STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075263	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Cromwell	385 Main Street Cromwell, CT 06416

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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 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, the facility failed to ensure timely assessment and management of pain for 1 of 1 resident (Resident #1) reviewed for pain, when staff did not communicate the resident's report of severe pain to the licensed nurse and failed to ensure timely access to and administration of prescribed PRN pain medication.This resulted in Resident #1 experiencing unrelieved severe pain (rated 8/10 and described as unbearable) for approximately 1 hour and 45 minutes, accompanied by observable signs of distress, including facial grimacing, restlessness, and inability to reposition comfortably, as well as verbalized psychosocial distress.The failure occurred when (1) the nurse aide did not report the resident's complaints of pain to the nurse, (2) the assigned nurse was not available on the unit and medication cart keys were not transferred to another licensed nurse, and (3) no alternate system was in place to ensure timely pain intervention, resulting in a delay in administration of physician-ordered analgesic medication. The findings include:Resident #1's diagnoses included radiculopathy lumbar region, cervicalgia, and dorsalgia.The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 had a Brief Interview of Mental Status score of 13 indicating normal cognitive function, was always incontinent of urine and dependent for toilet transfers. Additionally, Resident #1 required as needed pain medication.The Resident Care Plan (RCP) dated 3/3/26 identified Resident #1 had acute and chronic pain related to left Achilles tear, myasthenia gravis, chronic back pain, radiculopathy, and lumbar degenerative disc disease. Interventions included assessing pain every shift, coordinate with the physician as needed for optimal pain control, administer analgesics (pain medication) per the physician orders and document effectiveness and any side effects.Physician's orders dated 2/23/26 and in effect through 3/30/26 directed to administer tramadol hydrochloride (HCL) (medication used to treat pain) 50 milligram (mg) 1 tablet by mouth every 12 hours as needed for chronic pain.Review of Resident #1's Medication Administration Record (MAR) identified that 1 tablet of tramadol HCL 50 mg was administered on 3/30/26 at 10:45 AM (approximately 1 hour and 45 minutes after requesting the medication). Additionally, the MAR identified that Resident #1 had a pain level of 7 prior to medication administration.Observation of Resident #1 on 3/30/26 at 10:10 AM noted Resident #1 in bed with facial grimacing, eyes closed, moving about in the bed attempting to find a comfortable position. Resident #1 stated he/she had severe sharp, stabbing pain in the right hip and right leg and had been waiting for pain medication since 9:00 AM (approximately 1 hour and 10 minutes) after reporting pain to Nurse Aide (NA) #2. Resident #1 rated the pain as 8 on a scale of 0 out of 10 (0 indicating no pain and 10 indicating severe pain). Resident #1 stated it was unbearable and unlike any pain he/she ever felt before and the worst pain he/she has ever had. Observation on 3/30/26 at 10:43 AM noted LPN #3 exiting an area behind the nurse's station and returning to the medication cart, then proceeding to Resident #1's room (approximately 1 hour and 45 minutes after the resident first reported pain).Interview with Licensed Practical Nurse (LPN) #2 on 3/30/26 at 10:16 AM identified she was not assigned to Resident #1 and unaware the resident was in pain. LPN #2 indicated she was unaware that LPN #3 was off the unit and did not have access to the keys for the medication cart to access Resident #1's medication.Interview with LPN #3 on 3/30/26 at 11:02 AM identified (the nurse (continued on next page)

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

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F 0697 Level of Harm - Actual harm Residents Affected - Few	assigned for Resident #1) and was not made aware by staff that the resident was in pain. LPN #3 indicated she became aware of Resident #1's pain after finding a handwritten note on her medication cart upon return to the unit. LPN #3 indicated after seeing the note, she went to Resident #1's room to assess the resident and administer the ordered pain medication.Interview with Nurse Aide (NA) #2 on 3/30/26 at 11:07 AM identified during morning care around breakfast time (approximately 8:30-8:45 AM), Resident #1 stated he/she did not want to be changed due to pain and requested pain medication. NA #2 indicated she did not inform LPN #3 because she thought she already knew. NA #2 identified when she returned to the room later, Resident #1 reported he/she was still in pain and had not yet received pain medication. NA #2 stated she again did not notify LPN #3, because she observed LPN #3 with the medication cart and assumed she was going to the resident's room next.Interview with the Director of Nursing (DON) on 3/30/26 at 11:22 AM identified staff were responsible for communicating any resident reports of pain to the nurse so the nurse can assess and administer pain medication if needed. The DON indicated each medication cart had a designated key, as well as a separate key for controlled substance storage. The DON identified when a nurse leaves the unit or goes on break, the nurse should transfer the medication cart keys to another nurse to ensure timely medication access. The DON identified Resident #1 should not have waited 1 hour and 45 minutes to receive pain medication after reporting pain)Reinterview with Resident #1 on 3/30/26 at 11:30 AM identified the pain had decreased to 3 out of 10. Resident #1 stated he/she was upset and that it was completely unacceptable to have to wait that long for pain medication with unbearable pain and the resident further stated, I hope other residents never have to experience that. Resident #1 experienced psychosocial distress, as evidenced by verbal expressions of frustration and distress, which constitute harm under the regulatory definition.Review of Pain Assessment and Management Policy undated directed, in part, for staff to identify if the resident had pain and to develop interventions that are consistent with the resident's goals and needs and that address the underlying causes of pain. Additionally, the policy identified that pain management is defined as the process of alleviating the resident's pain to a level that is acceptable to the resident and based on his or her clinical condition and established treatment goals.

