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	09/23/2025

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 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. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation review, facility policy review, and interviews for two residents (Resident #1 and #2) reviewed for medication error, the facility failed to include anticoagulation therapy in the resident care plan timely for a resident on Coumadin. The findings include1. Resident #1's hospital Discharge summary dated [DATE] directed Coumadin (Warfarin) (anticoagulant, used to prevent blood clots), 4 milligrams (mg) daily and to maintain an International Normalized Ratio (INR, blood test to measure how long blood takes to clot, used to monitor the effectiveness Coumadin) between 2.5 and 3.5. Further, the Summary directed to monitor INR every other day and adjust Coumadin dose if needed. Record review identified Resident #1 was admitted to the facility on [DATE] with diagnoses that included cerebral infarct with hemiplegia/hemiparesis (paralysis/weakness) affecting the right dominant side, atrial fibrillation (rapid irregular heartbeat), and antiphospholipid syndrome (autoimmune disorder that produces antibodies which can lead to blood clots). Physician order dated 8/1/2025 directed to administer Coumadin 4.5 mg daily. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of nine out of fifteen (9/15), indicated moderate cognitive impairment, and received an anticoagulant during the last seven (7) days. Review of the clinical records identified Resident #1 received Coumadin from 7/31 through 9/3/2025. Review of the Resident Care Plan (RCP) dated 8/8/2025 failed to identify a care plan related to anticoagulation therapy. 2. Resident #2's diagnoses included atrial fibrillation and transient ischemic attack (TIA). Record review identified Resident #2 was admitted during 8/2025. Physician order dated 8/12/2025 directed Coumadin 4 milligrams (mg) daily. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had a Brief Interview for Mental Status (BIMS) score of fifteen out of fifteen (15/15), indicative of intact cognition, and received an anticoagulant during the last seven (7) days. Record review identified Resident #2 received Coumadin from 8/11 through 9/23/2025. Review of the Resident Care Plan (RCP) dated 8/21/2025 failed to identify the record included a care plan related to anticoagulation therapy. Interview and review of Resident #1 and #2's clinical records with the DON, Administrator, and RN #2 on 9/23/2025 at 3:30 PM identified both Resident #1 and #2 received Coumadin. Interview identified it was the nursing team or MDS team responsibility to ensure care plans reflect resident needs and treatment plan, and a comprehensive care plan should be completed 14 to 21 days after a resident's admission date. The facility was unable to provide documentation of a care plan for anticoagulant use for Resident #1 and Resident #2, and indicated both residents should have care plans in place. Interview failed to identify why the care plans were not included for Residents #1 and #2. Review of the undated Care Plan Policy directed in part, the interdisciplinary team (IDT) is responsible for the development of an individualized comprehensive care plan for each resident. A comprehensive care plan is developed within seven (7) days of completion of the resident assessment (MDS), and will be updated by Nursing and/or the IDT as needed. Review of the undated Coumadin Protocol Policy directed in part, all residents receiving Coumadin will have a care plan for risk for bleeding related to anticoagulation therapy.

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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 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. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation review, facility policy review, and interviews for one of three (Resident #2) reviewed for medication error, the facility failed to ensure Coumadin was administered to maintain the INR in accordance with physician orders. The findings include: Review of the Hospital Discharge summary dated [DATE] directed Coumadin (anticoagulant used to prevent blood clots), 4 milligrams (mg) daily for six (6) days, and take 5 mg, once a week, on Thursdays. Further the Summary directed an International Normalized Ratio ((INR, blood test to measure how long blood takes to clot, used to monitor the effectiveness Coumadin) goal to be maintained between 2.0 and 3.0. Resident #2's diagnoses included atrial fibrillation and transient ischemic attack (TIA). The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had a Brief Interview for Mental Status (BIMS) score of fifteen out of fifteen (15/15), indicative of intact cognition, and received an anticoagulant during the last seven (7) days. Review of the clinical record identified the following timeline for Resident #2's Coumadin management with the corresponding treatment plan: 8/12/2025, the INR level was 3.0 (within the therapeutic range). APRN #2 ordered Coumadin 4 mg daily, ordered an INR on 8/15/2025, and APRN #2 signed the Coumadin Tracking Form. Record review identified LPN #3 transcribed the order incorrectly; LPN transcribed the Coumadin to start on 8/13/2025, and Resident #2 did not receive any Coumadin on 8/12/2025. 