

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 05/22/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Fox Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37293 Based on observations, review of the clinical record, review of facility documentation, and interviews for 2 of 5 residents (Resident #27 and 83) reviewed for dining, the facility failed to ensure a dignified dining experience when breakfast was served and utensils were not provided to residents for 35 minutes, and for 3 of 5 residents (Resident #54, 63, and 67) reviewed for dining, the facility failed to ensure a dignified dining as the necessary assistance for residents who were dependent for eating was not provided, and for 1 of 2 residents (Resident #22) reviewed for urinary devices, the facility failed to ensure the urinary device had a privacy cover for dignity. The findings include: 1. Resident #27 was admitted to the facility in November 2023, with diagnoses which included dementia with agitation, dysphagia, diabetes, dysarthria and anarthria, and traumatic brain injury. The care plan dated 2/15/24 identified Resident #27 has an ADL self-care performance deficit related to activity intolerance, dementia, stroke. Interventions included to provide the resident with a lip plate and built-up utensil for all meals. The quarterly MDS assessment dated [DATE] identified Resident #27 had severely impaired cognition and required set up with eating. The physician's order dated 5/1/24 directed to provide a regular texture, thin consistency, weighted utensils, and plate divider. Review of the resident roster on 5/19/24 for the Red Oak Terrace South Right Wing identified the resident census was 20. Observation on 5/19/24 at 9:00 AM on the Red Oak Terrace South Right Wing identified the dietary aide delivered a cart with coffee, hot water, juices, milk, tea, sugar, condiments, empty coffee/tea cups, and eating utensils on the unit. Observation on 5/19/24 at 9:10 AM on the Red Oak Terrace South Right Wing identified DA #1 pushing a cart with multiple breakfast plates with a lid, multiple bowls of oatmeal, and multiple bowls with a variety of cold cereals. Interview with DA #1 indicated she only delivers the breakfast plates, bowl of hot oatmeal, and bowl of cold cereal to the resident in the rooms and places it on the overbed tables. DA #1 indicated she does not pass out the coffee, juice, or the eating utensils as it is the responsibility of the nurse aides on the unit. (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 075183	Facility ID: 075183 If continuation sheet Page 1 of 58

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 05/22/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Fox Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 5/19/24 at 9:11 AM on the Red Oak Terrace South Right Wing identified DA #1 delivered and placed a plate of scrambled eggs and toast with a lid over the plate (with a hole in the middle of lid for grasping), and a bowl of oatmeal with a plastic lid on Resident #27's overbed. Resident #27 was not provided with eating utensils, no coffee, no juice, no milk, no sugars, no condiments, no napkin at that time. Resident #27 was sitting in a regular standard wheelchair in his/her room fully dressed. No nurse aides were observed in the hallway on the unit at that time. Observation on 5/19/24 at 9:15 AM identified NA #16, and NA #2 in different resident rooms providing care with the doors closed. RN #6 was observed distributing morning medications. Observation on 5/19/24 at 9:30 AM (20 minutes after receiving breakfast) identified Resident #27 sitting in the wheelchair in his/her room in front of the overhead table eating the scrambled eggs with his/her fingers out of the plate. No nurse aides were observed in the hallway on the unit at that time. Observation on 5/19/24 at 9:45 AM (35 minutes after breakfast was distributed to the residents) observed NA #16 pushing the cart with coffee, hot water, juices, milk, tea, sugar, condiments, empty coffee/tea cups, and eating utensils on the unit going from room to room distributing the items. Interview with RN #6 on 5/19/24 at 10:00 AM identified she was aware that the unit was short of nurse aide staff on the 7:00 AM - 3:00 PM shift. RN #6 indicated there are 20 residents on the unit. RN #6 indicated she was aware that the residents on the unit did not receive coffee, and eating utensils when breakfast was served. RN #6 indicated there is 11/2 nurse aide for the unit. RN #6 indicated both nurse aides had answered call lights and had to provide care to soiled residents at the time breakfast was on the unit. Interview with Resident #27 on 5/19/24 at 10:05 AM identified his/her scrambled eggs cold were cold, and he/she had to eat the scrambled eggs with his/her fingers because there was no fork, or spoon to eat with. Resident #27 indicated his/her breakfast was cold by the time he/she received the eating utensils. Resident #27 indicated he/she took one spoonful of oatmeal and he/she did not want the rest because the oatmeal was cold as well as the coffee was cold, and the toast. Resident #27 indicated he/she did not enjoy his/her breakfast. The nurse aide care card dated 5/21/24 identified Resident #27 was able to eat independently after set-up, uses divided plate, and weighted utensils with meals. 2. Resident #83 was admitted to the facility in April 2024, with diagnoses which included acute respiratory failure, chronic kidney disease stage 4, and diabetes. The admission MDS assessment dated [DATE] identified Resident #83 had intact cognition and was independent with eating meals. The April 2024 care plan identified Resident #83 was at risk for decreased ability to perform ADL's in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, toileting related to chronic obstructive pulmonary disease, coronary artery disease, congestive heart failure, chronic kidney disease, recent intensive care unit admission. Interventions included monitor for decline in ADL function. Refer to rehabilitation therapy if decline in ADL's is noted. (continued on next page)		

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 05/22/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Fox Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The physician's order dated 5/1/24 directed to provide Resident #83 with a regular texture, thin consistency diet. Observation on 5/19/24 at 9:10 AM on the Red Oak Terrace South Right Wing identified DA #1 pushing a cart with multiple breakfast plates with a lid, multiple bowls of oatmeal, and multiple bowls with a variety of cold cereals. Interview with DA #1 indicated she only delivers the breakfast plates, bowl of hot oatmeal, and bowl of cold cereal to the resident in the rooms and place it on the overbed tables. DA #1 indicated she does not pass out the coffee, juice, or the eating utensils it is the responsibility of the nurse aides on the unit. Observation on 5/19/24 at 9:10 AM on the Red Oak Terrace South Right Wing identified DA #1 delivered and placed a plate of scrambled eggs and toast with a lid over the plate (with a hole in the middle of lid for grasping), a bowl and a small box of cold cereal on Resident #83 overbed table by the first bed. Resident #83 was not provided with eating utensils, no coffee, no juice, no milk, no sugars, no condiments, no napkin at that time. Resident #83 was sitting in a regular wheelchair in his/her room. No nurse aides were observed in the hallway on the unit at that time. Interview with Resident #83 on 5/19/24 at 10:03 AM identified he/she did not receive milk and eating utensils when he/she was served his/her breakfast. Resident #83 indicated the nurse aides took too long to bring the milk and eating utensils. Resident #83 indicated the scrambled eggs were cold, and he/she did not get the milk on time for the cold cereal. Resident #83 indicated she did not call for assistance because they are always short of staff on the weekends on the 7:00 AM - 3:00 PM shift. Interview with RN #3 on 5/19/24 at 10:15 AM identified she has been employed by the facility for approximately 5 1/2 months. RN #3 indicated she is the 7:00 AM - 3:00 PM supervisor every weekend. RN #3 indicated she was not aware the residents on the Red Oak Terrace South Right Wing did not receive coffee and eating utensils when breakfast was served. RN #3 indicated she was on the North side of the facility helping with breakfast, feeding, picking up the dirty dishes, and answering call lights. RN #3 indicated the facility is short of staff every weekend and she has to assist in the care of residents and also do her duties as a supervisor. RN #3 indicated the DNS is aware of the staffing challenges. Interview with RN #7 (unit manager) on 5/19/24 at 10:25 AM identified she has been employed by the facility for 2 years. RN #7 indicated she was aware that the staffing was short for the 7:00 AM - 3:00 PM shift. RN #7 indicated she was not aware that the residents on the Red Oak Terrace South Right Wing did not receive coffee and eating utensils when breakfast was served. RN #7 indicated she was on the South Center Wing helping with breakfast and feeding residents. RN #7 indicated the facility is short of staff a lot on the weekends. RN #7 indicated the facility does not use agency replacement staff. The nurse aide care card dated 5/20/24 identified Resident #83 was encouraged to consume all fluids during meals. Provide fluids of choice. (continued on next page)		

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 05/22/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Fox Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the DNS on 5/21/24 at 1:25 PM identified the facility was not short of staff on 5/19/24 on the 7:00 AM - 3:00 PM shift. The DNS indicated RN #2, RN #3, and RN #7 were on the units working as nurse aides. The DNS was unable to verify that RN #2, RN #3, and RN #7 work every weekend when the facility is short of staff. The DNS indicated she was not aware that the residents on the Red Oak Terrace South Right Wing did not receive coffee and eating utensils when breakfast was served. The DNS indicated the facility has been reviewing applications and conducting interviews for nurse aides. The DNS indicated it is the responsibility of the nurse aides to pass out the coffee, juice, and eating utensils. 3. Resident #54 was admitted to the facility in December 2024, with diagnoses that included dementia with behavioral disturbance, pseudobulbar affect, anxiety disorder, and cerebrovascular disease. The care plan dated 3/20/24 identified Resident #54 had a nutrition/hospice care plan related to diagnoses of dementia and depression which sometimes affects weight/appetite. Intervention included to provide the resident with a lip plate. Further, review of the care plan failed to reflect the resident required level of assistance with meals. The quarterly MDS assesment dated 4/1/24 identified Resident #54 had severely impaired cognition and was dependent with eating. The physician's order dated 5/1/24 directed to provide a regular diet, chopped texture, and requires lip plate for all meals. Review of the resident roster on 5/19/24 for the Red Oak Terrace South Right Wing identified the resident census was 20. Observation on 5/19/24 at 9:00 AM on the Red Oak Terrace South Right Wing identified the dietary aide delivered a cart with coffee, hot water, juices, milk, tea, sugar, condiments, empty coffee/tea cups, and eating utensils on the unit. Observation and interview on 5/19/24 at 9:10 AM on the Red Oak Terrace South Right Wing identified DA #1 pushing a cart with multiple breakfast plates with a lid, multiple bowls of oatmeal, and multiple bowls with a variety of cold cereals. Interview with DA #1 indicated she only delivers the breakfast plates, bowl of hot oatmeal, and bowl of cold cereal to the resident in the rooms and place it on the overbed tables. DA #1 indicated she does not pass out the coffee, juice, or the eating utensils it is the responsibility of the nurse aides on the unit. Observation on 5/19/24 at 9:11 AM on the Red Oak Terrace South Right Wing identified DA #1 delivered a plate of scrambled eggs with a lid over the plate (with a hole in the middle of lid for grasping), and a bowl of oatmeal with a plastic lid on Resident #54's overbed table by the window bed. Resident #54 was not provided with eating utensils, no coffee, no juice, no milk, no sugars, no condiments, no napkin at that time. Resident #54 was lying in bed with eyes open, with head of the bed at 30 degrees in his/her room. Resident #54 is a feed (RN #6 indicated the resident was a feed). No nurse aides were observed in the hallway on the unit at that time. Observation on 5/19/24 at 9:15 AM identified NA #16, and NA #2 in different resident rooms providing care with the doors closed. RN #6 observed passing out morning medications. (continued on next page)		

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 05/22/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Fox Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 5/19/24 at 9:45 AM (35 minutes after breakfast was served) observed NA #16 pushing the cart with coffee, hot water, juices, milk, tea, sugar, condiments, empty coffee/tea cups, and eating utensils on the unit going from room to room distributing the items. Observation on 5/19/24 at 9:50 AM identified (40 minutes after breakfast was served) RN #3 was feeding Resident #54 his/her breakfast in bed. The nurse aide care card dated 5/21/24 identified Resident #54 prefer some meals in bed. Encourage the resident to consume all fluids during meals and offer fluids of choice. The care card failed to reflect Resident #54 was a feed with meals. Interview and clinical record review with the DNS on 5/21/24 at 10:25 AM identified she was not aware of Resident #54 care card failed to reflect that Resident #54 was a feed with all meals. Subsequent to surveyor inquiry Resident #54 care card was updated to reflect the resident required feedings. 4. Resident #63 was admitted to the facility in August 2019, with diagnoses that included Parkinson's disease, Alzheimer's disease, dementia with severe agitation, dysphagia, and diabetes. The quarterly MDS assessment dated [DATE] identified Resident #63 had severely impaired cognition and was dependent with eating. The care plan dated 3/30/24 identified Resident #63 was at risk for malnutrition secondary to diagnoses of dementia and depression, on psychotropic medication which affects weight and appetite. Interventions included resident was a feed at mealtimes, provide diet as ordered. The physician's order dated 5/1/24 directed to provide a no added salt (NAS) diet with ground texture, and thin consistency. Review of the resident roster on 5/19/24 for the Red Oak Terrace South Right Wing identified the resident census was 20. Observation on 5/19/24 at 9:00 AM on the Red Oak Terrace South Right Wing identified the dietary aide delivered a cart with coffee, hot water, juices, milk, tea, sugar, condiments, empty coffee/tea cups, and eating utensils on the unit. Observation and interview on 5/19/24 at 9:10 AM on the Red Oak Terrace South Right Wing identified DA #1 pushing a cart with multiple breakfast plates with a lid, multiple bowls of oatmeal, and multiple bowls with a variety of cold cereals. Interview with DA #1 indicated she only delivers the breakfast plates, bowl of hot oatmeal, and bowl of cold cereal to the resident in the rooms and place it on the overbed tables. DA #1 indicated she does not pass out the coffee, juice, or the eating utensils it is the responsibility of the nurse aides on the unit. (continued on next page)		

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 05/22/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Fox Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 5/19/24 at 9:11 AM on the Red Oak Terrace South Right Wing identified DA #1 delivered and placed a plate of scrambled eggs with a lid over the plate (with a hole in the middle of lid for grasping), and a bowl of oatmeal with a plastic lid on Resident #63 overbed table at the foot of the bed by the window. Resident #63 was not provided with eating utensils, no coffee, no juice, no milk, no sugars, no condiments, no napkin at that time. Resident #63 was lying in bed with eyes open with head of the bed at 60 degrees in his/her room. Resident #63 is a feed. No nurse aides were observed in the hallway on the unit or in resident's room at that time. Observation on 5/19/24 at 9:15 AM identified NA #16, and NA #2 in different resident rooms providing care with the doors closed. RN #6 observed passing out morning medications. Observation on 5/19/24 at 9:45 AM (35 minutes after breakfast was served) observed NA #16 pushing the cart with coffee, hot water, juices, milk, tea, sugar, condiments, empty coffee/tea cups, and eating utensils on the unit going from room to room distributing the items. Observation with RN #3 on 5/19/24 at 10:18 AM identified NA #2 entering Resident #63's room and exiting the room with the breakfast plate and bowl of oatmeal. NA #2 indicated she is going to warm up the breakfast before feeding Resident #63 the breakfast. Interview with NA #2 on 5/19/24 at 11:00 AM identified with NA #2 identified she has been employed by the facility for [AGE] years. NA #2 indicated the unit has 11/2 nurse aides. NA #2 indicated Resident #63 was on her assignment. NA #2 indicated she was the 1/2 for 3 different units. NA #2 indicated it is hard being the 1/2 nurse aide for 3 different units. NA #2 indicated she was providing care to a resident that was soiled that is why she was late feeding Resident #63, and did not pass out the breakfast coffee, juices, and eating utensils. The nurse aide care card dated 5/21/24 identified Resident #63 prefer to eat most of meals in bed. Assist times one for feeding-needs fork placed in hand. Encourage the resident to consume all fluids during meals and offer fluids of choice. Resident to be placed at a 90 degrees upright position or out of bed when swallowing food or drink. 5. Resident #67 was admitted to the facility in January 2020, with diagnoses that included dementia with agitation and behavioral disturbance, and dysphagia. The quarterly MDS assessment dated [DATE] identified Resident #67 had severely impaired cognition and was dependent with eating. The care plan dated 5/1/24 identified Resident #67 nutrition has been altered due to dysphagia. Resident #67 had a diagnoses of dementia, and is on psychotropic medications which affects weight and appetite. Interventions included feed at mealtimes and prefers to eat most of meals in bed. The physician's order dated 5/1/24 directed to provide a regular diet, dysphagia puree texture, nectar consistency, 1:1 assistance in feeding, ensure resident is positioned upright for eating and drinking. Review of the resident roster on 5/19/24 for the Red Oak Terrace South Right Wing identified the resident census was 20. (continued on next page)		

