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

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 clinical record reviews, resident interviews, review of policy and staff interviews for 2 of 7 residents reviewed for choices (Residents #62 and #80), the facility failed to ensure residents were not restricted from an outdoor common area without an individualized assessment and failed to notify residents of rule changes. The findings included: 1.Resident #62's diagnoses included polyneuropathy (a painful nerve condition that affects several areas of the body at the same time) and insomnia.A physician's order dated 9/17/2025 directed Resident #62's ambulation status as independent using a two-wheeled walker on/off the unit and in the community for Leave of Absence) LOA.A quarterly activity review dated 1/23/2026 identified that some of Resident #62's favorite activities included enjoying the outdoors, walking, and people watching.A quarterly MDS (Minimum Data Set) assessment dated [DATE] identified Resident #62 was cognitively intact and was independent for transfers and walking at least 150 feet in a corridor or similar space.A wandering/elopement risk evaluation dated 2/9/2026 identified Resident #62 was at low risk for elopement.A fall risk evaluation dated 2/9/2026 identified Resident #62 was a low fall risk.A social services care plan progress note dated 2/11/2026 identified Resident #62 preferred to engage in independent activities and noted the therapy orders continued as independent with transfers and ambulation using a walker. Additionally, the note indicated that Resident #62 continued with outpatient physical therapy at a different healthcare facility and independently managed her/his own appointments and transportation.A care plan reviewed on 2/12/2026 identified Resident #62 enjoyed walking. Interventions included encouraging walking following facility guidelines. The care plan also identified that the resident had a self-care performance deficit related to failure to thrive and neuropathy. Interventions included encouraging the resident to discuss feelings about self-care deficit and ambulating independently using a two-wheeled walker on/off the unit and in the community for leave of absence.On 3/10/2026 at 12:00 PM, an interview with Resident #62 identified she/he had been in the facility for a few years and had not had a problem going outside. Resident #62 stated that on 3/10/2026, she/he was first informed that she/he needed a staff member to accompany them outside. Resident #62 indicated she/he enjoyed walking outside and sitting outside watching people, and the requirement for staff accompaniment was new as of that date.A follow-up interview on 3/16/2026 at 3:30 PM, Resident #62 indicated the facility had told residents they could use the back courtyard/garden or the smaller side patio. Resident #62 indicated that the suggested areas were boring because there was nothing there except the back of the building, whereas the front had more activity and people coming and going, and she/he could more easily enjoy people watching.2. Resident #80's diagnoses included brain injury and mild cognitive impairment.A wandering/elopement evaluation dated 1/2/2026 identified Resident #80 was at low risk for elopement.An annual MDS assessment dated [DATE] identified Resident #80 was cognitively intact and did not exhibit behaviors of wandering. The MDS assessment further indicated that Resident #80 identified the ability to go outside for fresh air when the weather was good as very important.A care plan reviewed 1/15/2026 indicated Resident #80 needed continued social interaction to help promote positive well-being. Interventions included providing friendly (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reminders of resident council meetings.An activity quarterly review dated 3/9/2026 identified Resident #80 enjoyed the outdoors.On 3/11/2026 at 1:05 PM, Resident #80 was observed in the main lobby in her/his wheelchair. Resident #80 was observed self-propelling in her/his wheelchair and stopping to talk to other residents sitting in a sitting area in the main lobby. Resident #80 was overheard by the surveyor saying to other residents that it did not make sense that residents needed to have a staff member to go outside with them. An interview with Resident #80 indicated Resident #80 was upset that she/he needed to have someone accompany them to the outside front patio. Resident #80 indicated the rule requiring staff accompaniment was new, and that prior to 3/9/2026, she/he had always gone outside by her/himself. Resident #80 further stated she/he learned about the new rule on 3/9/2026 when attempting to go outside and did not know why it was implemented.On 3/11/2026 at 1:29 PM, an interview with the Recreation Director identified residents can go outside in the back courtyard/garden or in the smaller side patio since the areas are enclosed. The Recreation Director indicated there was concern with residents independently going to the front patio due to cars and ambulances driving by, and to ensure that residents do not walk in the roadway or sit in the direct sun. The Recreation Director indicated she found out about the change from the administrator at a morning staff meeting but could not recall the date. A tour with the Recreation Director identified that the courtyard/patio was partially enclosed (there was a gap between the end of the fence and the building) and had small branches in the walkways. The side patio was observed to be enclosed, clean, with a small concrete area and a larger grassy area. An observation with the Recreation Director identified that access to both the courtyard/garden and the side patio was locked and required a code. The Recreation Director indicated that residents are not given the code.On 3/11/2026 at 2:56 PM, an interview with Receptionist #1 identified that the rule requiring residents to be accompanied by a staff member or a family member when going to the outside front patio was a new rule, and that he was informed about it on 3/10/2026. Receptionist #1 indicated that, prior to 3/10/2026, residents could access the front patio by signing out on a log. He clarified that the log was different from the LOA log because it only tracked residents who were