STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075412	A. Building B. Wing	06/11/2025

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** \ Based on clinical record review, facility documentation review, facility policy review, and interviews for one resident (Resident #1) reviewed for accidents, the facility failed to ensure the physician was notified timely of an increase in agitation. The findings include: Hospital Discharge summary dated [DATE] identified Resident #1 presented to the emergency department from home on 5/21/2025 after a fall. During hospitalization, Resident #1 was identified as a fall risk, with interventions that included a bed alarm, chair alarm, and bilateral wrist restraints required. Resident #1 had diagnoses that included dementia with behavioral disturbance and a history of falls. Fall risk dated 5/25/2025 at 1:48 PM identified a history of one (1) to two (2) falls in the last 3 months. Resident #1 received a score of nineteen (19), indicative of a high fall risk. Nursing admission assessment dated [DATE] at 3:35 PM identified Resident #1 was confused and disoriented, and had behaviors that included intermittent sleeping and wandering at night. Resident #1 was noted to have an unsteady gait and poor balance standing. A nursing note dated 5/25/2025 at 6:58 PM by RN #1 identified Resident #1 was alert/confused, status post a new admission and was ambulating without assistance with a walker improperly into the hallway. Resident #1 was assisted into a wheelchair with increase in agitation noted. Resident #1 was observed yelling and screaming stating, I'm going home. Assistance with incontinence care was encouraged but refused, and Resident #1 wheeled him/herself into the hallway in attempt to leave. Resident #1 was redirected with education provided. RN #2/RN Supervisor was updated, and a new PRN (as needed) Trazodone (anti-depressant) order was obtained. Medication was offered by RN #2 but was refused and Resident #1 was then placed at the nurse's station with RN #2. Resident #1 was offered the Trazodone a second time, and he/she accepted the medication. Resident #1 remained at the nursing station and a UTI (urinary tract infection) watch was placed. A nursing note dated 5/25/2025 at 7:16 PM by RN #2 identified Resident #1 was very restless, combative, getting up and walking around, being loud, and not easily redirected. MD #1 was notified, obtained an order for Trazodone daily at bedtime as needed, and was administered with results pending. (continued on next page)

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	A nursing note dated 5/26/2025 at 3:19 AM by LPN #1 identified Resident #1 refused vital signs and was resting in bed most of the shift. Safety precautions maintained, call bell within easy reach and monitoring continued. A nursing note dated 5/26/2025 at 5:30 AM by LPN #1 identified Resident #1 was combative with staff, refused medications despite education provided, and was a high fall risk and need constant redirecting. A Brief Interview for Mental Status (BIMS) dated 5/26/2025 at 10:36 AM identified a score of 8, indicative of severe cognitive impairment. Although the physician was notified of Resident #1's agitated behaviors on 5/25/2025, clinical record review failed to identify the nursing staff alerted a physician regarding Resident #1's increased agitation noted on 5/26/2025 at 5:30 AM. Facility reportable event dated 5/26/2025 at 12:35 PM identified Resident #1 required assistance to ambulate and transfer, was combative and non-compliant with directions and call light use, and had an unwitnessed fall. Resident #1 was found lying, face up, on the floor near his/her bed with a reddened area was found to the back of the head, and was transferred to the hospital. Interview with NA #1 on 6/11/2025 at 11:40 AM identified Resident #1 was unstable on his/her feet, was a high fall risk, and was abusive to staff during the shift prior to the fall (night shift). Further, NA #1 stated Resident #1 was not agitated during her shift on 5/26/2025 (from 7 AM to 3 PM). Interview with MD #1 on 6/11/2025 at 2:20 PM identified Resident #1 was a new admission on [DATE], and he was notified of an episode of agitation soon after admission. MD #1 identified he was not notified of the increased agitation behavior noted on 5/26/2025 at 5:30 AM and he would have wanted to be notified. MD #1 stated if he was notified, he would have given new orders for resident safety which may have included a new medication, close monitoring, floor mats, or may have directed a transfer to the hospital for evaluation. MD #1 identified that although he was not notified of the increased agitation, his expectation is that the nursing staff should have notified him to ensure another intervention was ordered/provided for resident safety. Interview and clinical record review with DON (Director of Nursing) on 6/11/2025 at 2:50 PM identified her expectation was that the nursing staff should have notified the physician regarding Resident #1's increase in agitation of behavior that was noted on 5/26/2025 at 5:30 AM. The interview failed to identify why the physician or on-call provider was not notified. Review of the facility Notification, Change in Condition, and Change in Treatment/Services Policy dated 2/2025 identified the facility will inform the resident, resident's physician and the resident's family/legal representative when there is a change in condition.