form. The DNS indicated the Administrator had informed her during the morning meeting to provide staff with an in-service regarding customer service. The DNS indicated that she was not aware that the following staff members had not received the customer service in-service: NA #15, 21, 23, 24, LPN 7, and 13. The DNS indicated that going forward she would review resident grievance forms and investigate any allegations related to customer service. The DNS indicated she was unaware which nurse aide was assigned to Resident #16 or which staff member failed to provide the resident with an extra blanket or informed the resident that no bedpan was available. The DNS indicated the facility has adequate supply of extra blankets and bedpans. The DNS indicated the resident should have been provided with an additional blanket if requested. The DNS indicated staff should not inform residents that bedpans are unavailable.Interview with the Administrator on 3/11/26 at 11:30 AM identified she was aware of the resident grievance form dated 1/21/26. The Administrator indicated that an all staff meeting was held on 1/23/26 and the agenda included customer service and mutual respect in the workplace for colleagues, visitors, vendors, providers, and residents. The Administrator indicated that she had informed the DNS during a morning meeting to provide staff with an in-service regarding customer service. The Administrator indicated she was not aware the DNS had not reviewed the resident (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	grievance form dated 1/21/26 or conducted an investigation. Interview with NA #24 on 3/13/26 at 4:12 PM identified he has been employed by the facility since September 2021 and works per diem. NA #24 indicated he was assigned to Resident #16 during 3:00 PM - 11:00 PM shift on 1/20/26. NA #24 indicated he was not familiar with the resident. NA #24 indicated he does not recall Resident #16 requesting a blanket or a bedpan from him during that shift. NA #24 indicated the facility does have extra blankets and bedpans. Interview with NA #23 on 3/13/26 at 4:29 PM identified she has been employed by the facility since 8/15/25. NA #23 indicated she was not assigned to Resident #16 during 3:00 PM - 11:00 PM shift on 1/20/26. NA #23 indicated she does not recall Resident #16 requesting a blanket or a bedpan from her during that shift.Interview with LPN #13 on 3/13/26 at 4:33 PM identified she has been employed by the facility since 11/11/24. LPN #13 indicated she does not remember if she was assigned to Resident #16 during 3:00 PM - 11:00 PM shift on 1/20/26. LPN #13 indicated she does not recall Resident #16 requesting a blanket or a bedpan from her during that shift. LPN #13 indicated the facility does have extra blankets and bedpans.Interview with NA #15 on 3/13/26 at 4:45 PM identified she has been employed by the facility since 10/5/18. NA #15 indicated she was not assigned to Resident #16 during 3:00 PM - 11:00 PM shift on 1/20/26. NA #15 indicated she does not recall Resident #16 requesting a blanket or a bedpan from her during that shift.Interview with LPN #7 on 3/13/26 at 4:50 PM identified she has been employed by the facility since 9/29/25. LPN #7 indicated she does not remember if she was assigned to Resident #16 during 3:00 PM - 11:00 PM shift on 1/20/26. LPN #7 indicated she does not recall Resident #16 requesting a blanket or a bedpan from her during that shift. LPN #7 indicated the facility does have extra blankets and bedpans.Attempts to interview NA #21 were unsuccessful.Review of the resident bill of rights identified the resident has the right to dignity, respect, and freedom: To be treated with consideration, respect, and dignity. Right to participate in one's own care: Receive adequate and appropriate care. 2. Resident #110 was admitted to the facility in December 2025 with diagnoses that included legal blindness, muscle wasting and atrophy, repeated falls, lumbar radiculopathy, and right knee osteoarthritis.The care plan dated 12/16/25 identified Resident #110 was at risk for skin breakdown related to immobility. Interventions included offer toileting every 2-3 hours while awake. Staff to check for incontinence and assist with changes routinely and as needed.The admission MDS dated [DATE] identified Resident #110 had intact cognition, was occasionally incontinent of bladder, frequently incontinent of bowel, and required partial/moderate assistance with toilet transfer and toileting hygiene.The care plan dated 12/22/25 identified Resident #110 had incontinent episodes. Interventions included conducting incontinence checks and providing care as needed. Encourage to use call light for assistance with toileting. Toilet resident as needed.The physician's order dated 1/1/26 directed to provide the resident with assist of one for bed mobility and stand, pivot, and transfer to wheelchair, and with ADL's and toileting and wheelchair level. Further, ambulation only with therapy.The resident grievance form dated 1/12/26 identified Resident #110 indicated that on 1/12/16 at approximately 5:00 AM, he/she rang the call light requesting a bedpan. According to the grievance documentation, the nurse aide instructed the resident to use his/her brief instead of providing a bedpan and subsequently, Resident #110 soiled his/her brief. Resident #110 indicated peri care was later provided. Resident #110 indicated the nurse aide said (shouldn't you be sleeping at this time). The Administrator and resident representative were notified. The resolution included providing education to staff regarding customer service, and the Social Worker to follow up with the resident.Review of the nursing home customer service handout sheet (no date and time) identified customer service is the act of providing residents, families, and visitors with respectful, helpful, and compassionate care while meeting their needs and expectations. Treat everyone with dignity. Address needs and questions promptly.Review of the staff in-service sign-in forms failed to reflect documentation of signature for NA #20 indicating the facility could not verify attendance for the staff member.Review of the weekly skin evaluation form dated 1/19/26 identified Resident #110 had no open areas or wounds.Review of the clinical record and facility documentation failed to reflect that (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the allegation was address or investigated.Interview with the DNS on 3/11/26 at 11:45 AM identified she was not aware that Resident #110 had requested a bedpan that was not provided at 5:00 AM on 1/12/26. The DNS indicated she had not reviewed the resident grievance form dated 1/12/26 and had not conducted an investigation regarding the allegations documented on the grievance form. The DNS indicated the Administrator had informed her during the morning meeting to provide staff with an in-service regarding customer service. The DNS indicated that she was not aware that the following staff member had not received the customer service in-service: NA #20. The DNS indicated that going forward she would review resident grievance forms and investigate any allegations related to customer service. The DNS indicated she was unaware which nurse aide had been assigned to Resident #110 at the time of the incident. The DNS indicated that Resident #110 should not be instructed to urinate or have a bowel movement in a brief, as this would be a dignity concern. The DNS indicated that when Resident #110 requested to use the bathroom, the nursing staff should have assisted him/her to the bathroom or provided a bedpan rather than instructing the resident to urinate or have a bowel movement in the brief.Interview with the Administrator on 3/11/26 at 11:55 AM identified she was aware of the resident grievance form dated 1/12/26. The Administrator indicated that she had informed the DNS during a morning meeting to provide staff with an in-service regarding customer service. The Administrator indicated she was not aware the DNS had not reviewed the resident grievance form dated 1/12/26 or conducted an investigation. Interview with NA #20 on 3/13/26 at 1:58 PM identified she has been employed by the facility since 11/12/24. NA #20 indicated she was assigned to Resident #110 on 1/11/26 on the 11:00 PM - 7:00 AM shift. NA #20 indicated on 1/12/26 at approximately 5:00 AM Resident #110 had rang the call light and requested to go to the bathroom. NA #20 indicated Resident #110 asked to be transferred into the wheelchair and taken to the bathroom. NA #20 indicated she explained to Resident #110 that it was not safe to transfer him/her into the wheelchair and take him/her to the bathroom. NA #20 indicated Resident #110 requires an assist of one with transfers. NA #20 indicated she instructed Resident #110 to soil the brief and that she would provide incontinent care afterward. NA#20 indicated she was not aware that Resident #110 had reported incident to the Social Worker. NA #20 indicated the nurse aides are allowed to make judgement calls regarding transferring residents from bed to wheelchair or wheelchair to bed. NA #20 indicated she did not feel it was safe to transfer Resident #110 and made a judgement call not to perform the transfer. NA #20 indicated she continued to provide care to Resident #110 until the resident was discharged home. NA #20 indicated she did not notify the RN supervisor or the floor nurse that the resident was not safe to transfer bed to wheelchair with assistance of one staff member. NA #20 indicated she did not recall telling the resident, (shouldn't you be sleeping at this time). Interview with LPN #11 on 3/13/26 at 2:42 PM identified she is from the agency. LPN #11 indicated she was not aware of Resident #110 having rung the call light for the bedpan and NA #20 instructed the resident to soil the brief. LPN #11 indicated RN #10 and NA #20 did not inform her of the issue during the 11:00 PM - 7:00 AM shift.Interview with RN #10 on 3/16/26 at 8:55 AM identified he worked on 1/11/26 during the 11:00 PM - 7:00 AM shift as the RN supervisor. RN #10 indicated he was an agency staff and that it was his first time working at the facility. RN #10 indicated he was not aware that NA #20 told Resident #110 to go to the bathroom in his/her brief. RN #10 indicated NA #20 should have offered a bedpan to Resident #110 and should not have instructed the resident to soil the brief. RN #10 indicated NA #20 should have notified LPN #11 or him if Resident #110 was not safe to transfer from the bed to the wheelchair to use the bathroom.Attempts to interview NA #21 were unsuccessful.Review of the resident bill of rights identified right to dignity, respect, and freedom: To be treated with consideration, respect, and dignity. Right to participate in one's own care: Receive adequate and appropriate care.

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

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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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for 1 of 5 residents (Resident #99) reviewed for resident rights, the facility failed to honor the residents request for a room change due to negative interactions with his/her roommate. Subsequently, the resident and his/her roommate had a resident-to-resident altercation. The findings include:Resident #99 was admitted to the facility in December 2022 with diagnoses that included schizoaffective disorder and dementia.The quarterly MDS dated [DATE] identified Resident #99 was moderately cognitively impaired and independent with bed mobility, transfers and ambulation.The care plan dated 10/19/25 identified Resident #99 had an actual mood problem related to dementia, schizoaffective disorder and anxiety. Interventions included monitoring mood, providing supportive psychotherapy and administering medications as ordered.Review of the grievances included a handwritten note from Resident #99 to an unidentified staff member requesting a room change due in part that he/she and roommate both hate each. This was attached to a separate resident grievance dated 11/10/25 and completed and signed by the Administrator, Nurse's note dated 1/26/26 at 6:15 PM identified Resident #99 engaged in a verbal altercation with his/her roommate. For de-escalation purposes, Resident #99 was relocated to an alternate room for the night. Management was to review and a decision pending. The resident representative was updated.Nurse's note dated 1/27/26 at 5:15 AM identified Resident #99 was observed in his/her original room at the beginning of shift, slept through the night with no behaviors.Social service note dated 2/9/26 at 6:12 PM identified the resident requested a room change due to roommate compatibility. A voice message was left for the resident representative with awaiting call back.Social service note dated 2/11/26 identified the requested room change would not take effect as intended peer's responsible party was not in agreement.Interview with Resident #99 on 2/24/26 at 8:26 AM identified he/she had frequent altercations with Resident #23 who often curses at him/her and keeps the TV too loud. Resident #99 indicated in recent days, while in their room, Resident #23 yelled the F word at him/her. In response, Resident #23 grabbed his/her leg momentarily. The frequent altercations have left Resident #99 feeling anxious and upset, often not wanting to stay in his/her room and had made requests to an alternate facility. Resident #99 further identified she had also been making repeated requests for a room change with nothing being done to honor his/her request.Interview with the Director of Social Services on 2/24/26 at 8:46 AM identified Resident #23 and Resident #99 were roommates who did not get along. Resident #99 complains Resident #23 keeps the TV too loud and Resident #23 complains about Resident #99's perfume. On 2/9/26, Resident #99 had called Resident #23 the B word. Both residents were ?socially' separated following the altercation and seen by psychiatry. Referrals have been made for Resident #99 to be transferred to an alternate facility which was under review The Director of Social Services further indicated she would have to refer to the facility's policies for abuse to determine any further required procedures.Interview with the Administrator on 2/25/26 at 9:59 AM identified although the handwritten room change request from Resident #99 was attached to a grievance she completed and signed dating back to 11/10/25, she stated she had not previously seen the note.Subsequent interview with the Director of Social services on 2/27/26 at 2:06 PM identified her hire date was 11/10/25. Therefore, she had not seen the handwritten request for a room change by Resident #99. A room change was planned following the verbal altercation on 2/9/26. However, the responsible party of the alternate roommate did not agree, and the facility census was at capacity so Resident #99 was not moved. The Director of Social Services further identified she did not explore any other room options to honor Resident #99's request at that time or any other time following an altercation.Review of the facility daily census dated 2/9/26 through 2/24/26 identified a capacity of 108 beds and between 100 and 105 occupied beds with no (continued on next page)

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented bed holds.Review of the facility policy for Room Changes directs that changes room and/or roommate assignments may change when considered necessary and/or when requested by the resident or resident representative. Reasons for a change in room or roommate could include incompatibility of residents in a shared room. Requests for changes in room or roommate should be communicated to the Social Service Designee. Prior to making a room/roommate assignment change, all persons involved including residents and their representatives, will be given advance notice of such a change as is possible, informing the resident and family as soon as possible of the room or roommate change, involving the resident in the decision and selection of a room or roommate when possible.The facility may make an emergency change in room or roommate assignment should it become necessary for the safety, health and well-being of the resident.

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F 0580

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 5 residents (Resident #93) reviewed for abuse, the facility failed to notify the physician and the resident representative of verbal and physical abuse by Resident #41 and for 2 of 5 residents (Resident #74 and 90) reviewed for nutrition, the facility failed to notify the physician of a significant weight gain in a timely manner. The findings include:

1a. Resident #41 was admitted to the facility in September 2004 with diagnoses that included schizophrenia, dementia, and anxiety disorder.

The annual MDS dated [DATE] identified Resident #41 had moderately impaired cognition.

A nurse's note dated 7/7/25 at 7:34 AM by LPN #5 (11:00 PM – 7:00 AM charge nurse) identified Resident #41 was observed at 5:00 AM having a verbal altercation with his/her roommate (Resident #93). LPN #5 identified the altercation occurred without a reason, and that Resident #41 continued with behaviors despite attempts at redirection, and that Resident #41 was observed yelling at other residents in the unit hallway. The note further identified that Resident #41 was observed by 3 facility staff kicking his/her roommate in the hallway. LPN #5 identified she notified her supervisor and that a referral to be seen by psychiatry in the morning had been placed.

A psychosocial evaluation note dated 7/7/25 identified that Resident #41 displayed rudeness towards his/her roommate and aggression towards staff overnight. The note further identified that individual psychotherapy would be provided 1 – 5 times monthly to reduce emotional symptoms.

A psychiatric evaluation note dated 7/8/25, by APRN #4, identified she was asked to see Resident #41 due to agitated behaviors per nursing. APRN #4 identified no signs of delusions, auditory or visual hallucinations, agitation or aggression. APRN #4 further identified no changes were recommended based on her evaluation.

A nurse's note dated 10/21/25 at 5:13 AM by LPN #5 identified Resident #41 was observed up all night yelling and screaming at his/her roommate for no reason. LPN #5 identified she attempted to redirect Resident #41 with no result.

Review of a Behavioral Health Visit Request/Follow Up Log identified a note on 10/21/25 which identified Resident #41 was up all night yelling at his/her roommate for no reason and accosting him/her for coughing.

A medical APRN note dated 10/31/25 identified during the visit, Resident #41 was mildly anxious, ambulating the hallway asking where is my roommate. The note further identified that staff reported Resident #41 had a recent escalation in behaviors that included yelling and screaming at his/her roommate during the night and being disruptive. The note also identified that redirection was not successful, and that Resident #41 was seen by the psychiatric provider with an increase of Risperdal ordered.

b. Resident #93 was admitted to the facility in May 2024 with diagnoses that included schizophrenia,
(continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	psychosis, and adjustment disorder. The clinical record identified Resident #41 had a room change to Resident #93's room on 3/13/25. The care plan dated 4/28/25 identified Resident #93 had potential for impaired thought processes related to difficulty expressing him/herself. Interventions included communicating with the resident and his/her resident representative regarding his/her needs. The quarterly MDS dated [DATE] identified Resident #93 had intact cognition. A psychiatric supportive services note by SW #3 on 11/8/25 identified Resident #93 reported ongoing issues with his/her roommate. A nurse's note dated 11/10/25 at 7:52 PM by RN #5 (7:00 AM – 3:00 PM RN Supervisor) identified Resident #93 requested to be transferred to another room, the room transfer was completed, and Resident #93's representative was notified. Review of a facility grievance form dated 11/12/25 (two days after the room change) identified Resident #93 requested a room change due to verbal abuse by his/her roommate. An undated letter addressed to the administrative office, which was attached to the grievance form was signed by Resident #93. The grievance form was completed by SW #1 (Social Work Director) and signed by Resident #93, SW #4, and the Administrator, identified that the resident's room was changed and the resident reported that things were better following the change. Review of the letter (attached to the grievance dated 11/12/25) written and signed by Resident #93 identified the following. Resident #41 abuses me verbally and has hit me a few times. I fight back and hopefully won't get violent and be in trouble for it. He/she does it every day when I enter the room or leave and when I go to my closet. I want a different room. Interview with Resident #93 on 2/24/26 at 3:18 PM identified he/she had been in the same room with Resident #41 since March 2025. Resident #93 identified beginning sometime in the summer, Resident #41 began to make advances towards him/her (Resident #93) that made him/her feel uncomfortable. Resident #93 identified once he/she rejected the advances, Resident #41 became more aggressive, and would intermittently yell at him/her for no reason. Resident #93 identified that over time, the yelling escalated from intermittent episodes to constant yelling overnight, and then occasionally included being hit or kicked by Resident #41. Resident #93 identified that by the time he/she had written the letter to the Administrator in November 2025, Resident #41 was yelling overnight several times a week, and anytime Resident #93 attempted to access his/her closet, which was located near the door and Resident #41's bed, Resident #41 would approach from behind and shove Resident #93 into the closet door. Resident #93 identified that he/she had reported the incidents several times to multiple nursing staff, but they had instructed Resident #93 to tell Resident #41 he/she did not want to talk and to stop the behavior. Resident #93 identified he/she tried but that only made Resident #41's behavior worse. Resident #93 identified that he/she would often sit in the hallway to avoid Resident #41 and only go in his/her room as necessary, but it did not help and the behaviors continued. Resident #93 reported he/she feared Resident #41 and did not feel safe while in the same room with him/her and so he/she wrote a letter to the Administrator and asked for a room change. Resident #93 identified no staff had ever offered to move him/her to another room prior to the letter, and after the (continued on next page)

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F 0580

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

room change, a staff member who he/she could not remember, followed up once to make sure the new room was working out.

Interview with SW #1 on 2/26/26 at 9:05 AM identified she began working at the facility on 11/10/25 and was shadowing SW #4 for the first few days. SW #1 identified that SW #4 had outstanding grievances that needed to be completed and to help SW #4 out, she completed the grievance form for Resident #93's request for a room change but did not address the issue herself. SW #1 was unable to identify if Resident #93's allegation of abuse was addressed outside of his/her request for a room change and reiterated that it was SW #4's responsibility.

Interview with the Administrator on 2/26/26 at 9:07 AM identified she received a letter from Resident #93 related to a room change but didn't read the letter from Resident #93 because she could not read the handwriting. The Administrator directed SW #4 to address it as a grievance and she did not make any attempt to discuss or review the letter with Resident #93, and was unaware that the letter, addressed to her, included allegations of daily verbal and physical abuse by Resident #41. The Administrator further identified she was unaware of the incidents documented in Resident #41's clinical record related to verbal and physical altercation with Resident #93 on 7/7/25 or verbal altercation on 10/21/25.

Interview with RN #5 (7:00 AM – 3:00 PM supervisor) on 2/26/26 at 10:55 AM identified he assisted with Resident #93's room change but was not sure why Resident #93 had made the request. RN #5 identified based on his recollection, Resident #93 had approached him sometime during the day on 11/10/25 to request the room change. RN #5 identified he was unsure who he spoke to about the issue. RN #5 identified that he was not aware of Resident #93's grievance or the allegations of abuse by Resident #41 or yelling overnight by Resident #41, and that he was not aware of any issues between the residents. RN #5 identified that when Resident #93 was moving his/her belongings to the new room on 11/10/25, he did recall Resident #41 asking him where his/her roommate was going and said (I love my roommate).

