STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075387	A. Building B. Wing	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Norwalk	34 Midrocks Drive Norwalk, CT 06851

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 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, facility documentation, and staff interviews for one of three residents (Resident #1) reviewed for advanced directives, the facility failed to ensure the code status was obtained from the legal representative, and failed to ensure the medical record included the accurate advance directives. The findings include: Resident #1 had a diagnosis of dementia, hypertension (high blood pressure), and cirrhosis of the liver. Record review identified Resident #1 had a court appointed Conservator of Person (COP), with an effective date of [DATE]. The COP was listed as Emergency Contact #1 in the record. Advanced Directives Level of Treatment Options dated [DATE] identified the form directed DNR (Do Not resuscitate) - No CPR will be performed, CMO (Comfort Measures Only/DNR/DNI (Do Not Intubate) - no CPR will be performed. The form was signed by Emergency Contact #2. Additional review identified the line for the COP to sign was blank, and the line for the physician to sign was blank. Physician admission order dated [DATE] directed full code (administer CPR). The quarterly Minimum Data Set (MDS) dated [DATE] identified Resident #1 had a Brief Interview Mental Status (BIMS) score of 7 indicating severely impaired cognition. Resident Care Plan (RCP) dated [DATE] identified a full code status with interventions that directed to administer Cardiopulmonary Resuscitation (CPR) as needed. Physician order dated [DATE] directed full code. The nursing note dated [DATE] at 9:23 AM identified staff notified the supervisor at approximately 8:15 or 8:20 AM that Resident #1 was observed unresponsive. The note identified the resident's chart was reviewed with a signed advanced directive located that directed Do Not Resuscitate (DNR, no CPR) and a physician order that directed full code (perform CPR). The conservator was called and confirmed Resident #1 was a full code. At 8:20 AM a code blue (medical emergency) was paged overhead, all licensed staff responded, and CPR was initiated. At 8:25 AM the crash cart and Automated External Defibrillator (AED, advises when to deliver an electric shock to restore a normal heart rhythm) was on site. Emergency Medical Services (EMS) arrived and continued to deliver CPR until 8:45 AM. EMS then called the local hospital's provider who advised to stop CPR at 8:45 AM and was then pronounced deceased by EMS. (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 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	EMS run sheet dated [DATE] identified upon arrival of EMS, the Fire Department was performing CPR, and no shock was advised. The run sheet indicated the staff provided EMS with a DNR that was incomplete and dated [DATE]. Additional paperwork indicated full code in the Advanced Directive section. The staff could not obtain updated paperwork or reach the family. CPR was continued and pause identified asystole (no heartbeat) with no palpable pulse, and Resident #1 was pronounced. Interview with the local Assistant Fire Chief #1 on [DATE] at 4:08 PM identified staff were performing CPR upon the Fire Department's arrival at the facility. Record review identified Resident #1 had a DNR advanced directive in the paper medical record that was signed by Emergency Contact #2 who was not the court appointed Conservator of Person. Further, there was a physician order in the electronic health record that directed full code status. Interview with LPN #2 on [DATE] at 12:37 PM identified she found Resident #1 unresponsive between 8:15 and 8:30 AM on [DATE] and she immediately paged the supervisor (RN #1). Interview and record review with RN #1/day shift unit manager on [DATE] at 12:32 PM identified the residents' code status in the hard/paper chart was a DNR and in the electronic medical record it was listed as a full code. RN #1 stated she called the COP who verified Resident #1 was a full code and CPR was initiated. RN #1 further stated she did not know why the code status in the electronic medical record and in the paper chart did not match, and stated they should have matched. RN #1 identified she and RN #2 (night supervisor) performed chest compressions and rescue breaths (artificial respirations) - alternating chest compressions while the other would provide respirations with an Ambu bag (device that delivers air to residents who are not breathing). Interview with RN #2 on [DATE] at 8:50 AM identified she was the night supervisor during the 11 PM to 7 AM shift ending on [DATE], and she responded the code blue page. RN #2 stated she checked the chart for code status which identified DNR, but the nurse stated the resident was a full code and CPR was administered by RN #1 and RN #2. The COP was contacted to verify code status, and the COP verified a full code. RN #2 stated she did not know why the medical record had conflicting code status directions, and stated the paper and electronic records should have matched. Interview with the DNS and Administrator on [DATE] at 3:07 PM identified Emergency Contact #2 was not a POA, and the advanced directive form should have been signed by the court appointed COP. Interview failed to identify why the advanced directive form was signed by Emergency Contact #2. The DNS and Administrator stated they did not know why the code status in the paper medical record and the electronic medical record did not match. They stated the records should direct the same and the court appointed conservator should have signed the advanced directive. Review of the Advanced Directive policy dated 9/2017 directed the facility will approach the health care proxy to formulate an Advance Directive. The decision making will be documented in the resident's medical record and communicated to the interdisciplinary team. The attached form directed to be signed by the resident/responsible party/COP and physician.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, facility documentation, and staff interviews for one of three residents (Resident #1) reviewed for quality of care, the facility failed to ensure the medical record was complete and accurate to include the responsible party was notified of a change in condition. The findings include: Resident #1 had a diagnosis of dementia, hypertension (high blood pressure), and cirrhosis of the liver. Record review identified Resident #1 had a court appointed Conservator of Person (COP), effective [DATE]. The COP was listed as Emergency Contact #1 in the record. The quarterly Minimum Data Set (MDS) dated [DATE] identified Resident #1 had a Brief Interview Mental Status (BIMS) score of 7 indicating severely impaired cognition. Resident Care Plan (RCP) dated [DATE] identified a full code status with interventions that directed to administer Cardiopulmonary Resuscitation (CPR) as needed. The nursing note dated [DATE] at 9:23 AM identified staff notified the supervisor at approximately 8:15 or 8:20 AM that Resident #1 was observed unresponsive. At 8:20 AM a code blue (medical emergency) was paged overhead, all licensed staff responded, and CPR was initiated. Emergency Medical Services (EMS) arrived and continued to deliver CPR until 8:45 AM. EMS then called the local hospital's provider who advised to stop CPR at 8:45 AM and Resident #1 was pronounced deceased by EMS. EMS run sheet dated [DATE] identified EMS arrived at 8:39 AM and identified upon arrival, the Fire Department was performing CPR. The Fire Department reported no shock was advised. CPR was continued and pause identified asystole with no palpable pulse, pupils were dilated, with absent lung sounds. At 8:47 AM no pulse, no blood pressure, no respirations, no eye movement, no vocal or motor response, and Resident #1 was pronounced at 8:47 AM. The nursing note dated [DATE] at 11:58 AM identified the facility provider was notified and Resident #1's body was picked up at 9:20 AM by the designated funeral home. Although record review identified the COP was contacted to confirm advance directives when Resident #1 was found unresponsive, record review failed to identify the COP was notified after Resident #1 was pronounced deceased . Interview and record review with RN #1 on [DATE] at 1:50 PM identified after EMS pronounced Resident #1 deceased , she notified the COP (via telephone) of the death. RN #1 stated although she notified the COP, she did not write a nursing note because she thought RN #2 was writing the note. Interview with RN #2 on [DATE] at 8:50 AM identified she contacted the COP after the resident was pronounced deceased , but she forgot to write a nursing note. RN #2 stated she should have written a note. Interview with the DNS and Administrator on [DATE] at 3:07 PM identified the [NAME] was notified, but the nurse failed to document the notification in the medical record. Interview identified the notification should have been documented and they did not know why it was not done. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Charting and Documentation policy (No date) directed to document the notification of family, physician, or other staff if indicated.