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	11/18/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interview for 2 residents (Resident #41 and 58) reviewed for abuse, the facility failed to ensure the residents were treated in a respectful and dignified manner. The findings included: Resident #41 was admitted to the facility in 6/2019 with diagnoses that included morbid obesity and anxiety disorder. The annual MDS dated [DATE] identified Resident #41 was moderately cognitively impaired, and required one person assist with bed mobility, and two person assist with transfer to the toilet and chair. The care plan dated 10/10/25 identified Resident #41 was at risk for functional decline in mobility, was highly demanding and had a potential to demonstrate verbally abusive behaviors related to ineffective coping skills. Interventions included assist of two at bed level due to behaviors, anticipate needs, analyze/document triggers and what deescalates behavior. A Reportable Event Form dated 11/16/25 at 7:38 AM identified Resident #41 reported NA #7 was rough while providing incontinent care. Resident #41 told NA #7 not to be rough with him/her and stated that he/she did not like NA #7. NA #7, in response, replied I don't like you either. NA #7 was removed from the schedule, and an assessment of the resident was completed. Social services planned to meet with Resident #41. Local law enforcement, the physician and resident representative were notified. A statement dated 11/16/25 (untimed) by LPN #8 identified she was in the hallway passing medications when she overheard Resident #41 tell NA #7, he/she did not like her. LPN #8 then heard NA #7 reply, I don't like you either. Interview with the DNS on 11/17/25 at 2:00 PM identified NA #7 denied the allegation despite being overheard by LPN #8 to have said she did not like Resident #41 either. The DNS indicated she would expect all residents to be treated in a dignified manner. Interview with NA #7 on 11/20/25 at 10:52 AM identified she was the assigned nurse aide for Resident #4 working overnight 11:00 PM to 7:00 AM from 11/15/25 to 11/16/25. NA #7 indicated Resident #41 was accusatory, demanding and often yelled at staff to adjust clothing and items according to preference or made other requests to keep staff engaged in care and would scream if they had to leave. NA #4 indicated Resident #41 was experiencing frequent loose stools that night requiring additional incontinent care and called often for herself or the nurse. Resident #41 did (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care and did not see any aggressive jerking or that the treatment was harsh. Resident #58 indicated they were harming him/her and that he/she was in pain. Resident #58 indicated they should have moved slower and more cautiously. Resident #58 felt that Police Officer #2 was siding with the staff. A written statement from NA #8 dated 8/26/25 (untimed) identified that she had explained to Resident #58 that she needed to get another nurse aide and had explained each procedure prior to performing the procedure. NA #8 indicated she and NA #7 grabbed the draw sheet and gently rolled Resident #58 onto his/her back. NA #8 indicated that during incontinence care provided with NA #7, Resident #58 repeatedly yelled and screamed that we were hurting her and being mean. NA #8 indicated Resident #58 continued yelling and screaming at them again. NA #8 indicated Resident #58 did not respond when asked whether staff should stop care. NA #8 indicated they continued providing care. NA #8 indicated LPN #4 entered the room, asked if everything was okay, and left after being told yes. NA #8 indicated that after care was completed at approximately 12:55 AM, Resident #58 continued yelling and stated he/she was going to call the police and get you all put in jail. NA #8 indicated at approximately 1:10 AM the police arrived to obtain their statements. NA #8 indicated that during a reenactment of the care provided, Resident #58 again began screaming. NA #8 indicated the DNS and the Administrator instructed NA #7 and NA #8 to write statements and then leave the facility pending investigation. A written statement from NA #7 dated 8/26/25 (untimed) identified that she assisted NA #8 with providing incontinence care to Resident #58. NA #7 indicated NA #8 explained the procedure to Resident #58. NA #7 indicated they turned Resident #58 gently with the draw sheet onto his/her back and the resident started yelling and screaming that they were hurting him/her. NA #7 indicated that during incontinence care provided with NA #8, Resident #58 repeatedly yelled and screamed that we were hurting him/her. NA #7 indicated Resident #58 continued yelling and screaming at them again. NA #7 indicated Resident #58 did not respond when asked whether staff should stop care. NA #7 indicated they continued providing care. NA #7 indicated that after care was completed Resident #58 continued yelling and stated he/she was going to call the police. A written statement from LPN #4 dated 8/26/25 at 2:30 AM identified that at approximately 12:40 AM to 12:45 AM she overheard yelling coming from Resident #58's room. LPN #4 indicated that when she entered the room, she observed two nurse aides providing incontinent care to Resident #58. LPN #4 indicated she asked the two nurse aides what was going on and if everything was okay and they told her yes. LPN #4 indicated she then left the room to respond to another call light. LPN #4 indicated at approximately 1:10 AM the police arrived at the nurse's station and informed her that the NA was rough with the resident. LPN #4 indicated she notified RN #4, who accompanied the officers to Resident #58's room. LPN #4 indicated Resident #58 reported right leg pain rated 5 out of 10, and that Tylenol was administered at 12:52 AM for pain. Review of LPN #4 written statement dated 8/26/25 at 2:30 AM failed to reflect documentation that she had asked Resident #58 why he/she was yelling during incontinent care. A written statement from RN #4 dated 8/26/25 (untimed) identified she was notified by LPN #4 that the police were in the facility in response to a call made by Resident #58 alleging that staff were rough while providing care. RN #4 indicated she accompanied the police to Resident #58's room. The summary report dated 8/28/25 at 11:58 AM identified Resident #58 had called the police on 8/26/25 alleging that he/she was rough handled by two facility staff causing him/her pain in the leg. Resident #58 requires extensive assistance with activities of daily living. While staff were providing (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	incontinent care, Resident #58 yelled out and reported pain in his/her right leg, NA's stopped care. LPN #4 heard yelling and entered the room; Resident #58 did not complain of pain to LPN #4, and LPN #4 exited the room. Both NA's completed incontinent care with resident permission and exited the resident room. The police interviewed Resident #58 who later expressed mistrust of the responding officer. Based on the facility investigation and inconsistencies in the resident's statements, refusal to allow assessments, and lack of evidence or injury the allegation was unsubstantiated. Interview with Resident #58 on 11/16/25 at 10:12 AM identified he/she called the police on two NA's a few months ago. Resident #58 indicated the two nurse aides rough handled him/her while turning and positioning him/her during care. Resident #58 indicated he/she did not like the way the nurse aides handled him/her. Resident #58 indicated he/she did not report the allegation of staff rough handled him/her to the LPN #4 or RN #4. Resident #58 indicated he/she called the police. Interview with Resident #58 on 11/18/25 at 9:15 AM identified he/she feels safe at the facility. Resident #58 indicated I know how to call the police if they are rough with me again. Interview with NA #8 on 11/18/25 at 6:55 AM identified NA #7 assisted her with providing incontinent care to Resident #58. NA #8 indicated NA #7 pulled the draw sheet towards her so the resident can go closer to her. NA #8 indicated that during incontinence care Resident #58 repeatedly yelled and screamed that they were hurting him/her and that they don't know what they're doing. NA #8 indicated Resident #58 continued yelling and screaming at them again. NA #8 indicated Resident #58 did not respond when asked whether staff should stop care. NA #8 indicated they continued providing care. NA #8 did not answer why she did not stop and reapproach at a later time. NA #8 indicated she should have stopped when Resident #58 was yelling and screaming that we were hurting him/her and reported it to LPN #4 and reapproach. NA #8 indicated with RN #4, and Police Officer #2 in the room that Resident #58 stated NA #7 should be ashamed of herself. NA #8 indicated NA #7 said to Resident #58 mind your business it does not have anything to do with you. and NA #7 started arguing with Resident #58 in the presence of RN #4 (the supervisor) and Police Officer #2. NA #8 indicated Police Officer #2 told NA #7 and Resident #58 to stop arguing. NA #8 indicated she never had an issue with Resident #58 prior to this incident. Interview with RN #4 on 11/18/25 at 7:32 AM identified she was the RN supervisor when Resident #58 called the police. RN #4 indicated she texted the DNS and the Administrator immediately. RN #4 indicated Resident #58 did not report that he/she had been handled roughly. RN #4 indicated she accompanied the police to Resident #58's room and observed Resident #58 say something to NA #7 and NA #7 and Resident #58 started arguing in her presence, NA #8 and Police Officer #2. RN #4 indicated Police Officer #2 told NA #7 to tone it down and intervene. Interview with the DNS on 11/18/25 at 10:06 AM identified she was not aware that NA #7 and Resident #58 had an argument in the room in the presence of the RN supervisor, Police Officer #2, and NA #8. The DNS indicated during her investigation it was not brought up. The DNS indicated her investigation was directed at Resident #58 alleged allegation of rough handled during care. The DNS indicated she was unable to substantiate rough handled during incontinence care, turning and position. The DNS indicated the two nurse aide should have stopped the care and reapproach when Resident #58 was yelling and screaming. The DNS indicated there were two staff present with care. The DNS indicated that if she was aware of the argument between NA #7 and Resident #58, she would have investigated that incident. The DNS indicated RN #4 did not inform her that there was an argument between NA #7 and Resident #58 in the room. The DNS indicated that the two nurse aides were removed from the facility pending investigation. The DNS indicated the facility staff must treat all (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents with respect and dignity. Although attempted, an interview with LPN #4 and NA #7 was not obtained. Review of the facility resident rights policy identified resident has a right to dignified existence. A facility must treat each resident with respect, dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the residents. Review of the facility abuse, neglect and exploitation policy identified abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. Verbal abuse means the use of oral, written or gestured communication or sounds that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, facility documentation, facility policy, and interviews for 1 of 5 residents (Resident # 55) reviewed for accidents, the facility failed to conduct an assessment to ensure the resident could safely self-administer medications. The findings include:Review of the hospital Discharge summary dated [DATE] identified Resident #55's active medications included Efinaconazole 10 % solution (a topical medication used for toenail fungal infections) once daily and Ammonium Lactate 12 % (a topical medication used for skin dryness and itching).Resident #55 was admitted to the facility in [DATE] with diagnoses that included acute kidney failure, cerebral infarction, and allergic contact dermatitis.A physician's order dated [DATE] directed to apply Ammonium Lactate 12% over the whole body every evening for dry skin/itchiness. The admission MDS dated [DATE] identified Resident #55 had intact cognition, was frequently incontinent of bowel, occasionally incontinent of bladder, was dependent on staff to assist with bathing, lower body dressing, and putting on/taking off footwear. The care plan dated [DATE] identified Resident #55 had a self-care performance deficit due to weakness. Interventions included encouraging the resident to participate to the fullest extent possible with each interaction. Review of the physician's orders for [DATE] - [DATE] failed to identify an order for Efinaconazole. Observation on [DATE] at 9:18 AM identified a box labeled Jublia (the brand name for Efinaconazole) on Resident # 55's bedside table and two 225 gram bottles of Ammonium Lactate 12 %, one on Resident #55's dresser and one inside of a wash basin. Interview with Resident #55 at that time identified that he/she had been using the Jublia for several years and brought it from home as the facility had not been able to obtain it due to insurance issues. Resident #55 also identified he/she had brought in the Ammonium Lactate from home to ensure he/she had an adequate supply available. Resident #55 identified that he/she applied both medications topically and facility staff did not assist him/her. Review of the clinical record failed to identify documentation related to the Efinaconazole, an assessment demonstrating the resident could safely self-administer the Efinaconazole and/or where the Efinaconazole would be stored. Interview with RN #6 (7 AM - 3 PM nursing supervisor) on [DATE] identified that residents of the facility who wanted to self-administer medications were required to be assessed for safe administration. RN #6 identified if the resident was identified to be able to safely self-administer, then a physician's order was placed, RN #6 also identified that residents were not to use any outside medications unless in specific circumstances when the facility was not able to obtain a medication for the resident. RN #6 identified if a medication was required for a resident and brought from home, the medication would be labeled with the resident's information and kept locked in the medication cart, and at no time were any medications to be kept at the resident's bedside. RN #6 identified she would speak with Resident #55 regarding the medications and assess for self-administration. Interview with APRN #1 on [DATE] identified she was not aware that Resident #55 was self-administering Efinaconazole at the bedside and further identified she had not heard of Efinaconazole and was not aware of the use of that medication. APRN #1 was observed looking up the medication on her phone. APRN #1 identified that she would have expected the facility staff to notify her that Resident #55 required the medication and had been actively using the medication prior to admission and identified the admitting nurse should have provided her with the medications. APRN #1 identified she would discuss the medications with Resident #55. Interview with the DNS on [DATE] identified she was not aware Resident #55 was self-administering medications or had medications at the bedside. The DNS also identified she did not know what Efinaconazole was or what it was used for, and was not aware that Resident #55 was actively on the medication prior to admission to the facility.Interview with RN #6 on [DATE] at 8:45 AM identified she completed an assessment of Resident #55 and determined he/she was able to safely self-administer medications. RN #6 identified she had updated Resident #55's care plan and also had Resident #55 sign a (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	notification of contraband form which included education on outside medications. RN #6 identified that Resident #55 had one bottle of Efinaconazole located in a nightstand drawer and 2 bottles of Ammonium Lactate. RN #6 identified the bottle of Efinaconazole expired on [DATE]. Further, RN #6 indicated she had not discussed the need to continue the medication with Resident #55 or APRN #1.Interview with the DNS on [DATE] at 12 PM identified she completed Resident #55's admission assessment and medication reconciliation. The DNS identified that, subsequent to surveyor inquiry, she now remembered she had noted that Resident #55 had Efinaconazole listed as an active medication on his/her discharge summary, and reviewed the medication with APRN #1 who declined to order the medication but did not document any of this information in Resident #55's clinical record. The DNS further identified in her experience there were always several medications listed that residents may be taking that were not actual active medications, and those medications would not be ordered by the facility. The DNS identified that while this was her experience, she did not discuss the need for Efinaconazole with Resident #55. The DNS identified she would discuss the medication with Resident #55 and APRN #1. Subsequent to surveyor inquiry, a physician's order dated [DATE] directed to apply Efinacmonazole 10% topical solution to the toes once daily for onychomycosis (fungal infection) once daily for 3 months. The order further identified Resident #55 may self-administer.Review of a notification of contraband policy signed by Resident #55 on [DATE] identified that the policy directed the facility had developed a list of items that residents may not have in their position in order to maintain a safe and healthy environment for all residents. The policy further directed that these items included medications, including prescribed and over the counter drugs, unless approved by the interdisciplinary team. The policy also directed that failure to abide by the aforementioned policy may result in the need for close observation, revoking of LOA privileges, and or issuance of a 30-day discharge notice.The facility policy on medications brought to the facility by the Resident/Family directed that the facility shall not ordinarily permit residents and families to bring medications into the facility. The policy directed that residents and families must report to the nursing staff any medications they want to bring or have brought into the facility and that the facility discouraged the use of medications from the outside and would inform residents and families of that policy as well as applicable laws and regulations. The policy also directed that if a medication was not otherwise available or it had been determined to be essential to the residence life, health, safety, overall wellbeing to be able to take a medication brought in from the outside, the DNS and nursing staff, with the support of the attending physician and consultant pharmacist would check to ensure that state law and regulations allowed such use; the medications had been ordered by the residents attending physician and documented on the physicians order sheet. The contents of each container was labeled in accordance with established policy; and the contents of each container was verified by a licensed pharmacist. The policy also directed that medications brought into the facility that had not been approved for the resident's use would be returned to the resident's family. If the family did not pick up those medications within 30 days, the facility may destroy the medication in accordance with established policies.The facility policy on self-administration of drugs directed that residents would not be permitted to self-administer or retain medications in their rooms unless approved by the attending physician and interdisciplinary team. The policy further directed an assessment for self-administration of medications, and the resident must be able to perform each step indicated prior to beginning self-administration of medications.

