STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075407	A. Building B. Wing	09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at West Hartford	1 Emily Way West Hartford, CT 06107

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31310 Based on clinical record review, facility documentation, facility policy and interviews for one (1) of three (3) residents reviewed for advanced directives, (Resident #1), the facility failed to ensure the Advanced Directive was addressed upon admission to the facility in accordance with facility policy. The findings include: Resident #1 was admitted to the facility on [DATE] and had diagnoses included hypertension and chronic obstructive pulmonary disease. Review of the clinical record from [DATE] through [DATE] failed to identify that advanced directives were addressed. The Advanced Practice Registered Nurse's (APRN) progress note dated [DATE] identified no code status was on file. The Resident/patient health Care Instructions form dated [DATE] identified Resident #1 elected yes, attempt cardiopulmonary resuscitation (CPR), transfer to hospital for any condition requiring hospital-level care, all medical tests, antibiotics, artificial ventilation even indefinitely, artificially administered fluids and nutrition even indefinitely, and other life-sustaining treatments even indefinitely or repeatedly. The verbal order was obtained via telephone from Resident #1's emergency contact and signed by two (2) nurses. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 as having no cognitive impairment. Interview with the 8:00 AM to 4:30 PM Nursing Supervisor, Registered Nurse (RN) #2, on [DATE] at 5:05 PM identified she was checking charts on [DATE] and realized Resident #1 did not have a code status signed since admission on [DATE]. RN #2 indicated she had a conversation with Resident #1 and in the midst talking with Resident #1 she asked Resident #1 if she wanted to sign his/her admission paperwork, including code status. RN #2 identified Resident #1 wanted her to call Resident #1's emergency contact and discuss the code status with him/her as well. The responsible party was contacted and a an order for code status was obtained on [DATE]. Interview with the Director of Nursing (DON) on [DATE]/21 at 3:00 PM identified the nurses were responsible to address code status on admission. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Health Care Decision making policy directed to approach a capable resident who does not have an advanced directives upon admission, the resident will be approached by the Social Worker or another designated staff person on admission, quarterly and with any change in condition to discuss whether he/she wished to consider developing advanced directives. Upon admission determine whether the resident had an advanced directive and/or portable medical orders.

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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 review, facility documentation, facility policy and interviews for one (1) of three (3) residents, (Resident #1), who was reviewed for a change in condition, the facility failed to ensure a Registered Nurse (RN) assessment was completed when a resident experienced a change in condition. The findings include: Resident #1's diagnoses included hypertension and chronic obstructive pulmonary disease. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had -no cognitive impairment, required extensive assistance of two persons with bed mobility and transfer. The Resident Care Plan dated 8/30/23 identified Resident #1 had chronic obstructive pulmonary disease, clinical management chronic respiratory failure with interventions directed to administer oxygen as ordered/indicated, observe for worsening shortness of breath (SOB), notify physician of unrelieved or new SOB at rest. The nurse's note, written by the 7:00 AM-3:00 PM charge nurse, LPN #1 dated 9/4/23 at 4:23 PM identified at 8:15 AM NA #1 reported to LPN #1 Resident #1 was not looking good, LPN #1 went in to assess Resident #1, shortness of breath was noted, and Resident #1 felt clammy. Nebulizer treatment was administered, and blood sugar was checked and noted to be 222. Vital signs were as follows: blood pressure 117/84, pulse 98, respirations 20, temperature 96.5 degrees Fahrenheit and oxygen saturation level 98% on 2 liters of oxygen. After administration of nebulizer treatment Resident #1 was asked by LPN #1 how do you feel and Resident #1 stated I feel a little tired, and when asked if he/she was feeling pain, Resident #1 stated no. Interview with the 7:00 AM-3:00 PM charge nurse, Licensed Practical Nurse (LPN) #1, on 9/7/23 at 12:02 PM identified she assessed Resident #1 when NA #1 reported to her Resident #1 did not look good. LPN #1 indicated she did not report the change of condition to the nursing supervisor, RN #1 at the time when Resident #1 experienced shortness of breath because the supervisor would come and do her own rounds. LPN #1 identified Resident #1 stated he/she was ok, he/she said just tired, and was not in any pain. LPN #1 indicated normally the supervisor would come and asked if there were any residents with problems/issues and LPN #1 would give the supervisor the rundown on report of what was going on. Interview and review of the clinical record with the Director of Nursing (DON) on 9/8/23/21 at 10:00 AM identified if a resident experienced a change in condition the expectation was for the Registered Nurse supervisor to complete a change in condition assessment. The DON indicated LPN can input the information into the change in condition form, LPN can initiate the assessment, however the RN supervisor oversee the entire assessment and input her information, her assessment in the change in condition form. The DON identified the change in condition assessment on 9/4/23 at 8:15 AM was not completed by RN #1 and it should have been. The DON identified that RN #1 captured the information regarding SOB and nebulizer treatment in her note, however RN #1 did not assess Resident #1 when he/she experienced SOB.

