STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075382	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodlake at Tolland	26 Shenipsit Lake Road Tolland, CT 06084

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 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 clinical record review, facility documentation/policies, and interviews, for one (1) of three (3) residents (Resident #117) reviewed for a change in condition, the facility failed to ensure timely provider notification of a significant change in condition, which resulted in a delay in medical intervention and subsequent transfer to the hospital. The findings include:Resident #117 was admitted to the facility on [DATE] with diagnoses that included acute on chronic heart failure (CHF), protein calorie malnutrition and malignant cancer of the colon.The Nursing admission assessment dated [DATE] identified Resident #117 was alert to person, place, time and situation and required supervision for eating.The Resident Care Plan (RCP) dated 1/16/25 identified Resident #117 had nutritional problems related to advanced age, altered nutrition labs, impaired skin, protein-calorie malnutrition and CHF. Interventions included to monitor/document/report any signs of dysphagia; pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing and refusing to eat.The admission Nutrition assessment dated [DATE] identified Resident #117's feeding ability was independent with supervision. Resident #117 had no problems with chewing and/or swallowing.Physician's order dated 1/16/25 directed a regular diet, regular texture and thin liquids.The Brief Interview for Mental Status (BIMS) assessment dated [DATE] identified a score of 15 indicating intact cognition.A progress note by APRN #2 dated 1/18/25 identified Resident #117 had ongoing nausea and was on aspiration precautions. A progress note by APRN #1 dated 1/20/25 identified Resident #117 was having nausea two days prior and Zofran was ordered with good effect. She identified to continue to monitor for nausea and vomiting symptoms.A nursing note dated 1/21/25 at 6:35 AM identified Resident #117's vital signs were stable, Resident #1 was alert and able to make his/her needs known and no signs or symptoms of distress were noted.A pulse obtained by LPN #1 on 1/21/25 at 11:16 AM was 47 beats per minute (BPM) manual (normal range 60-100 BPM).Review of the clinical record failed to identify provider notification of the pulse obtained outside of normal ranges. A nursing note by LPN #1 dated 1/21/25 at 1:10 PM identified Resident #117 was alert, had some forgetfulness, denied pain and discomfort, had no respiratory or cardiac distress, vital signs were stable, had no cough or congestion, denied nausea and appetite remained fair.A Situation Background Assessment and Recommendation (SBAR) note by RN #1 dated 1/21/25 at 5:28 PM identified Resident #117 was lethargic, confused, not responding and had low blood pressure (BP). Vital signs obtained at 5:35 PM identified a BP of 90/50, pulse of 52, respiratory rate of 18, temperature of 97.4 degrees Fahrenheit and an oxygen saturation of 95%. The APRN and Resident #117's family member were notified at 5:00 PM. A progress note by APRN #1 dated 1/21/25 identified Resident #117's BP was low (80s over 40s) with a recheck of 90/50. Resident #117 reported feeling unwell but was unable to explain what he/she was feeling. Resident #117's heart rate was 52 BPM and he/she was pale with cool skin. The note identified Resident #117 could be septic due to vital signs and mental status in the setting of chronic wounds. Resident (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#117 was sent to the ED for further evaluation.An EMS (emergency medical services) Care Record by EMT #1 dated 1/21/25 identified dispatch was called at 5:27 PM and arrived at the facility at 5:34 PM. A blood pressure (BP) could not be obtained and Resident #117's SP02 (oxygen level in the blood) was 55 on room air (normal range is 95-100). EMT #1 applied 4 Liters (L) of oxygen and at 5:50 PM applied 15 L of oxygen via a non-rebreather mask (high flow oxygen device used to deliver oxygen to a person with severe hypoxia).The hospital chest x-ray dated 1/21/25 identified bilateral small-to-moderate pleural effusions (fluid buildup around both lungs) and bilateral lower lobe consolidation/atelectasis (areas of lung inflammation or partial collapse in the lower parts of both lungs).Review of hospital records identified Resident #117 expired on 1/21/25.Interview with Person #1 on 2/5/26 at 1:55 PM identified he went to visit Resident #117 on 1/21/25 around 4:45 PM. He identified when he walked into Resident #117s' room, Resident #117 was lying on his/her side, with the head of the bed flat, and NA #1 was spooning liquid into Resident #117's mouth. He identified the day prior, Resident #117 had no issues with eating independently. He identified Resident #117 was observed breathing heavily and dribbling liquid out of his/her mouth but NA #1 continued inserting more liquid into Resident #117's mouth. He identified he panicked, told NA #1 to stop, and left the room to find the nursing supervisor. He identified he told the nursing supervisor that Resident #117 was gasping for air and needed to go to the hospital. He identified the nursing supervisor assessed Resident #117 and called 911. He identified he was told he needed to leave the facility so staff could prepare Resident #117 transfer. Interview with LPN #1 on 2/6/25 at 11:57 AM identified she did not remember Resident #117. She identified if she obtained a pulse that was abnormal (47 BPM) she would have notified the APRN who is frequently in the building and would document that they were notified.Interview with LPN #2 on 2/6/25 at 12:17 PM identified 1/21/25 was the first time she provided care for Resident #117 and at around 5:00 PM NA #1 notified her that Resident #117 was not eating. She identified she evaluated Resident #117 and NA #1 reported Resident #117 normally ate independently. LPN #2 directed NA #1 to assist Resident #117 with eating. LPN #2 identified she reported Resident #117 was not eating, required assistance to eat and had an altered mental status (AMS) to RN #1. She identified Resident #117 then had a low BP and she notified RN #1, who notified the APRN. The APRN ordered Resident #117 be transferred to the ED. Interview with RN #1 on 2/6/25 at 12:36 PM identified LPN #1 reported Resident #117 was lethargic. She identified she assessed Resident #1 and identified he/she was alert and breathing but lethargic. She identified Resident #117's BP was low, but Resident #117's BP usually trended low. RN #1 called 911. She further identified she was not notified that Resident #117 was not eating and was unaware LPN #2 instructed NA #1 to feed Resident #117.Interview with NA #1 on 2/6/25 at 12:50 PM identified she could not remember Resident #117.Interview with APRN #1 on 2/6/25 at 1:10 PM identified she did not recall the specific details regarding Resident #117. She identified she would expect to be notified of an abnormal pulse and that nursing staff typically document provider notification in the medical record. She further identified that if she had been notified of the abnormal pulse, she would have included it in her 1/21/25 progress note. APRN #1 identified that if a resident who was previously independent with eating was no longer eating, she would expect to be notified and would initiate a speech therapy referral for a swallowing evaluation.Interview with the DNS on 2/6/26 at 2:00 PM identified that when an abnormal vital sign is obtained, it should be repeated to confirm accuracy and if confirmed, the physician should be notified. He identified if staff have concerns such as a change in mentation, the nursing supervisor should be notified. Once notified, the nursing supervisor should conduct a change in condition assessment and notify the physician. Review of the Change of Condition in a Resident Status policy directed for the nurse to notify 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 attending physician when there had been a significant change in the resident's physical/emotional/mental condition, a need to alter the resident's medical treatment significantly, refusal of treatment or medications and a need to transfer the resident to a hospital. The RN will assess the resident's change of condition and document their findings in the medical record.Review of the Vital Signs policy directed that any time a resident's vital signs significantly deviate from their normal baseline, the attending provider is to be informed. Such notification must be documented in the resident's medical record.