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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 review of the clinical record, facility documentation, facility policy, and interviews for 1 of 2 residents (Resident #2) reviewed for food and on a restricted diet, the facility failed to provide the resident with his/her choice of meals. The findings include:Resident #2 was admitted to the facility in August 2025 with diagnoses that included end stage renal disease, diabetes, and severe protein-calorie malnutrition. The Nutrition Evaluation dated 8/20/25 and a dietitian progress note dated 8/20/25 at 11:27 AM identified Resident #2 feeds him/herself and only needs to be set up. Resident #2 has had variable meal intake from 25 - 100%. Resident #2 may benefit from supplements secondary to variable oral intake and increased needs due to diagnosis and need for specialized treatment. Nutrition interventions will include adding a nephron supplement daily and to honor food preferences as appropriate.A physician's order dated 8/20/25 directed to provide Resident #2 with a renal diet, regular texture, and a renal nutritional supplement once a day. The admission MDS dated [DATE] identified Resident #2 had intact cognition, a poor appetite 2 - 6 days a week and required no assistance with eating.The care plan dated 8/27/25 identified Resident #2 was on a renal diet, with interventions that included diet as ordered, provide supplements as ordered, and offer substitutes as available. A Diet Requisition Form written by LPN #7 dated 9/1/25 identified Resident #2 wanted a chef salad with dinner. A Diet Requisition Form written by LPN #7 dated 9/9/25 identified Resident #2 was to receive a chef salad with dinner and a bagged lunch on Monday, Wednesday, and Fridays. The dietitian note dated 9/25/25 at 2:09 PM identified Resident #2 is receiving a renal diet, regular texture with an 1800ml fluid restriction with oral intake noted 25 - 100% of most meals. Renal supplements are in place daily for added calories and protein intake. The dietitian note dated 10/27/25 at 12:13 PM identified Resident #2 is receiving a renal diet, regular texture with an 1800ml fluid restriction with oral intake noted 25 - 100% of most meals. Renal supplements are in place daily for added calories and protein intake. Recommend continuing current plan of care.Interview with Resident #2 on 11/16/25 at 9:50 AM indicated that he/she had asked a nurse a few times but did not recall the nurse's names to have the dietitian come and see him/her about a month ago and she still has not seen her yet. Resident #2 indicated she has called the kitchen and requested a chef salad many times and depending on the person's mood in the kitchen sometimes he/she will get it and other times he/she does not. Resident #2 indicated the kitchen staff get upset when he/she calls and gives him/her an attitude. Resident #2 indicated that he/she has asked the nurse aides to call the kitchen on his/her behalf to order the chef's salad, but they tell him/her they cannot call the kitchen because the kitchen staff will think the food is for them (the employee). Resident #2 indicated he/she knew the rule to call the kitchen before 2:30 PM for a dinner request but when he/she calls before 2:30 PM they will say they have already prepared the salads for the day and will not make a new chef salad for him/her that day. Resident #2 indicated sometimes you call the kitchen, and the kitchen staff just don't bring it or say they don't have lettuce to make it. Resident #2 indicated that he/she cannot eat tomato sauce so when pasta is on the menu, he/she tries to get the chef salad and when he/she does not like other food on the menu. Resident #2 indicated that he/she would like a chef salad almost every day for dinner if he/she could get it. Interview with RD #1 on 11/18/25 at 8:11 AM indicated she had only spoken with Resident #2 on 8/20/25 and reviewed the renal diet and the menu and that the resident could order food as appropriate and off the always available menu. RD #1 indicated she tries to document on this resident monthly. RD #1 indicated she is only 8 hours a week and comes in usually on Mondays and sometimes on Thursday. After clinical review, RD #1 indicated she did not meet with Resident #2 on 9/25 or 10/27/25. RD #1 indicated she reviewed the clinical record and wrote a note based on the clinical record. RD #1 indicated she was not aware Resident #2 had been requesting to see her. RD #1 indicated Resident #2 could have a chef salad daily, but he/she cannot get tomatoes (continued on next page)

