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	08/05/2025

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 observation, review of the clinical record, review of facility documentation, review of facility policy, and interviews for 1 resident (Resident #1) reviewed for ADLs, the facility failed to ensure weekly skins were performed in accordance with facility policy. The findings include: Based on observation, review of the clinical record, review of facility documentation, review of facility policy, and interviews for 1 resident (Resident #1) reviewed for ADLs, the facility failed to ensure weekly skins were performed in accordance with facility policy. The findings include: Resident #1 had diagnoses that included anemia, diabetes mellitus, chronic kidney disease, and congestive heart failure. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of nine out of fifteen (9/15), indicative of moderately impaired cognition, was at risk for alteration in skin integrity and was always incontinent of bowel and bladder. The Resident Care Plan dated 7/23/25 identified Resident #1 had the potential for alteration in skin integrity related to fragile skin and had an actual stage III pressure ulcer on his/her coccyx. Interventions directed to conduct weekly body audits. Review of the clinical documentation identified the following for Resident #1's weekly skin evaluations:1. During the month of July 2025, Resident #1 only had a skin evaluation performed on 7/7/2025.2. During the month of June 2025, the record failed to identify any skin evaluations were completed.3. During the month of May 2025, Resident #1 had a skin evaluations performed on 5/1, 5/8, and 5/28/2025.4. In the month of April 2025, Resident #1 had a skin evaluation performed on 4/1, 4/13, and 4/24/2025. Review of the nursing notes failed to identify Resident #1 had refused any skin evaluations from 4/2025 through 8/2025. Interview with the DON on 8/5/25 at 2:00 PM identified weekly skin checks are documented in the electronic medical records (EMR) under the weekly skin evaluations. The DON identified Resident #1 refuses care/treatment services at times, and indicated nursing staff should document refusals and update the provider accordingly. The DON was unable to provide documentation that the weekly skin checks were performed during the weeks of 4/7, 5/12, 5/19, the month of June, and 7/14, 7/21, and 7/28/2025, and stated they should have been completed. Review of the undated Skin Check Policy directed in part, skin checks will be conducted by Certified Nursing Assistants during daily care. Skin checks by Licensed Nursing personnel will be routinely conducted on all resident care units in addition to daily checks by the nursing assistants.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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	08/05/2025

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

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. (continued on next page)

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, facility documentation review, facility policy review, and interviews for 2 of 43 residents (Resident #1 and Resident #3) reviewed for ADL care, the facility failed to ensure facility staffing was utilized across the facility to ensure residents received personal care and incontinent care in a timely manner. The findings include: Based on observations, clinical record review, facility documentation review, facility policy review, and interviews for 2 of 43 residents (Resident #1 and Resident #3) reviewed for ADL care, the facility failed to ensure facility staffing was utilized across the facility to ensure residents received personal care and incontinent care in a timely manner. The findings include: A) Resident #1 had diagnoses that included bipolar disorder, depression, and anxiety. The quarterly Medicare Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of nine out of fifteen (9/15), indicative of having moderately impaired cognition, required maximum assistance with ADL's (activities of daily living) and bed mobility, and was always incontinent of bowel and bladder. The Resident Care Plan dated 7/23/25 identified Resident #1 had an alteration in ADL function and was incontinent of bowel and bladder. Interventions directed to provide personal care, provide incontinent care and reposition every two hours. Interview with Resident #1 on 8/5/25 at 10:15 AM identified he/she had not received AM care or incontinent care since approximately 5:00 AM. Resident #1 indicated he/she called for assistance, but it was not assisted. Observation of Resident #1 at the time of the interview identified he/she appeared to not have received AM care at the time of the observation (still in bed wearing johnny). Observation on 8/5/25 at 10:30 AM identified Resident #1's door was closed with staff providing care. Interview with NA #2 on 8/6/25 at 12:20 PM identified her shift started at 7 AM and Resident #1 was on her assignment for care. NA #2 stated Resident #1 received incontinent care at approximately 10:15 AM (3 hours and 15 minutes after her shift started). NA #2 identified Resident #1 was not that wet (referring to incontinent level) and she was providing care as quickly as possible to all her residents due to being short staffed. NA #2 identified Resident #1 had not refused care (she was busy and had not given the care) and she did not receive any report that Resident #1 refused incontinent care during night shift. NA #2 identified although she was not able to provide incontinent care for Resident #1 prior to 10:30 AM, she did not notify any staff that she needed assistance to provide care for the residents on her assignment. Record review identified NA #3 worked the night shift that ended at 7 AM on 8/5/2025. Although attempted, an interview with NA #3 was unable to be obtained during survey. B) Resident #3 had diagnoses that included diabetes mellitus and anemia.The quarterly Medicare Minimum Data Set (MDS) assessment dated [DATE] identified Resident #3 had a Brief Interview for Mental Status (BIMS) score of eleven out of fifteen (11/15), indicative of moderately impaired cognition, was dependent with ADLs and bed mobility, and was always incontinent of bowel and bladder. The Resident Care Plan dated 7/22/25 identified Resident #3 had an alteration in ADL function, and was incontinent. Interventions directed to assist with ADLS and bed mobility, and provide incontinent care. Interview with NA #1 on 8/5/25 at 11:40 AM identified her shift started at 7 AM, and she had not provided AM care or incontinent care for Resident #3 since her shift started (4 hours and 40 minutes). NA #1 stated the unit was short staffed and she did not notify anyone that she needed assistance; NA #1 stated as staffing is aware they are short staffed. Interview with Resident #3 on 8/5/25 at 11:45 AM identified he/she last received incontinent care at 5:30 AM and had been waiting to be washed up. Resident #3 identified he/she rang the call bell but care was not provided. Observation of Resident #3 at the time of the interview identified he/she appeared to not have received AM care at the time of the observation (still in bed wearing johnny). Continued observation on 8/5/25 at 11:48 AM (4 hours and 48 minutes after the shift stated) identified NA #1 entered Resident #3's room to perform AM care. Record review identified NA #4 worked the night shift that ended at 7 AM on 8/5/2025. Although attempted, an interview with NA #4 was unable to be obtained during survey. Facility documentation review identified Resident #1 and Resident #3's unit/floor had a census of 43. The usual staffing pattern on Resident #1 and Resident #3's unit/floor was two (2) licensed staff and four (4) NAs on the unit during the 7 AM to 3 PM shift. Observations and facility documentation review identified on 8/5/2025 the unit was staffed with two (2) licensed staff and three (3) NAs. Additional review identified the alternate unit/floor had a census of 32 residents (11 less residents than the other unit) and was staffed with two (2) licensed staff and four (4) NAs. Review failed to identify why there were not four (4) NAs as per the usual staffing pattern. Interview with the DON on 8/5/25 at 2:00 PM identified nursing staff