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Form Approved OMB
No. 0938-0391

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	08/25/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, and facility policy reviewed for the initial tour of the kitchen, the facility failed ensure thawing of meat per the requirement. The findings include:Observation on 8/15/2025 at 9:38 AM, identified fish being thawed on one side of a double sink in a water bath and chicken patties in the other side of the double sink in a plastic package without any running water being used. Interview with the Food Service Manager on 8/19/2025 at 11:32 AM identified the fish was in a water bath on 8/15/2025 and he drained the water with the fish in it. The Food Service Manager further indicated that the facility policy for thawing frozen food was to thaw the items either in the refrigerator or under cold running water. Occasionally they thaw frozen food in the microwave. He could not determine why the cook had the fish in a water bath rather than under cold running water, or why the chicken patties in the sink were being thawed without the benefit of running water. Review of the Food Storage Cold policy dated May 2014 directed, in part, the cook thaws frozen items requiring defrosting, before preparation, under refrigeration, in the microwave for immediate use, or in a sealed container immersed in cold running water.

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 observations, facility documentation, interviews and policy review for 2 of 2 samples residents (Resident #33 and Resident #58) reviewed for choices, the facility failed to honor the residents right to make choices within the facility. The findings included:1. Resident #33's diagnoses included malignant neoplasm of the frontal lobe, atherosclerosis of bilateral extremities, and apraxia. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #33 had a Brief Interview of Mental Status (BIMS) score of 10 indicating moderate cognitive impairment and was dependent on staff for personal hygiene, oral hygiene, and dressing. The Resident Care Plan dated 7/6/25 identified Resident #33 was at risk for a communication problem related to unclear speech. Interventions included anticipating and meeting the resident's needs as well as avoiding isolation. Interview with the Responsible Party, Person #1, on 8/19/25 at 2:15 PM identified that Resident #33 had presented with long, greasy hair during the last couple of medical appointments. Additionally, Person #1 identified the request for a haircut was brought up to social services and nursing staff multiple times throughout the last couple of months, as well as a form for receiving a haircut had been filled out in the business office, but Resident #33 still had not received a haircut. Observations between 8/19/25 and 8/25/25 identified Resident #33 with slicked back hair extending about 3 inches below the nape of his/her neck. Interview with Resident #33 on 8/20/25 at 1:29 PM identified he/she did not like their current hair length and preferred it short. Interview with the Administrator on 8/20/25 at 1:58 PM identified there was a family meeting held on 8/5/25 with Resident #33's Person #1 to address care concerns, including a haircut. Additionally, she identified that the requests for a haircut were not honored because she did not think the hairdresser would be comfortable cutting his/her hair due to Resident #33's neck positioning (leaning to one side), adding that the nursing assistants or hospice could provide him/her with a haircut. The Administrator failed to indicate why a haircut had not been provided to Resident #33 since Person #1 requested the haircut for several months or since the meeting on 8/5/25 (15 days). Interview with the Hairdresser on 8/20/25 at 2:14 PM identified she was notified by written request when a resident asked to have a haircut. She indicated that she kept all her request forms, could not recall that Resident #33 had ever submitted a request for his/her hair to be cut, and was unable to find a request among her stored records. Interview with the Business Office Manager on 8/20/25 at 4:34 PM identified Resident #33's responsible party submitted a haircut request, which was passed on to the hairdresser. The Business Office Manager could not recall when the haircut request had been written, could not provide a copy of the haircut request, and stated the next time the hairdresser came to the facility, Resident #33 would receive a haircut. 2. Resident #58's diagnoses included a fracture of the right femur, anxiety, and parkinsonism. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The admission Nursing assessment dated [DATE] identified Resident #58 had a Brief Interview of Mental Status (BIMS) score of 12 but the assessment was incomplete (as 2 questions were not addressed). Resident #58 was independent with eating, required moderate assistance with chair/bed-to-chair transfers, and extensive assistance with locomotion. The Resident Care Plan (RCP) dated 8/5/2025 identified Resident #58 had a potential nutritional risk due to medical comorbidities. Interventions included providing/serving the diet as ordered, monitor intake and record every meal, offer replacement foods as necessary, and the registered dietician would evaluate and make diet change recommendations as needed. Review of a physician's order dated 8/5/2025 identified Resident #58 was on a regular texture, regular consistency diet. Review of the dietician Nutritional Evaluation dated 8/6/2025 identified Resident #58 had allergies to food dyes but failed to note any further intolerance or problems. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #58 had a Brief Interview of Mental Status (BIMS) score of 14 indicating intact cognition, required maximal assistance for chair/bed-to-chair transfers, was dependent for personal hygiene, and required supervision for eating. Interview with Resident #58's family member, Person #7, on 8/15/2025 at 12:41 PM identified that caffeinated coffee made the resident violently ill. Person #7 indicated that he/she had requested decaffeinated (decaf) coffee, and tea, but staff, on multiple occasions, were unable to convey if the coffee being served was regular or decaf, so Resident #58 could not consume any coffee during meals. Interview and observation on 8/15/2025 at 12:37 PM with Person #7 identified that Resident #58 had just been served an unknown type of coffee with his/her meal, he/she questioned NA #4 whether the coffee was regular or decaf, but NA #4 was unable to indicate which type of coffee was served. Further, Person #7 stated Resident #58 had been upset because he/she enjoyed decaf coffee and was unable to drink any coffee served due to the fear of becoming violently ill. Interview with Nurse Aide (NA) #4 on 8/15/2025 at 12:39 PM identified she was unaware of the type of coffee, regular or decaf, contained in the carafe she used, was unaware that Person #7 had questioned her as to the type of coffee served, and she had never been told by anyone what coffee type she distributed to residents. Additionally, NA #4 indicated that the beverage cart was presented from the Dietary Department without any other coffee choices and lacked a decaf coffee option. Interview with the Dietary Director on 8/15/2025 at 12:57 PM identified that all residents were served regular coffee from the carafe, but that instant coffee was available in a packet as a decaf option but never served in a carafe. Interview and review of Resident #58's self-selected menu options with the Dietary Director on 8/25/2025 at 12:33 PM for menus dated 8/5/2025 through 8/20/2025 identified that the resident had requested tea to be served with meals as his/her beverage of choice. Review of Resident #58's printed meal tickets, used to indicate preferences during meal distribution, failed to identify his/her request for tea and directed to provide either tea or coffee. The Dietary Director stated beverages were served from the beverage cart by nursing aides (NA)/servers and that both options of coffee and (continued on next page)