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	11/18/2025

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on it. RD #1 indicated the food service director was responsible to meet with the residents for likes and dislikes and updating the food tracker system. RD #1 indicates the meal tracker for Resident #2 did not identify Resident #2 likes or prefers chef salads. Interview with LPN #7 on 11/18/25 at 8:35 AM indicated she had filled out the slip for Resident #2 to receive a chef salad on 9/1 and 9/9/25. LPN #7 indicated that Resident #2 had informed her a couple of times that the evening before he/she had requested a chef salad and the kitchen would not make it or bring it to him/her. LPN #7 indicated she does not recall why the kitchen did not make or bring the salad, but she had informed her supervisor or the DNS regarding Resident #2 not receiving the chef salads as requested. LPN #7 indicated she was a full-time nurse on Resident #2's unit and she does not recall if Resident #2 had asked to speak with the food service director or the dietitian. Interview with Resident #2 on 11/18/25 at 8:46 AM indicated that he/she was calling the kitchen a few times a week for the chef salad but would like a chef salad almost every dinner meal. Resident #2 indicated he/she was aware he/she cannot have tomatoes and that was not a problem. Resident #2 indicated that he/she has not seen the dietitian or the food service director to inform them he/she wanted a chef salad every evening or as an alternative when it was a meal, he/she could not have. Resident #2 indicated that the kitchen staff make him/her feel like he/she cannot call the kitchen as instructed to do by the nurse aide. Interview with the DNS on 11/18/25 at 9:40 AM indicated LPN #7 had not informed her that Resident #2 was not receiving his/her chef salad as requested. The DNS indicated she was not aware that the nurse aides were instructing the residents to call the kitchen and would not call the kitchen on behalf of the residents. The DNS indicated the nurse aide could call the kitchen when asked by the residents. The DNS indicated that dietary director was responsible to make sure residents are seen and receiving their choices.Interview with the Administrator on 11/18/25 at 9:45 AM indicated the food service director was responsible to meet with all new residents within the first 24 hours and finding out the residents' preferences. The Administrator indicated that she has recently hired a new food service director. The Administrator indicated that she would have the food service director meet with Resident #2 right now. Interview with Food Service Director on 11/18/25 at 10:23 AM indicated she is from a contracted company and not an employee of the facility. The FSD indicated she had started 14 days ago and indicated she was in the process with meeting all the residents. The FSD indicated she had met 28 residents last Friday to introduce herself and one of the residents was Resident #2. The FSD indicated Resident #2 had only mentioned wanting a diet ginger ale and a glass of milk. The FSD indicated she does not recall if Resident #2 had requested to see the dietitian. The FSD indicated there were no notes in the meal tracker profile or in the office to identify that the prior food service director had met with Resident #2 on admission, or after, to discuss likes and dislikes. Interview with District Food Service Manager on 11/18/25 at 10:27 AM indicated that she was in the facility to train the new FSD. District Food Service Manager indicated they are a contracted company working at the facility since December 2023. The District Food Service Manager indicated that if a resident requests a chef salad for dinner and it is allowed on their diet the resident should receive it no matter what time they call the kitchen even if it was 7:00 PM at night and the resident requests it. The District Food Service Manager indicated there may be times when things are not available like lettuce, but we can offer alternative foods. The District Food Service Manager indicated the resident, or the nursing staff, can call down to the kitchen to request a resident's choice for a meal if it is different than the main menu at any time. After record review, the District Food Service Manager indicated there were no notes in the meal tracker profile to indicate the prior food service director had met with Resident #2 on admission, or after, to discuss likes and dislikes. The District Food Service Manager indicated today after surveyor inquiry they met with Resident #2 and went over the next 2-week menu, likes and dislikes. Review of the Nutritional Assessment Policy identified the dietitian in conjunction with the nursing staff and healthcare practitioners, will conduct a nutritional assessment for each resident upon admission and as indicated by a change in condition that places the resident at risk for impaired nutrition. The nutritional assessment will be conducted by the multidisciplinary process that includes (continued on next page)

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	075407	A. Building B. Wing	11/18/2025

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	gathering and interpreting data and using that data to help define meaningful interventions for the resident at risk for or with impaired nutrition. The nutrition assessment will be conducted by the multidisciplinary team and shall identify at least the following components: usual body weight, a description of the resident's usual intake and appetite, a history of gains and losses in weights prior to admission, usual meals and snakes, food preferences and dislikes, and food restrictions. The individualized care plan shall address the resident's personal preferences.Review of the Resident Rights Policy identified residents have a right to a dignified existence, self-determination, and communication with and access to people and services inside and outside the facility, including those specified in this section. The facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his/her quality of life, recognizing each resident's individuality. The facility must incorporate the resident's personal and cultural preferences in developing goals of care. The facility must protect and promote the rights of the residents.

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	075407	A. Building B. Wing	11/18/2025

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interview for 1 of 3 residents (Resident #1) reviewed for hospitalization, the facility failed to ensure the physician was immediately notified when the resident had of a change in condition including difficulty with speech and right sided weakness and for 1 of 5 residents (Resident #7) reviewed for accidents, the facility failed to ensure that the physician and resident representative were notified of newly identified skin issues. The findings include: 1.Resident #1 was admitted to the facility in May 2023 with diagnoses that included repeated falls and malignant neoplasms of the spinal cord, prostate, bone, liver, and intrahepatic bile duct. The annual MDS dated [DATE] identified Resident # 1 had moderately impaired cognition, no functional limitation in range of motion impairments to the upper or lower extremities, clear speech-distinct intelligible words, the ability to express ideas and wants, required partial/moderate assistance with sitting to standing and chair/bed-to-chair transfers, and required setup or clean-up assistance with eating. The care plan dated 9/22/25 identified Resident #1 had impaired cognitive functions/dementia or impaired thought processes, with interventions that included monitoring/documenting and reporting to the physician any changes in cognitive function, specifically changes in: decision making ability, memory recall, general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, or mental status. The nurse's note dated 10/19/25 at 2:25 PM identified that Resident #1 was alert and confused during the shift, vital signs were stable, with no complaint of pain or discomfort. Resident #1 had right side upper and lower extremity weakness. The supervisor was updated, and Resident #1 was on continuous monitoring. The nurse's note dated 10/19/25 at 7:17 PM identified that at 6:00 PM (3 hours and 35 minutes after the documented onset of right sided upper and lower extremity weakness), Resident #1 was noted to be restless in bed and appeared that he/she could not get comfortable. Staff noted that Resident #1 was having a difficult time forming complete sentences but was able to tell staff thank you. Resident #1 denied pain and was able to follow commands. After receiving medication and a breathing treatment, Resident #1 was able to calm down and was repositioned in bed; vital signs were stable. Resident #1's representative was updated, and staff continued to monitor throughout the shift. The nurse's note dated 10/20/25 at 3:37 PM identified that the writer was called to Resident #1's room out of concern for increased weakness, unable to communicate and it was worse from his/her baseline. Resident #1 was unable to lift his/her right arm or leg, and a right sided facial droop was noted. The medical APRN saw Resident #1, EMS was called, and the resident was transferred to the ED via stretcher. The medical APRN note dated 10/20/25 (untimed) identified Resident #1 was seen for medical management of chronic conditions and acute conditions, increased confusion, dysphagia, and right sided weakness. Asked to see patient by nursing for increased confusion and dysphasia, per nursing staff, Resident #1 was noted to have increased confusion and difficulty swallowing. Resident #1 was (continued on next page)

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	075407	A. Building B. Wing	11/18/2025

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	noted to be eating in bed with increased confusion, denied dysphasia, cough and choking. Resident #1 was alert and oriented to self, with no signs or symptoms of dysphasia, his/her mood was stable with no history of uncontrolled behaviors; vital signs were within normal limits. Later in the afternoon during hygienic care, the nurse aide noted Resident #1 to have right sided weakness and requested for this writer to evaluate. Resident #1 was alert with expressive aphasia, dysarthria, and facial drooping. Weakness was noted to the right side of the body. Resident #1 was unable to lift his/her upper and lower extremities, no tremor or twitching noted. Resident #1 was transferred to the hospital via 911 for a stroke evaluation and treatment. The Discharge summary dated [DATE] identified Resident #1 presented to the ED with a one-hour history of right-sided facial droop, as well as concern for right-sided pronator drift and right lower extremity weakness, as per EMS. Head CT (imaging test used to show detailed images of the bones, blood vessels, and soft tissues) was negative for acute pathology but showed bilateral chronic lacunar infarcts. No thrombolytics were administered, as Resident #1 had just received Eliquis before the symptoms started in the afternoon. Further stroke workup: Brain MRI (imaging test showing detailed pictures of the body's organs, soft tissues, and bones) identified an acute pontine infarct. Resident #1's discharge condition was stable, with outpatient stroke neurology follow-up. Interview with LPN #2 on 11/18/25 at 10:06 AM identified that she had worked for the facility for a little more than a month and was the nurse providing care for Resident #1 on 10/19/25 from 7:00 AM - 3:00 PM. LPN #2 further identified that at one point during her shift, she had noticed that Resident #1's speech sounded different, the resident wasn't holding a cup the way he/she normally holds a cup, had difficulty raising his/her arm when she applied the blood pressure cuff, and wasn't the way she normally saw him/her. LPN #2 indicated that Resident #1's vital signs were stable; she reported her observations to a female nurse supervisor but could not remember the supervisor's name. LPN #2 further indicated that the nursing supervisor told her that Resident #1 had been declining, there were talks about starting hospice, and that she would notify the resident representative. LPN #2 identified that she was not aware if the supervisor had completed an assessment or notified the APRN. LPN #2 indicated that Resident #1 appeared ok for the remainder of her shift, took medications without an issue, and when she saw him/her the next morning, he/she seemed ok. Interview with the DNS on 11/18/25 at 8:20 AM identified that Resident #1 could be hard to understand due to a speech impediment, had intermittent confusion, and a history of falls and weakness, and RN #7, as a new nurse, may not have been aware of Resident #1's baseline, but she would have expected the medical provider to have been notified of the concerns on 10/19/25. Interview with the 7:00 AM - 3:00 PM RN Supervisor (RN #6) on 11/18/25 at 10:36 AM identified that based off a review of the nursing schedule, she was the only daytime nurse supervisor on 10/19/25, but she could not recall anything being brought to her attention that Resident #1 was having issues with speech or extremity weakness. RN #6 indicated that she usually was the supervisor of the first floor; Resident #1 resided on the second floor. RN #6 identified that, in general, she was aware that Resident #1 has had falls and some confusion, but she was not familiar with pending hospice status or conversations with the resident representative, nor could she recall being notified of LPN #2's concerns. Interview with the 3:00 PM - 11:00 PM RN Supervisor (RN #7) on 11/18/25 at 1:05 PM identified that he was a new nurse to the facility and was the evening RN Supervisor working on 10/19/25. RN #7 indicated that while reading the off-going nurse's shift report it was identified that Resident #1's representative had called the facility with concern that Resident #1 was having a hard time speaking. (continued on next page)

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	075407	A. Building B. Wing	11/18/2025

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RN #7 could not recall the name of the nurse that had written that in the shift report. RN #7 indicated that he spoke to the nursing staff, some had felt that Resident #1 was restless and could speak better than he had been speaking. RN #7 indicated that he assessed Resident #1, and the resident seemed alert and oriented, he could understand Resident #1's speech, and his/her vital signs were stable. RN #7 further indicated that while a neurological assessment was not documented as being completed, it was done and was within normal limits. RN #7 indicated that after repositioning, Resident #1 settled down, had an uneventful evening, and was alert and awake. RN #7 identified that he notified Resident #1's representative that Resident #1 was restless but did not notify the medical provider because he was able to understand Resident #1's speech, the resident was alert and oriented, his/her vital signs were stable, and he/she calmed down after repositioning. The facility's Change in a Resident's Condition or Status policy directs that the facility shall promptly notify the resident, his/her attending physician, and representative of changes in the resident's medical/mental condition and/or status. The nurse will notify the resident's attending physician or the physician on call when there has been an accident or incident, discovery of injury of unknown source, an adverse reaction to medication, significant change in the resident's physical/emotional/mental condition, a need to alter the resident's medical treatment significantly, refusal of treatment or medications 2 or more consecutive times, need to transfer the resident to a hospital/treatment center, discharge without proper medical authority, and/or specific instruction to notify the physician of changes in the resident's condition. 2. Resident #7 was admitted to the facility in December 2024 with diagnoses that included anaplastic astrocytoma (brain tumor), epilepsy, and sick sinus syndrome. Review of the clinical record identified Resident #7 was hospitalized from [DATE] - 9/19/25 following an unwitnessed fall that resulted in a hip fracture and required surgery. A physician's order dated 9/19/25 directed for weekly skin evaluations. The 5 day MDS dated [DATE] identified Resident #7 had severely impaired cognition, was frequently incontinent of bowel, occasionally incontinent of bladder, required substantial assistance with toileting and bathing, and was dependent on staff to assist with transfers. The care plan dated 9/24/25 identified Resident #7 had potential/actual impairment to skin integrity to fragile skin. Interventions included to conduct weekly body audits and identify/document potential causative factors and eliminate/resolve where possible. Observation on 11/17/25 identified 2 dressings located on Resident #7's head. The observation identified one dressing on the top of the scalp, above the forehead, and one dressing located at the left temple. Each dressing identified (11/14/25 7-3) Review of the clinical record failed to identify any documentation related to wounds on Resident #7's head or face, including an assessment of the wounds. Review of the clinical record failed to identify a physician's order related to wounds on Resident #7's head or face. Interview with LPN #5 on 11/17/25 at 10:30 AM identified she was the nurse assigned to Resident #7 on 11/14/25 on the 7 AM-3 PM shift. LPN #5 identified that Resident #7 had multiple lesions on (continued on next page)