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 05/22/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Fox Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 5/19/24 at 9:00 AM on the Red Oak Terrace South Right Wing identified the dietary aide delivered a cart with coffee, hot water, juices, milk, tea, sugar, condiments, empty coffee/tea cups, and eating utensils on the unit. Observation and interview on 5/19/24 at 9:10 AM on the Red Oak Terrace South Right Wing identified DA #1 pushing a cart with multiple breakfast plates with a lid, multiple bowls of oatmeal, and multiple bowls with a variety of cold cereals. Interview with DA #1 indicated she only delivers the breakfast plates, bowl of hot oatmeal, and bowl of cold cereal to the resident in the rooms and place it on the overbed tables. DA #1 indicated she does not pass out the coffee, juice, or the eating utensils it is the responsibility of the nurse aides on the unit. Observation on 5/19/24 at 9:11 AM on the Red Oak Terrace South Right Wing identified DA #1 delivered and placed a plate of puree eggs with a lid over the plate (with a hole in the middle of lid for grasping), and a bowl of puree oatmeal with a plastic lid on Resident #67 overbed table by the wall by the first bed. Resident #67 was not provided with eating utensils, no coffee, no juice, no milk, no sugars, no condiments, no napkin at that time. Resident #67 was lying in bed facing the door with eyes closed with head of the bed at 60 degrees in his/her room. Resident #67 was a feed. No nurse aides were observed in the hallway on the unit or in resident's room at that time. Observation on 5/19/24 at 9:15 AM identified NA #16, and NA #2 in different resident rooms providing care with the doors closed. RN #6 observed passing out morning medications. Observation on 5/19/24 at 9:45 AM (35 minutes after breakfast was served) observed NA #16 pushing the cart with coffee, hot water, juices, milk, tea, sugar, condiments, empty coffee/tea cups, and eating utensils on the unit going from room to room distributing the items. Interview with RN #6 (nurse on the unit on the 7:00 AM - 3:00 PM shift) on 5/19/24 at 10:00 AM identified she was aware that the unit was short of nurse aide staff on the 7:00 AM - 3:00 PM shift. RN #6 indicated there are 20 residents on the unit. RN #6 indicated she was aware that the residents on the unit did not receive coffee, and eating utensils when breakfast was served. RN #6 indicated there was 11/2 nurse aide schedule for the unit. RN #6 indicated both nurse aides had answered call lights and had to provide care to soiled residents at the time breakfast was on the unit. RN #6 indicated RN #3 was aware of the issue. Observation on 5/19/24 at 10:00 AM identified NA #16 had warmed up the breakfast and started feeding Resident #67 breakfast in bed. Interview with NA #16 on 5/19/24 at 10:05 AM identified she was providing care to a resident that was soiled that is why she was late feeding Resident #67, and late passing out the breakfast coffee, juices, and eating utensils. The nurse aide care card dated 5/21/24 identified Resident #67 prefer to eat most of meals in bed. Resident #67 requires staff to feed with meals. (continued on next page)		

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 05/22/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Fox Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with RN #3 on 5/19/24 at 10:15 AM identified she has been employed by the facility for approximately 5 1/2 months. RN #3 indicated she is the 7:00 AM - 3:00 PM supervisor every weekend. RN #3 indicated she was not aware the residents on the Red Oak Terrace South Right Wing did not receive coffee and eating utensils when breakfast was served. RN #3 indicated she was on the North side of the facility helping with breakfast, feeding, picking up the dirty dishes, answering call lights. RN #3 indicated she was aware that the staffing was short for the 7:00 AM - 3:00 PM shift. RN #3 indicated the facility is short of staff every weekend and she has to assist in the care of residents and also do her duties as a supervisor. RN #3 indicated the DNS was aware of the schedule. RN #3 indicated she had to feed Resident #54 his/her breakfast. RN #3 indicated she was not aware the residents that needed to be fed by the nursing staff were not fed in a timely manner. Interview with RN #7 (unit manager during the week days) on 5/19/24 at 10:25 AM identified she has been employed by the facility for 2 years. RN #7 indicated she was aware that the staffing was short for the 7:00 AM - 3:00 PM shift. RN #7 indicated she was not aware that the residents on the Red Oak Terrace South Right Wing did not receive coffee and eating utensils when breakfast was served. RN #7 indicated she was on the South Center Wing helping with breakfast and feeding residents. RN #7 indicated the facility is short of staff a lot on the weekends. RN #7 indicated the facility does not use agencies for replacing staff. RN #7 indicated she was not aware the residents that needed to be fed by the nursing staff were not fed in a timely manner. Interview with the DNS on 5/21/24 at 1:25 PM identified the facility was not short of staff on 5/19/24 on the 7:00 AM - 3:00 PM shift. The DNS indicated RN #2, RN #3, and RN #7 were on the units working as nurse aides. The DNS was unable to verify that RN #2, RN #3, and RN #7 work every weekend when the facility is short of nurse aides. The DNS indicated she was not aware that the residents on the Red Oak Terrace South Right Wing did not receive coffee and eating utensils when breakfast was served. The DNS indicated it is the responsibility of the nurse aides to pass out the coffee, juice, and eating utensils. Review of the facility resident rights policy identified: Respect and Dignity The resident has a right to be treated with respect and dignity, including: The right to resident and receive services in the facility with reasonable accommodation of resident needs and preferences, except when to do so would endanger the health or safety of the resident or other residents. 42117 6. Resident #22 was admitted to the facility on [DATE] with diagnoses that included urinary retention, obstructive uropathy, and benign prostatic hyperplasia. The admission MDS assessment dated [DATE] identified Resident #22 had moderately impaired cognition, requires maximum assistance with toileting, bathing, showering, dressing upper and lower body, and personal hygiene. Additionally, Resident #22 has a indwelling catheter. The care plan dated 3/27/24 does not reflect Resident #22 has a urinary catheter. (continued on next page)		

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 05/22/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Fox Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physician's order dated 4/15/24 directed to a Foley catheter to drainage, perform Foley catheter care on evening and night shift, and empty catheter drainage bag at least once every 8 hours to when it becomes 1/2 to 2/3's full as needed. Additionally, had Flomax 0.8 mg and bladder scan if post void residual is greater than 300 ml insert Foley catheter. Observation on 5/19/24 at 7:40 AM noted Resident #22 was lying in bed with urinary device hanging on left side of bed facing the hallway lying on floor with urine visible from hallway and without the benefit of a privacy bag. Interview with charge nurse LPN # 1 on 5/19/24 at 7:45 AM indicated Resident #22's urinary device should not be lying on the floor and should have a privacy bag covering it. Observation and interview with the DNS on 5/19/24 at 7:49 AM identified Resident #22's urinary device needs to be covered for dignity and that it should not be touching the floor for infection control/ sanitary reasons. The DNS indicated that it was lying on the floor because the bed was in the low position as Resident #22 was a fall risk. Review of the facility Catheter Care identified it is the policy of the facility to ensure that residents with indwelling catheters receive appropriate catheter care and maintain their dignity and privacy. Privacy bags will be available and catheter drainage bags will be always covered while in use. Empty drainage bags when bag is half full or every 3 to 6 hours.		

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 05/22/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Fox Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37293 Based on review of the clinical record, facility documentation, facility policy, and interviews for 2 of 2 residents (Resident #100 and #160) reviewed for notify of change, the facility failed to notify the resident representative of the new physician orders and changes in condition for (Resident #100) and the facility failed to ensure the resident representative was notified of a change in skin condition, new antibiotic/diuretic medication orders, and blood work in a timely manner for (Resident #160). The findings include: 1. Resident #100 was admitted to the facility on [DATE] with diagnoses that included dementia and hypertension. The admission MDS assessment dated [DATE] identified Resident #100 had severely impaired cognition, was always incontinent of bowel and bladder and required total assistance with eating, toileting, bathing, dressing, and personal hygiene. Additionally, Resident #100 was at risk of developing a pressure ulcer. There were no pressure ulcers on admission. Furthermore, skin treatment was to apply a pressure reducing device for bed and chair. a. The APRN progress note dated 3/14/24 indicated that she was asked to see Resident #100. APRN indicated that nursing reported resident had been agitated and restless. Nursing reported resident was screaming, verbally assaultive, and combative with care. Resident is confused and unable to verbalize needs. A physician's order dated 3/14/24 directed to give Trazodone 50 mg tablet every 6 hours as needed for agitation for 14 days. Review of the APRN and nursing notes dated 3/14/24-3/17/24 did not reflect the resident representative was notified of the new order for Trazodone. b. The physician progress note dated 4/1/24 identified Resident #100 was seen today for an eye infection. On the exam eyes had thick yellow purulent drainage and crust that started over the weekend. Will start antibiotic eye drops. Review of the physician and nursing notes dated 4/1/24-4/3/24 did not reflect the resident representative was updated regarding the change in condition and the new order for antibiotics. c. The APRN progress note dated 4/9/24 identified Resident #100 was seen for increased agitation and a follow up on the eye infection. APRN indicated that she would continue the antibiotic for conjunctivitis, continue the Ativan 0.5mg three times a day and start p.r.n. (as needed) Ativan 0.5mg every 6 hours for agitation. Review of the physician and nursing noted dated 4/9- 4/11/24 did not reflect the resident representative was notified of the new orders. d. The nurses note dated 4/10/24 at 6:56 PM identified a bruise noted to the left heel. (continued on next page)		

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 05/22/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Fox Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the nursing notes dated 4/10/24 - 4/12/24 did not reflect the resident representative or provider were notified of the new bruise to the left heel. e. A physician's order written by APRN #1 dated 4/18/24 directed to cleanse left heel with normal saline and pat dry. Then apply silver alginate and cling wrap daily until resolved. Review of the physician and nursing notes dated 4/18/24 - 4/20/24 did not reflect the resident representative was notified of the new treatment order for a wound that had a change in condition. Interview with DNS on 5/20/24 at 7:55 AM indicated that any time there was a new order or a change in condition the resident must be notified and if the resident was not cognitively intact that the resident's representative must be notified. The DNS indicated that Resident #100 was not cognitively intact so the resident's representative must be updated before the medication is started that same day. The DNS indicated that once the nurse notifies the resident representative the nurse must write a progress note indicating who was notified and what they were notified of. Interview with the ADNS on 5/20/24 at 9:58 AM indicated the charge nurse was responsible for updating the APRN and resident representative of any new wounds, changes in wounds, or new treatment orders. The ADNS indicated for Resident #100 the resident representative would have to be notified. The ADNS indicated that the nurse must document in the medical record who they spoke to and what they called them for. After clinical record review, the ADNS indicated that for the changes in condition and new orders for 3/14, 4/1, 4/9, 4/10, and 4/18/24 she did not see any documentation that that Resident #100's resident representative was notified of the changes in the medical record. 2. Resident #160 was admitted to the facility in September 2023 with diagnoses which included diabetes, atrial fibrillation, and acute kidney fracture. The admission MDS assessment dated [DATE] identified Resident #160 had intact cognition, required extensive assistance with personal hygiene. The care plan dated 12/13/23 failed to reflect documentation for comprehensive care plan related to antibiotic and diuretic medications. The APRN note dated 11/16/23 identified she was asked to see Resident #160 this morning for warmth and redness to right lower extremity at skin tear site. Pedal edema to bilateral lower extremities. Resident #160 denies pain to the area. There is no drainage from skin tear and edges are well approximated on exam. Resident #160 noted with +2 to +3 pedal edema to right lower extremity. Right lower extremity edema is worse than left. Resident #160 denies shortness of breath, or any other signs and symptoms associated with fluid overload. New orders included: Keflex 500mg three times a day for 7 days for cellulitis to right lower leg, complete blood count with diff 11/17/23, monitor temperature daily and as needed. in addition, skin tear to right lower extremity leave open to air, monitor every shift for signs and symptoms of infection and monitor edema. The APRN note failed to reflect documentation that the resident representative was notified. (continued on next page)		

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 05/22/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Fox Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nurse note dated 11/16/23 at 10:41 AM identified Resident #160 was seen by the APRN. The right toes were reddened and slightly warm, maybe ingrown toenail to right great toe. No complaint of pain. Right calf skin tear is healing. Examined by the APRN, the area was warm indicating cellulitis. Resident #160 also complained of pain and stiffness to the right hip. The APRN will order a hip x-ray. The nurse note failed to reflect documentation that the resident representative was notified. The APRN note dated 11/21/23 at 8:39 PM identified Resident #160 was seen for follow up for cellulitis to right lower extremity. Redness to right lower extremity and pedal edam to bilateral lower extremities. New orders included to start Lasix 20mg once a day for 7 days, check comprehensive metabolic panel next week and continue with Keflex three times a day. The APRN note failed to reflect documentation that the resident representative was notified. The nurse's note dated 11/21/23 through 11/30/23 failed to reflect documentation that resident representative was notified of the new orders. Interview and clinical record review with the DNS on 5/20/24 at 2:45 PM identified Resident #160's representative should have been notified of the change in condition, as well as any new orders related to the change. The DNS indicated the licensed staff are responsible for notifying the resident and the resident representative of any change in condition. Review of the facility Change in Condition Policy last revised 5/2021 identified the facility must consult with the with the resident if competent, notify the physician, and designated representative immediately when there is a significant decline in a resident's physical, mental, or psychosocial status, a need to alter treatment (a need to discontinue an existing form of treatment and start a new form of treatment. The notification is documented in the nurse's notes and reflects the name of person notified and the change in condition and/or treatment. 42117		

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 05/22/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Fox Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43032 Based on review of the clinical record, review of facility documentation, and interviews for 1 of 4 residents (Resident # 7) reviewed for abuse, the facility failed to ensure the resident was free from abuse. The findings include. Resident #7 was admitted to the facility on [DATE] with diagnoses that included dementia with behavioral disturbance, delusional disorders, and muscle weakness. The quarterly MDS assessment dated [DATE] identified Resident #7 had moderately impaired cognition, was frequently incontinent of bowel and bladder and required extensive assistance with turning from side to side and positioning. The MDS failed to identify any behaviors exhibited for Resident #7. The care plan dated June 2022 identified a concern with ADL assistance related to cellulitis, chronic respiratory failure, chronic obstructive pulmonary disease (COPD), and pressure ulcer left hip, osteomyelitis left thigh, and cognitive loss. Interventions included to provide assistance of 1 for toileting in bed, and an assist of 1 for bathing, grooming, dressing in bed. An Accident / Incident report dated 8/23/22 at 1:44 PM identified on 8/23/22 a resident representative alleged abuse as the resident representative identified bruising on bilateral arms and a bruise noted on Resident #7 left temporal area. The report further identified on 8/17/22 at 9:15 PM, NA #15 was attempting to provide care and as she rolled Resident #7 to his/her side, the resident began yelling, thrashing and kicking his/her legs. RN #10 (nursing supervisor) came into the room, spoke to Resident #7 and he/she calmed down as NA #15 continued with care. NA #15 was able to position Resident #7 on his/her back, and as she attempted to secure Resident #7's brief, the resident started yelling and striking out at NA #15, scratched, and pulled NA #15's hair and grabbed her glasses. NA #15 further indicated she put Resident 7's arms down to his/her body crisscrossed, to protect the resident from hurting his/her self or NA #15 any further. RN #10 nurse supervisor came in at that time (second visit) and saw Resident #7 holding NA #15's wrists and NA #15 holding Resident #7 down and spoke to Resident #7 until he/she let go of the NA wrists. Resident #7 was noted to have skin tears on the top of the right hand, no other injury was noted at that time. RN #10 initiated a change in condition report (SBAR) dated 8/17/22 which identified Resident #7 was combative with care and as a result had a new tear on the back of the right hand. (continued on next page)		