8/15/2025, the INR level was 3.7 (over the therapeutic range by 0.7). New orders were obtained to hold the Coumadin and obtain an INR on 8/16/2025. 8/16/2025, the INR level was 2.5 (within the therapeutic range). No new orders were located in the clinical record. 8/18/2025, the INR level was 1.8 (under the therapeutic level by 0.2). No new orders were located in the clinical record. 8/19/2025, the INR level was 1.6 (under the therapeutic level by 0.4). New orders were obtained for Coumadin 5 mg with the next INR on 8/22/2025, and the Tracking Form was signed by APRN #1. 8/22/2025, the INR level was 2.8 (within the therapeutic range). APRN #2 ordered Coumadin 5 mg daily for five (5) days, the next INR was ordered for 8/28/2025, and APRN #2 signed the Coumadin Tracking Form. Record review identified LPN #4 transcribed the order incorrectly; the order was transcribed to start on 8/23/2025 and Resident #2 did not receive Coumadin on 8/22/2025. 8/29/2025, the INR level was 3.4 (over the therapeutic range by 0.4). No new orders were located in the clinical record. 9/2/2025, the INR level was 1.7 (under the therapeutic level by 0.3). APRN #1 ordered Coumadin 7 mg daily until 9/4/2025 with the next INR on 9/5/2025. Record review identified LPN #5 transcribed the order incorrectly; the order was transcribed to start on 9/3/2025, and Resident #2 did not receive Coumadin on 9/2/2025. 9/5/2025, the INR level was 2.5 (within the therapeutic range). New orders were obtained to hold the Coumadin for two (2) days (prior order was for Coumadin 7 mg), obtain an INR on 9/10/2025, and APRN #2 signed acknowledgement of the tracking form. 9/10/2025, the INR level was 6.2 (over the therapeutic range by 3.2). a new order was obtained that directed to hold the Coumadin for two (2) days, obtain an INR on 9/11 and 9/12/2025, and APRN #2 signed acknowledgement of the tracking form. 9/11/2025, the INR level was 3.1 (over the therapeutic range by 0.1). The Coumadin Tracking Form identified the current Coumadin dose was on hold, directed to continue to hold Coumadin for one (1) day and obtain an INR on 9/12/2025. APRN #2 signed acknowledgement of the tracking form. 9/12/2025, the INR level was 1.6 (under the therapeutic level by 0.4). APRN #2 placed a new order for Coumadin 5 mg. Review of the Coumadin Tracking form dated 9/12/2025 identified a new Coumadin order of 1.5 mg (conflicted with the clinical record of 5 mg), and to obtain an INR on 9/15/2025. 9/15/2025, the INR level was 1.9 (under the therapeutic level by 0.1). APRN #2 placed a new order for Coumadin 1.5 mg (despite the previous order for the Coumadin 5 mg dose did not achieve a therapeutic INR goal). 9/18/2025, the INR level was 1.3 (under the therapeutic level by 0.7). the prior Coumadin order was for 1.5 mg. New orders were obtained for Coumadin 10 mg for one (1) dose with an INF on 9/19/2025, and APRN #2 signed acknowledgement of the tracking form. 9/19/2025, the INR level was 1.8 (under the therapeutic level by 0.2). A new order was obtained for Coumadin 10 mg for one (1) dose, then 6 mg for the following two (2) days, an INR on 9/22/2025, and APRN #2 signed acknowledgement of the tracking form. 9/22/2025, the INR level was 3.3 (over the therapeutic level by 0.3). New orders were obtained for Coumadin 5 mg, and an INR to be drawn on 9/24/2025, and APRN #2 signed acknowledgement of the tracking form. Record review identified Resident #2 missed doses of Coumadin on 8/12, 8/22 and 9/2/2025. Additional review identified the INR results were under the therapeutic level 8/18 and 8/19, 9/2, 9/12, 9/15, 9/18, and 9/19/2025. INR results were