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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 Note: The nursing home is disputing this citation.	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 review of the clinical record, facility documentation/policies, Emergency Medical Services (EMS) records, and interviews, for one (1) of three (3) residents (Resident #117) reviewed for a change in condition, the facility failed to recognize and respond appropriately to an acute change in condition and failed to ensure staff remained with the resident during a medical emergency until EMS assumed care. Resident #117 was found by EMS in respiratory distress without staff present, with severe hypoxia (dangerously low oxygen levels in the body), and was subsequently hospitalized . The findings include:Resident #117 was admitted to the facility on [DATE] with diagnoses that included acute on chronic heart failure (CHF), protein calorie malnutrition and malignant cancer of the colon.The Nursing admission assessment dated [DATE] identified Resident #117 was alert to person, place, time and situation and required supervision for eating.The Resident Care Plan (RCP) dated 1/16/25 identified Resident #117 had nutritional problems related to advanced age, altered nutrition labs, impaired skin, protein-calorie malnutrition and CHF. Interventions included to monitor/document/report any signs of dysphagia; pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing and refusing to eat.The admission Nutrition assessment dated [DATE] identified Resident #117's feeding ability was independent with supervision. Resident #117 had no problems with chewing and/or swallowing.A Physician's order dated 1/16/25 directed a regular diet, regular texture and thin liquids.The Brief Interview for Mental Status (BIMS) assessment dated [DATE] identified a score of 15 indicating intact cognition.A progress note by APRN #2 dated 1/18/25 identified Resident #117 had ongoing nausea and was on aspiration precautions. A progress note by APRN #1 dated 1/20/25 identified Resident #117 was having nausea two days prior and Zofran was ordered with good effect. She identified to continue to monitor for nausea and vomiting symptoms.A nursing note dated 1/21/25 at 6:35 AM identified Resident #117's vital signs were stable, Resident #1 was alert and able to make his/her needs known and no signs or symptoms of distress were noted.A pulse obtained by LPN #1 on 1/21/25 at 11:16 AM was 47 beats per minute (BPM) manual (normal range 60-100 BPM).Review of the clinical record failed to identify provider notification of the pulse obtained outside of normal ranges.A nursing note by LPN #1 dated 1/21/25 at 1:10 PM identified Resident #117 was alert, had some forgetfulness, denied pain and discomfort, had no respiratory or cardiac distress, vital signs were stable, had no cough or congestion, denied nausea and appetite remained fair.A Situation Background Assessment and Recommendation (SBAR) note by RN #1 dated 1/21/25 at 5:28 PM identified Resident #117 was lethargic, confused, not responding and had low blood pressure (BP). Vital signs obtained at 5:35 PM identified a BP of 90/50, pulse of 52, respiratory rate of 18, temperature of 97.4 degrees Fahrenheit and an oxygen saturation of 95%. The APRN and Resident #117's family member were notified at 5:00 PM. A progress note by APRN #1 dated 1/21/25 identified Resident #117's BP was low 80s over 40s with a recheck of 90/50. Resident #117 reported feeling unwell but was unable to explain what he/she was feeling. Resident #117's heart rate was 52 BPM and he/she was pale with cool skin. The note identified Resident #117 could be septic due to vital signs and mental status in the setting of chronic wounds. Resident #117 was sent to the ED for further evaluation.An EMS Care Record by EMT #1 dated 1/21/25 identified dispatch was called at 5:27 PM and arrived at the facility at 5:34 PM. EMT #1 identified Resident #117's room door was closed and when opened, there was no nurse or provider in the room or nearby. Resident #117 was observed lying in bed, hunched to his/her side, drooling, had labored breathing and lips were slightly purple. A BP could not be obtained and Resident #117's SP02 (oxygen level in the blood) was 55 on room air (normal range is 95-100). EMT #1 applied 4 Liters (L) of oxygen. The care record (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	identified EM.; #1's partner arrived on scene at 5:50 PM (16 minutes after EMS #1 arrived) and located Resident #117's nurse. Resident #117's nurse identified at 5:00 PM a nurse aid (NA) spoon-fed Resident #117 liquid food and then staff shortly after found Resident #117 to be hypotensive with severely altered mental status. No interventions were provided prior to EMS arrival. Resident #117 was transferred into the ambulance and became unresponsive with a fixed gaze. Resident #117 was placed on a non-rebreather oxygen mask (high flow oxygen device used to deliver oxygen to a person with severe hypoxia) at 15 L and a blood pressure could not be obtained. Resident #117 was breathing at an adequate rate but labored.The hospital chest x-ray dated 1/21/25 identified bilateral small-to-moderate pleural effusions (fluid buildup around both lungs) and bilateral lower lobe consolidation/atelectasis (areas of lung inflammation or partial collapse in the lower parts of both lungs).Review of hospital records identified Resident #117 expired on 1/21/25.Interview with EMT #1 on 2/3/26 at 3:00 PM identified she arrived at the facility at 5:34 PM on 1/21/25 and entered the building without being met by or encountering any facility staff. She located Resident #117's room, observed the door was closed, and upon entering found Resident #117 alone with no staff present. Resident #117 did not have a roommate. EMT #1 observed Resident #117 lying on his/her right side, drooling, with