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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075292	A. Building B. Wing	09/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at New Britain	400 Brittany Farms Rd New Britain, CT 06053

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31310 Based on clinical record reviews, facility documentation, policy, and interviews for one of three sampled residents (Resident #1) who were a new admission and received a medication to treat a low thyroid level, Levothyroxine, the facility failed to transcribe the medication on admission to ensure the resident was free of a significant medication error. The findings include: Resident #1's diagnoses included hypothyroidism. The Inter-Agency Referral Report dated 7/25/23 directed Levothyroxine (Synthroid) 100 micrograms (mcg) take one tablet by mouth daily. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 made consistent and reasonable decisions regarding tasks of daily life, required set up help only with eating, and had a thyroid disorder. The Resident Care Plan dated 8/10/23 identified Resident #1 had hypothyroidism. Interventions directed to give thyroid replacement therapy as ordered, to monitor and document for side effects and effectiveness. The Facility Reported Incident form dated 7/25-8/21/23 identified upon receiving a letter from Resident #1's spouse, Person #1, an investigation revealed Resident #1's Synthroid was omitted from the admission orders and Resident #1 did not receive the Synthroid for the duration of Resident #1's stay from 7/26/23 through 8/21/23, twenty-eight (28) days. The facility was unaware of any side effects that may have occurred secondary to the omission of the Synthroid. Review of the clinical record and the Electronic Medication Administration Record (EMAR) for July and August 2023 failed to reflect the Levothyroxine order was transcribed upon admission resulting in Resident #1 missing twenty-seven (27) doses of Levothyroxine. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Person #1 on 9/27/23 at 9:20 AM identified Resident #1 was discharged from the facility on August 21, 2023. Person #1 indicated the next morning he/she was reviewing the paperwork Resident #1 received upon discharge including the list of medications and noticed the thyroid medicine was not on that list. Person #1 identified he/she called the facility and told the staff Resident #1 did not receive the thyroid medication while at the facility. Person #1 indicated Resident #1 had bloodwork drawn on 8/23/23 including a thyroid-stimulating hormone (TSH) level which was 6.10 (normal levels between 0.45-4.5) and the Synthroid dose was not changed by the doctor Resident #1 received the same dose of Synthroid 100 mcg once a day. Interview with the 7AM-3PM Unit Manager, Registered Nurse (RN) #1, on 9/27/23 at 10:25 AM identified when she was transcribing the admission orders she got distracted with a personal phone call. RN #1 indicated she came off the floor and when she came back, she resumed the transcription of the admission orders. RN #1 identified she thought she was picking up where she left off, however she omitted the Synthroid at that point because of the distractions. RN #1 identified the 11PM-7AM shift was to conduct a second reconciliation of Resident #1's admission orders. Interview with the Director of Nurses (DON) on 9/27/23 at 11:00 AM identified the process to transcribe the admission orders was for the nursing supervisor or unit manager to review the Inter-Agency Referral Report (W-10) or the hospital discharge summary with the provider, then the orders get inputted into the Electronic Medication Administration Record (EMAR). The DON indicated the 11PM-7AM nursing supervisor was to review the new admission orders again against the W-10 and that was the second check. The DON identified then the 7AM-3PM unit manager or quality assurance nurse would review the orders against the W-10 again, and that was the third check. The DON indicated RN #1 did not transcribe the Synthroid order upon Resident #1's admission due to being distracted and somehow the second and the third checks did not pick up on the omitted Synthroid order. Interview with 11PM-7AM Nursing Supervisor, Registered Nurse (RN) #2, on 9/28/23 at 8:45 AM identified she believed she reconciled Resident #1's medications during the 11PM-7AM shift and could not recall what happened during the shift and how Resident #1's Synthroid order was missed for the second time. Review of the Medication/Transcription Orders directed when transcribing orders of medications, specify the type, route, dosage, frequency, and strength of the medication ordered.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. 31310 Based on clinical record reviews, facility documentation, and interviews for one of three sampled residents (Resident #1) who were a new admission, the facility failed to implement the physician's order and obtain laboratory blood work. The findings include: Resident #1's diagnoses included malignant neoplasm of bladder, pancreatic adenocarcinoma, chronic anemia, hypomagnesemia, and hypokalemia. A physician's progress note dated 7/25/23 identified Resident #1 was evaluated today and the plan was to draw admission blood work. A physician's order dated 7/25/23 at 2:37 PM directed to obtain a Complete Blood Count (CBC) and Comprehensive Metabolic Panel (CMP) on 7/27/23. Review of the clinical record and facility documentation failed to identify the CBS and CMP had been obtained on 7/27/23. Interview with Advanced Practice Registered Nurse (APRN) #1 on 9/27/23 at 9:50 AM identified he would expect the CBC and CMP to be drawn per the physician's order. Interview with the Director of Nurses (DON) on 9/28/23 at 1:30 PM identified she could not locate the CBC and CMP results report for 7/27/23. The DON indicated she called the laboratory services and there were no results of a CBC and CMP drawn on 7/27/23 for Resident #1. The DON identified she did not know what happened or why the CBC and CMP were not drawn on 7/27/23 and there was no documentation in the nurse's notes regarding the laboratory blood work.