outside for fresh air.On 3/13/2026 at 10:35 AM, an interview and observation with the Director of Maintenance identified no environmental hazards in the patio, such as excessively uneven surfaces. The Director of Maintenance indicated that the construction cones on the upwards sloping sidewalk leading from the patio to the street were there from a prior construction to fix the drain on the road, but that the work had been completed at the beginning of November 2025 but could not recall the exact date. The Director of Maintenance indicated that he was aware that residents could not be in the patio independently and believed it was related to elopement risks.On 3/13/2026 at 11:45 AM, an interview with Receptionist identified residents were not allowed to independently go to the front patio and needed to have someone with them, such as a staff member or family member. Receptionist #2 indicated the rule started on 3/9/2026, and she was informed by the Administrator. Additionally, Receptionist #2 indicated that she did not think residents were aware because residents were asking her to let them out, and she had to tell residents she could not let them out, and she noticed that residents were confused and upset by the change. On 3/13/2026 at 12:10 PM, the Administrator indicated that shortly after starting employment in October 2025, she implemented a facility-wide rule prohibiting all residents from going to the front of the building without staff or family accompaniment. The Administrator identified the rule applied to all residents, including those considered independent or oriented. According to the Administrator, even though she made the decision earlier, residents only became aware of the change on 3/9/2026 and 3/10/2026, when attempts to go outside coincided with unexpectedly warm weather. She had planned to further address the change at a future Resident Council meeting.Although requested, the facility was unable to provide a written policy that addressed residents' access to the outdoors.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documents, review of facility policy and interviews for 1 of 7 residents (Resident # 57) reviewed for choices, the facility failed to ensure that the resident received scheduled showers as per resident preferences. The findings include: Resident #57's diagnoses included muscle weakness and difficulty walking.The annual MDS assessment dated [DATE] identified Resident #57 as cognitively intact and was dependent for shower and bathing and required partial to moderate assistance for tub and shower transfers. The MDS assessment further indicated Resident #57 had not exhibited behaviors of rejection of care.On 3/9/2026 at 10:41 AM, Resident #57 indicated that she/he should be getting a shower twice a week on Mondays and Thursdays but usually missed the Monday shower. Resident #57 indicated she/he prefers to get two showers weekly.A review of the facility shower schedule identified Resident #57 was scheduled for a shower on Mondays and Thursdays during the 7:00 AM to 3:00 PM shift.Review of the nurse aide care card failed to identify the frequency of showers. Or any indication that the resident had refused showers but did indicate that the resident required assistance for bathing.A review of the nurse aide bathing flowsheet from 2/1/2026 through 3/10/2026 identified Resident #57 had missed Monday showers on 2/9, 2/16, 2/23, 3/2, and 3/9, as well as a Thursday shower on 2/26. The bathing flowsheet further indicated Resident #57 received a bath on those days instead of a shower.On 3/10/2025 at 10:30 AM, an interview and tour of the unit shower rooms with NA#1 identified that the bathtub in the unit was not in use.On 3/11/2025 at 2:08 PM, an interview with NA#8 identified Resident #57's scheduled showers were on Mondays and Thursdays, and the resident did not refuse showers. NA#8 also indicated that she provides showers only until around 9:00 AM because she must report to the dining room afterward. NA#8 indicated Resident #57 often preferred to sleep in on Mondays and, at times, requests her/his shower as late as 11:45 A.M., but the nurse aide indicated she could not accommodate that time due to diningˆroom responsibilities and therefore provided a bed bath as an alternative. NA#8 further indicated that although she had spoken to the nurse regarding the resident requesting showers late in the morning, there had not been a conversation about switching the shower days or shift times.On 3/13/2026 at 1:14 PM, an interview with the Unit Manager/Coordinator Licensed Practical Nurse (LPN#2) identified there had been recent adjustments to dining room responsibilities, but she was not aware Resident #57 had been missing her/his Monday showers; otherwise, she would have worked with the resident on finding a time for showers.A review of the facility policy for Activities of Daily Living (ADLs) indicated that the facility will provide services based on the resident's comprehensive assessment and consistent with the resident's needs and choices, including bathing, dressing, showering, grooming, and oral care.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on review of facility assessment, review of facility documentation and staff interview, the facility failed to ensure all Nurse Aide Resident Care competencies were completed for 2025. The findings include: The Facility Assessment Tool reviewed on 1/13/2026 indicated staff training/education and competencies(skill checks) are necessary to provide the level and types of support and care needed for the resident population. An interview and facility document review on 3/13/2026 at 11:23 AM with the ADNS, responsible for staff development in the facility identified the Nurse Aide Resident Care competencies (observations made to ensure a person can provide care to meet the needs of the residents) had been completed in 2024. The ADNS further indicated when s/he was given the responsibility late in 2025 she/he was only able to complete the Intravenous (IV) Care competencies for the nurse aides and was currently starting to work toward completion of all competencies.