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tea were always printed on Resident #58's ticket. The Dietary Director was unable to explain how a NA/server would be able to identify Resident #58's choice of tea if the request was not printed on the meal ticket. The Dietary Director stated he did not provide decaf coffee packets on the beverage cart that was sent to Resident #58's unit. Further, he was unaware that Resident #58 could not drink caffeinated coffee due to becoming ill, or that Resident #58 had requested decaf coffee. The Dietary Director indicated that going forward, Resident #58's ticket would be printed to indicate decaf under beverage to be served. The facility's Standardized menus policy identified in part, that the facility will support the resident's right to make personal dietary choices, and if during meal observations a resident's dietary intake appears inadequate, the facility will make reasonable efforts to review and/or adjust the menu and/or the resident's food plan to meet the nutritional, religious, cultural, ethnic needs, and preferences of the resident. Review of the Resident Rights Policy dated 7/21 directed in part that residents have the right to self-determination and a dignified existence.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for 2 of 2 sampled residents (Resident #30 and Resident #33) reviewed for choices, the facility failed to follow their grievance policy. The findings include:1. Resident #30's diagnosis included multiple sclerosis, anxiety, and pain. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #30 had a Brief Interview of Mental Status score of 15 indicating no cognitive impairment and required partial to moderate assistance with upper body dressing and was dependent for lower body dressing. The Resident Care Plan dated 5/7/2025 identified a problem with self-care for Activities of Daily Living (ADLs). Interventions included providing extensive assistance with bathing, dressing, and bed mobility. Interview with Resident #30 on 8/15/2025 at 10:30 AM identified missing pants. Resident #30 indicated that he/she had informed the laundry personnel but had not received any response. Review of Resident #30's nurse's notes and the grievance log for July and August 2025 failed to identify Resident #30 had any missing items. Interview with Social Worker (SW) #1 on 8/20/2025 at 9:04 AM identified she was never informed that Resident #30 had a missing item. Interview with Registered Nurse (RN) #1 on 8/20/25 at 9:21 AM identified that she was never informed of Resident #30's missing pants. Interview with Laundry Aide #2 on 8/20/2025 at 9:50 AM identified that she was aware of Resident #30's missing pants, had attempted to find the missing item but was unable, and had informed her previous District Director of Laundry and Housekeeping of the lost pants. Interview with the District Director of Laundry and Housekeeping on 8/20/2025 at 9:50 AM identified that he had only been with the facility for a week and had no knowledge of Resident #30's missing pants. Interview with the Administrator on 8/20/2025 at 11:50 AM identified that subsequent to surveyor inquiry, her staff had notified her of the missing item on 8/20/2025 and she was currently completing a grievance form. The Administrator indicated that anyone in the facility would have been able to fill out a grievance form and that if the laundry aides were not comfortable filling out the form, they should have escalated the missing item information to a manager to complete. 2. Resident #33's diagnoses included malignant neoplasm of the frontal lobe (brain), atherosclerosis of bilateral extremities, and apraxia (a brain motor disorder). The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #33 had a Brief Interview of Mental Status (BIMS) score of 10 indicating moderate cognitive impairment and was dependent on staff for personal hygiene, oral hygiene, and dressing. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Resident Care Plan dated 7/6/25 identified Resident #33 was at risk for a communication problem related to unclear speech at times. Interventions included anticipating and meeting needs as well as avoiding isolation. A Social Service note dated 8/5/25 at 11:40 PM identified a meeting was held with Resident #33's responsible party, social worker, Business Office Manager, Director of Nursing Services, and Administrator. Family concerns were addressed, and support was available. The facility was to follow up with the psychiatrist and doctor, and a second meeting would occur with updates. Interview with the Responsible Party, Person #1 on 8/19/25 at 2:15 PM identified that both communication with the facility and Resident #33's personal care had progressively gone downhill. In the last couple months Resident #33 looked disheveled like he/she just came out from under a bridge, with dirty long hair, dirty long fingernails and food in his/her teeth. Person #1 indicated that the resident had 3 medical appointments scheduled and for one of the appointments scheduled on 7/22/25 he/she waited for Resident #33 at the physician's office. When the resident did not show up, he/she called the facility and was told by staff that the resident was on the way. A while later, when the resident had still not shown up, he/she called the facility a second time and was told that Resident #33's transportation for the appointment was cancelled by the transportation company and the resident never actually left the facility. Although he/she did not remember who she spoke to, a staff member at the facility identified that Resident #33 was never scheduled for an appointment on 7/22/25, even though the business office had confirmed the transportation to the 7/22/25 appointment had been arranged. Person #1 stated he/she had a meeting with the interdisciplinary team on 8/5/25 to voice his/her concerns about the missed appointment and the lack concern for Resident #33's personal care. When he/she did not hear back from the facility he/she questioned the Administrator and was told that she (the Administrator) hadn't thought of responding to the concern. Person #1 indicated that he/she had not completed or signed a grievance during his/her 8/5/25 meeting. Subsequent to the meeting, the 7/22/25 missed appointment was rescheduled for 8/11/25, but Resident #33 arrived late, with food in his/her teeth, unkept hair, and an overall disheveled appearance. A review of the grievance book and grievance logs (where concerns are written when received) from July 2005 and August 2005 failed to identify any grievances logged or documented for Resident #33. Interview and record review with the Administrator on 8/20/25 at 1:58 PM identified she was the grievance officer, and it was facility policy that a grievance form be filled out when a family member or resident made a complaint, with a lead person tracking the grievance and presenting a solution. If there was a verbal complaint, then she would fill out the grievance form on the matter. Additionally, the Administrator identified that she received concerns from Resident #33's responsible party regarding personal care and transportation. Record review with the Administrator identified a grievance that was initiated on 7/23/25 regarding missed transportation, and that she was currently working on a resolution, so it remained on her desk. The grievance failed to include the lack of a haircut being provided or the concern for Resident #33's lack of personal care. The Administrator identified that she did not initiate a grievance for personal care concerns because every time she saw Resident #33, he/she looked good. The resolution to Person #1's personal appearance concern had been to provide support to Person #1 during the meeting on 8/5/25. Additionally, the Administrator identified that the responsible party was not updated on the grievance resolution because it was still on her desk and incomplete. Interview with the transportation company customer service representative on 8/21/25 at 9:32 AM (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	identified that the transportation arrangement was not a no call no show, but that it was cancelled by the facility on 7/21/25 at 10:54 AM. Per their policy, she was unable to give specifics or disclose the name of the staff member who she identified as cancelling the appointment. Additionally, physician offices do not cancel transportation arrangements. Review of the Resident and Family Grievances Policy dated 12/23/22 directed, in part, that the Grievance Official is responsible for overseeing the grievance process. All staff involved in the grievance process should make prompt efforts to resolve the grievance, prompt efforts include acknowledgement of complaint/grievances and actively working toward a resolution of that complaint/grievance. grievances may be voiced in the FOLLOWING forums: verbal complaint to a staff member, the staff member receiving the grievance will record the nature and specifics of the grievance on the designated grievance form or assist the resident to complete the form, then forward the grievance form to the grievance official as soon as practicable.