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of the clinical record, facility policy and interviews for 3 of 3 sampled residents (Resident #30, Resident #34, and Resident #69) residing on the secure unit, the facility failed to ensure a systematic way of determining placement, continued placement, involvement by the physician, resident representative, interdisciplinary team, or the impact residing on a secure unit had on the residents. The findings include:1. Resident #30 ?s diagnoses included Alzheimer's dementia early onset, anxiety disorder, and epilepsy.A wander risk assessment dated [DATE] identified a high risk for wandering.The admission Minimum Data Set assessment dated [DATE] identified Resident #30 was severely cognitively impaired with short- and long-term memory problems, fluctuations in attention and required total staff assistance with eating, hygiene, transfer, bed mobility, dressing and was non ambulatory.The Resident Care Plan dated 1/27/26 identified Resident #30 was an elopement risk/wanderer as evidenced by impaired safety awareness, wander risk assessment and history of elopement attempts at home prior to hospitalization. Interventions included to complete wander risk assessment per policy, consider wander guard as needed, distract resident from wandering, document and report any wandering or exit seeking behaviors every shift, room located on the secure unit.A review of the physician's orders in effect from 3/1/26 through 3/31/26 failed to direct Resident #30's placement on the secured unit.A review of the Advanced Practice Registered Nurse (APRN) notes dated 3/12/26, 3/17/26, 3/20/26, 3/23/26, and 3/30/26 failed to direct Resident #30's placement on the secured unit.2. Resident #34's diagnosis included vascular dementia, schizoaffective disorder and personality disorder.The annual Minimum Data Set assessment dated [DATE] identified a Brief Interview for Mental Status score of 14 indicating no cognitive impairment, no wandering behaviors and was independent with dressing, bed mobility, transfers, and ambulation.The Resident Care Plan dated 3/31/26 identified Resident #34 as an elopement risk/wanderer as evidenced by history of exit seeking behaviors. Interventions included complete a wander risk assessment distract the resident from wandering, document and report any wandering or exit seeking behaviors every shift, room located on the secure unit, wander guard (anti elopement device) as ordered, check placement every shift, check function on 11:00 PM to 7:00 AM shift A physician's order in effect from 2/14/26 through 4/1/26 directed to check the wander guard function every day on 11:00 PM to 7:00 AM shift.A physician's order in effect from 2/14/26 through 4/1/26 directed to check wander guard placement to right wrist every shift.An Advanced Practice Registered Nurse (APRN) note dated 3/2/26 identified exit seeking behaviors but failed to identify criteria for remaining on a secure unit.A wandering elopement assessment dated [DATE] identified high risk for wandering. A review of nurse's notes dated 3/1/26, 3/2/26, 3/7/26, 3/8/26, 3/9/26, 3/10/26, and 3/11/26 identified Resident #34 with exit seeking behaviors.A social service Resident Care Plan meeting note dated 3/31/26 failed to identify Resident #34 met criteria to remain on, had resident representative involvement in placement on, that the least restrictive area was discussed, or that the interdisciplinary team reviewed the impact residing on the secure unit had on the resident.3. Resident #69's diagnosis included Wernicke's encephalopathy, alcohol abuse, and protein calorie malnutrition.The quarterly Minimum Data Set assessment dated [DATE] identified a Brief Interview for Mental Status score of 13 indicating no cognitive impairment, no wandering behavior and was independent with dressing, bed mobility, transfers and ambulation.A wandering elopement assessment dated [DATE] identified Resident #34 at risk to wander.The Resident Care Plan dated 3/13/26 identified Resident #69 was an elopement risk/ wanderer as evidenced by a risk assessment score. Interventions included complete wander risk assessments per policy, monitor, document and report any wandering or exit seeking behaviors every shift, and that Resident #34's room was located on the secured unit.An APRN note dated 3/30/26 failed to identify criteria to remain on the secured unit.A review of the physician's orders dated (continued on next page)