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	075407	A. Building B. Wing	11/18/2025

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	his/her forehead and scalp, and that she observed Resident #7 had 2 oozing areas. LPN #5 identified she applied a 4x4 gauze and tape to each area and then labeled the dressings with the date, time, and her initials. LPN #5 identified she did not assess the areas, did not notify the RN supervisor, APRN, or Resident #7's representative, and did not document about the wounds in the clinical record. Interview with APRN #1 on 11/17/25 at 3:10 PM identified that Resident #7 had a history of skin lesions to his/her face present for several months that were rough, scaly, and were likely actinic keratoses (precancerous skin lesions) and that Resident #7 would periodically pick at the areas. APRN #1 identified that while she was aware that there had been open areas to Resident #7's head or face in the past, she was not aware or notified of any newly opened or oozing areas and had not been notified that the areas required a dressing. APRN #1 advised she would have expected to be notified regarding the new wounds and would have expected the dressings were not left in place for 3 days. Interview with the DNS on 11/17/25 at 3:30 PM identified that for any newly identified skin wound, the nurse assigned to the resident was expected to notify the RN supervisor to assess the wound, and the nurses were also expected to contact the APRN or MD to determine if the wound required treatment and to obtain a treatment order, if indicated. The DNS identified that the resident's representative should be notified, and that all the information regarding the new wound should be documented in the clinical record. The DNS identified she would expect that any nurse that identified a new wound that required a dressing would have notified the APRN or MD to obtain an order. The facility policy on change in a resident's condition or status directed that the nurse would notify the resident's physician for issues that included the discovery of injuries from an unknown source or a significant change in the resident's physical status. The policy further identified that a significant change included a change in status that would not normally resolve itself without intervention by staff. The policy also directed that the nurse would notify the resident's family or representative when the resident had injuries from an unknown source or a significant change in the resident's physical status, and the nurse would record information in the resident's medical record relative to changes in physical condition or status.

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	075407	A. Building B. Wing	11/18/2025

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on review of facility documentation, facility policy and interviews for 1 of 3 sampled nurse aide and 1 of 2 licensed staff employee files, the facility failed to ensure criminal background checks were completed prior to the employee starting employment and caring for residents in the facility. The findings include: A review of LPN #5's employee file identified her date of hire was effective 9/9/22. The employee file failed to reflect a criminal background check had been completed for LPN #5.Interview and employee file review with HR Specialist #1 on 11/18/25 at 1:34 PM identified it was human resource's responsibility to ensure criminal background checks were completed prior to employment. HR Specialist #1 indicated one should have been completed for LPN #5 as she transferred from another location but was unable to produce the documentation. HR Specialist #1 further identified she was not an employee of the facility during the time the background check would have been obtained and had not conducted an audit to determine compliance since becoming employed.The abuse policy directed that potential employees will be screened for a history of abuse, neglect, and misappropriation of resident property. Background, reference and credentials checks shall be conducted on potential employees, contracted temporary staff, students, volunteers, and consultants. Screenings may be conducted by the facility itself, third party agency or academic institution. The facility will maintain documentation of proof that the screening occurred. 2. A review of NA #11's employee file identified her date of hire was effective 7/24/24.NA #11's orientation checklist was completed 7/25/24.The Department of Public Health eligibility determination background check was not completed until 7/31/24, 7 days after NA #11's date of hire.Interview and employee file review with HR Specialist #1 on 11/18/25 at 1:34 PM identified it was human resource's responsibility to ensure criminal background checks were completed prior to employment. HR Specialist #1 was unable to explain why the background check was not completed prior to NA #11's date of hire as she was not an employee of the facility during the time and had not conducted an audit to determine compliance since becoming employed.The facility Employee Handbook directs as a condition of employment; the facility may require a criminal background check in accordance with federal laws.The abuse policy directed that potential employees will be screened for a history of abuse, neglect, and misappropriation of resident property. Background, reference and credentials checks shall be conducted on potential employees, contracted temporary staff, students, volunteers, and consultants. Screenings may be conducted by the facility itself, third party agency or academic institution. The facility will maintain documentation of proof that the screening occurred.

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	075407	A. Building B. Wing	11/18/2025

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interview for 1 of 5 residents (Resident #2) reviewed for PASARR, the facility failed to review the PASARR on admission for accuracy and failed to update the state designated authority when the resident received a new diagnosis of major depression. The findings include: A PASARR Level 1 Preadmission Screening Outcome dated 12/23/24 identified no mental health diagnosis is known or suspected. Resident #2 does not have a diagnosis of dementia and had no known mental health behaviors which affect interpersonal interactions. Resident #2 is not on any antidepressants, mood stabilizers, antipsychotics, or other mental health medications prescribed currently or anytime within the last 6 months. There is no evidence of a PASARR condition of a serious behavioral mental health condition. If changes occur or new information refutes these findings, a new screen must be submitted.The hospital Discharge summary dated [DATE] identified Resident #2 had anxiety, depression, and post-traumatic stress syndrome.Resident #2 was admitted to the facility in December 2024 with diagnoses that included anxiety, depression, and post-traumatic stress syndrome. A physician's order dated 12/25/24 directed to administer Amitriptyline (antidepressant) 25 mg at bedtime, Remeron (antidepressant) 15 mg at bedtime, and Zoloft (antidepressant) 100 mg daily. The Social Services assessment dated [DATE] identified Resident #2 had a diagnosis of anxiety and depression and was receiving Zoloft and Remeron. The APRN note dated 12/26/24 identified she was seeing Resident #2 as a new admission and she reviewed the hospital history and physical, the hospital discharge summary, and provider notes. APRN #2 indicated Resident #2 has a diagnosis of depression and was on the following medications for depression Amitriptyline, Remeron, and Zoloft. Medications are to be continued. The Diagnosis List dated 12/26/24 identified a new diagnosis of major depressive disorder single episode in a partial remission added by APRN #2. The admission MDS dated [DATE] identified Resident #2 had intact cognition, and over the last 2 weeks was feeling down, depressed, or hopeless between 12 to 14 days out of 14 days.The care plan dated 1/6/25 identified Resident #2 had a diagnosis of depression, with interventions that included administering antidepressant medication as ordered by the physician and to monitor and document any side effects and effectiveness. Interview with the Admissions Coordinator on 11/16/25 at 2:01 PM indicated that she was responsible to receive the PASARR Level 1 or Level 2 from the hospital prior to or on admission before a resident could be admitted to the facility. The admission Coordinator indicated she was responsible to print out the PASARR Level 1 or Level 2 from her computer system and place a copy into the resident's medical record at the facility. The admission Coordinator indicated that after the resident arrives at the facility it was the social workers' responsibility to review and follow up on the PASARR as needed. Interview with the Director of Social Services (SW #1) on 11/17/25 at 12:24 PM indicated that she was responsible for making sure all residents have a PASARR on admission and any follow-up that was needed for Level 2's or if an admission PASARR was not accurate. SW #1 indicated that she was responsible to review the new admission residents PASARR put them in the residents' medical record. SW #1 indicated that Resident #2 does not have a prescreening PASARR printed out in his/her medical record. SW #1 indicated that she could look it up in the state agency system. After reviewing the PASARR dated 12/23/24, SW #1 indicated that she did not review it and did not realize that Resident #2 diagnosis of mild and/or situational depression on admission was not reflected on the prescreening PASARR for admission. SW #1 indicated that she should have reviewed the prescreening PASARR on admission and immediately notified the State designated authority that Resident #2 had a diagnosis of depression for the state agency to review and make a determination.Interview with the Administrator on 11/18/25 at 9:30 AM indicated the social worker is responsible to review the admission PASARR and follow up. The Administrator indicated the admission coordinator and SW #1 were responsible to make sure the PASARR was printed out on (continued on next page)

