STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075387	A. Building B. Wing	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Norwalk	34 Midrocks Drive Norwalk, CT 06851

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record reviews, observations, facility policy and staff interviews for 1 of 7 residents (Resident #1) reviewed for choices, the facility failed to ensure that a physician's order regarding leave of absence (LOA) was followed, and for 2 of 4 residents reviewed for accidents (Residents #17 and #130), the facility failed to ensure a nursing assessments were completed following a near-fall event and a change of condition and for 1 of 1 resident (Resident # 38)reviewed for communication, the facility failed to ensure staff appropriately identified a venous access site, obtain the correct physician orders for its use. The findings included: Resident #17's diagnoses included orthopedic conditions, phantom limb syndrome with pain, cervical disc (discs that provide space between the bones of the neck) degeneration, chronic pain syndrome, cervical radiculopathy (neck compression that causes pain to radiate to the arms or changes feeling in the arms), heart failure, asthma, bipolar disorder, depression, anxiety, and schizoaffective disorder (a chronic mental health condition characterized by a combination of schizophrenia symptoms, such as hallucinations, delusions, disorganized speech, and mood disorders, such as mania or depression). A Medicare 5-Day Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #17 was cognitively intact. The resident used no assistive device for mobility, had a reduced range of motion on one side of the upper extremities, required set-up assistance for eating and showering, moderate assistance for toilet hygiene and repositioning, and was independent with oral hygiene, dressing, and transfers. The assessment also identified that the resident was prescribed multiple psychoactive (medications that alter brain function and can change perception, mood, behavior, and consciousness) medications, opioids (strong pain medications), and an antipsychotic medication. On 11/12/25, Resident #17 experienced a witnessed fall, with subsequent identification of non-displaced fractures of several toes on the left foot. Nursing assessments were completed on 11/12/25, along with a change-in-condition nursing note describing the incident and assessment findings. A follow-up evaluation was conducted on 11/13/25 by an advanced practice registered nurse (APRN) who ordered a left foot x-ray to rule out fracture due to focal (specific spot or area) pain in the foot. A Resident Care Plan (RCP) update, dated 11/12/25, included interventions such as orthostatic blood pressure monitoring (checking blood pressure with changes in position) each shift for three days, a medical work-up, and monitoring for signs and symptoms of latent (present but not yet showing signs or symptoms) injury or pain. A change-in-condition note dated 11/14/25 at 4:52 PM indicated the resident was evaluated by orthopedics, and a repeat x-ray confirmed fractures of the third, fourth, and fifth toes of the left foot. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident was placed in a surgical boot for ambulation with instructions for follow-up in three weeks. A physician's order dated 11/15/25 directed Resident #17 could ambulate in and out of the unit with a cane or without an assistive device. A Resident Care Plan update, dated 11/17/25, reflected the physician's order. On 12/8/25, Resident #17 experienced a slip when exiting an elevator but did not descend to the ground. Facility staff did not classify the event as a fall. This event was not reported to the nursing supervisor on the evening of the incident, and no nursing assessment or documentation was completed that day. The clinical record did not contain evidence that a nursing assessment was completed following the 12/8/25 slip event. On the morning of 12/9/25, Resident #17 informed the Assistant Director of Nursing Services (ADNS) about the incident while they were riding the elevator together. A change-in-condition note, dated 12/9/25 at 8:34 AM, written by the ADNS, indicated the resident reported slipping in the elevator the prior evening and pain in the same foot, previously injured and currently in an orthopedic boot. A physiatry provider note, dated 12/9/25 at 4:57 PM, indicated the resident was evaluated for pain management follow-up. The provider documented the reported slip and observed the resident ambulating in the hallway wearing socks, with no motor weakness noted. The provider continued the planned dose reduction of pain medication while maintaining pain control. A quarterly MDS assessment dated [DATE] indicated Resident #17 was cognitively intact. He/she used no devices for mobility and was independent with all activities of daily living, hygiene, and transfers. He/she was reported as having had one fall with major injury, including broken bones. Taking multiple psychoactive medications, opioids, and an antipsychotic. Surveyor observations of Resident #17's room on 3/9/26 at 11:10 AM and 3/11/26 at 6:25 AM identified clutter and various items obstructing or narrowing the resident's walking path within the room, creating potential trip hazards. Additionally, during observations on: 3/9/26 between 11:10 AM and 1:00 PM; 3/10/26 between 8:30 AM and 11:30 AM; 3/13/26 between 8:30 AM and 10:00 AM, Resident #17 was observed ambulating in his/her room and hallways wearing gripper socks rather than shoes. During an interview with the ADNS on 3/13/26 at 1:00 PM, the ADNS stated Resident #17 reported the 12/8/25 elevator slip to her the following morning while they were on the elevator together. The ADNS stated she asked