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3/1/26 through 3/31/26 failed to direct placement on a secured unit.A review of nurse's notes dated 3/3/26 through 4/1/26 failed to identify criteria to remain on a secure unit.Interview and observation with Resident #69 on 3/29/26 at 11:17 AM identified he/she rode the exercise bike in the Rehabilitation Therapy Gym on the 3rd floor to assist with improving his/her shuffling gait but needed to be escorted off the unit due to it being locked. Resident #69 indicated that when he/she requested to be escorted, staff indicated that they did not have the time to accompany him/her. According Resident #69's activity calendar (used to track his exercise bike riding time) the last time the resident rode the exercise bike was on 3/17/26 (12 days prior) when he/she was able to ride 3.5 miles. Resident #69 denied having the exit code off the unit.Interview with Person #3 on 4/1/26 at 11:32 AM identified he/she and Resident #69 did not want the resident to be located on the secured unit. Person #3 indicated that at the next care meeting, he/she was going to discuss having Resident #69 placed on a less secure unit. Person #3 indicated that Resident #69 wanted to ride the bike in the gym and it helped with his/her shuffling gait. Additionally, Person #3 indicated that Resident #69 did not want or try to leave the facility and would never try to leave without permission.Interview with Social Worker (SW#1) and the Director of Nursing (DNS) on 4/1/26 at 1:00 PM identified that Resident #69 was appropriately placed on the secure unit, however, the DNS indicated that she needed to check the secured unit policy to identify the criteria for and/or the need for reevaluations for placement on the secure unit. SW#1 and the DNS further indicated that Person #3 had never discussed moving Resident #69 to a less restrictive unit, however, there currently was no bed available to move the resident. The SW indicated that Resident #69 had Wernicke's encephalopathy, was negative, had difficulty interacting with others, and was not a very pleasant person. Further the interdisciplinary team would discuss which resident would be appropriate to move from the secure unit when a bed became available. Although the SW#1 indicated she had seen the resident on the exercise bike daily, (which Resident #69 denied). The surveyor failed to observe Resident #69, over the last 3 days, at any time, to be off the unit. Additionally, The DNS and SW #1 indicated that they could check for a less restrictive environment for Resident #69 at a sister facility and could reevaluate the resident placement. The DNS and SW #1 were unable to indicate if they routinely had used a criteria or reevaluated Resident #69's need to remain on a secure unit. A reinterview with Resident #69 on 4/1/26 at 2:00 PM identified that he/she was p****d and upset that staff did not take him to ride the exercise bicycle and that he/she had been unable to ride at all this week. An interview with the Director of Rehabilitation on 4/1/26 at 2:51 PM indicated that the gym was always open to every resident in the facility but Resident #69 was on a secure unit. This had been discussed in the Resident Care Plan meetings and the staff on the unit were responsible for making sure Resident #69 got to the gym to ride the exercise bike.An interview and record review with LPN #8 on 4/1/26 at 2:42 PM failed to identify that Resident #69 or his/her conservator consented to be placed on a secure unit.An interview and review of the clinical record with the DNS and Registered Nurse (RN) #3 (Regional Clinical Services) on 4/1/26 at 3:01 PM failed to identify they were able to provide any information used for Resident #30, #34, or #69 to reside on a secured unit including:Criteria used for placementCriteria to remain placed on the unitResident representative involvement in the decision to be on a secure unitPhysician involvement/evaluation to remain on or be placed on the unitInterdisciplinary team reviews of documentation to ensure the resident was placed in the least restrictive environment orEvaluation of the impact on the resident from residing on a secure unit.A review of the Abuse policy directed, in part, involuntary seclusion is defined as separation of a resident from other residents or from his/her room or confinement to his/her room with or without roommates against the resident's will or the will of the resident's legal representative.A review of elopements and wandering residents' policy dated 11/27/25 directed, in part, the facility was equipped with door locks/alarms to help avoid elopements. The facility shall establish and utilize a systemic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, (continued on next page)

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	implementation interventions to reduce hazards and risks, monitoring for effectiveness and modifying interventions when necessary.Although requested, a facility policy for a secure/dementia unit was not provided.