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 05/22/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Fox Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Accident / Incident report contained a statement from NA #15 which identified as she provided incontinent care to Resident #7, he/she began to yell out. At that time RN #10 came into the room and questioned the reason for the yelling, and RN #10 left the room. NA #15 attempted to roll Resident #7 to finish his/her incontinent care and secure the brief, Resident #7 became combative and began yelling out. NA #15 noticed that she had secured the right side of the brief however the left side was not secured so NA #15 rolled Resident #7 again. Resident #7 continued to be combative; yelling and thrashing, pulled NA #15's hair, scratched NA #15 and pulled NA #15's glasses off. NA #15 stated she did put Resident #7's arms down onto his/her body crisscrossed to protect the resident and herself from getting hurt, and that is when RN #10 returned to the room. NA #15 acknowledged in her statement she did not witness Resident #7 bumping his/her head during the incident however it was possible for Resident #7 to have bumped it on the side rail. NA #15 indicated she noticed blood from Resident #7's right hand and RN #10 addressed the skin tear. On 8/19/22 bruising was noted on bilateral arms and left temporal area. An interview with RN #10 on 5/22/24 at 9:12 AM identified she remembers the incident and went to Resident #7's room twice during the incident. RN #10 further indicated she saw NA #15 holding Resident #7's arms down while Resident #7 held NA #15's wrists. She indicated she believed the incident was over after the first occurrence until she heard yelling a second time. When asked if she thought to treat the incident as abuse due to the fact that NA #15 was observed holding Resident #7's hand down, and when Resident #7 became combative NA #15 continued to provide care RN #10 indicated she never considered abuse, did not initiate an investigation on the matter or communicate the incident to the DNS, but did an SBAR (change in condition) report indicating the skin tear on the right hand. RN #10 further identified she would have expected NA #15 to ensure the Resident was safe and walked away from Resident #7 and attempted to reapproach at a later time to provide care. Interview and clinical record review with the DNS on 5/22/24 at 10:50 AM identified the incident with Resident #7 occurred on 8/17/22. The DNS indicated she did not know why she did not report the incident to the State Agency as abuse. She further indicated because she did not think of the incident as abuse, NA #15 was not removed from the premises on 8/17/22 pending investigation and was allowed to work 8/18/22. The investigation began when the family representative expressed concern regarding the multiple bruises identified on Resident #7's body. She further identified it is her expectation that when a resident becomes combative during care, that the resident is made safe, and the resident is reapproached at a later time. Although attempted, an interview with NA #15 was not obtained. The facility's policy for ADL date care dated 11/2018 states that if residents with cognitive impairment or dementia resist care, staff will attempt to identify the underlying cause of the problem and not just assume the resident is refusing or declining care. Approaching the resident in a different way or at a different time or having another staff member speak with the resident may be appropriate. The facility's policy for restraints dated 11/2018 identified restraints shall only be used to treat the resident's medical symptom (s) and never for discipline or staff convenience, or for the prevention of falls. (continued on next page)		

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 05/22/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Fox Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy on Abuse, Neglect and Misappropriation dated 1/2019 states each resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation. Residents must not be subject to abuse by anyone, including but not limited to facility staff, other residents, consultants, contractors, volunteers, or staff of other agencies serving the resident, family members, legal guardians, friends, or other individuals. The policy states the facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion and to take appropriate actions when abuse, neglect or exploitation is suspected. In identifying abuse, the facility must consider factors indicating possible abuse including but not limited to physical marks such as bruises or patterned appearances such as a hand print belt or ring mark on a resident's body, verbal abuse of a resident overheard, physical abuse of a resident observed. Alleged violations involving abuse are to be reported immediately but not later than 2 hours after the allegation is made to the Administrator of the facility and the State Survey Agency.		

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 05/22/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Fox Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43032 Based on review of the clinical record, facility documentation, facility policy, and interviews for 2 of 4 residents (Resident # 7 and Resident #24) reviewed for abuse, the facility failed to implement their policy when investigating an allegation of abuse and an injury of unknown origin. The findings include. 1. Resident #7 was admitted to the facility on [DATE] with diagnoses that included dementia with behavioral disturbance, delusional disorders, and muscle weakness. The quarterly MDS assessment dated [DATE] identified Resident #7 had moderately impaired cognition, was frequently incontinent of bowel and bladder and required extensive assistance with turning from side to side and positioning of body. The care plan dated June 2022 identified a concern with ADL assistance related to cellulitis, chronic respiratory failure, chronic obstructive pulmonary disease (COPD), and pressure ulcer left hip, osteomyelitis left thigh, and cognitive loss. Interventions included to provide assistance of 1 for toileting in bed, and an assist of 1 for bathing, grooming, dressing in bed. An Accident / Incident report dated 8/23/22 at 1:44 PM identified on 8/23/22 a resident representative alleged abuse as the resident representative identified bruising on bilateral arms and a bruise noted on Resident #7 left temporal area. The report further identified that on 8/17/22 at 9:15 PM, NA #15 was attempting to provide care and as she rolled Resident #7 to his/her side, the resident began yelling thrashing and kicking his/her legs. RN #10 (nursing supervisor) came into the room, spoke to Resident #7 and he/she calmed down as NA #15 continued with care. NA #15 was able to get Resident #7 on his/her back, and as she attempted to secure Resident #7's brief, the resident started yelling and striking out at NA #15, scratched, and pulled NA #15's hair and grabbed her glasses. NA #15 further indicated she put Resident 7's arms down to his/her body crisscrossed, to protect the resident from hurting his/her self or NA #15 any further. RN #10 nurse supervisor came in at that time (second visit) and saw Resident #7 holding NA #15's wrists and NA #15 holding Resident #7 down and spoke to Resident #7 until he/she let go of the wrists. Resident #7 was noted to have skin tears on the top of the right hand, no other injury was noted at that time. RN #10 initiated a change in condition report (SBAR) dated 8/17/22 which identified Resident #7 was combative with care and as a result had a new tear on the back of the right hand. (continued on next page)		

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 05/22/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Fox Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Accident/ Incident report contained a statement from NA #15 which identified as she provided incontinent care to Resident #7; he/she began to yell out. At that time RN #10 came into the room and questioned the reason for the yelling, and RN #10 left the room. NA #15 attempted to roll Resident #7 to finish his/her bottom and secure the brief, Resident #7 became combative and began yelling out. NA #15 noticed that she had secured the right side of the brief however the left side was not secured so NA #15 rolled Resident #7 again. Resident #7 continued to be combative; yelling and thrashing, pulled NA #15's hair, scratched NA #15 and pulled NA #15's glasses off. NA #15 stated she did put Resident #7's arms down onto his/her body crisscrossed to protect the resident and herself from getting hurt, and that is when RN #10 returned to the room. NA #15 acknowledged in her statement she did not witness Resident #7 bumping his/her head during the incident however it was possible for Resident #7 to have bumped it on the side rail. NA #15 indicated she noticed blood from Resident #7's right hand and RN #10 addressed the skin tear. On 8/19/22 bruising was noted on bilateral arms and left temporal area. An interview with RN #10 on 5/22/24 at 9:12 AM identified she remembers the incident and went to Resident #7's room twice during the incident. RN #10 further indicated she saw NA #15 holding Resident #7's arms down while Resident #7 held NA #15's wrists. She indicated she believed the incident was over after the first occurrence until she heard yelling a second time. When asked if she thought to treat the incident as abuse due to the fact that NA #15 was observed holding Resident #7's hands down, and when Resident #7 became combative NA #15 continued to provide care? RN #10 indicated she never considered abuse, did not initiate an investigation on the matter or communicate the incident to the DNS, but did an SBAR (change in condition) report indicating the skin tear on the right hand. RN #10 further identified she would have expected NA #15 to ensure the Resident was safe and walked away from Resident #7 and attempted to reapproach at a later time to provide care. Interview and clinical record review with the DNS on 5/22/24 at 10:50 AM identified the incident with Resident #7 occurred on 8/17/22. The DNS indicated she did not know why she did not report the incident to the State Agency as abuse or begin the investigation earlier. She further indicated, because she did not think of the incident as abuse, NA #15 was not removed from the premises on 8/17/22 pending investigation and was allowed to work 8/18/22. The investigation began when the resident representative expressed concern regarding the multiple bruises identified on Resident #7's body on 8/23/22. She further identified it is her expectation that when a resident becomes combative during care, that the resident is made safe, and the resident is reapproached at a later time. Although attempted, an interview with NA #15 was not obtained. The facility's policy for ADL care states that if residents with cognitive impairment or dementia resist care, staff will attempt to identify the underlying cause of the problem and not just assume the resident is refusing or declining care. Approaching the resident in a different way or at a different time or having another staff member speak with the resident may be appropriate. 2. Resident # 24 was admitted to the facility on [DATE] with diagnoses that included Atrial Fibrillation, muscle weakness, and dementia. The admission MDS assessment dated [DATE] identified Resident # 24 had severely impaired cognition, was incontinent of bowel and bladder and required a walker for mobility. (continued on next page)		

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 05/22/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Fox Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The care plan dated 3/17/22 identified a concern with skin breakdown with interventions that included to observe skin daily with care and report abnormalities. A physician's order dated 3/10/22 directed to provide a pressure reducing mattress to the bed. The nurse's note by RN #5 (RN supervisor) dated 4/24/22 at 6:28 PM identified that Resident #24 had a bruise of unknown origin, discovered by staff on resident's 4th finger of left hand. Interview with RN #5 on 5/20/22 at 9:40 AM identified he identified the bruising, completed an incident report, and notified the DNS. Review of the Accident / Incident report identified that of the 19 staff members interviewed regarding the bruising, none were interviewed the day of the incident which was identified 4/24/22. The incident report identified the statements were taken on the following dates: 4/24/22-no employees identified as interviewed 4/25/22-no employees identified as interviewed 4/26/22-13 employees interviewed 4/27/22-2 employees interviewed 4/28/22-3 employees interviewed 4/29/22-1 employee interviewed Interview and clinical record review with the DNS on 5/22/24 at 10:50 AM, failed to provide an explanation for the delayed investigation of the unknown bruise as RN #5 (RN Supervisor) identified the bruise on 4/24/22 at 6:28 PM, yet the earliest interview was identified 4/26/22 which was 2 days later. The facility policy states each resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation. Residents must not be subject to abuse by anyone, including but not limited to facility staff, other residents, consultants, contractors, volunteers, or staff of other agencies serving the resident, family members, legal guardians, friends, or other individuals. The policy states the facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion and to take appropriate actions when abuse, neglect or exploitation is suspected. In identifying abuse, the facility must consider factors indicating possible abuse including but not limited to physical marks such as bruises or patterned appearances such as a hand print belt or ring mark on a resident's body, verbal abuse of a resident overheard, physical abuse of a resident observed. Alleged violations involving abuse are to be reported immediately but not later than 2 hours after the allegation is made to the Administrator of the facility and the State Survey Agency. The policy further states that the facility should obtain witness statements, following appropriate policies, suspend the accused employee pending completion of the investigation and remove the employee from the resident care areas immediately.		

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 05/22/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Fox Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43032 Based on review of the clinical record, facility documentation, facility policy, and interviews for 3 of 4 residents (Resident # 7, Resident #24, Resident #25) reviewed for abuse, the facility failed to report an allegation of abuse, failed to report an injury of unknown origin, and a fall from a mechanical lift to the state agency in a timely manner. The findings include. 1. Resident #7 was admitted to the facility on [DATE] with diagnoses that included dementia with behavioral disturbance, delusional disorders, and muscle weakness. The quarterly MDS assessment dated [DATE] identified Resident #7 had moderately impaired cognition, was frequently incontinent of bowel and bladder and required extensive assistance with turning from side to side and positioning of body. The care plan dated June 2022 identified a concern with ADL assistance related to cellulitis, chronic respiratory failure, chronic obstructive pulmonary disease (COPD), and pressure ulcer left hip, osteomyelitis left thigh, and cognitive loss. Interventions included to provide assistance of 1 for toileting in bed, and an assist of 1 for bathing, grooming, dressing in bed. An Accident / Incident report dated 8/23/22 at 1:44 PM identified that on 8/23/22 a resident representative alleged abuse as the resident representative identified bruising on bilateral arms and a bruise noted on Resident #7 left temporal area. The report further identified that on 8/17/22 at 9:15 PM, NA #15 was attempting to provide care and as she rolled Resident #7 to his/her side, the resident began yelling thrashing and kicking his/her legs. RN #10 (nursing supervisor) came into the room, spoke to Resident #7 and he/she calmed down as NA #15 continued with care. NA #15 was able to get Resident #7 on his/her back, and as she attempted to secure Resident #7's brief, the resident started yelling and striking out at NA #15, scratched, and pulled NA #15's hair and grabbed her glasses. NA #15 further indicated she put Resident 7's arms down to his/her body crisscrossed, to protect the resident from hurting his/her self or NA #15 any further. RN #10 nurse supervisor came in at that time (second visit) and saw Resident #7 holding NA #15's wrists and NA #15 holding Resident #7 down and spoke to Resident #7 until he/she let go of the wrists. Resident #7 was noted to have skin tears on the top of the right hand, no other injury was noted at that time. RN #10 initiated a change in condition report (SBAR) dated 8/17/22 which identified Resident #7 was combative with care and as a result had a new tear on the back of the right hand. (continued on next page)		

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 05/22/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Fox Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Accident / Incident report contained a statement from NA #15 which identified as she provided incontinent care to Resident #7; he/she began to yell out. At that time RN #10 came into the room and questioned the reason for the yelling, and RN #10 left the room. NA #15 attempted to roll Resident #7 to finish his/her bottom and secure the brief, Resident #7 became combative and began yelling out. NA #15 noticed that she had secured the right side of the brief however the left side was not secured so NA #15 rolled Resident #7 again. Resident #7 continued to be combative; yelling and thrashing, pulled NA #15's hair, scratched NA #15 and pulled NA #15's glasses off. NA #15 stated she did put Resident #7's arms down onto his/her body crisscrossed to protect the resident and herself from getting hurt, and that is when RN #10 returned to the room. NA #15 acknowledged in her statement she did not witness Resident #7 bumping his/her head during the incident however it was possible for Resident #7 to have bumped it on the side rail. NA #15 indicated she noticed blood from Resident #7's right hand and RN #10 addressed the skin tear. On 8/19/22 bruising was noted on bilateral arms and left temporal area. An interview with RN #10 on 5/22/24 at 9:12 AM identified she remembers the incident and went to Resident #7's room twice during the incident. RN #10 further indicated she saw NA #15 holding Resident #7's arms down while Resident #7 held NA #15's wrists. She indicated she believed the incident was over after the first occurrence until she heard yelling a second time. When asked if she thought to treat the incident as abuse due to the fact that NA #15 was observed holding Resident #7's hands down, and when Resident #7 became combative NA #15 continued to provide care? RN #10 indicated she never considered abuse, did not initiate an investigation on the matter or communicate the incident to the DNS, but did an SBAR (change in condition) report indicating the skin tear on the right hand. RN #10 further identified she would have expected NA #15 to ensure the Resident was safe and walked away from Resident #7 and attempted to reapproach at a later time to provide care. Interview and clinical record review with the DNS on 5/22/24 at 10:50 AM identified the incident with Resident #7 occurred on 8/17/22. The DNS indicated she did not know why she did not report the incident to the State Agency as abuse or begin the investigation earlier. The incident was reported to the State Agency after the resident representative expressed concerns about the bruising on 8/23/22 which was 6 days later. Although attempted, an interview with NA #15 was not obtained. The facility policy states each resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation. Residents must not be subject to abuse by anyone, including but not limited to facility staff, other residents, consultants, contractors, volunteers, or staff of other agencies serving the resident, family members, legal guardians, friends, or other individuals. The policy states the facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion and to take appropriate actions when abuse, neglect or exploitation is suspected. In identifying abuse, the facility must consider factors indicating possible abuse including but not limited to physical marks such as bruises or patterned appearances such as a hand print belt or ring mark on a resident's body, verbal abuse of a resident overheard, physical abuse of a resident observed. Alleged violations involving abuse are to be reported immediately but not later than 2 hours after the allegation is made to the Administrator of the facility and the State Survey Agency. (continued on next page)		

