STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075418	A. Building B. Wing	11/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Bucks Hill	2817 North Main Street Waterbury, CT 06704

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** 31310 Based on clinical record reviews, facility documentation, facility policy and interviews for one of three sampled residents (Resident #1) who had poor decision-making skills regarding tasks of daily life, the facility failed to notify the Power of Attorney at the time the resident experienced a change in condition, and a new medication and laboratory blood work were recommended by a medical provider. The findings include: Resident #1's diagnoses included Alzheimer's dementia, retinal occlusion, hypermetropias, presbyopia, cataract, and glaucoma. The Resident Care Plan dated 7/19/23 identified Resident #1 was at risk for visual function related to retinal occlusion, hypermetropias, presbyopia, cataract, and glaucoma. Interventions directed to monitor, document, report to a physician the following sign signs and symptoms of acute eye problems: change in ability to perform activity of daily living, decline in mobility, sudden visual loss, pupils dilated, gray or milky, complain of halos around lights, double vision, tunnel vision, blurred or hazy vision. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had poor decision-making skills regarding tasks of daily life, required extensive assistance with bed mobility, transfer, toilet use, and personal hygiene. The Advanced Practice Registered Nurse (APRN) progress note dated 8/2/23 identified Resident #1 complained of dry eyes, there was no report of pain or drainage, Resident #1 reportedly rubbed the eyes at times, and the eyes teared. The APRN recommended artificial tears one (1) drop to both eyes every six (6) hours as needed for dry eyes or itch. The APRN progress note dated 8/22/23 identified Resident #1 was evaluated for reports of right eye drainage and increased congestion. Upon evaluation redness was present to the right sclera, right eye conjunctiva red, there was dry drainage present to outer the right eye, Resident #1 reported the right eye itchiness started a few days ago. The APRN recommended Erythromycin 5 grams four (4) times daily for seven (7) days, monitor for any adverse reactions, notify MD or APRN, monitor for pain, and administer pain medication as needed. (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	The APRN progress note dated 8/25/23 identified Resident #1 was seen for medication evaluation. The APRN recommended to obtain a complete blood count (CBC), comprehensive metabolic panel (CMP), lipid panel, liver function test (LFT), hemoglobin A1C, free T4, thyroid stimulating hormone (TSH), vitamin B12, folic acid, and vitamin D level on 8/28/23 and will make medication adjustments accordingly if indicated. A review of the clinical record from 8/2/23 through 8/25/23 failed to identify documentation the Power of Attorney, Person #1 was notified when Resident #1 experienced a change in condition, and artificial tears, Erythromycin and blood work were ordered. Interview and review of the clinical record with the 7AM-3PM Nursing Supervisor, Registered Nurse (RN) #1, on 11/15/23 at 2:13 PM identified the Resident #1's Power of Attorney was not notified on 8/2, 8/22 and 8/25/23 when Resident #1 experienced a change in condition. RN #1 indicated Power of Attorney was to be notified with every new order. Notification of Change policy directed the facility must inform the resident, consult with the resident's physician, and notify the resident's family member or legal representative when there was a change requiring such notification. Circumstances requiring notification included a new treatment.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31310 Based on clinical record reviews, facility documentation, policy, and interviews for one of three sampled residents (Resident #1) who had potential for impairment to skin integrity, the facility failed to conduct and document an initial wound assessment when blisters were identified. The finding include: Resident #1's diagnoses included Alzheimer's dementia, acute kidney injury, chronic kidney disease, and heart failure. The Resident Care Plan dated 7/19/23 identified Resident #1 was at risk for pressure ulcer or potential for pressure ulcer development related to decreased mobility and bowel and bladder incontinence. Interventions directed to monitor, document, report to a physician as needed changes in skin status: appearance, color, wound healing, signs or symptoms of infection, wound size (length by width by depth), and stage. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had poor decision-making skills regarding tasks of daily life, required extensive assistance with bed mobility, transfer, toilet use, and personal hygiene. The nurse's note dated 9/1/23 at 3:49 PM identified the left lower extremity remained red, edematous, two raised blisters were noted, Advanced Practice Registered Nurse (APRN) was made aware, and a new order for Keflex, and skin prep for blisters was obtained. Review of the clinical record failed to reflect documentation that a complete assessment, i.e., size color and exact location of the blisters had been conducted when the area was first identified on 9/1/23 to establish a baseline description of the area for further evaluation to determine if there was an improvement or a decline of the blisters. Interview and clinical record review with the wound nurse, Licensed Practical Nurse (LPN) #1, on 11/15/23 at 12:32 PM identified the nurse who identified a new skin impairment was responsible to assess and measure the new area. LPN #1 indicated she could not answer as to why the measurement and initial assessment was not completed. Interview and review of the clinical record with the 7AM-3PM Nursing Supervisor, Registered Nurse (RN) #1, on 11/15/23 at 1:11 PM identified whoever identified a new skin impairment was responsible to assess and document in the progress notes. Skin Assessment policy directed a skin assessment will be conducted by a licensed or registered nurse upon admission/re-admission. The assessment may also be performed after a change in condition or after any newly identified area.