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record review, observations, review of policy and staff interviews for 1 of 1 resident reviewed for Communication (Resident # 38), the facility failed to ensure normal saline syringes for flushing an Intravenous Therapy (IV) line were stored appropriately and the facility failed to ensure saline flushes and IV supplies for resident use, stored in the medication rooms were labeled appropriately. The findings included: 1.Resident #38's diagnosis included Sepsis(an infection that had spread to the bloodstream).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 reporting to the physician any signs of redness at the IV insertion site. An observation and interview with RN #1 The unit manager and supervisor on 3/10/2026 at 11:10 AM identified a large bag of normal saline IV flushes labeled from the pharmacy for Resident #38 was hanging from the IV pole in Resident #38's room. RN #1 indicated not knowing why the flushes were on the IV pole in the resident's room as they should have been in the medication room. 2. An observation of the 3rd floor medication room (C/D) with LPN #7 on 3/09/2026 at 10:48 AM identified saline solution syringes in a drawer of the medication room.Inspection of 2nd floor medication room (A/B) with LPN #7 at 11:02 AM on 3/9/26, identified saline solution syringes in two drawers. LPN #7 indicated the saline flushes in the drawers were from residents that had been discharged and used now as house stock for other residentsAn observation and interview with RN #1 on 3/10/2026 at 11:20 AM of the first-floor medication room identified a large 3 drawer clear plastic chest of drawers with each drawer filled to the top with IV flushes and on the counter a box containing 2 dark brown plastic bags one with a pharmacy label for Resident #38 which contained multiple IV medications for Resident #38. Another box to the left of the first box has unlabeled IV supplies including IV tubing to administer the medications and tubing caps. RN #1 indicated we place all the residents supplies in one bin and use them. RN #1 indicated the large amount of IV flushes in the chest of drawers were used when needed and further indicated staff use the saline flushes for wound care as well.An interview on 03/10/2026 at 12:15 PM with the administrative staff including the Director of Nursing Services (DNS), the Assistant Director of Nursing Services, the Administrator, the 2 regional RN's # 3 and #4 the regional nurse RN #4 indicated the current IV supply storage would be corrected immediately as the current practice is not how it should be. A request was made for the last 6 months of IV house stock supplies ordered but were not provided.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, facility policy and staff interviews for 1 of 18 residents on Enhanced barrier precautions (Resident #69),the facility did not ensure proper Personal Protective Equipment (PPE) was readily available and for 5 of the 18 residents (Residents #5, #88, #121,#132 and #160) on enhanced Barrier precautions, the facility did not ensure trash receptacles were available to dispose of the used PPE prior to exiting the resident's rooms.The findings included: 1. Resident #69 ?s diagnoses included diverticulitis with perforation and ileostomy.During observations conducted on 3/9/26 from 10:00 AM to 1:00 PM, 3/10/26 from 8:30 AM to 12:30 PM, and 3/11/26 from 6:00 AM to 8:00 AM, surveyors observed multiple residents designated as requiring Enhanced Barrier Precautions (EBP).For Resident #69 identified a sign indicating EBP was present outside the resident's room; however, required PPE, including gowns and gloves, was not readily accessible at or immediately outside the point of care. Surveyors observed that staff would need to leave the immediate resident care area and retrieve PPE from a hallway storage location more than three rooms away before providing care.2.During the same observation periods, surveyors observed that designated PPE disposal receptacles were not present in the resident rooms of Residents #5, # 88, 121, 132, and #160. Instead, disposal bins were in the hallway outside of the resident rooms. This required staff to exit resident rooms while wearing contaminated PPE to dispose of used equipment.Residents requiring EBP had the following conditions: Residents #5, #132, and #160 had wounds; Resident #88 had a history of vancomycin-resistant enterococci (VRE); and Resident #121 had a wound and an ostomyDuring an interview with the Infection Prevention (IP) Nurse on 3/11/26 at 11:17 AM, the IP Nurse stated PPE should be consistently stocked outside or immediately accessible to rooms with residents on Enhanced Barrier Precautions.The IP Nurse acknowledged that while staff may retrieve PPE from other locations, it should not be located at a substantial distance from the point of care.The IP Nurse further stated PPE disposal bins should be located inside resident rooms and that staff are expected to remove PPE and perform hand hygiene before exiting the room.The IP Nurse further indicated during a review of facility policy and the infection prevention program on 3/11/26 at 11:17 AM staff receive ongoing education regarding PPE use and Enhanced Barrier Precautions, including training at hire, annually, and during infection control updates. The IP Nurse stated that she conducts routine rounds and provides real-time education when breaches are identified.Review of the facility's infection prevention and control policy (reviewed February 2026) indicated that PPE must be readily accessible at the point of use, and that contaminated PPE must be removed and discarded prior to leaving the resident room. After surveyor inquiry, the IP Nurse reported that during facility rounds on 3/11/26 she/he identified that disposal bins had been removed from some resident rooms by family members due to bin size. The facility responded by providing smaller disposal bins and re-educating staff and family members on maintaining disposal receptacles within resident rooms and proper PPE disposal practices. This information was shared with the survey team on 3/13/26 at 10:11 AM. These corrective actions occurred after the identified deficient practice.The facility failed to ensure that PPE was readily accessible at the point of care and failed to ensure appropriate disposal of contaminated PPE within resident rooms, which is inconsistent with infection prevention and control standards.