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety 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** 31310 Based on clinical record review, facility documentation, emergency medical technician report, facility policy, and interviews, for one (1) resident, (Resident #1), the facility failed to provide Cardio-Pulmonary Resuscitation (CPR) in accordance with the resident's request and physician's order for full code (resuscitation procedures will be provided including but not limited to CPR) resulting in a finding of Immediate Jeopardy. The finding includes: Resident #1's diagnoses included hypertension and Chronic Obstructive Pulmonary Disease (COPD). The admission Minimum Data Set (MDS) dated [DATE] identified Resident #1 was cognitively intact, and received oxygen daily. A care plan dated [DATE] identified Resident #1 had an established an advanced directive to be a full code with interventions that directed to activate Resident #1's advanced directives as indicated. A physician's order dated [DATE] directed that Resident #1 was a full code. The Resident/patient health Care Instructions form dated [DATE] signed by Resident #1's responsible party elected yes, attempt cardiopulmonary resuscitation (CPR), transfer to hospital for any condition requiring hospital-level care, all medical tests, antibiotics, artificial ventilation even indefinitely, artificially administered fluids and nutrition even indefinitely, and other life-sustaining treatments even indefinitely or repeatedly. The Advanced Practice Registered Nurse's (APRN) progress note dated [DATE] identified the resident as a full code. Review of a facility census dated [DATE] identified that Resident #1 and Resident #2 were in the same room. A facility reportable event form dated [DATE] at 9:16 AM identified that Resident #1 was a full code. Resident #1 had a change in condition that required CPR, CPR was unsuccessful and Resident #1 was pronounced deceased by a paramedic at the facility at 10:07 AM on [DATE]. A nurse's note written by the 7:00 AM to 3:00 PM charge nurse (LPN#1) dated [DATE] at 4:23 PM identified at 8:15 AM NA #1 reported to LPN #1 Resident #1 did not look good, LPN #1 went in to assess Resident #1 who was short of breath and felt clammy. A nebulizer treatment was administered, and the blood sugar was checked and resulted at 222, the resident's vital signs were stable. Subsequent to the completion of the nebulizer treatment LPN #1 asked Resident #1 how h/she felt, the resident denied pain, however stated I feel a little tired. At 9:15 AM NA #1 called LPN #1 stated that Resident #1 was did not look good once again. LPN #1 assessed Resident #1 to be unresponsive, administered a sternal rub and directed NA #1 to call nursing supervisor, RN #1. RN #1 assessed Resident #1 and went to check Resident #1's code status. RN #1 back to the room and stated, he/she is DNR (Do Not Resuscitate). (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A nurse's note written by the 7:00 AM to 3:00 PM Nursing Supervisor, (RN #1) dated [DATE] at 5:19 PM identified LPN #1 notified her at 9:15 AM that Resident #1 was unresponsive. RN #1 went to Resident #1's room and assessed Resident #1. LPN #2 brought CPR equipment and attempted to perform CPR, 911 was called at approximately 9:20 AM. Review of the pre-hospital report (written by Emergency Medical Services) dated [DATE] at 9:31 AM identified that the EMT's were dispatched to the facility for a likely presumption of death for a DNR resident. Upon arrival the staff identified that they had paperwork that indicated Resident #1 was a DNR, however, facility staff were having trouble locating the DNR paperwork. Emergency Medical Services began CPR given the lack of DNR paperwork at 9:40 AM. At approximately 10:10 AM facility staff entered Resident #1's room while EMT's were still performing CPR and identified that they had been looking at Resident #2's advanced directives instead of Resident #1's advanced directive, and identified that Resident #1 was a full code, not a DNR. Review of case incident report dated [DATE] (written by Police Officer #1) at 2:49 PM identified that RN #1 requested that the EMT's respond to the facility to make a death pronouncement. Upon arrival at the facility RN #1 showed Police Officer #1 facility paperwork regarding Resident #1's code status and RN #1 pointed out to the Officer that Resident #1 