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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 observations, review of the clinical record, facility documentation, facility policy and interviews for 1 of 2 sampled residents (Resident #180) reviewed during the initial pool screening, the facility failed to provide a privacy bag for a resident with an indwelling urinary catheter. The findings include:Resident # 180?s diagnoses included a neurological cause of urinary retention, chronic kidney disease, weakness, and a comprehension communication deficit. The nursing admission assessment dated [DATE] identified Resident #180 was cognitively intact and required set up or clean up assistance for eating and oral hygiene and partial to moderate assistance for toileting, walking and transferring.The baseline Resident Care Plan in effect 3/27/26 to 3/30/26 identified Resident #180 had an indwelling urinary catheter related to urinary retention. Interventions included positioning the catheter bag and tubing below the level of the bladder and away from the entrance door to the room.A physician's order dated 3/27/26 directed to ensure privacy cover was on the urinary collection bag each shift.A nurse's note dated 3/27/26 at 6:40 PM identified Resident #180 was admitted with a draining indwelling urinary catheter.Observation on 3/29/26 at 9:54 AM identified the resident lying in bed with an uncovered urinary catheter bag filled with 700 milliliters of yellow urine visible from the hall. Observation on 3/29/26 at 12:12 PM identified the resident lying in bed with an uncovered urinary catheter bag filled with 300 milliliters of yellow urine visible from the hall. Observation and Interview with Assistant Director of Nursing (ADNS) on 3/29/26 at 2:02 PM identified Resident #180 lying in bed on their right side facing the wall with the uncovered urinary catheter visible from the hallway filled with yellow urine. The ADNS identified on admission a catheter cover should have been provided for the urinary catheter bag to ensure privacy and dignity. The ADNS was unable to identify why Resident #180 had not been provided with a privacy cover.Subsequent to surveyor inquiry a blue privacy bag was placed on Resident #180's urinary catheter bag to conceal urinary output.Review of the Foley catheter policy directed, in part, to change the catheter bag as needed because of discoloration of the bag, odor, leakage, etc. The policy failed to indicate the use of privacy covers to maintain dignity.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review and policy review for 1 of 3 sampled residents (Resident #82) for pressure ulcers, the facility failed to follow an intervention to prevent the deterioration of an exisiting pressure ulcer. The findings include:Resident #82's diagnoses included chronic respiratory failure, hypoxia, and diabetes mellitus 2.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #82 had a Brief Interview of Mental Status of 11 indicating moderate cognitive impairment and was dependent on staff for bed mobility, sitting to lying, lying to sitting and to stand. Additionally, the MDS identified Resident #82 was at risk for developing pressure ulcers/injuries and did not exhibit rejection of care necessary to achieve goals for health and wellbeing.The Resident Care Plan dated 2/26/26 identified Resident #82 had a potential for impaired skin/pressure ulcer injury development related to oxygen tubing use. Interventions included administering treatments as ordered and checking skin and oxygen tubing placement every shift.A nurse's note dated 3/18/26 at 2:30 PM identified Resident #82 was observed with a stage 2 pressure ulcer between the right ear and where the ear met the head measuring 0.3 centimeters (cm) x 1.0 cm x 0.1 cm, no signs or symptoms of infection, and denied pain to the area. Additionally, the physician was updated, new treatment orders were obtained, and foam padding was placed on the oxygen tubing as an intervention.A physician's order dated 3/18/26 directed to apply foam padding to bilateral earpieces of oxygen tubing, check placement and replace as needed for displacement every shift.Review of the nurse's notes the Treatment Administration Record dated 3/18/26 through 3/31/26 failed to identify that Resident #82 refused the foam padding or that the resident was removing the foam padding from the oxygen tubing. Observation on 3/29/26 at 11:17 AM identified Resident # 82 wearing a nasal cannula which was lying directly on the wound without the benefit of a foam padding. Further observation failed to identify that a foam padding was in the residents bed or on the floor.Interview and observation with Resident #82 on 3/31/26 at 9:05 AM identified a nasal cannula lying directly on the wound without the benefit of foam padding. Resident #82 stated that the nurses had been applying cream to the open area on the right ear and that there was supposed to be padding on the oxygen tubing, but those darn ear things keep falling off. Further observation failed to identify that a foam padding was in the residents bed or on the floor.Interview, observation and clinical record review with the Assistant Director of Nursing/Wound Nurse (ADNS) on 3/31/26 at 9:28 AM indicated that Resident #82's wound to the right ear was identified on 3/18/26 as a facilityˆacquired Stage 2 pressure ulcer caused by oxygen tubing. Additionally, the ADNS identified interventions included application of SSD cream (a topical antibiotic used to prevent infection) and placement of foam padding to the oxygen tubing. On observation, Resident #82 was being administered oxygen by an oxygen concentrator via a nasal cannula, but without the benefit