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	11/18/2025

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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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	admission and reviewed for accuracy. The Administrator indicated if the prescreening PASARR was not accurate it was SW #1's responsibility to do an upadate. Interview with Director of SW #1 on 11/17/25 at 12:24 PM indicated that when a resident receives a new mental health diagnosis, she was responsible to update the state agency PASARR for review within a few days. After reviewing the medical record, SW #1 indicated that Resident #2 had received a diagnosis on 12/29/24 of major depression. SW #1 indicated that for PASARR mild and/or situational depression is different than major depression and would be coded differently. SW#1 indicated that if she was informed that Resident #2 had a new diagnosis of major depression on 12/26/24 by the APRN she would have updated the state designated authority to determine if Resident #2 was to remain a Level 1 or become a Level 2. SW #1 indicated she did not update state designated authority because she was not notified by the APRN of the new diagnosis.Interview with the Administrator on 11/18/25 at 9:30 AM indicated that when a resident receives a new mental health diagnosis it is the social workers' responsibility to update the state designated authority. The Administrator indicated when APRN #2 added the diagnosis of major depression on 12/29/24, the APRN should have informed SW #1 so SW #1 could have update the state designated authority. After surveyor inquiry, SW #2 on 11/18/25 at 9:11 AM indicated she and SW #1 had started an audit and education with staff and provided a copy. Although attempted, an interview with APRN #2 on 11/17/25 at 2:05 PM was not obtained. Review of the PASARR Policy identified the facility coordinates assessments with the preadmission screening and resident review (PASARR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs. All applicants to the facility will be screened for serious mental disorders or intellectual disabilities and related conditions in accordance with state Medicaid rules for screening. PASARR Level 1 is the initial pre-screening that is completed prior to admission, The facility will only admit individuals with a mental disorder or intellectual disability who the State mental health or intellectual disability authority has determined as appropriate for admission. A record of pre-screening shall be maintained in the resident's medical record. The social worker director shall be responsible for keeping track of each resident PASARR screening status and referring to the appropriate authority Any resident who exhibits a newly evident or possible serious mental illness disorder, intellectual disability, or a related condition will be referred promptly to the state mental health authority for review.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, facility documentation, facility policy, and interview for 1 of 5 residents (Resident #7) reviewed for accidents, the facility failed to ensure that the care plan was revised to reflect identified skin issues. The findings include:Resident #7 was admitted to the facility in December 2024 with diagnoses that included anaplastic astrocytoma (brain tumor), epilepsy, and sick sinus syndrome.Review of the clinical record identified Resident #7 was hospitalized from [DATE] - 9/19/25 following an unwitnessed fall that resulted in a hip fracture which required surgery.The 5-day MDS dated [DATE] identified Resident #7 had severely impaired cognition, was frequently incontinent of bowel, occasionally incontinent of bladder, required substantial assistance with toileting and bathing, and was dependent on staff to assist with transfers.The care plan dated 9/24/25 identified Resident #7 had potential/actual impairment to skin integrity and fragile skin. Interventions included to conduct weekly body audits and identify/document potential causative factors and eliminate/resolve where possible. Observation on 11/17/25 identified 2 dressings located on Resident #7's head. The observation identified one dressing on the top of the scalp, above the forehead, and one dressing located at the left temple. Each dressing identified the following information: (11/14/25 7-3 M). Review of the clinical record failed to identify documentation related to wounds on Resident #7's head or face, including an assessment of the wounds. Review of the clinical record failed to identify a physician's order related to wounds on Resident #7's head or face. Interview with LPN #5 on 11/17/25 at 10:30 AM identified she was the nurse assigned to Resident #7 on 11/14/25 on the 7 AM - 3 PM shift. LPN #5 identified that Resident #7 had multiple lesions on his/her forehead and scalp, and that she observed Resident #7 had 2 oozing areas. LPN #5 identified she applied a 4 x 4 gauze and tape to each area and labeled the dressings with the date, time, and her initials. LPN #5 identified she did not assess the areas, did not notify the RN supervisor, APRN, or Resident #7's resident representative, and did not document information about the wounds in Resident #7's clinical record. Interview with APRN #1 on 11/17/25 at 3:10 PM identified that Resident #7 had a history of skin lesions to his/her face present for several months that were rough, scaly, and were likely actinic keratoses (precancerous skin lesions) and that Resident #7 would periodically pick at the areas. APRN #1 identified that while she was aware that there had been open areas to Resident #7's head or face in the past, she was not aware or notified of any newly opened or oozing areas by any staff at the facility and had not been notified that the areas required a dressing. Review of the care plan failed to identify any issues or interventions related to skin lesions or recurrent open areas. Interview with the DNS on 11/17/25 at 3:30 PM identified that for any newly identified skin wound, the nurse assigned to the resident was expected to notify the RN supervisor to assess the wound, and the nurses were also expected to contact the APRN or physician to determine if the wound required treatment and to obtain a treatment order, if indicated. The DNS identified she would expect the care plan be updated to reflect Resident #7's history of skin lesions and intermittent open wounds on the head. The facility policy on comprehensive care plans directed that the comprehensive care plan was based on a thorough assessment of the resident, was ongoing, and was revised, and was updated as information about the resident and resident's condition changed. The policy further directed that comprehensive care plan would incorporate identified problem areas and aid in preventing or reducing declines in the resident's functional status.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, facility policy, and interviews for 1 of 2 residents (Resident #20) reviewed for activities of daily living (ADLs), the facility failed to assist the resident out of bed upon his/her request. The findings include:Resident #20 was admitted to the facility in April 2025 with diagnoses that included weakness, anxiety, and depression. The quarterly MDS dated [DATE] identified Resident #20 had intact cognition, exhibited no behavioral symptoms, and was dependent for chair/bed-to-chair transfers, lying to sitting, and sitting to standing.The care plan dated 11/4/25 identified Resident #20 was at risk for skin breakdown related to decreased mobility, incontinence, and need for assistance with bed mobility, with interventions that included staff to assist with bed mobility, turning, and repositioning. The care plan further identified Resident #20 was at risk for falls related to the need for assistance with ADLs/transfers, and medication use, with interventions that included encouraging the resident to use the call bell when he/she needs assistance. Interview with Resident #20 on 11/16/25 at 8:25 AM identified that the day before, he/she did not get out of bed all day. Resident #20 indicated that he/she had asked the nurse aides and nurses on both the day and evening shifts if he/she could get out of bed or sit at the edge of the bed, but he/she was not provided the assistance and stayed in bed all day. Resident #20 further indicated that he/she likes to get out of bed every day for a few hours around lunch time and would eat in the dining room during the week, but on the weekends the nursing staff didn't always get him/her out of bed.Observation on 11/16/25 at 1:18 PM identified that Resident #20 was lying in bed.Interview with Resident #20 on 11/16/25 at 1:18 PM identified that he/she had asked the nurse aide to get him/her out of bed earlier in the day, and that he/she hoped that he/she would get out of bed before the nurse aide went home, today. Interview with LPN #1 on 11/16/25 at 1:25 PM identified that almost everyday Resident #20 requests to get out of bed for lunch and then wants to get back in bed after lunch; if Resident #20's personal health aide was there then he/she would sit up in the recliner for longer. LPN #1 indicated that while Resident #20 would normally ask to get out of bed, she would expect the nurse aide to offer to get him/her out of bed if he/she did not ask. LPN #1 identified that she was the nurse assigned to Resident #20 the day before, and Resident #20 did ask to get out of bed, and she had communicated the request to the nurse aide.During an interview with the 7:00 AM - 3:00 PM nurse aides (NA #1 and NA #2) on 11/16/25 at 1:30 PM, NA #2 indicated that Resident #20 had requested to get out of bed today, and that she and NA #1 planned on getting him/her up. NA #2 indicated that she was the nurse aide assigned to Resident #20 the day before, also, and she did not get Resident #20 out of bed because the resident did not ask. NA #2 further indicated that Resident #20 was alert and was able to tell her when he/she would like to get out of bed. NA #2 identified that yesterday, Resident #20 did not suggest that he/she wanted to get out of bed so she did not offer, and she could not recall if LPN #1 had told her that Resident #20 had requested to get out of bed. NA #1 indicated that when Resident #20's personal health aide was not at the facility to assist with care, she would assist NA #2 with care and transfers of Resident #1, but she did not assist with getting Resident #20 out of bed the day before.Interview with the 7:00 AM - 3:00 PM RN Supervisor (RN #1) on 11/16/25 at 1:54 PM identified that if there was no resident refusal then she would expect a dependent resident to be offered to get out of bed; residents shouldn't have to ask to get out of bed because not all residents can verbalize the request, nursing staff should be offering to get residents out of bed.Interview with the DNS on 11/17/2025 at 8:32 AM identified that Resident #20 could verbalize a request to get out of bed, but if he/she did not ask then the nursing staff should offer, and if the resident requested to get out of bed, then she would expect the nurse aide to transfer him/her out of bed. The facility's Actives of Daily Living (ADLs) policy directs that care and services will be provided for the following ADLs: bathing, dressing, grooming, transfer and ambulation, toileting, eating, and using speech, language or other functional communication systems. The policy further directs that a resident who is unable to carry (continued on next page)

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	075407	A. Building B. Wing	11/18/2025

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	out ADLs will receive the necessary services to maintain good nutrition, grooming, and personal and oral care.

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	075407	A. Building B. Wing	11/18/2025

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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 documentation, facility policy, and interviews for 1 of 5 residents (Resident # 7) reviewed for accidents, the facility failed to ensure that an RN assessment was completed following newly identified skin issues on the resident's face, and failed to ensure weekly body audits were completed per the physician's order, and for 1 of 3 residents (Resident #1) reviewed for hospitalization, the facility failed to ensure a comprehensive RN assessment was completed and documented upon the identification of a change in condition. The findings include: Resident #7 was admitted to the facility on [DATE] with diagnoses that included anaplastic astrocytoma (brain tumor), epilepsy, and sick sinus syndrome. Review of the clinical record identified Resident #7 was hospitalized from [DATE] - 9/19/25 following an unwitnessed fall that resulted in a hip fracture which required surgery. A physician's order dated 9/19/25 directed to complete weekly skin evaluations. The 5-day MDS dated [DATE] identified Resident #7 had severely impaired cognition, was frequently incontinent of bowel, occasionally incontinent of bladder, required substantial assistance with toileting and bathing, and was dependent on staff to assist with transfers. The care plan dated 9/24/25 identified Resident #7 had potential/actual impairment to skin integrity and fragile skin. Interventions included to conduct weekly body audits and identify/document potential causative factors and eliminate/resolve where possible. Review of the clinical record failed to identify body audits had been completed in 10/2025 or 11/2025. Observation on 11/17/25 identified 2 dressings located on Resident #7's head. The observation identified one dressing on the top of the scalp, above the forehead, and one dressing located at the left temple. Each dressing identified the following information: (11/14/25 7-3 M). Review of the clinical record failed to identify documentation related to any wounds on Resident #7's head or face, including any assessments of the wounds. Review of the clinical record failed to identify a physician's order related to wounds on Resident #7's head or face. Interview with LPN #5 on 11/17/25 at 10:30 AM identified she was the nurse assigned to Resident #7 on 11/14/25 on the 7 AM - 3 PM shift. LPN #5 identified that Resident #7 had multiple lesions on his/her forehead and scalp, and that she observed Resident #7 had 2 oozing areas. LPN #5 identified she applied a 4 x 4 gauze and tape to each area and then labeled the dressings with the date, time, and her initials. LPN #5 identified she did not assess the areas, did not notify the RN supervisor, APRN, or Resident #7's resident representative, and did not document information related to the wounds in Resident #7's clinical record. Interview with APRN #1 on 11/17/25 at 3:10 PM identified that Resident #7 had a history of skin lesions to his/her face present for several months that were rough, scaly, and were likely actinic (continued on next page)

