STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075263	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Cromwell	385 Main Street Cromwell, CT 06416

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, review of the clinical records, facility documentation, and facility policy for 5 of 6 sampled residents (Residents #20, Resident #80, Resident #140, Resident #153, and Resident #668) reviewed for a resident-to-resident altercations, the facility failed to ensure an allegation of mistreatment was reported to the appropriate agencies. The findings include: A.1. Resident #20s diagnoses included dementia, hallucinations, and obesity. The Annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #20 was severely cognitively impaired, required substantial/maximum assist for personal hygiene, was independent/set up for eating, toileting, and transfers. The Resident Care Plan (RCP) dated 2/8/24 identified that Resident #20 had the potential to demonstrate physical behaviors related to dementia. Interventions included that when Resident #20 becomes agitated intervene before agitation escalates, guide away from source of distress, engage calmly in conversation, and redirect Resident #153 away from Resident #20. 2. Resident #153's diagnoses included dementia, anxiety, and visual hallucinations. The admission MDS assessment dated [DATE] identified Resident #153 was severely cognitively impaired, required substantial max assist for personal hygiene, and was dependent for eating, toileting, and bathing. The Resident Care Plan dated 2/8/24 identified that Resident #153 had the potential to demonstrate physical behaviors related to dementia. Interventions included redirecting Resident #153 from Resident #20, and behavior monitoring every shift. A Reportable Event form dated 2/8/24 identified, at approximately 12:30 PM, a staff member yelled for help and LPN #9 went to intervene. Resident #153 went into Resident #20's room, held onto Resident #20's walker and told him/her to let it go. Resident #153 did not let go of the walker and Resident #20 then slapped Resident #153 on the cheek. The staff member separated both residents and neither was injured at the time. The care plans were updated, the Advanced Practice Registered Nurse (APRN), Police, and responsible parties were notified. Both residents were placed on 1 to 1 until cleared by psychiatric services. Adult Protective Services was not identified as being notified. A second Reportable Event form dated 6/12/24 identified, at approximately 11:20 AM identified that Resident #153 was outside Resident #20's room, saw a rollator walker and seated his/herself on the (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	rollator walker seat. Resident #20 looked out his/her door, saw Resident #153 sitting on his/her rollator, and walked over to him/her and hit Resident #153 in the face. Resident #20 was yelling he/she was in my chair and in my stuff. The nurse on the unit heard the commotion and ran to the area to separate the residents. Neither resident appeared injured. The Advanced Practice Registered Nurse (APRN), Police, and responsible parties were notified. Resident #153 was placed on 1 to 1 until cleared by psychiatric services. Resident #20 was sent to a behavioral unit at another facility. The Reportable Event failed to identify that Adult Protective Services were notified. Interview with the Director Nursing Service (DNS) 7/23/24 at 1:18 PM identified that she did not notify Adult Protective Services regarding the incident on 2/8/24 and 6/12/24 because she did not know she was required to do so for a resident-to-resident altercation. B. 1. Resident #80 diagnoses included dementia, diabetes, and muscle weakness. The Quarterly MDS assessment dated [DATE] identified Resident #80 had long and short term memory problems and required partial to moderate assistance from staff with upper body dressing and was independent with ambulation and transfers. The Resident Care Plan in effect on 7/1/24 identified Resident #80 with risk for impaired cognitive function related to dementia. Interventions included administering medications as ordered, monitoring and documenting any changes in cognitive function and engaging in simple structured activities. 2. Resident #140's diagnoses included dementia, hypertension, depression, and anxiety. The Annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #140 was severely cognitively impaired, and was independent with bed mobility, transfers, and ambulation. The Resident Care Plan in effect on 7/1/2024 identified Resident #140 with risk for impaired cognitive function related to dementia. Interventions included engaging the resident in simple structured activities that avoid overly demanding tasks, monitoring and documenting any changes in cognitive function, and using task segmentation to support short memory deficits. Review of the DNS nurse's note dated 7/8/24 at 4:04 PM identified that Resident #140 was observed with a new behavior of touching Resident #80 on top of her chest over her clothing. Review of the Reportable Event dated 7/8/24 identified that Resident #140 placed an open hand on the chest of Resident #80 over his/her clothing. The Reportable Event had a state classification of