STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075331	A. Building B. Wing	11/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at the Willows	225 Amity Rd Woodbridge, CT 06525

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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 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 documentation, facility policy and interview, the facility failed to ensure ophthalmic medications were labeled properly after opening. The findings include:Observation on 9/16/25 at 10:20 AM of 4 of 6 medication cart inspections identified the following ophthalmic medication, which were open, had no documented dates regarding when they were open. a. Medication cart identified as 2nd floor long hall.1 bottle of brimonidine tartrate 0.2% eye drops.1 bottle of Systane eye drops.1 bottle of Refresh eye drops. b. Medication cart identified as 2nd floor short hall.1 bottle of Dorzolamide hydrochloride/timolol maleate 2%/0.5% eye drops.1 bottle of Latanoprost 0.005% eye drops.2 bottles of Brimonidine tartrate 0.2% eye drops.1 bottle of Ciprofloxin 0.3% eye drops.1 bottle of Latanoprost 0.005% eye drops.1 bottle of Timolol eye drops 0.5% eye drops. c. Medication cart identified as private short hall.1 bottle of Brimonidine tartrate 0.2% eye drops.2 bottles Latanoprost 0.005% eye drops.1 bottle of Refresh eye drops. d. Medication cart identified as private long hall.1 bottle of Latanoprost 0.005% eye drops. Interview with the Pharmacy Consultant on 9/16/25 at 1:05 PM identified ophthalmic medications should be dated according to facility policy. Interview with the DNS on 9/16/25 at 1:13 PM identified she would expect eye drops to be dated after opening according to policy. Review of the facility policy for Medication Storage directed ophthalmic medications are to be dated at the time of opening. Although requested, a list of specific ophthalmic medications with specified discard dates after opening was not provided.

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on review of facility documentation, facility policy and interviews for 4 of 5 residents, (Resident #3, 9, 12 and 75) reviewed for pneumococcal and influenza vaccine administration, the facility failed to ensure informed consent and documented administration of pneumococcal and influenza vaccinations was done according to policy. The findings include: 1. Resident #3 was admitted to the facility in April 2022 with diagnoses that included cerebral palsy and mitral insufficiency. Resident #3 was self-responsible.A review of Resident #3's immunization record identified the pneumococcal vaccine (PV20) was administered on 4/28/23.The Pneumococcal Vaccine Informed Consent form dated 4/28/23 identified no documented signed consent for the pneumococcal vaccine. 2. Resident #9 was admitted to the facility in March 2021 with diagnoses that included chronic obstructive pulmonary disease and atherosclerotic heart disease. Resident #9 was not self-responsible.Review of the clinical record failed to identify documentation the influenza vaccine was offered to Resident #9 or the responsible party in 2024. 3. Resident #12 was admitted to the facility in May 2024 with diagnoses that included atherosclerotic heart disease and type II diabetes. Resident #12 was not self-responsible.The Pneumococcal Vaccine Informed Consent dated 9/11/24 identified consent was obtained from the responsible party to administer the pneumococcal vaccine.Review of the clinical record failed to identify documentation the vaccine had been administered. 4. Resident #75 was admitted to the facility in December 2022 with diagnoses that included history of bronchitis. Resident #75 was self-responsible.The Pneumococcal and Influenza Informed Consent dated 12/11/23 identified Resident #75 gave consent for administration of both vaccines, pneumococcal and influenza.The clinical record failed to identify documentation the pneumococcal or influenza vaccine had been administered following consent. Additionally, the clinical record had no documentation the influenza vaccine was offered in 2024. Interview with RN #1 (Infection Preventionist) on 9/18/25 at 2:19 PM identified she has held the role since April 2024 and was responsible for overseeing the facility's vaccination program. RN #1 identified she relied solely on clinical records to monitor vaccination status, had not implemented a tracking system, and could not provide information on any prior systems. RN #1 was also unable to explain how resident vaccination status was monitored over time.Interview with the DNS on 9/18/25 at 3:25 PM identified all immunizations should be offered on admission and annually as indicated, tracked over time and remain up to date with documented refusals.Review of the facility policy for Pneumococcal Vaccines directed each resident to be offered the pneumococcal vaccine with informed consent unless contraindicated, the resident is up to date or the resident/representative refuses.Review of the Influenza Vaccine policy directed each resident be offered the vaccine annually from October 1st through March 31st with informed consent unless medically contraindicated or the resident/representative refuses.