liquid noted on his/her clothing, and exhibiting labored breathing consistent with respiratory distress. Resident #117 was not receiving supplemental oxygen and was semi-responsive with severe hypoxia. EMT #1 initiated oxygen at 4 liters via nasal cannula. She stated she did not leave the resident's room to locate staff because it was unsafe to leave Resident #117 unattended. EMT #1 further indicated her partner arrived at approximately 5:50 PM, and she directed him to locate facility staff, as no staff had presented to the room and staff were unaware EMS had arrived in the building.Interview with Person #1 on 2/5/26 at 1:55 PM identified he went to visit Resident #117 on 1/21/25 around 4:45 PM. He identified when he walked into Resident #117s' room, Resident #117 was lying on his/her side, with the head of the bed flat, and NA #1 was spooning liquid into Resident #117's mouth. He identified the day prior, Resident #117 had no issues with eating independently. He identified Resident #117 was observed breathing heavily and dribbling liquid out of his/her mouth but NA #1 continued inserting more liquid into Resident #117's mouth. He identified he panicked, told NA #1 to stop, and left the room to find the nursing supervisor. He identified he told the nursing supervisor that Resident #117 was gasping for air and needed to go to the hospital. He identified the nursing supervisor assessed Resident #117 and called 911. He identified he was told he needed to leave the facility so staff could prepare Resident #117 transfer.Interview with LPN #1 on 2/6/25 at 11:57 AM identified she did not remember Resident #117. She identified if she obtained a pulse that was abnormal (47 BPM) she would have notified the APRN who is frequently in the building and would document that they were notified.Interview with LPN #2 on 2/6/25 at 12:17 PM identified 1/21/25 was the first time she provided care for Resident #117 and at around 5:00 PM NA #1 notified her that Resident #117 was not eating. She identified she evaluated Resident #117 and NA #1 reported Resident #117 normally ate independently. LPN #2 directed NA #1 to assist Resident #117 with eating. LPN #2 identified she reported Resident #117 was not eating, required assistance to eat and had an altered mental status (AMS) to RN #1. She identified Resident #117 then had a low BP and she notified RN #1, who notified the APRN. The APRN ordered Resident #117 be transferred to the ED. LPN #2 identified she did not stay in the room with Resident #117 until EMS arrived because she had another Resident to care for. She identified she thought NA #1 stayed with Resident #117.Interview with RN #1 on 2/6/25 at 12:36 PM identified LPN #1 reported Resident #117 was lethargic. She identified she assessed Resident #1 and identified he/she was alert and breathing but lethargic. She identified Resident #117's BP was low, but Resident #117's BP (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	usually trended low. RN #1 called 911. She identified that after her assessment she left Resident #117's room to do paperwork for the transfer. She identified someone should have stayed in the room with Resident #117 until EMS arrived. She further identified she was not notified that Resident #117 was not eating and was unaware LPN #2 instructed NA #1 to feed Resident #117.Interview with NA #1 on 2/6/25 at 12:50 PM identified she could not remember Resident #117.Interview with APRN #1 on 2/6/25 at 1:10 PM identified she did not recall the specific details regarding Resident #117. She identified she would expect to be notified of an abnormal pulse and that nursing staff typically document provider notification in the medical record. She further identified that if she had been notified of the abnormal pulse, she would have included it in her 1/21/25 progress note. APRN #1 identified that if a resident who was previously independent with eating was no longer eating, she would expect to be notified and would initiate a speech therapy referral for a swallowing evaluation. She identified a staff member should have stayed in the room with Resident #117 until EMS arrived.Interview with the DNS on 2/6/26 at 2:00 PM identified that when an abnormal vital sign is obtained, it should be repeated to confirm accuracy and if confirmed, the physician should be notified. He identified if staff have concerns such as a change in mentation, the nursing supervisor should be notified. Once notified, the nursing supervisor should conduct a change in condition assessment and notify the physician. He further identified a staff member should remain with the resident, if a medical emergency is identified, until EMS arrives and assumes care.Review of the Change of Condition in a Resident Status policy directed for the nurse to notify the resident's attending physician of a significant change in the resident's physical/emotional/mental condition, a need to alter the resident's medical treatment significantly, refusal of treatment or medications and a need to transfer the resident to a hospital. The RN will assess the resident's change of condition and document their findings in the medical record.Review of the Vital Signs policy directed that any time a resident's vital signs significantly deviate from their normal baseline, the attending provider is to be informed. Such notification must be documented in the resident's medical record.Review of the Aspiration Precautions policy directed that resident's needing aspiration precautions will be; positioned so that the resident's head is at 90 degrees upright or as close as possible given the resident's physical condition for meals, snack and ingestion of medication, the resident must be assessed by the Speech Language Pathologist for the aspiration precautions to be discontinued and develop a plan of care with feeding strategies and place feeding strategies on the NA care card.