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	05/11/2026

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, facility policies, and interviews, for one (1) of three (3) sampled residents (Resident #1) reviewed for pain management, the facility failed to ensure ongoing assessment, implementation of additional interventions, and provider notification when Resident #1 continued to report severe unrelieved pain following administration of prescribed pain medication. The failures included lack of reassessment, failure to administer available asˆneeded (PRN) pain medication, and failure to notify the provider when pain remained unchanged. The findings include:Resident #1 was admitted to the facility in September 2021 with diagnoses that included malignant neoplasm of the anus, chronic pain syndrome, and unspecified osteoarthritis.The Comprehensive Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 was severely cognitively impaired (Brief Interview for Mental Status (BIMS) score of 00) and was dependent with toileting, lower body dressing, and transfers.The Resident Care Plan (RCP) dated 5/16/25 identified Resident #1 was at risk for alterations in comfort related to anal cancer, osteoarthritis, and multiple right rib fractures. Interventions directed to medicate Resident #1 as ordered for pain, monitor for effectiveness and side effects, and report to the physician as indicated.1.A physician order directed 100 milligrams (mg) of Nucynta (an immediate release opioid analgesic used to treat moderate to severe pain) every two (2) hours as needed for severe pain, not to exceed six (6) tablets per day.The June 2025 Medication Administration Report (MAR) identified Resident #1 reported a pain level of seven (7) on 6/8/25 at 5:00 PM prior to being administered 100 mg of Nucynta.A nurse note by LPN #4 dated 6/8/25 at 6:20 PM, one (1) hour and twenty (20) minutes following the administration of 100 mg of Nucynta, identified the medication was ineffective and Resident #1's pain level remained seven (7) on a scale of one (1) to ten (10). The nurse note failed to identify any further assessment or intervention was performed.The June 2025 MAR identified Resident #1 reported a pain level of seven (7) on 6/8/25 at 8:09 PM, unchanged from the previous pain assessment, prior to being administered 100 mg of Nucynta by LPN #4.Although attempted, an interview with LPN #4 was not obtained.Although attempted, an interview with RN #3 was not obtained.Interview with APRN #1 on 5/6/26 at 3:10 PM identified Resident #1's baseline level of pain was five (5) or below on a pain scale of one (1) to ten (10). APRN #1 identified any report greater than five (5) should have resulted in further assessment and provider notification. APRN #1 identified he/she was not informed Resident #1 had unrelieved pain following the administration of pain medication on 6/8/25.2.A nurse note by the Director of Nursing Services (DNS) dated 6/10/25 identified Resident #1 had been placed on hospice.A physician order directed administration of Morphine Sulfate Concentrate Solution, 20 mg per milliliter (mg/mL), 0.25 milliliters (mL) sublingually every two (2) hours for dyspnea, and directed staff to obtain a new order for an increased dose if no relief occurred.A physician order directed 100 mg of Nucynta every four (4) hours as needed (PRN) for severe pain, not to exceed six (6) tablets per day.The June 2025 MAR identified Resident #1 reported a pain level of ten (10) on 6/11/25 at 4:00 PM and again at 6:00 PM, prior to being administered 0.25 mL of Morphine Sulfate Concentrate Solution, 20 mg/mL, by LPN #5. The June 2025 MAR failed to identify Resident #1 was administered 100 mg of Nucynta for the severe pain reported at those (continued on next page)

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

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	times.The June 2025 MAR identified Resident #1 reported a pain level of zero (0) at 8:00 PM, which was the next scheduled dose time for Morphine Sulfate Concentrate Solution, 20 mg/mL, 0.25 mL sublingually.Nursing documentation dated 6/11/25 failed to identify Resident #1's pain level remained unchanged or that further assessment or interventions were performed.Interview with LPN #5 on 5/7/26 at 9:39 AM identified he/she was unable to recall Resident #1 or the circumstances; however, LPN #5 identified a resident reporting a pain level of seven (7) or greater should have prompted administration of the PRN pain medication, a repeated assessment to determine effectiveness, and documentation of the result in nursing notes. LPN #5 identified that if the medication was ineffective, the nurse supervisor should have been notified.Interview with the DNS on 5/7/26 at 9:48 AM identified when a resident reported a pain level of ten (10), the nurse was to administer the scheduled medication, reassess the resident thirty (30) minutes to one (1) hour following administration, and if the pain level remained elevated, administer the PRN medication. The DNS identified that if the pain level remained ten (10) at the time the next scheduled pain medication was due, the nurse was to administer the scheduled medication again, reassess, and notify the nurse supervisor if the pain level remained elevated.The Pain Management policy directed staff to evaluate the resident for pain and its causes upon admission, during scheduled assessments, and when a significant change in condition occurred. The policy further directed to manage or prevent pain consistent with the comprehensive assessment and plan of care, professional standards of practice, and the resident's goals and preferences.