an E indicating that the event was not Reportable to the State Agency. Review of the Psychiatric and Consultation note dated 7/8/24 identified that Resident #140 was observed by staff touching the chest area of a resident of the opposite gender outside of his/her clothes. When Resident #140 was being reviewed by the psychiatric physician, Resident #140 became agitated over the conversation and stated that Resident #80 put his/her hands over there. Interview with the DNS on 7/23/24 at 11:23 AM identified that LPN #1 contacted her and reported an allegation of mistreatment between Resident #80 and Resident #140. The DNS indicated that she immediately went to the unit and started an investigation of the incident. The DNS identified that she did not report the incident to the state survey agency after she determined that Resident #140 briefly touched Resident #80 on the chest area over his/her clothing. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview and review of the investigative statement with LPN #1 on 7/24/24 at 10:15 AM identified that on 7/8/24 during her shift, NA #5 reported to her that she was walking in the hallway when she observed Resident #140 sitting in the doorway of his/her room with Resident #80 standing over him/her. Resident #140's hands were noted to be on the outside of Resident #80's clothing, and he/she was holding Resident #80's breasts. LPN #1 further identified that NA #5 had already separated the Residents prior to reporting the issue to her. Additionally, LPN #1 identified that she informed the DNS of the allegation. Interview and review of the investigative statement with NA #5 on 7/24/24 at 10:25 AM identified that she was walking in the hallway when she observed Resident #140 sitting on a chair in the doorway of his/her room with Resident #80 standing over him/her with Resident #140's hands on the outside of Resident #80's clothing and he/she was holding Resident #80's breasts. NA #5 stated that she told Resident #140 to stop, separated Resident #140 from Resident #80 and reported the issue to LPN #1. Interview with the Administrator, DNS, and Clinical Regional Director (RN #3), on 7/24/24 at 11:30 AM identified they did not notify the state agency of the allegation of mistreatment between Resident #80 and Resident #140 because both Residents' Brief Interview for Mental Status (a cognitive test) were low, (cognitive impairment). They further identified that after the facility's internal investigation, it was determined that there was no malintent because Resident #140 did not know what he/she was doing due to severe cognitive impairment. The Administrator identified that he would have reported the allegation of mistreatment to the State Agency had he known that this type of situation still needed to be reported. C. 1. Resident #20's diagnoses included dementia, hypertension, and depression. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #20 was moderately cognitively impaired, independent with bed mobility and transfers, and required supervision with ambulation. The Resident Care Plan (RCP) in effect on 5/1/23 identified Resident #20 had the potential to demonstrate physical behaviors related to dementia. Interventions included intervening before agitation escalates, guiding away from source of distress, engaging calmly in conversation, if response is aggressive, staff to walk calmly away and approach later. 2. Resident #668's diagnoses included dementia, anxiety, and diabetes. The quarterly MDS assessment dated [DATE] identified Resident #668 was moderately cognitively impaired and independent with bed mobility, transfers and ambulation. The Resident Care Plan in effect on 5/1/23 identified Resident #668 had behavior issues related to physical altercation with peers and staff. Interventions included to provide a psychiatric consultation as needed and redirection from other residents' personal space. A Reportable Event form dated 5/4/23 at 10:00 AM, identified an unwitnessed event had occurred. A staff member was walking in the hallway when she saw Resident #20 sitting on the ground near the doorway of his/her room while Resident #668 was noted to be holding Resident #20's phone in his hand leaving Resident #20's room. Staff responded and separated Resident #20 and Resident #668. Resident #20 stated that Resident #668 entered his/her room and attempted to take his/her cellphone. Resident #20 tried to take his/her cell phone back but in the process both Residents struck each other, and (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #20 was pushed to the ground. Review of the resident interviews identified that Resident #668 stated he/she hit Resident #20 while Resident #20 stated that he/she hit Resident #668. Resident #20 and Resident #668 were placed on 1 to 1 observation until they were cleared by the psychiatric physician. Nursing Assessments were completed, and Resident #20 was noted to have an open area on his/her right elbow and left hand. Resident #668 was noted to have a skin tear on the left knee. Advanced Nurse Practitioner (APRN), resident's responsible party, and the police were notified of the altercation. Psychiatric and Social Services were provided. Adult Protective Services was not identified as being