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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 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 observation, review of the clinical record, facility policy, and interviews for 1 of 5 residents (Resident #2) reviewed for pressure ulcers, the facility failed to ensure the implementation of appropriate measures to prevent the possible worsening of pressure ulcers for a dependent resident. The findings include: Resident #2's diagnosis included diabetes type 2 with diabetic neuropathy, venous insufficiency, and dementia. The admission Minimum Data Set assessment dated [DATE] identified Resident #2 had a Brief Interview of Mental Status score of 9 indicating moderate cognitive impairment and required maximal/substantial assistance to turn in bed, to sit to stand, and chair to bed to chair transfers. Additionally, Resident #2 had 1 stage 2 pressure ulcer present on admission and was at risk for pressure ulcer development.The Resident Care Plan dated 4/9/25 identified an actual impairment to the resident's skin, new deep tissue injuries (pressure ulcers) to the bilateral heels. Interventions included to ensure socks were in place with offload heel boots to prevent rubbing/friction, offload heel boots when resident was in bed and encourage use, wrap entire foot with kerlix wrap followed by a sock followed by offload heel boots.A resistance to care Resident Care Plan dated 5/21/25 identified Resident #2 would, at times, kick off his/her multi-podus boots, and staff were to leave and return at a later time, try again, and review outcomes of noncompliance.A pressure ulcer Resident Care Plan dated 9/2/25 identified bilateral unstageable heels unchanged. Interventions included to offload heels and assist with bed mobility.A Pressure ulcer risk assessment dated [DATE] identified a score of 12 indicating Resident #2 was at high risk for pressure ulcer development.The facility provided, in-house pressure ulcer list as of 9/16/25 identified Resident #2 had a community acquired pressure ulcer to the right and left heels with an onset date of 4/9/25. Review of the Nurse Aide (NA) Care Card (Resident Care Plan directing NAs) dated 9/23/25 directed to wrap the resident entire foot with kerlix wrap followed by a sock, followed by offload heel boots and if the resident resisted treatment, re-approach and re-offer care when behavior subsided.Review of physician orders in effect from 9/1/25 through 9/23/25 directed the use of heel boots when in bed. A physician wound care progress note dated 9/19/25 identified pressure ulcers of the left and right heels, both measuring 1.2 centimeters (cm) by 1 by 0 depth, unstageable with 100% eschar (dead, dry, hard, leathery tissue). The Plan to Address Factors Affecting Wound Healing included turning and repositioning, off-load pressure per facility protocol, and heel off-loading. The Plan of Care was discussed with facility staff and the resident.Review of the September Treatment Administration Record indicated Resident #2's heel boots were identified as in place or intermittently refused, however the nurse's notes failed to indicate all the refusals or reason for refusals.Intermittent observations on 9/23/25 at 6:35 AM, 7:05 AM, and 7:34 AM identified Resident #2, lying in bed on his/her back without the benefit of off-loading (relief of pressure) of his/her bilateral heels. A pillow was observed at the end of the bed not in use, and the resident did not have off-loading boots on his/her feet. Observation at 8:04 AM noted that the resident was boosted up in bed for breakfast by Nurse Aide (NA) #1 and another NA still being positioned on his/her back. The NA's failed to place the pillow at the end of the bed under Resident #2's legs, failed to place the physician ordered off-loading boots, and failed to offer the resident any type of off-loading prior to exiting the room. Continued intermittent observations at 8:30 AM and 9:00 AM identified Resident #2's bilateral heels lacked any type of off-loading. Interview and observation with RN #2 on 9/23/25 at 9:32 AM identified that Resident #2 often refused to wear his/her boots or were kicked off. When the boots were kicked off by the resident, staff were told to store the boots in the closet because it would be hazardous to leave the boots with the resident. RN #2 stated that Resident #2 also kicked the pillow out from under his/her legs despite being educated by staff and the wound physician. When the resident refused, RN #2 would wrap the heels in kerlix to keep pressure from the resident, but he/she would also unravel the kerlix. RN #2 indicated that the facility has made no further attempts to provide Resident #2 with (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	alternative methods of off-loading which Resident #2 may have preferred and/or tolerated. RN #2 located the boots in the closet, noted the flattened pillow (no off-loading capacity) at