of foam padding applied to the oxygen tubing and the tubing was directly on the wound. Resident #82 had an additional nasal cannula connected to a portable oxygen concentrator (not in use) suspended on the back of his/her wheelchair. Upon observation the nasal cannula connected to the portable oxygen concentrator failed to have foam padding applied. The ADNS asked Resident #82 if he/she had removed the padding, to which the resident responded, No, they fall off and I find them everywhere. The ADNS indicated that the unit nurse was responsible for checking and applying the foam protectors and that Resident #82 should have been wearing foam protectors as an intervention to prevent deterioration of the pressure ulcer.Subsequent to surveyor inquiry the ADNS instructed the nurse on the unit to apply foam padding protectors to Resident #82's oxygen tubing.Review of the Pressure Ulcer Prevention Policy dated 12/15/22 directed in part that residents determined as a risk for pressure ulcers will have interventions documented in plan of care based on specific factors identified in the risk assessment.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record and policy review for 1 of 4 sampled residents (Resident #40) reviewed for dignity, the facility failed to obtain a consent and provide a resident with podiatry services. The findings include:Resident #40's diagnoses included disc degeneration, chronic kidney disease and heart failure.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #40 had a Brief Interview of Mental Status of 13 indicating intact cognition and was independent for eating, dressing and toileting.The Resident Care Plan dated 1/29/26 identified Resident #40 had a self-care performance deficit related to a deconditioned status. Interventions included for staff to adjust to the amount of physical function as residents' functional status/participation changed with behavior and to check nail length with bathing.Review of the physician's orders signed 3/11/26 failed to identify an order for podiatry services (although orders for other ancillary services were in place).Interview and observation on 3/30/26 at 9:37 AM identified Resident #40 in bed with the residents feet exposed. The toenails were thick, overgrown approximately 1/4 inch, and the right great toenail appeared jagged and uneven. Resident #40 stated that his/her toenails have not been trimmed since he/she was admitted in October 2025, even though he/she has been asking staff to do so.Interview with Licensed Practical Nurse (LPN) # 5 on 3/31/26 at 9:20 AM identified it was the facility policy for anyone needing podiatry services to be placed on the list which was overseen by the scheduler.Interview and review of facility documentation with the Scheduler on 3/31/26 at 9:25 AM identified she was responsible for maintaining the podiatry list. She stated the podiatrist visits monthly to provide services, including toenail trimming, for any residents in need. Review of Resident #40's record failed to identify that he/she had been seen by the podiatrist since being admitted in October 2025.Interview and record review with the Director of Nurses (DON) on 3/31/26 at 10:01 AM indicated that it was facility policy to obtain signed consents upon admission unless the resident was admitted for shortˆterm rehabilitation. Review of Resident #40's clinical record with the DON showed that although he/she was initially admitted as a shortˆterm resident on 10/13/25, he/she transitioned to longˆterm care on 10/31/25, at which point a podiatry consent should have been obtained. The DON was unable to identify why Resident #40 did not have a signed consent for podiatry services; however, she confirmed that one should have been in place since 10/31/25, as all podiatry services are provided by an outside vendor.Subsequent to surveyor inquiry, the DON contacted the conservator, obtained a signed consent for podiatry services dated 3/31/26, and Resident #40 was placed on the podiatry list to be seen at the next visit.Review of the Podiatry Services Policy revised 10/28/25 directed in part that it was facility policy to ensure residents receive proper treatment and care to maintain mobility and good foot health.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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, interviews, and facility policy review for 1 of 3 medication rooms reviewed for medication storage, the facility failed to store Schedule II-V controlled medications in a permanently affixed compartment within the medication refrigerator. The findings include:Interview and observation of the second floor medication room with Licensed Practical Nurse (LPN) #4 on 3/31/26 at 6:41 AM identified the following:For the North Side unit, located in the refrigerator on the second shelf, it was identified that although the controlled substance storage box was noted to be locked, it was not permanently affixed to the refrigerator. Inside the North Side controlled medication compartment was 1 unopened bottle Lorazepam two (2) milligram (mg) per milliliter (ml), 30 milliliter (ml) vial with an expiration date of 3/2027.For the South Side unit, located in the refrigerator on the second shelf, it was identified that although the controlled substance storage box was noted to be locked, it was not permanently affixed to the refrigerator. Inside the South Side controlled medication compartment were 4 unopened bottles of Lorazepam 2 milligram (mg) per milliliter (ml), 30 milliliter (ml) vials with an expiration date of 3/2027.LPN #4 indicated that she was unaware controlled substance storage in the medication refrigerator needed to be permanently affixed and that if she had known, she