was a DNR, in turn the Officer pointed out to RN #1 that the paperwork that she provided was a DNR paperwork for Resident #2 (Resident #1's roommate). Interview with the 7:00AM-3:00PM Nurse Aide (NA) #1, on [DATE] at 10:28 AM identified that she found Resident #1 unresponsive and notified LPN #1. NA #1 identified that she did not witness LPN #1 or RN #1 performing CPR on Resident #1, the first responders had initiated CPR upon arrival at the facility. Interview with the 7:00 AM-3:00 PM charge nurse, Licensed Practical Nurse (LPN) #1, on [DATE] at 12:02 PM identified that she had administered a nebulizer treatment to Resident #1 at 8:15 AM for complaints of shortness of breath, the nebulizer treatment was given with good effect and the resident stated that she felt tired. At 9:15 AM NA #1 notified her that Resident #1 did not look well, LPN #1 identified that she went into Resident #1's room and assessed him/her to be unresponsive. LPN #1 identified she performed a sternal rub on Resident #1 with no response and directed NA #1 to notify the nursing supervisor (RN#1). LPN #1 stated that she initiated CPR because she remembered seeing Resident #1 was a full code on the computer screen when she administered the nebulizer treatment at 8:15 AM. LPN #1 identified she administered approximately twenty (20) compressions, however stopped CPR because the compressions were ineffective without a back board, and the crash cart with the back board had not arrived at the bedside yet. At this time LPN #2 arrived to the room with the crash cart, and at the same time RN #1 came into the room and stated stop CPR, the resident is a DNR, (LPN #1 was unable to identify how long it had been since she had stopped performing CPR) LPN #1 indicated although she had seen that the resident was a full code in the computer, she thought maybe the supervisor found updated information that identified the resident was a DNR in the chart so she did not re-start CPR when the crash cart arrived at the bedside. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with the 7:00 AM to 3:00 PM Nursing Supervisor, (RN #1) on [DATE] at 12:20 PM identified that she received a call from LPN #1 around 9:15 AM on [DATE] that identified Resident #1 was unresponsive. RN #1 went to the room assessed the resident to be pulseless, at this time LPN #1 informed RN #1 that the resident was a full code and LPN #1 started CPR. RN #1 called 911 and at the same time she printed what she thought was Resident #1's code status, and stated to the dispatcher that she thought Resident #1 was full code but had a document in hand that she identified that Resident #1 was a DNR. RN #1 identified that she called 911 to help decide if CPR should be performed, however, when RN #1 looked at the paperwork closely, she realized that it was the roommate's paperwork (Resident #2) that was DNR, and she went running back to room to tell staff to resume CPR, however at this time EMS was at the bedside and was performing CPR. RN #1 denied telling LPN #1 to stop CPR at any time during the incident. Interview with Police Officer #1 on [DATE] at 12:40 PM identified that 911 received the phone call at 9:26 AM and he arrived at the facility at 9:35 AM. Police Officer #1 identified when he walked into Resident #1's room, LPN was performing a sternal rub Resident #1's chest, however, no staff were performing CPR. The PO repeatedly asked for Resident #1's DNR paperwork, which was not provided. Police Officer #1 indicated the fire department arrived and began their assessment, started CPR at approximately 9:42 AM and pronounced Resident #1 as deceased at 10:07 AM. Interview with Licensed Practical Nurse (LPN) #2 on [DATE] at 1:27 PM identified she brought the crash cart and left it by the door of Resident #1's room little after 9:00 AM. LPN #2 indicated when she entered the room, she did not see anybody performing CPR. Interview with the Director of Nursing (DON) on [DATE]/21 at 3:00 PM identified Resident #1 was a full code, and the expectation was for the licensed staff to perform CPR in accordance with Resident #1's wishes. Although there are inconsistencies in RN #1 and LPN #1 recollection of the event and documentation in the clinical record, it was determined that CPR was interrupted and not re-started by facility staff. The DON further identified that the investigation had been concluded and the two employees, RN #1, and LPN #1, were terminated on [DATE] as a result of the incident. Although the facility documentation contained inconsistencies as to the administration of CPR and whether or not staff were told stop CPR, it was determined that although CPR may have been started, it was stopped and not restarted by facility staff. CPR was initiated by EMS. Review of the Cardiopulmonary Resuscitation (CPR) policy directed centers support the right of every resident to choose CPR in the event of cardiac or respiratory arrest. The center will perform CPR on all residents who have chosen to be a full code.