the end of the bed, and failed to find evidence that kerlix had been used but the physician orders did direct the use of heel boots.Interview with NA #1 on 9/23/25 at 10:05 AM identified Resident #2's assigned NA was NA #2. NA #1 indicated that she worked on different units throughout the facility. NA #1 stated Resident #2 would frequently refuse his/her boots and when this happened, she would reassure him/her and notify the nurse. Further NA #2 indicated that she had not noticed Resident #2's heels on the bed.Interview with LPN #10 Resident #2's charge nurse, on 9/23/25 at 10:08 AM identified that staff had not informed her Resident #2 refused to wear his/her boots, refused an off-loading pillow, or that he/she did not have kerlix covering his/her heels. LPN #10 stated she would go speak with the resident to try to get him/her to accept an off-loading device and if the resident still refused, she would tell the supervisor. Interview with NA #2 on 9/23/25 at 10:10 AM identified that she had not seen Resident #2 yet during her shift. She indicated that 2 NA's had been in earlier to check on the resident and boosted him/her up for breakfast. Although NA #2 initially indicated that she had not seen the resident yet, she stated that she had been to see him/her once but failed to check if his/her heels were off-loaded. NA #2 stated that Resident #2 wore his/her boots for the most part but frequently removed the devices, noting that she was on her way to see Resident #2 now.Interview and review of the clinical record with RN #2 on 9/23/25 identified that when a resident refused care performed by a NA, she had developed a form to show the resident's refusal. Once the form had been completed by the charge nurse, the supervisor was informed, would sometimes go see the resident, and the refusal document was filed in the back of the paper record. RN #2 was unable to recall being told the Resident #2 had refused to off-load this shift or previous shifts. After looking in her office and reviewing the clinical record, RN #2 indicated she had failed to locate her documentation form that Resident #2 had refused off-loading boots or pillows during the months of August and September 2025. Interview with the Regional Nurse, RN #4 on 9/23/25 at 2:22 PM identified that although Resident #2 had been refusing his/her current off-loading devices, other mechanisms were available and should have been attempted. Additionally, RN #4 identified that the Resident should not have been left for 3 hours without off-loading attempts.Subsequent to surveyor inquiry a physician's order dated 9/23/25 was implemented to direct heel boots in place when the resident was in bed, if refused, use pillows followed by gel pillows under a fitted sheet every shift for skin protection.Review of the facility Repositioning/Bed and Wheelchair undated policy directed, in part, residents who are in bed should be turn and repositioned and that if the resident refused to notify the supervisor and identify and evaluate for potential alternatives.Review of the Prevention of Pressure Ulcers/Injuries policy dated 1/2018 directed, in part, to reposition more frequently based on the condition of the ski and comfort, provide support devices, and review the interventions and strategies for effectiveness on an ongoing basis.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **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 resident (Resident #65) reviewed for enteral feeding, the facility failed to provide enteral feeding according to professional standards to prevent aspiration. The findings include:Resident #65 was admitted to the facility in January 2025, with a readmission in May 2025, after a hospitalization. Diagnosis included Parkinson's disease, dysphagia and gastrostomy tube. Physician's orders for September 2025 (original order date 6/3/25) directed to administer the following enteral feeding; Jevity 1.5 at 75mg/hour for 16 hours, on at 6:00 AM, off at 10:00 PM. Additionally, the September 2025 physician's orders directed to elevate the residents head of bed 30 - 45 degrees during feeding and for at least 30 - 45 minutes after feedings, and elevate head of bed 60 minutes after medication administration via feeding tube. The quarterly MDS dated [DATE] identified Resident #65 had intact cognition, fluctuating disorganized thinking, had a feeding tube while a resident at the facility, and received 51% or more proportion of total calories through the feeding tube.Review of the care plan on 9/16/25 failed to reflect the residents feeding tube. Observation on 9/16/25 at 11:40 AM identified the resident was in bed with the tube feed infusing at 75cc/hour. The head of the bed was less than 30 degrees (almost flat) and the resident was alone in the room. Observation on 9/16/25 at 11:53 AM with LPN #12 identified the resident was flat in bed receiving tube feeding at 75cc/hour while receiving care by NA #11. Interview with LPN #12 on 9/16/25 at 11:53 AM identified the residents head of the bed was flat but should be up between 30 - 45 degrees if the tube feeding is infusing. Subsequently, LPN #12 turned off the tube feeding. Interview with NA #11 on 9/16/25 at 12:00 PM indicated she did not know that the tube feeding should be paused while the resident is flat in bed receiving care. Subsequent to the observation of Resident 65 flat in bed with the tube feeding infusing, the facility initiated staff training including to ensure the head of bed is elevated when the feeding is infusing. Although a policy on tube feeding was requested, the policy provided did not speak to ensuring the head of the bed is elevated when a resident is receiving tube feeding.