Interview with NA #3 on 2/26/26 at 11:43 AM identified that she worked on the 11:00 PM – 7:00 AM shift but did not recall being assigned to Resident #41 and Resident #93's unit. NA #3 identified that while she was not assigned to the residents, it was common knowledge with the nursing staff throughout the facility that Resident #41 would confront Resident #93 with aggressive behaviors on a regular basis. NA #3 identified she never saw Resident #41 become physical with Resident #93 on 7/7/25 but did witness on multiple occasions Resident #41 yelling at Resident #93 overnight, and witnessed Resident #41 go directly into Resident #93's face and yell on multiple occasions. NA #3 identified it was very hard to redirect Resident #41 away from Resident #93 and to deescalate the behaviors. NA #3 also identified that while she did not observe Resident #41 attempt to hit or kick Resident #93, Resident #41 had attempted to hit her in the past but stopped before actually striking her. NA #3 identified that Resident #41 was verbally abusive to Resident #93, and the behavior had gone on for several months in 2025. NA #3 also indicated that Resident #93 had reported to her she was afraid of Resident #41. NA #3 identified Resident #41 felt disrespected because Resident #93 would not speak with him/her, and that caused Resident #41 to escalate and begin yelling. NA #3 identified that she reported behaviors to the unit charge nurse but was unable to provide any specifics on the nurse or when she reported the issues. NA #3 reported that staff at the facility would attempt to redirect Resident #41 but a room change was not attempted prior to 11/10/25. NA #3 indicated she was not aware of any other interventions to protect Resident #93, and that she never observed Resident #93 being aggressive or instigating any altercations with Resident #41. NA #3 also identified that it was the longstanding culture of the nursing staff, including the nurse aides and licensed
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nurses, to ignore Resident #41's behaviors and not address the issues, which was likely why Resident #93 had to self-request the room change. Interview with SW #3 on 2/26/25 at 12:17 PM identified that Resident #93 had reported issues with Resident #41, however the issues were that Resident #93 found Resident #41 to be annoying. SW #3 identified Resident #93 reported Resident #41 was loud and she had a hard time sleeping because of this, but did not report any physical abuse, safety or inappropriate behavior. Interview with APRN #4 on 2/26/26 at 1:26 PM identified that she was not aware of any issues related to Resident #41 and Resident #93, including any issues related to physical or verbal altercations. Interview with the DNS on 2/26/26 at 1:42 PM identified that she had been the DNS of the facility since March 2025. The DNS identified that she was not aware of any issues between Resident #41 and Resident #93, was not aware of the incidents on 7/7/25 or 10/21/25, and was not aware of the letter written by Resident #93 to the Administrative office in November 2025 which alleged daily abuse by Resident #41, and was not aware why Resident #93 requested a room change. The DNS identified that following the incident on 7/7/25, the residents should have been placed in separate rooms for safety and if Resident #41 did not respond to redirection, the resident should have been sent to the hospital for psychiatric evaluation. The DNS also identified that the medical and psychiatric providers should have been notified of every incident between the residents as well as the resident representatives, and that social work should have been involved. Interview with LPN #5 on 2/27/26 at 6:38 AM identified there had been an ongoing issue between Resident #41 and Resident #93 for several months in 2025. LPN #5 identified she observed that Resident #41 wanted to be close friends with Resident #93, but Resident #93 was not interested in any friendship or interactions with Resident #41. LPN #5 identified that Resident #41 responded to the rejection by becoming angry and aggressive towards Resident #93, and Resident #41 appeared to fixate on Resident #93 and would often ask where Resident #93 was when he/she left the room. LPN #5 identified that the staff were aware of the issues between Resident #41 and Resident #93, and that it regularly occurred during the evening and overnight shifts, but that she was the only nurse who would document Resident #41's behaviors towards Resident #93 as other nursing staff did not want their names associated with the incidents. LPN #5 identified that on 7/7/25, she observed Resident #41 kick and slap Resident #93 while he/she was in the hallway. LPN #5 could not recall who the other 3 staff were who were present during the incident. LPN #5 identified that she, along with the 3 staff, separated Resident #41 and Resident #93 following the incident. LPN #5 identified she notified the RN supervisor of the incident. LPN #5 indicated it may have been RN #5 (7:00 AM – 3:00 PM RN Supervisor) or RN #6, a prior 11:00 PM – 7:00 AM supervisor who is no longer employed at the facility. LPN #5 identified that she recalled assessing Resident #93 following the incident but did not document. LPN #5 identified that she put a request in the Behavioral Health Visit Request/Follow Up Log for Resident #41 to be seen following the incident, and no further action was taken on her part. LPN #5 also identified she was present for the incident on 10/21/25, and Resident #41 was yelling all night at Resident #93 and did not respond to any redirection by staff. LPN #5 identified she was unsure if she notified the supervisor, but that she placed another request in the Behavioral Health Visit Request/ Follow Up Log for Resident #41 to be seen. LPN #5 identified she had repeatedly notified the DNS and prior Administrator of the issues with Resident #41 and Resident #93, and they were aware of the incidents between the residents. LPN #5 also identified that she would often place requests in the Behavioral Health Visit Request/Follow Up Log when Resident #41 would have behaviors overnight and would attempt to redirect Resident #41, but this often did not work. LPN #5 (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was unable to identify any additional interventions related to Resident #41 and Resident #93, or why she failed to document any incidents or subsequent assessments in Resident #93's clinical record. Although attempted, an interview with RN #6 and SW #4 was not obtained. Review of Resident #93's clinical record failed to reflect that the physician and resident representative had been notified of the witnessed verbal and physical abuse on 7/7/25, the verbal abuse on 10/21/25, or the grievance dated 11/12/25. Further, the clinical record failed to reflect the physician and resident representative had been notified of the letter Resident #93 wrote to the administrative office that identified daily abuse by the roommate. Interview with the Medical Director on 3/11/26 at 10:56 AM and review of Resident #93's clinical record, grievance, and letter requesting a room change identified that he was recently notified by the DNS at a medical director meeting that Resident #41 and Resident #93 were placed in separate rooms, but he was not made aware of the specific issues that prompted the room change. In review of the nurses note dated 7/7/25 with the Medical Director he identified he had not been notified that Resident #41 had yelled at and kicked Resident #93 and he was not aware that Resident #41 had also slapped Resident #93, which was ascertained during a staff interview. The Medical Director identified he was not aware of any additional incidents, including the 10/21/25 verbal altercation, or the letter written by Resident #93 and given to the Administrator on 11/10/25 which alleged daily verbal and physical abuse by Resident #41. The Medical Director identified first and foremost, he would expect all staff to keep the residents safe and this would include a room change separating Resident #41 and Resident #93 immediately following the incident on 7/7/25. The Medical Director also identified Resident #41 and Resident #93 should have had physical assessments by a medical provider to determine if they were harmed as a result of the incidents, and to determine if there was a medical cause for Resident #41's behavior. The Medical Director identified that an accident and incident investigation should have been completed, the state agency should have been notified immediately following the incidents, and psychiatric follow-up should have been provided. Further, the residents care plans should have been updated and a root cause analysis should have been done to determine the cause of the incident. The Medical Director identified that the facility had open beds, and if the residents had been separated following 7/7/25, the incident on 10/21/25 and allegations identified by Resident #93 in the letter to the Administrator would not have occurred. The Medical Director also identified that it was completely unacceptable to make a note in a resident's chart regarding any verbal or physical altercation and not do anything else. The Medical Director identified at a minimum, the residents should have been separated and assessed to ensure they were safe. The facility policy on Abuse, Neglect and Exploitation directed that abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain or mental anguish. The policy also directed an alleged violation was a situation or occurrence observed or reported by staff, resident, relative, or others but had not yet investigated and if verified, could be an indication of noncompliance of federal requirements with abuse. The policy further directed mental abuse included, but was not limited to, humiliation, harassment, threats of punishment, or deprivation, and physical abuse included, but was not limited to, hitting, slapping, punching, biting, and kicking. The policy also identified that possible indicators of abuse included but were not limited to resident reports of abuse, verbal abuse of a resident overheard, physical abuse of a resident observed, and psychological abuse of a resident observed. The policy further identified that an immediate investigation was warranted when suspicion of abuse or reports of abuse occur. The policy also (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	identified that the facility would make efforts to ensure all residents were protected from physical and psychosocial harm as well as additional abuse during and after an investigation. Examples included but were not limited to responding immediately to protect the alleged victim and the integrity of the investigation, examining the alleged victim for any sign of injury including a physical exam or psychosocial assessment, increased supervision of the alleged victim and residents, room changes if necessary to protect the resident from the alleged perpetrator, protection from retaliation, provide emotional support and counseling to the resident during and after the investigation if needed, and revision of the residence care plan if the residents medical, nursing, physical, mental, or psychosocial needs change as a result of an incident of abuse. The policy also directed that reporting of all alleged violations to the Administrator, state agency, Adult Protective Services and all other required agencies including law enforcement when applicable, should be done immediately but not later than two hours after an allegation was made, if the events that cause the allegation involve abuse. The facility policy on Accident and Incidents directed that an incident was any occurrence or event that caused trouble or disrupted the normal procedure of the facility. The policy further directed that following an accident or incident, the charge nurse or designee was responsible to examine the victim, notify the physician of the incident, and notify the resident representative of the incident. The policy further directed the charge nurse, or designee, must investigate immediately and the following data must be included in the Accident investigation report form: The date and time the incident took place. The circumstances surrounding the incident. The names of any witnesses and their account of the incident. The injured person's account of the incident. The time the injured person's attending physician was notified, time of response, and instructions. The date and time the injured person's resident representative was notified and by whom. Disposition of the injured person. Corrective action taken. Other pertinent data as necessary or required Signature and title of the person completing the report. Submission of the report to the DNS. The facility policy on Change in a Resident's Condition or Status directed the nurse would notify the resident's attending physician or an on-call physician when there was an incident involving a resident or there was a significant change in the resident's physical/emotional/mental condition. The policy directed that a significant change of condition was a major decline in the resident status that would not normally resolve itself without intervention by staff. The policy also directed that the nurse would notify the resident representative when the resident was involved in any incident that resulted in an injury, there was a significant change in the resident's physical, mental or psychosocial status. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #74 was admitted to the facility in February 2020 with diagnoses that included severe morbid obesity due to excess calories, diabetes, hypothyroidism, and celiac disease. The quarterly MDS dated [DATE] identified Resident #74 had severely impaired cognition and required setup or clean-up assistance with eating. The weights summary dated 12/23/25 identified Resident #74 weighed 140.2 lbs. Review of the nutrition evaluation dated 12/24/25 identified Resident #74 was on a regular diet and was independent with meals. Resident #74 was very selective about what he/she eats. Glucerna was offered at breakfast and lunch. Resident #74 refused supplement. Resident #74 realized significant weight loss over a 180 day period. The resident was informed of the weight loss. Weekly weight times four weeks and follow up. Documentation indicated the resident's skin was intact at the time of review. Continue to monitor and follow up as needed. The weights summary dated 12/31/25 identified Resident #74 weighed 145.8 lbs. The weights summary dated 1/6/26 identified Resident #74 weighed 145.0 lbs. The weights summary dated 1/12/26 identified Resident #74 weighed 145.8 lbs. The physician's order dated 2/1/26 directed to provide a regular diet and thin liquids consistency, weigh the resident every week for 4 weeks and then monthly unless otherwise indicated. The weights summary dated 2/3/26 identified Resident #74 weighed 179.2 lbs., a 33.4 lbs. weight gain over 23 days. The dietitian note dated 2/9/26 at 2:32 PM identified Resident #74 had a weight gain. Weight changed from 145.8 lbs. on 1/12/26 to 179.2 lbs. on 2/3/26. Request a weight recheck and follow up. Review of the clinical record and nurse's note dated 2/9/26 through 2/16/26 failed to reflect documentation of a weight recheck and follow up. The note failed to reflect documentation that the physician and the resident representative were notified of the weight gain. The weights summary dated 2/17/26 identified Resident #74 weighed 181.8 lbs. Review of the nurse's note dated 2/17/26 through 2/26/26 failed to reflect documentation that the physician and the resident representative were notified of the weight gain. Review of the nutrition evaluation dated 2/25/26 identified Resident #74 was on a regular diet and was independent with meals. The resident's intake varies and that the resident has been asking for ice cream with every meal, and he/she receives cold cereal as well as oatmeal with breakfast. Resident #74 agreed to stop ice cream at each meal and will have ice cream only at lunch. Resident #74 agreed to have only oatmeal at breakfast. Resident #74 was educated regarding diagnoses of diabetes but insisted he/she is not diabetic and requested a regular diet. Current weight 181.8 lbs. Start weekly weight times four weeks. Interview with RN #5 (nursing supervisor) on 2/27/26 at 8:37 AM identified he was not aware of Resident #74's weight gain. RN #5 indicated the charge nurse was to notify him of any weight (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	discrepancies. RN #5 indicated he was going to reweigh and assess Resident #74. RN #5 indicated he would notify the APRN and the resident representative. Interview with the Dietitian on 2/27/26 at 8:59 AM identified she was responsible for reviewing the resident weights and she was aware of Resident #74's weight gain. The Dietitian indicated she reviewed Resident #74's weights, and identified a weight gain on 2/3/26, and documented a progress note on 2/9/26 requesting a weight recheck. The Dietitian indicated she notified the nursing staff including the RN Supervisor and the DNS that Resident #74 required a weight recheck; however, the weight was not rechecked. The Dietitian indicated that significant weight changes are discussed during the facility's risk meeting and that Resident #74's weight gain was discussed. The Dietitian indicated she assessed Resident #74 on 2/25/26 regarding a weight of 181.8 pounds. The Dietitian indicated that on 2/25/26 she provided the APRN with a list of residents who had significant weight changes. The Dietitian identified Resident #74's weight gain would be considered significant given the weight gain happened in 23 days, and she would have expected to be notified to provide recommendations. Interview with the DNS on 2/27/26 at 9:14 AM identified she was not aware of Resident #74's weight gain of 33.4 lbs. The DNS indicated that the nurse aide obtains resident weights at the beginning of each month and reports the weight to the charge nurse, who documents the weight in the resident's clinical record. The DNS indicated that if there is a discrepancy in a resident's weight, the nursing supervisor reweighs and assesses the resident. The DNS indicated the supervisor is responsible for notifying the physician and/or the APRN and the resident representative of significant weight changes. The dietitian is also notified and assessed the residents. The DNS indicated during the facility risk meeting, the dietitian discusses residents with weight concerns. The DNS indicated that the dietitian did not discuss Resident #74 during the risk meeting. Interview with APRN #2 on 2/27/26 at 10:20 AM identified she was not notified of Resident #74's weight gain of 33.4 lbs. in 23 days. APRN #2 indicated it is the responsibility of the licensed nurses and the supervisors to notify her of any changes in the residents. APRN #2 indicated she will assess Resident #74 and review the weights. Subsequent to surveyor inquiry, an RN, and APRN assessment were performed. The change in condition note dated 2/27/26 at 1:18 PM identified weight gain assessment by RN supervisor and APRN. Resident #74 indicated that weight gain and weight loss that is not the first time there is nothing wrong with that. The DNS was notified and resident representative was called with no answer. The APRN note dated 2/27/26 identified an assessment of Resident #74 was performed regarding a weight gain, review of blood sugar, and abdominal folds redness. The note documented a current weight of 181.8 pounds. Resident #74 denied shortness of breath or difficulty breathing. Edema to the left lower extremity was noted as significantly improved. Lung sounds were documented as clear bilaterally with normal respiratory effort. The plan included obtaining daily weights for 14 days, notifying the MD/APRN if weight increased greater than 3 pounds in one day, and obtaining stat labs. Although attempted, an interview with LPN #2 was not obtained. Review of the facility change in a resident's condition or status policy identified the facility shall promptly notify the resident, his or her attending physician, and representatives of changes in the (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's medical/mental condition and/or status. Review of the facility acute condition changes/RN assessment – clinical protocol policy identified as part of the initial assessment, the physician/RN will help identify individuals with a significant risk for having acute changes of condition during their stay. The nursing staff will contact the physician based on the urgency of the situation. Review of the facility weight assessment and intervention policy identified the nursing staff will measure resident weight on day of admission and/or readmission, the day after and weekly times 4. If no weight concerns are noted at this point, weights will be measured monthly thereafter. Weights will be recorded in each resident's medical record. Any weight change of 5 lbs. less or more since the last weight assessment will be retaken. If the weight is verified and is determined a weight loss, nursing will consult the Dietitian, MD and the resident representative. The dietitian will review the unit weight record monthly and as needed to follow individual weights trends over time. 3. Resident #90 had diagnoses that included type II diabetes and anemia. The quarterly MDS dated [DATE] identifi