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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** 31310 Based on clinical record reviews, facility documentation, policy, and interviews for one of three sampled residents (Resident #1) who had potential for impairment to skin integrity, the facility failed to conduct and document weekly skin assessments in accordance with the physician's order. The finding include: Resident #1's diagnoses included Alzheimer's dementia, acute kidney injury, chronic kidney disease, and heart failure. A physician's order dated 7/13/23 directed body audit on admission and daily for a total of three (3) days, then weekly one (1) time a day every Tuesday. The Resident Care Plan dated 7/19/23 identified Resident #1 was at risk for pressure ulcer or potential for pressure ulcer development related to decreased mobility and bowel and bladder incontinence. Interventions directed to monitor, document, report to a physician as needed changes in skin status: appearance, color, wound healing, signs or symptoms of infection, wound size (length by width by depth), and stage. The admission Minimum Data Set assessment dated [DATE] identified Resident #1 had poor decision-making skills regarding tasks of daily life, required extensive assistance with bed mobility, transfer, toilet use, and personal hygiene. Review of the clinical record failed to reflect documentation weekly skin checks were conducted on 7/25, 8/1, 8/8, 8/22, 8/29, 9/5, and 9/12/23. Interview and review of the clinical record with the 7AM-3PM Nursing Supervisor, Registered Nurse (RN) #1, on 11/15/23 at 1:11 PM identified the weekly skin assessments were not conducted on 7/25, 8/1, 8/8, 8/22, 8/29, 9/5, and 9/12/23. RN #1 indicated the floor nurses were responsible for the weekly skin assessments and they must fill out the skin assessment form in the computer. Although requested a weekly skin assessment policy was not provided.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31310 Based on clinical record reviews, facility documentation, facility policy and interviews for one of three sampled residents (Resident #1) who was reviewed for a change in condition, the facility failed to follow the physician's order and obtain the laboratory blood work that was ordered. The findings include: Resident #1's diagnoses included Alzheimer's dementia, acute kidney injury, chronic kidney disease, and heart failure. The Resident Care Plan dated 7/19/23 identified Resident #1 was at risk for dehydration related to medication use. Interventions directed to obtain laboratory blood work as ordered. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had poor decision-making skills regarding tasks of daily life, required extensive assistance with bed mobility, transfer, toilet use, and personal hygiene. The Advanced Practice Registered Nurse (APRN) progress note dated 8/31/23 identified Resident #1 with multiple comorbidities was evaluated for acute kidney injury, routine lab work was obtained revealing an elevated blood urea nitrogen (BUN) and creatinine and decrease GFR from baseline and an elevated Vitamin B12 level, blood pressure was stable averaging 120's to 130's over 60's to 70's on Norvasc and Metoprolol daily and recommended intravenous fluids, 0.45% Normal Saline at 75 milliliters (ml)/hour times two (2) liters and to repeat a Basic Metabolic Panel (BMP) on 9/3/23. The nurse's note dated 8/31/23 at 2:36 PM identified blood work was evaluated by an APRN, noted to have an elevated BUN and creatinine, a new order for intravenous hydration, normal saline 0.45% at 75 ml/hour times two (2) liter, order in place, IV department called for peripheral line insertion, repeat laboratory blood work for BMP on 9/3/23, and the family was called and updated. A physician's order dated 8/31/23 directed to obtain a Basic Metabolic Panel one (1) time only on 9/3/23. Interview and review of the clinical record with the Administrator on 11/15/23 at 12:40 PM identified she could not locate the laboratory blood work that was ordered for 9/3/23. The Administrator indicated she placed a call to the laboratory services and the laboratory supervisor stated she sent all the blood work reports for Resident #1 which was the blood work obtained on 8/31/23. The Administrator was unable to answer as to why the blood work was not obtained on 9/3/23. Interview and review of the clinical record with the 7AM-3PM Nursing Supervisor, Registered Nurse (RN) #1, on 11/15/23 at 1:11 PM identified the 9/3/23 BMP was not drawn. RN #1 indicated the process was for the APRN to place an order in the computer, then the floor nurse or the supervisor noted the order, filled the laboratory sheet for the ordered blood work and placed it in the laboratory folder under the date the blood work was to be drawn. RN #1 identified when the laboratory technician came in, they check the laboratory folder and fill the order. Review of the laboratory folder failed to identify documentation from September 2023 and the facility staff was unsure where the copies of the drawn blood work were. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Consulting Physician/Practitioner Orders policy directed for consulting physician, practitioner orders received in writing or via fax the nurse in a timely manner will call the attending physician to verify the order. Document the verification order by entering the order and the time, date, and signature on the physician order sheet. Follow facility procedure for verbal or telephone order including noting the order, submitting to pharmacy, and transcribing to medication or treatment administration record.