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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** 43184 Based on clinical record reviews, facility documentation, facility policy and interviews for one sampled resident (Resident #2) who was reviewed for a medication error, the facility failed to ensure Resident #2's insulin was readily available to prevent two doses from being omitted, the facility failed to ensure the physician was notified when the Insulin was not available and failed to ensure the resident's blood glucose was monitored per the physician's order. The findings include: Resident #2's diagnoses included Diabetes Mellitus, metabolic encephalopathy, acute respiratory failure, and schizoaffective disorder. A physician's order dated 7/18/23 directed to give a medication to decrease blood sugar, Novolog Insulin Flex Pen Subcutaneous Solution pen injector 100 units per ml inject per sliding scale before meals and at bedtime: if blood sugar is 150-200 give 2 units, if blood sugar is 201-250 give 4 units, if blood sugar is 251-300 give 6 units, if blood sugar is 301-350 give 8 units, if blood sugar is 351-400 units give 10 units, notify provider if blood glucose is >400. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #2 made reasonable and consistent decisions regarding tasks of daily life and received insulin injects daily. The Resident Care Plan dated 8/31/23 identified Diabetes Mellitus. Interventions directed to record blood glucose, administer medications as ordered, diabetic foot checks and blood work as ordered. A physician's order dated 8/9/23 directed to give Insulin Aspart (Novolog Insulin) Flex Pen Subcutaneous Solution pen injector 100 units per ml inject 10 units subcutaneously before meals and at bedtime. The nurse's note dated 9/9/23 at 5:53 PM identified Insulin Aspart (Novolog) 10 units was not available, the pharmacy was notified and the insulin will be delivered within the next day. The nurse's note dated 9/9/23 at 5:54 PM identified Novolog Flex Pen sliding scale before meals and at bedtime was not available, the pharmacy was notified, and the insulin will be delivered within the next day. The nurse's note dated 9/9/23 at 9:27 PM identified Novolog Flex Pen sliding scale before meals and at bedtime was not available waiting for delivery. The nurse's note dated 9/9/23 at 9:29 PM identified the Insulin Aspart (Novolog) 10 units before meals and bedtime was not available awaiting delivery. The nurse's note dated 9/9/23 at 9:45 PM identified Resident #2 was out of Novolog Insulin, the pharmacy was notified and reported the Novolog Pen had been delivered to the facility on [DATE], but the medication was not found in the refrigerator or cart, another pen was requested, awaiting delivery. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the September 2023 Medication Administration Record (MAR) identified the Novolog Insulin was not administered on 9/9/23 for both the 4:30 PM and the 9:30 PM doses per the physician's order dose due to medication not being available. Review of the clinical record from 9/9/23 through 9/10/23 failed to reflect documentation the physician or Advanced Practice Registered Nurse were notified the Novolog Insulin was not available to be administered at 4:30 PM and 9:30 PM. The medication error documentation dated 9/10/23, written by the Night Supervisor, Registered nurse (RN) #3, identified the charge nurse, Licensed Practical Nurse (LPN) #3, reported and admitted to administering Novolog Insulin to Resident #2 that belonged to another resident because Resident #2's medication was not available. The documentation identified while the Supervisor was doing rounds, it was learned that Resident #2 had an elevated blood sugar, which was not documented, and LPN #3 had documented the medication