STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075263	A. BUILDING _____ B. WING _____	10/02/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 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 clinical record review, review of facility documentation, and interviews, for one of three residents reviewed for a change in condition (Resident #1), the facility failed to ensure that a medication was placed on hold in accordance with physician's orders [REDACTED].#1 had [DIAGNOSES REDACTED]. A Minimum Data Set ((MDS) dated [DATE] identified that the resident had moderate cognitive impairment and required extensive assistance with Activities of Daily Living (ADL's). Review of a care plan dated 7/20/20 identified that Resident #1 had a potential for behavioral issues related to a [DIAGNOSES REDACTED]. Review of a physician's orders [REDACTED]. Review of physician's orders [REDACTED]. Review of physician's orders [REDACTED].#1 directed to hold trazadone until 8/20/20. Review of the Medication Administration Record [REDACTED]. Further review did not reflect that the medication was administered on 8/18, 8/19, and 8/20/20. Interview with Advanced Practice Registered Nurse (APRN) #1 on 10/2/20 at 3:45 PM identified that he/she had spoken to Resident #1's family member who had concerns about the resident's lethargy and requested that the [MEDICATION NAME] be put on hold. APRN #1 identified that he/she wrote the order to hold the trazadone and it would be the expectation to discontinue all of the trazadone orders, including the as needed dose of 25 mg. Interview with the Assistant Director of Nurses (ADNS) on 10/2/20 identified that the 25 mg as needed dose of trazadone remained as an active order on the MAR from 8/18/20 until 8/20/20. Review of the transcription policy identified that all orders must be transcribed by a licensed nurse.
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 clinical record review, review of facility documentation, and interviews, for one of three residents reviewed for change in condition, (Resident #1), the facility failed to ensure that the medical record was accurate and complete. The findings include: a. Resident #1 had [DIAGNOSES REDACTED]. A Minimum Data Set ((MDS) dated [DATE] identified that the resident had moderate cognitive impairment and required extensive assistance with Activities of daily Living (ADL's). 1. Review of a care plan dated [DATE] identified that Resident #1 had a potential for behavioral issues related to a [DIAGNOSES REDACTED]. Review of a psychiatric evaluation dated [DATE] identified that Resident #1 was restless, with periods of agitation, trazadone 25 milligrams (mg) will be added to the medication regime. Review of a physician's orders [REDACTED].#2 on [DATE] at 11:51 AM identified that there was a new order for trazadone 25 mg by mouth every 8 hours as needed for anxiety. Review of physician's orders [REDACTED]. The Medication Administration Record [REDACTED]. Review of the clinical record failed to identify that the responsible party was notified of the medication change. Interview with Person #1 who is the second contact for the resident identified that neither he/she or the resident's Power of Attorney (POA) were notified of the addition of the trazadone to Resident #1's medication regime. Interview with Licensed Practical Nurse (LPN) #2 on [DATE] at 2:00 PM identified that he/she had notified that responsible party of the new medication, although he/she could not recall which family member he/she had notified. He/She further identified that he/she should have documented the notification in the clinical record and was unsure why he/she did not. Interview with the Director of Nurses (DNS) on [DATE] at 1:45 PM identified that LPN #2 should have documented in the clinical record when the responsible party was notified of the new medication. 2. Review of Resident #1's Advanced Directives dated [DATE] identified that the resident was a Do Not Resuscitate (DNR). Review of a nurses' note written by Registered Nurse (RN) #1 on [DATE] at 8:56 PM identified that he/she was paged to Resident #1's room, upon entering the room the charge nurse reported that the resident presented without respiration or chest movement. On assessment Resident #1 was lying in bed, with no chest movement, the carotid pulse and radial pulse were absent, and no heart beat was present upon auscultation. The resident did not have any vital signs. The resident was then pronounced deceased . The family and physician were updated. A nurses' note dated [DATE] written by Licensed Practical Nurse (LPN) #1 on [DATE] at 9:17 PM identified that the resident had expired at 6:40 PM and the funeral home had picked up the decedent at 8:40 PM. The clinical record failed to identify events that corresponded prior to the supervisor arriving to Resident #1's room and pronouncing the resident deceased . Interview with LPN #1 on [DATE] at 2:00 PM identified that he/she was the charge nurse for Resident #1 on [DATE], the evening that the resident passed away. LPN #1 identified that before dinner time the resident presented with some upper airway congestion, so he/she suctioned Resident #1 in accordance with physician's orders [REDACTED]. Resident #1 was alert, and when asked, the resident stated that he/she was feeling OK. Resident #1 accepted his/her 6:00 PM medications without difficulty, but the resident had refused dinner that evening. LPN #1 identified that he/she had taken Resident #1's vital signs earlier in the shift, although he/she remembered they were stable, he/she could not identify exactly what the vital signs were. LPN #1 stated that he/she had reported off to the other charge nurse, and went to his/her dinner break a little after 6:00 PM. LPN #1 stated that he/she was called back to the unit by the other charge nurse because Resident #1 had pulled out the peripheral Intravenous (IV). He/She immediately notified the supervisor and headed back to the unit. He/She arrived to Resident #1' s room and the resident was alert, in no distress, but appeared very pale, so he/she went to the crash cart to get the emergency oxygen and attempted to obtain a pulse oxygenation level, but there was no reading. He/She applied the non rebreather to administer the oxygen and at that time it was noted that the resident had taken his/her last breath. At that time the supervisor had arrived and pronounced the resident deceased . LPN #1 identified that he/she was not aware he/she had to write a nurses' on the change in condition because the resident was a DNR. 3. Review of a care plan dated [DATE] identified that Resident #1 had a [DIAGNOSES REDACTED]. Review of physician's orders [REDACTED].