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	075407	A. Building B. Wing	11/18/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	keratoses (precancerous skin lesions) and that Resident #7 would periodically pick at the areas. APRN #1 identified that while she was aware that there had been open areas to Resident #7's head or face in the past, she was not aware or notified of any newly opened or oozing areas by any staff at the facility and had not been notified that the areas required a dressing. APRN #1 advised she would have expected to be notified regarding the new wounds and would have expected the dressings were not left in place for 3 days. Interview with the DNS on 11/17/25 at 3:30 PM identified that for any newly identified skin wound, the nurse assigned to the resident was expected to notify the RN supervisor to assess the wound, and the nurses were also expected to contact the APRN or MD to determine if the wound required treatment and to obtain a treatment order, if indicated, which should be documented in the clinical record. Although requested, the facility failed to provide a policy related to RN assessments, nursing assessments, nursing documentation, or weekly body audits. 2. Resident #1 was admitted to the facility in May 2023 with diagnoses that included repeated falls and malignant neoplasms of the spinal cord, prostate, bone, liver, and intrahepatic bile duct. The annual MDS dated [DATE] identified Resident #1 had moderately impaired cognition, no functional limitation in range of motion impairments to the upper or lower extremities, clear speech-distinct intelligible words, and the ability to express ideas and wants. The resident required partial/moderate assistance with sitting to standing and chair/bed-to-chair transfers, and required setup or clean-up assistance with eating. The care plan dated 9/22/25 identified Resident #1 had impaired cognitive functions/dementia or impaired thought processes, with interventions that included monitoring/documenting and reporting to the physician any changes in cognitive function, specifically changes in: decision making ability, memory, recall, general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, or mental status. The nurse's note dated 10/19/25 at 2:25 PM identified that Resident #1 was alert and confused during the shift, vital signs were stable, and there was no complaint of pain or discomfort. The nurse's note identified Resident #1 had right side upper and lower extremity weakness. The supervisor was updated, and Resident #1 was on continuous monitoring. The nurse's note dated 10/19/25 at 7:17 PM identified that at 6:00 PM (3 hours and 35 minutes after the documented onset of right sided upper and lower extremity weakness), Resident #1 was observed in bed and noted to be restless and appeared that he/she could not get comfortable in bed. Staff noted that Resident #1 was having a difficult time forming complete sentences but was able to tell staff thank you. Resident #1 denied pain and was able to follow commands. After receiving medication and a breathing treatment, Resident #1 was able to calm down and was repositioned in bed; vital signs were stable. Resident #1's representative was updated, and staff continued to monitor throughout the shift. The nurse's note dated 10/20/25 at 3:37 PM identified that the writer was called to Resident #1's room out of concern for increased weakness, unable to communicate and it was worse from his/her baseline. Resident #1 was unable to lift his/her right arm or leg, and a facial droop was noted to the right side. The medical APRN saw Patient #1, EMS was called, and the resident was transferred to (continued on next page)

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	11/18/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the hospital via stretcher. The medical APRN note dated 10/20/25 (untimed) identified Resident #1 was seen for medical management of chronic conditions and acute conditions, increased confusion, dysphagia, and right sided weakness. Asked to see patient by nursing for increased confusion and dysphasia, per nursing staff, Resident #1 was noted to have increased confusion and difficulty swallowing. Resident #1 was noted to be eating in bed with increased confusion, denied dysphasia, cough and choking. Resident #1 was alert and oriented to self, with no signs and symptoms of dysphasia, his/her mood was stable with no history of uncontrolled behaviors; vital signs were within normal limits. Later in the afternoon during hygienic care, the nurse aide noted Resident #1 to have right sided weakness and requested for this writer to evaluate. Resident #1 was alert with expressive aphasia, dysarthria, and facial drooping. Weakness was noted to the right side of the body. Resident #1 was unable to lift his/her upper and lower extremities, no tremor or twitching noted. Resident #1 was transferred to the hospital via 911 for a stroke evaluation and treatment. The Discharge summary dated [DATE] identified Resident #1 presented to the ED with a one-hour history of right-sided facial droop, as well as concern for right-sided pronator drift and right lower extremity weakness, as per EMS. Head CT (imaging test used to show detailed images of the bones, blood vessels, and soft tissues) was negative for acute pathology but showed bilateral chronic lacunar infarcts. No thrombolytics were administered, as Resident #1 had just received Eliquis before the symptoms started in the afternoon. Further stroke workup: Brain MRI (imaging test showing detailed pictures of the body's organs, soft tissues, and bones) identified an acute pontine infarct (type of stroke). Resident #1's discharge condition was stable, with outpatient stroke neurology follow-up. Interview with LPN #2 on 11/18/2025 at 10:06 AM identified that she had worked for the facility for a little more than a month and was the nurse providing care for Resident #1 on 10/19/25 from 7:00 AM - 3:00 PM. LPN #2 further identified that at one point during her shift, she had noticed that Resident #1's speech sounded different, the resident wasn't holding a cup the way he/she normally holds a cup, had difficulty raising his/her arm when she applied the blood pressure cuff, and wasn't the way she normally saw the resident. LPN #2 indicated that Resident #1's vital signs were stable and she reported her observations to a female nurse supervisor but could not remember the supervisor's name. LPN #2 further indicated that the nursing supervisor told her that Resident #1 had been declining, there were talks about starting hospice, and that she would notify the resident representative. LPN #2 identified that she was not aware if the supervisor had completed an assessment or notified the APRN. LPN #2 indicated that Resident #1 appeared ok for the remainder of her shift, took medications without an issue, and when she saw him/her the next morning, he/she seemed ok. Interview with the DNS on 11/18/25 at 8:20 AM identified that she would have expected an RN assessment, including an assessment of Resident #1's neurological status, to have been completed. Interview with the 7:00 AM - 3:00 PM RN Supervisor (RN #6) on 11/18/25 at 10:36 AM identified that based off a review of the nursing schedule, she was the only daytime nurse supervisor on 10/19/25, but she could not recall anything being brought to her attention that Resident #1 was having issues with speech or extremity weakness. RN #6 indicated that she usually was the supervisor of the first floor; Resident #1 resided on the second floor. RN #6 identified that, in general, she was aware that Resident #1 has had falls and some confusion, but she was not familiar with pending hospice status or conversations with resident representatives, nor could she recall being notified of LPN #2's (continued on next page)

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	075407	A. Building B. Wing	11/18/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	concerns. Interview with the 3:00 PM - 11:00 PM RN Supervisor (RN #7) on 11/18/25 at 1:05 PM identified that he was a new nurse to the facility and was the evening RN Supervisor working on 10/19/25. RN #7 indicated that while reading the off-going nurse's shift report it was identified that Resident #1's representative had called the facility with concern that Resident #1 was having a hard time speaking. RN #7 could not recall the name of the nurse that had written that in the shift report. RN #7 indicated that he spoke to the nursing staff, some had felt that Resident #1 was restless and could speak better than he had been speaking. RN #7 indicated that he assessed Resident #1, and he/she seemed alert and oriented, he could understand Resident #1's speech, and his/her vital signs were stable. RN #7 further indicated that while a neurological assessment was not documented as being completed, it was done and was within normal limits. RN #7 indicated that after repositioning Resident #1 settled down, had an uneventful evening, and was alert and awake. The facility's Change in a Resident's Condition or Status policy directs that prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider.

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	075407	A. Building B. Wing	11/18/2025

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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 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 review of the clinical record, facility policy, and interview for 1 of 3 residents (Resident # 52) reviewed for pressure ulcers, the facility failed to ensure weekly skin audits were completed per the facility policy and failed to ensure a comprehensive RN assessment was completed upon the identification of a new skin issue. The findings include:Resident #52 was admitted to the facility in December 2020 with diagnoses that included venous insufficiency, transient ischemic attack, and major depressive disorder. The quarterly MDS dated [DATE] identified Resident #52 had moderately impaired cognition, was always incontinent of bladder, always continent of bowel, was independent with sitting to standing and toilet transfers, and was at risk for developing pressure ulcers/injuries.The care plan dated 5/10/25 identified Resident #52 was at risk for skin breakdown as evidenced by limited mobility and incontinence, with interventions that included weekly skin assessments by licensed nurse, observing skin condition with ADL care daily and reporting abnormalities, and monitoring the skin for signs and symptoms of skin breakdown. The care plan further identified Resident #52 was resistive to care related to medication refusals, transfer status, weight refusals, incontinent care, and housekeeping, with interventions that included providing a consistent and trusted caregiver when possible. a. A physician's order dated 5/24/24 directed to complete a weekly skin audit with shower, on Friday, day shift. The Weekly Skin Evaluation dated 7/20/25 identified that there were no concerns with Resident #52's skin integrity and no new skin areas were observed. The Weekly Skin Evaluation dated 8/15/25 identified the following; continue with treatment in place for the left heel and coccyx and no new skin issues were noted. Review of the Weekly Skin Evaluations dated July 2025 through August 2025 failed to identify the weekly skin evaluations were completed on 8/1 and 8/8/25. The July 2025 through August 2025 nurse's notes failed to identify Resident #20 had refused weekly skin evaluations. Interview with LPN #3 on 11/18/25 at 9:22 AM identified that weekly skin assessments were to be completed by the charge nurse on a resident's shower day, if there was a refusal the charge nurse should notify the nursing supervisor, educate the resident and reapproach later. If the resident continued to refuse the nurse should notify the resident representative and document in a nursing note.Clinical record review with the DNS on 11/18/25 at 8:36 AM failed to identify that weekly skin evaluations were completed on 8/1 and 8/8/25. Interview with the DNS on 11/18/25 at 8:36 AM identified that she would expect to have seen 2 additional weekly skin evaluations between 7/20/25 through 8/15/25. The DNS indicated that she would expect skin evaluations to be completed by the charge nurse, weekly on the assigned shower day. The DNS identified that Resident #52 often refused care and hygiene assistance, but she would expect to see documentation if Resident #52 had refused a skin evaluation and documentation that the resident was educated and reapproached later. The facility's Skin Audits by Nursing Assistants directs that nursing assistants shall inspect skin surfaces during bath/shower and report any concerns to the nurse immediately after the task. Nursing assistants shall also report changes in skin condition that are noted during any care procedure. Notifications shall be made to the nurse verbally or in writing.b. The nurse's note dated 7/31/25 at 3:38 PM identified that the excoriated area to the buttocks was cleansed with normal saline and zinc oxide was applied. The RN Assessment note dated 7/31/25 at 3:54 PM identified Resident #52 was observed with an open area to the coccyx, the APRN was notified, and a new order was given to cleanse the area with normal saline, apply calcium alginate for 7 days every shift and as needed. All necessary parties were notified. The nurse's note dated 8/1/25 at 2:28 PM identified that this writer entered Resident #52's room with wound the PA and the resident refused assessment/wound care to the new open area on coccyx. The supervisor and DNS were notified. The nurse's note dated 8/8/25 at 11:07 AM identified that Resident #52 had a new open area to the coccyx, a Stage 2, and the resident refused to be seen by the weekly wound doctor and wound RN for a new wound consultation. Resident #52 frequently refused wound (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care and was noncompliant with recommendations. The Change in Condition note dated 8/20/25 at 12:10 PM identified a new open area measuring 3 x 2 x 0.3 noted to coccyx area, treatment was in place, Resident #52 was routinely followed by the wound team.The Wound Specialist Follow-up Progress Note dated 8/20/25 identified a new stage 2 pressure ulcer to coccyx was noted. Resident #52 had a sore on his/her bottom but was refusing care until today. Reports mild pain to the area on palpation, no concerning peri-wound erythema, drainage, or malodor. Debridement done and treatment orders placed. Interview with the DNS on 11/18/25 at 8:36 AM identified that the Wound Nurse saw Resident #52's coccyx wound on 8/8/25 and called it a stage 2 but did not document measurements. The DNS indicated that Resident #52 had documented refusals of wound assessment attempts, but she would have expected Resident #52 to have been reapproached between 7/31/25 through 8/20/25 for a complete RN assessment which would include wound measurements for tracking.The Pressure Injury Surveillance policy directs that RNs and LPNs participate in surveillance through assessment of residents and reporting changes in condition to the resident's physicians and management staff, per protocol for notification of changes and in-house reporting of new or worsened pressure injuries.

