STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075292	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at New Britain	400 Brittany Farms Rd New Britain, CT 06053

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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for the one (1) of (3) three residents (Resident #1), reviewed for the discharge process, the facility failed to notify the homecare agency timely of a discharge delaying start of care. The findings include: Resident #1's diagnoses included sepsis (complications of an infection), low back pain, dyspnea (difficulty breathing), and orthostatic hypotension (low blood pressure that occurs when standing up from a sitting a lying position). The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1was moderately cognitively impaired and required supervision assistance with bed mobility, and moderate assistance with transfers and personal hygiene. The Resident Care Plan dated 2/16/23 identified that Resident #1had a self-care performance deficit related to decreased strength and endurance with interventions that included utilizing the assistance of 1 staff for dressing, bathing, bed mobility, and transfers, and an assist of 1 staff for toileting and ambulation with a rolling walker. A physician's order dated 2/24/23 directed that Resident #1 was stable for discharge home with services on 2/24/23. A late entry social service note dated 2/27/23 at 4:05 PM identified that Resident #1 was discharged and transported home by a family member on 2/24/23. The resdient chose a homecare agency for Physical Therapy (PT), Occupational Therapy (OT), and Skilled Nursing (SN) services. Review of progress notes from 2/17/23 through 2/23/23 failed to identify any previous documentation related to a plan for Resident #1's discharge by social work staff. Review of facility documentation identified that the Interagency Patient Referral Report was sent to the homecare agency on 2/27/23 at 12:01 PM, 3 days after the resident discharged home on 2/24/23. Interview with RN #1 (Home Health Intake Nurse) on 7/18/23 at 11:27 AM identified that the facility sent the referral to them on 2/23/23 but did not send the discharge paperwork until 2/27/23, so they were not aware that Resident #1 had been discharged on 2/24/23 until that time, delaying the start of care for PT, OT and skilled nursing services. When they were made aware of the facility discharge on [DATE], they immediately called the primary care physician to obtain orders. She indicated that the resident was started on services 3/1/23. Further, she identified that admission clinicians are (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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NAME OF PROVIDER OR SUPPLIER: Autumn Lake Healthcare at New Britain		STREET ADDRESS, CITY, STATE, ZIP CODE: 400 Brittany Farms Rd New Britain, CT 06053	

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	available for start of service on the weekend. Interview and clinical record review with Social Worker #1 and the DNS on 7/18/24 at 12:03 PM identified that SW #2 was responsible for Resident #1's discharge planning, but she was no longer employed at the facility. They indicated that it's the expectation that the Social Worker would document in the clinical record an initial admission note, a progress note on any encounters that they had with the resident and/or family and then a discharge note. They also identified that it would be the expectation that the Social Worker would send the Interagency Report to the homecare agency the same day the resident was discharged . They reported that discharge planning begins on admission, but that a concrete discharge plan is dependent on the insurance. The facility has weekly Medicare meetings, where they obtain more information on how long a resident's stay will be covered for, and once they have a ballpark date, they will start referrals for aftercare, durable medical equipment needed for discharge, and any follow-up appointments required. They indicated that once they identify who will accept a resident's insurance for homecare services, they will call the agency and speak with the representative, and they will let the facility know exactly what they need to send with the referral, and then once the agency reviews the documents, they will call the facility back to let them know if they can accept the resident. They will then communicate to the homecare agency the planned discharge date when it is determined. They indicated they were unable to identify why the facility did not send the Interagency Form and notify the homecare agency that Resident #1 was discharged home until 3 days after the discharge. They were also unable to identify why there was no documentation on the discharge plan prior to the actual discharge home on 2/24/23. Although attempted, SW #2 was unavailable for an interview. Review of the Discharge Summary and Plan policy dated 2015 directed, in part, that the post-discharge plan will contain, at a minimum, a description of the resident's and family's preference for care, a description of how the resident and family will access such services, a description of how the care should be coordinated if continuing treatment involves multiple caregivers, the identity of specific resident needs after discharge, and a description of how the resident and family -need to prepare for the discharge. A copy of the post-discharge plan and summary will be provided to the resident and receiving facility and a copy will be filed in the resident's medical record. Although requested, a policy on referrals to home care agencies was not obtained.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for the one (1) of three (3) residents reviewed for admission plan of care, (Resident #1), the facility failed to follow physician's orders regarding a medication. The findings include: Resident #1's diagnoses included glaucoma (an eye condition that damages the optic nerve) and type 2 diabetes mellitus. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 was moderately cognitively impaired and required supervision assistance with bed mobility, and moderate assistance with transfers and personal hygiene. Review of the hospital Discharge summary dated [DATE] directed to continue taking Latanoprost (treats glaucoma) ophthalmic solution 1 drop to each eye daily at bedtime. A physician's order dated 2/8/23 directed to administer Latanoprost Ophthalmic Solution 0.005% one drop in both eyes at bedtime for glaucoma. A medication administration note dated 2/8/23 at 8:51 PM identified that Latanoprost was not administered, as it was not available and was pending delivery from the pharmacy. A medication administration note dated 2/9/23 at 8:54 PM identified that Latanoprost was not administered, as it was not available, and the pharmacy was contacted by the supervisor. No follow-up note was available as to what the pharmacy had communicated to the facility. A medication administration note dated 2/10/23 at 5:45 PM identified that Latanoprost was not administered, but there was no reason documented. Interview with the Pharmacist on 7/18/24 at 10:15 AM identified that the facility first ordered Latanoprost for Resident #1 on 2/8/23 at 7:12 PM. He indicated the medication was filled on 2/8/23 and delivered to the facility and signed for by RN #2 on 2/9/23 at 3:32 AM. Additionally, he reported that for a resident who has been on this medication, missing doses can lead to eye pain or pressure and headaches, depending on the severity of the glaucoma. Interview with the DNS on 7/18/23 at 10:45 AM identified that in February of 2023, the facility had not yet been scanning incoming delivery orders from the pharmacy, and they did not retain any of the pharmacy delivery slips. She indicated the pharmacy would deliver one large delivery for the entire building, and the supervisor would sign for it and then deliver the medications to each unit. She identified that due to the volume of medications in each delivery and time constraints, the supervisor would only individually check and count the narcotics, but best practice would be to check to be sure each medication on the delivery slip was included in the order and then contact the pharmacy as soon as possible to request a STAT order of the missing medications. She reported that if floor nurses are administering medications and discover a medication is missing for a new admission resident, she would expect the staff to be contacting the pharmacy within 24 hours to inquire when the medication would be arriving, and then writing a note in the Electronic Health Record (EHR) identifying that they had called the pharmacy, information on any delays, and when it should be expected to arrive. Additionally, she identified that the nurse should be notifying the physician for all missed doses (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on medication to request an alternative until the original medication is delivered if applicable, and then documenting their encounter with the physician in the EHR. She indicated that she was unsure of why there was a gap in administration from when the pharmacy reported that the medication was delivered on 2/9/23, and then when nursing first administered the medication to Resident #1 on 2/11/23. Although requested, a policy on new admission pharmacy orders was not obtained.