#1 with a regular diet and thin liquids and to keep at a 90 degree angle at meal time. Review of a nurses' note dated [DATE] at 2:28 PM identified that Resident #1 was noted to be coughing at meals, and the diet was immediately downgraded to a puree with nectar thick liquids, and a speech therapy evaluation was ordered. Review of a speech therapy note dated [DATE] identified that Resident #1 was presenting with intermittent alertness impacting the ability for intake by mouth. Resident #1's diet was downgraded to puree with nectar thick liquids and to feed only when awake and alert, with one to one supervision with strict oral care. Review of a physician's orders [REDACTED]. The physician's orders [REDACTED]. Review of the [DATE] Medication Administration Record [REDACTED]. Interviews on [DATE] with staff that fed Resident #1 between [DATE] and [DATE] identified that that Resident #1 was provided with a puree diet with nectar thick liquids which was tolerated without difficulty. Interview with the Assistant Director of Nurses on [DATE] at 4:15 PM identified that the physician's orders [REDACTED]. He/She further identified that Resident #1 received the correct diet between ,[DATE] and [DATE]. The diet order that was being signed off by the nurses for the regular diet with thin liquids was entered into the wrong area of the MAR,

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

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F 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) and identified that the correct diet order would appeared on the electronic record at the top of the MAR, so staff would have access to the current diet order.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide and implement an infection prevention and control program.** Based on observations, review of facility documentation, and interviews, the facility failed to ensure that a staff member who was providing personal care to a resident (Resident #2), had a surgical mask donned at all times while providing care and while in the same room as the resident. The findings include: Observation with the Assistant Director of Nurses (ADNS) on 9/25/20 at 9:58 AM identified that Nurse Aide (NA) #1 was in the room with Resident #2 (a negative unexposed resident), and NA #1 was not wearing a surgical mask. The ADNS immediately directed NA #1 to don a surgical mask. Interview with NA #1 in the presence of the Director of Nurses (DNS) on 9/25/20 at 9:15 AM identified that Resident #2 was in bed, and while changing the resident's brief, his/her mask fell off and landed on the dirty linen that was located on the floor. NA #1 finished washing Resident #2, and then after care was completed he/she transferred the resident in to the wheelchair and made the bed without wearing the surgical mask, although he/she was aware a mask was required at all times while caring for residents. Observation of NA #1 during the interview on 9/25/20 at 9:15 AM identified that his/her mask fell off of his/her right ear a total of six (6) times during the interview exposing his/her nose and mouth. Further interview on 9/25/20 at 9:20 AM (approximately 5 minutes after NA #1's initial interview) with NA#1 identified that he/she had gotten confused with the surveyor questions and wanted to clarify what had happened while caring for Resident #2 that morning. NA #1 identified that he/she was wearing the surgical mask during care, although he/she had to re-apply the mask several times as it kept falling off of his/her ear during care. He/She then identified that after he/she finished care and was making the bed, his/her mask fell on to the dirty linen and he/she continued to make the bed unmasked although he/she was approximately two (2) to three (3) feet away from the resident. NA #1 further stated that the resident was not wearing a mask at any time while he/she was in the room. NA #1 stated that if he/she was having trouble keeping the mask on, he/she should have left the room and alerted the charge nurse of his/her issues with the mask. Interview and observation of Resident #2's room with the ADNS on 9/24/20 at 10:00 AM identified that he/she had opened Resident #2's door and observed Resident #2 by the bathroom door and NA#1 at the foot of the bed not wearing a mask. The ADNS identified that NA #1 was approximately 8 feet away from the resident unmasked. The ADNS identified that at the time of the initial observation he/she saw something colored on the resident's face and would assume that it was a surgical mask. The ADNS further identified that the resident always wears a mask, although observation on 9/25/20 at 10:00 AM identified that Resident #2 was not wearing a mask until it was applied by the ADNS. Interview with the Director of Nurses (DNS) on 9/25/20 at 10:30 AM identified that all staff must wear a surgical mask while in the facility and especially when providing personal care for the residents. The DNS further identified that NA #1 was wearing a hair bonnet and with the weight of NA #1's hair, it was causing his/her ears to bend in a forward direction which was causing the mask to fall off of his/her ear. The DNS stated that if the mask was continually falling off during care, NA #1 should have left the room and consulted with the charge nurse. Furthermore, the DNS did not have an explanation for the discrepancies between NA #1's initial and subsequent interviews. The facility policy on face masks identified that the facility will follow Centers for Disease Controls guidance on face masks. Review of the CDC guidance for Covid-19 guidance identified that health care workers will wear face masks at all times while in the facility.