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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 3 of 5 residents (Resident #93, 23 and 99) reviewed for abuse, the facility failed to report allegations of abuse to the state agency according to regulatory requirement and facility policy. The findings include: 1a. Resident #41 was admitted to the facility in September 2004 with diagnoses that included schizophrenia, dementia, and anxiety disorder. The annual MDS dated [DATE] identified Resident #41 had moderately impaired cognition. A nurse's note dated 7/7/25 at 7:34 AM by LPN #5 (11:00 PM – 7:00 AM charge nurse) identified Resident #41 was observed at 5:00 AM having a verbal altercation with his/her roommate. LPN #5 identified the altercation occurred without a reason, and that Resident #41 continued with behaviors despite attempts at redirection, and that Resident #41 was observed yelling at other residents in the unit hallway. The note further identified that Resident #41 was observed by 3 facility staff kicking his/her roommate in the hallway. LPN #5 identified she notified her supervisor and that a referral to be seen by psychiatry in the morning had been placed. Review of the accident and incident reports and state agency reportable event portal regarding the 7/7/25 incident identified the facility did not complete an accident and incident report or report the allegation of abuse to the state agency. A psychiatric evaluation note dated 7/8/25, by APRN #4, identified she was asked to see Resident #41 due to agitated behaviors per nursing. APRN #4 identified no signs of delusions, auditory or visual hallucinations, agitation or aggression. APRN #4 further identified no changes were recommended based on her evaluation. A nurse's note dated 10/21/25 at 5:13 AM by LPN #5 identified Resident #41 was observed up all night yelling and screaming at his/her roommate for no reason. LPN #5 identified she attempted to redirect Resident #41 with no result. Review of the accident and incident reports and state agency reportable event portal regarding the 10/21/25 witnessed all night screaming by Resident #41 at Resident #93 identified the facility did not complete an accident and incident report or report the verbal abuse to the state agency. Review of a Behavioral Health Visit Request/Follow Up Log identified a note on 10/21/25 which identified Resident #41 was up all night yelling at his/her roommate for no reason and accosting him/her for coughing. A medical APRN note dated 10/31/25 identified Resident #41 during the visit, Resident #41 was mildly anxious, ambulating the hallway asking where is my roommate. The note further identified that staff reported Resident #41 had a recent escalation in behaviors that included yelling and screaming at his/her roommate during the night and being disruptive. The note also identified that redirection was not successful, and that Resident #41 was seen by the psychiatric provider with an increase of Risperdal ordered. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Resident #93 was admitted to the facility in May 2024 with diagnoses that included schizophrenia, psychosis, and adjustment disorder. The care plan dated 4/28/25 identified Resident #93 had potential for impaired thought processes related to difficulty expressing him/herself. Interventions included communicating with the resident and his/her resident representative regarding his/her needs. The quarterly MDS dated [DATE] identified Resident #93 had intact cognition. A nurse's note dated 11/10/25 at 7:52 PM by RN #5 (7:00 AM – 3:00 PM RN Supervisor) identified Resident #93 requested to be transferred to another room, the room transfer was completed, and Resident #93's representative was notified. Review of a facility grievance form dated 11/12/25 (two days after the room change) identified Resident #93 requested a room change due to verbal abuse by his/her roommate. An undated letter addressed to the administrative office, which was attached to the grievance form was signed by Resident #93. The grievance form was completed by SW #1 (Social Work Director) and signed by Resident #93, SW #4, and the Administrator, and identified that the resident's room was changed and the resident reported that things were better following the change. Review of the letter (attached to the grievance dated 11/12/25) written and signed by Resident #93 identified the following. Resident #41 abuses me verbally and has hit me a few times. I fight back and hopefully won't get violent and be in trouble for it. He/she does it every day when I enter the room or leave and when I go to my closet. I want a different room. The form also identified that Resident #41's resident representative was notified of the grievance, that local law enforcement was not notified, and that the grievance did not result in a state agency reportable event. Review of the accident and incident reports and state agency reportable event portal regarding the grievance dated 11/12/25 and the undated letter from Resident #93 to the administrative office identified the facility did not complete an accident and incident report or report the allegation of verbal and physical abuse to the state agency. Interview with Resident #93 on 2/24/26 at 3:18 PM identified he/she had been in the same room with Resident #41 since March 2025. Resident #93 identified beginning sometime in the summer, Resident #41 began to make advances towards him/her (Resident #93) that made him/her feel uncomfortable. Resident #93 identified once he/she rejected the advances, Resident #41 became more aggressive, and would intermittently yell at him/her for no reason. Resident #93 identified that over time, the yelling escalated from intermittent episodes to constant yelling overnight, and then occasionally included being hit or kicked by Resident #41. Resident #93 identified that by the time he/she had written the letter to the Administrator in November 2025, Resident #41 was yelling overnight several times a week, and anytime Resident #93 attempted to access his/her closet, which was located near the door and Resident #41's bed, Resident #41 would approach from behind and shove Resident #93 into the closet door. Resident #93 identified that he/she had reported the incidents several times to multiple nursing staff, but they had instructed Resident #93 to tell Resident #41 he/she did not want to talk and to stop the behavior. Resident #93 identified he/she tried but that only made Resident #41's behavior worse. Resident #93 identified that he/she would often sit in the hallway to avoid Resident #41 and only go in his/her room as necessary, but it did not help and the behaviors continued. Resident #93 reported he/she feared Resident #41 and did not feel safe while in the same room with him/her and so he/she wrote a letter to the Administrator and asked for a room change. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #93 identified no staff had ever offered to move him/her to another room prior to the letter, and after the room change, a staff member who he/she could not remember, followed up once to make sure the new room was working out. Interview with the Administrator on 2/26/26 at 9:07 AM identified she received a letter from Resident #93 related to a room change but didn't read the letter from Resident #93 because she could not read the handwriting. The Administrator directed SW #4 to address it as a grievance and she did not make any attempt to discuss or review the letter with Resident #93, and was unaware that the letter, addressed to her, included allegations of daily verbal and physical abuse by Resident #41. The Administrator further identified she was unaware of the incidents documented in Resident #41's clinical record related to verbal and physical altercation with Resident #93 on 7/7/25 or verbal altercation on 10/21/25. Interview with RN #5 (7:00 AM – 3:00 PM supervisor) on 2/26/26 at 10:55 AM identified he assisted with Resident #93's room change but was not sure why Resident #93 had made the request. RN #5 identified based on his recollection, Resident #93 had approached him sometime during the day on 11/10/25 to request the room change. RN #5 identified he was unsure who he spoke to about the issue. RN #5 identified that he was not aware of Resident #93's grievance or the allegations of abuse by Resident #41 or yelling overnight by Resident #41, and that he was not aware of any issues between the residents. RN #5 identified that when Resident #93 was moving his/her belongings to the new room on 11/10/25, he did recall Resident #41 asking him where his/her roommate was going and said (I love my roommate). Interview with NA #3 on 2/26/26 at 11:43 AM identified that she worked on the 11:00 PM – 7:00 AM shift but did not recall being assigned to Resident #41 and Resident #93's unit. NA #3 identified that while she was not assigned to the residents, it was common knowledge with the nursing staff throughout the facility that Resident #41 would confront Resident #93 with aggressive behaviors on a regular basis. NA #3 identified she never saw Resident #41 become physical with Resident #93 on 7/7/25 but did witness on multiple occasions Resident #41 yelling at Resident #93 overnight, and witnessed Resident #41 go directly into Resident #93's face and yell on multiple occasions. NA #3 identified it was very hard to redirect Resident #41 away from Resident #93 and to deescalate the behaviors. NA #3 also identified that while she did not observe Resident #41 attempt to hit or kick Resident #93, Resident #41 had attempted to hit her in the past but stopped before actually striking her. NA #3 identified that Resident #41 was verbally abusive to Resident #93, and the behavior had gone on for several months in 2025. NA #3 also indicated that Resident #93 had reported to her she was afraid of Resident #41. NA #3 identified Resident #41 felt disrespected because Resident #93 would not speak with him/her, and that caused Resident #41 to escalate and begin yelling. NA #3 identified that she reported behaviors to the unit charge nurse but was unable to provide any specifics on the nurse or when she reported the issues. NA #3 reported that staff at the facility would attempt to redirect Resident #41 but a room change was not attempted prior to 11/10/25. NA #3 indicated she was not aware of any other interventions to protect Resident #93, and that she never observed Resident #93 being aggressive or instigating any altercations with Resident #41. NA #3 also identified that it was the longstanding culture of the nursing staff, including the nurse aides and licensed nurses, to ignore Resident #41's behaviors and not address the issues, which was likely why Resident #93 had to self-request the room change. Interview with APRN #4 on 2/26/26 at 1:26 PM identified that she was not aware of any issues related to Resident #41 and Resident #93, including any issues related to physical or verbal altercations. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DNS on 2/26/26 at 1:42 PM identified that she had been the DNS of the facility since March 2025. The DNS identified that she was not aware of any issues between Resident #41 and Resident #93, was not aware of the incidents on 7/7/25 or 10/21/25, and was not aware of the letter written by Resident #93 to the Administrative office in November 2025 which alleged daily abuse by Resident #41, and was not aware why Resident #93 requested a room change. The DNS identified that following the incident on 7/7/25, the residents should have been placed in separate rooms for safety and if Resident #41 did not respond to redirection, the resident should have been sent to the hospital for psychiatric evaluation. The DNS also identified that the medical and psychiatric providers should have been notified of every incident between the residents as well as the resident representatives, and that social work should have been involved. The DNS identified that investigations should have also taken place on 10/21/25 and 11/10/25, and both incidents should have been reported to the state agency immediately. Interview with LPN #5 on 2/27/26 at 6:38 AM identified there had been an ongoing issue between Resident #41 and Resident #93 for several months in 2025. LPN #5 identified she observed that Resident #41 wanted to be close friends with Resident #93, but Resident #93 was not interested in any friendship or interactions with Resident #41. LPN #5 identified that Resident #41 responded to the rejection by becoming angry and aggressive towards Resident #93, and Resident #41 appeared to fixate on Resident #93 and would often ask where Resident #93 was when he/she left the room. LPN #5 identified that the staff were aware of the issues between Resident #41 and Resident #93, and that it regularly occurred during the evening and overnight shifts, but that she was the only nurse who would document Resident #41's behaviors towards Resident #93 as other nursing staff did not want their names associated with the incidents. LPN #5 identified that on 7/7/25, she observed Resident #41 kick and slap Resident #93 while he/she was in the hallway. LPN #5 could not recall who the other 3 staff were who were present during the incident. LPN #5 identified that she, along with the 3 staff, separated Resident #41 and Resident #93 following the incident. LPN #5 identified she notified the RN supervisor of the incident. LPN #5 indicated it may have been RN #5 (7:00 AM – 3:00 PM RN Supervisor) or RN #6, a prior 11:00 PM – 7:00 AM supervisor who is no longer employed at the facility. LPN #5 identified that she recalled assessing Resident #93 following the incident but did not document. LPN #5 identified that she put a request in the Behavioral Health Visit Request/Follow Up Log for Resident #41 to be seen following the incident, and no further action was taken on her part. LPN #5 also identified she was present for the incident on 10/21/25, and Resident #41 was yelling all night at Resident #93 and did not respond to any redirection by staff. LPN #5 identified she was unsure if she notified the supervisor, but that she placed another request in the Behavioral Health Visit Request/ Follow Up Log for Resident #41 to be seen. LPN #5 identified she had repeatedly notified the DNS and prior Administrator of the issues with Resident #41 and Resident #93, and they were aware of the incidents between the residents. LPN #5 also identified that she would often place requests in the Behavioral Health Visit Request/Follow Up Log when Resident #41 would have behaviors overnight and would attempt to redirect Resident #41, but this often did not work. LPN #5 was unable to identify any additional interventions related to Resident #41 and Resident #93, or why she failed to document any incidents or subsequent assessments in Resident #93's clinical record. Interview with the Medical Director on 3/11/26 at 10:56 AM and review of Resident #93's clinical record, grievance, and letter requesting a room change identified he was not made aware that Resident #41 had slapped Resident #93, which was ascertained during a staff interview or of any additional incidents, including the 10/21/25 verbal altercation, or the letter written by Resident #93 and given to the Administrator on 11/10/25 which alleged daily verbal and physical abuse by Resident #41. The Medical Director identified that he was recently notified by the DNS at a medical director meeting that Resident #41 and Resident #93 were placed in separate rooms, but he was not made (continued on next page)

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	aware of the specific issues that prompted the room change. The Medical Director identified that an accident and incident investigation should have been completed, the state agency should have been notified immediately following the incidents, and psychiatric follow-up should have been provided. In review of the nurses note dated 7/7/25 with the Medical Director he identified he had not been notified that Resident #41 had yelled at and kicked Resident #93 and he was not aware that Resident #41 had also slapped Resident #93, which was ascertained during a staff interview. The Medical Director identified he was not aware of any additional incidents, including the 10/21/25 verbal altercation, or the letter written by Resident #93 and given to the Administrator on 11/10/25 which alleged daily verbal and physical abuse by Resident #41. The Medical Director identified first and foremost, he would expect all staff to keep the residents safe and this would include a room change separating Resident #41 and Resident #93 immediately following the incident on 7/7/25. The Medical Director also identified Resident #41 and Resident #93 should have had physical assessments by a medical provider to determine if they were harmed as a result of the incidents, and to determine if there was a medical cause for Resident #41's behavior. The Medical Director identified that an accident and incident investigation should have been completed, the state agency should have been notified immediately following the incidents, and psychiatric follow-up should have been provided. Further, the residents care plans should have been updated and a root cause analysis should have been done to determine the cause of the incident. The Medical Director identified that the facility had open beds, and if the residents had been separated following 7/7/25, the incident on 10/21/25 and allegations identified by Resident #93 in the letter to the Administrator would not have occurred. The Medical Director also identified that it was completely unacceptable to make a note in a resident's chart regarding any verbal or physical altercation and not do anything else. The Medical Director identified at a minimum the residents should have been separated and assessed to ensure they were safe. Although attempted, an interview with RN #6 and SW #4 was not obtained. Review of facility documentation identified accident and incident reports regarding alleged and witnessed verbal and physical abuse of Resident #93 by Resident #41 not been filed during all of 2025. Review of the state agency reportable events portal failed to identify any incidents regarding alleged and witnessed verbal and physical abuse of Resident #93 by Resident #41 had been reported in 2025. The facility policy on Abuse, Neglect and Exploitation directed that abuse was the willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain or mental anguish. The policy also directed an alleged violation was a situation or occurrence observed or reported by staff, resident, relative, or others but had not yet investigated and if verified, could be an indication of noncompliance of federal requirements with abuse. The policy further directed mental abuse included, but was not limited to, humiliation, harassment, threats of punishment, or deprivation, and physical abuse included, but was not limited to, hitting, slapping, punching, biting, and kicking. The policy also identified that the facility would make efforts to ensure all residents were protected from physical and psychosocial harm as well as additional abuse during and after an investigation. The policy also directed that reporting of all alleged violations to the Administrator, state agency, adult Protective Services and all other required agencies including law enforcement when applicable should be done immediately, but not later than two hours after an allegation was made, if the events that cause the allegation involved abuse. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2a. Resident #99 was admitted to the facility in December 2022 with diagnoses that included schizoaffective disorder and dementia. The quarterly MDS dated [DATE] identified Resident #99 was moderately cognitively impaired and independent with bed mobility, transfers and ambulation. The care plan dated 10/19/25 identified Resident #99 had an actual mood problem related to dementia, schizoaffective disorder and anxiety. Interventions included monitoring mood, provide supportive psychotherapy and administer medications as ordered. b. Resident #23 was admitted to the facility in March 2022 with diagnoses that included stroke and major depressive disorder with mood disturbances. Nurse's note dated 3/12/25 identified Resident #99 moved to Resident #23's room and was adjusting to the new room. The annual MDS dated [DATE] identified Resident #23 was cognitively intact and required one person assist with bed mobility, two person assist with transfers and utilized a motorized wheelchair. The care plan dated 10/19/25 identified Resident #23 had a mood problem related to major depressive disorder with interventions that included psychiatric consultation for behavioral concerns and supportive services. For Resident #99, a social service note dated 2/9/26 at 6:12 PM identified he/she requested a room change due to roommate compatibility. A voice message was left for the responsible party with awaiting call back. For Resident #99, a social service note dated 2/11/26 identified the requested room change would not take effect as intended as the new roommates responsible party was not in agreement. For Resident #23, a social service note dated 2/9/26 identified Resident #23 reported not getting along with his/her roommate and requested the roommate be moved. For Resident #23, a social service note dated 2/11/26 identified the requested room change would not take effect as intended as the new roommates responsible party was not in agreement. Interview with Resident #99 on 2/24/26 at 8:26 AM identified he/she had frequent altercations with Resident #23 who often curses at him/her and keeps the TV too loud. Resident #99 indicated in recent days, while in their room, Resident #23 yelled the F word at him/her. In response, Resident #99 indicated he/she grabbed Resident #23's leg momentarily. The frequent altercations have left Resident #99 feeling anxious and upset, often not wanting to stay in his/her room and had made requests to an alternate facility and a room change with nothing being done to honor her request. Interview with the Director of Social Services on 2/24/26 at 8:46 AM identified Resident #23 and Resident #99 were roommates who did not get along. Resident #99 complains Resident #23 keeps the TV too loud and Resident #23 complains about Resident #99's scent. On 2/9/26, Resident #99 had called Resident #23 the B word. Both residents were 'socially' separated following the altercation and seen by psychiatry. When asked, the Director of Social Services indicated she would have to refer to the facility's policies for abuse to determine the required procedures. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Resident #23 on 2/24/26 at 8:36 AM identified he/she did not get along with Resident #99. Resident #23 indicated an altercation over the TV volume had taken place between the two residents on 2/22/26 in their room at approximately 2:30 AM. Resident #23 said the F word to Resident #99 who in response, grabbed Resident #23's right foot with both hands. Resident #23 told Resident #99 that he/she was going to report him/her for assault. Interview with NA #4 on 2/24/26 at 10:17 AM identified while the resident-to-resident incident that occurred on 2/22/26 was not reported to her, it was known that Resident #23 and Resident #99 did not get along. NA #4 had observed the two residents yelling at each other, with Resident #23 often swearing at Resident #99. These incidents were reported to the nurse who did their best to separate the two residents. Subsequent interview with the Director of Social Services on 2/24/26 at 2:50 PM clarified that on 2/9/26 Resident #99 called Resident #23 the B word, and in turn Resident #23 said the F word (F you) to Resident #99. The Director of Social Services further identified she notified the Director of Nursing and Administrator when the allegation of resident-to-resident verbal mistreatment was first reported to her on 2/9/26. A subsequent interview with Resident #23 on 2/25/26 at 7:15 AM identified Resident #23 often crossed his/her legs as a layer of protection when having an altercation with Resident #99. Resident #23 indicated altercations were frequent, however, the resident felt that Resident #99 had crossed the line when it became physical and told Resident #99 he/she could report him/her for assault. Resident #23 further identified there had been another recent incident earlier in the month that occurred in the hall. LPN #8 was present and separated the two residents. Resident #23 was aware that LPN #8 reported the incident to the social worker and was told there was going to be a room change, which never occurred. Interview and facility documentation review with the DNS on 2/25/26 at 9:30 AM identified she had not been notified of any other incidents that occurred between Resident #23 and Resident #99 prior to 2/24/26 and there was no prior incident reports related to resident-to-resident altercations. The DNS indicated for any resident-to-resident altercation, she would expect the two residents to be immediately separated, with notification to the nursing supervisor and herself. Interview with the DNS on 2/25/26 at 9:30 AM identified she had not been previously notified of any ongoing resident-to-resident verbal altercations between Resident #23 and Resident #99 prior to 2/24/26 and further identified there were no incident reports or reporting to the state agency related to those resident-to-resident altercations. The DNS indicated for any resident-to-resident altercation, she would expect the two residents to be immediately separated, with notification to the nursing supervisor and herself. Interview with the Administrator on 2/25/26 at 9:59 AM identified she was unaware of the ongoing resident-to-resident verbal altercations including the incident on 2/9/26 which had not been reported to her. The Administrator indicated that the incident on 2/9/26 should have been reported to the state agency. Review of the facility policy for Abuse directs that the facility provides protections for the health welfare and rights of each resident to develop and implement policies that prohibit and prevent abuse. All alleged violations are to be reported to the Administrator, state agency, adult protective services and all other required state agencies such as local law enforcement immediately, but no later than (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	two hours after the allegation is made if the events result in serious bodily injury , or 24 hours – if the alleged violation involves neglect, exploitation , mistreatment , or misappropriation of resident property; and does not result in serious bodily injury.

