STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075183	A. Building B. Wing	03/03/2026

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

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observations of dining and interviews, the facility failed to ensure that substitutions made during the noon meal were posted on the daily menu prior to mealtime. The findings include: An observation and interview with the Regional Dietary Manager on 2/24/2025 at 12:10 PM indicated the kitchen was out of peas and they were substituting cabbage and spinach because their delivery was not received the day prior due to the snowstorm. Outside the main dining room, the daily meal list was posted but the substitutions had not been added to the menu. The Regional Dietary Manager indicated when the residents were served in the dining room they would be notified of the change. Observation of the main dining room meal identified no staff communicating to the residents the substitutions made for the noon meal. During the observation of the breakfast steam table service on 2/25/2026 at 8:25 AM noted each resident's diet type was called out to the cook and plated, no gravy was served as indicated on the menu which included biscuits and gravy, also noted corn bread being served that was not on the menu. The Dietary Manager indicated there were not enough biscuits, so corn bread was made instead. An observation and interview with the cook on 2/25/2026 at 8:27 AM indicated corn bread was also made secondary to not enough biscuits and indicated the gravy would break down the corn bread if used and the residents do not like the gravy. Although, the [NAME] indicated having made gravy none was visible on the steam table and residents would have to ask for gravy if they wanted it. The cook also indicated she/he knew the residents' diets and what they wanted. On 2/25/2026 at 9:00 AM a copy of the Service Line check list for breakfast items made and temperatures taken, no gravy was found on the list. 0n 2/25/2026 10:50 AM a meeting with Residents #8, # 50, 51, 55, 83, 89, 91, 108 and #123 indicated they were not being notified of changes to the menu and not being served what was on the menu.An interview on 2/27/2026 at 10:55 AM with the Regional Dietary Manager indicated the Dietary Manager met with residents regarding their concerns and indicated she/he was working on improvements and will continue to discuss residents' concerns at the monthly food committee meetings.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, facility policies and staff interviews for 1 of 4 sampled residents (Resident #53), the facility failed to ensure the resident was assessed for self-administration of medications prior to allowing the resident to self-administer medication independently. The findings include:Resident #53's diagnoses included schizoaffective disorder, bipolar type; chronic obstructive pulmonary disease; type II diabetes mellitus; lumbar intervertebral disc degeneration; anxiety disorder; major depressive disorder; lumbar intervertebral disc disorders with radiculopathy; syncope and collapse; low back pain; and incontinence.A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #53 was cognitively intact, mobilized in a wheelchair, and independent with activities of daily living, including hygiene, eating, and transfers.During observation of medication administration on 2/24/26 at 9:22 A with Licensed Practical Nurse (LPN #3) identified LPN # 3 administered Resident #53's oral medications without incident. LPN #3 then left a medicated oral rinse solution and a medicated pain relief patch at the resident's bedside, stating that the resident preferred to self-administer these medications.During clinical record review and interview with LPN #3 on 2/24/26 at 9:34 AM, LPN #3 identified Resident #53 did not have a screening or assessment for self-administration of medications and did not have a physician's order for self-administration. LPN #3 stated the resident was alert and oriented and leaving the medications was based on the resident's preference. LPN #3 stated she would return to confirm application of the patch and use of the oral rinse.LPN #3 returned to the resident's room at 9:45 AM to verify medication use but found the resident in the restroom and refused entry at that time. LPN #3 returned a second time at 10:00 AM and confirmed the resident had applied the patch and used the oral rinse.Further review of the clinical record on 2/24/26 identified no physician's order authorizing self-administration of medications. Record review identified an existing physician's order dated 10/12/20 indicating the resident may not self-administer medications, which renewed every 60 days.During an interview and medical record review with the Director of Nursing Services (DNS) on 2/26/26 at 12:55 PM, the DNS indicated that medications are expected to be consumed or applied in the presence of the licensed nurse. The DNS stated that if medications are left at the bedside for self-administration, the resident must have an assessment for self-administration, a care plan reflecting the resident's ability and choice, and a physician's order authorizing self-administration.The DNS also stated she had not been made aware Resident #53 had requested to self-administer the medicated mouth rinse or pain patch. However, based on her knowledge of the resident, she believed the resident could potentially self-administer medications if the required assessments and documentation were completed. A review of the clinical record with the DNS identified no assessment or physician's order authorizing self-administration was present when the medications were left at the bedside.After inquiry, the facility updated the resident's physician's orders. Physician orders dated 2/26/26 at 9:00 PM directed the resident to self-administer the medicated mouth rinse and the pain-relief patch. An additional physician's order dated 2/27/26 at 12:03 PM authorized the resident to self-administer medications and discontinued the prior order dated 10/12/20 that indicated the resident may not self-administer medications.Review of the facility policy Medication Administration (NUR086), dated 7/1/24, directed that medications are to be administered by licensed nurses or other legally authorized staff in accordance with physician's orders and professional standards of practice, and directed staff to observe the resident consuming the medication.Review of the facility policy Resident Rights (SS022), dated 7/1/24, indicated that residents have the right to participate in their care and may self-administer medications when the interdisciplinary team has determined that the practice is clinically appropriate.