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, review of clinical record, and facility policy for 1 of 5 (Resident #58) residents reviewed for abuse, the facility failed to report an allegation of neglect to the State Agency within the 24-hour time requirement. The findings include:Resident #58's diagnoses included fracture of the right femur, anxiety, and parkinsonism.The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #58 had a Brief Interview of Mental Status (BIMS) score of 14 indicating intact cognition, required maximal assistance for toileting and chair/bed-to-chair transfers, and was dependent for personal hygiene.The Resident Care Plan (RCP) dated 8/5/2025 identified Resident #58 had Parkinson's Disease. Interventions included monitoring for constipation, and monitor/document/report side effects of Parkinson's including gait disturbance, incontinence, decline in range of motion, skin breakdown, and decline in cognitive function.Review of the Nurse Aid (NA) care card (used to direct care) in effect during August 2025, identified Resident #58 required extensive assist of 2 staff to reposition and turn in bed.Interview on 8/15/2025 at 11:33 AM with Person #7 (family member) identified on the morning of 8/13/2025 Person #7 went into the facility to visit Resident #58. The resident informed him/her that during the night shift (11:00 PM to 7:00 AM) sometime after midnight Resident #58 rang for assistance with toileting and was told to poop in his/her diaper because the aide was too busy to help. He/she further indicated that the resident sat in the dirty brief overnight and felt disrespected. Person #7 stated he/she voiced his/her concern to an unknown nurse and Medical Doctor (MD) #1 on the morning on 8/13/2025. Interview on 8/19/2025 at 11:10 AM with MD #1 identified he was notified by Person #7 on 8/13/2025 that the resident was left in a dirty brief overnight and stated he/she was upset and requested Resident #58 be checked. Further, he identified he notified the nursing supervisor (whose name he did not know) on the unit, of the allegation of neglect and that the Nursing Department was responsible for following up on the allegation. Review of the staffing schedule identified Registered Nurse (RN) #1 was the supervisor working on 8/13/2025. Interview on 8/19/2025 at 12:46 PM with Registered Nurse (RN) #1 (supervisor) identified that she worked the morning of 8/13/2025, and although MD #1 indicated he had notified the nursing supervisor on the unit, she denied being made aware of the allegation of neglect towards Resident #58 and stated if she were aware, then the allegation would have been reported (to management).Subsequent to surveyor inquiry, on 8/19/2025 at 4:17 PM, the facility generated a Reportable Event document from 8/13/2025 for the allegation of neglect. Interview with the Administrator on 8/20/2025 at 10:15 AM identified that she could not provide the surveyor with a copy of the document as it was still incomplete.Interview on 8/20/2025 at 10:44 AM with the Director of Nursing Services (DNS) identified that on 8/19/2025 she was made aware that Resident #58 did not receive care and sat in a dirty brief for hours. Further, she indicated someone at the facility had since contacted Person #7 regarding his/her concern. The DNS was unable to explain why she was not notified prior to 8/19/2025 of the allegation of neglect, or why a Reportable Event form had not been generated and sent to the SA immediately after the incident had been reported to the MD and to a staff member.Review of the facility's Accidents and Incidents policy identified in part, that an incident is any occurrence or event that causes trouble or interrupts normal procedure, for all incidents, that an accident/incident report (RE) form must be completed on the shift the accident/incident occurred, and the form will be submitted to the Director of Nursing Services.Review of the facility's Abuse policy identified in part, that reporting of all alleged violations are to be made to the Administrator, state agency, adult protective services, and to all other required agencies (e.g. law enforcement when applicable) within specified timeframes: immediately but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious injury; not later than 24 hours if the events that cause the allegation do not involve abuse or and do not result in serious injury.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, review of clinical record, and facility policy for 1 of 5 sampled residents, (Resident #58) reviewed for abuse, the facility failed to investigate an allegation of neglect. The findings include:Resident #58's diagnoses included fracture of the right femur, anxiety, and parkinsonism. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #58 had a Brief Interview of Mental Status (BIMS) score of 14 indicating intact cognition, required maximal assistance for toileting and chair/bed-to-chair transfers, and was dependent for personal hygiene.The Resident Care Plan (RCP) in effect for August 2025 identified Resident #58 had Parkinson's Disease. Interventions included monitoring for constipation, and monitor/document/report side effects of Parkinsons including gait disturbance, incontinence, decline in range of motion, skin breakdown, and decline in cognitive function.Review of the Nurse Aid (NA) care card (used to direct care) in effect during the survey identified Resident #58 required extensive assist of 2 staff to reposition and turn in bed.Interview on 8/15/2025 at 11:33 AM with Person #7 (family member) identified on the morning of 8/13/2025 Person #7 went into the facility to visit Resident #58. The resident informed him/her that during the night shift (11:00 PM to 7:00 AM) sometime after midnight Resident #58 rang for assistance with toileting and was told to poop in his/her diaper because the aide was too busy to help. He/she further indicated that the resident sat in the dirty brief overnight and felt disrespected. Person #7 stated he/she voiced his/her concern to an unknown nurse and Medical Doctor (MD) #1 on the morning on 8/13/2025. Interview on 8/19/2025 at 11:10 AM with MD #1 identified he was notified by Person #7 on 8/13/2025 that the resident was left in a dirty brief overnight and stated he/she was upset and requested Resident #58 be checked. Further, he identified he notified the nursing supervisor (whose name he did not know) on the unit, of the allegation of neglect and that the Nursing Department was responsible for following up on the allegation. Review of the staffing schedule identified Registered Nurse (RN) #1 was the supervisor working on 8/13/2025. Interview on 8/19/2025 at 12:46 PM with Registered Nurse (RN) #1 (supervisor) identified that she worked the morning of 8/13/2025, and although MD #1 indicated he had notified the nursing supervisor on the unit, she denied being made aware of the allegation of neglect towards Resident #58 and stated if she were aware, then the allegation would have been reported (to management).Subsequent to surveyor inquiry, on 8/19/2025 at 4:17 PM, the facility generated a Reportable Event document from 8/13/2025 for the allegation of neglect. Interview with the Administrator on 8/20/2025 at 10:15 AM identified that she could not provide the surveyor with a copy of the investigation as it was still incomplete.Interview on 8/20/2025 at 10:44 AM with the Director of Nursing Services (DNS) identified that on 8/19/2025 she was made aware that Resident #58 did not receive care and sat in a dirty brief for hours. Further, she indicated someone at the facility had since contacted Person #7 regarding his/her concern. The DNS was unable to explain why she was not notified prior to 8/19/2025 of the allegation of neglect, or why a Reportable Event form had not been generated as well as starting an investigation after the incident had been reported to the MD and to a staff member on 8/13/25Review of the facility's Abuse policy identified, in part, that an immediate investigation is warranted when reports of abuse, neglect or exploitation occur. Written procedures for investigations include identifying staff responsible for the investigation, exercising caution in handling evidence that could be used in a criminal investigation, investigating different types of alleged violations, identifying and interviewing all involved persons including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegation, and providing complete and thorough documentation of the investigation.