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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 documentation, facility policy, and interviews for 3 of 5 residents (Resident #93, 23 and 99) reviewed for abuse, the facility failed to ensure the allegations of abuse were thoroughly investigated and the residents protected from future abuse. The findings include: 1a. Resident #41 was admitted to the facility in September 2004 with diagnoses that included schizophrenia, dementia, and anxiety disorder. The annual MDS dated [DATE] identified Resident #41 had moderately impaired cognition. A nurse's note dated 7/7/25 at 7:34 AM by LPN #5 (11:00 PM – 7:00 AM charge nurse) identified Resident #41 was observed at 5:00 AM having a verbal altercation with his/her roommate. LPN #5 identified the altercation occurred without a reason, and that Resident #41 continued with behaviors despite attempts at redirection, and that Resident #41 was observed yelling at other residents in the unit hallway. The note further identified that Resident #41 was observed by 3 facility staff kicking his/her roommate in the hallway. LPN #5 identified she notified her supervisor and that a referral to be seen by psychiatry in the morning had been placed. Review of facility documentation regarding the 7/7/25 verbal and physical abuse identified no investigation had been completed nor was Resident #93 removed from the room or protected from future abuse. A psychiatric evaluation note dated 7/8/25, by APRN #4, identified she was asked to see Resident #41 due to agitated behaviors per nursing. APRN #4 identified no signs of delusions, auditory or visual hallucinations, agitation or aggression. APRN #4 further identified no changes were recommended based on her evaluation. A nurse's note dated 10/21/25 at 5:13 AM by LPN #5 identified Resident #41 was observed up all night yelling and screaming at his/her roommate for no reason. LPN #5 identified she attempted to redirect Resident #41 with no result. Review of facility documentation regarding the 10/21/25 witnessed all night screaming by Resident #41 at Resident #93 identified no investigation had been completed, nor was Resident #93 removed from the room or protected from future abuse. Review of a Behavioral Health Visit Request/Follow Up Log identified a note on 10/21/25 which identified Resident #41 was up all night yelling at his/her roommate for no reason and accosting him/her for coughing. A medical APRN note dated 10/31/25 identified Resident #41 during the visit, Resident #41 was mildly anxious, ambulating the hallway asking where is my roommate. The note further identified that staff reported Resident #41 had a recent escalation in behaviors that included yelling and screaming at his/her roommate during the night and being disruptive. The note also identified that redirection was not successful, and that Resident #41 was seen by the psychiatric provider with an increase of Risperdal ordered. b. Resident #93 was admitted to the facility in May 2024 with diagnoses that included schizophrenia, (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	psychosis, and adjustment disorder. The care plan dated 4/28/25 identified Resident #93 had potential for impaired thought processes related to difficulty expressing him/herself. Interventions included communicating with the resident and his/her resident representative regarding his/her needs. The quarterly MDS dated [DATE] identified Resident #93 had intact cognition. A nurse's note dated 11/10/25 at 7:52 PM by RN #5 (7:00 AM – 3:00 PM RN Supervisor) identified Resident #93 requested to be transferred to another room, the room transfer was completed, and Resident #93's representative was notified. Review of a facility grievance form dated 11/12/25 (two days after the room change) identified Resident #93 requested a room change due to verbal abuse by his/her roommate. An undated letter addressed to the administrative office, which was attached to the grievance form was signed by Resident #93. The grievance form was completed by SW #1 (Social Work Director) and signed by Resident #93, SW #4, and the Administrator, and identified that the resident's room was changed and the resident reported that things were better following the change. Review of the letter (attached to the grievance dated 11/12/25) written and signed by Resident #93 identified the following. Resident #41 abuses me verbally and has hit me a few times. I fight back and hopefully won't get violent and be in trouble for it. He/she does it every day when I enter the room or leave and when I go to my closet. I want a different room. The form also identified that Resident #41's resident representative was notified of the grievance, that local law enforcement was not notified, and that the grievance did not result in a state agency reportable event. Review of facility documentation regarding the 11/12/25 grievance and the undated letter from Resident #93 to the administrative office alleging daily abuse identified no investigation had been completed. Interview with Resident #93 on 2/24/26 at 3:18 PM identified he/she had been in the same room with Resident #41 since March 2025. Resident #93 identified beginning sometime in the summer, Resident #41 began to make advances towards him/her (Resident #93) that made him/her feel uncomfortable. Resident #93 identified once he/she rejected the advances, Resident #41 became more aggressive, and would intermittently yell at him/her for no reason. Resident #93 identified that over time, the yelling escalated from intermittent episodes to constant yelling overnight, and then occasionally included being hit or kicked by Resident #41. Resident #93 identified that by the time he/she had written the letter to the Administrator in November 2025, Resident #41 was yelling overnight several times a week, and anytime Resident #93 attempted to access his/her closet, which was located near the door and Resident #41's bed, Resident #41 would approach from behind and shove Resident #93 into the closet door. Resident #93 identified that he/she had reported the incidents several times to multiple nursing staff, but they had instructed Resident #93 to tell Resident #41 he/she did not want to talk and to stop the behavior. Resident #93 identified he/she tried but that only made Resident #41's behavior worse. Resident #93 identified that he/she would often sit in the hallway to avoid Resident #41 and only go in his/her room as necessary, but it did not help and the behaviors continued. Resident #93 reported he/she feared Resident #41 and did not feel safe while in the same room with him/her and so he/she wrote a letter to the Administrator and asked for a room change. Resident #93 identified no staff had ever offered to move him/her to another room prior to the letter, and after the room change, a staff member who he/she could not remember, followed up once to make (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sure the new room was working out. Interview with the Administrator on 2/26/26 at 9:07 AM identified she received a letter from Resident #93 related to a room change but didn't read the letter from Resident #93 because she could not read the handwriting. The Administrator directed SW #4 to address it as a grievance and she did not make any attempt to discuss or review the letter with Resident #93, and was unaware that the letter, addressed to her, included allegations of daily verbal and physical abuse by Resident #41. The Administrator further identified she was unaware of the incidents documented in Resident #41's clinical record related to verbal and physical altercation with Resident #93 on 7/7/25 or verbal altercation on 10/21/25. Interview with RN #5 (7:00 AM – 3:00 PM supervisor) on 2/26/26 at 10:55 AM identified he assisted with Resident #93's room change but was not sure why Resident #93 had made the request. RN #5 identified based on his recollection, Resident #93 had approached him sometime during the day on 11/10/25 to request the room change. RN #5 identified he was unsure who he spoke to about the issue. RN #5 identified that he was not aware of Resident #93's grievance or the allegations of abuse by Resident #41 or yelling overnight by Resident #41, and that he was not aware of any issues between the residents. RN #5 identified that when Resident #93 was moving his/her belongings to the new room on 11/10/25, he did recall Resident #41 asking him where his/her roommate was going and said (I love my roommate). Interview with NA #3 on 2/26/26 at 11:43 AM identified that she worked on the 11:00 PM – 7:00 AM shift but did not recall being assigned to Resident #41 and Resident #93's unit. NA #3 identified that while she was not assigned to the residents, it was common knowledge with the nursing staff throughout the facility that Resident #41 would confront Resident #93 with aggressive behaviors on a regular basis. NA #3 identified she never saw Resident #41 become physical with Resident #93 on 7/7/25 but did witness on multiple occasions Resident #41 yelling at Resident #93 overnight, and witnessed Resident #41 go directly into Resident #93's face and yell on multiple occasions. NA #3 identified it was very hard to redirect Resident #41 away from Resident #93 and to deescalate the behaviors. NA #3 also identified that while she did not observe Resident #41 attempt to hit or kick Resident #93, Resident #41 had attempted to hit her in the past but stopped before actually striking her. NA #3 identified that Resident #41 was verbally abusive to Resident #93, and the behavior had gone on for several months in 2025. NA #3 also indicated that Resident #93 had reported to her she was afraid of Resident #41. NA #3 identified Resident #41 felt disrespected because Resident #93 would not speak with him/her, and that caused Resident #41 to escalate and begin yelling. NA #3 identified that she reported behaviors to the unit charge nurse but was unable to provide any specifics on the nurse or when she reported the issues. NA #3 reported that staff at the facility would attempt to redirect Resident #41 but a room change was not attempted prior to 11/10/25. NA #3 indicated she was not aware of any other interventions to protect Resident #93, and that she never observed Resident #93 being aggressive or instigating any altercations with Resident #41. NA #3 also identified that it was the longstanding culture of the nursing staff, including the nurse aides and licensed nurses, to ignore Resident #41's behaviors and not address the issues, which was likely why Resident #93 had to self-request the room change. Interview with the DNS on 2/26/26 at 1:42 PM identified that she had been the DNS of the facility since March 2025. The DNS identified that she was not aware of any issues between Resident #41 and Resident #93, was not aware of the incidents on 7/7/25 or 10/21/25, and was not aware of the letter written by Resident #93 to the Administrative office in November 2025 which alleged daily abuse by Resident #41, and was not aware why Resident #93 requested a room change. The DNS (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	identified that following the incident on 7/7/25, the residents should have been placed in separate rooms for safety and if Resident #41 did not respond to redirection, the resident should have been sent to the hospital for psychiatric evaluation. The DNS also identified that the medical and psychiatric providers should have been notified of every incident between the residents as well as the resident representatives, and that social work should have been involved. The DNS identified that investigations should have also taken place on 10/21/25 and 11/10/25, and both incidents should have been reported to the state agency immediately. Interview with LPN #5 on 2/27/26 at 6:38 AM identified there had been an ongoing issue between Resident #41 and Resident #93 for several months in 2025. LPN #5 identified she observed that Resident #41 wanted to be close friends with Resident #93, but Resident #93 was not interested in any friendship or interactions with Resident #41. LPN #5 identified that Resident #41 responded to the rejection by becoming angry and aggressive towards Resident #93, and Resident #41 appeared to fixate on Resident #93 and would often ask where Resident #93 was when he/she left the room. LPN #5 identified that the staff were aware of the issues between Resident #41 and Resident #93, and that it regularly occurred during the evening and overnight shifts, but that she was the only nurse who would document Resident #41's behaviors towards Resident #93 as other nursing staff did not want their names associated with the incidents. LPN #5 identified that on 7/7/25, she observed Resident #41 kick and slap Resident #93 while he/she was in the hallway. LPN #5 could not recall who the other 3 staff were who were present during the incident. LPN #5 identified that she, along with the 3 staff, separated Resident #41 and Resident #93 following the incident. LPN #5 identified she notified the RN supervisor of the incident. LPN #5 indicated it may have been RN #5 (7:00 AM – 3:00 PM RN Supervisor) or RN #6, a prior 11:00 PM – 7:00 AM supervisor who is no longer employed at the facility. LPN #5 identified that she recalled assessing Resident #93 following the incident but did not document. LPN #5 identified that she put a request in the Behavioral Health Visit Request/Follow Up Log for Resident #41 to be seen following the incident, and no further action was taken on her part. LPN #5 also identified she was present for the incident on 10/21/25, and Resident #41 was yelling all night at Resident #93 and did not respond to any redirection by staff. LPN #5 identified she was unsure if she notified the supervisor, but that she placed another request in the Behavioral Health Visit Request/ Follow Up Log for Resident #41 to be seen. LPN #5 identified she had repeatedly notified the DNS and prior Administrator of the issues with Resident #41 and Resident #93, and they were aware of the incidents between the residents. LPN #5 also identified that she would often place requests in the Behavioral Health Visit Request/Follow Up Log when Resident #41 would have behaviors overnight and would attempt to redirect Resident #41, but this often did not work. LPN #5 was unable to identify any additional interventions related to Resident #41 and Resident #93, or why she failed to document any incidents or subsequent assessments in Resident #93's clinical record. Interview with the Medical Director on 3/11/26 at 10:56 AM and review of Resident #93's clinical record, grievance, and letter requesting a room change identified he was not made aware that Resident #41 had slapped Resident #93, which was ascertained during a staff interview or of any additional incidents, including the 10/21/25 verbal altercation, or the letter written by Resident #93 and given to the Administrator on 11/10/25 which alleged daily verbal and physical abuse by Resident #41. The Medical Director identified that he was recently notified by the DNS at a medical director meeting that Resident #41 and Resident #93 were placed in separate rooms, but he was not made aware of the specific issues that prompted the room change. The Medical Director identified that an accident and incident investigation should have been completed, the state agency should have been notified immediately following the incidents, and psychiatric follow-up should have been provided. Although attempted, an interview with RN #6 and SW #4 was not obtained. (continued on next page)