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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** Based on clinical record review, facility documentation, review of facility policy and staff interviews for 1 of 4 sampled residents (Resident # 141) reviewed for abuse, the facility failed to report an allegation of verbal abuse yelling to the state agency within 2 hours. The findings include:Resident # 141's diagnoses included ovarian cancer, lymph edema, congestive heart failure (CHF), encephalopathy (altered mental state), cirrhosis of the liver, depression, anxiety disorder, cognitive communication deficit, anemia, diabetes mellitus type 2 and dysphagia.The admission Minimum Data Set (MDS) assessment dated [DATE] identified the resident was moderately cognitively impaired and identified the resident required assistance with Activities of Daily Living (ADL).The ADL care plan dated 12/23/25 identified an intervention to have two staff members assist with transfer from bed to chair.A review of the Grievance Form dated 12/29/25 identified Person #3 complained that during transferring Resident # 141 to bed on 12/29/25 the resident was short of breath. The form additionally noted Resident # 141 was interviewed on the day of incident and stated Nurse Aide # 4 was trying to help her/him get into bed. Person # 3 confirmed the aide was trying to assist the resident to return to bed. Education was provided and Resident # 141 was interviewed and no care concerns identified.A review of the local police report dated 12/30/25 at 1:57 PM identified Person # 3 calling the police to the facility and stating a staff member yell at Resident # 141 last night. Additionally, the report noted Person#3 shared complaints of staff rudeness during what sounded like lift assistance. Person #3 believed that during the assist Resident # 141 was struggling to breathe and staff was on top of the resident. The report further indicated that Person#3 believed that the facility looked up her/his credentials after she/he filed this complaint. Staff are conducting their own internal investigation and noted this is not a police matter at this time. Person #3 requested that the incident be documented for the record.A review of the Grievance Form file dated 12/29/25 and the facility investigation dated 12/29/25 identified the facility conducted an investigation with staff members and 5 residents between 12/29/25 through 1/2/26. The investigation further identified staff alleged that Person # 3 was speaking profanity to them and stated get the F---- out of Resident # 141's room and threaten facility staff. Additionally, noted Resident # 141 during an interview identified no care concerns or issues at this time. The investigation further identified during resident interviews no resident felt that NA # 4 was threatening or rude and that staff interviewed believed that Person #3 was threatening to staff. However, further review of facility documentation of the investigation of grievance filed on 12/29/25 and facility investigation on 3/2/2/26 and 3/3/26 failed to identify that the state agency had been notified of a potential allegation of verbal abuse within 2 hours.Interview with Nurse Aide (NA) # 4 on 3/2/26 at 11:15 AM identified she/he heard someone yelling for help at which time she/he started walking down the hallway and saw Resident # 141hanging and dangling off the bed. NA # 4immediately went to assist the resident and LPN # 6 came into the room with her/him. NA # 4 further indicated Person # 3 was screaming and yelling at them, so she got the resident back to bed safely and left the room. Nurse Aide #4 identified she/he was not on top of Resident # 141 during the transfer so the resident could not breathe.Interview with Person # 3 on 3/2/26 at 11:30 AM and again on 3/4/26 at 10:55 AM identified she/he told the facility on 12/29/25 that staff were speaking to Resident # 141 like a child and on 12/30/25 call the local police because staff were yelling at Resident # 141 and she/he wanted the incident documented because it was a form of abuse. Person#3 also indicated she/he told administration and facility staff that she/he believes Resident # 141 felt threatened and unsafe at the facility. Person#3 further indicated she/he believed that administration did not take her/his allegation of abuse seriously that is why she/he called the local police to come onsite to document the incident.Interview with the DNS on 3/2/26 at 12:15 PM identified the facility investigated the grievance on 12/29/25 as a grievance because the facility did (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not believe any abuse had occurred. She believes it was a miss understanding between the NA # 4 and Resident # 141.Interview with multiple facility staff from 3/2/26 to 3/3/26 identified Person #3 was speaking profanity to staff and made threatening comments to staff members in resident areas at which time supervisory staff had to intervene to de-escalate the situation. Additionally, interview with multiple staff members identified at no time did Person # 3 express any concerns of abuse.Interview with the Administrator on 3/2/26 at 