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation, facility policies, and interviews, for one (1) of three (3) residents (Resident #1) reviewed for medication administration, the facility failed to ensure Resident #1's Schedule II pain medication was available for administration in accordance with the physician order. For two (2) of eleven (11) residents (Resident #2 and Resident #3) reviewed for medication administration, the facility failed to document the administration of a controlled substance in accordance with facility policy and failed to remove a controlled substance from the medication cart after the order expired. The findings include:1.Resident #1 was admitted to the facility in [DATE] with diagnoses that included malignant neoplasm of the anus, chronic pain syndrome, and unspecified osteoarthritis.The Comprehensive Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 was severely cognitively impaired (Brief Interview for Mental Status (BIMS) score of 00) and was dependent with toileting, lower body dressing, and transfers.The Resident Care Plan (RCP) dated [DATE] identified Resident #1 was at risk for alterations in comfort related to anal cancer, osteoarthritis, and multiple right rib fractures. Interventions directed to medicate Resident #1 as ordered for pain, monitor for effectiveness and side effects, and report to the physician as indicated.A physician order directed 200 milligrams (mg) of Nucynta ER (an extended release opioid analgesic used to treat moderate to severe pain) every twelve (12) hours for severe pain.A nurse note by APRN #1 dated [DATE] at 12:00 AM identified Resident #1 was readmitted to the facility on [DATE] following a hospital evaluation for multiple right^sided rib fractures sustained from a fall. APRN #1 identified Resident #1 was alert, oriented, verbal, in no acute distress, and reported pain was controlled. APRN #1 further identified chronic pain syndrome and osteoarthritis were stable and directed continuation of Nucynta ER 200 mg every twelve (12) hours.Resident #1's Controlled Substance Disposition Record identified the last administered dose of 200 mg Nucynta ER occurred on [DATE] at 9:00 AM.The [DATE] Medication Administration Report (MAR) identified Resident #1's order for Nucynta ER 200 mg was placed on hold on [DATE], seven (7) days after the medication supply had been depleted.Interview with Pharmacist #1 on [DATE] at 9:56 AM identified the pharmacy received an order for Nucynta ER 200 mg for Resident #1 from APRN #1 on [DATE]. Pharmacist #1 identified the order was cancelled on [DATE] due to an insurance preauthorization issue and was not reordered. Pharmacist #1 identified issues with orders or refills were communicated to the facility via fax, although verification of the fax could not be confirmed. Pharmacist #1 identified the last filled order of Nucynta ER 200 mg occurred on [DATE], with twenty^eight (28) tablets dispensed.Interview with the Administrator, the Director of Nursing Services (DNS), and the Regional Clinical Director on [DATE] at 4:00 PM identified the facility was unaware Resident #1's prescription for Nucynta ER 200 mg was on hold. They identified that when a refill or order issue occurred, the pharmacy should fax the facility, and the facility should authorize a refill, cover the cost temporarily if insurance approval was pending, or request a new provider order. They identified Resident #1 should not have been without the ordered medication without staff intervening.Although requested, the facility did not provide a policy outlining specific procedures for insurance preauthorizations related to medication orders or refills.2a.Resident #2 was admitted in [DATE] with diagnoses that included chronic pain syndrome, unspecified osteoarthritis, and bilateral knee pain.The Comprehensive Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 was cognitively intact (BIMS score of 15), required supervision with bathing, and was independent with transfers and ambulation.A physician order dated [DATE] directed hydromorphone HCl, two (2) mg by mouth every six (6) hours as needed for moderate to severe pain for thirty (30) days.The [DATE] Controlled Substance Disposition Record identified Resident #2 was administered twelve (12) doses of hydromorphone between [DATE] and [DATE]. LPN #1 administered three (3) (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	doses ([DATE] at 9:00 AM and [DATE] at 9:00 AM and 9:00 PM). LPN #2 administered seven (7) doses ([DATE] at 9:00 PM; [DATE] at 9:00 PM; [DATE] at 9:00 PM; [DATE] at 9:00 PM; [DATE] at 9:00 PM; [DATE] at 9:00 PM; and [DATE] at 8:00 PM).The March and [DATE] MARs failed to identify documentation by LPN #1 for the administration of hydromorphone on [DATE] at 9:00 AM and [DATE] at 9:00 AM and 9:00 PM. The MARs also failed to identify documentation by LPN #2 for the hydromorphone doses administered on [DATE] at 9:00 PM; [DATE]; [DATE]; [DATE]; [DATE]; [DATE]; and [DATE].2b.Resident #3 was admitted