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of clinical records, facility policy, and interviews for the only sampled residents (Resident #43) reviewed for skin conditions, the facility failed to follow professional standards of care for the utilization of a post surgically placed wound vac. The findings include: Resident #43 was admitted on [DATE] with the included diagnoses of fusion of spine, type 2 diabetes, and hypertension.The admission Nursing assessment dated [DATE] identified that Resident #43 had a Brief Interview of Mental Status (BIMS) score of 15 indicating intact cognition, was admitted with a surgical incision to the lumbar region of his/her back and required supervision with chair/bed to chair transfers and walking 150 feet. The admission Weekly Skin assessment dated [DATE] indicated that Resident #43 had a lumbar back incision and a wound vac (device to aid in healing). The admission Baseline Care Plan dated 8/3/2025 indicated Resident #43 had a surgical incision with a wound vac. Interventions included keeping the skin as clean and dry as possible, monitor wound area for signs and symptoms of infection, and monitor nutritional status. Review of a Physician's order dated 8/2/2025 directed to keep the dressing clean, dry, and intact at all times. Leave the dressing intact until 8/4/2025 then open to air. Sutures and staples were to be removed post operative on day 14. Observation and interview with Resident #43 on 8/15/2025 at 10:43 AM identified that following his/her back surgery he/she had a wound vac device placed to assist with healing. Both Resident #43 and his/her family member indicated the surgeon directed that the wound vac should have been left in place until seen by the surgeon but had been removed by the facility. A. Review of the hospital Discharge Summary and Interagency transfer documents dated 8/2/2025 failed to include the placement of the wound vac device. Interview on 8/19/2025 at 11:10 AM with Medical Doctor (MD) #1 identified that treatment orders for a wound vac would be written according to the surgeon's preference and a wound vac would only be removed if there was a problem with the wound vac or if the surgeon directed it to be removed.An interview and review of the clinical record with the Infection Preventionist, Registered Nurse (RN) #3 on 8/21/25 at 1:35 PM identified that on Resident #43's date of admission, 8/2/2025, a physician's order directed to keep the dressing clean, dry, and intact at all times. Leave the dressing intact until 8/4/2025 then open to air. RN #3 indicated that although there were no orders in the clinical record directing the care of, or the removal of Resident #43's wound vac, he assumed that, according to the physician order, the wound vac was to be discontinued on 8/4/2025 due to reading open to air. RN #3 indicated he removed the wound vac on 8/4/2025 and left the wound open to air but failed to confirm the orders for the wound vac. RN #3 indicated that according to the facility policy, a physician's order was necessary prior to the wound vac removal. RN #3 stated that since there were no orders for the removal of Resident #43's wound vac, the admitting nurse (RN #4) or himself should have contacted a provider: the physician, APRN, or the resident's surgeon who placed the device for further details, prior to removing. RN #3 indicated in retrospect he should have clarified how to care for the wound vac by calling a provider for a directive.Review of the facility's Admissions from Other Healthcare Facilities policy identified in part, that should the transferring facility fail to provide necessary medical information upon admission, implement the following: Contact the transferring facility; Implement emergency admission procedures; Notify the Medical Director and Administrator; and Document in the resident's admission notes.Review of the facility's Wound Treatment Management policy identified in part, that wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing changes. In the absence of treatment orders, the licensed nurse will notify the physician to obtain treatment orders.B. Although the facility admitted Resident #43 with a wound vac for post operative wound care, the facility failed to have a policy for the provision of wound vac care. A written surveyor Resident Document Request form for a wound vac policy that had been given to the facility was returned to the surveyor indicating that the facility did not have a policy to guide staff (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075405	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/25/2025
NAME OF PROVIDER OR SUPPLIER Autumn Lake Healthcare at Madison		STREET ADDRESS, CITY, STATE, ZIP CODE 34 Wildwood Avenue Madison, CT 06443	

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	as to how to provide care for residents admitted to the facility with a wound vac. According to the American Association of Post Acute Care Nursing, Writing Effective Policies for Long Term Care, Writing effective policies is more than a bureaucratic exercise - it is a foundational strategy for delivering safe, ethical, and compliant care. Policies ensure that regulatory expectations are met, resident rights are protected, and staff actions are guided with clarity and consistency.Attempts to reach RN #4 were unsuccessful. Although requested, the facility did not have a wound vac policy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075405	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/25/2025
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 observation, review of the clinical record, facility policy, and interviews for the only sampled residents (Resident #43) reviewed for skin conditions, the facility failed to obtain physician order to instruct care for a wound vac for a post-surgical resident. The findings include: Resident #43 was admitted on [DATE] with the included diagnoses of fusion of spine, type 2 diabetes, and hypertension.The admission Nursing assessment dated [DATE] identified that Resident #43 had a Brief Interview of Mental Status (BIMS) score of 15 indicating intact cognition, was admitted with a surgical incision to the lumbar region of his/her back and required supervision with chair/bed to chair transfers and walking 150 feet.The admission Weekly Skin assessment dated [DATE] indicated that Resident #43 had a lumbar back incision and a wound vac (device to aid in healing). The admission Baseline Care Plan dated 8/3/2025 indicated Resident #43 had a surgical incision with a wound vac. Interventions included keeping the skin as clean and dry as possible, monitor wound area for signs and symptoms of infection, and monitor nutritional status.Review of a Physician's order dated 8/2/2025 directed to keep the dressing clean, dry, and intact at all times. Leave the dressing intact until 8/4/2025 then open to air. Sutures and staples were to be removed post operation on day 14.Review of an Advanced Practice Registered Nurse (APRN) order dated 8/7/2025 directed to cleanse the incision with Betadine, cover with a dressing every 8 hours and as needed for soiling, saturation, or dislodgement.Observation and interview with Resident #43 on 8/15/2025 at 10:43 AM identified that following his/her back surgery he/she had a wound vac device placed to assist with healing. Both Resident #43 and his/her family member indicated the surgeon directed that the wound vac should have been left in place until seen by the surgeon. Further, they stated that wound care was not performed daily, resulting in him/her lying on wet, bloody sheets in a wet shirt. Observation of Resident's sheets identified the bottom bed sheet had dried yellow stains in the location of where his/her wound was located.Review of the hospital discharge summary and interagency transfer documents dated 8/2/2025 failed to include the placement of the wound vac device.Interview on 8/19/2025 at 11:10 AM with Medical Doctor (MD) #1 identified that treatment orders for a wound vac would be written according to the surgeon's preference and a wound vac would only be removed if there was a problem with the wound vac or if the surgeon wanted it removed.An interview and review of the clinical record on 8/21/25 at 8:30 AM with the Infection Preventionist/Wound Nurse Registered Nurse (RN) #3 identified that when Resident #43 was admitted to the facility he could not locate physician or hospital wound care orders for the resident. He indicated that on 8/2/2025 RN #4 (the admitting nurse) entered orders for the wound to remain open to the air beginning on 8/4/2025. RN #3 stated that the wound APRN was responsible for writing wound care orders during her initial evaluation of the resident but that did not occur until 8/7/2025, and that he removed the wound vac on 8/4/2025 (3 days prior to the first APRN wound evaluation). He indicated that he was not notified by nursing that the wound had a large amount of drainage after the wound vac was removed and it was the expectation that he and the wound APRN be notified of any changes to the wound. The APRN placed new orders on 8/7/2025, after her evaluation, directing to cleanse the incision with Betadine, and cover with an dressing every 8 hours. RN #3 stated the risk of the wound not being covered and draining while it was open to air (8/4/25 through 8/7/25) increased the likelihood of delayed healing and risk of infection for Resident #43. During a second interview and review of the clinical record on 8/21/25 at 1:35 PM with RN #3 he identified that