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident interview, and staff interviews, for 1 of 7 residents reviewed for choices (Resident #9), the facility failed to provide written notice before a resident's room was changed. The findings include: Resident #9 was admitted with diagnoses that included severe morbid obesity, Post-Traumatic Stress Disorder (PTSD), and panic disorder.A quarterly MDS assessment dated [DATE] identified Resident #15 was cognitively intact, utilized a walker, and was independently able to ambulate at least 50 feet and make two turns.A social services note dated 1/22/2026 indicated that social services had met with Resident #9 to follow up on concerns related to facility policies and procedures for maintaining a tidy room and the risks of excessive belongings.A social services note dated 1/23/2026 indicated Resident #9's room was changed related to infection control needs, and the resident's family member agreed.A further review of the electronic medical record and the paper chart on the unit failed to identify evidence of a written notice given to Resident #9 prior to the room change.On 3/9/2026 at 1:00 PM, an interview with Resident #9 indicated that she/he was changed from a private room to a double room on 1/23/2026. Resident #9 indicated the facility moved her/his room without prior notice. The resident was under the impression she/he was moved because she/he had too many personal belongings or were giving advice to other residents.On 3/17/2026 at 10:45 AM, an interview with Social Worker #1 and Social Worker #2 identified Resident #9 was moved from her/his private room on 1/23/2026 so the facility could accommodate a resident who required a private room for infectionˆcontrol isolation. Social Worker #1 indicated that the facility learned of the need for a private isolation room a couple of days in advance and notified the resident verbally at that time. Social Worker #1 further indicated Resident #9 preferred moving on 1/23/2026 because that's when the resident was able to receive help from family to move their belongings. Social Worker #1 indicated residents are given the opportunity to refuse a room change and that neither Resident #9 nor their family members had refused. However, Social Worker #1 and #2 indicated the facility did not provide written notice for room changes.A review of the facility policy for Change of Room or Roommate given during the survey indicated that the notice of a change in room or roommate would be provided in writing and would include the reason why the move or change was required.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, review of policy and staff interviews for 1 of 1 resident reviewed for communication (Resident #38) , the facility failed to comprehensively assess a resident with hearing loss in the comprehensive Minimum Data Set assessment. The findings include: Resident #38 diagnosis includes Metabolic Encephalopathy. The Care Plan Conference Summary dated 2/24/2026 indicated the 72-hour care plan meeting was held with a family member and caregiver present via phone with the RN supervisor, social worker, and physical and occupational therapy representatives present. The summary indicated Resident #38 presented as alert oriented, hard of hearing and able to make needs known. The admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #38 was cognitively intact, had adequate hearing. A provider encounter note dated 2/27/2026 at 00:00 indicated Resident #38 had a cognitive deficit and hearing impairment. A provider encounter note dated 3/08/2026 at 00:00 indicated Resident #38 was using a communication device. An observation in Resident #38's room on 3/9/2026 at 12:12 PM identified a sign posted on the wall on the right side of the bed indicating Resident #38 could not hear, and to use the communication device with writing supplies. An interview and record review with the MDS nurse (LPN #5) indicated the MDS assessment that was completed was most likely done by the nursing staff and indicated Resident #38 had adequate hearing although provider note and signage in Resident #38's room and communication device noted different. LPN#5 indicated she/he did not know how the hearing loss was missed on the assessment. LPN #5 also indicated the assessment did not accurately reflect the resident's status. She/he further indicated as a charge nurse in the facility prior to the MDS role she/he believed nursing received training in the past on how to complete the assessments for the MDS. An interview on 3/16/2026 at 9:58 AM with the Speech Language Pathologist (SLP #1) indicated Resident #38 was on service for dysphagia and s/he could not hear. SPL #1 also indicated that the resident can communicate effectively by using the communication device. Resident #38 would then verbalize the answers or any questions s/he had. On 3/16/2026 at 10:10 AM an interview with RN # 7 indicated s/he was the regular charge nurse for Resident #38. S/he indicated the sign posted in Resident #38's room that indicated Cannot Hear, use communication device was brought in by the resident's caregiver in the home setting and further indicated the communication device for the resident and staff to ensure resident understands questions being asked. LPN #5 indicated everyone knows Resident #38 cannot hear and they need to use the communication device but did not know if it was on the NA care card or in the care plan. An interview and record review on 03/16/2026 at 12:10 PM with the Regional MDS Nurse RN #6 indicated it was up to the MDS nurse to put in a care plan or correct an assessment entry if the clinical record shows information to the contrary that requires care planning. It is also up to any of the departments to add a care plan if needed. RN #6 indicated a modification of the admission MDS would need to be made and proceed with care planning for Resident #38's hearing loss with interventions indicating how to meet his/her needs The facility policy labeled Comprehensive Care Plans indicated the care planning process would include an assessment of the resident's strengths and needs and would be individualized and person centered.