in [DATE] with diagnoses that included cerebral infarction and malignant neoplasm of the liver, intrahepatic bile duct, prostate, and spinal cord.The Quarterly MDS assessment dated [DATE] identified Resident #3 was severely cognitively impaired (BIMS score of 5) and was dependent with toileting, bathing, personal hygiene, and transfers.A physician order dated [DATE] directed hydromorphone HCl, four (4) mg by mouth every six (6) hours as needed for severe pain for thirty (30) days, with an expiration date of [DATE].The [DATE] Controlled Substance Disposition Record identified Resident #3 was administered seven (7) doses of hydromorphone between [DATE] and [DATE]. LPN #1 administered four (4) of those doses on [DATE] at 8:00 PM; [DATE]; [DATE]; and [DATE].The [DATE] MAR failed to identify documentation by LPN #1 for the hydromorphone doses administered on [DATE] at 8:00 PM; [DATE]; [DATE]; and [DATE].Interview with LPN #1 on [DATE] at 12:07 PM identified he/she did not know why the documentation was missing. LPN #1 identified he/she signed the Controlled Substance Disposition Record when the medication was removed from the bubble pack but waited to document on the MAR until after administration and must have forgotten to return to document. LPN #1 identified he/she was unaware of the facility's medication administration process.Although attempted, an interview with LPN #2 was not obtained.Interview with the DNS on [DATE] at 3:56 PM identified nurses were to sign both the Controlled Substance Disposition Record and the MAR immediately when the medication was administered.The Administering Medications policy directed staff to initial the MAR on the appropriate line after administering each medication and before administering additional medications.3a. A physician order dated [DATE] directed hydromorphone HCl, two (2) mg by mouth every six (6) hours as needed for moderate to severe pain for thirty (30) days, with an expiration date of [DATE].An observation conducted on [DATE] of the Second Floor Narcotic Medication Binder identified Resident #2's Controlled Substance Disposition Record and hydromorphone pill pack were still stored in the locked medication cart, eighteen (18) days after the order expired.3b. A physician order dated [DATE] directed hydromorphone HCl, four (4) mg by mouth every six (6) hours as needed for severe pain for thirty (30) days, with an expiration date of [DATE].An observation conducted on [DATE] of the Second Floor Narcotic Medication Binder identified Resident #3's Controlled Substance Disposition Record and hydromorphone pill pack in the locked medication cart, four (4) days after the order expired.Interview with the DNS on [DATE] at 3:56 PM identified controlled substances were to be brought to the DNS immediately after the order expired for proper disposal and reconciliation.The Inventory Control of Controlled Substances policy directed the facility should reconcile the total number of controlled medications on hand, add newly received medications to the inventory, and remove medications that were completed or discontinued from inventory in accordance with the Controlled Substance Verification and Shift Count Sheet.

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation, facility policies, and interviews, for one (1) of three (3) residents (Resident #1) reviewed for medication administration, the facility failed to ensure the physician's order for a Schedule II controlled substance was followed. The failures included unapproved substitution of medications, inaccurate documentation on the Controlled Substance Disposition Record, and inaccurate documentation on the Medication Administration Record (MAR). The findings include: Resident #1 was admitted to the facility in September 2021 with diagnoses that included malignant neoplasm of the anus, chronic pain syndrome, and unspecified osteoarthritis.The Comprehensive Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 was severely cognitively impaired (Brief Interview for Mental Status (BIMS) score of 00) and was dependent with toileting, lower body dressing, and transfers.The Resident Care Plan (RCP) dated 5/16/25 identified Resident #1 was at risk for alterations in comfort related to anal cancer, osteoarthritis, and multiple right rib fractures. Interventions directed to medicate Resident #1 as ordered for pain, monitor for effectiveness and side effects, and report to the physician as indicated.a.A physician order directed 200 milligrams (mg) of Nucynta ER (an extended release opioid analgesic used to treat moderate to severe pain) to be administered every twelve (12) hours for severe pain.A physician order directed 100 mg of Nucynta (an immediate release opioid analgesic used to treat moderate to severe pain) every two (2) hours as needed (PRN), not to exceed six (6) tablets per day.The Controlled Substance Disposition Record identified Resident #1 was administered the last 200 mg dose of Nucynta ER on [DATE] at 9:00 AM.Resident #1's Medication Administration Record (MAR) identified 200 mg of Nucynta ER was administered on 5/27/25 at 8:00 AM and 9:00 PM; 5/28/25 at 9:00 PM; 5/29/25 at 9:00 AM and 9:00 PM; 5/31/25 at 9:00 AM and 9:00 PM; 6/1/25 at 9:00 AM and 9:00 PM; and 6/2/25 at 9:00 AM.The Controlled Substance Disposition Record identified Resident #1 was