on 8/2/2025, the day Resident #43 was admitted , the Nursing admission Skin Assessment identified the presence of the wound vac. Review of the physician's orders failed to indicate that Resident #43 had a wound vac in place on admission. Because the admitting nurse, RN #4 was aware of the presence of the wound vac on admission, she should have reviewed the hospital discharge summary and the interagency discharge instructions to determine how the wound vac should have been cared for by the facility. Further, if there were no (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	orders directing how to care for the wound vac, she should have called the hospital to review what the surgeon was directing for wound care. This information should have been written on the admission physician orders then the admitting nurse would confirm those orders with the facility physician and the order transcribed onto the Treatment Administration Record, so staff was aware how to treat Resident #43's wound. Additionally, RN #3 identified he had removed the wound vac according to the physician order dated 8/2/2015. Although the order failed to specifically indicate the removal of the wound vac, he stated that he assumed the wound vac was to be removed on 8/4/2025 due to the physician's order dated 8/2/2025 directing to leave the dressing intact until 8/4/2025 then leave the wound open to air. RN #3 indicated in retrospect he should have clarified the order for clarity with a provider. Attempts to reach RN #4 were unsuccessful.Review of the facility's Admissions from Other Healthcare Facilities policy identified in part, that should the transferring facility fail to provide necessary medical information upon admission, implement the following: Contact the transferring facility; Implement emergency admission procedures; Notify the Medical Director and Administrator; and Document in the resident's admission notes.Review of the facility's Wound Treatment Management policy identified in part, that wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing changes. In the absence of treatment orders, the licensed nurse will notify the physician to obtain treatment orders.Although requested, the facility did not have a wound vac policy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075405	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/25/2025
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of clinical records, facility documentation, facility policy, and interviews for the only sampled resident (Resident #58) reviewed for pressure ulcers, the facility failed to implement interventions for pressure ulcer prevention per the Resident Care Plan, report a change in skin integrity, and prevent the development of a pressure ulcer. Resident #58's diagnoses included fracture of the right femur, anxiety, and parkinsonism.The Nursing admission assessment dated [DATE] identified Resident #58's skin was normal in color, warm and dry, and no pressure ulcers or deep tissue injuries were present.The admission Resident Care Plan (RCP) dated 8/5/2025 identified Resident #58 was at risk for skin breakdown related to impaired mobility. Interventions included floating (not touching the mattress) heels off the bed, keep skin as clean and dry as possible, provide a pressure reducing mattress, and perform skin evaluations as ordered by the Medical Doctor (MD).MD orders dated 8/5/2025 directed to apply skin prep to bilateral heels and ensure that heels were offloaded (not touching the mattress), monitor skin for any changes to skin integrity every shift, ensure a pressure reducing mattress was in place at all times.An Advance Practice Registered Nurse (APRN) progress note dated 8/6/2025 identified no visible rashes, lesions, or wounds.Review of a Braden score (pressure ulcer risk assessment) dated 8/5/2025 identified a total score of 16 indicating low risk for pressure ulcer development.Resident #58's Skilled Nursing Assessments dated 8/7/2025, 8/8/2025, 8/9/2025, 8/10/2025, 8/14/2025, 8/15/2025, 8/16/2025, 8/17/2025, and 8/18/2025 identified his/her skin was intact with no pressure ulcers present.The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #58 had a Brief Interview of Mental Status (BIMS) score of 14 indicating intact cognition, required maximal assistance for toileting and chair/bed-to-chair transfers, was dependent for personal hygiene, and was at risk, but had no current pressure injuries.Observation and interview on 8/15/2025 at 11:46 AM with Nurse Aide (NA) #4 identified that Resident #58's feet were at the end of the bed with the sheets tucked tightly under the mattress and his/her heels were not offloaded. NA #4 stated she did not realize his/her heels were not on a pillow and she would check his/her heels when she was providing him with care shortly. Interview on 8/15/2025 at 11:58 AM with Person #7 (Resident #58's family member) identified that NA #4 had informed him/her that Resident #58 had reddened areas on his/her heels that needed to be treated, and he/she was ordered special boots to wear at night. Person #7 stated he/she was very concerned about the injury that occurred to Resident #58's heels.Observation and interview on 8/18/2025 at 8:09 AM with NA #5 identified Resident #58 was lying supine in bed with his/her feet pressed against the footboard of the bed, was not wearing any boots, and his/her heels were not offloaded. NA #5 was unaware how she would know if a resident's heels needed to be offloaded and stated she was from the staffing agency and usually worked on the other side of the facility.Observation and interview on 8/19/2025 at 8:08 AM with Licensed Practical Nurse (LPN) #1 identified Resident #58 was in bed, was wearing his/her left yellow non-slip sock only, had no pillow under his/her heels to ensure offloading, and did not have heel boots in place. Heel boots were not observed in the area at the bottom of the bed, no pressure reduction mattress was noted to be on his/her bed, and his/her heels were pressed up against the footboard, with no headroom above indicating the bed was too short for him/her. LPN #1 indicated that the facility had received new beds with standard mattress and the pressure reducing mattresses had to be requested for placement. Resident #58 had not had a pressure reducing mattress placed as yet. Further, LPN #1 identified he/she had a new non-blanchable area that was dark reddish purple in color on his/her left heel area. LPN #1 indicated no staff had reported to her any changes in skin condition and she was unaware that Resident #58 had skin issues on his/her heels beginning on 8/15/2025. Although LPN #1 was aware that the resident's bed was too short, she failed to request or inform anyone to have the bed modified to accommodate the resident's height. LPN #1 indicated that she would ask the APRN to evaluate (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #58's left heel immediately.Observation and interview on 8/19/2025 at 8:23 AM with APRN #1 identified that Resident #58 had a non-blanchable area to his/her left heel, dark red to maroon in color. APRN #1 stated that the injury was suggestive of his/her heels not being offloaded and that a factor in the development of Resident #58's pressure may have been the too short bed. Review of the nurses note written by Registered Nurse (RN) #3 (IP/Wound Care Nurse) dated 8/19/2025 identified he assessed Resident #58's heels, noting a 0.2 x 0.3 x 0 centimeter pink/maroon discoloration to the left heel, and the peri-wound was boggy (soft and spongy). The note further indicated that the resident had a past medical history of a resolved injury to his/her heel, orders were in place for heel boots to be applied by nursing, and the MD order for skin prep to Resident #58's heel was to continue.A Weekly Wound assessment dated [DATE] identified Resident #58 had a new facility acquired pressure ulcer and had interventions for a pressure reducing mattress, heel boots, and skin prep.Observation on 8/20/2025 at 8:23 AM and at 4:03 PM identified Resident #58 in bed, wearing yellow non-slip socks, not wearing heel boots, and his/her heels were not elevated off the bed. No pressure reduction mattress was on his/her bed.Interview with the Director of Nursing Services (DNS) on 8/20/2025 at 10:44 AM identified when the NA identified Resident #58's skin integrity issue on 8/15/2025, this should have been reported to the nurse and unit manager to ensure the area was assessed quickly, but licensed staff failed to perform a skin assessment until 8/19/2025 (4 days after the change was observed). Additionally, the DNS was unable to explain why staff had not consistently off-loaded Resident #58's heels or why the request for a bed extender was not placed prior to 8/19/2025 (14 days after admission) if the bed was known to be too short.Interview on 