STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075407	A. Building B. Wing	12/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at West Hartford	1 Emily Way West Hartford, CT 06107

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation review, facility policy review, and interviews for one resident of three residents (Resident #1) reviewed for quality of care, the facility failed to ensure staff coverage timely to ensure a blood sugar measurement was obtained prior to a meal in accordance with physician orders. The findings include: Resident #1 was admitted with diagnoses that included diabetes mellitus (DM). A resident care plan (RCP) dated 9/3/2024 identified Resident #1 had insulin dependent diabetes. Interventions directed to access and record blood glucose levels and labs as ordered. An annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a BIMS of 11 meaning mildly impaired cognition, had a diagnosis of diabetes and received insulin seven out of the prior seven days. A physician's order dated 11/20/2024 directed to check blood sugar (via blood glucose monitor) before meals and at bedtime for DM. A late entry nursing progress note written by the Director of Nurses (DON) dated 12/7/2024 (Saturday) at 3:14 PM identified Resident #1's blood glucose was monitored two (2) hours late today (12/7/2024). No acute distress was noted, blood glucose was done immediately by supervisor (RN # 2); reading was 243 and the APRN and family were updated. A facility written interview of RN #2 by the DON dated 12/12/2024 identified she was informed by LPN #1 at 2:00 PM on 12/7/2024 that Resident #1's family was upset that Resident #1's blood sugar had not been checked prior to eating lunch. LPN #1 indicated that she was waiting for RN #2 to come and did not ask the other nurse on the unit to assist her when RN #2 did not respond. RN #2 identified that she assessed Resident #1 at that time and completed the blood sugar check with a result of 243 that was reported to the APRN and family with no new orders obtained. A facility corrective counseling report dated 12/21/2024 for LPN #1 identified on 12/7/2024, LPN #1 failed to communicate with the supervisor about Resident #1 who needed a blood glucose monitored prior to lunch, leading to a delay in treatment. LPN # 1 had been previously directed to not go into Resident #1s room due an issue that had happened in the past. The counseling report indicated the direction for LPN #1 not to enter the room should not have prevented LPN #1 from ensuring Resident #1's blood sugar was monitored timely. (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and review of facility investigative documentation and Resident #1's medical record with the DON on 12/30/2024 at 1:00 PM identified LPN #1 had previously been requested to not provide care for Resident #1 by the family, and LPN #1 had been recently reassigned to Resident #1's unit. The DON stated the assignments were made for the day prior to LPN #1's arrival to work, and there was a second LPN (LPN #4) working on the floor who had already started her assignment. LPN #1 was aware that she should not care for Resident #1 and upon learning she had been assigned to Resident #1, LPN #1 notified RN #1 (night supervisor) who provided care to Resident #1 instead of LPN #1 on the morning of 12/7/2024. When the ordered blood sugar was due prior to lunch, LPN #1 attempted to contact the day supervisor (RN #2) who did not respond. The DON continued that RN #2 was addressing another resident's urgent need on another floor and she would have expected LPN #1 to seek out the other nurse on the unit to assist her to complete the blood sugar check. The DON stated LPN #1 did not request assistance from the LPN #4, and was waiting for RN #2 to assist. Interview failed to identify why LPN #1 was assigned to the unit where she was not allowed to provide care for all residents who resided there. Review of facility documentation identified although the facility provided education to LPN #1 regarding obtaining timely blood sugars and provided education to additional nursing staff regarding preventing treatment delays, review failed to identify education was provided regarding staffing and communication when a staff member is prevented from providing care for any resident. The facility completed a QAPI meeting on 12/7 and audits were initiated on 12/9/2024, however review failed to identify past non-compliance. Interview with RN #1 on 12/30/2024 at 1:37 PM identified on 12/7/2024 she assessed Resident #1, completed the ordered blood sugar prior to breakfast, and provided Resident #1 her/his scheduled medications. RN #1 stated she reported to the oncoming supervisor (RN #2) the need to follow up with Resident #1's care needs until the end of LPN #1's shift at 3:00 PM. RN #1 stated she was specific to include that LPN #1 could not provide care for Resident #1. Although attempted, interviews with LPN #1, LPN #4, and RN #2 were not obtained during the survey. The facility policy Blood Glucose Monitoring dated 3/2024 directed in part, that blood glucose monitoring is performed as per physician's order.