STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075183	A. Building B. Wing	04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Fox Hill	1253 Hartford Tpke Rockville, CT 06066

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for one (1) of two (2) residents (Resident #2) reviewed for facility discharge, the facility failed to provide a medically necessary walker for a resident upon discharge. The findings include: Resident #2 was admitted to the facility with diagnoses that included acute respiratory failure and congestive heart failure. The care plan dated 4/29/23 identified Resident #2 had the potential for discharge. Interventions included to evaluate discharge planning needs taking into consideration care plans, resident/patient goals, cognitive skills, functional mobility and need for assistive devices. The occupational therapy discharge summary for dates of service 5/1/23 - 5/12/23 identified Resident #2 demonstrated an increase in active tolerance and balance using the walker for mobility. The physical therapy discharge summary for dates of service 5/1/23 - 5/12/23 identified the discharge recommendations were for an assistive device for safe functional mobility, home health services, grab bars and a walker. A social services note dated 5/12/23 at 4:07 PM identified the plan was for Resident #2 to be discharged home safely on 5/15/23 with services. Resident #2's family would purchase a tub bench for Resident #2. The social worker would order oxygen for Resident #2 for him/her to return home with. The discharge MDS dated [DATE] identified Resident #1 had a Brief Mental Interview for Mental Status (BIMS) score of fourteen (14) indicative of intact cognition and required extensive assistance with transfers and walking in the room. A physician's note dated 5/15/23 identified Resident #2 was being discharged and that Resident #2's discharge condition was stable, Resident #2 did well in short term rehab, was walking with a walker and had home health services. The note identified the durable medical equipment needed was a walker, shower bench and oxygen. (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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A social services note dated 5/15/23 at 3:55 PM identified Resident #2 would be discharged home safely with his/her family member, oxygen would be delivered to his/her home and an oxygen tank was delivered to his/her room for transport home. A home health care agency was set up for home care services. The social services note failed to include documentation that a walker was ordered for Resident #2's discharge. Review of the post-discharge assessment day 3 dated 5/18/23 identified there were problems with the oxygen and walker. The medical record failed to identify a follow up for Resident #2's post discharge problems and the outcome. Review of the post-discharge assessment day 30 dated 6/16/23 identified one call attempt was made to Resident #1's family member with no further details. Interview with the Director of Social Services on 4/29/25 at 12:46 PM identified the social worker prepared resident discharges to include arranging services and equipment. She identified if a resident needed oxygen for discharge, the social worker would set it up. She identified if the family or resident specified needing a commode, walker, or wheelchair, the facility would order the equipment. Although requested, documentation that Resident #2 was provided with a walker or that a walker was ordered for discharge, was not provided. Interview with Person #1 on 4/30/25 at 1:59 PM identified when his/her family member was discharged , they were not provided with a wheelchair or walker. She identified the day after Resident #2 came home, he/she fell two times. Person #1 identified she had to go out and buy a walker the following day. Review of the discharge planning process policy directed that an active individualized discharge care plan will address, at a minimum, the identified needs, such as medical, nursing, equipment, educational, or psychosocial needs. The facility will document any referrals to local contact agencies or other appropriate entities made for the purpose of the resident's interest in returning to the community.