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 05/22/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Fox Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident # 24 was admitted to the facility on [DATE] with diagnoses that included atrial fibrillation, muscle weakness, and dementia. The admission MDS assessment dated [DATE] identified Resident # 24 had severely impaired cognition, was incontinent of bowel and bladder and required a walker for mobility. The care plan dated 3/17/22 identified a concern with skin breakdown with interventions that included to observe skin daily with care and report abnormalities. A physician's order dated 3/10/22 directed to provide a pressure reducing mattress to the bed. The nurse's note by RN #5 (RN supervisor) dated 4/24/22 at 6:28 PM identified that Resident #24 had a bruise of unknown origin, discovered by staff on resident's 4th finger of left hand. Interview with RN #5 on 5/20/22 at 9:40 AM identified he identified the bruising, issued an incident report, and notified the DNS. Interview and clinical record review with the DNS on 5/22/24 at 10:50 AM, failed to provide an explanation for the delayed reporting of the unknown bruise as RN#5 (RN Supervisor) identified the bruise on 4/24/22 at 6:28 PM, yet the report to the State Agency identified the bruising first noted on 4/25/22 at 10:30 AM and reported 4/26/22 at 1:54 PM. The facility policy on Abuse identified that each resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation. The facility will consider factors indicating possible abuse, neglect and/ or exploitation of residents including but not limited to the following possible indicators; physical marks such as bruises or pattern appearances such as a hand print, belt, or ring mark on a resident's body. When there is a suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur, an investigation is immediately warranted, and the State Agency must be notified no later than 2 hours of forming the suspicion. 3. Resident # 25 was admitted to the facility on [DATE] with diagnoses that included localization-related (focal) partial symptomatic epilepsy and epileptic syndromes with complex partial seizures not intractable without status epilepticus, muscle weakness, and cerebral palsy. The annual MDS assessment dated [DATE] identified Resident # 25 had moderately impaired cognition, was incontinent of bowel and bladder and required a manual wheelchair for mobility. The care plan dated 12/20/22 identified a concern with risk for falls due to cognitive loss, lack of safety awareness, impaired mobility, and cerebral palsy. Interventions included to place call bell within reach while in bed and place all necessary personal items within reach. An Accident / Incident report dated 1/3/23 identified on 1/3/23 at 7:30 AM Resident #25 fell from a mechanical lift after the stiffening of entire body in seizure-like activity, fell backwards, and bumped his/her head. Resident #25 was assisted in the mechanical lift by both an LPN and NA. Resident #25 was on anticoagulant therapy and was transported to the hospital for evaluation. The hospital discharge summary dated 1/3/23 at 8:19 AM identified, Resident #25 denied head pain, and the following diagnostics were completed: (continued on next page)		

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 05/22/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Fox Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. CT scan of head without contrast due to blunt head trauma- results negative 2. CT scan of cervical spine without contrast due to blunt neck trauma with altered mental status-negative 3. Pelvis 1 or 2 views due to fall-negative Resident #25 was diagnosed with no evidence of intracranial hemorrhage, the craniocervical junction was normal, and the pelvis imaging identified no evidence of acute fracture or subluxation (partial dislocation of a joint). Resident #25 was transported back to the skilled nursing facility. A nurse's note on 1/8/23 at 3:03 PM identified Resident #25 complained of right hip pain. A nurse's note 1/8/23 at 3:13 PM identified Resident #25 was assessed by the RN supervisor who determined the resident complained of pain in the right hip and knee. The right knee was slightly swollen, no bruising noted. An order was secured from the APRN for x-rays. A nurse's note 1/8/23 at 6:44PM identified Resident #25 had a fractured right hip and was transferred to the hospital. Interview and clinical record review with the DNS on 5/22/24 at 10:50 AM reviewed the events associated with Resident #25 fall from the mechanical lift on 1/3/23 and was cleared with no fracture yet was returned to the facility on 1/10/23 to be diagnosed with a right hip fracture 5 days later. The DNS indicated when Resident #25 fell from the mechanical lift she did not think it necessary to report to the State Agency, further indicating she could not remember a resident falling from a mechanical lift in this manner in her nursing career. The DNS further acknowledged the fracture was identified on 1/8/23 however the fracture was reported to the State Agency 1/11/23 which was 3 days later. The DNS indicated at the time the fracture was diagnosed , she did not know how the resident was injured and tried to contact the hospital. She failed to provide an explanation of why the State Agency was not notified within 2 hours of the confirmed pelvic x-ray on 1/8/23 as the facility policy states because at that time Resident #25's fracture was an unknown injury. The facility policy on abuse states each resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation. In identifying abuse, the facility must consider factors indicating possible abuse including but not limited to physical marks such as bruises or patterned appearances such as a hand print belt or ring mark on a resident's body, verbal abuse of a resident overheard, physical abuse of a resident observed. Alleged violations involving abuse are to be reported immediately but not later than 2 hours after the allegation is made to the Administrator of the facility and the State Survey Agency.		

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 05/22/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Fox Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42117 43032 Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 4 residents (Resident # 7) reviewed for abuse, the facility failed to investigate an allegation of abuse in a timely manner and 1 of 3 residents (Resident #100) reviewed for pressure ulcer, the facility failed to conduct an investigation for an injury of unknown origin. The findings include. 1. Resident #7 was admitted to the facility on [DATE] with diagnoses that included dementia with behavioral disturbance, delusional disorders, and muscle weakness. The quarterly MDS assessment dated [DATE] identified Resident #7 had moderately impaired cognition, was frequently incontinent of bowel and bladder and required extensive assistance with turning from side to side and positioning of body. The care plan dated 6/6/22 identified a concern with ADL assistance related to cellulitis, chronic respiratory failure, chronic obstructive pulmonary disease (COPD), and pressure ulcer left hip, osteomyelitis left thigh, and cognitive loss. Interventions included to provide assistance of 1 for toileting in bed, and an assist of 1 for bathing, grooming, dressing in bed. An Accident/ Incident report dated 8/23/22 at 1:44 PM identified that on 8/23/22 a resident representative alleged abuse as the resident representative identified bruising on bilateral arms and a bruise noted on Resident #7 left temporal area. The report further identified that on 8/17/22 at 9:15 PM, NA #15 was attempting to provide care and as she rolled Resident #7 to his/her side, the resident began yelling thrashing and kicking his/her legs. RN #10 (nursing supervisor) came into the room, spoke to Resident #7 and he/she calmed down as NA #15 continued with care. NA #15 was able to get Resident #7 on his/her back, and as she attempted to secure Resident #7's brief, the resident started yelling and striking out at NA #15, scratched, and pulled NA #15's hair and grabbed her glasses. NA #15 further indicated she put Resident 7's arms down to his/her body crisscrossed, to protect the resident from hurting his/her self or NA #15 any further. RN #10 nurse supervisor came in at that time (second visit) and saw Resident #7 holding NA #15's wrists and NA #15 holding Resident #7 down and spoke to Resident #7 until he/she let go of the wrists. Resident #7 was noted to have skin tears on the top of the right hand, no other injury was noted at that time. RN #10 initiated a change in condition report (SBAR) dated 8/17/22 which identified Resident #7 was combative with care and as a result had a new tear on the back of the right hand. (continued on next page)		

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 05/22/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Fox Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Accident/ Incident report contained a statement from NA #15 which identified as she provided incontinent care to Resident #7; he/she began to yell out. At that time RN #10 came into the room and questioned the reason for the yelling, and RN #10 left the room. NA #15 attempted to roll Resident #7 to finish his/her bottom and secure the brief, Resident #7 became combative and began yelling out. NA #15 noticed that she had secured the right side of the brief however the left side was not secured so NA #15 rolled Resident #7 again. Resident #7 continued to be combative; yelling and thrashing, pulled NA #15's hair, scratched NA #15 and pulled NA #15's glasses off. NA #15 stated she did put Resident #7's arms down onto his/her body crisscrossed to protect the resident and herself from getting hurt, and that is when RN #10 returned to the room. NA #15 acknowledged in her statement she did not witness Resident #7 bumping his/her head during the incident however it was possible for Resident #7 to have bumped it on the side rail. NA #15 indicated she noticed blood from Resident #7's right hand and RN #10 addressed the skin tear. On 8/19/22 bruising was noted on bilateral arms and left temporal area. An interview with RN #10 on 5/22/24 at 9:12 AM identified she remembers the incident and went to Resident #7's room twice during the incident. RN #10 further indicated she saw NA #15 holding Resident #7's arms down while Resident #7 held NA #15's wrists. She indicated she believed the incident was over after the first occurrence until she heard yelling a second time. When asked if she thought to treat the incident as abuse due to the fact that NA #15 was observed holding Resident #7's hands down, and when Resident #7 became combative NA #15 continued to provide care? RN #10 indicated she never considered abuse, did not initiate an investigation on the matter or communicate the incident to the DNS, but did an SBAR (change in condition) report indicating the skin tear on the right hand. RN #10 further identified she would have expected NA #15 to ensure the Resident was safe and walked away from Resident #7 and attempted to reapproach at a later time to provide care. Interview and clinical record review with the DNS on 5/22/24 at 10:50 AM identified the incident with Resident #7 occurred on 8/17/22. The DNS indicated she did should have followed the protocols which included the initiation of a timely investigation. The investigation began when the resident representative expressed concern regarding the multiple bruises identified on Resident #7's body on 8/23/22, six days after the incident was witnessed by RN #10. The DNS further identified it is her expectation that when a resident becomes combative during care, that the resident is made safe, and the resident is reapproached at a later time. Although attempted, an interview with NA #15 was not obtained. The facility's policy for ADL care states that if residents with cognitive impairment or dementia resist care, staff will attempt to identify the underlying cause of the problem and not just assume the resident is refusing or declining care. Approaching the resident in a different way or at a different time or having another staff member speak with the resident may be appropriate. The facility policy states each resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation. When suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur, an investigation is immediately warranted. Once the resident is cared for and initial reporting has occurred, an investigation should be conducted. Components of an investigation may include: A. Interview the involved resident, if possible, and document all responses. If a resident is cognitively impaired, interview the resident several times to compare responses. (continued on next page)		

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 05/22/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Fox Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B. If there is no discernible response from the resident, or the resident's response is incongruent with that of a reasonable person, interview the resident's family, responsible parties, or other individuals involved in the resident's life to gather how he/she believes the resident would react to the incident. c. Interview all witnesses separately. Include roommates, residents in adjoining rooms, staff members in the area, and visitors in the areas. Obtain witness statements according to appropriate policies. All statements should be signed and dated by the person making the statement. d. Document the entire investigation chronologically. 2. Resident #100 was admitted to the facility on [DATE] with diagnoses that included dementia and hypertension. A physician's order dated 3/12/24 directed to encourage resident to off load heels as tolerated in bed, pressure redistribution cushion to bed and mattress, and skin prep to bilateral heels for 14 days. The admission MDS assessment dated [DATE] identified Resident #100 had severely impaired cognition, was always incontinent of bowel and bladder and required total assistance with eating, toileting, bathing, dressing, and personal hygiene. Additionally, Resident #100 was at risk of developing a pressure ulcer. There were no pressure ulcers on admission. Furthermore, skin treatment was to apply a pressure reducing device for bed and chair. The care plan dated 3/27/24 identified actual skin breakdown to left heel. Interventions included to off load heels while in bed and in wheelchair. A nurse's note written by LPN #3 dated 4/10/24 at 6:58 PM identified a skin check was performed which identified a bruise to left heel. Interview with DNS on 5/20/24 at 7:37 AM identified that the charge nurses complete weekly skin checks of all residents. The DNS indicated that any new bruises, new pressure areas, or changes in conditions, the RN supervisor or herself as DNS will complete the assessment. The DNS indicates that any new bruise and a new facility acquired pressure ulcer would require a reportable event form and investigation. Interview with LPN # 3 on 5/20/24 at 9:03 AM indicated she recalls seeing the new bruise on 4/10/24 does not recall if she reported the new bruise to Resident #100's left heel to the RN supervisor. LPN #3 indicated that the procedure was to report it to an RN for an assessment. LPN #3 indicated that if she had reported it to the RN, it would be in her progress note. LPN #3 indicated she does not recall if she started a reportable event form for the new bruise but does know that any new bruise requires a reportable event form to be completed. Interview with APRN #1 on 5/20/24 at 9:30 AM indicated she depends on the charge nurses to update her of any changes including new bruises. The APRN #1 indicated that she was not notified on 4/10/24 about any bruise on the left heel. (continued on next page)		

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 05/22/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Fox Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the ADNS on 5/20/24 at 9:58 AM indicated there was a progress note dated 4/10/24 indicating there was a new bruise to Resident #100, so there should be a reportable event form with the DNS. The ADNS indicated that any new bruises or pressure ulcers must have an RN assessment completed on the same shift that it is found. After clinical record review, the ADNS indicated there was not an RN assessment completed on 4/10 or 4/11/24 for the bruise in the clinical record. Interview with the DNS on 5/20/24 at 11:22 AM indicated she does not have a reportable event form completed with an investigation for the new bruise dated 4/10/24. The DNS indicated that it is the responsibility of the nursing staff to complete the reportable event form and start the investigation and then the interdisciplinary team would try to determine how the resident got the bruise to prevent it from occurring again. A review of the facility Abuse, Neglect, and Misappropriation Policy dated 5/2021 identified neglect means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Identification of abuse, neglect, and exploitation the facility will consider factors indicating possible abuse, neglect, and/or exploitation of residents, including but not limited to, the following possible factors: physical marks such as bruises, physical injury of unknown origin, psychological abuse of a resident such as failure to provide care needs as feeding, bathing, turning, and repositioning. Investigations of alleged abuse and neglect when suspicion of abuse an investigation must be conducted. Document the entire investigation in chronological order and obtain written statements.		