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, review of policy and staff interviews for 1 of 1 resident (Resident # 38) reviewed for communication, the facility failed to add hearing loss and interventions to the baseline care plan to meet the immediate needs within 48 hours of admission. The findings include: Resident #38 diagnosis includes metabolic encephalopathy. The Care Plan Conference Summary dated 2/24/2026 indicated the 72-hour care plan meeting was held with a family member and caregiver present via phone with the RN supervisor, social worker, and physical and occupational therapy representatives present. The summary indicated Resident #38 presented as alert oriented, hard of hearing and able to make needs known. The admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #38 was cognitively intact, had adequate hearing. A provider encounter note dated 2/27/2026 at 00:00 indicated Resident #38 had a cognitive deficit and hearing impairment. A provider encounter note dated 3/8/2026 at 00:00 indicated Resident #38 was using a communication device. An observation in Resident #38's private room on 3/9/2026 at 12:12 PM had a sign posted on the wall on the right side of the bed indicating Resident #38 could not hear, and to use a communication device with writing supplies. An interview and record review with the MDS nurse LPN #5 at the time of observation indicated Resident #38's care plan initiated 2/23/2026 through present did not indicate the resident could not hear. An interview on 3/16/2026 at 9:58 AM with the Speech Language Pathologist (SLP #1) indicated Resident #38 was on service for dysphagia and s/he could not hear. SPL #1 also indicated the resident can communicate effectively by using the communication device. Resident #38 would then verbalize the answers or any questions s/he had. On 3/16/2026 at 10:10 AM an interview with RN # 7 indicated s/he was the regular charge nurse for Resident #38. S/he indicated the sign posted in Resident #38's room that indicated Could Not Hear, communication device was brought in by the resident's caregiver in the home setting. She/he also indicated she/he could not explain why a baseline care plan had not been developed with intervention for Resident # 38's hearing loss within 48 hours of admission.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075387	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/17/2026
NAME OF PROVIDER OR SUPPLIER: Autumn Lake Healthcare at Norwalk		STREET ADDRESS, CITY, STATE, ZIP CODE: 34 Midrocks Drive Norwalk, CT 06851	

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility policy for 1 of 1 resident (Resident # 38) reviewed for communication, the facility failed to develop a comprehensive care plan with goals, timetable and interventions to meet the needs of a resident with hearing loss and for 1 of 2 residents reviewed (Resident # 2) reviewed for dementia, the facility failed to ensure staff identified cognitive deficits and developed plan of care for a resident with cognitive loss and a diagnosis of dementia. The findings included: Resident #38 diagnosis includes metabolic encephalopathy. The Care Plan Conference Summary dated 2/24/2026 indicated the 72-hour care plan meeting was held with a family member and caregiver present via phone with the RN supervisor, social worker, and physical and occupational therapy representatives present. The summary indicated Resident #38 presented as alert oriented, hard of hearing and able to make needs known. The admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #38 was cognitively intact, had adequate hearing. A provider encounter note dated 2/27/2026 at 00:00 indicated Resident #38 had a cognitive deficit and hearing impairment. A provider encounter note dated 3/8/2026 at 00:00 indicated Resident #38 was using a communication device. An observation in Resident #38's private room on 3/9/2026 at 12:12 PM had a sign posted on the wall on the right side of the bed indicating Resident #38 could not hear, and to use a communication device with writing supplies. An interview and record review on 3/16/2026 at 12:10 PM with the Regional MDS nurse (RN #6) indicated it was up to the MDS nurse and the nursing department to ensure the resident had a care plan and the information was placed on Nurse Aide Assignment Card . The facility policy labeled Comprehensive Care Plans indicated the care planning process would include an assessment of the resident's strengths and needs and would be individualized and person centered and developed within 7 days after the completion of the comprehensive MDS assessment. Resident #2's diagnosis includes dementia. The Nursing admission assessment dated [DATE] indicated Resident #2 was rarely or never understood and indicated s/he had severe cognitive impairment. The admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #2 had moderate cognitive loss and indicated the facility was to proceed with care planning for dementia. On 3/16/2026 at 11:24 AM the MDS Nurse (LPN #3) indicated she/he could not find a dementia care plan though the MDS indicated a care plan with interventions to meet Resident #2's cognitive needs. On 3/16/2026 at 11:40 AM an interview and clinical record review with RN #6 (Regional MDS Nurse) indicated the social worker was responsible for the cognitive assessment and adding the care plan and facility MDS nurse who completed the admission assessment should have added the care plan if it had not already been added by the social worker.