administered two (2) 100 mg Nucynta tablets at the same dates and times that the MAR identified 200 mg Nucynta ER was administered. The clinical record failed to identify a physician order authorizing two (2) 100 mg tablets of Nucynta to be administered in place of the 200 mg Nucynta ER dose.Interview with APRN #1 on 5/7/26 at 10:35 AM identified a oneˆtime order was given for two (2) 100 mg tablets of Nucynta immediate release after the nurse dispensed the medication. APRN #1 identified the order did not authorize continued substitution of the immediate release formulation for the 200 mg Nucynta ER, and that the two formulations were different medications and should not have been used interchangeably.Interview with the Director of Nursing Services (DNS) on 5/7/26 at 4:18 PM identified it was not the facility's standard of practice to substitute one medication for another when a resident ran out of a prescribed medication. The DNS identified the charge nurse was to check the OmniˆCell for the medication, and if it was unavailable, notify the nurse supervisor, place the order on hold, and contact the provider to determine if an alternate medication could be administered.b.A physician order again directed 200 mg of Nucynta ER every twelve (12) hours for severe pain, and 100 mg of Nucynta immediate release every two (2) hours as needed for severe pain, not to exceed six (6) tablets per day.The Controlled Substance Disposition Record identified Resident #1 was administered the last 200 mg dose of Nucynta ER on [DATE] at 9:00 AM.Resident #1's MAR identified an additional 200 mg dose of Nucynta ER was administered on 5/26/25 at 9:00 PM.Interview with the DNS on 5/7/26 at 3:56 PM identified nursing staff were required to sign both the MAR and the Controlled Substance Disposition Record when a controlled substance was administered. The DNS identified the absence of the 5/26/25 9:00 PM dose on the Controlled Substance Disposition Record indicated the MAR entry was incorrect.The Administering Medications policy directed medications must be administered in accordance with the physician order, including time parameters.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. Based on clinical record review, observations, interviews, and facility documentation, the facility failed to ensure discontinued Schedule II through V controlled substances brought into the facility from an outside pharmacy and stored in bubble packs and bottles were secured in a permanently affixed, separately locked compartment as required. The findings include:Interview with the Director of Nursing Services (DNS) on 5/6/26 at 12:28 PM identified discontinued controlled substances were stored in a locked file cabinet located inside the DNS office until they were destroyed. The DNS identified the office door acted as the second lock for the controlled substances stored in the cabinet.An observation on 5/6/26 at 12:37 PM identified the DNS office door was wide open with no staff present. The surveyor went to the Administrator's office and requested the Regional Clinical Director (RCD) return to the DNS office. The Administrator's office and Admissions office were located in the same hallway as the DNS office, and both rooms had access to the DNS office when its door was open. Approximately one (1) minute elapsed while the DNS office remained vacant, and the door leading to the office hallway remained open.Upon entry into the DNS office, the RCD was asked whether the file cabinet used to store discontinued controlled substances was permanently affixed to the wall and whether it had a double lock. The RCD identified the file cabinet could not be moved easily, a single lock secured the drawer containing discontinued controlled substances, and that the DNS office door was locked. However, the file cabinet was not permanently affixed to the wall, and the door leading from the DNS office to the administrative offices was open, allowing access to the file cabinet. Although the hallway leading to the administrative offices required a passcode, access was not limited to only those who worked in that office space.The DNS and RCD identified fourteen (14) discontinued controlled substance prescriptions stored inside the file cabinet. Each medication was stored in bubble packs or bottles that had been brought into the facility from an outside pharmacy. Observation and counting of the discontinued controlled substances identified the following remaining quantities: Hydromorphone 2 mg: 182 tablets remaining Oxycodone 5 mg: 83 tablets remaining Lyrica 50 mg: 7 capsules remaining Tramadol 50 mg: 107 tablets remaining Hydromorphone 2 mg: 101 tablets remaining Alprazolam 0.25 mg: 40 tablets remaining Lorazepam 0.5 mg: 52 tablets remaining Pregabalin 75 mg: 74 capsules remaining Pregabalin 50 mg: 29 capsules remaining Lorazepam 1 mg: 24 tablets remaining Hydromorphone 4 mg: 12 tablets remaining Lorazepam Intensol 2 mg/milliliter: 19.50 milliliters remaining Morphine Sulfate 100 mg/5 milliliters: 72.5 milliliters remaining Hydromorphone 5 mg/5 milliliters: 15 milliliters remainingObservation and facility documentation identified each discontinued controlled substance stored in the filing cabinet had a reconciliation form attached, and counts matched the remaining quantities in the bubble packs and bottles.