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 05/22/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Fox Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47457 Based on review of the clinical record, facility documentation review and interviews for 1 of 5 residents (Resident #89) reviewed for Preadmission Screening and Resident Reviews (PASRR), the facility failed to ensure a resident with an intellectual disability had a Level of Care rescreen or PASRR level II, completed timely. The findings include: Resident #89 was admitted to the facility on [DATE] with a diagnosis that included unspecified lack of expected normal physiological development in childhood. The admission MDS assessment dated [DATE] identified Resident #89 had moderately impaired cognition, had been evaluated by Level II PASRR, and was determined to have a Level II PASRR condition of mental retardation. The care plan dated 1/18/24 identified Resident #89 met PASRR II Level of determination secondary to a diagnosis of intellectual disability. Interventions included coordinating and/or informing the appropriate agency to conduct the PASRR evaluation and obtain results if it is learned that the PASRR was not completed or is incorrect. The Preadmission Screening Determination Notification dated 1/25/24 identified Resident #89 was eligible for admission because of his/her intellectual disability or a developmental disability and he/she met the criteria for nursing facility level of care and his/her previously approved 30-day or respite stay was extended for an additional 60 days. The Preadmission Screening Determination Notification dated 5/7/24 identified Resident #89 was eligible for admission because of his/her intellectual disability or a developmental disability and he/she met the criteria for nursing facility level of care and his/her previously approved 30-day or respite stay was extended for an additional 180 days. Interview and clinical record review with the Director of Social Services (SW) #1 on 5/21/24 at 2:05 PM failed to identify documentation that a PASRR rescreen was completed after 3/25/24, when Resident #89's 60-day short term approval, issued on 1/25/24, had ended. SW #1 further identified that the gap was identified on 5/3/24, subsequently a Level of Care rescreen was completed on 5/3/24, a request was placed to the outside agency for a retroactive approval, and a Level II PASRR was completed on-site, on 5/7/24, with a 180-day approval. The Pre-Admission Screening for Mental Illness and/or Intellectual/Developmental Disability policy directs that facility staff will ensure that appropriate pre-admission screening for mental illness and/or intellectual/developmental disability is conducted per the federal/state regulations and social services will coordinate any updates as needed and per federal/state regulations.		

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 05/22/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Fox Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42117 Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 2 residents (Resident #210) reviewed for respiratory care, the facility failed to ensure a baseline care plan reflected the use of oxygen. The findings include: Resident #210 was admitted to the facility on [DATE] with diagnoses that included pneumonia, acute respiratory failure, asthma exacerbation, and sepsis. The Hospital Discharge Summary dated 5/9/24 identified Resident #210 had a diagnosis of pleural effusion, asthma exacerbation, and acute hypoxic respiratory failure. Resident #210 will continue to use supplemental oxygen and wean as tolerated as resident continues to improve. The admission nursing assessment dated [DATE] identified Resident #210 was admitted from the hospital on oxygen at 2 liters per minute via nasal cannula. The admission MDS assessment dated [DATE] identified Resident #210 had intact cognition and requires total assistance with toileting and dressing, and moderate assistance with personal hygiene. Additionally, the MDS did not reflect that Resident #210 was on continuous oxygen. The baseline care plan dated 5/9/24 does not reflect Resident #210 was on oxygen. Review of the physician's order dated 5/9/24 through 5/20/24 did not reflect Resident #210 was on continuous oxygen. Observation on 5/19/24 at 7:30 AM Resident #210 was lying in bed on oxygen via nasal cannula with a bubbler connected to a concentrator on 1 liter oxygen. The nasal cannula and the bubbler were not dated when last changed. Interview with Resident #210 on 5/19/24 at 7:30 AM indicated he does not recall anyone changing the oxygen tubing since being at the hospital. Resident #212 indicated that he has been on oxygen since being at the hospital until now but was not on oxygen at home prior to the hospital. Interview and observation with LPN #1 on 5/19/24 at 7:32 AM indicated that Resident #210 was on 1 liter of oxygen via nasal cannula and noted that the oxygen tubing and the bubbler were not dated when last changed and she was not able to identify when it was last changed since being admitted from the hospital. After clinical record review, LPN #1 indicated that the physician order dated 5/16/24 stated just titrate oxygen and was on room air while at home. LPN #1 indicated that the physician order does not make sense and was not an actual order for oxygen because Resident #210 was currently on 1 liter of oxygen via nasal cannula and there was not an order to change the oxygen tubing weekly. (continued on next page)		

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 05/22/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Fox Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DNS on 5/21/24 at 12:12 PM indicated that on admission they do not have a baseline care plan the nurses just start a care plan in the electronic medical record and everyone adds to that. The DNS indicated that Resident #210 does not have a baseline or a comprehensive care plan for the oxygen for his/her asthma from the hospital, but she will add it to the care plan now. The DNS indicated that the oxygen use should be on the care plan on admission on 5/9/24 (12 days earlier). After surveyor inquiry, the care plan dated 5/21/24 at 12:15 PM reflected Resident #210 was on oxygen. Intervention included following physician order for oxygen, monitoring and report oxygen levels via pulse oximetry as ordered and as needed, observe for increased wheezing and for a lower activity tolerance and report to physician as needed. Additionally, monitor and record lung sounds and report to physician as indicated. Review of the facility Baseline Care Plans Policy identified a baseline plan of care to meet the resident's immediate needs shall developed for each resident within 48 hours of admission. Implantation of a baseline care plan to meet the residents immediate care needs including but not limited to: initial goals based on admission orders, physician orders, dietary orders, therapy services, social services and PASSARR recommendations. The resident and their representative will be provided a summary of the baseline care plan that includes but is not limited to: the initial goals of the resident, a summary of the residents medications and dietary instructions, any services and treatments to be administered by the facility and personnel acting on behalf of the facility, and any updated information based on the details of the comprehensive care plan.		

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 05/22/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Fox Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 42117 Based on observation, review of the clinical record, and facility documentation, facility policy, and interviews for 1 of 3 residents (Resident #22) reviewed for accidents, the facility failed to ensure a comprehensive care plan was developed and implemented for a resident who experienced multiple falls. The findings include: Resident #22 was admitted to the facility on [DATE] with diagnoses that included urinary retention, obstructive uropathy, benign prostatic hyperplasia, and depression. The admission MDS assessment dated [DATE] identified Resident #22 had moderately impaired cognition, requires maximum assistance with toileting, bathing, showering, dressing upper and lower body, and personal hygiene. Resident #22 had no falls prior to admission in the last 6 months. Resident #22 had 1 fall with no injury since admission. The care plan dated 3/27/24 identified resident was at risk for falls Interventions included to offer toileting after lunch, encourage resident to use call light, and provide verbal cues to resident to utilize the call bell for assistance with toileting and ambulation. Additionally, Resident #22 was an assist of 1 for bed mobility and transfers. 1. A physician order dated 3/11/24 indicated that Resident #22 was to wear non-skid footwear for safety. Reportable Event Form dated 4/22/24 at 1:15 PM Resident #22 had an unwitnessed fall in bathroom in front of toilet. Resident #22 was noted to have regular socks without the benefit of the non-skid socks. The intervention was to wear non-skid socks, however, there was a physician's order already in place on 3/11/24 for the use of non skid socks 2. Reportable Event Form dated 3/17/24 at 3:30, 3/22 at 1:15 PM, and 5/12/24 at 8:30 PM identified an unwitnessed fall in the resident's bathroom. Resident #22 was an assistant of 1 for transfers. Resident was alert with confusion. The intervention was to educate resident to call or use call light for assistance for toileting /ambulation. 3. Reportable Event Form dated 3/30/24 at 12:00 AM identified witnessed fall from wheelchair at the nurse's station. The nursing assistant indicated that Resident #22 slid out of wheelchair leaning forward hitting head on medication cart causing an abrasion to the right side of the forehead. The intervention was dycem added to the seat of the wheelchair. (continued on next page)		

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 05/22/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Fox Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Reportable Event Form dated 5/13/24 at 4:15 PM resident #22 had an unwitnessed fall from wheelchair noted with 2 lacerations both were 1 inch long to the left eyebrow bleeding was controlled with pressure. Steri-strips were applied to the 2 lacerations. Resident #22's eyeglasses were noted to be broken. Resident #22 was alert but confused at baseline and an assist of 1 for transfers. The intervention was to educate resident for safe techniques and when to use call bell for toileting needs. 5. Reportable Event Form dated 5/16/24 at 6:00 PM Resident #22 had an unwitnessed fall from the wheelchair with injury. Resident #22 noted with a laceration to right eyebrow 0.1 cm x 1.5 cm x 0.5cm, cleansed with Normal Saline and applied 2 steri-strips. Dycem was applied to wheelchair, however the intervention was already implemented on 3/30/24. The Physical Therapy Evaluation and Plan of Treatment dated 5/15/24 identified that Resident #22 was referred to improve transfers and balance status post frequent falls. Resident #22 has had many falls. The number was unknown and there were no injuries. Resident #22 was unsteady when standing and ambulating. Resident #22 was unable to stand unsupported with an assistive device for 10 seconds. Resident #22 has decreased safety awareness. Due to the documented physical impairments and associated functional deficits, without skilled therapeutic intervention, the resident is at risk for falls and further decline in function. Occupational Therapy Evaluation and Plan of Treatment dated 5/16/24 identified referral was to evaluate for recurrent falls in bathroom when transferring on and off toilet. Resident tends to self-ambulate and transfer independently when resident is an assist of 1 for ambulation and transfers. Resident #22's safety awareness is impaired. Initial assessment was determined that Resident #22 is at high risk for falls. Additionally, Resident #22 fluctuates from assistance of 1 to maximum assistance of 2 for stand pivot transfers using a rolling walker. Resident #22 moderate assist of 2 for toileting transfers from wheelchair level. Resident #22 has increased tone and rigidity in the right upper extremity. Observation on 5/19/24 at 7:30 AM Resident #22 lying in bed with a bruise to the left eye and steri-strips to left side of face. Occupational note dated 5/20/24 identified that Resident #22 was seated in a standard wheelchair attempting to reach for items needed. Resident #22 was provided with a reacher to retrieve items floor level with supervision and cueing. Resident #22 requires maximum assistance for brake management on wheelchair. Resident demonstrates decreased safety awareness. (continued on next page)		

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 05/22/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Fox Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Director of Rehabilitation (OT #1), on 5/22/24 at 8:20 AM indicated that she was working with Resident #22 reaching for items, balance and standing, transfers, and evaluation of the wheelchair. OT #1 indicated that rehab was evaluating the residents positioning and cushion in the wheelchair on 5/16/24 during the day prior to the fall at 6:00 PM. OT #1 indicated that on 5/16/24 she had noted that Resident #22 needed an adaptive wheelchair, but she did not have one available. OT #1 indicated that Resident #22 does not remember to lock the brakes prior to attempting to stand. OT #1 indicated that because she did not have an adaptive wheelchair available that she would have maintenance place the anti-rollback locking system for the brakes on Resident #22's standard wheelchair to help prevent falls. OT #1 indicated that on 5/16/24 she thought she emailed via electronic medical record communication system to the Director of Maintenance the request for the anti-lock brakes for Resident #22. After reviewing the emails and medical record, OT #1 indicated there was nothing so maybe she told the Director of Maintenance verbally. OT #1 indicated her expectation was the antilock brakes would be put on the standard wheelchair that same day. OT #1 indicated that she was aware that the antilock brake system as of today 5/22/24 (7 days later) still was not applied to Resident #22's wheelchair. OT #1 indicated that she had not requested an adaptive wheelchair from the Administrator or anyone else since 5/16/24 (7 days later) when she did the evaluation and determined that the adaptive wheelchair would be the best strategy for the prevention of falls for Resident #22 and to assist in decreasing or preventing further falls. OT #1 indicated that she did not know why she had not spoken to the DNS or Administrator regarding needing the adaptive wheelchair and the antilock braking system to assist in the future prevention of falls. Interview with the Director of Maintenance on 5/22/24 at 8:35 AM indicated he was not asked to put on the antilock braking system on Resident #22's wheelchair. Director of Maintenance indicated that if OT #1 had asked him, he would have done it on the same day. After review in the electronic medical record, Director of Maintenance indicated he looked back and there were no messages or requests from OT #1 or anyone in rehab requesting that he put the antilock braking system on the wheelchair. Interview with the DNS on 5/22/24 at 8:40 AM indicated that if the rehab department had informed the Maintenance Director that Resident #22's wheelchair needs the antilock braking system it would be done on the same day. The DNS indicated that OT #1 had not discussed with her the need for an adaptive wheelchair or the antilock braking system with her. Interview with the DNS on 5/22/24 at 8:45 AM indicated Resident #22 had approximately 20 falls in the first 2 months since admission to the facility. The DNS indicated she tried to put a different intervention in place after every fall to prevent future falls. The DNS indicated she did not realize that she had used the same interventions on multiple occasions. The DNS indicated that Resident #22 was confused and education and teaching him/her may not be an appropriate intervention for someone that was not cognitively intact. (continued on next page)		

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 05/22/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Fox Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility Falls Management identified the interdisciplinary team identifies and implements appropriate interventions to reduce the risk of falls or injuries while maximizing dignity and independence. Assess and review resident risk factors and injuries upon admission, re-admission, quarterly, and a significant change in condition or after a fall. Implementation of goals and interventions with the resident and resident representative for inclusion in the interdisciplinary plan of care based on individual needs. Communicate interventions to the care giving team and resident representative. Review and revise the interdisciplinary plan of care at the time of the fall and update as indicated. In the event of a fall, do a head-to-toe assessment. Post fall resident will be referred to therapy for a screen if needed. Review the plan of care and discuss findings and interventions for fall risk reduction.		

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 05/22/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Fox Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37293 Based on review of the clinical record, facility documentation, facility policy, and interviews for 2 of 2 residents and (Resident #14 and Resident #160) reviewed for activities of daily living, the facility failed to provide weekly showers. The findings include: 1. Resident #14 was admitted to the facility on [DATE] with diagnoses that included right ankle fracture and diabetes. The admission MDS assessment dated [DATE] identified Resident #14 had intact cognition and requires moderate assistance with bathing, showering, and dressing. The April 2024 care plan identified activities of daily living. Interventions included providing extensive assistance with bathing. Additionally, it was important for Resident #14 to have showers per his/her preference. The Unit Shower Assignment Sheet (not dated) identified Resident #14 was to be offered showers on Tuesdays 3:00 PM -11:00 PM shift. The nurses note written by LPN #3 on 5/15/2024 at 11:31 PM indicated that Resident #14 had missed shower date on 5/14/24. Interview with Resident #14 on 5/19/24 at 9:00 AM indicated he/she had not received a shower for the first 4 weeks at the facility from 4/13/24 until 5/15/24 (33 days later). Resident #14 indicated that she has asked many nurses and nurse's aides for showers, but they informed him/her that it is not his/her scheduled day. Resident #14 indicated that he/she was informed his/her shower day is Tuesdays on 3:00 PM to 11:00 PM shift. Resident #14 indicated that he/she believes there were not enough staff in the evenings to provide the showers. Resident #14 indicated that last Tuesday was his/her shower day, but he/she was at an appointment that day and the staff informed him/her could get the shower on Wednesday instead. Resident #14 indicated that on Wednesday when he/she had asked the male nursing assistant, he informed him/her that the shower was scheduled for Tuesday and he/she had missed it and would not get one that day because he did not have enough time to do it. Resident #14 indicated he/she was upset and crying and called his/her representative. Interview with the ADNS on 5/20/24 at 11:01 AM indicated after clinical record review, that she did not see any nursing notes that Resident #14 had refused a shower since admission. The ADNS indicated that there was no documentation to indicate if Resident #14 did or did not receive any showers. The ADNS indicated last week they had just started and educated nursing staff on the new system for documentation of showers. The ADNS indicated that as of last week they had educated the nursing staff that if a resident refuses a shower to the nursing assistant the nursing assistant must inform the charge nurse. The ADNS indicated the charge nurse must go to the resident and reapproach and confirm that the resident does not want a shower and then the charge nurse must document the refusal of the shower and why. The ADNS indicated that for Resident #14 she did not see any refusal notes. (continued on next page)		

