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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075412	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lord Chamberlain Manor	7003 Main Street Stratford, CT 06614

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 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. Based on clinical record review, facility documentation review, facility policy review, and interviews for one resident (Resident #1) reviewed for respiratory services, the facility failed to ensure that the medical provider was notified timely of a change in condition. The findings include: Resident #1 was admitted to the facility with diagnoses that included chronic obstructive pulmonary disease (COPD), sleep apnea, chronic cellulitis, morbid obesity and congestive heart failure. The nursing admission form dated 2/20/2025 identified Resident #1 was alert and oriented, experienced shortness of breath or trouble breathing with exertion, and was on two (2) liters (L) of oxygen (O2) through a nasal and a continuous positive airway pressure (CPAP) device. Resident #1 had an unstageable pressure injury on the coccyx that measured 12 centimeters (cm) in length by 14 cm in width, had extremity weakness, and used a wheelchair. A 48-hour discharge planning meeting form dated 2/20/2025 identified Resident #1 required a Hoyer (mechanical) lift transfer with an assist of two (2) staff. A physician's order dated 2/21/2025 directed an Average Volume - Assured Pressure support (AVAP -a type of CPAP) machine (provided non-invasive positive airway ventilation/support) at bedtime and during naps due to sleep apnea. Resident #1 liked to wear the device between 11:00 PM and 1:00 AM and 2:00 PM to 4:00 PM. Offer Resident #1 to wear the device for a minimum of 6 hours total via a full-face mask with three (3) liters per minute (LPM) oxygen. Continuous O2 at three (3) LPM via nasal cannula, do not titrate. A nursing note written by LPN #1 dated 2/22/2025 at 10:51 PM identified Resident #1 refused CPAP use. Resident #1 had vaginal bleeding that Resident #1 reported was normal due to Eliquis (blood thinner) use. RN assessed and issue noted for APRN to address. Record review failed to identify the MD/APRN was notified of the vaginal bleeding noted on 2/22/2025. A nursing note by RN #2, nursing supervisor, on 2/23/2025 at 7:17 AM (8 hours and 26 minutes after the note that identified the bleeding) identified that the on-call Physician Assistant (PA) was notified of the vaginal bleeding, and orders were obtained for stat bloodwork and to place Eliquis on hold. (continued on next page)

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

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with RN #2 on 4/3/2025 at 11:41 AM identified she was the nursing supervisor from 7:00 PM to 7:00 AM on 2/22/2025 (shift ended on 2/23 at 7 AM) and she recalled the charge nurse had called her to assess Resident #1 on 2/22/2025 due to vaginal bleeding. Resident #1 was on a blood thinner, vital signs were stable, had no complaints, and that he/she had vaginal bleeding prior that was normal due to the blood thinner. RN #2 stated she made a note in the APRN follow-up book regarding the vaginal bleeding. Interview failed to identify that she notified the APRN/MD on 2/22/2025. Interview with APRN #1 On 4/3/2025 at 11:55 AM identified she would have wanted to be notified of the vaginal bleeding. a. A nursing note written by LPN #2 dated 2/23/2025 at 6:33 AM identified Resident #1 was on oxygen at four (4) L via nasal cannula and refused to wear the CPAP throughout the night, despite review of importance. Resident #1 became short of breath when turned with four (4) staff assistance and requested CPAP to be applied. A nursing note by LPN #2 dated 2/23/2025 at 6:57 PM identified that Resident #1 refused AVAP administration at bedtime. A nursing note on 2/24/2025 at 4:07 AM by RN #2 identified she was called to assess the resident who was sleeping, with pulse oximetry (pulse ox) 88% (normal over 90%) on oxygen at three (3) L via nasal cannula. Resident #1 was difficult to arouse initially, Resident #1 was placed on AVAP machine with pulse ox increased to 96% and Respiratory therapy (RT) was updated. RN #2 nursing note dated 2/24/2025 at 6:52 AM identified Resident #1 was increasingly lethargic, pale and the APRN was notified. Resident #1 was transferred to the hospital for evaluation. Interview with LPN #2 on 4/3/2025 at 2:05 PM identified that she cared for Resident #1 on 2/22 and 2/23/2025 on the 11:00 PM to 7:00 AM shift. LPN #2 stated Resident #1 would refuse the AVAP at bedtime and did not wear it overnight. She continued that she believed she had reported the refusals to the nursing supervisor on 2/22 and 2/23/2025. Interview with LPN #3 who cared for Resident #1 on 2/22/2025 and 2/24/3035 on the 7:00 AM to 3:00 PM shift on 4/3/2025 at 1:08 PM identified that Resident #1 liked to wear the AVAP after breakfast, but it was always reported that Resident #1 had refused to wear the AVAP at bedtime and overnight. She was aware that the refusals had been communicated to the RT but could not recall if it had been reported to the APRN. She stated the RT generally handled any issues with the CPAP devices. Interview with RN #2 on 4/3/2025 at 11:41 AM identified she was the nursing supervisor from 7:00 PM to 7:00 AM on 2/23/2025 (shift ended on 2/24 at 7 AM) RN #2 stated she was not notified that Resident #1 had refused to wear the AVAP device. RN #2 stated if she was notified, she would have reported it and stated anytime a resident refuses to wear their AVAP device, it should be reported as it is a physician's order. RN #1 stated she assessed Resident #1 on 2/24/2025 about 4:00 AM due to increased lethargy with a pulse ox of 88% on three (3) L of O2, and she did not recall that the charge nurse notified her Resident #1 had refused the AVAP on 2/24/2025. RN #2 placed Resident #1 on the AVAP after her assessment and notified the Respiratory Therapist (RT) about Resident #1's pulse ox level while sleeping without the AVAP. RN #2 stated she would have contacted the APRN as well as the RT if she had known Resident #1 had refused the AVAP. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with RN #1/acting DON, on 4/3/2025 at 1:16 PM identified she would have expected the nurses to contact the APRN each time Resident #1 refused to wear the AVAP at bedtime as ordered by the physician. RN #1 stated residents can refuse to wear the AVAP, but the APRN should be notified when a resident refuses to wear an ordered AVAP. RN #1 stated although the APRN should have been notified, she did not know why the staff had not reported Resident #1's refusals. Interview with APRN #1 On 4/3/2025 at 11:55 AM identified that if a Resident refused to wear their CPAP or AVAP device, she would need to be notified, as it is a physician's order. APRN #1 stated in her experience, when any resident had refused to wear a CPAP or AVAP, having the MD or APRN reinforce the importance of using the device had been successful when the nursing staff were unable to convince the resident to wear it.