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, policy, and interviews for the only sampled resident (Resident #7) reviewed for a specialized treatment, the facility failed to ensure that a recommendation for a change in medication received from the specialized treatment center was acted upon. The findings include:Resident #7's diagnosis included end stage renal disease, schizoaffective disorder and multiple myeloma. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #7 had a Brief Interview of Mental Status score of 15 indicating no cognitive impairment and was independent with bed mobility, dressing, and transfers. The Resident Care Plan dated 9/2/25 identified impaired renal function at risk for complications related to specialized treatments. Interventions included to monitor laboratory values and report abnormal values to the physician and send the communication book to the specialized treatment center and review upon return.Review of specialized treatment communication book identified a request to decrease Sevelamer Carbon to 800 mg from 2 tables to 1 table 3 times daily with meals. Review of the physician orders from 9.1.25 through 9/23/25 failed to identify any changes to the order for Sevelamer Carbon to 800 mg 2 tablets ordered 3 times per day with meals.Interview with the Facility Administrator at the specialized treatment center on 9/23/25 at 9:22 AM identified that there was an order written on 9.10.25 directing the Sevelamer Carbon 800 mg from 2 tables to 1 table 3 times daily with meals but that the dietician would have more information. Interview with the specialized treatment center dietician on 9/23/25 at 9:45 AM identified that Resident #7's phosphorus was trending down so there was a recommendation, per the protocol, to decrease the Sevelamer Carbon 800 mg from 2 tables to 1 table 3 times daily with meals. The specialized treatment center dietician stated she spoke with the facility dietician on 9.16.25 and informed her of the recommendation. Additionally, this was communicated to the facility via the resident communication binder on 9/17/25.Interview with Registered Nurse (RN) #2, the Unit Manager on 9/23/25 at 9:49 AM identified that the process for specialized treatment center recommendations was to make a copy of the recommendation and place it in the APRN book for review and order approval. RN #2 indicated that the APRN would sign off the recommendation as approved then a nurse would enter the new physician order into the system. Review of the APRN book failed to identify that the recommendation had been given to the APRN. RN #2 indicated that the facility uses agency and that the agency staff probably just took the communication book and set it down without looking to see if there were any recommendations. Subsequent to surveyor inquiry, during a reinterview with RN #2 on 9/23/25 at 10:22 AM she contacted the APRN, who was unaware that there was a recommendation. RN #2 indicated after speaking with the APRN she was going to change the Sevelamer Carbon to 800 mg from 2 tables to 1 table 3 times daily with meals.Review of the Outside Consultants undated policy directed, in part, the facility supports residents' right to obtain care and services from outside consultant or providers. When a resident receives services off-site the facility will coordinate care, ensure safe transport, and document all findings, recommendation, and follow up actions in the resident's medical record. The facility staff schedules the appointment with the external provider. Any new medications or treatment orders from the external provider must be reviewed and signed by the attending physician. The facility must support residents and families in coordinating safe and appropriate care transitions.