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, facility documentation, facility policy, and interviews for three (3) of six (6) residents (Resident #2, #3 and #4) reviewed for oxygen, the facility failed to ensure the residents' care plan included oxygen use per facility policy. The findings include: 1. Resident #2 was admitted to the facility with diagnoses that included acute respiratory failure and diastolic heart failure. The nursing admissions assessment dated [DATE] identified Resident #2 had oxygen at 1 liter per minute via nasal cannula. A physician's order dated 4/29/23 directed oxygen via nasal cannula 1 to 4 liters to maintain an oxygen saturation greater than ninety (90) percent. The Resident Care Plan (RCP) dated 4/29/23 identified Resident #2 had an ADL self-care performance deficit related to activity intolerance, fatigue and limited mobility. Interventions included to provide Resident #2 with limited assist of one staff for bed mobility and staff assistance with personal hygiene and oral care. The RCP failed to identify a focus and interventions for oxygen therapy. A physician's note dated 5/1/23 directed to continue to wean Resident #2 off oxygen as tolerated and noted Resident #2 was currently on 1 liter. The admission MDS dated [DATE] identified Resident #2 had a Brief Mental Interview for Mental Status (BIMS) score of fifteen (15) indicative of intact cognition, required extensive assistance of one staff member for activities of daily living (ADL's) and received oxygen therapy. A physician's note dated 5/15/23 identified Resident #2 was being discharged on 1 liter of oxygen. 2. Resident #3 was admitted to the facility with diagnoses that included acute respiratory failure. A physician's order dated 9/4/24 directed oxygen at 0 to 4 liters/minute via nasal cannula continuously. The quarterly MDS dated [DATE] identified Resident #3 had a Brief Mental Interview for Mental Status (BIMS) score of thirteen (13) indicative of intact cognition, required extensive assistance of one staff member for activities of daily living (ADL's) and received oxygen therapy. The Resident Care Plan (RCP) dated 3/24/25 identified Resident #3 was at risk for decreased ability to perform ADL's related to recent illness resulting in fatigue, activity intolerance and confusion. Interventions included to monitor for decline in ADL function, provide Resident #2 with an assist of one for bed mobility and monitor medications. The RCP failed to identify a focus and interventions for oxygen therapy. The nursing quarterly assessment dated [DATE] identified Resident #3 had oxygen at 2 liters per minute via nasal cannula. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation conducted on 4/29/25 at 11:50 AM identified Resident #3 was lying upright in his/her bed eating lunch with oxygen being administered at 2 liters/minute via nasal cannula. Subsequent to surveyor inquiry, the RCP was updated on 4/29/25 and identified Resident #3 exhibited or was at risk for respiratory complications related to asthma. Interventions included oxygen as ordered via nasal cannula. 3. Resident #4 was admitted to the facility with diagnoses that included chronic obstructive pulmonary disease. A physician's order dated 1/22/25 directed oxygen at 2 liters/minute via nasal cannula to maintain oxygen greater than ninety-two (92) percent. The quarterly MDS dated [DATE] identified Resident #4 had a Brief Mental Interview for Mental Status (BIMS) score of eleven (11) indicative of a moderate impairment in cognition, required extensive assistance of one staff member for activities of daily living (ADL's) and received oxygen therapy. The Resident Care Plan (RCP) dated 2/25/25 identified Resident #4 exhibited or was at risk for respiratory complications related to chronic cough and shortness of breath. Interventions included to obtain labs as ordered, monitor and report oxygen levels, nebulizer treatments and position upright to facilitate respirations. The RCP failed to identify a focus and interventions for oxygen therapy. The nursing quarterly assessment dated [DATE] identified Resident #4 had oxygen at 2 liters per minute via nasal cannula. Subsequent to surveyor inquiry, the RCP was updated on 4/29/25 to include interventions for oxygen as ordered via nasal cannula. Interview with the DNS on 4/29/25 at 12:46 PM identified oxygen use should be a part of the RCP. Review of the oxygen administration policy directed that the resident's care plan shall identify the interventions for oxygen therapy, based upon the resident's assessment and orders, such as, but not limited to the type of oxygen delivery system, when to administer, such as continuous or intermittent and/or when to discontinue, equipment setting for the prescribed flow rates, monitoring of SP02 (oxygen saturation) levels and/or vital signs as ordered and monitoring for potential complications associated with the use of oxygen. Review of the comprehensive care plans policy directed that the care planning process will include an assessment of the resident's strengths and needs, and will incorporate the resident's personal and cultural preferences in developing goals of care. The comprehensive care plan will describe, at a minimum, the services that are to furnished to attain or maintain the residents' highest practicable physical, mental, and psychosocial well-being.