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy on Abuse, Neglect and Exploitation directed that abuse was the willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain or mental anguish. The policy also directed an alleged violation was a situation or occurrence observed or reported by staff, resident, relative, or others but had not yet investigated and if verified, could be an indication of noncompliance of federal requirements with abuse. The policy further identified that an immediate investigation was warranted when suspicion of abuse or reports of abuse occur. The policy also identified that the facility would make efforts to ensure all residents were protected from physical and psychosocial harm as well as additional abuse during and after an investigation. The policy also directed that reporting of all alleged violations to the Administrator, state agency, adult Protective Services and all other required agencies including law enforcement when applicable should be done immediately, but not later than two hours after an allegation was made, if the events that cause the allegation involved abuse. The policy directed that investigation of alleged abuse should include: Identifying staff responsible for the investigation. Exercising caution when handling evidence that could be used in a criminal investigation. Investigating different types of alleged violation. Identifying and interviewing all alleged involved persons, including the alleged victim, alleged perpetrator, witnesses, and others that might have knowledge of the allegations. Focus the investigation on determining if abuse, neglect, exploitation, or mistreatment had occurred, the extent, and cause. Provide a complete and thorough documentation of the investigation. The facility policy on Accident and Incidents directed that an incident was any occurrence or event that caused trouble or disrupted the normal procedure of the facility. The policy further directed that following an accident or incident, any employee witnessing an incident involving a resident must report such an occurrence to their immediate supervisor as soon as practical, and the charge nurse must be informed of all incidents. The policy further directed the charge nurse or designee must investigate immediately and the following data must be included in the accident investigation report form: The date and time the incident took place. The circumstances surrounding the incident. The names of any witnesses and their account of the incident. The injured person's account of the incident. The time the injured person's attending physician was notified, time of response, and instructions. The date and time the injured person's resident representative was notified and by whom. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Disposition of the injured person. Corrective action taken. Other pertinent data as necessary or required. Signature and title of the person completing the report. Submission of the report to the DNS. 2a. Resident #99 was admitted to the facility in December 2022 with diagnoses that included schizoaffective disorder and dementia. The quarterly MDS dated [DATE] identified Resident #99 was moderately cognitively impaired and independent with bed mobility, transfers and ambulation. The care plan dated 10/19/25 identified Resident #99 had an actual mood problem related to dementia, schizoaffective disorder and anxiety. Interventions included monitoring mood, provide supportive psychotherapy and administer medications as ordered. b. Resident #23 was admitted to the facility in March 2022 with diagnoses that included stroke and major depressive disorder with mood disturbances. Nurse's note dated 3/12/25 identified Resident #99 moved to Resident #23's room and was adjusting to the new room. The annual MDS dated [DATE] identified Resident #23 was cognitively intact and required one person assist with bed mobility, two person assist with transfers and utilized a motorized wheelchair. The care plan dated 10/19/25 identified Resident #23 had a mood problem related to major depressive disorder with interventions that included psychiatric consultation for behavioral concerns and supportive services. Review of the grievance log identified a handwritten note from Resident #99 dated 11/10/25 (attached to a separate resident grievance), in which Resident #99 requested a room change due in part to his/her roommate, Resident #23, both hate each other. No action was taken. Nurse's note dated 1/26/26 at 6:15 PM identified Resident #99 engaged in a verbal altercation with his/her roommate Resident #23. For de-escalation purposes, Resident #99 was relocated to an alternate room for the night. Management was to review and a decision was pending. Nurse's note dated 1/27/26 at 5:15 AM identified Resident #99 was observed back in his/her original room at the beginning of shift and slept through the night with no behaviors. Psychiatric Consultation dated 1/27/26 identified Resident #99 was evaluated post verbal altercation with his/her roommate. A room change was requested at the time. Resident #99 denied feelings of depression, anxiety, feeling fearful or distressed and was determined not to be at risk for self-harm/harm to others. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	For Resident #99, a social service note dated 2/9/26 at 6:12 PM identified he/she requested a room change due to roommate compatibility. A voice message was left for the responsible party with awaiting call back. For Resident #99, a social service note dated 2/11/26 identified the requested room change would not take effect as intended as the new roommate's responsible party was not in agreement. For Resident #23, a social service note dated 2/9/26 identified Resident #23 reported not getting along with his/her roommate and requested the roommate be moved. For Resident #23, a social service note dated 2/11/26 identified the requested room change would not take effect as intended as the new roommate's responsible party was not in agreement. Interview with Resident #99 on 2/24/26 at 8:26 AM identified he/she had frequent altercations with Resident #23 who often curses at him/her and keeps the TV too loud. Resident #99 indicated in recent days, while in their room, Resident #23 yelled the F word at him/her. In response, Resident #99 indicated he/she grabbed Resident #23's leg momentarily. The frequent altercations have left Resident #99 feeling anxious and upset, often not wanting to stay in his/her room and had made requests to an alternate facility and a room change with nothing being done to honor her request. Interview with the Director of Social Services on 2/24/26 at 8:46 AM identified Resident #23 and Resident #99 were roommates who did not get along. Resident #99 complains Resident #23 keeps the TV too loud and Resident #23 complains about Resident #99's scent. On 2/9/26, Resident #99 had called Resident #23 the B word. Both residents were 'socially' separated following the altercation and seen by psychiatry. When asked, the Director of Social Services indicated she would have to refer to the facility's policies for abuse to determine the required procedures. Interview with Resident #23 on 2/24/26 at 8:36 AM identified he/she did not get along with Resident #99. Resident #23 indicated an altercation over the TV volume had taken place between the two residents on 2/22/26 in their room at approximately 2:30 AM. Resident #23 said the F word to Resident #99 who in response, grabbed Resident #23's right foot with both hands. Resident #23 told Resident #99 that he/she was going to report him/her for assault. Interview with NA #4 on 2/24/26 at 10:17 AM identified while the resident-to-resident incident that occurred on 2/22/26 was not reported to her, it was known that Resident #23 and Resident #99 did not get along. NA #4 had observed the two residents yelling at each other, with Resident #23 often swearing at Resident #99. These incidents were reported to the nurse who did their best to separate the two residents. Subsequent interview with the Director of Social Services on 2/24/26 at 2:50 PM clarified that on 2/9/26 Resident #99 called Resident #23 the B word, and in turn Resident #23 said the F word (F you) to Resident #99. The Director of Social Services further identified she notified the Director of Nursing and Administrator when the allegation of resident-to-resident verbal mistreatment was first reported to her on 2/9/26. The Director of Social Services indicated she did not implement the other measures or completely document the incident in the clinical record when the allegation of resident-to-resident verbal mistreatment when first identified on 2/9/26 and indicated she was not as familiar with the policies as required. A subsequent interview with Resident #23 on 2/25/26 at 7:15 AM identified Resident #23 often (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	crossed his/her legs as a layer of protection when having an altercation with Resident #99. Resident #23 indicated altercations were frequent, however, the resident felt that Resident #99 had crossed the line when it became physical and told Resident #99 he/she could report him/her for assault. Resident #23 further identified there had been another recent incident earlier in the month that occurred in the hall. LPN #8 was present and separated the two residents. Resident #23 was aware that LPN #8 reported the incident to the social worker and was told there was going to be a room change, which never occurred. Interview and facility documentation review with the DNS on 2/25/26 at 9:30 AM identified she had not been notified of any other incidents that occurred between Resident #23 and Resident #99 prior to 2/24/26 and there was no prior incident reports related to resident-to-resident altercations. The DNS indicated for any resident-to-resident altercation, she would expect the two residents to be immediately separated, with notification to the nursing supervisor and herself. Interview with the DNS on 2/25/26 at 9:30 AM identified she had not been previously notified of any ongoing resident-to-resident verbal altercations between Resident #23 and Resident #99 prior to 2/24/26 and further identified there were no incident reports or reporting to the state agency related to those resident-to-resident altercations. The DNS indicated for any resident-to-resident altercation, she would expect the two residents to be immediately separated, with notification to the nursing supervisor and herself. Interview with the Administrator on 2/25/26 at 9:59 AM identified she was unaware of the ongoing resident-to-resident verbal altercations including the incident on 2/9/26 which had not been reported to her. The Administrator indicated that the incident on 2/9/26 should have been reported to the state agency. Review of the clinical record and facility documentation failed to identify a thorough investigation had been completed including details of the frequent altercations between Resident #23 and Resident #99, statements from staff about the altercations, and how the facility protected the residents from each other to mitigate future abuse. The facility policy on Abuse, Neglect and Exploitation directed that abuse was the willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain or mental anguish. The policy also directed an alleged violation was a situation or occurrence observed or reported by staff, resident, relative, or others but had not yet investigated and if verified, could be an indication of noncompliance of federal requirements with abuse. The policy further identified that an immediate investigation was warranted when suspicion of abuse or reports of abuse occur. The policy also identified that the facility would make efforts to ensure all residents were protected from physical and psychosocial harm as well as additional abuse during and after an investigation. The policy also directed that reporting of all alleged violations to the Administrator, state agency, adult Protective Services and all other required agencies including law enforcement when applicable should be done immediately, but not later than two hours after an allegation was made, if the events that cause the allegation involved abuse. The policy directed that investigation of alleged abuse should include: Identifying staff responsible for the investigation. Exercising caution when handling evidence that could be used in a criminal investigation. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Investigating different types of alleged violation. Identifying and interviewing all alleged involved persons, including the alleged victim, alleged perpetrator, witnesses, and others that might have knowledge of the allegations. Focus the investigation on determining if abuse, neglect, exploitation, or mistreatment had occurred, the extent, and cause. Provide complete and thorough documentation of the investigation. The facility policy on Accident and Incidents directed that an incident was any occurrence or event that caused trouble or disrupted the normal procedure of the facility. The policy further directed that following an accident or incident, any employee witnessing an incident involving a resident must report such an occurrence to their immediate supervisor as soon as practical, and the charge nurse must be informed of all incidents. The policy further directed the charge nurse or designee must investigate immediately and the following data must be included in the accident investigation report form: The date and time the incident took place. The circumstances surrounding the incident. The names of any witnesses and their account of the incident. The injured person's account of the incident. The time the injured person's attending physician was notified, time of response, and instructions. The date and time the injured person's resident representative was notified and by whom. Disposition of the injured person. Corrective action taken. Other pertinent data as necessary or required. Signature and title of the person completing the report. Submission of the report to the DNS.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for 4 residents (Resident #3, 8, 74, and 107) reviewed for hospitalization, the facility failed to ensure the Office of the State Long-Term Care Ombudsman was notified in accordance with regulatory requirements when the residents were transferred to the hospital. The findings include: 1. Resident #3 was admitted to the facility in June 2017 with diagnoses that included Parkinson's disease.A nurse's note dated 10/2/25 identified that at 12:20 AM Resident #3 was transferred to the hospital and was readmitted on [DATE]. A nurse's note dated 11/11/25 at 1:19 PM identified Resident #3 was transferred to the hospital and readmitted on [DATE]. A nurse's note dated 11/19/25 at 3:11 PM identified Resident #3 was transferred to the hospital and readmitted on [DATE]. 2. Resident #8 was admitted to the facility on [DATE] with diagnoses that included schizophrenia. A nurse's note dated 9/12/25 at 4:34 PM identified Resident #8 was transferred to the hospital and readmitted on [DATE]. A nurse's note dated 11/14/25 at 11:02 PM identified at 7:00 PM Resident #8 was transferred to the hospital. 3. Resident #74 was admitted to the facility in February 2020 with diagnoses that included diabetes.A nurse's note dated 11/14/25 at 7:16 PM identified Resident #74 was transferred to the hospital and readmitted on [DATE]. A nurse's note dated 11/26/25 at 10:41 Resident #74 was transferred to the hospital. 4. Resident #107 was admitted to the facility in June 2025 with diagnoses that included pleural effusion.A nurse's note dated 12/9/25 at 8:48 PM identified Resident #107 was sent to the hospital and readmitted on [DATE]. A nurse's note dated 1/9/26 at 3:22 PM identified Resident #107 was sent to the hospital and was readmitted on [DATE]. A nurse's note dated 1/30/26 at 1:37 PM identified Resident #107 left the facility at 8:00 AM for a physician appointment. Resident #107 did not return to the facility on the first shift.A nurse's note dated 1/30/26 at 8:07 PM identified a resident representative approached RN #5 and informed RN #5 that Resident #107 was transferred to the hospital from the Oncology clinic. Interview with the Administrator on 2/26/26 at 7:25 AM identified she was unable to provide documentation demonstrating that the Office of the State Long-Term Care Ombudsman had been notified when Residents #3, 8, 74, and 107 were transferred to the hospital. Review of hospitalizations indicated the State Long-Term Care Ombudsman were not notified of the residents who were transferred to the hospital between November 1, 2025, through January 31, 2026. The Administrator indicated she was not aware the list of residents transferred to the hospital had not been submitted. The Administrator further indicated that SW #1 is responsible for notifying the Office of the State Long-Term Care Ombudsman monthly of residents who had been transferred to the hospital. The Administrator indicated she would educate SW #1 on the process for submitting the list to ensure all residents transferred to the hospital are reported going forward. Interview with SW #1 on 2/26/26 at 9:45 AM identified she was responsible for sending the monthly transfer to hospital form to the Office of the State Long-Term Care Ombudsman. SW #1 indicated she did not send the monthly transfer to hospital form for the months of November 1, 2025, through January 31, 2026. SW #1 was unable to provide documentation demonstrating that the Office of the State Long-Term Care Ombudsman had been notified of residents transferred out to the hospital for the year 1/1/25 through 10/31/25. Interview with the DNS on 2/26/26 at 10:00 AM identified SW #1 was responsible to notify the Office of the State Long-Term Care Ombudsman of any resident that was transferred to the hospital, and she was not aware the notifications were not being done monthly.Review of the facility transfer, and discharge (including AMA) policy identified it is the policy of this facility to permit each resident to remain in the facility and not transfer or discharge the resident from the facility, except in limited circumstances. This policy applies to all residents regardless of their payment source. The Social Services Director, or designee, will provide copies of notices for emergency transfers to the Ombudsman, but they may be sent when practicable, such as in a list of residents on a monthly basis, (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	as long as the list meets all requirements for content of such. The facility will maintain evidence that the notice was sent to the Ombudsman.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interview for 1 of 3 residents, (Resident #7) reviewed for Preadmission Screening and Resident Review, PASARR, the facility failed ensure a reassessment was completed following the identification of a suspected mental illness. The findings include:Resident #7 was admitted to the facility in August 2019 with diagnoses that included schizoaffective disorder and dementia.Level I PASARR dated 7/24/19, completed during hospitalization prior to admission to the facility, identified Resident #7 did not have a diagnosis of a major mental illness and no further level I screening was required unless suspected of a serious mental illness (MI) or intellectual disability (ID) and exhibits a significant change in treatment needs.Psychiatric consultations beginning 11/15/19 noted a diagnosis code for of schizoaffective disorder (F25.9) with history auditory hallucinations previously treated while hospitalized , with chronic management including medication management and supportive psychotherapy.The annual MDS dated [DATE] identified Resident #7 was not considered by the state level II PASARR to have a serious mental illness and/or intellectual disability or related condition, was cognitively intact, had an active diagnosis of schizophrenia and was prescribed psychotropic medications.The care plan dated 10/14/25 (original initiation dated 2/20/20) identified Resident #7 had the potential for adverse effects related to psychotropic medications to manage schizoaffective disorder. Interventions included administering medications as ordered and providing psychiatric consultation as ordered.Interview and review of the clinical record review with the Director of Social Services on 2/24/26 at 3:07 PM identified social services was responsible for ensuring notification to the State-designated authority to determine if a PASSAR reassessment was required for newly suspected mental illness. Although Resident #7 was admitted with the diagnosis of schizoaffective disorder, it was not included on his/her level I screen, therefore did not trigger the required level II assessment. The Director of Social Services indicated the State-designated authority should have been notified once the diagnosis was identified to determine if a reassessment was indicated. Subsequent interview with the Director of Social Services on 2/26/26 at 8:51 AM identified she contacted the State-designated authority and confirmed a PASSAR reassessment was required for suspected mental illness.Interview with the DNS on 2/26/26 at 9:02 AM identified she would expect a PASSAR reassessment be completed when a resident has a newly suspected mental illness according to policy.Interview with LPC #1 (Licensed Professional Counselor) on 2/26/26 9:15 AM identified she provided routine psychotherapy for Resident #7. LPC #1indicated Resident #7 had a diagnosis of schizoaffective disorder and confirmed this was a primary diagnosis and not a symptom of dementia.Review of the Resident Assessment-Coordination with PASARR Program directed the facility to coordinate assessments with the PASARR program to ensure individuals with a mental disorder, intellectual disability or related condition receive the care and services in a setting appropriate to their needs. A PASARR Level I screen is to be completed prior to admission. A negative level I screen allows for admission to the facility and ends the PASARR process unless a possible serious mental illness/intellectual disability arises later. A level II comprehensive evaluation is to be completed by the appropriate state-designated authority that determines whether the individual has MI, ID, or related condition, determines the appropriate setting and recommends any specialized services the individual needs.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, facility documentation, facility policy, and interviews for 1 of 5 residents (Resident #41) reviewed for abuse, the facility failed to ensure that the resident's care plan was revised, and interventions were implemented following resident-to-resident altercations. The findings include: Resident #41 was admitted to the facility in September 2004 with diagnoses that included schizophrenia, dementia, and anxiety disorder. A physician's order dated 7/15/22 directed behavior monitoring for yelling, delusions, pacing, or weeping every shift including the behavior and number of episodes. A physician's order dated 8/16/24 directed to administer Risperdal (an anti-psychotic medication used to treat schizophrenia) 1 mg tablet every 12 hours. Review of the clinical record identified Resident #41 had a room change to Resident #93's room on 3/13/25. The annual MDS dated [DATE] identified Resident #41 had moderately impaired cognition, was always continent of bowel and bladder, required moderate assistance by staff with bathing, and set up assistance with eating and lower body dressing.A nurse's note dated 7/7/25 at 7:34 AM by LPN #5 (11:00 PM - 7:00 AM charge nurse) identified Resident #41 was observed at 5:00 AM having a verbal altercation with his/her roommate Resident #93. LPN #5 identified the altercation occurred without a reason, and that Resident #41 continued with behaviors despite attempts at redirection, and that Resident #41 was observed yelling at other residents in the unit hallway. The note further identified that Resident #41 was then observed kicking his/her roommate in the hallway by 3 facility staff. LPN #5 identified she notified her supervisor and that a referral to be seen by psychiatry in the morning had been placed.Review of Resident #41's care plan failed to identify any revisions or interventions related to the resident-to-resident altercation documented by LPN #5 on 7/7/25. A nurse's note dated 10/21/25 at 5:13 AM by LPN #5 identified Resident #41 was observed up all night yelling and screaming for no reason at his/her roommate Resident #93. LPN #5 identified she attempted to redirect Resident #41 with no result. Further review of the clinical record failed to identify any additional interventions attempted or implemented by staff related to Resident #41's behaviors against his/her roommate Resident #93. Review of a Behavioral Health Visit Request/Follow Up Log identified a note on 10/21/25 which identified Resident #41 was up all night yelling at his/her roommate Resident #93 for no reason and accosting him/her for coughing. Further review of the note failed to identify any staff information on who placed the note and failed to identify that a psychiatric provider reviewed the note or signed off on the request. Review of Resident #41's care plan failed to identify any revisions or interventions related to verbal behaviors towards his/her roommate that failed to respond to redirection on 10/21/25.Review of a Behavioral Health Behavioral Health Visit Request/Follow Up Log identified a note on 10/29/25 which identified Resident #41 had escalating behavior.A psychiatric evaluation note dated 10/29/25 identified Resident #41 was seen to assess for psychosis. The note identified Resident #41 had increased paranoia and agitated behaviors, and the treatment plan included to increase Risperdal to 2 mg twice daily. A medical APRN note dated 10/31/25 identified Resident #41 was seen for routine monthly follow-up. The note identified that during the visit, Resident #41 was mildly anxious, ambulating in the hallway asking, where is my roommate. The note further identified that staff reported Resident #41 had a recent escalation in behaviors that included yelling and screaming at his/her roommate, Resident #93, during the night and being disruptive. The note also identified that redirection was not successful, and that Resident #41 was seen by the psychiatric provider with an increase of Risperdal ordered. Review of Resident #41's care plan failed to identify any revisions or interventions related to verbal behaviors towards his/her roommate that failed to respond to redirection per the APRN note on 10/31/25.Review of a facility grievance form dated 11/12/25 identified Resident #93 requested a room change due to verbal abuse by his/her roommate, Resident #41. An undated letter addressed to the Administrator, which was (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	attached to the grievance form and signed by Resident #93, identified Resident #41 was verbally and physically abusing him/her daily and Resident #93 was requesting a room change. The form, which was completed by SW #1 (Social Work Director) and signed by Resident #93, SW #4, and the Administrator, identified that the resident's room was changed and the resident reported that things were better following the change. The form also identified that Resident #41's resident representative was notified of the grievance, that local law enforcement was not notified, and that the grievance did not result in a reportable event to the state agency.Interview with the DNS on 2/26/26 at 1:42 PM identified that she had been the DNS of the facility since March 2025. The DNS identified that she was not aware of any issues between Resident #41 and Resident #93. The DNS also identified that the residents' care plans should have been reviewed and revised after each incident, and that Resident #41 should have had additional interventions initiated if redirection was not working. Review of the clinical record and interview with LPN #5 on 2/27/26 at 6:38 AM identified there had been an ongoing issue with Resident #41 and Resident #93 for several months in 2025. LPN #5 identified she observed that Resident #41 wanted to be close friends with Resident #93, but Resident #93 was not interested in any friendship or interactions with Resident #41. LPN #5 identified that Resident #41 responded to the rejection by becoming angry and aggressive towards Resident #93, and Resident #41 appeared to fixate on Resident #93 and would often ask where Resident #93 was when he/she left the room. LPN #5 identified that all the nursing staff who worked in the facility were aware of the issues with Resident #41 and Resident #93, and that it occurred during the evening and overnight shifts regularly, but that she was the only nurse who would document Resident #41's behaviors towards Resident #93 as other nursing staff did not want their names associated with the incidents. LPN #5 identified that on 7/7/25, she observed Resident #41 kick Resident #93 while he/she was in the hallway and also slap Resident #93 during the same incident but could not recall where Resident #93 was struck or the 3 staff were present during the incident as she was unable to remember who they were. LPN #5 identified that she, along with the 3 staff, separated Resident #41 and Resident #93 following the incident. LPN #5 identified she notified the RN supervisor and initially identified RN #5 (7:00 AM - 3:00 PM RN Supervisor) was present during the incident, but identified it may have been RN #6, a prior 11:00 PM - 7:00 AM supervisor who is no longer employed at the facility. LPN #5 also identified she was present for the incident on 10/21/25, and Resident #41 was yelling all night at Resident #93 and did not respond to any redirection by staff. LPN #5 identified she was unsure if she notified the supervisor, but that she placed another request in the Behavioral Health Visit Request/Follow Up Log for Resident #41 to be seen. LPN #5 identified she had repeatedly notified the DNS and prior Administrator of the issues with Resident #41 and Resident #93, and they were aware of the incidents between the residents. LPN #5 also identified that she would often place requests in the Behavioral Health Visit Request/ Follow Up Log when Resident #41 would have behaviors overnight and would attempt to redirect Resident #41, but this often did not work. LPN #5 was unable to identify any additional interventions related to Resident #41. Although attempted, an interview with RN #6 and SW #4 was not obtained. The facility policy on Abuse, Neglect and Exploitation directed that abuse was the willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain or mental anguish. The policy also directed an alleged violation was a situation or occurrence observed or reported by staff, resident, relative, or others but had not yet investigated and if verified, could be an indication of noncompliance of federal requirements with abuse. The policy also directed the facility would implement procedures to prevent and prohibit all types of abuse that achieved the identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors that might lead to conflict. The policy further directed that the facility would make efforts to ensure all residents were protected from physical and psychosocial harm as well as additional abuse during and after an investigation including revisions of the resident's care plan if the resident's medical physical mental or psychosocial needs or preferences change as a result of an incident of abuse. The facility policy on comprehensive care (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	plans directed that the facility would develop and implement a comprehensive person-centered care plan for each resident. The policy also directed that the comprehensive care plan would describe, at a minimum, resident specific interventions that reflected the resident's needs. The policy also directed that the comprehensive care plan would include measurable objectives and time frames to meet the resident's needs and the objectives would be utilized to monitor the resident's progress, and alternative interventions would be documented as needed.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, facility documentation, facility policy and interview for 1 of 5 residents (Residents #19) observed during medication administration, the facility failed to administer Levothyroxine according to professional standards. The findings include. Resident #19 was admitted to the facility in October 2020, diagnosis included with diagnoses that included bipolar disorder and hypothyroidism.Physician's order dated 2/7/25 directed to administer Levothyroxine 112mcg for hypothyroidism daily. The February 2026 MAR identified that between 2/1/26 - 2/19/26 the Levothyroxine was being administered daily at 6:30 AM.The clinical record identified Resident #19 was hospitalized on [DATE] and returned to the facility on 2/21/26.Physician's order dated 2/21/26 directed to administer Levothyroxine 112mcg daily, Vitamin C 500mg daily, Vitamin D 25mg daily, and Ferrous Sulfate Oral Solution 300 (60 Fe) mg/ml give 5ml daily.The February 2026 MAR identified that between 2/22/26 - 2/25/26 the Levothyroxine was being administered daily at 9:00 AM along with Vitamin C 500mg, Vitamin D 25mg, and Ferrous Sulfate Oral Solution 300 (60 Fe) mg/ml 5ml.Observation during medication administration on 2/26/26 at 10:04 AM identified that LPN #4 administered Levothyroxine 112mcg, Vitamin C 500mg, Iron (Ferrous Sulfate) tablet 325mg/65mg (medication error), and Vitamin D 25mg. Review of the Levothyroxine blister pack on 2/26/26 (used by LPN #6 to administer the Levothyroxine) identified the following directions from the pharmacy.Take this medication at least 4 hours before taking Antacids, Iron or Vitamin/Mineral Supplements. Take this medicine on an empty stomach preferably 1/2 to 1 hour before breakfast. Interview with LPN #6 on 2/26/26 at 11:59 AM identified prior to the hospitalization, Resident #19 would receive the Levothyroxine at 6:30 AM, and it was changed when the resident returned from the hospital. LPN #6 did not know why the administration time of the Levothyroxine had changed to 9:00 AM Interview with RN #2 on 2/26/26 at 2:00 PM identified that the Levothyroxine should be administered at 6:30 AM. Subsequent to surveyor inquiry on 2/26/26 the administration time of the Levothyroxine was changed to daily at 6:00 AM, and a TSH and Iron level were ordered. The medication administration policy identified medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Compare medication source (bubble pack, vial, etc.) with MAR to verify resident name, medication name, form, dose, route, and time. Administer medication as ordered and in accordance with manufacturer specifications. Medications requiring administration on an empty stomach include Levothyroxine.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, facility documentation, facility policy, and interviews for 3 residents (Residents #93, 57 and 4) the facility failed to provide care according to professional standards. For 1 of 5 residents (Resident #93) reviewed for abuse, the facility failed to complete an RN assessment after a witnessed resident to resident altercation. For 1 of 2 residents (Resident #57) reviewed for pressure ulcers, the facility failed to ensure that the resident's heels were offloaded per the physician's order. For 1 of 5 residents (Resident #4) reviewed for unnecessary medications, the facility failed to consult the outside cardiologist for the resident regarding his/her implanted medical device. The findings include: 1a. Resident #41 was admitted to the facility in September 2004 with diagnoses that included schizophrenia, dementia, and anxiety disorder. A physician's order dated 7/15/22 directed behavior monitoring for yelling, delusions, pacing, or weeping every shift including the behavior and number of episodes. A physician's order dated 8/16/24 directed to administer Risperdal (an anti-psychotic medication used to treat schizophrenia) 1 mg tablet every 12 hours. Review of the clinical record identified Resident #41 had a room change to Resident #93's room on 3/13/25. The annual MDS dated [DATE] identified Resident #41 had moderately impaired cognition, was always continent of bowel and bladder, required moderate assistance by staff with bathing, and set assistance with eating and lower body dressing. A nurse's note dated 7/7/25 at 7:34 AM by LPN #5 (11:00 PM – 7:00 AM charge nurse) identified Resident #41 was observed at 5:00 AM having a verbal altercation with his/her roommate. LPN #5 identified the altercation occurred without a reason, and that Resident #41 continued with behaviors despite attempts at redirection, and that Resident #41 was observed yelling at other residents in the unit hallway. The note further identified that Resident #41 was then observed kicking his/her roommate, Resident #93, in the hallway by 3 facility staff. LPN #5 identified she notified her supervisor and that a referral to be seen by psychiatry in the morning had been placed. A psychosocial evaluation note dated 7/7/25 identified that Resident #41 displayed rudeness towards his/her roommate and aggression towards staff overnight. The note further identified that individual psychotherapy would be provided 1-5x monthly to reduce emotional symptoms. A psychiatric evaluation note dated 7/8/25 by APRN #4 identified she was asked to see Resident #41 due to agitated behaviors per nursing. APRN #4 identified Resident #41 reported sleeping and eating well, and had no signs of delusions, auditory or visual hallucinations, agitation or aggression. APRN #4 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	further identified no changes were recommended based on her evaluation. Review of the nurse staffing schedule for 7/6/25 identified LPN #5 and NA #3 as staff assigned to South Unit, where Resident #41 resided, for the 11:00 PM – 7:00 AM shift, and NA #2 was assigned to the North Unit, located across from the South Unit. The schedule also identified that RN #6 was the 11:00 PM – 7:00 AM nursing supervisor, and that RN #5 was the nursing supervisor who took over on the 7:00 AM – 3:00 PM shift on 7/7/25. b. Resident #93 was admitted to the facility in May 2024 with diagnoses that included schizophrenia, psychosis, and adjustment disorder. The care plan 4/28/25 dated identified Resident #93 had potential for impaired thought processes related to difficulty expressing him/herself. Interventions included communicating with the resident and his/her resident representative regarding his/her needs. Review of the clinical record failed to identify any documentation related to an altercation with Resident #93 and his/her roommate (Resident #41) for 7/2025. The quarterly MDS dated [DATE] identified Resident #93 had intact cognition, was always continent of bowel and bladder and required supervision by staff with bathing, toileting, and dressing. A psychiatric supportive services note by SW #3 on 11/8/25 identified Resident #93 reported ongoing issues with his/her roommate, Resident #41. The note failed to identify any additional information regarding specific issues. A nurse's note dated 11/10/25 at 7:52 PM by RN # 5 (7:00 AM – 3:00 PM RN Supervisor) identified Resident #93 requested to be transferred to another room, the room transfer was completed, and Resident #93's resident representative was notified. Review of a facility grievance form dated 11/12/25 identified Resident #93 requested a room change due to verbal abuse by his/her roommate, Resident #41. An undated letter addressed to the Administrator, which was attached to the grievance form and signed by Resident #93, identified Resident #41 was verbally and physically abusing him/her daily and Resident #93 was requesting a room change. The form, which was completed by SW #1 (Social Work Director) and signed by Resident #93, SW #4, and the Administrator, identified that the resident's room was changed and Resident #93 reported that things were better following the change. The form also identified that Resident #41's resident representative was notified of the grievance, that local law enforcement was not notified, and that the grievance did not result in a state agency reportable event. Review of the grievance letter and interview with Resident #93 on 2/24/26 at 3:18 PM identified he/she had been in the same room with Resident #41 since March 2025. Resident #93 identified that initially there were no issues Resident #41, but beginning sometime in the summer, Resident #41 began to make indirect romantic advances towards Resident #93. Resident #93 was unable to identify any specific incidents regarding the advances, only that they were verbal and made Resident #93 feel uncomfortable. Resident #93 identified once he/she rejected the advances, Resident #41 became more aggressive, and would intermittently yell at him/her for no reason. Resident #41 identified over time, the yelling escalated from intermittent episodes to constant yelling overnight, and then occasionally included being hit or kicked by Resident #41. Resident #93 identified that by the time he/she had written the letter to the Administrator in November 2025, Resident #41 was yelling (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	overnight several times a week, and anytime Resident #93 attempted to access his/her closet, which was located near the door and Resident #41's bed, Resident #41 would approach from behind and shove Resident #93 into the closet door. Resident #93 identified that he/she had reported the incidents several times to multiple nursing staff, but they had instructed Resident #93 multiple to tell Resident #41 that he/she did not want to talk and to stop the behaviors. Resident #93 identified he/she tried but that it only made Resident #41's behaviors worse. Resident #93 identified that he/she would often sit in the hallway to avoid Resident #41 and only go in the room as necessary, but it did not help and the behaviors continued. Resident #93 reported he/she feared Resident #41 and did not feel safe while in the same room with him/her and so he/she wrote a letter to the Administrator to try to change rooms. Resident #93 identified no staff had ever offered to move him/her to another room prior to the letter, and after the room change, a staff member who he/she could not remember, followed up once to make sure the new room was working out. Interview with the DNS on 2/26/26 at 1:42 PM identified that she had been the DNS of the facility since March 2025. The DNS identified that she was not aware of any issues between Resident #41 and Resident #93, and was not aware of the incident on 7/7/25. The DNS identified that following the incident on 7/7/25, the residents should have been placed in separate rooms for safety and if Resident #41 did not respond to redirection, the resident should have been sent to the hospital for psychiatric evaluation. The DNS also identified Resident #93 should have had a physical assessment following the incident on 7/7/25, and that the medical and psychiatric providers should have been notified of the all the incident as well as the residents' representatives, and that social work should have been involved. The DNS also identified that an investigation should have been initiated immediately on 7/7/25, with statements from the 3 staff who witnessed the incident, and that law enforcement should have been notified of the witnessed physical altercation. The DNS identified that it was not acceptable to document a supervisor or staff were present or notified without providing the specific staff identifiers. Review of the clinical record and interview with LPN #5 on 2/27/26 at 6:38 AM identified there had been an ongoing issue with Resident #41 and Resident #93 for several months in 2025. LPN #5 identified that on 7/7/25, she observed Resident #41 kick Resident #93 while he/she was in the hallway and also slapped Resident #93 during the same incident but could not recall where Resident #93 was struck or the 3 staff were present during the incident, she was unable to remember who they were. LPN #5 identified that she, along with the 3 staff, separated Resident #41 and Resident #93 following the incident. LPN #5 identified she notified the RN supervisor and initially identified RN #5 (7:00 AM – 3:00 PM RN Supervisor) was present during the incident, but identified it may have been RN #6, a prior 11:00 PM – 7:00 AM supervisor no longer employed at the facility. LPN #5 identified that she recalled assessing Resident #93 following the incident but did not document it, and it was not her responsibility to notify the resident's providers or the resident representatives regarding the altercation, as it was the responsibility of the RN supervisor. LPN #5 identified that she put a request in the Behavioral Health Visit Request/Follow Up Log for Resident #41 to be seen following the incident, and no further action was taken on her part. LPN #5 was unable to indicate why she did not document the incidents or subsequent assessments in Resident #93's clinical record. Although attempted, an interview with RN #6 was not obtained. The facility policy on Accident and Incidents directed that an incident was any occurrence or event that caused trouble or disrupted the normal procedure of the facility. The policy further directed that following an accident or incident, the charge nurse or designee must be notified so that medical attention could be provided, and that the charge nurse was responsible to examine the incident (continued on next page)

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F 0684

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

victims, notify the physician of the incident, and notify the resident representative of the incident. The policy further directed the charge nurse, or designee, must investigate immediately and the following data must be included in the Accident investigation report form:

1) The date and time the incident took place

2) The circumstances surrounding the incident

3) the names of any witnesses and their account of the incident

4) the injured person's account of the incident

5) the time the injured person's attending physician was notified, time of response, and instructions

6) the date and time the injured person's resident representative was notified and by whom

7) Disposition of the injured person

8) Corrective action taken

9) Other pertinent data as necessary or required

10) Signature and title of the person completing the report

11) Submission of the report to the DNS

The facility policy on Acute Condition Changes and RN assessments directed that with acute changes of condition, nursing staff would make pertinent observations and collect appropriate information to report to the resident's physician.

