

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 04/20/2026
NAME OF PROVIDER OR SUPPLIER Lord Chamberlain Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, facility documentation review, and staff interviews for one of three residents (Resident #2) reviewed for discharge planning, the facility failed to ensure the resident was discharged with home care services. The findings include: Resident #2 had a diagnosis of acute respiratory failure and septic shock (infection), admission Minimum Data Set (MDS) dated [DATE] identified Resident #2 had a Brief Interview Mental Status (BIMS) score of 14 indicating an intact cognition and required maximal assistance with toileting and transfers. The Resident Care Plan (RCP) dated 9/20/22 identified Resident #2 required assistance with ADLs. Interventions directed to provide an assistance as indicated. Facility Discharge summary dated [DATE] at 1:53 PM identified Resident #2 was being discharged from the facility and will receive skilled services. The form indicated a referral was made, requesting nursing, physical therapy, occupational therapy, and home health aide service. Nursing note dated 11/10/22 at 6:57 PM identified Resident #2 was discharged from the facility to home with home care services. Interview with home care agency listed on the discharge summary, RN #1, on 4/20/26 at 11:41 AM identified there was no record of Resident #2 receiving home care services from their company and the home care agency does not service the area in which the resident lived. Interview with RN #2 on 4/20/26 at 12:37 PM identified the home care agency never received a referral for home care services from the facility for Resident #2. Interview and record review with the DNS on 4/20/26 at 1:40 PM identified Resident #2 should have been discharged home with home care services but was not sure when home care services were supposed to start and does not know if the company services the area in which the resident resides. Interview with Social Worker (SW) #1 on 4/20/26 at 12:18 PM identified she contacted the home care agency where Resident #2 was supposed to receive home care services from (listed on the Discharge Summary), and they informed her that the resident never received home care services from their company after the resident was discharged from the facility. SW #1 stated the resident should have received home care services after discharge, and interview failed to identify why a referral was not made and confirmed to a home care agency for Resident #2's care post discharge from the facility. Review of facility Transfer and Discharge policy (no date) directed in part to plan discharge with the participation of the resident and to assist the resident to adjust to his/her new living environment.</p>

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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