would have notified her supervisor. LPN #4 identified that she had been employed at the facility for approximately 6 months and that the controlled medication compartments had not been permanently affixed to the medication refrigerator since she began working at the facility.Interview and observation with the Assistant Director of Nursing (ADNS) on 3/31/26 at 7:11 AM identified that both the North and South side unit controlled substance storage boxes in the medication room refrigerator were noted to be locked but not permanently affixed to the medication refrigerator. The ADNS indicated that controlled substances medication boxes were required to be permanently affixed to the refrigerator. Subsequent to surveyor inquiry, the ADNS indicated she would be contacting the Maintenance Department to permanently affix both boxes.Interview and observation with the Director of Nursing (DNS) on 3/31/26 at 7:45 AM identified that the keys to both of the controlled substance storage boxes had broken approximately 6 months ago and were replaced with new boxes. She indicated she assumed the boxes had been permanently affixed to the refrigerator when replaced and was unaware they had not been. The DNS stated that it was her responsibility and the facility policy to ensure narcotic boxes were permanently affixed, and she would have the Maintenance Department correct the issue as soon as possible.Subsequent to surveyor inquiry, the North Side and South Side controlled medication boxes in the second floor medication room refrigerator were permanently affixed.Review of the storage of undated medications policy directed, in part, that Schedule II-V controlled medications are stored in separately locked, permanently affixed compartments.

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	075263	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Cromwell	385 Main Street Cromwell, CT 06416

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observation, interviews, and review of facility policy, the facility failed to ensure resident identifiable information and resident medical records were stored in a secure location. The findings include:Observation on 3/30/26 at 1:42 PM in the unoccupied and unlocked medical record room located in the basement of the facility identified there were 217 banker boxes with medical records ranging from 2013 to 2026. The boxes contained resident medical records with personally identifiable information including name, date of birth , medical record number, social security numbers, and diagnoses.Observation and interview with the Director of Nurses (DON) on 3/30/26 at 2:35 PM identified 217 banker boxes in the unoccupied and unlocked medical record room located in the basement of the facility. The boxes contained resident medical records with personally identifiable information including name, date of birth , medical record number, social security numbers, and diagnoses from 2013 to 2026.The DNS indicated that she was not familiar with the facility policy on resident medical records and personally identifiable information. The DNS identified that medical records should be stored in a secured (locked) location and that it was the responsibility of the staff member who entered the medical record room to ensure that it was locked when they exited. The interview failed to identify why the medical record room was not secured.Review of the maintenance of clinical records policy dated 5/7/24 directed in part that clinical records of the facility will be safeguarded against loss, destruction, or unauthorized use. Additionally, the policy directed that records will be filed by resident name and year and kept in a locked and monitored area of the Medical Records Department.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of the clinical record, facility documentation and interviews for 1 of 3 sampled residents (resident #30) reviewed for falls, the facility failed to ensure appropriate hospice provider communication had occurred for seating and following a fall. The findings include:The admission Minimum Data Set assessment dated [DATE] identified Resident #30 was severely cognitively impaired with short- and long-term memory problems, fluctuations in inattention and required total staff assistance with transfers, bed mobility, dressing and was non ambulatory. Resident #30 had a history of falls prior to admission.The Resident Care plan dated 3/22/26 identified Resident #30 had a terminal prognosis related to hospice services beginning 3/22/26. Interventions included hospice Registered Nurse (RN), work cooperatively with the hospice team to ensure the resident's, physical and social needs were met, and work with nursing staff to provide maximum comfort for Resident #30.A nurse's note dated 3/22/26 at 2:28 PM identified that Resident #30 was accepted into a hospice program.A nurse's note dated 3/28/26 at 11:41 AM identified Resident #30 was observed on the floor in a semi-prone (face-down) position in front of the wheelchair. Staff reported the Resident #30 leaned forward, lost his/her balance, and fell out of the wheelchair. Resident #30 was noted to have a small open area on the bridge of his/her nose and right inner nostril. Resident #30 did not exhibit signs of acute pain or discomfort during the assessment. The nurse's note failed to include documentation that hospice was notified of Resident #30's fall with injury.Facility Accident and Incident report dated 3/28/26 identified Resident #30 was observed on the floor in a left semi-prone position in front of his/her wheelchair. Resident #30's injuries included a small skin tear on the bridge of the nose measuring 0.2 centimeter (cm) in length, 0.2 cm in