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, policy, observation, and interviews for the only sampled resident (Resident #85) reviewed for dental services, the facility failed to act upon a dental recommendation for a consultation with an oral surgeon. The findings include:Resident #85's diagnosis included prostate and bone cancer, anxiety and depression.The comprehensive Minimum Data Set assessment dated [DATE] identified Resident #85 was cognitively intact and required substantial to maximal assistance with bed mobility, was independent with eating, and required set-up/clean-up assistance with oral hygiene. The assessment failed to identify Resident #85 had dental irregularities including broken teeth.The Resident Care Plan in effect from 7/8/25 through 9/16/25 failed to identify Resident #58 had dental issues. Interview and observation on 9/16/25 12:37 PM with Resident #85 identified that he/she had been seen by the in-house dentist a few months ago and was told that he/she needed to be seen by an oral surgeon outside of the facility. Resident #85 opened his/her mouth, and 2 broken teeth were noted.Review of physician orders dated 6/28/25 directed a referral to an oral surgeon.Review of Resident #85's clinical record identified 2 consultation reports by the in-house dentist who had examined the resident on 3/13/25 and 5/14/25. The consultation dated 3/13/25 identified Resident #85 required a referral to an oral surgeon. The consultation dated 5/14/25 identified that no extractions had been performed and the order would be rewritten with the recommendation to see an oral surgeon for extractions as the resident could not be treated on site.Review of Nurse Practitioner notes dated 5/21/25, 6/2/25, 6/26/25, and 7/7/25 indicated that a referral to a dental oral surgeon for extraction consult was in place.Interview with the Regional Nurse, RN #4, on 9/23/25 at 1:10 PM identified that Resident #85 had not had an appointment scheduled since the in-house dentist referred the resident to see an oral surgeon but should have been scheduled. Subsequent to surveyor inquiry, Resident #85 was scheduled to see an oral surgeon for possible extraction of broken teeth.Review of the Outside Consultants undated policy directed, in part, the facility supports residents' right to obtain care and services from outside consultants or providers. When a resident receives services off-site the facility will coordinate care, ensure safe transport, and document all findings, recommendations, and follow up actions in the resident's medical record. The facility staff schedules the appointment with the external provider. Any new medications or treatment orders from the external provider must be reviewed and signed by the attending physician. The facility must support residents and families in coordinating safe and appropriate care transitions.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of facility policy and interview for 1 resident (Resident #43) reviewed for food, the facility failed to serve meals at a palatable temperature. The findings include:Resident #43's diagnosis included heart disease, emphysema, and chronic obstructive pulmonary disease.The admission Minimum Data Set (MDS) dated [DATE] identified Resident #43 as cognitively intact, required set-up assistance for eating and partial moderate assistance for bathing. Also, Resident #43 required substantial, maximal assistance for toileting and transfers.Interview with Resident #43 on 09/17/2025 at 2:25 PM identified that the food was cold at times.On 9/23/25 at 12:32 PM, a test tray was conducted. The following was identified.The lunch meal was plated from a warming plate which was placed in a blue-plate holder with a blue enclosed lid and left the dietary department at 12:25 PM in a metal cart which was enclosed all around and filled with 7 to 8 meals. The Administrator transferred the last cart, 6, with meal trays to the first floor. The test temperature tray was followed to the first-floor unit and arrived quickly on the unit and trays were passed in an efficient manner. The last tray was served to a resident at 12:31 PM and temperatures were obtained at 12:32 PM with the Dietary Manager identifying the following. a. The pork entrees' internal temperature was 127 degrees F with the surveyor's thermometer and 129 degrees F with the Dietary Manager's thermometer. b. The beef's internal temperature was 135 degrees with both the Dietary Manager and surveyor's thermometer.c. The cooked carrot's internal temperature was 119 degrees with the surveyor's thermometer and 122.5 degrees with the Dietary Manager's thermometer.The food temperature log was reviewed with all foods identified at appropriate temperatures for each item on the steam table.An interview with the Dietary Manager on 9/23/25 at 12:35 PM identified the serving temperature for hot food items should be no less than 135 degrees. Also, identifying the cooks are responsible for making sure food was kept at the appropriate serving temperature and she would check the working status of the steam table in the kitchen.Review of the service line check list identified hot temperatures for food items should be at 135 degrees or higher.Review of the Food Quality and Palatability policy directed food should be at the appropriate temperature as determined by the type of food to ensure residents' satisfaction and minimize the risk of scalding and burns.