notified. Interview with the Director of Nursing Services (DNS) on 7/13/24 at 1:18PM identified that she did not notify the Adult Protective Services about the resident-to-resident altercation. She identified that she was unaware of the state guidelines regarding notifying Adult Protective Services. She further identified that had she been aware of the guidelines, she would have notified Adult Protective Services. Review of the Abuse Reporting and Investigation policy, in part, identified that the facility will not permit residents to be subjected to abuse by anyone including other residents. An investigative report will be conducted to identify the incident, identify staff members responsible for the initial reporting, investigation of alleged violations and reporting results to the proper authorities. Should the investigation reveal that suspected or actual abuse occurred, the administrator/designee must report such findings to the resident representative, Department of Public Health and others that may be required within the mandated time frames. Review of the Abuse: Reporting and Investigation policy, in part, identified that the facility will not permit residents to be subjected to abuse by anyone including other residents. An investigative report will be conducted to identify the incident, identify staff members responsible for the initial reporting, investigation of alleged violations and reporting results to the proper authorities. Should the investigation reveal that suspected or actual abuse occurred, the administrator/designee must report such findings to the resident representative, Department of Public Health and others that may be required within the mandated time frames.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of the clinical record, facility policy, and interviews for the only resident (Resident #103), reviewed for incontinence, the facility failed to provide timely incontinent care to a dependent resident. The findings include: Resident #103's diagnoses included hemiplegia and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke) and chronic pain syndrome. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #103 was mildly cognitively impaired, was totally dependent on staff for bed mobility and toileting hygiene and did not transfer out of bed. Resident #103 was always incontinent of bowel and bladder. The Resident Care Plan dated 5/15/24 identified Resident #103 had bowel and bladder incontinence and is at risk for complications with yeast in the urine. Interventions included washing, rinsing, and drying the perineum and changing clothing after incontinence episodes every 2 hours and as needed. Continuous observations of Resident #103 on 7/24/24 from 9:00 AM to 11:39 AM identified that at 11:39 AM, NA#1 and NA #2 entered Resident #103's room to perform incontinent care. After obtaining permission from the resident to observe care, Resident #103, was identified to have had a small liquid bowel movement. Dried fecal material was noted to be adhering to the outside ring of fecal material on his/her buttocks which required NA #2 to apply friction to remove the fecal matter. Interview with NA #1 and NA #2 on 7/24/24 at 11:45 AM identified that incontinent care is given every 2 hours and as needed. NA #2 identified she had last given Resident #103 care at 7:45 AM. Although NA #2 indicated she went in at 11:00 AM and checked Resident #103 for incontinence, constant observation by the surveyor failed to identify NA#2 had entered Resident #103's room. Interview with LPN #3 on 7/24/24 at 1:26 PM identified that incontinent care is given every 2 hours and when the residents use their call bell. The NA's get the residents up and change them if the residents are soiled and then transfer the residents back to their chairs. LPN #3 stated that NA #2 indicated care was provided to Resident #103 at 8:45 AM. LPN #3 additionally stated that NA#2 should have provided Resident #103 with an incontinent check/care at 10:45 AM (within approximately 2 hours) and further stated she would have expected Resident #103 to be checked/care given sooner than the surveyor observed. In a second interview with NA#2 at 1:37 PM she confirmed she was responsible for Resident #103's incontinent care and that she had last provided Resident #103 incontinent care at 7:45 AM (approximately 4 hours prior to the observation of care). Interview with Resident #103 on 7/24/24 at 1:58 PM identified that he/she could not recall being checked earlier than when the surveyor observed his/her care. Interview with Director of Nursing Services (DNS) on 7/25/24 at 8:55 AM identified that incontinent care is given 4 times a shift and when a resident needs to be changed. The DNS indicated that incontinent care is not given exactly every 2 hours but is given more frequently than every 4 hours. Review of the Perineal care policy dated 12/14/2022 directed, in part, to provide perineal care to (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	all incontinent residents during routine bath and as needed to promote cleanliness and comfort, prevent infection to the extent possible, and to prevent and assess for skin breakdown. Although requested, a facility policy for incontinence care was not provided.