width, 0.1 cm in depth and a small open area inside the right nostril. Resident #30 was alert but confused and required assistance from 1 staff member for transfers and wheelchair mobility both prior to and following the incident. An investigation statement written by LPN #6 dated 3/28/26 identified she was alerted the resident had fallen out of the chair. A written statement by Nurse Aid (NA) #5 indicated Resident #30 was transferred into the wheelchair and began to lean to the left side. NA #5 repositioned Resident #30 who then began leaning again and the resident was repositioned a second time. NA #5 called for the nurse for help and as soon as the nurse arrived, Resident #30 started to fall to the floor and NA #5 attempted but was unable to prevent the fall. The Accident and Incident report failed to include documentation that hospice was notified of the fall with injury.An interview with LPN #6 on 3/31/26 at 1:21 PM indicated she was at the nurse's desk when NA #5 informed her Resident #30 was on the floor. LPN #6 identified prior to the fall Resident #30 had been placed in a black transport wheelchair. LPN #6 indicated the hospice nurse had informed her that Resident #30 should have been seated in a Broda chair; however, she stated she was unaware of this requirement. LPN #6 identified the Broda chair was not present in Resident #30's room at the time of the fall and was unsure when it had been ordered, indicating it may have arrived on Friday, 3/27/26.An interview and review of facility documentation with RN #2 (hospice RN) on 3/31/26 at 2:23 PM identified the recommendation for the Broda chair was made on 3/22/26 (8 days prior to the fall) due to Resident #30's trunk instability and lack of control. The Broda vendor had notified RN #2's hospice when the Broda chair had been delivered to the facility on 3/23/26 (7 days prior to the fall), it was delivered to the resident's room and indicated that he/she had notified facility staff of the delivery. She indicated that the facility process when changing the plan of care directed the hospice nurse to make the recommendation on a recommendation form, notify the family member and the facility staff, then place the form in the binder, which she indicated had been done. On review of the hospice binder the recommendation dated 3/22/26 was present and RN #2 indicated that the facility nurse should have conveyed the information to the appropriate staff for implementation. Additionally, RN #2 indicated that a family (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	member had notified her of Resident #30's fall, and that the facility never made notification to the hospice vendor. After an assessment post fall, on 3/29/26 between 1:00 PM and 2:00 PM RN #2 discovered that Resident #30 had been placed in a transport wheelchair instead of the Broda chair that should have been used because a transport chair was not appropriate to stabilize Resident #30's trunk.An interview and clinical record review with RN #4 on 4/2/26 at 10:35 AM indicated that he completed Resident #30's post fall Accident Incident report. RN #4 stated when he assessed Resident #30, he/she was on the floor in front of a small black wheelchair not a Broda chair and the Broda chair was absent from the room. The resident's assigned staff, NA #5, was from a staffing agency and failed to ask any staff member which chair Resident #30 should have been placed in and she had incorrectly utilized a transport wheelchair. On review of the clinical record, RN #4 failed to identify that there an order placed for the Broda chair or that the information had been placed on Resident #30's NA care card/Kardex (used to direct NA resident care) but since hospice had made the recommendation, it should have been noted in both areas. The facility protocol included the hospice provider writing the recommendation on a hospice form, notifying the nursing staff, then placing the recommendation in the hospice binder. Nursing staff would then place the recommendation in the APRN book for approval and nursing would write an order, transcribe it onto the NA care card and the Resident Care Plan. RN #4 was unable to explain why the hospice recommendation sheet was not reviewed and placed in the APRN book, but the recommendation should have been addressed and further, if it had been placed in the APRN book, why the APRN had not been addressed the recommendation.A review of the Hospice Services facility policy dated 1/26/23 directed, in part, the written agreement will set out at least the following: The services hospice will provide, the hospice's responsibilities for determining the appropriate hospice plan of care, and the services the facility will continue to provide based on each resident's plan of care. A communication process including how communication will be documented between the facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. Additionally, a provision that the facility will immediately notify the hospice about the following: A significant change in the resident's physical, mental, social or emotional status, clinical complications that suggest a need to alter the plan of care. An agreement that it is the facility's responsibility to furnish 24-hour room and board care, meet the residents' personal care and nursing needs in coordination with the hospice representative and ensure that the level of care provided is appropriate based on the individual's needs. A delineation of the hospice's responsibilities including but not limited to, providing medical direction and management of the resident, nursing, providing medical supplies, durable medical equipment and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions.