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical record, facility documentation, facility policy, and interviews for one of three residents (Resident #1) reviewed for medication errors, the facility failed to ensure Coumadin therapy to adequately maintain INR levels as ordered, failed to monitor the INR levels timely, and failed to act on the INR results timely in accordance with physician orders. The failures resulted in a finding of Immediate Jeopardy. The finding includes: The Hospital Discharge summary dated [DATE] directed Coumadin (Warfarin) (anticoagulant, used to prevent blood clots), 4 milligrams (mg) daily and to maintain an International Normalized Ratio (INR, blood test to measure how long blood takes to clot, used to monitor the effectiveness Coumadin) between 2.5 and 3.5. Further, the Summary directed to monitor INR every other day and adjust Coumadin dose if needed.Record review identified Resident #1 was admitted to the facility on [DATE]. Resident #1's diagnoses included cerebral infarct with hemiplegia/hemiparesis (paralysis/weakness) affecting the right dominant side, atrial fibrillation (rapid irregular heartbeat), and antiphospholipid syndrome (autoimmune disorder that produces antibodies which can lead to blood clots).The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of nine out of fifteen (9/15), indicated moderate cognitive impairment, and received an anticoagulant during the last seven (7) days. Review of the clinical records identified the following timeline for Coumadin and INR monitoring: 8/1/2025 INR test results were 2.6 (within the goal of 2.5 to 3.5). New orders were obtained to administer Coumadin 4.5 mg and the next INR on 8/3/2025. APRN #1 signed acknowledgement on the Coumadin Tracking Form. INR results were not located for 8/3/2025. Record review identified Coumadin 4 mg was administered from 8/1 through 8/5/2025. 8/5/2025 INR test results level were 1.7 (under the goal by 0.8). The Coumadin Tracking Form indicated conflicting information, that the current Coumadin dose was 4 mg, and new orders were obtained for 4.5 mg with the next INR due on 8/8/2025. APRN #1 signed acknowledgement of the tracking form. Record review identified Coumadin 4.5 mg was administered from 8/5 through 8/7/2025. 8/8/2025 INR test results were 1.7 results (goal was 2.5 to 3.5). New orders were obtained to administer Coumadin 5 mg daily. Review of the Coumadin Tracking Form identified conflicting information, that new orders were not obtained. 8/11/2025 INR 2.0 (under goal INR by 0.5). No change in orders; continued to receive Coumadin 5 mg daily. 8/14/2025 Coumadin 5 mg was discontinued. No Coumadin was administered on 8/14 and 8/15/2025. 8/16/2025 INR test results 1.6 (under the goal INR of 2. 5 to 3.5), new orders to administer Coumadin 2.5 mg daily and obtain a new INR on 8/18/2025. No physician or APRN acknowledged the Coumadin Tracking Form results. 8/18/2025 Coumadin 2.5 mg order was discontinued. 8/18/2025 INR test results 1.2 (under the goal INR by 1.3). No new Coumadin orders were obtained. APRN #1 progress note acknowledged the INR results with recommendations to monitor. No Coumadin was administered on 8/18, 8/19, 8/20, 8/21, 8/22, 8/23, and 8/24/2025. 8/25/2025 an in-house INR level was performed; the results were not documented. APRN note dated 8/25/2025 identified Resident #1 was seen for follow up of Coumadin and ordered Coumadin 5 mg on 8/25/2025 (discontinue date of 8/26/2025) and obtain an INR on 8/26/2025. APRN #1 signed acknowledgement on the Coumadin Tracking Form. 8/26/2025 INR results 1.1 (under the goal INR by 1.4). APRN #1 evaluated Resident #1 for an unrelated issue. No Coumadin orders were obtained, and no Coumadin was administered on 8/26/2025. Review of the Coumadin Tracking Form dated 8/26/2025 identified conflicting information that new orders were obtained for Coumadin 7 mg with the next INR ordered on 8/28/2025. APRN #1 signed acknowledgement of the tracking form. No Coumadin was administered on 8/26/2025. 8/27/2025 APRN #1 ordered Coumadin 7 mg daily for two (2) days, and was administered on 8/27/2025. 8/28/2025 INR results 1. 2 (under the goal INR by 1.3). The second day of Coumadin 7 mg was administered and was then discontinued. The Coumadin Tracking Form failed to identify new orders were obtained for Coumadin and the next INR due date. No Coumadin was administered on 8/29, 8/30 and 8/31/2025. 9/1/2025 INR level was 1.2 (under the goal INR by 1.3). APRN #1 ordered Coumadin 10 mg daily, with next INR due on 9/4/2025, and APRN #1 signed acknowledgement of the Tracking Form. Coumadin 10 mg was administered on 9/1 and 9/2/2025, and Resident #1 was transferred to the hospital on 9/3/2025 for an unrelated event.Review identified the INR was not maintained within the ordered therapeutic level of 2.5 to 3.5, and Resident #1 did not receive any Coumadin doses on thirteen (13) days (8/14, 15, 18, 19, 20, 21, 22, 23, 24, 26, 29, 30 and 8/31/2025). Interview and clinical record review with APRN #2 on 9/18/2025 at 12:15 PM identified Resident