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 05/22/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Fox Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with NA #3 on 5/21/24 at 8:40 AM indicated that on 4/30/24 and 5/14/24 she was assigned to Resident #14 but did not give Resident #14 a shower because they were short staffed. NA #3 indicated that she was the only nursing assistant on that unit, so she did not have time to give showers. Interview with NA #4 on 5/21/24 at 9:53 AM indicated that he did not give Resident #14 a shower on 4/23/24 and 5/7/24 and 5/15/24 because he felt because Resident #14's was not getting out of bed to go to the bathroom due to his/her medical condition he assumed Resident #14 did not want to shower. NA #4 indicated on Wednesday 5/15/24 Resident #14 informed him that he/she did not get a shower on Tuesday evening. NA #4 indicated that he had informed Resident #14 that he would try to give him/her a shower later after he completed his rounds. NA #4 indicated that after the resident representative came into the facility, he did provide Resident #14 a shower. Interview with LPN # 3 on 5/21/24 at 10:42 AM indicated that on most evenings during the week we do not have enough staff to give Resident #14 a shower on Tuesdays or any other residents. LPN #3 indicated that Resident #14 had come back about 5pm from an appointment on that Tuesday 5/14/24, and the only nursing assistant that day told Resident #14 it was too late to give the shower because she was the only nursing assistant on the unit. LPN #3 indicated that on 5/15/24 that Resident #14 informed her that someone from the day shift had told him/her that NA #4 would give him/her a shower, so Resident #14 was demanding a shower from NA #4. LPN #3 indicated that NA #4 informed Resident #14 that he would try but he was the only aide on the unit. LPN #3 indicated that Resident #14 was upset so she spoken with Resident #14 at about 4:00 PM and told Resident #14 that they would try but there was only one aide. LPN #3 indicates that if the nursing assistant gives a shower, they must leave the unit and the showers take at least 30 minutes to almost an hour. LPN #3 indicated that would leave her by herself to pass medications, answer lights, toilet residents, and provide care. Review of the facility Bathing/Shower Policy identified it is the policy to shower residents to cleanse and refresh the resident, observe the skin, and provide increased circulation. 2. Resident #160 was admitted to the facility in September 2023 with diagnoses that included diabetes, atrial fibrillation, and acute kidney fracture. The admission MDS assessment dated [DATE] identified Resident #160 had intact cognition, required extensive assistance with personal hygiene, and was dependent with shower/bath. The care plan dated September 2023 identified Resident #160 was at risk for decreased ability to perform ADL's in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, and toileting related to decreased mobility and recent fracture to right upper limb. Interventions included provide resident with supervision/setup assist times one for personal hygiene and bathing. Review of the shower list for Nightingale Boulevard (North Center) unit identified Resident #160 shower day was on Tuesdays 3:00 PM - 11:00 PM shift. Review of the nurse aide flowsheet, and the nurse's note dated 9/10/23 - 9/30/23 failed to reflect documentation Resident #160 had been provided a shower on his/her scheduled day Tuesday 9/12/23, 9/19/23, and 9/26/23 during the 3:00 PM - 11:00 PM shift. Also, the nurse's note failed to reflect documentation that Resident #160 had refused his/her shower. (continued on next page)		

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 05/22/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Fox Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the nurse aide flowsheet, and the nurse's note dated 10/1/23 - 10/31/23 failed to reflect documentation that Resident #160 had been provided a shower on his/her scheduled day Tuesday 10/3/23, 10/17/23, 10/24/23, and 10/31/23 during the 3:00 PM - 11:00 PM shift. Also, the nurse's note failed to reflect documentation that Resident #160 had refused his/her shower Review of the nurse aide flowsheet, and the nurse's note dated 11/1/23 - 11/30/23 failed to reflect documentation that Resident #160 had been provided a shower on his/her scheduled day Tuesday 11/7/23, and 11/14/23 during the 3:00 PM - 11:00 PM shift. Also, the nurse's note failed to reflect documentation that Resident #160 had refused his/her shower. Interview and review of the clinical record with the DNS on 5/20/24 at 2:39 PM identified she was not aware that Resident #160 had not been receiving his/her weekly showers. The DNS indicated Resident #160 shower day was on Tuesday on the 3:00 PM - 11:00 PM shift. The DNS indicated the nurse aides should have provided Resident #160 with a shower on his/her schedule shower days. The DNS indicated the licensed nurses were not documenting when the resident refuses their shower. Interview with NA #10 on 5/22/24 at 9:54 AM identified she and LPN #4 are always the only staff scheduled for the unit on the 3:00 PM - 11:00 PM shift. NA #10 indicated she is the only nurse aide on the unit. NA #10 indicated Resident #160 refused showers multiple times. NA #10 indicated she does report to the nurse when Resident #160 refuses to take shower. Interview with NA #13 on 5/22/24 at 11:02 AM identified she was the only nurse aide scheduled on 9/19/23 on 3:00 PM - 11:00 PM shift. NA #13 indicated she did not give Resident #160 a shower that day because she was by herself on the unit. NA #13 indicated she was responsible for all the residents on the unit answering call lights, feeding, picking up the dishes, toileting, and putting residents back to bed. NA #13 indicated she did not inform the charge nurse Resident #160 did not have a shower on 9/19/23. Review of the facility Bathing/Shower Policy identified it is the policy to shower residents to cleanse and refresh the resident, observe the skin, and provide increased circulation. 42117		

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 05/22/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Fox Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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** 42117 Based on review of the clinical record, facility documentation, facility policy, and interviews for 2 of 3 residents (Resident #22) reviewed for reviewed for accidents, the facility failed to ensure neurological assessments after falls were completed per facility policy and 1 of 3 resident's reviewed for pressure ulcers, (Resident #100) the facility failed to perform and RN assessment following the discovery of a new bruise. The findings include: 1. Resident #22 was admitted on [DATE] with diagnoses that included urinary retention, obstructive uropathy, benign prostatic hyperplasia, and depression. A physician order dated 3/11/24 indicated Resident #22 was to wear non-skid footwear for safety. The admission MDS assessment dated [DATE] identified Resident #22 had moderately impaired cognition, requires maximum assistance with toileting, bathing, showering, dressing upper and lower body, and personal hygiene. Resident #22 had no falls prior to admission in the last 6 months. Resident #22 had 1 fall with no injury since admission. The care plan dated 3/27/24 identified resident was at risk for falls Interventions included to offer toileting after lunch, encourage resident to use call light, and provide verbal cues to resident to utilize the call bell for assistance with toileting and ambulation. Additionally, Resident #22 was an assist of 1 for bed mobility and transfers. a. Reportable Event Form dated 3/17/24 at 3:30 PM identified an unwitnessed fall. Resident #22 was found on knees on floor in front of toilet. Resident #22 was an assistant of 1 for transfers. The intervention was to educate resident to call for assistance for toileting /ambulation. b. Reportable Event Form dated 3/22/24 at 1:15 PM identified an unwitnessed fall. Resident #22 was found on floor in bathroom with an abrasion on mid back 0.3 cm x 0.3 cm x 0,1 cm. The intervention was to educate resident to call for assistance when needing to transfer. c. Reportable Event Form dated 3/29/24 at 9:50 AM identified an unwitnessed fall. Resident #22 was found sitting on the floor in bathroom with left sided rib pain. Intervention encourages resident to sit in common area after breakfast. d. Reportable Event Form dated 3/30/24 at 12:00 AM identified witnessed fall from wheelchair by nursing assistant standing at the nurse's station. The nursing assistant indicated that Resident #22 slid out of wheelchair leaning forward hitting head on medication cart causing an abrasion to the right side of the forehead. e. Reportable Event Form dated 4/5/2024 at 8:30 AM identified an unwitnessed fall. Resident #22 was found sitting on floor in bathroom with his/her back to wall and hand holding on to grab bar. The Intervention was to offer toileting before breakfast. f. Reportable Event Form dated 4/13/24 at 2:00 AM Resident #22 had an unwitnessed fall from wheelchair. The intervention was to keep the door of the room open when resident was in the wheelchair. (continued on next page)		

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 05/22/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Fox Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	g. Reportable Event Form dated 4/13/24 at 6:45 AM Resident #22 had an unwitnessed fall from the bed. The intervention was to perform frequent checks during the night. h. Reportable Event Form dated 4/13/24 at 7:00 AM Resident #22 had an unwitnessed fall in the bathroom found sitting on buttocks on floor in front of toilet. The intervention was to bring resident to the common area to sit when awake. i. Reportable Event Form dated 4/22/24 at 1:15 PM Resident #22 had an unwitnessed fall in bathroom in front of toilet. Resident #22 was noted to have regular socks without the benefit of the non-skid socks. The intervention was to wear non-skid socks. j. Reportable Event Form dated 5/2/24 at 1:45 AM Resident #22 had a witnessed fall out of wheelchair wearing dress socks without the benefit of wearing the non-skid socks by the nursing assistant. The intervention was to offer resident to go to bed on first rounds. Resident #22 indicated that he/she hit his/her head on the bedrails. k. Reportable Event Form dated 5/9/24 at 5:00 AM Resident #22 had an unwitnessed fall and was found on floor. The intervention was that on the 11:00 PM to 7:00 AM shift on their last rounds to wake resident and offer toileting. Interview with the DNS on 5/22/24 at 8:40 AM indicated that when a resident had an unwitnessed fall, or a fall witnessed hitting head, that the neurological assessment policy would be followed and documented on paper then filed in the resident's chart. The DNS indicated that the neurological assessments for the unwitnessed falls would be in Resident #22's chart. Review of the clinical record, the DNS indicated she did not have any neurological assessments or they were incomplete neurological assessment forms for the following falls on 3/17, 3/22, 3/29, 3/30, 4/5, 4/13 at 2:00 AM, 4/13 at 6:45 AM, 4/13 at 7:00 AM, 4/22, 5/2, and 5/9/24. The DNS indicated that there were 11 missing or incomplete neurological assessment forms, and she could not verify that they had been completed. The DNS indicated that she did not know why the nurses did not complete the neurological assessment and vital signs per the facility policy. Review of the facility Falls Management policy identified the interdisciplinary team identifies and implements appropriate interventions to reduce the risk of falls or injuries while maximizing dignity and independence. Assess and review resident risk factors and injuries upon admission, re-admission, quarterly, and a significant change in condition or after a fall. Implementation of goals and interventions with the resident and resident representative for inclusion in the interdisciplinary plan of care based on individual needs. Communicate interventions to the care giving team and resident representative. Review and revise the interdisciplinary plan of care at the time of the fall and update as indicated. In the event of a fall, do a head-to-toe assessment. Obtain neurological assessment per policy for any unwitnessed fall or any fall with evidence of injury to the head. Post fall resident will be referred to therapy for a screen if needed. Review the plan of care and discuss findings and interventions for fall risk reduction, (continued on next page)		

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 05/22/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Fox Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Neurological Assessment Policy identified neurological assessments are performed to evaluate a residents nervous system including brain function. Early detection of an injury or underlying condition provides the best chance of decreasing long term complications. Residents with conditions resulting in a change, potential for change in their neurological status will be assessed for transfer to the hospital. Neurological assessments will be completed by a licensed nurse. Neurological assessments will be completed every 15 minutes for the first hour, every 30 minutes for the next 2 hours, every hour for the net 2 hours, every shift for the next 72 hours. 2. Resident #100 was admitted to the facility on [DATE] with diagnoses that included dementia and hypertension. A physician's order dated 3/12/24 directed to encourage resident to off load heels as tolerated in bed, pressure redistribution cushion to bed and mattress, and skin prep to bilateral heels for 14 days. The admission MDS assessment dated [DATE] identified Resident #100 had severely impaired cognition, was always incontinent of bowel and bladder and required total assistance with toileting, bathing, dressing, and personal hygiene. Additionally, Resident #100 was at risk of developing a pressure ulcer. There were no pressure ulcers on admission. Furthermore, skin treatment was to apply a pressure reducing device for bed and chair. A nurse's note written by LPN #3 dated 4/10/24 at 6:58 PM identified a skin check was performed. LPN #3 identified a bruise to Resident #100's left heel. Interview with DNS on 5/20/24 at 7:37 AM identified that the charge nurses conduct weekly skin checks of all residents. The DNS indicated that any new bruises, new pressure areas, or changes in conditions the RN supervisor or herself as DNS will conduct the assessment. The DNS indicated RN must do an assessment and document it in the resident's clinical record. The DNS indicates that any new bruise would require a reportable event form and investigation. Interview with LPN # 3 on 5/20/24 at 9:03 AM indicated she recalls seeing the new bruise on 4/10/24 does not recall if she reported the new bruise to Resident #100's left heel to the RN supervisor. LPN #3 indicated that the procedure was to report it to an RN for an assessment. LPN #3 indicated that if she had reported it to the RN, it would be in her progress note. LPN #3 indicated she does not recall if she started a reportable event form for the new bruise but does know that any new bruise requires a reportable event form to be completed. Interview with APRN #1 on 5/20/24 at 9:30 AM indicated she depends on the charge nurses to update her of any changes including new bruises. The APRN #1 indicated that she was not notified on 4/10/24 about any bruise on the left heel. Interview with the ADNS on 5/20/24 at 9:58 AM indicated there was a progress note dated 4/10/24 indicating there was a new bruise to Resident #100, so there should be a reportable event form with the DNS. The ADNS indicated that any new bruise must have an RN assessment done on the same shift that it is found. After clinical record review, the ADNS indicated there was not an RN assessment completed on 4/10 or 4/11/24 for the bruise in the clinical record. (continued on next page)		

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 05/22/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Fox Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DNS on 5/20/24 at 11:22 AM indicated she does not have a reportable event form completed with an investigation for the new bruise noted on 4/10/24 by LPN #3. The DNS indicated that for a new bruise she would have expect the supervisor to have completed a reportable event form and that it would have been given to her as the DNS. Although requested, a facility policy for RN (Registered Nurse) Assessments was not provided.		