the resident twice whether a fall had occurred, and the resident reported he/she had slipped but did not fall. The ADNS stated that she encouraged the resident to obtain a new X-ray to assess the healing status of the injured foot. The ADNS stated she later asked staff why an Accident and Incident (A&I) report had not been completed. Staff informed her they did not complete an A&I report because the resident described the (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	event as a slip rather than a fall. The ADNS further stated that the Director of Nursing Services at the time, who was no longer employed at the facility, advised that an A&I report was not necessary because no fall had occurred. The ADNS stated that, given the circumstances, she would complete an A&I report for such an event in the future, but at the time, she followed the Director of Nursing Services direction. The MDS definition of a fall includes any episode in which a resident loses balance and would have fallen if not for catching themselves. During an interview with Registered Nurse (RN) 1 on 3/16/26 at 11:07 AM, RN #1 stated she was the nursing supervisor on 12/8/25 when the slip occurred. RN #1stated the incident was not reported to her by staff or the resident, and therefore, no nursing assessment was completed on that date. RN #1 stated that if she had been notified, she would have completed a nursing assessment, documented a change-in-condition note, and notified the APRN to determine whether additional evaluation or new physician's orders were needed, consistent with facility policy and practice. All facility policies were reviewed by the administrative team and Medical Director in January 2026. These policies included Charting and Documentation. This policy directed that any changes in the resident's condition and any events, incidents, or accidents involving the resident must be documented in the medical record. The policy, Falls Clinical Protocol, directed staff to evaluate and document falls that occur while the individual is in the facility, including the time and location of the event and any observations. Additionally, the Accidents and Incidents policy, directs that an accident or incident must be reported to the department director, and the Accident/Incident Report Form must be completed on the shift that the accident or incident occurred; the charge nurse must be informed, and that the charge nurse or designee shall examine the victim, notify the physician, notify the resident's family or legal representative, and if necessary transfer the injured person to the hospital. The facility failed to follow its policies regarding documentation, fall evaluation, and reporting of accidents or injuries, resulting in unidentified injuries and missed opportunities to prevent future falls. Resident #130's diagnosis included dementia and cerebral infarction. The 6/13/2025 quarterly Minimum Data Set (MDS) assessment indicated Resident #130 had a moderate cognitive decline. The care plan dated 6/18/2025 indicated Resident #130 had altered cardiovascular status. Interventions included: to assess chest pain, shortness of breath and cyanosis (when oxygen moves away from the lips and nail beds, leaving the skin/nailbeds a blue/gray color versus pink), and to report changes to the physician. A progress note labeled Change in Condition dated 8/15/2025 at 5:06 PM indicated Resident #130 was sitting in a wheelchair and noted to be pale and unresponsive at which time the physician was notified and an order was obtained to send to the emergency room. 911 was called while awaiting their arrival Resident #130 had become alert and at his/her baseline. The resident was sent to the emergency room for an evaluation. An assessment labeled Change in Condition/Concurrent Review completed by LPN # 3 indicated Resident #130's blood pressure was 142/65, pulse 52 and regular rhythm, and temperature was 97.0 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	degrees F. and the physician and responsible party were notified of Resident #130s transfer to the hospital for evaluation. An interview and clinical record review with the current Director of Nursing Services (DNS) on 3/11/2026 at 1:21 PM indicated there was no documented Registered Nurse (RN) assessment of Resident #130 prior to the transfer to the emergency room and s/he would have expected an RN assessment of Resident #130 written in the progress notes if the LPN documented the assessment the RN would then sign the assessment the LPN had documented. The DNS further indicated not finding evidence of assessment that included the following: the exact time of the incident, when the Emergency Medical Services (EMS) arrived and left the facility with the resident, the state of alertness at the time of the transfer, sending a copy of the resident face sheet including all diagnosis medications and other pertinent data with the resident to the hospital and calling the hospital emergency room with expectation of the resident arriving to them along with the reason for the transfer and resident condition. The DNS further indicated not finding any documentation in Resident #130's clinical record. On 3/12/2026 at 2:45 PM an interview with LPN #4 working the 3-11PM shift on 8/15/2025 indicated s/he arrived late to his/her shift and while counting medication at the medication cart with LPN #3 a nurse aide rolled Resident #130 in her wheelchair to the nurses as s/he was not responding. LPN#4 indicated having immediately checked the blood sugar level of Resident #130, but she/he was unable to remember the exact reading but recall it was within normal range (70-110) and having minimally responded to a sternal rub (a painful stimulus technique used by professionals to check