2.Resident #57 was admitted to the facility in October 2023 with diagnoses that included hypertensive urgency, muscle weakness, and bilateral osteoarthritis of the knees.

A physician's order dated 12/21/25 directed to offload Resident #57's heels while in bed every shift.

The quarterly MDS dated [DATE] identified Resident #57 had moderately impaired cognition, was frequently incontinent of bowel and bladder and required substantial assistance by staff with toileting, dressing, and transfers.

The care plan dated 1/12/26 identified Resident #57 had potential for skin integrity related to fragile skin and limited mobility. Interventions included offloading heels when in bed.

A weekly wound assessment note dated 1/21/26 identified that Resident #57 was found to have a new facility acquired stage 3 pressure ulcer on the plantar surface of the left foot which measured 1.6 x by 1.1 cm x 0.2 cm.

A telemedicine initial wound care note dated 1/21/26 by MD #2 (wound care physician) identified that Resident #57 was seen for initial evaluation and treatment of a stage 3 pressure ulcer to the left heel
(continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	which measured 1.6 cm x 1.1 cm by 0.2 cm and had moderate serosanguinous drainage. The treatment recommendations included honey and dry protective dressing daily and as needed, and offload heels per facility protocol. The note also identified to provide incontinence care as needed and optimize nutrition. A care plan dated 2/12/26 identified Resident #57 refused a heel bootie and wheelchair footplate for left heel wound prevention. Interventions included encourage leg elevation while seated to reduce pressure on the heel. A wound care note dated 2/18/26 by APRN #3 identified Resident #57 was seen for evaluation and treatment of a stage 3 pressure ulcer to the left heel present since 1/21/26. The note identified the wound measured 1.2 cm x 1.0 cm by 0.2 cm and had moderate sanguinous drainage. The treatment recommendations included calcium alginate, dry protective dressing daily and as needed, offload heels per facility protocol, provide incontinence care as needed, and optimize nutrition. The note also identified that the wound had improved, and no new concerns were noted on exam. Review of the facility wounds list dated 2/20/26 identified that Resident #57 had a vascular wound to the left heel which was acquired on 1/21/26 and was stable. Review of the clinical record failed to identify an assessments or documentation related to the change in classification of Resident #57's wound from facility acquired pressure ulcer to vascular wound as of 2/20/26. Observation on 2/24/26 at 7:30 AM identified Resident #57 in bed with both heels directly on the bed, and no offloading observed. Observations on 2/25/26 at 8:20 AM, 9:25 AM, 10:12 AM, and 10:30 AM identified Resident #57 in bed with both heels directly on the bed, and no offloading observed. Interview with RN #4 on 2/25/26 identified that Resident #57's wound was reclassified based on a discussion between RN #2 (Corporate [NAME] President of Clinical Operations) and MD #2. Interview with RN #2 on 2/25/26 at 10:45 AM identified that she had a discussion with nursing staff on 2/20/26 and was notified that Resident #57's wound was located on the plantar aspect of Resident #57's left foot. RN #2 also identified she spoke with APRN #3 on 2/20/26 regarding the wound and asked for her to reassess but APRN #3 was unable to look at the wound on that date. RN #2 identified she then reached out to MD #2, who reviewed photos of Resident #57's wound that were sent by RN #2 but not located in Resident #57's clinical record. RN #2 identified that following her discussion with MD #2, and the review of the photos, MD #2 reclassified the wound as likely vascular. Interview with MD #2 on 2/25/26 on 10:50 AM identified that she completed the initial evaluation of Resident #57's wound on 1/21/26 via a telemedicine visit and only visualized the wound via video assessment and not in person. MD #2 identified that based on the telemedicine exam, she determined that Resident #57 wound was a facility acquired pressure injury, however it was hard for her to fully appreciate the wound with a telemedicine assessment. MD #2 identified that based on Resident #57 having shiny skin and hair loss on the legs, the static nature of the wound with no change since 1/21/26, and following discussion with RN #2, she determined the wound was vascular in nature. MD #2 identified since 1/21/26 she had not been in the facility to exam the wound in person and based her decision to change in wound classification on photos and a chart review with RN #2. MD #2 also (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	identified that while there was an order in place for Resident #57's heels to be offloaded while in bed, the observations made of Resident 57's heels being directly on the bed, not offloaded, would not matter and have no impact on the wound or ability to heal because of the wound location (plantar of the left foot). Interview with RN #2 on 2/25/26 at 12:20 PM identified that while she had discussed reclassification of Resident #57's wound with MD #2, and had photos of the wound, she obtained the photos from nursing staff at the facility and had never actually seen or assessed the wound in person, including confirmation the location of the wound. Observation with the DNS on 2/26/26 at 10:07 AM identified Resident #57 resting in bed with both heels directly on the bed surface and no offloading observed. The DNS identified that Resident #57's heels were not offloaded but should have been, and that she would reposition Resident #57 and provide additional education to the nursing staff regarding the need to offload the heels as ordered. Observation with APRN #3 and RN #4 on 2/26/26 at 11:47 AM identified that Resident #57's wound was located directly on the back part of the left heel. During this observation, RN #4 removed Resident #57's dressing for APRN #3 to assess the wound. RN #4 removed the dressing and then placed Resident #57's heel directly on his/her bed, which had a white blanket in place, and the wound was not observable due the anatomical location at the heel and placement directly on the bed which obscured the ability to visualize any portion of the wound. Additionally, observation of Resident #57's plantar aspect of the left foot failed to identify any wounds, and during the observation the plantar aspect of the left foot was fully visible. APRN #3 then lifted Resident #57's left foot, and a small ring of red staining in the shape of the wound was observed on the bed. RN #4 identified that the wound appeared to be in a different location than it originally presented. APRN #2 identified that when the wound was originally identified by nursing on 1/21/26, there was a lot of drainage, and it was hard to visualize the wound. APRN #3 provided one photo of the wound from 1/21/26, not located in the clinical record. The photo appeared to be taken at an angle from the distal portion of the left foot but failed to capture any portion of the posterior heel. APRN #3 identified that the wound now had much less drainage, and that the wound was located on Resident #57's left heel. RN #4 identified the wound was located on the left heel and that the heel wound made direct contact with the bed when not offloaded. APRN #3 identified she would have to speak with MD #2 regarding the observations to determine the next steps, as MD #2 determined the change in classification from pressure to vascular identifying the wound was on the plantar aspect and not on the back of the heel. Subsequent to surveyor inquiry, a wound note dated 2/25/26 by APRN #3 identified Resident #57's wound was located at the left heel, and the wound measured 1 cm x 1 cm by 0.2 cm and had moderate sanguinous drainage. APRN #3 identified that as of 2/25/26, the wound continued to improve, however the delayed course of progression provoked additional vascular consideration. APRN #3 further identified that vascular insufficiency was substantiated by muscle atrophy, hair loss, and shiny skin, and while vascular insufficiency was likely the original factor, pressure had also contributed to the perpetuation of the wound due to resident noncompliance. Review of the clinical record failed to identify any documentation related to Resident #57 being noncompliant with offloading the heels while in bed. Review of the care plan failed to identify that Resident #57 refused offloading and/or interventions to address such. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy on pressure ulcer prevention directed that residents at risk for pressure ulcers would have interventions documented in the plan of care based on specific risk factors. 3.The hospital discharge instructions dated 4/18/23 identified Resident #4's History of Present Illness identified Resident #4 had a medical history significant for hypertension, chronic kidney disease, coronary artery disease with a stent, pacemaker, congestive heart failure, cognitive impairment, dependent on assistance from caregiver and was admitted to the emergency department for observation on 2/7/2023. The 12 lead ECG (electrocardiogram- used to diagnose issues with the heart's electrical system) resulted on 3/3/23 identified, in part, a biventricular pacemaker. The document further identified Resident #4's Primary Discharge Diagnoses included congestive heart failure, essential hypertension, automatic cardioverter/defibrillator (AICD), stent in the left anterior descending artery, hypoxia, and coffee ground emesis. Review of the discharge instructions failed to identify follow-up appointments or active issues for follow-up related to Resident #4's pacemaker and/or AICD. Resident #4 was admitted to the facility in 4/23 with diagnoses that included heart failure, atherosclerotic heart disease, and the presence of an automatic (implantable) cardiac defibrillator. A physician's order dated 4/28/2025 and 9/6/25 directed to refer Resident #4 for a Cardiology consult for a battery check- patient has AICD. A fax dated 9/8/25 requesting a cardiology consultation for Resident #4 was sent on 9/7/25 at 9:38 PM. The quarterly MDS dated [DATE] identified Resident #4 had severely impaired cognition and had coronary heart disease and hypertension. The care plan dated 2/13/26 identified Resident #4 had a diagnosis of heart failure, presence of an implanted automatic cardiac defibrillator, hypertension, hyperlipidemia, and coronary artery disease with interventions that included monitoring blood pressure, pulse, respirations and oxygen saturation daily and notifying the physician for any signs of heart failure. Review of the clinical record from 9/6/25 through 2/26/26 failed to identify a Cardiology consultation had been completed for Resident #4's AICD battery check. Clinical record review with the DNS and the Regional [NAME] President of Clinical Services (RN #2) on 2/26/26 at 4:30 PM failed to identify a Cardiology Consult had been completed for Resident #4. During an interview with the DNS and RN #2 on 2/26/26 at 4:30 PM, RN #2 identified that Resident #2 was admitted to the facility in 2023 and did not have any rehospitalizations; follow-up instructions for the AICD were not provided in the hospital discharge paperwork. RN #2 indicated that she did not see documentation in the clinical record that Resident #4 had seen the Cardiologist, since admission, but she would have expected that consultation to have taken place, as it would be the Cardiologist who would have set forth the guidelines and recommendations for the AICD. RN #2 further indicated that it would be the responsibility of the RN Supervisor to have printed the 9/6/25 order for a Cardiology consultation for a battery check and give it to the Administrative Assistant, who would then schedule the appointment and transportation. RN #2 identified that process had been started on 9/8/25, when the Administrative Assistant sent a fax for an appointment request, but she was unsure of the status. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Administrative Assistant, responsible for scheduling resident appointments and transportation, on 2/27/26 at 6:25 AM identified that she had reached out to the consulting cardiologist's office, back in September, but had been playing telephone tag; she had dropped the ball on scheduling some of the appointments and was working with the medical APRN on triaging the appointments and getting caught up with scheduling. Subsequent to surveyor inquiry, the Administrative Assistant indicated that yesterday the DNS had inquired about the status of Resident #4's Cardiology consult, and she was able to make contact with the office and schedule the appointment for 4/10/26. The Administrative Assistant further indicated that there had been a lot of back and forth via telephone with the consulting Cardiology practice, but she had not documented her attempts to schedule the appointment. Interview with the Medical APRN (APRN #2) on 2/27/26 at 10:28 AM identified that she began working at the facility on 12/31/25 with 2 other APRNs, and while she had not personally seen Resident #4, her colleague established care with him/her on 12/31/25. APRN #2 indicated it would be the responsibility of the Cardiologist to determine the frequency of the battery checks, and in the absence of guidance from the hospital's discharge instructions, she would have expected, at a minimum, the facility to call the Cardiologist to schedule a battery check for the AICD, identify a time when the battery was last checked, and also obtain a history of both the pacemaker and the AICD. Although attempted an interview with the Medical Director was not obtained. Although requested a policy on scheduling appointments with external medical providers was not provided. The Medical Appointments policy directs the facility to assist with transportation arrangements upon the request of the resident and or resident representative for resident driven appointments. Upon notification of the request, the attending physician will be contacted to determine if the outside appointment is medically necessary. If the appointment is deemed medically unnecessary, the facility will assist with transportation, however the resident and/or resident representative will be responsible for arranging an escort if required.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for 3 of 5 residents (Resident #57, 90 and 74) reviewed for pressure ulcers and/or nutrition, for Resident #57, reviewed for pressure ulcers, the dietitian did not complete a nutritional assessment for 1 month, until surveyor inquiry, after a new wound was identified, for Resident #90, reviewed for nutrition, the facility failed to address a significant weight loss in a timely manner and for Resident #74, reviewed for nutrition, the facility failed to obtain a reweight for 2 weeks after the resident had a significant weight gain. The findings include: 1. Resident #57 was admitted to the facility in October 2023 with diagnoses that included hypertensive urgency, muscle weakness, and bilateral osteoarthritis of the knees. The quarterly MDS dated [DATE] identified Resident #57 had moderately impaired cognition, was frequently incontinent of bowel and bladder and required substantial assistance by staff with toileting, dressing, and transfers. The care plan dated 1/12/26 identified Resident #57 had potential for skin integrity related to fragile skin and limited mobility. Interventions included promoting good nutrition and hydration to promote healthier skin. A weekly wound assessment note dated 1/21/26 identified that Resident #57 was found to have a new facility acquired stage 3 pressure ulcer on the plantar surface of the left foot which measured 1.6 cm x 1.1 cm by 0.2 cm. A telemedicine initial wound care note dated 1/21/26 by MD #2 (Wound care physician) identified that Resident #57 was seen for initial evaluation and treatment of a stage 3 pressure ulcer to the left heel which measured 1.6 cm x 1.1 cm by 0.2 cm and had moderate serosanguinous drainage. The treatment recommendations included honey and dry protective dressing daily and as needed, and offload heels per facility protocol. The note also identified to provide incontinence care as needed and optimize nutrition. Review of the clinical record failed to identify a nutritional assessment or evaluation following the newly identified pressure ulcer on 1/21/26 had been completed. Interview with MD #2 on 2/25/26 on 10:50 AM identified that she completed the initial evaluation of Resident #57's wound on 1/21/26 via a telemedicine visit. MD #2 identified that while she made a recommendation to optimize nutrition, she was unsure how the facility would notify the Dietician. Interview with the Dietitian on 2/25/26 at 11:10 AM identified she was not aware that Resident #57 had a newly identified wound as of 1/21/26. The Dietitian identified the facility had recently undergone a change of ownership in November 2025, and reported prior to the change, the previous wound nurse would provide her a copy of the wound lists for each week. The Dietitian identified once she received the list, she would review the newly identified wounds and complete the nutritional assessments. The Dietitian identified that she only recently began receiving the wounds lists on 2/13/26. Upon review of the list provided by the Dietitian, Resident #57 was identified as having a facility acquired pressure ulcer on 1/21/26. Following the review, the Dietitian identified that she must have missed it and that she would make sure to see Resident #57 that day. The Dietitian (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	identified that she was responsible for assessing any residents with newly identified pressure ulcers and wounds to ensure that they were eating regularly, discuss wound healing, and a nutritional plan. The Dietitian also identified that the plan may include additional hydration, protein supplementation, or double portions of protein supplementation. Subsequent to surveyor inquiry, a Dietitian progress note dated 2/25/26 at 12:10 PM identified Resident #57 had a wound and received a regular diet eating over 75% with an upward weight trend and had snacks such as cookies and chips. The note identified to continue to monitor and follow up as needed. Although requested, the facility failed to provide a policy on nutritional assessments. The facility policy on pressure ulcer prevention directed that residents at risk for pressure ulcers would have interventions documented in the plan of care based on specific risk factors. 2. Resident #90 had diagnoses that included type II diabetes and anemia. The quarterly MDS dated [DATE] identified Resident #90 was cognitively intact and independent with eating. The care plan dated 12/21/25 identified Resident #99 had limited adherence to inconsistent compliance with the diet plan. Interventions included monitor meal intake records, weight and report significant weight changes to the physician/APRN and registered dietitian further noting non-compliance with weight checks at times. The weight record dated 2/10/26 at 3:44 PM identified a weight of 144.9 lbs., a 10% loss from the previous 90 days weight of 163.2 lbs. The dietitian progress note dated 2/11/26 at 9:49 AM identified Resident #90 had been refusing meals and had no appetite but would eat something at dinner. No dietary recommendations were made that addressed the 10% weight loss. The APRN progress note dated 2/11/26 at 6:55 PM identified Resident #90 had a recent fall with no injury and was experiencing a gradual decline with poor oral intake and a weight of 144.9 lbs. Resident #90 was treated with intravenous fluids without improvement and antibiotics for a deteriorating skin graph. Resident #90 was weak, frail, unstable and subsequently transferred to the hospital for further evaluation. The hospital Discharge summary dated [DATE] identified Resident #90 was admitted and treated for a urinary tract infection and pancreatitis. Resident #90 was treated with vigorous hydration and supportive care before being discharged back to the facility. Hospital weight dated 2/14/26 on discharge was 160 lbs. The Nursing admission assessment dated [DATE] identified Resident #90's weight was 144.9 lbs. dating back to 2/10/26 prehospitalization and without a current admission weight. The dietitian progress note dated 2/15/26 at 1:34 PM identified Resident #20 returned post hospitalization, was feeling much better and eating over 75% of meals. Weight loss was 11% in 60 days with a weight loss change from 162.7 lbs. to 144.9 lbs. Recommendations included yogurt for a low (continued on next page)

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F 0692

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

calcium level and weekly weights

A Nutritional Evaluation dated 2/18/26 identified Resident #90 had reduced oral intake, and dehydration requiring hospitalization resulting in significant weight loss. Weight changed from 162.8 lbs. on 11/3/25 to 144.9 lbs. on 2/20/26 (a 17.8 lbs. loss). Since return from the hospital, Resident #90's intake has improved. Recommendations were made to monitor weight weekly for four weeks and follow up as needed.

A weight record dated 2/19/26 identified the resident weighed 128.2 lbs., an 11.53%/16.7 lbs. loss from the previous weight of 144.9 lbs. obtained on 2/10/26.

The clinical record did not include documentation that addressed the 11.53% weight loss.

Weight record dated 2/19/26 identified a recorded weight of 127 lbs.

The APRN note dated 2/22/26 at 1:54 PM identified Resident #90 was assessed via video and audio for reports of a cough. The 11.53% weight loss was not addressed.

The dietitian progress note dated 2/25/26 identified a follow up for weight loss. Intake variable. Discussed preferences and agreed to Ensure Clear as a supplement. Weekly weights to continue. The APRN was notified of weight loss (6 days after identification).