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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 interviews, review of the clinical record, and review of facility policy for 3 of 3 residents (Resident #63, Resident #161, Resident #168) reviewed for smoking, the facility failed to accurately code the Minimum Data Set (MDS) assessment for tobacco use. The findings include:1. Resident #63's diagnoses included chronic obstructive pulmonary disease, paranoid schizophrenia, and type 2 diabetes.An annual MDS assessment dated [DATE] identified Resident #63 had a Brief Interview of Mental Status score of 7 indicating severe cognitive impairment, was independent with eating, oral hygiene, and ambulation and did not currently use tobacco. The MDS failed to identify Resident #63 smoked cigarettes.A Resident Care Plan dated 2/13/26 and in effect through 4/1/26 identified Resident #63 was a supervised smoker. Interventions included provide supervised smoking per the schedule posted at the nurses station and smoking assessments quarterly.Smoking assessments dated 2/12/25 and 5/12/25 identified Resident #63 smoked 5 to 10 cigarettes a day. Smoking safety screenings dated 8/12/25, 12/8/25, and 3/8/26 identified Resident #63 smoked 2 to 5 cigarettes a day.2. Resident #161's diagnoses included chronic obstructive pulmonary disease, dementia, and nicotine dependance.An annual MDS assessment dated [DATE] identified Resident #161 had a Brief Interview of Mental Status score of 7 indicating severe cognitive impairment, was independent with eating, oral hygiene, and ambulation and did not currently use tobacco. The MDS failed to identify Resident #161 smoked cigarettes.A Resident Care Plan dated 2/13/26 and in effect through 4/1/26 identified Resident #161 was at risk for injury due to smoking. Interventions included supervision when smoking, smoking during designated times, and smoking assessments quarterly.Smoking assessments dated 12/21/24, 9/21/25, 12/21/25, and 3/21/26 identified Resident #161 smoked 2 to 5 cigarettes a day. Smoking assessments dated 3/21/25 and 6/21/25 identified Resident #161 smoked 5 to 10 cigarettes a day.3. Resident #168's diagnoses included chronic obstructive pulmonary disease, acute and chronic respiratory failure with hypoxia, and nicotine dependence.An annual MDS assessment dated [DATE] identified Resident #168 had a Brief Interview of Mental Status score of 13 indicating no cognitive impairment, was independent with eating, oral hygiene, and ambulation and did not currently use tobacco. The MDS failed to identify Resident #168 smoked cigarettes.A Resident Care Plan dated 2/13/26 and in effect through 4/1/26 identified Resident #168 was at risk for injury due to smoking. Interventions included supervision when smoking, smoking during designated times, and smoking assessments quarterly.Smoking assessments dated 6/20/25, 9/20/25, 12/20/25, and 3/20/26 identified Resident #168 smoked 1 to 2 cigarettes a day.Interview on 4/1/26 at 10:24 AM with Licensed Practical Nurse (LPN) #7 (MDS Coordinator) identified she was responsible for the coding of comprehensive MDSs. LPN #7 identified Resident #63's comprehensive MDS, Resident #161's comprehensive MDS, and Resident #168's comprehensive were incorrectly coded as not using tobacco. LPN #7 indicated that since all 3 residents were active smokers at the time of their assessments, the MDS coding was incorrect and should have included tobacco use.Interview with the Director of Nursing (DON) on 4/1/26 at 1:10 PM identified MDS staff were responsible for the coding of MDSs' and that residents who smoke should be correctly coded as smoking on their MDS.Review of the Resident Assessment Instrument (RAI) instruction manual (used to direct MDS processes) dated October 2025 directed in part, that if a resident used tobacco products in some form within the look back period then the coding of section J1300 should indicate yes for tobacco use.Review of the facility's Minimum Data Set policy identified in part, the MDS coordinator will complete assigned sections and triggered care area assessments. MD notes and orders, the current plan of care, and the treatment record will be used to support MDS completion.