for responsiveness in unconscious patients, involving firm, grinding knuckle pressure on the breastbone LPN #4 and the nurse aide brought Resident #130 to her/his room and transferred him/her to the bed and Resident #130 had started to come around further indicating the 3-11PM nursing supervisor, RN #5 was at the nurses station making the calls and preparing the transfer paperwork and had not been in the room. An interview on 3/12/2026 at 2:40 PM with RN #5 indicated she had seen Resident #130 in the wheelchair and started to come to but was unable to remember any details. The facility policy labeled Acute Condition Changes/RN Assessment Protocol indicated as part of the initial assessment RN would help identify the resident having acute changes of condition, document and consult with the physician. Resident #38's diagnosis included sepsis (an infection that had spread to the bloodstream). The physician's orders dated 2/21/2026 directed to observe the central catheter every two hours during continuous therapy every shift with intermittent therapy or when not in use, before and after administration of intermittent medications, during dressing changes documenting in notes at least every shift considering prescribed therapy and resident condition. A second physician's order is directed to change the central catheter dressing and securement devise every week and as needed with using transparent dressing. The third physician's order directed to flush the unused ports of the catheter every 12 hours with 5 milliliters(ML)of normal saline(flushed the Intravenous Therapy (IV) line of the prior solution in the line) followed by 5ml's of Heparin 10 units/ml(which prevents blood from clotting in the line). A fourth physician's order directed to flush a central line called a PICC line(Peripherally inserted Central catheter every 12 hours with normal saline. Another physician's order directed to change the needleless access device every 24 hours with Total Parenteral Nutrition(a specialized IV treatment that provides nutrition intravenously) another physician's order directs to (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	change the IV administration set (tubing)every 96 hours. The admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #38 was cognitively intact had an intravenous (IV) device and was receiving intravenous(IV)medication. Resident #38's care plan dated 2/23/2026 indicated Resident #38 was receiving IV medications for an infection with interventions including documenting and to report to the physician any signs of redness at the IV insertion site. On 3/10/2026 at 10:40 AM an interview and record review with charge nurse LPN #1 identified Resident #38 had orders for a central line catheter for administration of antibiotic medication intravenously (a central line is the longest IV catheter that reaches large veins near the heart, designed for long-term use, high-volume fluid resuscitation, and administration of caustic medications). While reviewing the paper clinical record with LPN #1, a loose paper document labeled PICC/Midline Nursing Documentation from an outside IV company, placement company dated 3/03/2026 indicated Resident #38 had a midline catheter(an intermediate-length venous access line inserted into an upper arm vein with its tip stopping near the axilla, used for 1–4 weeks of intravenous therapies such as antibiotics) placed in the hospital but the line was pulled out by the Resident # 38 and the IV Nurse was there to replace the midline catheter. A 12 centimeter (cm) long midline catheter (one valve) was placed in a vein in the middle of the inside of the left arm with notes indicating to provide midline catheter care per protocol and post procedure instructions were provided to a facility nurse(not named). LPN # 1 reviewed the hospital discharge summary and the Intra-Agency Report upon surveyor request, and it indicated Resident #38 was discharged to the facility with a midline catheter (not a central line). LPN #1 indicated not knowing why the admitting nurse obtained physician orders for a Central Line Catheter. LPN #1 was unable to locate any physician's orders in the clinical record for dressing changes to the IV site and called for the nursing supervisor. On 3/10/26 at 10:42 AM a clinical record review, interview and observation with the nurse manager/Supervisor RN #1 indicated Resident #38 physician's orders were for a central line and the resident did not receive anything s/he should not have. Review of the physician's orders indicated not only flush the catheter with normal saline but Heparin as well. RN #1 indicated the facility does not use Heparin in any IVs as the practice ended years ago. She/he further indicated that when the physician's orders are electronically by the nurse the prepopulated orders for heparin need to be removed. RN #1 pulled up the standing physician's orders for a midline catheter and the same normal saline flush as the central line was what would have been ordered. An observation of the resident room found a labeled bag of saline syringes for IV-line flushing, and the observations of the medication rooms by surveyors identified only normal saline syringes containing 10ml of solution for IV flushing, no heparin syringes were found. Further review of the orders identified no documentation for a dressing change was completed since admission; no documentation of the IV line being flushed, or consistent documentation every shift as there were no orders on the Medication/Treatment Administration records(MAR/TAR) indicating how to take care of the IV devise and document that care was completed per the physician's orders and facility protocol. Review of the admission orders for the central line catheter identified the scheduling of the dressing changes and flushes were not completed. An observation at 11:10 AM with RN #1 in the resident's room identified Resident #38 had a clear dressing over the insertion site of the midline catheter in the inner left elbow dated 3/9/2026 and the catheter had a manufactural label that stated MIDLINE. RN #1 indicated s/he would inform the APRN and obtain new physician's orders. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/10/2026 (no time indicated) subject to surveyor inquiry, physician orders were obtained for a Midline catheter(long peripheral catheter, not a central catheter) directed to flush the catheter with 10ml of normal saline solution, to change the catheter dressing 24 hours after insertion; on admission, and weekly using a transparent dressing , to observe the IV site every 2 hours during continuous therapy, every shift during intermittent therapy or when not in use. The facility policy labeled(Midline/Extended Dwell Catheter Flushing given onsite indicated a physician's order is required for vascular access devices with orders specific to the flushing solution and documentation of the procedures in the resident's clinical record will include date and time, site assessment flushing agent and volume amount used, any difficulty flushing and intervention, the resident's response to the procedure and any resident/caregiver education provided. The facility policy labeled Midline/Extended Dwell Catheter Dressing Change given onsite indicated the physician IV therapy order for care and maintenance is required, a transparent dressing is preferred referring to the IV order form for the frequency of the change utilizing sterile technique once the soiled dressing is removed. Assessment of the vascular access device included checking the site at least every 2 hours during a continuous infusion, before during and after medication administration, during dressing changes at a minimum of once per shift when not in use and at prescribed intervals if complications are observed. Resident #1's diagnoses included type 2 diabetes mellitus, depressive episodes, schizophrenia, anxiety disorder, chronic kidney disease, end-stage renal disease (ESRD) requiring hemodialysis, weakness, chronic pulmonary edema, mild cognitive impairment of unknown etiology, and dementia with psychotic disturbance. A physician's order dated 11/15/25 directed Resident #1 may leave the facility on leave of absence (LOA) with a responsible party and medications. A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #1 was cognitively intact with a Brief Inventory of Mental Status (BIMS) Summary Score of 15. The resident used a walker and wheelchair for mobility, required varying levels of assistance with activities of daily living, and was receiving specialized treatment for ESRD. A psychiatric advanced practice registered nurse (APRN #1) evaluation dated 12/8/25 indicated the resident was psychiatrically stable with no acute concerns and no risk to self or others. A nursing note dated 12/11/25 indicated Resident #1 informed staff he/she was going to the lobby but subsequently left the facility via a ride-share without notifying staff or formally signing out on LOA, which was inconsistent with the physician's order requiring a responsible party accompaniment. Facility staff identified that the resident had left when he/she was no longer present in the lobby and initiated efforts to determine the resident's whereabouts. Staff contacted the resident by phone, and the resident reported that he/she had gone to a local hospital to see his/her nephrologist. Resident #1's conservator and co-conservator were notified, and upon the resident's return, an alert bracelet was placed on the resident's ankle as a reminder to notify staff prior to leaving the facility. Education was provided to the resident and conservators regarding the importance of notifying staff for safety and medication management. All parties expressed understanding. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An elopement assessment dated [DATE] identified the resident as low risk for elopement. On 12/11/25, Resident #1 left the facility independently, which was not consistent with the active physician's order requiring the resident to be accompanied by a party responsible for leave of absence. A physician's order dated 12/12/25 was subsequently updated to allow Resident #1 to leave the facility independently on LOA. The Resident Care Plan (RCP) was updated on 12/12/25 to include an alert bracelet as an intervention. A follow-up elopement assessment dated [DATE] continued to identify the resident as having low risk. A psychiatric APRN evaluation dated 1/15/26 indicated the resident had mild situational anxiety but remained stable with no change in care plan. During a resident interview on 3/10/26 at 9:45 AM, Resident #1 expressed frustration with wearing the bracelet but acknowledged understanding of the facility's safety concerns. This was reconfirmed on 3/11/26 at 6:46 AM, with no additional concerns identified. During an interview with the Facility Administrator on 3/16/26 at 11:00 AM, the Administrator stated that the alert bracelet was used as a reminder tool for Resident #1 to notify staff prior to leaving, rather than for traditional elopement monitoring. During an interview with APRN #1 on 3/18/26 at 9:38 AM, APRN #1 stated the resident was psychiatrically stable for independent community access and exhibited improved mood when outside the facility. During an interview with APRN #2 on 3/18/26 at 9:54 AM, APRN #2 stated the resident was medically stable for independent LOA, and that the prior physician's order requiring a responsible party likely reflected an earlier condition and had not been subsequently updated.