Interview with the Dietitian on 2/25/26 at 2:05 PM identified Resident #90's weight had been stable through December 2025 with a weight refusal in January 2026. Resident #90 had been experiencing poor intake after becoming ill with the flu and then was treated for dehydration. Resident #90 was hospitalized [DATE] and returned 2/14/26. Resident #90 experienced a significant weight loss on 2/10/26 that was not reviewed by her until 2/15/26 post hospitalization. At that time Resident #90's intake had improved so weekly weights were recommended with no other interventions. The Dietitian indicated she worked on 2/19/26 but was not aware of Resident #90 additional weight loss until her return on 2/24/26 with the resident's weight not documented as 128 lbs. The Dietitian indicated she only worked at the facility 2 1/2 days a week. Recommendations were made for supplementation and the APRN was notified using a weight log left in their communication folder to be reviewed when rounding.

Interview with the DNS on 2/25/26 at 7:26 AM identified weights were obtained at the beginning of the month. Significant weight discrepancies were to be reported to the physician, dietitian, family and nursing supervisor at the time it's identified. The DNS further identified Resident #90 should have been assessed and likely receive a medical workup for the continued weight loss.

Interview with LPN #8 on 2/27/26 at 7:20 AM identified she was the assigned nurse during the 7:00 AM to 3:00 PM shift on 2/19/26 and that it was her responsibility to determine if there were discrepancies from the previous weight. LPN #8 recalled the weight being reported as a confirmed re-weight. LPN #8 indicated she noted the significant weight loss and reported the finding to the nursing supervisor and had no other responsibilities once weight loss was verified.

Interview with RN #9 on 2/27/26 at 10:41 AM identified she was the assigned nursing supervisor during day shift on 2/10/26 beginning at 9:00 AM. RN #9 indicated she was not notified of Resident #90's continued significant weight loss. Had she been notified, an assessment would have been completed with notification to the physician and family.
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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy for Weight Management and Intervention directed that any weight change of 5 lbs. less or more since the last weight assessment will be re-taken. Once verified and determined a weight loss, nursing will consult the dietitian, physician and responsible party. Review of the facility policy for Change in a Resident Condition or Status directed in part that prior to contacting the physician the nurse will make detailed observations and gather relevant information for the provider. 3. Resident #74 was admitted to the facility in February 2020 with diagnoses that included severe morbid obesity due to excess calories, diabetes, hypothyroidism, and celiac disease. The quarterly MDS dated [DATE] identified Resident #74 had severely impaired cognition and required setup or clean-up assistance with eating. The care plan dated 11/25/25 identified Resident #74 was overweight and had a diagnosis of obesity. Resident #74 receives a regular diet, refuses a therapeutic diet and asks for ice cream daily. Resident #74 denies that requested items are placed on meal tray. Interventions include to provide meals per physician's orders, give oatmeal with breakfast and ice cream at lunch. Review of the nutrition evaluation dated 12/24/25 identified Resident #74 was on a regular diet, was independent with meals and was very selective about what he/she eats. Glucerna was offered at breakfast and lunch as the resident had refused medication pass supplement. Resident #74 realized significant weight loss over 180 days. The resident was informed of the weight loss. Recommendations included to obtain weekly weight for four weeks and follow up. The weights summary dated 1/6/26 identified Resident #74 weighed 145.0 lbs. The weights summary dated 1/12/26 identified Resident #74 weighed 145.8 lbs. The physician's order dated 2/1/26 directed to provide a regular diet and thin liquids consistency and weigh the resident every week for 4 weeks and then monthly unless otherwise indicated. The weights summary dated 2/3/26 identified Resident #74 weighed 179.2 lbs., a 33.4 lbs. weight gain over 23 days. The dietitian note dated 2/9/26 at 2:32 PM identified Resident #74 had a weight gain from 145.8 lbs. on 1/12/26 to 179.2 lbs. on 2/3/26. Request a weight recheck and follow up. Review of the clinical record and nurse's note dated 2/9/26 through 2/16/26 failed to reflect that a reweight or follow up had been done or that the physician or resident representative were notified of the weight gain. The weights summary dated 2/17/26 identified Resident #74 was reweighed and noted to be 181.8 lbs. Review of the nutrition evaluation dated 2/25/26 identified Resident #74 was on a regular diet and was independent with meals. The resident's intake varies and that the resident has been asking for ice cream with every meal, and he/she receives cold cereal as well as oatmeal with breakfast. Resident #74 agreed have only oatmeal at breakfast and ice cream only at lunch. Resident #74 was (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	educated of diagnoses of diabetes but insisted he/she is not diabetic and requested a regular diet. Current weight 181.8 lbs. Recommendations included to start weekly weight for four weeks. Interview with RN #5 (nursing supervisor) on 2/27/26 at 8:37 AM identified he was not aware of Resident #74's weight gain of 33.4 lbs. RN #5 indicated the charge nurse was to notify him of any weight discrepancies. Interview with the Dietitian on 2/27/26 at 8:59 AM identified she was aware of Resident #74's weight gain and indicated she was responsible for reviewing the resident weight. The Dietitian indicated she reviewed Resident #74's weights, and identified a weight gain on 2/3/26, and documented a progress note on 2/9/26 requesting a weight recheck. The Dietitian indicated she notified the nursing staff that Resident #74 required a weight recheck, however, the weight was not rechecked. The Dietitian indicated that significant weight changes are discussed during the facility's risk meeting and that Resident #74's weight gain was discussed. The Dietitian indicated she assessed Resident #74 on 2/25/26 regarding a weight of 181.8 pounds and provided the APRN with a list of residents who had significant weight changes. The Dietitian indicated that she had notified the RN supervisor, and the DNS that Resident #74 required a reweight and that it was not done. The Dietitian identified Resident #74's weight gain would be considered significant given the weight gain happened in 23 days, and she would have expected to be notified to provide recommendations. Interview with the DNS on 2/27/26 at 9:14 AM identified she was not aware of Resident #74's weight gain and indicated that the nurse aide obtains resident weights at the beginning of each month and reports the weight to the charge nurse, who documents the weight in the resident's clinical record. The DNS indicated that if there is a discrepancy in a resident's weight, the nursing supervisor reweighs and assesses the resident. The DNS indicated that the supervisor is responsible for notifying the physician/APRN, dietitian and the resident representative of significant weight changes and the dietitian assesses the resident. The DNS indicated during the facility risk meeting the dietitian did not discuss Resident #74. Interview with APRN #2 on 2/27/26 at 10:20 AM identified she was not notified of Resident #74's weight gain. APRN #2 indicated it is the responsibility of the licensed nurses and the supervisors to notify her of any changes. Subsequent to surveyor inquiry, an RN, and APRN assessment was performed. The change in condition note dated 2/27/26 at 1:18 PM identified weight gain assessment by RN supervisor and APRN. Resident #74 indicated is was not the first time he/she had weight gain and weight loss and indicated there was nothing wrong with that. The APRN notes dated 2/27/26 identified chief complaints of weight gain, review of blood sugar, and abdominal folds redness. The note documented a current weight of 181.8 lbs. Resident #74 denied shortness of breath or difficulty breathing. Edema to the left lower extremity was noted as significantly improved. Lung sounds were documented as clear bilaterally with normal respiratory effort. The plan included obtaining daily weights for 14 days, notifying the MD/APRN if weight increased greater than 3 pounds in one day, and obtaining stat labs. Although attempted, an interview with LPN #2 was not obtained. Review of the facility registered dietitian job description identified the job position is to plan, (continued on next page)

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

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	organize, develop, and direct the overall operation of the dietary department in accordance with current federal, state, and local standards, guidelines, and regulations governing the facility, and as may directed by the Administrator, to assure that quality nutritional services are provided on a daily basis and that the dietary department is maintained in a clean, safe, and sanitary manner. Review of the facility weight assessment and intervention policy identified the nursing staff will measure resident weight on day of admission and/or readmission, the day after and weekly times 4. If no weight concerns are noted at this point, weights will be measured monthly thereafter. Weights will be recorded in each resident's medical record. Any weight change of 5 lbs. less or more since the last weight assessment will be retaken. If the weight is verified and is determined a weight loss, nursing will consult the Dietitian, MD and the resident representative. The dietitian will review the unit weight record monthly and as needed to follow individual weights trends over time.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, review of facility documentation, facility policy, and interviews for 1 of 4 medication carts, the facility failed to ensure shift to shift controlled drug counts were consistently completed. The findings include:Observation on 2/25/26 at 2:10 PM during the medication cart review (on the South unit) with the DNS included a review of the February 2026 controlled drugs shift count record (the on-coming and off-going nurses complete to ensure all controlled drugs are counted). The controlled drugs shift count record was missing 4 signatures on 2 shifts on 2/24/26 during the 7:00 AM - 3:00 PM and 3:00 PM - 11:00 PM shift. Interview with the DNS on 2/25/26 at 2:15 PM identified she was not aware of the missing controlled drugs shift count signatures until now. The DNS indicated it was the responsibility of all the nurses to sign the controlled drugs count record at the beginning of the shift and at the end of each shift when the controlled drugs count is completed. The DNS indicated she will provide in-service for the nursing staff.Review of the facility controlled substances policy identified the facility shall comply with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of Schedule II and other controlled substances. Nursing staff must count controlled drugs at the end of each shift. The nurse coming on duty and the nurse going off duty must make the count together. They must document and report any discrepancies to the Director of Nursing Services.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility policy, and interviews for 1 of 5 residents (Resident #6) reviewed for unnecessary medications, the facility failed to ensure dental services with an oral surgeon were scheduled in timely manner. The findings include: Resident #6 was admitted to the facility in January 2022 with diagnoses that included type 2 diabetes mellitus, schizophrenia, and dementia. The physician's order dated 10/28/25 directed to arrange with outpatient oral surgeon for dental extraction. The quarterly MDS dated [DATE] identified Resident #6 had moderately impaired cognition, broken or loosely fitting full or partial denture, and obvious or likely cavity or broken natural teeth. The care plan dated 12/3/25 identified Resident #6 had oral/dental health problems related to cavities, with interventions that included coordinating arrangements for dental care, transportation as needed/as ordered, monitoring/documenting/reporting to the MD, as needed, signs and symptoms of oral/dental problems needing attention, and providing mouth care as per ADL, personal hygiene. The care plan further identified that Resident #6 had behaviors of refusing medications or medical appointments, including self-scheduling and canceling outside medical appointments, with interventions that included assessing his/her ability to understand the behavior and the provision of support, assessment, and intervention, as needed, by social services. A dental consultation dated 12/22/25 identified Resident #6 was seen by an external dental practice for x-rays and possible dental implants. Resident #6 had multiple teeth that had cavities and/or were broken, but he/she was still using them for chewing. The writer informed the resident to come back whenever he/she wanted to move forward (extraction and denture or implant). The Consulting Dental Group document dated 1/22/26 identified a referral to an oral surgeon was made for extraction of teeth #2, 3, 10, 12, 22, 24, and 31. One clinic that takes the facility's residents with good results was identified. The consultant further identified that there was a wait so calling now would be beneficial. Review of the nurse's notes dated 12/22/25 through 2/26/26 failed to identify documentation regarding Resident #6 refusing dental care. Review of the APRN notes dated 12/22/25 through 2/26/26 failed to identify documentation regarding Resident #6 refusing dental care. Interview with the Administrative Assistant, responsible for scheduling resident appointments, on 2/26/26 at 2:00 PM identified that to the best of her knowledge, Resident #6 had not yet been seen by an oral surgeon. The Administrative Assistant indicated that she had accompanied Resident #6 to the 12/22/25 appointment, when he/she was experiencing a toothache, and when the dentist made the recommendation for dental extractions, Resident #6 refused. The Administrative Assistant identified that she observed Resident #6 tell the dentist, he/she will think about it, in response to him/her returning for another dental appointment. The Administrative Assistant identified that her process following outside appointments, with outside providers, was to scan the consult documentation, then the APRN and the RN Supervisor would review the consult and provider recommendations, and she would be responsible for scheduling follow-up appointments and transportation. The Administrative Assistant indicated that she had been playing phone tag with the dental office, but subsequent to surveyor inquiry she was able to make contact with their office and Resident #6 was scheduled for a dental appointment on 3/4/26. The Dental Services policy directs the facility to assist residents in obtaining routine and emergency dental care, and the facility will, if necessary or requested, assist the resident with making dental appointments and arranging transportation to and from the dental services location.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, facility documentation, facility policy, and interviews 2 residents (Resident #57 and 90) who were reviewed for wounds, the facility failed to implement enhanced barrier precautions (EBP) as per facility policy and professional standards. The findings include: Resident #57 was admitted to the facility in October 2023 with diagnoses that included hypertensive urgency, muscle weakness, and bilateral osteoarthritis of the knees. The quarterly MDS dated [DATE] identified Resident #57 had moderately impaired cognition, was frequently incontinent of bowel and bladder and required substantial assistance by staff with toileting, dressing, and transfers. A weekly wound assessment note dated 1/21/26 identified that Resident #57 was found to have a new facility acquired stage 3 pressure ulcer on the plantar surface of the left foot which measured 1.6 cm x 1.1 cm by 0.2 cm. A telemedicine initial wound care note dated 1/21/26 by MD #2 (Wound care physician) identified that Resident #57 was seen for initial evaluation and treatment of a stage 3 pressure ulcer to the left heel which measured 1.6 cm x 1.1 cm by 0.2 cm and had moderate serosanguinous drainage. The treatment recommendations included honey and a dry protective dressing daily and as needed. Review of the physician's orders failed to identify Enhanced Barrier Precautions (EBP) were in place on or after 1/21/26. A wound care note dated 2/18/26 by APRN #3 identified Resident #57 was seen for evaluation and treatment of a stage 3 pressure ulcer to the left heel present since 1/21/26. The note identified the wound measured 1.2 cm x 1.0 cm by 0.2 cm and had moderate sanguinous drainage. The treatment recommendations included calcium alginate, dry protective dressing daily and as needed. The care plan initiated on 2/21/26 identified that Resident #57 had a stage 3 pressure injury with a goal of the wound to remain free from infection. Interventions included administering treatments as ordered and monitor for effectiveness. Observation and interview with APRN #3 and RN #4 on 2/26/26 at 11:47 AM identified that Resident #57 had an open wound on the posterior heel of the left foot. APRN #3 completed the assessment of the wound, and RN #4 applied calcium alginate and a bordered dressing to the wound. During the observation, no barriers were used between the resident's bed and open wound, and APRN #3 and RN #4 were not observed donning any PPE other than disposable gloves. Interview with RN #2 on 2/27/26 at 10:23 AM identified that she was unclear if Resident #57's wound would require EBP and would have to investigate the matter. The facility policy on Enhanced Barrier Precautions directed it was the policy to implement EBP for the prevention of transmission of multi-drug organisms (MDRO). The policy further directed that EBP referred to an infection control intervention designed to reduce transmission of MDR's that employed target gown and glove use during high contact resident care activities. The policy also directed an (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	order for EBP would be obtained for residents with wounds (i.e. pressure ulcers and chronic venous status ulcers) even when a resident was not known to be infected or colonized with an MDRO. The policy also directed implementation of E BP included making gowns and gloves available immediately near or outside the residence room. The policy also directed EBP was only necessary when performing high contact care activities which included providing wound care to any skin opening that required a dressing. The policy also directed that EVP should be used until the resolution of the wound. 2. Resident #90 had diagnoses that included type II diabetes and graph versus host disease, GVHD (condition where donor immune cells are attacked by the body). The quarterly MDS dated [DATE] identified Resident #90 was cognitively intact, required one person assist with bed mobility, transfers and did not any skin integrity issues. The care plan dated 12/21/25 identified Resident #90 had a history of a foot rash and refusal of wound treatments. Interventions included to monitor and report skin changes and administer treatments as ordered. Physician's order dated 2/1/26 directed to apply Tacrolimus ointment 0.1% (medication used to reduce inflammation and calming the immune response in the skin) to the hands, feet and face twice daily to prevent rejection. The APRN note dated 2/10/26 at 12:00 AM identified a history of chronic ulcers with a new wound on the left foot with purulent drainage and no odor. The plan for treatment included Intravenous (IV) therapy, IV antibiotics for the wound and imaging to rule out an acute osseous process. The APRN progress note dated 2/11/26 at 6:55 PM identified Resident #90 had a recent fall with no injury and was experiencing gradual decline with poor oral intake and a weight of 144.9 lbs. Resident #90 was treated with intravenous fluids without improvement; antibiotics for a deteriorating skin graph. Resident #90 was weak, frail, unstable and subsequently transferred to an outside hospital for further evaluation. Hospital Discharge summary dated [DATE] identified Resident #90 was admitted and treated for a urinary tract infection and pancreatitis. A wound to the left foot was evaluated and GVHD was identified as the underlying cause. Recommendations for wound care included cleansing with normal saline, followed by silver alginate, cover with a rolled gauze once daily. Initial wound consult dated 2/18/26 identified Resident #90 had an abrasion on the dorsal (top) left foot measuring 6 x 6 x 0.1 36cm with no exudate. Treatment recommendations included to cleanse the wound with normal saline and apply xeroform followed by a dry sterile dressing. Physician's order dated 2/18/26 directed to cleanse the wound with normal saline and apply xeroform followed by a dry sterile dressing daily. Nurse's notes dated 2/18/26 through 2/20/26 identified Resident #90 was refusing wound treatments with the resident stating he/she wanted the wound to remain open to air. Observation on 2/24/26 at 11:51 AM identified Resident #90 sleeping in bed with an open abrasion on (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the top of the foot with small amount of red staining on the sheets. There was no signage on the door indicating infection control precautions were implemented and no personal protective equipment (PPE) located outside or nearby. Interview with RN #4 on 2/25/26 at 7:30 AM identified Resident #90 sustained recurrent rashes to the hands, feet and elsewhere on the body related to rash to GVHD which was now affecting the dorsum of the left foot beginning 2/10/26. Resident #90 previously had treatments in place that prevented graph rejection and had refused treatments after returning from the hospital. The current treatment includes xeroform only followed by a dry sterile dressing which he/she refuses at times. Resident #90 was seen by the wound APRN beginning 2/18/26 and will continue to follow weekly. Observation on 2/25/26 at 11:35 AM identified Resident #90 self-propelling out of his/her room with a left foot wound open to air . LPN #3 observed redirecting Resident #90 back to his/her room. Interview with LPN #5 on 2/25/26 at 11:35 AM identified Resident #90 was not placed on EBP but should be due to his/her wound. Observation on 2/25/26 at 12:05 PM identified no signage on the door and no personal protective equipment (PPE) located outside or nearby. Interview with NA #7 on 2/25/26 at 12:05 PM identified no special precautions were in place for Resident #90 and PPE was not required when providing care. Interview with the DNS on 02/25/2026 at 12:07 PM identified Resident #90 should have had enhanced barrier precautions in place due to having a wound. Interview with APRN #3 on 2/25/26 at 12:47 PM identified she provided wound consultative services on a weekly basis. APRN #3 indicated staff should be implementing EBP for a resident with a wound as there was a chance for cross contamination and increased risk for infection when PPE was not used. Wound consult dated 2/25/26 noted a chronic abrasion to the left foot measuring 3.5 x 6 x 0.2cm with a moderate amount of serosanguineous drainage. Recommendations included Tacrolimus ointment followed by a dry protective dressing daily and as needed. Observation on 2/26/26 9:52 AM identified no signage in place near Resident #90's room indicating EBP, and no PPE stored nearby. Subsequent interview and policy review with the DNS on 2/26/26 at 9:52 AM identified after further discussion with her regional leadership, it was determined EBP was not required for Resident #90. However, upon review of the policy with the DNS, implementation of EBP was consistent with policy and standards of practice. Review of the facility policy for Enhance Barrier Precautions directed the implementation to reduce the transmission of multi-drug resistant organisms and employs targeted gown and gloves during high contact resident care. High contact resident care includes dressing, bathing, transferring, providing hygiene, changing linens. Changing briefs or toileting assist, device care and wound care including any skin opening requiring a dressing.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility policy, and interviews for 2 of 5 residents (Residents #4 and 6) reviewed for immunizations, the facility failed to ensure the pneumococcal vaccine was administered in a timely manner. The findings include: 1. Resident #4 was admitted to the facility in April 2023 with diagnoses that included heart failure, dementia, and hypertension. The quarterly MDS dated [DATE] identified Resident #4 had severely impaired cognition and was not up to date on the pneumococcal vaccination; it was offered and declined. Review of Resident #4's Immunization Report identified Pneumococcal-Historical Type Unknown was administered on 3/20/24. The Resident Pneumonia Vaccine Education Document Form signed and dated 2/5/26 identified Resident #4 agreed to receive the Pneumococcal Conjugate Vaccine (PCV 20). 2. Resident #6 was admitted to the facility in January 2022 with diagnoses that included dementia, type 2 diabetes mellitus, and COPD. The annual MDS dated [DATE] identified Resident #6 had moderately impaired cognition and was not up to date on the pneumococcal vaccination; it was offered and declined. Review of Resident #6's Immunization Report failed to identify a pneumococcal vaccine had been administer while a resident at the facility or historically. The Resident Pneumonia Vaccine Education Document Form signed and dated 2/11/26 identified Resident #4 agreed to receive the Pneumococcal Conjugate Vaccine (PCV 20). During an interview with the MDS Coordinator/Interim Staff Development and Infection Control Nurse (LPN #6) and the Regional Clinical Leader on 2/26/26 at 11:00 AM, LPN #6 identified that she had started working at the facility in November 2025 following the change of ownership (11/1/15). LPN #6 identified that the prior owner did not maintain a vaccination log and the facility's vaccination documentation was fragmented; some documentation was available in the resident's electronic health record and other documentation was on paper. It was identified that a vaccination audit needed to be completed. LPN #6 indicated that the facility experienced an Influenza outbreak, which started on 12/26/25 and resolved on 1/28/26 and a Covid-19 outbreak, which started 1/7/26 and resolved on 1/28/26, additionally the facility hired a new Infection Control Nurse (ICN) that worked at the facility for one month; all of which created fragmentation in completing the audit and identifying which residents would be eligible for vaccinations. LPN #6 identified that a part-time Nursing Supervisor began the audit, including obtaining vaccination consents, the last week of January 2026 and completed the audit 2/12/26. Interview with LPN #6 on 2/26/26 at 1:48 PM identified that, subsequent to surveyor inquiry, Residents #4 was scheduled to receive the pneumococcal vaccine on 3/3/26 and Resident #6 was scheduled to receive the pneumococcal vaccine on 3/2/26. Interview with the DNS on 2/26/26 at 3:06 PM identified that prior to the change of ownership, only the influenza vaccines had been administered, most recently in October of 2025. The DNS indicated that the facility had been doing an audit of all residents' vaccination statuses and would be having a vaccination clinic for residents that were eligible and consented to the pneumococcal vaccine. The DNS indicated that completing the vaccination audit required additional resources, and that while the consented residents should have had their pneumococcal vaccines, there were multiple projects that all needed follow through. The Pneumococcal Vaccine policy directs each resident will be assessed for pneumococcal immunization upon admission. Self-report of immunization shall be accepted. Any additional efforts to obtain information shall be documented, including efforts to determine date of immunization or type of vaccine received. Each resident will be offered a pneumococcal immunization unless it is medically contraindicated or the resident has already been immunized. Following assessment for any medical contraindications, the immunization may be administered in accordance with physician-approved standing orders. Usually only one pneumococcal polysaccharide vaccination (PPSV) is needed in a lifetime. However, based on an assessment and practitioner recommendation, additional vaccines may be provided.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, facility documentation, facility policy, and interviews for 4 of 5 residents (Resident #4, 6, 8, and 99) reviewed for immunizations, the facility failed to ensure Covid-19 booster vaccines were administered in a timely manner. The findings include: 1. Resident #4 was admitted to the facility in April 2023 with diagnoses that included heart failure, dementia, and hypertension. The quarterly MDS dated [DATE] identified Resident #4 had severely impaired cognition and was not up to date on the Covid-19 vaccination. Review of Resident #4's Immunization Report identified the most recent SARS-COV-2 COVID-19 vaccine had been administered on 1/26/24. The Resident Covid Vaccine Education Document Form signed and dated 2/5/26 identified Resident #4 agreed to receive the Covid-19 booster vaccine. 2. Resident #6 was admitted to the facility in January 2022 with diagnoses that included dementia, type 2 diabetes mellitus, and COPD. The annual MDS dated [DATE] identified Resident #6 had moderately impaired cognition and was not up to date on the Covid-19 vaccination. Review of Resident #6's Immunization Report identified SARS-COV-2 (Covid-19) vaccine Dose 2 was administered on 11/3/24. The Resident Covid Vaccine Education Document Form signed and dated 2/11/26 identified Resident #6 agreed to receive the Covid booster vaccine. 3. Resident #8 was admitted to the facility in October 2025 with diagnoses that included hypertension and COPD. The quarterly MDS dated [DATE] identified Resident #8 had intact cognition and was not up to date on the Covid-19 vaccination. Review of Resident #8's Immunization Report identified SARS-COV-2 Covid-19 vaccine was last administered on 12/7/21. The Resident Covid Vaccine Education Document Form signed and dated 2/12/26 identified Resident #8 agreed to receive the Covid booster vaccine. 4. Resident #99 was admitted to the facility in October 2022 with diagnoses that included type 2 diabetes mellitus and dementia. The quarterly MDS dated [DATE] identified Resident #99 had moderately intact cognition and was up to date on the Covid-19 vaccination. Review of Resident #99's Immunization Report identified SARS-COV-2 Covid-19 vaccine was last administered on 12/18/24. The Resident Covid Vaccine Education Document Form signed and dated 1/6/26 identified Resident #99 agreed to receive the Covid booster vaccine. During an interview with the MDS Coordinator/Interim Staff Development and Infection Control Nurse (LPN #6) and the Regional Clinical Leader on 2/26/26 at 11:00 AM, LPN #6 identified that she had started working at the facility in November 2025 following the change of ownership (11/1/15), and it was identified that the prior owner did not maintain a vaccination log and the facility's vaccination documentation was fragmented; some documentation was available in the resident's electronic health record and other documentation was on paper. It was identified that a vaccination audit needed to be completed. LPN #6 indicated that the facility experienced an Influenza outbreak, which started on 12/26/25 and resolved on 1/28/26 and a Covid-19 outbreak, which started 1/7/26 and resolved on 1/28/26, additionally the facility hired a new Infection Control Nurse (ICN) that worked at the facility for one month; all of which created fragmentation in completing the audit and identifying which residents would be eligible for vaccinations. LPN #6 identified that a part-time Nursing Supervisor began the audit, including obtaining vaccination consents, the last week of January and completed the audit 2/12/26. Interview with LPN #6 on 2/26/26 at 1:48 PM identified that, subsequent to surveyor inquiry, Residents #4 and 6 were scheduled to receive the Covid-19 booster vaccine on 3/16/26, Resident #8 was scheduled to receive the Covid-19 booster vaccine on 3/3/26, and Resident #99 would be scheduled for the Covid-19 booster vaccine. LPN #6 further identified that per the Medical Director's guidance, the administration of the pneumococcal vaccine and the Covid-19 booster vaccine would be completed 2 weeks apart, so the residents that had consented to both the pneumococcal vaccine and Covid-19 booster were scheduled accordingly. Interview with the DNS on (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2/26/26 at 3:06 PM identified that prior to the change of ownership, only the influenza vaccines had been administered, most recently in October of 2025. The DNS indicated that the facility had been doing an audit of all residents' vaccination statuses and would be having a vaccination clinic for residents that were eligible and consented to the Covid-19 booster vaccine. The DNS indicated that completing the vaccination audit required additional resources, and that while the consented residents should have had their Covid-19 vaccine boosters, there were multiple projects that all needed follow through. The Covid-19 Vaccination policy directs the facility, in collaboration with the Medical Director, to have an immunization program against COVID-19 disease in accordance with national standards of practice. COVID-19 vaccinations will be offered to residents when supplies are available, as per CDC and/or FDA guidelines unless such immunization is medically contraindicated, the individual has already been immunized during this time period or refuses to receive the vaccine. Following assessment for potential medical contraindications, COVID-19 vaccinations for residents may be administered in accordance with physician-approved standing orders. The facility will educate and offer the COVID-19 vaccine to residents, resident representatives, and staff and maintain documentation of such. Residents or resident representatives retain the right to accept, refuse, or change their decision about COVID-19 immunization.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075011	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/11/2026
NAME OF PROVIDER OR SUPPLIER Autumn Lake Healthcare at Windsor		STREET ADDRESS, CITY, STATE, ZIP CODE 581 Poquonock Ave Windsor, CT 06095	