was not available. The documentation identified the Night Supervisor questioned LPN #3 as to what steps were taken and provided education on the importance and policies regarding medication not readily available. The documentation identified Resident #2 was closely monitored after the supervisor learned the medication was not given, the pharmacy was called and stated the Novolog Insulin would be delivered on the morning run on 9/10/23. The Facility Reported Incident form dated 9/10/23 identified on 9/9/23 at approximately 9:00 PM LPN #3 reported to the Night Supervisor, RN #3, that Resident #2's blood sugar was elevated, RN #3 checked the MAR and saw Resident #2 had not received the afternoon and the nighttime short acting insulin (Novolog) to which LPN #3 stated it was not available, so she did not give it. The report identified during morning report on 9/10/23 the Director of Nursing (DON), who had been the supervisor on 9/9/23 during the evening shift, was updated. The report identified when interviewed Resident #2 indicated he/she did receive the Novolog Insulin on 9/9/23, but it was administered with a regular needle and not the usual insulin pen. The report identified the DON had received report that LPN #3 had not given Resident #2 the Novolog Insulin per the physician's order, to which LPN #3 stated that she reported the situation to the supervisor and the supervisor told her it was ok to hold the insulin. The report indicated the DON was the supervisor in question and did not have any such conversation with LPN #3. The report identified LPN #3 was asked if Resident #2 received the insulin and if not, was the medical provider updated with LPN #3's response being I gave the resident the insulin, however in review of the documentation, the medication had not been charted as given and there was no documentation to indicate the supervisor or provider had been updated. Interview with Resident #2 on 9/14/23 at 10:40 AM identified he/she did get his/her Insulin but received it via a regular insulin syringe and not the resident's Insulin Flex Pen. Resident #2 identified when he/she questioned the nurse for the reason why it was in a regular syringe, the nurse replied, you are out of your pen. Interview with LPN #3 on 9/14/23 at 11:12 AM identified after giving Resident #2 the 11:30 AM insulin dose on 9/9/23, she called the pharmacy as the Novolog Insulin had run out and the pharmacy had informed LPN #3 the Novolog Insulin had been delivered on 9/8/23 and it was too soon to refill the medication. LPN #3 identified she did not give Resident #2 any Novolog Insulin after the 11:30 AM dose due to it not being available. LPN #3 identified she did not notify the provider regarding Resident #2 not getting his/her scheduled Novolog Insulin, just documented in the MAR that it was not available. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Director of Nursing (DON) on 9/14/23 at 11:35 AM identified on 9/10/23 it was reported to her by the night supervisor, RN #3, that Resident #2 did not receive the Novolog Insulin. The DON identified she then questioned LPN #3 regarding who this was reported to, and LPN #3 stated she reported it to the supervisor on the evening shift and did not report it to any care provider. The DON identified she was the supervisor who worked the evening shift on 9/9/23, and when she further questioned LPN #3 about who it was reported to, LPN #3 stated she had never said she reported it to the supervisor. The DON identified Resident #2's medical record reflected the Novolog Insulin was not given as it was not available for both the scheduled 4:30 PM and 9:30 PM dose. The DON indicated LPN #3 did not notify the provider at any time, which is policy when a medication is not available, and she should have notified the physician or APRN (provider). Interview with the Night Supervisor, RN #3, on 9/14/23 at 2:54 PM identified on 9/9/23, LPN #3 reported to her Resident #2's Novolog Insulin had not been delivered and was not administered. RN #3 identified she asked LPN #3 what Resident #2's blood sugar reading was, and she reported it was in the 300 range. RN #3 indicated at that time she informed LPN #3 that a solution had to be obtained, asked if there was a multi-dose vial available, which there was not, and LPN #3 stated she did give Resident #2 his/her long-acting insulin for the scheduled doses. RN #3 identified during