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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 review of the clinical record, facility documentation, facility policy, and interviews for 2 of 2 residents (Resident #2 and 21) reviewed for a specialty medical procedure and who were on a fluid restriction, the facility failed to monitor the resident's fluid intake to include 24-hour totals. The findings include: Resident #2 was admitted to the facility in August 2025 with diagnoses that included end stage renal disease and congestive heart failure. The admission MDS dated [DATE] identified Resident #2 had intact cognition. Resident #2 was on dialysis and had a therapeutic diet. The care plan dated 8/27/25 identified interventions that included a renal diet and an 1800 ml per day fluid restriction. A physician order dated 9/10/25 directed Resident #2 was to maintain an 1800 ml per day fluid restriction. A physician order dated 9/30/25 identified an 1800 ml fluid restriction per day and for nursing to give 720 ml per day and dietary to give 1080 ml per day. Observation on 11/16/25 at 9:50 AM identified on Resident #2's overbed table was a renal supplement container which contained 237 ml of supplement per container. Interview with Resident #2 on 11/16/25 at 9:50 AM indicated that the nurses give him/her the renal supplement each day to drink from the original cartoon. Resident #2 indicated he/she was aware he/she was on a fluid restriction. Interview with LPN #6 on 11/18/25 at 6:39 AM indicated that when a resident is on a fluid restriction the nurses document fluid intake on the TAR each shift and the nurse aides document in their system the resident's intakes for meals and snacks. LPN #6 indicated she was responsible for Resident #2, but she does not look daily to see if Resident #2 is within his/her fluid restriction for the 24 hours, she only looks at her shift. LPN #6 indicated she was not sure what nurse would be responsible to add up the fluid intakes from all 3 shifts for the 24-hour totals for a resident on a fluid restriction. LPN #6 indicated she is not sure where she would look in the computer to find the 24-hour fluid intake total. Interview with RN #4 (11:00 PM to 7:00 AM supervisor) on 11/18/25 at 6:46 AM indicated that the facility does not have a lot of residents on fluid restrictions. RN #4 indicated that currently there was no resident that she was aware of that was on a fluid restriction. RN #4 indicated in the past it was the 11:00 PM to 7:00 AM supervisors who were responsible but for right now she was not sure whose responsibility it was to do the 24-hour calculations to see if a resident had maintained their fluid restriction. RN #4 indicated she had not looked up any resident's 24-hour totals in at least a month. RN #4 indicated she would have to inquire with management to find the answer. Interview with the DNS on 11/18/25 at 9:27 AM indicated that there was no one responsible to add the 24-hour total for residents on fluid restrictions related to dialysis. The DNS indicated there was not a system in place and she was going to have to come up with a system. The DNS indicated that it (continued on next page)

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	075407	A. Building B. Wing	11/18/2025

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was the responsibility of the nurses but there was not anyone or a shift assigned to do it and to follow up with a provider if the residents went over their fluid restriction. The DNS indicated that she does not know how to find the 24-hour fluid intake totals. Review of the Fluid Restriction Policy identified it was to ensure that fluid restrictions will be followed in accordance with physician's orders. Fluid restrictions are basically the restriction of fluid intake. This may be due to an underlying medical condition that may cause a buildup such as congestive heart failure or end stage renal disease. Fluid restriction amounts can vary according to the resident's condition and the physician's judgement. The nurse will obtain the physician order for the fluid restriction and an order written to include the breakdown of the amount of fluid per 24 hours to be distributed between the food and nutrition department and the nursing department. Intake amounts will be documented on the medication record or other format as per facility protocol. The fluid restriction distribution will take into consideration the amount of fluid to be given at mealtimes, snacks, and medication passes. Review of the Hemodialysis Policy identified the facility will ensure that each resident receives care and services for the provision of hemodialysis consistent with professional standards of practice. Nutritional/fluid management including documentation of weights, resident compliance with food/fluid restrictions or the provision of meals before, during and/or after dialysis and monitoring intake and output measurements as ordered. 2. Resident #21 was admitted to the facility in November 2022 with diagnoses that included end stage renal disease and dependence on renal dialysis. A physician's order dated 6/19/25 directed for fluid restriction: 1000ml/day, dietary: breakfast-120mls, lunch-120mls, dinner-120mls (360mls/day), nursing 7a-3p: 320mls, 3p-11p: 200mls, 11p-7a: 120mls (640mls/day) every shift. The quarterly MDS dated [DATE] identified Resident #21 had intact cognition, required setup or clean-up assistance with eating, required hemodialysis, and was on a therapeutic diet. The care plan dated 8/29/25 identified Resident #21 receives dialysis related to renal failure, with interventions that included encouraging a fluid restriction of 1000mls per day. The care plan further identified that Resident #21 had behaviors related to the refusal of the plan of care including dialysis, with interventions that included resident and family education surrounding the importance of compliance with the plan of care. The Kardex Fluid Intake flowsheets (where the nurse aides document fluid intake), and the MAR Diet Fluid Restriction flowsheets (where the nurses document fluid intake) dated 11/1/25 – 11/14/25 were independent of one another and total fluid intake was not calculated. Further, review of both the Kardex Fluid Intake flowsheets and the MAR Diet Fluid Restriction flowsheets identified that of the 14 days, the resident went over the 1000ml fluid restriction 10 times. Interview with Resident #21 on 11/16/25 at 7:40 AM identified that he/she wasn't sure if all the nursing staff realized that he/she was on a fluid restriction, as some staff had delivered him/her water pitchers. Interview with NA #3 on 11/16/25 at 2:13 PM identified that as far as she knew, Resident #21 was not on a fluid restriction, but he/she does get a red tray which means the resident has a specialty (continued on next page)

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	075407	A. Building B. Wing	11/18/2025