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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 0582 Level of Harm - Potential for minimal harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interview for 4 of 4 residents (Resident #38, 68, 79 and 110) reviewed for beneficiary notification, the facility failed to provide the appropriate Medicare denial notices to the resident's upon being discharged from Medicare Part A with benefit days remaining. The findings include: Upon surveyor request, the facility provided a list of residents who were discharged from Medicare covered Part A stay with benefit days remaining in the past 6 months. Included in the facility provided list were Resident #38, 68, 79 and 110. The SNF Beneficiary Protection Notification Review form was given to the facility staff with the request for the following information regarding Resident #38, 68, 79 and 110.How was the Medicare Part A service termination/discharge determined?Was a Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN) form CMS-10055 provided to the residents yes or no? If no, explain why the form was not provided. Was a Notice of Medicare Non-Coverage (NOMNC) CMS 10123 provided to the residents? If no, explain why the form was not provided. None of the SNF Beneficiary Protection Notification Review forms for Residents #38, 68, 79 and 110 were completed by facility staff as requested. 1. Resident #38 was admitted to the facility on [DATE] with Medicare Part A as a payor source. Resident #38 is a current resident at the facility during the standard survey 2/24/26 - 2/27/26. Review of a SNF ABN form provided to Resident #38 identified beginning on 1/30/26, the resident may have to pay out of pocket for this care if you do not have other insurance that may cover these costs. The care includes physical therapy, occupational therapy and daily skilled nursing care. Resident #38 signed the form on 1/28/26 and chose option 3: I do not want the care listed above, I understand that I am not responsible for paying, and I cannot appeal to see if Medicare would pay. The NOMNC CMS 10123, (a notice that explains your right to appeal the Medicare Part A denial and how to ask for an immediate appeal) was not provided to Resident #38 as required. Interview with LPN #6 on 2/26/26 at 3:00 PM identified she just started doing the job of beneficiary notification last month and was being trained by one of the regional nurses. LPN #6 identified that no other notice had been provided to Resident #38. LPN #6 did not provide any other information about the beneficiary notification. 2. Resident #68 was admitted to the facility on [DATE] with Medicare Part A as a payor source and was discharged home on 2/18/26 with benefit days remaining. Although requested, a NOMNC CMS 10123 was not provided as required. Interview with LPN #6 on 2/26/26 at 3:00 PM identified she could not find a NOMNC CMS 10123 that had been provided to Resident #68. LPN #6 did not provide any other information about the beneficiary notification. 3. Resident #79 was admitted to the facility on [DATE] with Medicare Part A as a payor source. Resident #79 was discharged from Medicare Part A coverage on 1/23/26 and remained in the facility. Although requested, the facility did not provide the SNF ABN or the NOMNC. Interview with LPN #6 on 2/26/26 at 3:00 PM identified she could not find the SNF ABN or the NOMNC CMS 10123 that had been provided to Resident #79. LPN #6 did not provide any other information about the beneficiary notification. 4. Resident #110 was on Medicare Part A covered services as of 1/1/26. The resident was discharged home on 1/19/26 with benefit days remaining. Although requested, a NOMNC CMS 10123 was not provided as required. Interview with LPN #6 on 2/26/26 at 3:00 PM identified she could not find a NOMNC CMS 10123 that had been provided to Resident #110. LPN #6 did not provide any other information about the beneficiary notification. Review of the Advance Beneficiary Notices policy identified it is the policy of this facility to provide timely notices regarding Medicare eligibility and coverage. The facility shall inform Medicare beneficiaries of his or her potential liability for payment. A liability notice shall be issued to Medicare beneficiaries upon admission or during a resident's stay, before the facility provides:An item or service that is usually paid for by Medicare but may not be paid for in a particular instance because it is not medically reasonable and necessary, or Custodial care.The current CMS-approved version of the forms shall be used at the time of issuance to the beneficiary (resident (continued on next page)

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F 0582 Level of Harm - Potential for minimal harm Residents Affected - Some	or resident representative). Contents of the form shall comply with related instructions and regulations regarding the use of the form.For Part A items and services, the facility shall use the Skilled Nursing Facility Advance Beneficiary Notice (SNFABN), Form CMS-10055.A Notice of Medicare Non-Coverage (NOMNC), Form CMS-10123, shall be issued to the resident/representative when Medicare covered service(s) are ending, no matter if resident is leaving the facility or remaining in the facility. This informs the resident on how to request an appeal or expedited determination from their Quality Improvement Organization (QIO).This notice is used when all covered services end for coverage reasons.An exhaustion of benefits is not considered a termination for coverage reasons.Additional notices shall be issued to Medicare beneficiaries when appropriate. If a reduction in care occurs and the beneficiary wants to continue to receive the care that is no longer considered medically reasonable and necessary, the facility shall issue an ABN prior to furnishing non-covered care.If services are being terminated and the beneficiary wants to continue receiving care that is no longer considered medically reasonable and necessary, the facility shall issue an ABN prior to furnishing non-covered care.To ensure that the resident, or representative, has enough time to make a decision whether or not to receive the services in question and assume financial responsibility, the notice shall be provided at least two days before the end of a Medicare covered Part A stay or when all of Part B therapies are ending. The notices must not be provided while the resident/representative is under duress or in an emergency situation.The Business Office Manager, or designee, is responsible for issuing notices.The facility shall issue a notice each time, and as soon as, it makes the assessment that Medicare payment certainly or probably will not be made.The notice shall be prepared with an original and at least two copies. The facility shall retain the original and give a copy to the resident/representative.The original notice shall be placed into the resident's financial file. The notice shall be retained at least five years. In certain situations, such as delivery by fax, retention of a signed copy is acceptable. Electronic retention of the signed document is acceptable.

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for 1 resident (Residents #6), reviewed for activity of daily living (ADL), the facility failed to ensure the resident's activity of daily living (ADL) were accurately coded in the Minimum Data Set (MDS) assessment. The findings include: Resident #6 was admitted to the facility in January 2022 with diagnoses that included dementia, paranoid schizophrenia, and major depressive disorder.The quarterly MDS dated [DATE] identified Resident #6 had moderately impaired cognition and required set up or clean-up assistance with eating, oral hygiene, shower/bath, upper body dressing, lower body dressing, putting on/taking off footwear, and personal hygiene, (inaccurately coded).The quarterly MDS dated [DATE] identified Resident #6 had moderately impaired cognition and was independent with eating, independent with oral hygiene, independent with toileting hygiene, supervision or touching assistance with shower/bath, independent with upper body dressing, independent with lower body dressing, independent with putting on/taking off footwear, and independent with personal hygiene, (inaccurately coded).The annual MDS dated [DATE] identified Resident #6 had severely impaired cognition and required set up or clean-up assistance with eating, supervision or touching assistance with oral hygiene, shower/bath, and personal hygiene, dependent with toileting hygiene, upper body dressing, lower body dressing and putting on/taking off footwear.Interview and clinical record review with LPN #6 (MDS coordinator) on 2/26/26 at 1:00 PM identified indicated that a previous MDS coordinator was responsible for the position in November 2025. LPN #6 indicated during a recent MDS audit, the facility identified that the previous MDS coordinator failed to accurately code residents ADL assessments. Interview with the Administrator on 2/26/26 at 1:15 PM identified the facility had recently conducted an MDS audit and identified that residents activities of daily living (ADL) assessments had been inaccurately coded. Review of the facility conducting an accurate resident assessment policy identified the purpose is to assure that all residents receive an accurate assessment, reflective of the resident's status at the time of the assessment, by staff qualified to assess relevant care areas. Accuracy of assessment means that the appropriate, qualified health professionals correctly document the resident's medical, functional, and psychosocial problems and identify resident strengths to maintain or improve medical status, functional abilities, and psychosocial status using the appropriate Resident Assessment Instrument (RAI). The Administrator will ensure that all participants in the assessment process have the requisite knowledge to complete an accurate assessment.

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	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 2 of 5 residents (Residents #6 and 99) reviewed for unnecessary medications, the facility failed to ensure the medical records reflected accurate documentation that blood glucose readings outside of the ordered parameters were reported to the physician. The findings include: 1. Resident #6 was admitted to the facility in January 2022 with diagnoses that included chronic obstructive pulmonary disease (COPD), type 2 diabetes mellitus, and dementia. The quarterly MDS dated [DATE] identified Resident #6 had moderately impaired cognition, had received insulin injections insulin injections on 7 of the last 7 days, and was taking a hypoglycemic medication. The care plan dated 12/3/25 identified Resident #6 had Diabetes Mellitus and was refusing finger sticks and insulin, with interventions that included fasting serum blood sugar as ordered by the physician, and monitoring and reporting to the physician signs and symptoms of hypoglycemia and hyperglycemia. A physician's order dated 8/27/24 and discontinued 1/22/26 directed to monitor blood sugars twice daily, three times per week, call the provider for blood sugar above 200 two times a day every Mon, Wed, Fri, notify the physician if the blood sugar is less than 70 or greater 200 before breakfast. Review of Resident #6's Blood Sugar Summary dated 12/1/25 through 2/27/26 identified the following blood sugar readings greater than 200: 12/1/25 at 7:07 PM - 203.0 mg/dl. 12/8/25 at 7:54 AM - 216.0 mg/dl. 12/10/25 at 8:51 AM - 255.0 mg/dl. 12/10/25 at 9:58 PM - 243.0 mg/dl. 12/12/25 at 9:57 AM - 213.0 mg/dl. 12/15/25 at 11:23 AM - 210.0 mg/dl. 12/22/25 at 4:27 PM- 201.0 mg/dl. 12/24/25 at 5:30 PM - 218.0 mg/dl. The nurse's note dated 12/1/25 through 12/24/25 failed to identify the medical provider was notified of blood sugars greater than 200 before breakfast and failed to address if the AM blood sugars were obtained prior to Resident #6 eating breakfast. Clinical record review with the DNS and the [NAME] President of Clinical Services on 2/26/26 at 4:35 PM failed to identify the medical provider and the responsible party were notified when Resident #6's blood sugar was greater than 200. During an interview with the DNS and the [NAME] President of Clinical Services on 2/26/26 at 4:35 PM, the DNS identified that the charge nurse should have notified the RN Supervisor when Resident #6's blood sugar was greater than 200, and the RN Supervisor should have notified the APRN, potentially to obtain new orders or treatment plan. The DNS further indicated that the resident representative should also have been notified and documentation of the notifications, including any new orders obtained, should be in the clinical record. Interview with the Medical APRN (APRN #2) on 2/27/26 at 10:28 AM identified that she began working for the facility on 12/31/25 and was not providing care for Resident #6 from 12/1/25 through 12/24/25, when the blood sugars greater than 200 were not reported. APRN #2 indicated that since her medical group has begun providing care for Resident #6, his/her blood sugars have all been within normal limits and have not been outside the ordered range for provider notification; speaking as a medical provider, she would expect an order directing for provider notification to be followed through should medication or treatment need adjusting. 2. Resident #99 was admitted to the facility in October 2022 with diagnoses that included type 2 Diabetes Mellitus and dementia. A physician's order dated 6/24/25 directed to check Resident #99's blood sugar twice daily related to Diabetes Mellitus, notify the APRN if the finger stick blood sugar (FSBS) was less than 70 or greater than 300. The quarterly MDS dated [DATE] identified Resident #99 had moderately intact cognition, received no insulin injections in the last 7 days, and was taking a hypoglycemic. The care plan dated 1/17/26 identified Resident #99 has Diabetes Mellitus, with interventions that included administering diabetes medication, as ordered by the physician, monitoring and documenting for side effects and effectiveness. Resident #99's Hemoglobin A1C (a blood that is used to determine the average blood sugar control levels over a period of 3 months for a person with diabetes) result dated 2/25/26 was 9.7% (normal range 4.8-5.6%). Review of Resident #99's Blood Sugar Summary dated 2/1/26 through (continued on next page)

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	2/27/26 identified the following blood sugar readings greater than 300: 2/25/26 at 5:18 PM - 321.0 mg/dl. 2/25/26 at 8:04 AM - 336.0 mg/dl. 2/11/26 at 4:53 PM - 319.0 mg/dl. 2/4/26 at 8:12 AM - 333.0 mg/dl. The nurse's note dated 2/1/26 through 2/25/26 failed to identify documentation that the medical provider was notified of blood sugars greater than 300. Clinical record review with the DNS and the [NAME] President of Clinical Services on 2/26/26 at 4:40 PM failed to identify the medical provider and Conservator were notified when Resident #99's blood sugar was greater than 300. During an interview with the DNS and the [NAME] President of Clinical Services on 2/26/26 at 4:40 PM, the DNS identified that the charge nurse should have notified the RN supervisor when Resident #99's blood sugar was greater than 300, and the RN Supervisor should have notified the APRN, potentially to obtain new orders or treatment plan. The DNS further indicated that the resident representative should also have been notified and documentation of the notifications, including any new orders obtained, should be in the clinical record. The Change in a Resident's Condition or Status policy directs the facility to promptly notify the resident, his or her attending physician, and representative of changes in the resident's medical/mental condition and/or status.