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 05/22/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Fox Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42117 Based on review of the clinical record, facility documentation, facility policy, and interviews for 2 of 3 residents (Resident #95 and #100) reviewed for pressure ulcer, the facility failed ensure the air mattress settings were per the manufacturer recommendations and failed to have a treatment in place for a new facility acquired pressure ulcer. The findings include: 1. Resident #95 was admitted to the facility on [DATE] with diagnoses that included peripheral vascular disease, adult failure to thrive, and osteoporosis. A physician's order dated 4/3/24 directed to apply air mattress to bed, assess function, and integrity every shift. The admission MDS assessment dated [DATE] identified Resident #95 had intact cognition, was always incontinent of bowel and bladder and required total assistance with toileting, shower/bath, dressing, and personal hygiene. Additionally, Resident #95 had a stage 3 pressure ulcer to the sacrum. The care plan dated 4/16/24 identified Resident #95 as at risk for skin breakdown related to decreased activity. Resident #95 has a stage 3 pressure ulcer to buttocks. Interventions included providing a pressure redistribution surface to bed as per guideline of air mattress. A physician's order dated 5/13/24 directed low air loss mattress to bed every shift setting was to be at 160 lbs. Check settings and functions every shift. Observation on 5/19/24 at 8:30 AM and 10:10 AM Resident #95 was lying in bed on an air mattress with the air mattress dial setting was just above 80 lb. mark approximately 85 lbs. Review of the Weight Summary identified: 4/2/2024 155.4 Lbs 4/8/2024 157.6 Lbs 4/16/2024 156.2 Lbs 4/22/2024 153.0 Lbs 5/3/2024 148.2 Lbs 5/9/2024 148.8 Lbs 5/17/2024 146.0 Lbs. (continued on next page)		

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 05/22/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Fox Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the ADNS on 5/19/24 at 10:39 AM indicated that the air mattresses were set to the resident's weights. The ADNS indicated that maintenance was responsible for keeping track of which residents have an air mattress. The ADNS indicates that the clinical team, supervisors, and hospice determine who is at risk for skin breakdown or has a stage 3 or greater pressure ulcer that requires an air mattress. The ADNS indicated the charge nurses were responsible to make sure the settings of the air mattress were set to the weight of the resident and they need to change the setting of the air mattresses to reflect the correct weights. The ADNS indicated that the importance of the air mattress was to prevent wounds or assist in wound healing. Observation with the ADNS indicated that Resident #95 was lying in bed on the air mattress with the setting at 90 lbs. After clinical record review, the ADNS indicated that Resident #95's last weight was 146 lbs. on 5/17/24, so the air mattress was not at the correct weight. 2a. A. Resident #100 was admitted to the facility on [DATE] with diagnoses that included dementia and hypertension. A physician's order dated 3/12/24 directed to encourage resident to off load heels as tolerated in bed, pressure redistribution cushion to bed and mattress. The care plan dated 3/13/24 identified Resident #100 was on hospice. Interventions included to Resident #100 was assist of 2 mechanical lift from bed to wheelchair. The care plan did not reflect Resident #100 utilized an air mattress. The admission MDS assessment dated [DATE] identified Resident #100 had severely impaired cognition, was always incontinent of bowel and bladder and required total assistance with eating, toileting, bathing, dressing, and personal hygiene. Additionally, Resident #100 was at risk of developing a pressure ulcer. There were no pressure ulcers on admission. Furthermore, skin treatment was to apply a pressure reducing device for bed and chair. Observation of Resident #100 on 5/19/24 at 6:45 AM Resident #100 was lying in bed on an air mattress with the setting at 80 lbs. Interview with Resident #100's representative on 5/19/24 at 7:30 AM indicated Resident #100 had received a pressure ulcer while at the facility on his/her left heel from the wheelchair. Resident Representative felt that the air mattress looked deflated and was going to get the nurse for assistance. Observation and interview with the ADNS on 5/19/24 at 10:39 AM indicated Resident #100 was lying in bed on an air mattress with the setting at 80 lbs. After clinical record review, the ADNS indicated that she was not able to identify what date the air mattress was placed on the bed except for that hospice would have provided the air mattress and that Resident #100's last weight was done on 4/10/24 and was 152 lbs. The ADNS indicated the air mattress was not set to the last known weight so would not help in the prevention of wounds. The ADNS indicated that she would have Resident #100 reweigh today to be able to adjust the weight of the air mattress to the correct weight for the proper setting. Subsequent to surveyor inquiry, the care plan dated 5/19/24 identified actual skin breakdown. Interventions included to have low air loss mattress set at 130 lb. (continued on next page)		

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 05/22/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Fox Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the manufacturer recommendations for Resident #95's air mattress identified the air mattress was to reduce the incidence of pressure ulcers. The pressure adjustment knob is adjusted by the resident's weight. 2b. The nursing note dated 3/25/24 at 1:42 PM identified there was a change in condition and Resident #100 had a new pressure ulcer with pain. The primary care provider was notified and ordered to cleanse the wound with wound cleaner then apply a piece of Xeroform and cover with a foam dressing daily for 7 days. The Skin Integrity Report dated 3/25/24 identified the left heel was a stage 2 and was open with measurements of 2.0 cm by 4.0 cm by 0.1 cm with moderate amount of serosanguinous drainage. Review of the physician's orders and the Treatment Administration Record from 3/25-3/31/24 did not reflect that the nurses were providing the treatment with Xeroform daily to the new left heel open pressure area. Resident #100's care plan dated 3/27/24 identified actual skin breakdown to left heel. Interventions included to off load heels while in bed and in wheelchair. Interview with APRN #1 on 5/20/24 at 9:30AM indicated that on 3/25/24 open area to the left heel was related to pressure and she put in the initial treatment order on 3/25/24 for the left heel to include Xeroform dressing covered with foam for 7 days until seen next by the wound physician on his weekly wound rounds. She was not aware that Resident #100 was not being followed by the wound physician. After clinical record review, APRN #1 indicated that the treatment was not in the physician orders and was not done per the treatment administration record. APRN #1 indicated there was not a treatment in place for the new open stage 2 to the left heel starting on 3/25/24 for 7 days. Interview with the ADNS on 5/20/24 at 9:58 AM indicated that Resident #100 did not a pressure ulcer on his/her heels on admission on 3/12/24. The ADNS indicates that in the progress notes on 3/25/24 Resident #100 was first noted with 2.0 cm by 4.0 cm by 0.1 cm open area to the left heel and there was a treatment for Xeroform dressing change daily for 7 days. After clinical review, the ADNS indicated that she did not see that the physician order was put in place on 3/25/24, and that it was transcribed to the treatment record for the nurses to do the treatment to the left heel open area for the 7 days. After surveyor inquiry, the Wound Physician progress note dated 5/20/24 identified Resident #100 had an unstageable necrotic pressure ulcer to the left heel with measurements 4.0 cm by 4.5 cm by 0.1 cm with a moderate amount of serous drainage. The left heel wound has 20% thick adherent devitalized necrotic tissue and 80% granulated tissue. The physician order was to discontinue the calcium alginate and start new treatment of applying Santyl to wound bed once a day for 30 days and wrap with gauze roll. Recommendation to offload wound and elevate legs and float heels in bed. Review of the facility Pressure Ulcer/Injury Overview Policy identified a pressure ulcer refers to localized damage to the skin and/or underlying soft tissue usually over a bony prominence related to a medial or other device. The unstageable pressure ulcer appears as a full thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar. Although requested, a facility policy for treatment of pressure ulcers and prevention of pressure ulcers was not provided.		

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 05/22/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Fox Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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** 42117 Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 2 residents (Resident #210) reviewed for respiratory care, the facility failed to ensure there was a physician order for administration of oxygen and the oxygen tubing and humidifier canister were not labeled and dated when changed. The findings include: Hospital Discharge Summary dated 5/9/24 identified Resident #210 had a diagnosis of pleural effusion, asthma exacerbation, and acute hypoxic respiratory failure. Resident #210 will continue to use supplemental oxygen and wean as tolerated as resident continues to improve. Resident #210 was admitted to the facility on [DATE] with diagnoses that included pneumonia, acute respiratory failure, asthma exacerbation, and sepsis. The admission nursing assessment dated [DATE] identified Resident #210 was admitted from the hospital on oxygen at 2 liters per minute via nasal cannula. Review of the physician's order dated 5/9/24 until 5/20/24 did not reflect Resident #210 was on continuous oxygen. The admission MDS assessment dated [DATE] identified Resident #210 had intact cognition and requires total assistance with toileting, and dressing, and moderate assistance with personal hygiene. Additionally, the MDS did not reflect that Resident #212 was on continuous oxygen. Observation on 5/19/24 at 7:30 AM Resident #210 was lying in bed on oxygen via nasal cannula with a humidifier canister connected to a concentrator on 1 liter oxygen. The nasal cannula and the humidifier canister were not dated when last changed. Interview and observation with LPN #1 on 5/19/24 at 7:32 AM indicated that Resident #210 was on 1 liter of oxygen via nasal cannula and noted that the oxygen tubing and the humidifier canister were not dated when last changed and she was not able to identify when it was last changed since being admitted from the hospital. After clinical record review, LPN #1 indicated that the physician order dated 5/16/24 stated just titrate oxygen and was on room air while at home. LPN #1 indicated that the physician order does not make sense and was not an actual order for oxygen because Resident #210 was currently on 1 liter of oxygen via nasal cannula and there was not an order to change the oxygen tubing weekly. LPN #1 indicated the physician order should reflect how many liters and titrate based on the pulse oximetry readings every shift. (continued on next page)		

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 05/22/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Fox Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with ADNS on 5/20/24 at 3:03 PM indicated that the oxygen tubing gets changed on every Monday between 11:00 PM to 7:00 AM and must be dated on the tubing using a piece of tape on it when it was changed, and the humidifier canister is to be dated and changed as needed. The ADNS indicated that oxygen is a medication and must have a physician's order. Clinical record review, the ADNS indicated that Resident #210 was currently being weaned off oxygen because Resident #210 does not use oxygen at home. The ADNS indicated that she was aware that on admission Resident #210's was on oxygen. After clinical record review, the ADNS indicated that Resident #210 did not have a valid physician's order for oxygen since admission on 5/9/24. The ADNS indicated that there was only an order stating titrate oxygen. The ADNS indicates that is not a valid physician order for the use of oxygen. The ADNS indicated that Resident #210 was admitted on oxygen and there should have been an order for the oxygen since admission indicating how many liters per minute, check pulse oximetry every shift, titrate oxygen, and change and date oxygen tubing weekly. The ADNS indicated that she did not know why those orders were not put in place at admission. Review of the facility Oxygen Administration Policy identified to verify the physicians order for the oxygen. Oxygen therapy is administered by way of an oxygen mask or nasal cannula. The nasal cannula is a tube that is placed into the resident's nostrils and is held in place by an elastic band placed around the resident's head. While a resident is receiving oxygen therapy nursing must assess for the following: signs of cyanosis (skin turning blue color), hypoxia (rapid breathing, increased pulse, confusion), oxygen toxicity (slow shallow breathing, difficulty breathing), and lung sounds.		

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 05/22/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Fox Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42117 Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 1 resident (Resident #212) reviewed for pain management, facility failed to ensure the pain management medication was available to meet residents preference and provided in a timely manner. The findings include: Resident #212 was admitted to the facility on [DATE] with diagnoses that included right femur fracture, right hip cemented hemiarthroplasty. hypertension, and pain management. The hospital discharge summary dated 5/17/24 identified Resident #212 was receiving Naproxen 500 mg twice a day last dose given 5/17/24 at 2:41 PM. The nursing admission assessment completed by RN #5 dated 5/17/24 at 9:42 PM identified Resident #212 as alert and oriented to person, place, time, and situation. RN #5 noted Resident #212 was receiving scheduled pain medications, and prn (as needed) pain medications, and non-medication interventions for pain. RN #5 noted Resident stated pain was almost always constant, occasionally affects his/her sleep, and rarely interferes with day-to-day activities. The care plan dated 5/17/24 identified acute pain related to fracture of right hip post-surgery. Interventions included administering pain medications per physician orders and notify physician if goal was not met with regime. Also, anticipate the resident's need for pain relief and respond immediately to any complaint of pain. Complete a pain assessment on admission and per facility policy to determine the nature of the discomfort, his/her desired response and any previously successful strategies used. A physician's order dated 5/17/24 directed to provide Oxycodone 5 mg 1 to 2 tablets every 4 hours as needed for pain. Oxycodone was discontinued on 5/17/24 and Hydromorphone 4mg every 4 hours as needed for pain for 14 days was started. The nurse's note written by RN #3 dated 5/18/24 at 6:08 PM identified that Resident 3212 refused the Hydromorphone and requested Naproxen. Resident #212 stated he/she received at the hospital, and it alleviated the pain. APRN #1 was updated and new order for Naproxen 500 mg every 8 hours as needed and ice for pain and swelling 4 times a day for 20 minutes as needed was provided. Resident #212 aware of new orders. Interview with RN#3 on 5/19/24 at 8:31 AM indicated that in the morning on 5/18/24 Resident #212 had informed her that he/she preferred to have Naproxen instead of Hydromorphone. RN #3 indicated that Resident #212 had informed her that Naproxen works better for his/her pain than the narcotics in the hospital. RN #3 indicated that she had called the APRN #1 and received the new order for Naproxen on 5/18/24 for every 8 hours as needed, but it had not been delivered from the pharmacy. RN #3 indicated that it takes pharmacy a while to deliver medications because they are from out of state. RN #3 indicated that she had called the pharmacy on Saturday and requesting the Naproxen get delivered as soon as possible, but it still is not at the facility on 5/19/24. (continued on next page)		

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 05/22/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Fox Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Resident #212 on 5/19/24 at 8:45 AM indicated that he/she was having a problem getting his/her pain medications. Resident #212 indicated that he/she calls and asks for it about every 4 hours as prescribed and he/she will not receive it for up to 6 hours from the last one. Resident #212 indicated that he has had to wait up to 3 hours for the nurse to bring the pain medication. Resident #212 indicated when he/she was admitted on [DATE] and had requested to get Naproxen to RN #5 instead of the Hydromorphone. Resident #212 indicated that worked better in the hospital and would prefer non narcotics over the narcotics. Resident #212 indicated he/she was aware that he/she has to request the pain medication every 4 hours but when he/she requests the medication after the 4 hours he/she has to wait hours for the staff to deliver it after asking the nurses. Resident #212 indicated that initially he did refuse the Hydromorphone because he/she preferred the Naproxen but the next day when RN #3 educated him that they did not have the Naproxen and to manage his/her pain should take the Hydromorphone he/she began to take it until the Naproxen would come in. Resident #212 indicated that he does not understand why is taking so long to get Naproxen since admission 2 days ago. Resident #212 indicated that he does not get the pain medications when requested in a timely manner and still has not received the non-narcotic medication that he/she prefers. Resident #212 is requesting the Hydromorphone as needed every 4 hours be scheduled every 4 hours so maybe then he/she could get it timely. Interview with RN #3 on 5/19/24 at 2:00 PM indicated that the pharmacy informed her that they did not sent the Naproxen because the initial order was for every 8 hours then could not fill it unless it was every 12 hours. RN #3 indicated she called APRN #1 and got the order changed to Naproxen every 12 hours and called the pharmacy back and they indicated they could not fill the prescription for the Naproxen. Interview with the ADNS on 5/20/24 at 2:47 PM indicated that on Saturday morning RN #3 had ordered the Naproxen for Resident #212 and the pharmacy stated it could not be ordered as every 8 hours so RN #3 called APRN #1 and changed the order to scheduled every 12 hours. The ADNS indicated that RN #3 then had called the pharmacy, and they informed her the order was all set and would be delivered. The ADNS indicated that on Sunday RN #3 had informed her that the Naproxen still had not came into the facility, so she had called the pharmacy and requested the medication be sent stat. The ADNS indicated the pharmacy informed her that a stat would not be sent at 4:30 PM because it was to close to the regular scheduled delivery that would be leaving the pharmacy in New Jersey at 6:00 PM so they would not send it as a stat order. The ADNS indicated that she did not know what time the Naproxen had been delivered to the facility and the nurses that receive the non-narcotic medications discard the delivery slips. The ADNS indicated that she could have gone to the local pharmacy and picked up the Naproxen as an over the counter versus waiting over 2 days for the pharmacy to deliver medication from New Jersey. The ADNS indicated that when Resident #212 requested the Hydromorphone for pain Resident #212 should receive the medication within about 15 minutes. The ADNS indicated she was not aware that Resident #212 had to wait hours for pain the pain medications. Review of the list of facility Over the Counter Medications as house stock not dated identified that Naproxen was not held as stock in the facility. (continued on next page)		

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 05/22/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Fox Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility Pain Management identified the facility must ensure that pain management is provided to resident's who require such services, consistent with professional standard, the comprehensive person-centered care plan, and the resident's goals and preferences. Treatment if the resident's pain is not controlled by the current treatment regimen, the practitioner should be notified. Factors influencing the choice of treatments include the resident's underlying diagnosis or conditions that are causing or contributing to pain, the cause, location, nature and severity of pain, and the resident's preferences expressed verbally. Also, the resident's effectiveness of specific drugs and other treatments used in the past to treat pain.		