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	diet. NA #3 indicated that fluid restrictions were typically reported to nurse aides by the nurse, but it should also be listed on the care card. NA #3 indicated that Resident #21 has his/her own food and drink and was able to make his/her own decisions, and that during the breakfast Resident #21 usually has 180mls of coffee, 120mls of orange juice, sometimes 120mls of Ginger ale, and whatever the nurse provides with the meds. Interview with LPN #3 on 11/18/25 at 9:22 AM identified that Resident #21 was on a fluid restriction and was compliant. LPN #3 indicated that she would communicate to the nurse aide during report that Resident #21 was on a fluid restriction and that she would expect the nurse aides to come to her if they were going to serve Resident #21 fluids. LPN #3 identified that she was not sure where the nurse aides document the fluids that are passed during meals, and she was not sure who was responsible for tallying daily fluid intake totals. Interview with NA #4 on 11/18/25 at 9:28 AM identified initially that she wasn't sure if anyone on her assignment was on a fluid restriction but was able to confirm that Resident #21 was on a fluid restriction. NA #4 indicated that she documents Resident #21's fluid intake in the chart and would notify the nurse of his/her intake. NA #4 identified that she typically served Resident #21 juice with breakfast and water or juice with lunch. Interview with the RN Supervisor (RN #6) on 11/18/25 at 12:19 PM identified that when a resident has an order for a fluid restriction, she would sit with the Registered Dietitian and review fluid totals to be administered by nursing and nourishment during each shift, and it would be the responsibility of the charge nurse to ensure the patient received what they were ordered for that shift. RN #6 indicated that the charge nurse should follow up with the nurse aide either verbally or verify the documentation to ensure accurate shift totals, and if there was an issue with the resident's fluid intake then they should notify the RN supervisor. RN #6 further indicated that she was not sure if the documentation that the nurse aides enter in the Kardex imports to the shift totals in the MAR. RN #6 further indicated that she was not sure how the 24-hour totals were tallied. Interview with the DNS on 11/18/25 at 7:38 AM identified that the nurse aides document fluid intake in the Kardex in POC and the nurses document fluid intakes in the MAR, but currently there was not a mechanism in place to gather daily totals. The DNS indicated that the charge nurse would be responsible to ask the nurse aide for a resident's shift intake total or look at the nurse aide's documentation under the task flowsheet. The DNS indicated that moving forward she would implement an I&O book for residents on a fluid restriction to ensure accurate daily totals were being captured. The Fluid Restriction policy directs that the nurse will obtain and verify the physician's order for the fluid restriction and an order written to include the breakdown of the amount of fluid per 24 hours to be distributed between the food and nutrition department and the nursing department, and will be recorded on the medication record or other format as per facility protocol, the fluid restriction distribution will take into consideration the amount of fluid to be given at meal times, snacks, and medication passes. The policy further directs that water will not be provided at the bedside unless calculated into the daily total fluid restriction, the risks and benefits of fluid restriction will be explained to the resident and or resident representative. The resident has the right to refuse the fluid restriction, and if refused, documentation should support the reason for the refusal, the education of the risks and benefits, and any supporting documentation of the resident's continued refusal, assessment for any changes in condition related to the refusal, and the notification of the physician about the resident's refusal.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interview for 1 resident (Resident #4) reviewed for dental services, who required an extraction of a tooth and was receiving Eliquis (a blood thinner), the facility failed to hold the Eliquis which resulted in a delay in having the tooth extracted. The findings include:Resident #4 was admitted to the facility in October 2022 with diagnoses that included Parkinson's disease and history of thrombosis (clot) of the left femoral vein.An APRN progress note dated 11/13/24 directed to continue antibiotic for tooth/dental infection.A change in condition note dated 11/18/24 identified an infection in tooth #21.The quarterly MDS dated [DATE] identified Resident #4 had moderate cognitive impairment, required assistance with personal care and had no dental discomfort.The care plan dated 5/31/25 identified Resident #4 was at risk for oral health problems related to broken/missing teeth and was receiving anticoagulant (blood thinning) therapy related to a history of deep vein thrombosis. Interventions included dental consultation and monitor for symptoms of anticoagulant complications such as bleeding.A dental note dated 7/26/25 recommended antibiotic for a tooth infection.A dental consultation dated 8/13/25 identified tooth #21 has PAP. The resident went to an outside dentist who ordered antibiotics which have stopped working and the resident is in pain. Recommendations included to remove tooth #21 in the facility. Actions required by nursing home staff included to have the responsible party sign consent for extraction for tooth #21. This tooth has a failed RCT and is causing pain. Recommended treatment included extraction of tooth #21.Although requested, a copy of the signed consent for the extraction of tooth #21 was not provided.A dental consult dated 10/13/25 identified Resident #4 had discomfort from tooth #21. The tooth was to be removed today (10/13/25) but this did not occur as the resident was receiving Eliquis (blood thinner). The extraction date was rescheduled for 10/29/25.A dental note dated 10/29/25 identified the extraction did not occur due to resident unavailability and because the Eliquis was not held for the procedure.A nurse's note dated 10/29/25 identified Resident #4 returned from an out of facility appointment.Review of the medical and nursing progress notes dated 10/13/25 through 10/29/25 failed to identify the dental consultations had been reviewed by the APRN or that a physician's order was in place to pause the Eliquis for the extraction of tooth #21 on 10/13/25 or 10/29/25. Interview and facility documentation review with the DNS on 11/17/25 at 6:23 AM identified the Unit Manager and Medical Records staff were responsible for scheduling dental services routinely and as needed. A list was sent electronically by the consultant provider (provides onsite integrated healthcare to long-term care facilities) to the Unit Manager, Medical Records staff and herself to notify them of the date, time and purpose of the visit. A summary of recommendations for all residents seen were then sent following the consultation for review by medical records and Unit Manager for any further action. The DNS further identified recent replacement of the Unit Manger as a contributing factor to the missed appointments.Interview and clinical record review with APRN #1 on 11/17/25 at 7:43 AM identified she routinely received a list of residents scheduled to be seen for dental services and reviewed recommendations and prescribed orders based on recommendations. APRN #1 was unable to recall if she reviewed the dental consultation for 10/13/25 noting the extraction was not performed due to the Eliquis not being held. However, based on that information, APRN #1 indicated she would have contacted the resident representative to discuss any concerns, written an order to hold the Eliquis and documented her actions. APRN #1 was unaware of any current dental related concerns related to Resident #4 but would speak to the DNS.Interview and facility documentation review with the Medical Records staff on 11/17/25 at 8:40 AM identified communication for all dental appointments were electronically transmitted from the dental provider to the DNS, Unit manager and herself. The Medical Records staff would print the list and provide it to the nursing units. A summary of recommendations from the visits were then sent to the same personnel along with a separate individual consult detailing findings for (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	each resident that were filed in the overflow. The Medical Records staff indicated that she may notify the unit manager of recommendations if she noticed them. However, the Unit Manager was responsible for reviewing the consultations and summary of recommendations with the APRN. The Medical Records staff recalled discussing obtaining consent for Resident #4's extraction with the Unit manager, but not the holding the Eliquis which would have been the responsibility of the previous Unit Manager, who has since resigned.Interview with the Unit Manager, RN #2 on 11/17/25 at 9:04 AM identified she had been functioning in the role for approximately one month and was only recently added to the dental providers electronic communication thread. RN #2 was not aware which residents were routinely scheduled for dental services, the type of service, or appointment times as these were arranged through the Medical Records staff. RN #2 indicated she was responsible for referring medical concerns/recommendations noted in consultations to the APRN but was not in the role at the time Resident #4?s findings would have been reviewed. RN #2 further identified she had no existing system to track consult findings and recommendations that require APRN follow-up, nor was one provided by the previous Unit Manager and instead, managed these matters by memory. Additionally, RN #2 was unaware of any existing dental concerns related to Resident #4 or need for APRN follow up.Interview with Person #1 on 11/17/2025 at 9:48 AM identified he/she was aware that Resident #4 had been experiencing dental issues. Person #1 indicated although he/she could not recall being made aware of the missed dental appointment on 10/29/25 or any concern related to the need to hold a blood thinning medication, Resident #4 would not have missed that appointment had he/she been aware as the tooth had been bothering him/her for a while.Subsequent interview with the DNS on 11/17/25 at 2:00 PM identified she would expect consultation findings and recommendations to be addressed timely.Subsequent to surveyor inquiry, the Eliquis was held 11/17/25 and 11/18/25 and the resident obtained the extraction of tooth #21 on 11/18/25.Interview with Dentist #1 on 11/18/25 at 10:08 AM identified Resident #4 had sustained a crack in a previous root canal and developed a latent infection over time with some sensitivity, necessitating the need for the removal of the tooth, The extraction was planned for 10/13/25. On the morning of the scheduled extraction, Dentist #1 inquired about blood thinning medications and was informed it was not held so the procedure did not take place. The extraction was again deferred on 10/29/25 when in part, the Eliquis was still not placed on hold prior to the procedure. While the delay in extraction did not result in an acute infection or harm, Dentist #1 relied on the facility to review a residents medication list and hold the blood thinner prior to a dental procedure or call if there were any questions as a list was routinely sent to the facility about a week prior to a visit noting the date, resident and type of service so the facility could sufficiently prepare.A review of the facility policy for Dental Services directed routine and emergency services were to be available to meet the residents' oral health. These services were to be provided through a contract agreement with a local dentist, personal or community dentist or other health care dental services.Attempts to interview the previously employed Unit Manager were unsuccessful.

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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 observation, review of the clinical record, facility documentation, facility policy, and interviews for 1 of 3 residents (Resident #11) reviewed for pressure ulcers, the facility failed to ensure that staff adhered to enhanced barrier precautions (EBP) when providing care to the resident, and for 2 of 4 medication carts, the facility failed to ensure the medication carts were maintained in a clean and sanitary manner. The findings include: 1. Resident #11 was admitted to the facility on [DATE] with diagnoses that included hemiplegia affecting the right side, stage 3 pressure ulcer of the back, and weakness. A physician's order dated 10/8/25 directed enhanced barrier precautions (EBP) as a preventative measure due to a wound. The admission MDS dated [DATE] identified Resident #11 had moderately impaired cognition, was always incontinent of bowel, frequently incontinent of bladder and was dependent on staff to assist with toileting, bathing, and dressing. The care plan dated 10/15/25 identified Resident #11 had a stage 3 pressure injury to the sacrum. Interventions included following facility protocols for the treatment of the injury.Observation on 11/18/25 beginning at 11:07 AM identified a PPE cart and signage posted to the right side of Resident #11's exterior door frame which identified:Stop: Enhanced Barrier Precautions. Providers and staff must wear gloves and a gown for the following high-contact resident activities: Dressing Bathing/showering Transferring Changing Linens Providing Hygiene Changing briefs or assisting with toileting Continued observation on 11/18/25 beginning at 11:07 AM identified NA #9 was inside Resident #11's room providing care to Resident #11. NA #9 was observed standing in front of Resident #11 and brushing his/her teeth. Resident #11 was seated in a wheelchair. NA #9 was holding an emesis basin with her left hand and brushing Resident #11's teeth with her right hand while wearing clear gloves but no other PPE. NA #9 finished providing oral care to Resident #11, entered Resident #11's bathroom with the toothbrush and emesis basin. NA #9 stepped out of the bathroom and walked to Resident #11's bed with a large clear plastic bag. NA #9 was observed removing soiled linens from Resident #11's bed. NA #9 had clear gloves on and no other PPE. After removing and rolling the linen into a large ball, NA #9 partially placed half of the soiled linen into the clear bag but had difficulty fitting the bag around the linen due to size. NA #9, who was wearing a black scrub top, was observed using her abdomen to push the soiled linen while she used both hands to hold onto the bag. Interview with NA #9 immediately following this observation initially identified that she was not aware Resident #11 was on EBP. This surveyor showed NA #9 the signage posted outside Resident #11's door and NA #9 indicated while she did see the signage prior to entering Resident #11's room, she did not observe the PPE cart outside of the room prior to entering so she did not think she needed to don any PPE. Observation at that time indicated a PPE cart directly outside Resident #11's room. NA #9 identified she was not sure when she needed to don PPE when providing care for Resident #11, and began to read the sign. After reading the EBP sign, NA #9 identified she had been out of work for several days and it was her first day back.Interview and review of facility in-service documentation with RN #3 (Infection Control Nurse) on 11/18/25 at 11:45 AM identified that NA #9 had completed an in-service regarding EBP in 7/2025. RN # 3 identified she was aware that NA #9 had issues with maintaining infection prevention precautions for residents but was not aware of any recent issues and identified she would provide additional education to NA #9.Interview with the DNS on 11/18/25 at 12 PM identified that any staff caring for a resident on EBP should don PPE during any high contact activity which included providing hygiene and handling soiled linen. The DNS identified she was aware of issues with NA #9 in the past related to infection prevention and would be addressing the matter. The facility policy on enhanced barrier precautions directed enhanced barrier precautions was an infection control intervention designed to reduce transmission of multi resistant organisms and employed targeted gown and gloves during high contact resident care activities that included providing hygiene and changing linens. The policy further directed enhanced barrier precautions would be used for residents with a wound for the (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	duration of the affected resident's stay at the facility or until resolution of a wound that placed the resident at higher risk. 2. Observation with RN #6 on 11/18/25 at 9:10 AM identified the following. One light-colored capsule and 3 small tablets that were not packaged, and scattered debris underneath blister cards in one of the interior medication drawers. Further observation of the medication cart identified a significant amount of debris located behind the medication drawers at the bottom of the cart. The debris included a large amount of light pink powder throughout the bottom of the cart, along with what appeared to be partially crushed unpackaged tablets (approximately 6 in total) along with opened individual blister packets, paper, and plastic pieces.Interview with RN #6 during this observation identified that she typically went through the medication cards on the 1st floor unit twice monthly but there was no set schedule and no specific nurse assigned to ensure the carts were cleaned and organized. RN #6 identified that she had never attempted to look behind the drawers or the bottom of the cart, and was not aware there were loose medications located beneath the blister packs.Observation and interview with RN #2 on 11/18/25 at 9:32 AM of one of 2 medication carts located on the 2nd floor identified 6 various small tablets that were not packaged and scattered debris underneath blister cards in one of the medication drawers. Another medication drawer was observed to contain a small cardboard box with the top portion of the box removed. The box contained 11 individually packaged pen needles (used for insulin pens) and also contained 4 large white tablets that were unpackaged at the bottom of the box. Further observation of the medication cart also identified a significant amount of debris located behind the medication drawers at the bottom of the cart. The debris included multiple jagged pieces of clear, green, pink and white plastic that appeared broken off, multiple unpackaged tablets, a blank patient wristband, and 2 clear plastic ampules that appeared unopened. Additionally, this portion of the cart appeared to have multiple areas of a white substance scattered and located along the interior portions of the back and sides of the cart.Interview with RN #2 during the observation identified she recently began working at the facility approximately one month prior. RN #2 identified she had not been educated on cleaning of the medication carts, and was not aware if it had to be done.Interview with the DNS on 11/18/25 at 12 PM identified she was not aware of issues with the medication carts but it was the responsibility of all licensed nursing staff to ensure that the medication carts were kept clean and free of any loose medications or debris.The facility policy on storage of medications directed that the facility would store medications in a safe, secure, and orderly manner. The policy further directed that nursing staff were responsible for maintaining medication storage and preparation areas in a clean, safe and sanitary manner.