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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. 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. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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. (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 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. 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 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, review of facility documentation and staff interviews for 1 of 4 (Residents #17) reviewed for accidents, the facility failed to ensure that a resident's environment was free of potential hazards and failed to provide adequate interventions to mitigate fall risk, including ensuring safe footwear and a clear ambulatory path during a period of increased risk related to a recent lower extremity injury and the facility failed to ensure that the main entrance non-smoking area was free of cigarette butts to prevent a potential hazard. The findings included: Resident #17's diagnoses included orthopedic conditions, phantom limb syndrome with pain, cervical disc degeneration, chronic pain syndrome, cervical radiculopathy, heart failure, asthma, bipolar disorder, depression, anxiety, and schizoaffective disorder. A Resident Care Plan (RCP) initiated 7/14/24 and last updated 9/9/25, indicated the resident preferred to wear gripper socks and declined shoes. Interventions included encouraging the resident to wear shoes as tolerated and providing gripper socks as needed. A Medicare 5-Day Minimum Data Set (MDS) assessment dated [DATE] indicated the resident was cognitively intact, used no assistive device for mobility, required varying levels of assistance with activities of daily living, and was prescribed multiple psychoactive medications (medications that alter brain function and can change perception, mood, behavior, and consciousness), opioids, and an antipsychotic medication, all of which may increase fall risk. An additional RCP intervention dated 11/27/24 directed staff to encourage and remind the resident to wear proper footwear. On 11/12/25, Resident #17 was assessed as a moderate fall risk and experienced a witnessed fall, resulting in non-displaced fractures of several toes on the left foot. The resident was placed in a walking orthopedic shoe; however, a physician's order dated 11/15/25 indicated the resident could ambulate with or without an assistive device. A care plan update dated 11/17/25 reflected this order. On 12/8/25, Resident #17 experienced a slip while exiting an elevator without descending to the ground. The facility did not classify the event as a fall, and the clinical record lacked evidence of nursing assessment, change-in-condition documentation, or provider notification following the event. The clinical record also lacked evidence of updates to the resident's care plan interventions to address environmental or safety risks. A physiatry provider note dated 12/9/25 at 4:57 PM documented the reported slip and observed the resident ambulating in the hallway wearing socks, with no motor weakness identified. On 12/11/25, during orthopedic follow-up, the resident reported slipping on an unmarked wet floor, resulting in an ankle injury. The resident was fitted with a short orthopedic boot to stabilize the injury and support healing of prior fractures. A quarterly MDS assessment dated [DATE] indicated the resident remained cognitively intact, independent with activities of daily living, and had experienced one fall with major injury (fractures). (continued on next page)

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	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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident continued to receive psychoactive medications, opioids, and antipsychotic medication. Observations on 3/9/26 at 11:10 AM and 3/11/26 at 6:25 AM identified clutter and multiple items obstructing or narrowing the Resident #17's walking path, creating potential trip hazards within the resident's room. Additional observations on 3/9/26 (11:10 AM–1:00 PM); 3/10/26 (8:30 AM–11:30 AM); 3/13/26 (8:30 AM–10:00 AM) showed Resident #17 ambulating in his/her room and hallways wearing gripper socks instead of appropriate footwear. The prior fall with a fracture and subsequent slip indicated an ongoing pattern of accident risk that required more effective environmental and safety interventions to reduce it. Given the resident's recent fractures, use of an orthopedic boot, chronic pain condition, and prescribed psychoactive and opioid medications, the resident had an increased risk for falls. Facility policies reviewed by the facility administrative team and Medical Director in January 2026, including the Falls Clinical Protocol, directed that when a resident continues to experience falls or fall-related