STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075405	A. Building B. Wing	03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Madison	34 Wildwood Avenue Madison, CT 06443

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41223 Based on observation, clinical record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #1) reviewed for end of life, the facility failed ensure the responsible party was notified timely when a change in skin integrity was identified. The findings include: Resident #1 was admitted with diagnosis that include schizoaffective disorder, generalized muscle weakness and senile degeneration of the brain. The Resident Care Plan (RCP) dated 9/22/2023 identified Resident #1 was at risk for skin breakdown due to inadequate oral intake, fragile skin, incontinence, and limited mobility. Interventions directed to float heels while in bed, low loss mattress, and to evaluate for skin problems. A quarterly MDS assessment dated [DATE] identified Resident #1 was severely cognitively impaired, required extensive assistance for bed mobility, was non-ambulatory, was at risk for pressure ulcers and had one (1) Stage III pressure ulcer. Clinical record review identified Resident #1 had a court appointed Conservator. A facility consultant wound Nurse Practitioner (NP) consultation dated 10/23/2023 identified an initial assessment of a right foot deep tissue injury (DTI), non-blanchable, deep red, maroon/purple discolored pressure ulcer, 0.5 centimeters (cm) length by one (1) cm width with no measurable depth. The note directed to cleanse the wound with wound cleanser and protect the peri wound with no sting-skin prep twice a day and leave open to air. Review of the clinical record failed to identify the responsible party was notified of the new DTI. Interview with RN #1 on 3/6/2024 at 12:49 PM, the infection control/wound nurse in October 2023, identified she was responsible to make rounds with the wound NP and the NP would complete the documentation. RN #1 further indicated the nurse on the unit was responsible to contact the responsible party with any updates, and then write a note in the clinical record to identify the notification was completed. RN #1 indicated although she did not recall the new area for Resident #1, she identified the charge nurse should have notified the family. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LPN #1 on 3/6/2024 at 1:30 PM identified she was the charge nurse on 10/23/2023 when Resident #1's new skin area was identified, and further indicated as the charge nurse she would be responsible to notify the family. Although LPN #1 indicated she could not recall if she notified the family, she stated if she had notified the family, she would have written a nursing note to identify that it was done; if it was not documented, she indicated it was not done. Interview with the DON on 3/6/2024 at 2:00 PM identified that if a resident had a new pressure area, notification to the physician and family was necessary. The DON was unable to provide documentation that the family was notified, and indicated she did not know why it was not completed. The facility Change in Condition: Notification of, Policy dated 6/1/2021, directed in part, the facility must immediately inform, the resident's health care authority, Health Care Decision Maker, where there is a significant change in the resident's physical status or when there is need to commence new treatment.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41223 Based on clinical record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #1) reviewed for end-of-life care, the facility ensure a complete and accurate record to include records prior to facility ownership, to include documentation of ADL care, documentation of hospice services and documentation of an assessment of death. The findings include: Resident #1 was admitted with diagnosis that include schizoaffective disorder, generalized muscle weakness and senile degeneration of the brain. The Resident Care Plan (RCP) dated [DATE] identified Resident #1 was at risk for skin breakdown due to inadequate oral intake, fragile skin, incontinence, and limited mobility. Interventions directed to float heels while in bed, low loss mattress, and to evaluate for skin problems. A quarterly MDS assessment dated [DATE] identified Resident #1 was severely cognitively impaired, required extensive assistance for bed mobility, was non-ambulatory, was at risk for pressure ulcers and had one (1) Stage III pressure ulcer. Clinical record review identified Resident #1 had a court appointed Conservator. 1. Clinical record review failed to identify any documentation for ADLs during [DATE]. Interview and record review with the Administrator [DATE] at 1:15PM identified although the ADL documentation was requested from the facility, the Administrator indicated due to a change in ownership that occurred during [DATE], the ADL documentation for Resident #1 was not available as part of the medical record for review. The Administrator indicated a request was made to the prior owners for the documentation to be sent to the facility and indicated it should be a part of the Resident's accessible medical record. The facility ADL Policy dated [DATE] directed in part, that documentation of ADL care was recorded in the medical record and was reflective of care provided by the nursing staff. ADL care will be documented in real time. 2. The RCP identified that Resident #1 was on hospice services, with a start date of [DATE]. The RCP directed to assess for signs of discomfort, provide nonpharmacological and medications as needed. A Hospice physician order dated [DATE] recertified hospice level of care, and directed hospice staff provide all core services as outlined in the hospice plan of care. Interview with the DON on [DATE] at 1:00 PM identified that the facility had changed ownership in October of 2023 and that a request was made to the prior owner corporate office to send the ADL documentation for Resident #1 that was currently not available. The hospice services would also be contacted to request the missing hospice documentation since the facility was unable to locate that documentation at this time. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1's medical record included the hospice plan of care and recertification for [DATE] but lacked documentation of the hospice election form and any hospice services of any care provision during the month of [DATE]. The facility Hospice Policy dated [DATE] directed in part, the facility obtains the hospice election form from hospice. The facility policy Nursing Documentation dated [DATE] directed in part that the purpose of the policy was to communicate residents' status, provide complete, comprehensive, and accessible accounting of care and monitoring provided. All resident information was documented, scanned, or entered into the clinical record. 3. A physician's order dated [DATE] directed do not resuscitate (DNR), do not intubate (DNI), transfer for acute injury only, and RN Pronounce (RNP - RN may pronounce death). Review of a nursing note dated [DATE] at 5:57 PM identified Resident #1 had expired at 5:49 PM. The note further identified APRN #2 and Person #2 were notified of the death, however the note failed to identify Resident #1 was assessed at his/her time of death by an RN to pronounce the death. During an interview with RN #2 on [DATE] at 4:24 PM, RN #2 indicated he/she had pronounced Resident #1's death on [DATE], notified Resident #1's family immediately after the pronouncement, and she failed to document Resident #1 was assessed at his/her time of death. RN #2 further indicated that facility policy directed to assess residents at their time of death, which involved checking vitals, respirations, apical pulse, chest rising/falling, skin color, eye dilation, and relaxation of muscles, and to document the assessment in the resident's chart. RN #2 indicated he/she forgot to document the assessment in the resident's chart. Review of the Pronouncement of Death policy dated [DATE] directs the registered nurse (RN) who has determined and pronounced death will document the clinical criteria for such determination and pronouncement in the patient's medical record which include a description of the discovery of the patient, any treatment the patient had undertaken, findings from assessment (presumptive and conclusive signs identified) such as no carotid and peripheral pulse, pupils fixed and non-reactive to light, no response to tactile stimuli, no respirations for one full minute, no heart sounds for one full minute, the date and time of death, individuals notified of the patient's status/death, and results of any communications. Interview with the DON on [DATE] at 1:00 PM identified that the facility had changed ownership in October of 2023 and the facility did not have access to the prior owner's electronic medical records (and had no paper copies). The DON indicated a request was made to the prior owner's corporate office to send copies of the requested medical records that the facility did not have available. Review of facility Change of Ownership Pre-Licensure Consent Order dated [DATE] directed in part, any records maintained in accordance with any state or federal law or regulation or as required by this Order shall be made available to the INC and the Department upon request.