8/21/2025 at 8:46 AM with Registered Nurse (RN) #3 (the wound care nurse) identified no staff ever notified him of Resident #58's pressure ulcer per the facility policy (immediately) until 8/20/2025 (5 days later). RN #3 indicated that he had read a nurses note on 8/19/2025, evaluated his/her left heel, and determined the injury to be a new stage 1 pressure ulcer. He also noted during his evaluation that Resident #58's bed was too short. RN #3 noted that when he went in to evaluate the pressure ulcer on Resident #58's heel, he/she was not wearing boots nor were his/her heels offloaded. RN #3 further indicated that he had been made aware Resident #58's skin integrity issue had been identified on 8/15/2025 by facility staff, but the staff failed to document the information in resident #58's medical record. Additionally, RN #3 indicated Resident #58's mattress had not yet been exchanged for a pressure reducing type.A second interview on 8/25/2025 at 11:52 AM with LPN #1 identified that she placed an order on 8/19/2025 at 8:43 AM for heel boots for Resident #58 but was unable to identify why the order for boots was not placed on 8/15/2025, when the wound was first identified, and as relayed to Person #7. Review of the Treatment Administration Record (TAR) for 8/5/2025 through 8/20/2025 identified that on day shift and night shift (8/9/2025 through 8/19/2025) staff charted a pressure reducing mattress was in place at all times, and on evening shift (8/6/2025 through 8/19/2025) staff charted a pressure reducing mattress was in place at all times.A second interview on 8/25/2025 at 11:52 AM with LPN #1 identified that she placed an order on 8/19/2025 at 8:43 AM for heel boots for Resident #58 but was unable to identify why the order for boots was not placed on 8/15/2025, when the wound was first identified and as indicated by Person #7 on 8/15/2025.Observation and interview on 8/25/2025 at 12:02 PM with RN #1 (supervisor) identified Resident #58 did not have a pressure reducing mattress on his/her bed and heel boots were not ordered for him/her until 8/19/2025. RN #1 was unable to identify why staff were charting that Resident #58 had a pressure reducing mattress if one was not on the bed and why staff were not following the RCP for off-loading of heels. RN #1 indicated that the facility had purchased new beds and that Resident #58's non-pressure reducing mattress had not yet been replaced with a pressure reducing mattress.Interview and review of maintenance documents on 8/25/2025 at 12:27 PM with the Maintenance Director and Maintenance #1 identified that an order for a pressure reducing mattress for Resident #58 had never been received or placed and a pressure reducing mattress had never been placed in his/her room. Maintenance #1 further indicated the only bed related request for (continued on next page)

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	him/her was on 8/19/2025 when a request for a long bed was received, and there were no additional pending, cancelled, or deleted orders for him/her.Review of the facility's Pressure Ulcer Prevention Policy identified in part, that assessments will be conducted after a change in condition or after any newly identified pressure injury, and residents determined as at risk for developing pressure injuries will have interventions documented in plan of care based on specific factors identified in the risk assessment.

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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 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 interviews, review of the clinical record, and facility policy for the only sampled resident (Resident #9) reviewed for specialized treatments, the facility failed to communicate and collaborate with the specialized treatment center. The findings include:Resident #9?s diagnoses included chronic kidney failure and end stage renal disease.A physician's order dated 10/3/24 directed for Resident #9 to receive specialized treatments 3 days a week on Monday, Wednesday, and Friday. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #9 was cognitively intact and required supervision and touching assistance for chair/chair-to-bed transfers. The Resident Care Plan dated 1/7/25 identified Resident #9 was at risk for impaired renal function and complications related to specialized treatments. Interventions included to monitor treatment access device for a positive bruit and thrill every shift and as needed, monitor for increase fatigue or weakness, and provide a renal diet as ordered. Review of Resident #9's clinical record and communication book from 11/13/24 to 8/15/25 was noted to have several missing communication records and the electronic health record failed to identify that the specialized treatment center had been contacted for the missing communication documentation. Interview and clinical record review with Licensed Practical Nurse (LPN) #2 on 8/19/25 at 10:46 AM identified that the process for a resident who was transported to a specialized treatment appointment was to obtain vital signs before the resident left, document on the communication form, and give the communication form to the resident to bring with them to the specialized treatment appointment. Upon the residents return, the resident would have a communication form filled out by the specialized treatment center indicating what had occurred over the course of the resident's specialized treatment such as vital signs, weight, and any new recommendations, concerns, or orders. LPN #2 indicated that if the resident returned from the treatment appointment without a communication form, the nurse could take the resident's vital signs and weight but should call the center to ensure there were no new recommendations or orders that needed to be implemented. If the specialized treatment center was contacted by the facility this would have been documented in a nursing note in the electronic health record. LPN #2 identified that Resident #9's specialized communication binder was missing 71 communication forms for the time period of 11/13/24 to 8/15/25 out of 120 attended treatments and that there was no documentation or note in the resident's health records that the facility had contacted the specialized treatment center to inquire about Resident #9's treatment status. Although LPN #2 indicated that the facility nurses were responsible to ensure appropriate communication occurred, she was unable to explain why there were 71 missing communication forms missing with no documented nursing entries indicating that the specialized treatment center was contacted for Resident #9's treatment status. Interview and clinical record review with Registered Nurse (RN) #2 (nurse supervisor) on 8/19/25 at 12:32 PM identified that residents who receive specialized treatments at an outside center were sent with a communication form and that the resident should return with the same communication form which would have a post treatment weight, vital signs, and include any new recommendations or orders. RN #2 indicated that if a resident was to return from their appointment without a communication form, then the unit nurse or nurse supervisor should have called the center to obtain the post treatment information and document the call in the nurse's progress notes. RN #2 identified that Resident #9's communication binder was missing 71 out of 120 specialized appointment communication forms for the period of 11/13/24 to 8/15/25 and that there was no documentation in Resident #9's record which indicated the treatment center was called. Although RN #2 identified that the unit/supervising nurse was responsible to ensure communication had occurred with each of Resident #9's specialized treatments, she could not explain the lack of documentation or communication forms.Interview with the specialized treatment center nurse on 8/20/25 at 12:53 PM identified that when a long-term care patient comes to their facility for treatment, the resident should (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	come with a communication form which should have the patient's vital signs prior to their appointment. The specialized treatment center nurse indicated that post treatment, the treatment center staff document information obtained with the treatment and/or any new recommendations or orders. The form was sent back with the resident to the long-term care facility. Person #1 identified that to her knowledge, there had been no communication forms received from the long-term care for Resident #9. Additionally, the specialized treatment center nurse identified Resident #9 had attended appointments on their scheduled days with no missed appointments.Interview with the Director of Nursing Services (DNS) on 8/20/25 at 1:15 PM identified that residents receiving specialized treatment at an outside facility should be transported to the center with a communications form and should return to the facility with that form documenting results of the resident's treatment as well as any new recommendation or orders. Additionally, the DNS indicated that if the resident returned to the facility without the communication form the unit nurse or nurse supervisor was responsible to contact the specialized treatment center for post treatment information. Review of the facilities specialized treatment policy dated 12/13/22 directed in part that the facility will assure each resident receives care and services for the provision of the specialized treatment consistent with professional standards of practice including ongoing communication and collaboration with the treatment facility regarding care and services.