events, the staff and physician will re-evaluate the situation and reconsider possible reasons for the resident's falling (instead of, or in addition to those that have already been identified) and also reconsider the current interventions. The facility failed to ensure a safe environment and to implement effective fall-prevention interventions, including maintaining a clear ambulatory path and addressing unsafe footwear practices, despite the resident's known and ongoing fall risk. The facility also failed to reassess and revise interventions following repeated fall-related events. On 3/16/2026 at 11:22 AM, a tour of the front outdoor common area/patio identified multiple cigarette butts on the concrete area of the patio, including one on a support column of the patio cover. There were also at least 33 cigarette butts counted on the grass next to the far end of the patio near a brick wall. On 3/16/2026 at 2:00 PM, an interview with the Director of Maintenance indicated he usually cleans the area, but it had been covered in snow until recently, when the snow had melted. The Director of Maintenance indicated that he thought the cigarette butts may have been from visitors or people crossing through the property. On 3/16/2026 at 2:40 PM, an interview with the Administrator identified that the building was a non-smoking building and staff and visitors were not allowed to smoke in the building or the common areas.

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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 clinical record, review of facility policy and staff interviews for 1of 1 resident (Resident # 5) reviewed for specialized treatment, the facility failed to ensure physician orders were obtained for a specialized type of venous access site, its location, assessment and care for the access site and failed to avoid medications prohibited as outlined in the facility policy. The findings include:Resident #5's diagnosis includes End Stage Renal(kidney) Failure. The physician's orders dated 2/7/2026 directed to have Resident #5 attend appointments at a specialized service facility for treatment of the End Stage Renal Failure 3 times per week.A physician's order dated 2/7/2026 included to provide Milk of Magnesia 30 milliliters (ml) by mouth as needed for constipation and a Fleet enema (brand name rectal solution used for constipation for quick results) on day 3 if there is no bowel movement after day 2. The admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #5 was cognitively intact and received a specialized service for treatment of Renal Failure. The care plan dated 2/27/2026 indicated Resident #5 received a specialized service outside the facility 3 times per week with interventions including encouraging the resident to attend the appointments for service and to observe laboratory results. An interview and observation with charge nurse LPN #6 identified when Resident #5 went to the specialized service location 3 times weekly, the residents port referring to a vascular access site in the upper chest was used to provide specialized treatment). The access site would be checked to ensure the dressing was dry and intact. When asked how nurses would know what specific care needs Resident #5 required LPN #5 reviewed the physician's orders. However, LPN # 6 could not find any orders referring to the access site type or its location or any physician's orders for the assessment and care of the access site. (The access site could be a catheter in the chest, or an atrioventricular shunt placed in an arm or a resident could have both, each requiring different assessment and safety equipment). LPN #6 indicated a resident would have a red bracelet on the wrist to indicate not to take blood pressure in the upper arm(if there was an access shunt located there). However, observation of Resident #5'wrists identified no red bracelet and LPN #6 indicated she/he would obtain the bracelet and apply it. At 9:45 AM LPN #6 indicted consulting with the nursing supervisor who clarified to her/him the red bracelets came from the hospital already on the resident, so it is ok to do laboratory work or blood pressure on the lower portion of either arm. An interview, record review and facility policy review on 3/13/2026 at 10:35 AM with nursing supervisor, RN#1 indicated the facility did not apply red bracelets to residents if a blood pressure or laboratory work should not be utilized on a particular arm. RN #1 indicated nurses would know not to take blood pressure on an arm with specialized venous access by looking at the physician's orders. RN #1 could not locate any physician orders but indicated it was standard knowledge for nurses to know. While reviewing the facility policy labeled Dialysis given onsite indicated in for any type of access route the physician's order should be carried to the treatment kardex (where the nurse would look for care needs to be provided and sign off its completion). This would include the type and location of the catheter or graft(shunt), and the days and times for the appointments at the specialized service location. The policy further indicated the care of the Atrioventricular(AV) access site(a Fistula or Graft in an upper arm) notes not to utilize the arm with an access site for blood pressure or laboratory work, after specialized treatment the bandage should be removed the next day, any scabs being left intact. An assessment of the bruit and thrill of the access site in the arm(palpation of a pulsation and auscultation