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 05/22/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Fox Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 47457 Based on review of the clinical record, facility documentation, facility policy, and interviews, the facility failed to ensure sufficient nurse staffing levels to care for residents' needs. The findings include: Interview with Resident #14 on 5/19/24 at 9:00 AM indicated that his/her shower day was scheduled for Tuesdays. On Tuesday 5/14/24 he/she was out of the facility for an appointment and upon return the staff informed him/her that a shower would have to be given on Wednesday, instead. Resident #14 identified that on Wednesday the nurse indicated that his/her shower was scheduled for Tuesday, and a shower would not be given on Wednesday. Interview with NA # 3 on 5/21/24 at 8:40 AM indicated that on 5/14/24 she was assigned to Resident #14 but did not give Resident #14 a shower due to short staffing. NA #3 further indicated that she was the only nursing assistant on that unit, so she did not have time to give showers. Interview with NA #7 on 5/21/24 at 11:57 AM identified that staffing at the facility has been terrible, especially on the weekends. NA #7 further identified that sometimes she is on the master schedule to be on the floor by herself, particularly on weekends. NA #7 indicated that when the facility is short staffed, she prioritizes incontinent care but there have been times that she has been unable to get residents out of bed, perform mouth care, or provide showers due to lack of staff. NA #7 further indicated she had brought her staffing concerns to the attention of the facility's management, but they have indicated that they don't have the help available. Interview with the staff scheduler on 5/22/24 at 11:55 AM identified that on 5/14/24 the facility had one extra nurse aide scheduled for the 7AM-3PM shift, but then 2 nurse aides called out and they were unable to replace them; on the 3-11 PM shift 1 nursing staff member called out, but they were able to replace her. The staff scheduler further indicated that there are challenges with scheduling: call outs and sufficient staffing, especially on the weekend shifts. Interview with the DNS on 5/22/24 at 12:04 PM identified that the facility is experiencing challenges with having enough available staff, as well as challenges with nursing staff call-outs, particularly on the weekend shifts. Review of the Facility Assessment described resident's acuity level over the past year or during a typical month as follows: A. Number of residents requiring an assist of 1-2 staff for the following activities: Dressing-47 Bathing-57 Transfer-48 (continued on next page)		

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

Printed: 10/31/2024
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 05/22/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Fox Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Eating-39 Toileting-51 B. Number of dependent residents for the following activities: Dressing-44 Bathing-21 Transfer-23 Eating-9 Toileting-37		

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 05/22/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Fox Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42117 Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 5 residents (Resident #14) reviewed for unnecessary medications, the facility failed to ensure a pharmacy medication review was addressed in a timely manner. The findings include: Resident #14 was admitted to the facility on [DATE] with diagnoses that included right ankle fracture and diabetes. A physician's order dated 4/14/24 directed to inject Humalog insulin 100 units per 1 ml per sliding scale if blood sugar was 150-200 give 2 units, 201-250 give 4 units, 251-300 give 6 units, 301-350 give 8 units, 351 or greater give 10 units and notify the physician or APRN. If blood sugar is less than 70 notify physician. The care plan dated 4/16/24 does not reflect Resident #14 was diabetic and receiving insulin. The admission MDS assessment dated [DATE] identified Resident #14 had intact cognition and requires a high risk drug insulin. A pharmacy progress note dated 5/4/2024 at 9:50 AM identified there was a pharmacy recommendation to the prescriber and to refer to the Medication Regimen Review Report. The Medication Regimen Review Report dated 5/4/24 indicated that Resident #14 was currently receiving an active sliding scale insulin coverage without orders for a long acting or basal insulin. Consider discontinue insulin coverage and taper finger sticks to 2 times a week in the AM and PM and if the blood sugar was less than 70 or greater than 250 notify the physician. Review of the physician orders dated 5/4/24 to 5/21/24 revealed there were no changes. Review of the physician and APRN progress notes date 5/4/24 to 5/21/24 did not address or reflect a response to the Pharmacy medication review. Interview with Pharmacist #1 on 5/21/24 at 9:25 AM indicated that the monthly pharmacy medication reviews were to have a reply agreeing or disagreeing with the pharmacist recommendation within 24-72 hours. Pharmacist #1 indicated that the expectation was the APRN, or physician addresses the recommendation within the 24-72 hours and documents the response. Interview with APRN #1 on 5/21/24 at 10:20 AM indicated she was responsible to document a reply within a couple of days, agreeing or disagreeing with the pharmacy recommendations. APRN #1 indicated that if she does not agree with a pharmacy recommendation, she must document it on the pharmacy form and in a progress not as to why she does not agree. APRN #1 indicated that she did not document in a progress note or on the pharmacy form a response to the recommendation. (continued on next page)		

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 05/22/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Fox Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DNS on 5/21/24 11:32 AM indicated she was responsible to receive the monthly pharmacy medication reviews via email and she prints them out and divides them between the two (2)APRN's for the residents. The DNS indicated that the APRN's must follow up on the recommendations within 7 days and agree or disagree with the Pharmacist recommendations. The DNS indicated that if the APRN disagrees with the Pharmacist recommendations the APRN must write a rational why they disagree and do not want to make the changes. After clinical record review, the DNS indicated that APRN #1 did not respond or address the pharmacy recommendation for the blood sugars and sliding scale insulin. Review of the facility Pharmacy Drug Regimen Monthly Review policy identified in accordance with federal regulations a consultant pharmacist shall review the medical record of each resident and perform a drug regimen review at least once a month. The Consultant Pharmacist shall identify, document and report possible medications irregularities for review and action by the attending physician. The attending physician or licensed designee shall respond to the Drug Regimen Review within 7-14 days or less. Additionally, shall document on the drug regimen review form whether he/she agrees or disagrees with the recommendation and provide a brief clinical rationale if no change is to be made.		

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 05/22/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Fox Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47457 Based on observation, facility policy, and interviews, the facility failed to ensure dietary staff were wearing beard restraints, opened food and beverage items in the refrigerator were dated, the kitchen refrigerators were free of employee's personal beverages, and frozen food items were properly sealed. The findings include: 1. During an initial tour of the facility kitchen on 5/19/24 from 6:58 AM through 7:40 AM with cook #1, the following were identified: a. Observation of dietary aide #2 and cook #1 identified that they were without the benefit of a beard restraint while prepping for breakfast service. Interview with dietary aide #2 identified that he usually wears a beard restraint; today he was unable to obtain a beard restraint because they were stored in the food service manager's office and the office door was locked. Dietary Aide #2 indicated that he would not have access to a beard restraint until the manager arrived. Interview with cook #1 identified that this was his first day at the facility, as he was covering for the facility's full-time morning cook. [NAME] #1 further identified that he was unable to obtain a beard restraint because they were stored in the manager's office, the door had been locked, and he was unable to locate the key. [NAME] #1 indicated that the manager was on her way into the facility, and he would be able to put on a beard guard before breakfast was served. b. Observation of the reach-in refrigerator identified a metal pan containing chocolate pudding and a metal pan containing Jello uncovered and not labeled or dated. Additional observations identified the following containers were opened and not dated: 1-5lb container of sour cream 1-5lb container of cottage cheese 2-half gallons of whole milk 7-half gallons of orange juice 3-half gallons of chocolate milk 7-pitchers of iced tea Further observation of the reach-in refrigerator identified an opened 16 oz personal bottle of water and a blue personal coffee cup with a lid. Interview with cook #1 identified that the Jello and pudding were not covered because they were made the night before and could not be covered immediately after cooking due to the heat of the items. (continued on next page)		

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 05/22/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Fox Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. Observation of the reach-in freezer identified the following items were not covered and were open to air: 1-bag of breaded chicken patties 1-bag of pull and rise dinner rolls 1-bag of fish fillets Interview with the food services district manager on 5/21/24 at 9:53 AM identified that she was covering for the facility's food service manager. The food service district manager further identified that it is her expectation that beard restraints are worn by dietary staff to prevent hair from contacting the food; beard restraints were stored in her office, but the door had been accidentally locked the night before and prevented the dietary staff from having access to them, on the morning of 5/19/24. The food service district manager identified that it is her expectation that all opened containers are labeled and dated, employee's personal food and beverage items are not stored in the kitchen refrigerators, and frozen items are covered and sealed; a labeling and dating in-service was provided to the dietary staff on 5/20/24. The Food Safety Requirements policy directs the storage of food is done in a manner that helps prevent deterioration or contamination of the food, keeping foods covered or in tight containers, and labeling, dating, and monitoring refrigerator food, so it is used by its use by date, frozen, or discarded. The policy further directs dietary staff to wear hair restraints to prevent hair from contacting food. The Staff Attire policy directs all staff members to have their hair off the shoulders, confined in a hair net or cap, and facial hair properly restrained. The Food Storage: Cold Foods policy directs all foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination. Although requested a policy for the storage of staff personal beverage and food items was not provided.		

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 05/22/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Fox Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 47457 Based on observation, facility documentation, facility policy, and interviews, the facility failed to ensure ongoing surveillance of staff/resident COVID-19 testing was maintained, failed to ensure a nurse aide performed hand hygiene after exiting the room of a resident on contact precautions, and failed to ensure the resident-care equipment was sanitized upon leaving the room of a resident on contact precautions. The findings include: 1.A request was made on 5/20/24 to the facility to provide documentation identifying surveillance of staff and resident COVID-19 testing. Interview with the Infection Control Nurse (RN) #2 on 5/20/24 at 10:00 AM identified that the COVID-19 staff and resident testing logs were last updated in September 2023, but she would update the logs with information from the current outbreak, which began on 5/12/24. RN #2 indicated that prior to this outbreak, there had been no recent reports of staff having Covid-like symptoms and therefore no staff testing had been completed, except for one nursing staff member who reported a positive COVID test, earlier in the day. RN #2 further indicated that when a resident experiences COVID-like symptoms the nursing staff will complete an as needed (PRN) COVID-19 test and document the results in the electronic health record. RN #2 identified that maintaining an accurate facility log of COVID-19 resident tests would be challenging because nursing staff did not always report to her when a resident had been tested . Interview with the Regional Clinical Manager (RN #9) on 5/21/24 at 11:07 AM indicated that the facility should have documentation of routine COVID-19 testing for staff and residents. RN #9 further indicated that the expectation of the facility is that a file is maintained within the facility, including surveillance, contact tracing, and all the steps that the facility has taken. Interview and facility documentation review with the DNS on 5/22/24 at 7:35 AM failed to identify that COVID-19 resident and staff testing logs were maintained prior to surveyor inquiry. The DNS identified that it would be her expectation that a log of COVID-19 testing was maintained within the facility. The facility's Infection Preventionist policy directs the infection preventionist will collect, analyze, and provide infection and antibiotic usage data and trends to nursing staff and health care practitioners; consult on infection risk assessment and prevention control strategies; provide education and training; and implement evidence-based infection prevention and control practices. The facility's COVID-19 Prevention, Response, and Reporting policy directs the infection preventionist, or designee, will monitor and track COVID-19 related information to include, but not limited to the number of residents and staff who have suspected or confirmed COVID-19 and date of confirmation. (continued on next page)		

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 05/22/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Fox Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Observation with RN #2 on 5/21/24 at 8:00 AM identified NA #11 exiting the room of a resident on transmission-based precautions, secondary to a COVID-19 infection, without the benefit of hand hygiene or sanitizing the vital sign machine upon exit. Subsequent to surveyor inquiry, NA #11 performed hand hygiene and was then observed walking to the north wing nurse's station with the vital sign machine. Immediately following the observation, an interview with NA #11 identified that she should have washed her hands after removing her personal protective equipment (PPE) and should not have wheeled the vital sign machine to the nurse's station prior to cleaning it. NA #11 indicated that she had wheeled the vital sign machine to the nurse's station so she could clean it, as the appropriate sanitizing wipes were not available on the isolation cart. Interview with RN #2 on 5/21/24 at 8:05 AM identified that it is the expectation of the staff that they wash their hands or hand sanitize after coming out of an isolation room. RN #2 further identified that the vital sign machine should not have been brought to the nurse's station without first being sanitized; the vital sign machine should be sanitized after each use upon exiting a resident's room. RN #2 indicated that she would immediately begin staff education on hand hygiene and sanitizing the vital sign machine. Interview with the DNS on 5/22/24 at 12:04 PM identified that it is her expectation that staff perform hand hygiene after exiting a resident's room that is on transmission-based precautions and that any equipment brought into the room be sanitized. The facility's Hand Hygiene policy directs all staff to perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to: between resident contacts, before and after removing PPE (including gloves), and before and after providing care to residents on isolation. The facility's Standard Precautions Infection Control policy directs resident-care equipment and instrument/devices have established policies and procedures for containing, transporting, and handling resident-care equipment. The policy further directs employees are provided job and/or task-specific training and education on preventing the transmission of infectious agents associated with healthcare during their orientation program, annually, during regularly scheduled infection control training programs, and when new or modified procedures are implemented in the facility. Although requested, NA #11's clinical competency for sanitizing resident-care equipment was not provided.		

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 05/22/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Fox Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 47457 Based on review of the clinical record, facility documentation, facility policy, and interviews the facility failed to ensure 3 of 5 residents (#75, 79, and #88) were provided with education and consented to receive the COVID-19 vaccine and failed to ensure 2 of 5 residents (Resident # 62 and 80) were provided education about the COVID-19 vaccination and consented or refused to receive the COVID-19 vaccine. The findings include: 1. Resident #75's immunization record identified the COVID-19 vaccine additional dose/booster was last administered on 1/5/24. Resident #75's clinical record failed to show that he/she was provided with education on the COVID-19 vaccine or provided consent. 2. Resident #79's immunization record identified the COVID-19 vaccine additional dose/booster was last administered on 1/5/24. Review of Resident #79's clinical record failed to show that he/she was provided with education on the COVID-19 vaccine or provided consent. 3. Resident #88's immunization record identified the COVID-19 vaccine additional dose/booster was last administered on 1/5/24. Resident #88's clinical record failed to show that he/she was provided with education on the COVID-19 vaccine or provided consent. 4. Resident #62's immunization record identified the COVID-19 vaccine additional dose/booster was last administered on 1/4/23. Resident #62's clinical record failed to identify documentation that identified that he/she had been provided education on the COVID-19 vaccine and consented or refused the COVID-19 vaccine during the 2023/2024 season. 5. Resident #80's immunization record identified the COVID-19 vaccine additional dose/booster was last administered on 10/15/22. Resident #80's clinical record failed to identify documentation that identified that he/she had been provided education on the COVID-19 vaccination and consented or refused the COVID-19 vaccine during the 2023/2024 season. Interview and review of facility documentation with RN #2 and the regional clinical manager (RN) #9 on 5/21/24 at 10:52 AM identified that the facility was unable to locate and provide documentation of written or verbal consent for the 3 sampled residents (#75, 79, and 88) that received the COVID-19 vaccine on 1/5/24, nor could the facility provide documentation that the remaining 2 sampled residents (#62 and 80) were educated and offered the COVID-19 vaccine during the 2023/24 season. RN #2 indicated that there were no progress notes documented in the resident's clinical record nor could she find the paper consents. RN #9 indicated that she would expect to see documentation in the clinical record that the 3 sampled residents who received the COVID-19 vaccine had provided consent, and she would expect to see documentation in the clinical record supporting that the 2 sampled residents that did not receive the COVID-19 vaccine during the 2023/2024 season were educated and refused or consented. (continued on next page)		

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 05/22/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Fox Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's COVID-19 Prevention, Response, and Reporting policy directs the facility to educate and offer resources and counseling to healthcare personnel, residents, and visitors on the importance of receiving the COVID-19 vaccine and staying up to date with all recommended COVID-19 vaccine doses. The facility's Vaccination of Residents policy directs that all residents will be offered vaccines that aid in preventing infectious disease unless the vaccine is medically contraindicated, or the resident has already been vaccinated. Prior to receiving the vaccinations, the resident or legal representative will be provided information and education regarding the benefits and potential side effects of the vaccinations. Provision of such education shall be documented in the clinical record. The resident and legal representative may refuse vaccines, for any reason, if vaccines are refused, the refusal shall be documented in the resident's clinical record.		