morning meeting on 9/10/23 she informed the DON about Resident #2's missed doses of Novolog Insulin on 9/9/23 at both the 4:30 PM and 9:30 PM scheduled times. Although attempted, an interview with APRN #2 was unable to be obtained. Review of the facility policy titled Point of Care Testing directed, in part, documentation of testing should include date, time and results on the MAR/treatment administration record (TAR) and document physician/provider notification and actions taken, if applicable. Review of the facility policy titled Nursing Documentation directed, in part, nursing documentation will follow the guidelines of good communication and be concise, clear, pertinent, and accurate based on the resident's condition, situation and complexity. The policy further directed, in part, charting by exception is a term used to describe the documentation method where only a deviation from defined assessment elements or a variation from a standard of care is documented. Review of the facility policy titled Medication administration directed, in part if there are discrepancies in medication, notify the physician or advanced practice provider as indicated and to document if the drug is withheld, record reason and provider notification, if applicable.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31310 Based on clinical record review, facility documentation, facility policy, and interviews for one of three residents, (Resident #1), who required oxygen therapy, the facility failed to obtain a physician's order for oxygen administration. The findings include: Resident #1's diagnoses included hypertension and chronic obstructive pulmonary disease. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had -no cognitive impairment, required extensive assistance of two persons with bed mobility, transfer and received oxygen therapy while a resident. The Resident Care Plan dated 8/30/23 identified Resident #1 had chronic obstructive pulmonary disease, and chronic respiratory failure. Interventions directed to administer oxygen as ordered/indicated. Review of the nurse's notes from 8/28 through 9/4/23 identified Resident #1 received two (2) or three (3) liters of oxygen via nasal cannula. Review of the clinical record from 8/28 through 9/4/23 failed to reflect a physician's order was obtained for the type of oxygen delivery system, the settings, and when to administer or discontinue oxygen therapy. Interview and review of the clinical record with the DON on 9/7/23 at 3:00 PM identified Resident #1 had a diagnosis of chronic obstructive pulmonary disease, sleep apnea and used oxygen at home. The DON indicated the documentation in nurse's notes indicated Resident #1 received 3 liters of oxygen via nasal cannula, however, was unable to provide a physician order for the type of oxygen delivery system, the settings, and when to administer or discontinue oxygen therapy. The DON identified a physician's order should have been obtained for oxygen administration, at least for as needed administration.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075407	A. Building B. Wing	09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at West Hartford	1 Emily Way West Hartford, CT 06107

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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 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 31310 Based on review of employee files, interviews, and policy, for five of five Nurse Aide (Nurse Aide #1, #2, #3, #4, and #5) who were reviewed for performance evaluations, the facility failed to ensure that yearly evaluations were completed. The findings include: 1. Nurse Aide (NA) #1 had a hire date of 7/20/1998. Review of the employee file identified that the last performance evaluation was completed on 7/9/19 (4 years past due). 2. NA #2 had a hire date of 6/6/2000. Review of the employee file identified that the last performance evaluation was completed on 4/30/20 (3 years past due). 3. NA #3 had a hire date of 5/9/2006. Review of the employee file identified that the last performance evaluation was completed on 5/26/19 (4 years past due). 4. NA #4 had a hire date of 9/8/21. Review of the employee file filed to identify that the performance evaluation was completed since date of hire (3 years past due). 