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 observation, staff interviews, and facility policy while touring on the Tunxis Unit, the facility failed to ensure resident medications were properly stored and for 2 of 2 medication storage rooms, the facility failed to ensure narcotics were properly secured. The findings include:1. Observation on 8/18/25 at 11:08 AM identified Levothyroxine Sodium 200 Micrograms (mcg) 12 tablets and Doxycycline Hyclate 100 milligrams (mg), 2 tablets stored on the Tunxis Unit Nurse's Station counter. There were no staff observed in the area, but residents could be seen on the unit. The door to enter the nurse's station was open. LPN #3 was summoned by the surveyor to the Tunxis Unit Nurse Station. Interview and observation with Licensed Practical Nurse (LPN) #3 on 8/18/25 at 11:12 AM identified the Levothyroxine 200 mcg (12 tablets) and Doxycycline 100 mg (2 tablets) were left unattended and unsecured on the Tunxis Unit Nurse's Station counter. LPN #3 indicated that she left the medications on the counter because they were no longer used by the residents to whom they were prescribed, and she planned to discard them but forgot. Additionally, LPN #3 identified that she should not have left medications unattended and that it was her responsibility to ensure all medications were either secured or discarded appropriately. Review of Resident #9's order summary report identified an order for Doxycycline 100 mg oral tablet with directions to give 100 mg by mouth 2 times a day that had an end date of 8/15/25 (3 days prior to the observation). Review of Resident #52's order summary report identified an order for Levothyroxine Sodium tablet 200 mcg tablet with directions to give 1 tablet by mouth one time a day. The order had a start date of 9/2/22 and an order status of discontinued with an active order for Levothyroxine to be administered at a different dose beginning on 8/18/25. Interview with Registered Nurse (RN) #1 (unit manager) on 8/18/25 at 1:25 PM identified that resident medications should not be left unattended and unsecured due to a resident's ability to access the medications unsupervised. RN #1 indicated that once LPN #3 removed the medications from the cart to be discarded, she should have gone directly to the medication storage room and placed them in the discard medication area. Subsequent to surveyor inquiry, the medications were brought to the Tunxis unit Medication Room by LPN #3 and placed into the discard medication area. Review of the medication storage policy dated 12/14/22 directed in part that the facility must provide safe and effective storage of all drugs and biologicals in a locked storage area. 2. A. Observation and interview on 8/25/2025 at 8:44 AM with Licensed Practical Nurse (LPN) #4 identified the narcotic medication box located within the Tunxis Unit Medication Room refrigerator was affixed to a removable shelf but was not secured to the refrigerator. The medication lock box was unlocked and contained three boxes of 2mg/ml Lorazepam (a schedule IV-controlled substance). LPN #4 failed to identify why the Lorazepam had not been locked in the narcotic box or why the narcotic medication box was able to be removed from the refrigerator. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075405	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/25/2025

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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Registered Nurse (RN) #2 (nurse supervisor) on 8/25/2025 at 8:54 AM identified that she was unaware that the Lorazepam had not been locked in the narcotic box within the Tunxis Unit Medication Room refrigerator and that the Lorazepam was improperly stored in an unlocked narcotic box. RN #2 was unable to identify why the Lorazepam was not properly secured. B. Observation and interview on 8/25/2025 at 9:15 AM with Licensed Practical Nurse (LPN) #6 identified the narcotic medication box located within the [NAME] Point Unit Medication Room refrigerator was affixed to a removable shelf but was not affixed to the refrigerator. LPN #6 identified that the unit manager was responsible for ensuring the box was secured to the refrigerator and unable to be removed from the Medication Room. LPN #6 failed to identify what the facility's policy directed for the securing of the narcotic box to the refrigerator. Observation and interview on 8/25/2025 at 9:22 AM with Registered Nurse (RN) #1 (unit manager) identified the narcotic medication box located within the [NAME] Point unit Medication Room refrigerator was affixed to a removable shelf but was not secured to the refrigerator. RN #1 demonstrated that the narcotic box was able to be removed from the refrigerator without difficulty. RN #1 was unable to identify why the narcotic box was not secured to the refrigerator and stated the issue of the narcotic box not being secured to the refrigerator had been discussed at a past meeting. RN #1 indicated that the Maintenance Department was responsible for the addition of a means to affix the narcotic box to the inside of the refrigerator. Observation and interview with the Director of Nursing Services (DNS) on 8/25/2025 at 9:41 AM identified the narcotic medication boxes located within the [NAME] Point and Tunxis Unit Medication Room refrigerators were improperly affixed to a removable shelf within the refrigerator but should have been secured to the refrigerator. The DNS stated both narcotic medication boxes could be removed from the refrigerators, and she could just take them home with her which was not good. The DNS was unable to identify if the facility policy directed how the narcotic boxes were to be affixed to the refrigerator. She stated she would call the Director of Maintenance to immediately and properly secure the narcotic boxes to the refrigerator with a chain. Review of the facility's Controlled Substances Policy identified in part that controlled substances must be stored in the Medication Room in a locked container, separate from containers for any non-controlled medications. This container must remain locked at all times, except when it is accessed to obtain medications for residents. The Controlled Substances Policy failed to identify that controlled substances stored in the refrigerator must be in a locked box that is securely affixed to the refrigerator per the requirement.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, review of clinical records, review of photographs, and review of facility policy for 1 sampled resident (Resident #43) reviewed for discharge and 2 additional previously discharged residents (Resident #48 and Resident #89) the facility failed to ensure protected personal information remained secured and private. The findings include:Interview with Person #6 (Resident #43's family member) on 8/18/2025 at 11:31 AM identified that upon Resident #43's discharge on [DATE], he/she was sent home with a bag of prescriptions medications for Resident #48 and Resident #89. The medications were given to Person #6 by Registered Nurse (RN) #1. Person #6 stated that he/she had just returned the incorrect prescriptions to the Administrator. Person #6 indicated that although none of the incorrect other resident medications had been taken by Resident #43, he/she was very upset that the wrong medications were sent home at discharge and that he/she had taken pictures of the medications to report to the State Agency (SA) and would subsequently be providing the pictures to the surveyor.Review of Person #6's photographs identified a bag labeled with Resident #48's name, date of birth , and medical record number. The bag contained Dorzolamide-Timolol eye drops, Pilocarpine eye drops, and Megestrol Acetate oral suspension with Resident #48's full name and prescription information as well as Breyna 160-4.5 MCG HFA Inhalation Aerosol labelled with Resident 89's full name and prescription information. 