over the access site with a stethoscope to hear the blood flow) would be completed and the physician notified if either or both were absent. Uncontrolled or large amounts of bleeding from the access site would require applying direct pressure to the site and transfer to the emergency room, notifying the physician and family. RN #1 indicated s/he would obtain the appropriate physician orders that should have been in place. Further review of the physician orders, the Medication Administration Record (MAR) and the facility policy with RN#1 noted (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physician's orders for Milk of Magnesia and Fleets enema as needed. The MAR from admission through to present identified the fleets enema had not been utilized but the Milk of magnesia was administered on 2/16/2026 at 8:23 AM and on 2/23/2026 at 5:10 PM. The facility Specialized Treatment policy indicated Milk of Magnesia and Fleets enema were medications to be avoided. RN #1 identified she/he did not know why Resident #5 had the orders. On 3/13/2026 at 10:48 AM an interview, record review and policy review with APRN #3 indicated the physician's orders for Milk of Magnesia and Fleets enema were signed by the physician(Medical Doctor (MD #1) and indicated she/he would have discontinued the orders upon review if s/he felt they should not be given. When asked if complications could occur from their use, APRN #3 indicated with continued use blood levels of magnesium could build up, the risk is very low. On 3/13/2026 at 5:15 PM an interview and facility policy review with MD #1 indicated being involved in reviewing the facility policies and procedures. MD #1 further indicated specialized treatment patients should not receive Milk of Magnesia, and she/he would review the resident's physician's orders and the facility policy for administration.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, review of facility documentation, observation and staff interviews for 1 of 5 residents (Resident # 130) reviewed for unnecessary medications, the facility failed to ensure the physician acted upon a pharmacy recommendation timely. The finding included. Resident # 130's diagnoses included adjustment disorder, atherosclerotic heart disease, cerebral infarction, hypertension, anemia, cystic disease of the liver, cystic of the kidney, polyneuropathy, bradycardia and osteoarthritis.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 .A review of the Pharmacy Recommendation report dated 11/9/25 for Resident # 130 noted a recommendation for behavior monitoring for the following psychoactive medication is required for Trazodone when necessary.The Resident Care Plan dated 3/10/26 for Resident has impaired cognitive function/or impaired thought process. Interventions included: administering medications as ordered, follow up with psychiatry when needed, keep resident routine consistently and try to have consistent care givers as much as possible to decrease confusion, monitor and report to Medical Doctor (MD), any changes in decision making ability, memory, recall, general awareness, difficulty understanding others and level of consciousness.However, reviewing the electronic medical record from 11/10/25 through 3/17/26 failed to reflect the physician's response to the pharmacy recommendation on 11/9/2025.Observations on 3/17/26 at 11:15 AM identified Resident # 130 in a recreational activity groomed appropriately and noted with agitation. Resident # 130 was easily re-directed by recreational staff.A review of the electronic medical record and interview with the DNS on 3/17/26 at 11:48 AM identified no behavioral monitoring conducted from 11/9/2025 through 3/17/2026 and no physician's response to the pharmacy recommendation on 11/9/25. The DNS indicated it is nursing responsibility to follow up on pharmacy recommendations with the physician and indicated she could explain why this was done.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on clinical record review, observation and staff interview for 1 of 5 residents reviewed for Unnecessary Medication (Resident #39), the facility failed to ensure the resident's pain medication had a stop date. The findings include: Resident # 39's diagnoses included acute respiratory failure with hypoxia, pain in right shoulder, chronic pain, acute ischemic heart disease, hypotension, gastro-esophageal reflux, diabetes mellitus type 2, obstructive sleep apnea and anxiety. The physician's orders dated 3/5/26 at 12:30 PM directed Oxycontin Extended Release (ER) one tablet for pain total dose of 50 Milligrams (MG) with no stop date. The March Medication Administration Record for 2026 directed Oxycontin Extended Release (ER) one tablet for pain total dose of 50 Milligrams (MG) with no stop date or revaluation.Observation on 3/17/26 at 11:20 AM identified Resident # 39 alert and oriented and answering questions appropriately. The resident was also noted receiving morning care from a nurse aide while participating in the conversation about her/his care.Record review and interview with the DNS and Assistant Director of Nursing Services (ADNS) on 3/17/26 at 11:31A.M. identified they could not see a stop dated for Oxycontin Extended Release (ER) one tablet for pain total dose of 50 Milligrams (MG) ordered on 3/5/26. They also indicated it is the responsibility of the unit management during auditing to check narcotics for stop dates.

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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.