

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075183	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2025
NAME OF PROVIDER OR SUPPLIER Complete Care at Fox Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 1253 Hartford Tpke Vernon, 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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #2) reviewed for grievances, the facility failed to initiate a grievance timely. The findings include: Resident #2's diagnoses included chronic obstructive pulmonary disease, heart failure, pneumonia, obstructive sleep apnea, irritable bowel syndrome with constipation, and diarrhea. The admission Minimum Data Set (MDS) assessment dated [DATE] identified that Resident #2 had a Brief Interview for Mental Status (BIMS) score of 15 out of fifteen, indicative of no cognitive impairment and was dependent with toileting, transfers and ambulation, and was occasionally incontinent of urine and frequently incontinent of bowel. The Resident Care Plan (RCP) dated 7/24/2025 identified a decreased ability to perform ADLs, transfers, locomotion, and toileting. Interventions directed to assist with ADLS and toileting, and to provide toileting and incontinent care as needed. The nursing note dated 8/3/2025 at 6:06 PM written by RN #2 identified Resident #2 reported he/she had frequent diarrhea since 7/31/2025. Resident #2 appeared tired and fatigued and was having some respiratory difficulty, oxygen level was increased to two liters/minute (order for 1 to 4 liters/min), and Resident #2 received a nebulizer (breathing) treatment. Further, Resident #2 reported he/she often waited for a long time to be helped to the bathroom, get water or to get medications, and family member visiting at the time confirmed the concern. The note indicated RN #2 would notify the DNS of the concern. Review of facility grievance logbook on 9/25/2025 failed to identify a grievance was filed on Resident #2's behalf for the concerns expressed on 8/3/2025. Interview with RN #2 was not obtained during the survey. Interview, clinical record review, and facility documentation review on 9/24/2025 at 2:00 PM with DNS identified to her knowledge Resident #2 had no grievances or concerns that were voiced, and she did not recall being notified by RN #2 that Resident #2 and her/his family had shared care concerns with RN #2. The DNS stated she would have expected RN #2 to notify her when a resident and/or the family reported care concerns and further indicated any staff member can complete a grievance form. Review of facility Resident and Family Grievances Policy directed in part; it is the policy of this facility to support each resident's and family member's right to voice grievances without discrimination, reprisal or fear of discrimination or reprisal. Prompt efforts to resolved include facility acknowledgment of a compliant/grievance and actively working toward resolution of that compliant/grievance. The Grievance Official will take steps to resolve the grievance, and record information about the grievance, and those actions, on the grievance forms and will keep the resident appropriately apprised of progress towards resolution of the grievances. The facility will make prompt efforts to resolve grievances. Review of facility documentation identified staff education was initiated on 9/19/2025 regarding grievances and referring complaints to the supervisor and to refer families to the Family Council meetings. Audits were initiated on 8/12/2025 and a QAPI meeting was held on 9/16/2025. Based on documentation review a finding of past-non-compliance with identified.		

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