1. Resident #43's diagnoses included fusion of spine lumbar region, type 2 diabetes, and hypertension.A review of physician orders from 8/2/2025 through 8/20/2025 failed to identify that Resident #43 had been prescribed any of Resident #48 or Resident #89's medications that had been given to and photographed by Person #6.2. Resident #48's diagnoses included glaucoma, malignant neoplasm of the lung, and malignant neoplasm of the bone.A physician's order dated 7/30/2025 directed to administer Dorzolamide HCL-Timolol Mal Ophthalmic solution 1 drop in the right eye 2 times a day for glaucoma, Megestrol Acetate Oral Suspension 400 mg/10ml give 10 ml by mouth 1 time a day for appetite stimulator, and Pilocarpine HCL Ophthalmic Solution 2% 1 drop in right eye 2 times a day for glaucoma. The medications prescribed by the physician matched the medications labeled with Resident #48's information, and which were given to Resident #43 upon discharge. 3. Resident #89's diagnoses included asthma, Type 2 Diabetes, and chronic obstructive pulmonary disease (COPD).A physician's order dated 8/5/2025 directed to administer Budesonide-Formoterol Fumarate Inhalation Aerosol (Breyna) 2 puffs inhale orally two times a day for wheezing. The medications prescribed by the physician matched the medication labeled with Resident #89's information and which were given to Resident #43 upon discharge.Interview with the Administrator on 8/20/2025 at 8:45 AM identified that Person #6 had received and brought home different residents medications upon discharge. The Administrator stated after receiving the medications from Person #6, she gave the medications to RN #1 and referred Person #6 to RN #1 for follow-up. Interview on 8/20/2025 at 8:57 AM with RN #1 identified that she was responsible for sending the incorrect medications home with Resident #43, that protected personal information for Resident #48 and Resident #89 was provided to Resident #43 in error, and that she had not read the bottles before giving the wrong medications to Resident #43 due to not wearing her glasses. Further, RN #1 identified that she did not think to notify Resident #48 or Resident #89 that their protected personal information had been provided to an unauthorized individual. Interview with the Director of Nursing Services (DNS) at 10:44 AM on 8/20/2025 identified that on 8/20/2025 she had overheard staff speaking about RN #1 sending the wrong medications home upon Resident #43's discharge. She stated that neither staff nor the Administrator had reported the incident prior to what was overheard. The DNS indicated that upon discharge, residents are to receive education on each medication being sent home, and the resident was to sign they received education on every medication. The DNS was unable to explain why other resident medications were sent home with Resident #43 or why the (continued on next page)

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

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents/family members had not been notified of the improper release of protected personal information to an unauthorized individual (Resident #43).Although requested the facility did not have a policy for protecting health information.Review of the facility's Discharge Medications Policy identified in part that the nurse charge shall verify that medications are labelled consistent with current physician orders, the nurse will complete the medication disposition record including the resident's name, the name and prescription number of each medication, and the signatures of the person receiving the medications and the nurse releasing the medications. Further the nurse will review medication instructions with the resident, family member, or representative before the resident leaves the facility.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of the clinical record, facility policy, and staff interviews for 2 of 2 sampled residents (Resident #83, and #89) reviewed for blood glucose testing, the facility failed to clean and disinfect a Glucometer (glucose testing) device per the manufacturer's instructions for use. The findings include:Interview with RN #3 (Infection Prevention Nurse) on 8/15/2025 at 11:58 AM identified that glucometers are to be cleaned between every use and as needed with the Super Sani Disinfectant with the purple top lid. 1. Resident #83's diagnoses included type 2 diabetes, hypertension, and osteoarthritis.The Nursing admission assessment dated [DATE] identified Resident #83 had a Brief Interview of Mental Status (BIMS) score of 15 indicating intact cognition, required maximal assistance with his/her personal hygiene, and required extensive assistance with walking in his/her room.A physician's order dated 8/1/2025 directed to obtain a blood glucose level by fingerstick and to administer lispro (insulin) 100 unit/milliliter per a sliding scale subcutaneously before meals and at bedtime.The Resident Care Plan (RCP) dated 8/3/2025 identified Resident #83 had diabetes mellitus and included interventions of fasting serum blood sugar as ordered by the doctor, monitoring compliance with diet, and diabetes medication as ordered by doctor.During an observation and interview with Registered Nurse (RN) #5 on 8/19/2025 at 5:41 AM, she conducted blood sugar monitoring for Resident #83 using a blood glucose monitor. Following the procedure RN #5 obtained a wipe from a blue top container labelled Antimicrobial Hand Sanitizer, alcohol 67.9% and proceeded to clean the glucose meter with the wipe. RN #5 stated that the wipe she used to disinfect the glucose meter was the correct wipe for cleaning glucose monitors and were the wipes she had always used. She further stated that the glucose monitors were used on multiple residents on the unit and that the unit nurse using the blood glucose meter was responsible to ensure that correct wipes were used for disinfecting. Although the surveyor stopped RN #5 and had her read the label pointing out the contents were hand sanitizer, RN #5 insisted she was using the correct wipes and during a constant observation following Resident #83's blood glucose monitoring, went on to check Resident #89's blood sugar.2. Resident #89's diagnoses included Type 2 Diabetes, chronic obstructive pulmonary disease, and systemic [NAME] Erythematosus.The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #89 had a Brief Interview of Mental Status (BIMS) score of 10 indicating moderately impaired cognition and required moderate assistance with personal hygiene and rolling left and right in bed.The Resident Care Plan (RCP) dated 8/4/2025 identified Resident #89 was at risk for skin breakdown related to diabetes mellitus but failed to include interventions for blood glucose testing and monitoring. A physician's order dated 8/6/2025 directed to obtain a blood glucose level 4 times a day for diabetes mellitus.Observation of RN #5 on 8/19/2025 at 5:55 AM with Resident #89 identified that she continued on to Resident #89 and performed a blood glucose test with the same monitor used to test Resident #83 and that had been cleaned with the container labeled Antimicrobial Hand Sanitizer, alcohol 67.9%. Following Resident #89's blood glucose test, RN #5 placed the glucose monitor on a paper towel on top of the medication cart. During constant observation of RN #5, on 8/19/2025 from 5:55 AM through 6:29 AM the glucose monitor remained on the paper towel on top of the medication cart until she moved the glucose meter to store it in a drawer in her medication cart without the benefit of disinfecting. RN #5 was stopped again by the surveyor. RN #5 indicated that she had been unaware she had failed to appropriately cleanse the glucose meter prior to placing it in the medication cart drawer. Further, RN #5 identified that the glucose meter should have been disinfected after use and before storing it in the medication cart.An interview with the Director of Nursing Services (DNS) on 8/20/2025 at 10:44 AM identified the correct wipes used to clean the facility's glucometer should be either the purple top disinfection wipes or a bleach wipe per the glucometer manufacturer's recommendations. Further she identified that glucometers should always be cleaned by nurses between residents. The DNS was unable to explain (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	why RN #5 failed to use the correct manufacturer directed disinfection wipes and failed to appropriately clean the glucometer between residents. The DNS indicated that staff had just been in-serviced on proper glucose meter usage 2 days ago and that RN #5 had signed as attending the education. Review of the Glucometer Disinfection Policy identified that glucometers should be disinfected after each use with a disposable germicidal wipe. If a germicidal wipe is not available, the glucometer is to be cleaned with an alcohol prep pad and disinfected with a solution of 1:10 bleach.