5. NA #5 had a hire date of 5/13/22. Review of the employee file filed to identify that the performance evaluation was completed since date of hire (1 year past due). Interview with the Director of Nursing (DON) on 9/14/23 at 3:30 PM identified that performance evaluations were to be completed on an annual basis, and nursing supervisors were responsible for completing the evaluations. Review of the Performance Appraisal policy and procedure directed managers will meet with their regular full-time, regular part-time and regular casual employees at least annually to conduct a performance appraisal or have a performance-based conversation. In-service education will be provided based on the outcome of these reviews.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 31310 Based on facility documentation review, facility policy review, and interviews for facility Administration review, the facility failed to ensure the facility administered its resources effectively and to ensure effective administrative oversight of staff and resident care timely to maintain the highest practicable physical, mental, and psychosocial well-being of residents. The findings include: The facility administration failed to: Ensure cardiopulmonary resuscitation was fully performed when the resident was noted to be unresponsive and pulseless. Ensure the Advanced Directive was addressed upon admission to the facility. Ensure a Registered Nurse (RN) assessment was completed when a resident experienced a change in condition. Ensure medication administration was documented in the clinical record when the medication was administered in accordance with standards of practice. Ensure a physician's order was obtained for the type of oxygen therapy. Please cross reference F578, F658, F678, and F695. Based on the deficiencies during the survey, immediate jeopardy and substandard care was identified in the areas of Quality of Life, and Quality of Care. Interview with the Director of Nurses, and the Administrator on 9/8/23 at 10:15 AM failed to identify administrative oversight of the facility processes to ensure the resident was free from significant medication error. The facility failed to utilize resources effectively to attain/maintain the resident's well-being.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075407	A. Building B. Wing	09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 - Potential for minimal harm Residents Affected - Some	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** 32738 Based on clinical record review, facility documentation, facility policy and interviews for one (1) of three (3) residents, (Resident #1), reviewed for medication administration the facility failed to document in the clinical record when the medication was administered in accordance with standards of practice. The findings include: Resident #1's diagnoses included hypertension and chronic obstructive pulmonary disease. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had -no cognitive impairment, required extensive assistance of two persons with bed mobility and transfer. The Resident Care Plan dated 8/30/23 identified Resident #1 had chronic obstructive pulmonary disease, clinical management chronic respiratory failure with interventions directed to administer oxygen as ordered/indicated, observe for worsening shortness of breath (SOB), notify physician of unrelieved or new SOB at rest. A physician's order dated 9/3/23 directed Ipratropium-Albuterol Solution 0.5-2.5 (3) milligrams/3 milliliters (mg/ml) 3 ml inhale orally every four (4) hours as needed for SOB or wheezing. Notify the provider of any adverse reactions. Review of the clinical record and the Medication Administration Record (MAR) for September 2023, failed to reflect Ipratropium-Albuterol Solution was documented as administered during the 7:00 AM to 3:00 PM shift on September 4, 2023. Interview with the 7:00 AM to 3:00 PM charge nurse, Licensed Practical Nurse (LPN) #1, on 9/7/23 at 12:02 PM identified she administered the Ipratropium-Albuterol Solution on 9/4/23 when Resident #1 experienced a shortness of breath, however she forgot to document in the MAR. Interview and review of the clinical record with the Director of Nursing (DON) on 9/8/23/21 at 12:20 PM identified the expectation for the nurse who administered the medication to document administration in the Electronic MAR. Review of Medication Administration: Nebulizer policy directed to document date, time and dosage of medication administered.