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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 review of the clinical records, review of facility policy and staff interview for 1 of 4 residents (Resident # 130) reviewed for accidents, the facility failed to ensure the clinical record was complete and accurate. The findings include: Resident #130's diagnosis included dementia and cerebral infarction.The 06/13/2025 quarterly Minimum Data Set (MDS) Assessment indicate Resident #130 had moderate cognitive decline.The care plan dated 06/18/2025 indicated Resident #130 had altered cardiovascular status with interventions to assess for chest pain, shortness of breath and cyanosis(when oxygen moves away from the lips and nail beds, leaving the skin/nailbeds a blue/gray color versus pink), and to report changes to the physician.A progress note labeled Change in Condition dated 08/15/2025 at 05:06 PM indicated resident #130 was sitting in a wheelchair and noted to be pale and unresponsive the physician was notified and an order obtained to be sent to the emergency room. 911 was called while awaiting their arrival Resident #130 had become alert and was at his/her baseline and was sent to the emergency room.An assessment labeled Change in Condition/Concurrent Review completed by LPN # 3 indicated Resident #130's blood pressure was 142/65, pulse 52 and regular rhythm, and temperature was 97.0 degrees F. and the physician and responsible party were notified of Resident #130s transfer to the hospital for evaluation.An interview and clinical record review with the current Director of Nursing Services (DNS) on 03/11/2026 at 01:21 PM indicated there was no documented Registered Nurse (RN) assessment of Resident #130 prior to the transfer to the emergency room and s/he would have expected an RN assessment of Resident #130 written in the progress notes if the LPN documented the assessment the RN would then sign the assessment the LPN had documented. The DNS further indicated not finding Documentation of the exact time of the incident, when The Emergency Medical Services (EMS) arrived and left the facility with the resident, the state of alertness at the time of the transfer, sending a copy of the resident face sheet including all diagnosis medications and other pertinent data with the resident to the hospital and calling the hospital emergency room with expectation of the resident arriving to them along with the reason for the transfer and resident condition. The DNS further indicated not finding any documentation in Resident #130's clinical record.On 03/12/2026 at 2:45 PM an interview with LPN #4 working the 3-11 shift on 08/15/2025 indicated s/he arrived late to his/her shift and while counting medication at the medication cart with LPN #3 a nurse aide rolled Resident #130 in her w/c to the nurses as s/he was not responding. LPN#4 indicated having immediately checked the blood sugar level of Resident #130, unable to remember the exact reading but within normal range (70-110) and having minimally responded to a sternal rub (a painful stimulus technique used by professionals to check for responsiveness in unconscious patients, involving firm, grinding knuckle pressure on the breastbone LPN #4 and the nurse aide brought Resident #130 to her room ad transferred him/her to the bed and Resident #130 had started to come around further indicating the 3-11 nursing supervisor, RN #5 was at the nurses station making the calls and preparing the transfer paperwork and had not been in the room. No documentation of the medical evaluation and care provided by LPN #4 as described within his/her interview we found within the clinical record.An interview on 03/12/2026 at 02:40 PM with RN #5 indicated she had seen Resident #130 in the wheelchair and started to come to but was unable to remember any details.The facility policy labeled Charting and Documentation indicated documentation should include medications administered, treatments or services performed, changes in the resident's condition, events, incidents or accidents involving the resident.