4:30 PM and 3/3/26 at 3:15 identified at no time did the facility believe Resident 141 was abused and Person # 3 ?s comments about Resident # 141 being yelled at, threatened or feel unsafe based on interviews with staff and residents about abuse. Interview with the Administrator on 3/10/26 and 3/11/26 at 10:30 AM identified she still believes that based on the grievance filed 12/29/25, police report dated 12/30/25 and staff comments during the investigation that Person # 3 allegation that Resident # 141 was being threatened or felt unsafe at the facility was not an abuse issue. Interview with the Administrator on 3/11/26 at 10:38 AM identified although the facility conducted an investigation regarding the grievance file dated 12/29/25 by Person #3 and educated staff on Resident Rights, she could not provide evidence that staff reported the allegation of yelling at Resident # 141 and concerns of threatening behavior by staff was reported to the state agency within 2 hours.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility policy and interviews for 1 of 3 residents reviewed for reviewed for Preadmission Screening and Resident Review (PASARR) for (Resident # 85), facility failed to ensure a resident with a newly identified mental health diagnosis was refer to the appropriate state-designated authority for Level II PASARR evaluation and determination per facility policy. The findings include: Resident #85's diagnoses included psychotic disorder with delusions due to a known physiological condition, anxiety disorder, and chronic obstructive pulmonary disease.On 8/25/25, Resident #85's medical record indicated a new diagnosis of psychotic disorder with delusions due to a known physiological conditionThe care plan dated 12/1/25 identified Resident #85 uses antipsychotic medication related to diagnoses of anxiety and psychotic disorder. Interventions included, in part, administering psychotropic medications as ordered by the physician and monitoring for side effects and effectiveness every shift.The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #85 was moderately cognitively impaired and was independent with eating, toileting hygiene, and bed mobility.A physician's order dated 12/6/25 directed staff to administer 5 mg Buspirone HCl tablets for anxiety. A second physician's order dated 2/9/26 directed administration of 0.25 mg Alprazolam (Xanax) oral tablets for anxiety.Review of the resident's clinical records indicated the resident was initially assessed on 4/19/21 for a Preadmission Screening and Resident Review (PASARR Level I) at which time it was determined, There is no evidence of a PASARR condition of an intellectual/developmental disability or a serious behavioral health condition. If changes occur or new information changes these findings, a new screen must be submitted.An interview on 2/26/2026 at 9:23 AM with the Director of Social Services indicated that if a resident has a change in diagnosis, a new assessment request should have been submitted to evaluate the resident. She was unsure why this was not done.The facility's Resident Assessment - Coordination with PASARR Program policy, revised 7/1/24, states in part: Any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or related conditions will be referred promptly to the state mental health, intellectual disability authority for a Level II resident review.

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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** Based on clinical record reviews, facility documentation, facility policy and interviews for 2 of 3 residents reviewed for PASARR for (Residents # 8 and # 79), the facility failed to ensure a referral for a level 1 and/ or 2 evaluations. The findings included: 1.Resident #8's diagnoses include bipolar disorder, unspecified; anxiety; and depression.The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #8 as cognitively intact, requires setup assistance for eating, and is dependent for toilet hygiene and bed mobility. The MDS also noted in Section 1510 (Level II PASRR conditions) that a serious mental illness was identified; however, the section was not completed.The care plan dated [DATE] indicated Resident #8 has mood problems related to bipolar disorder, depression, and anxiety. Interventions include, in part, consulting with psychiatry for medication evaluation, nonˆpharmacological interventions, and ongoing treatment as needed. Interventions also include monitoring, recording, and reporting to the physician as needed for any acute episodes of sadness; loss of pleasure or interest in activities; feelings of worthlessness or guilt; changes in appetite or eating habits; changes in sleep patterns; diminished ability to concentrate; and changes in psychomotor skills.The clinical record identified Resident #8 was admitted to the facility with diagnoses and a 30ˆday exemption, which expired on [DATE]. The facility was unable to provide documentation to support that a PASRR Level I or Level II assessment was completed.A physician's order dated [DATE] directed staff to administer 100 mg of Sertraline HCl (Zoloft) oral tablets for depression.During an interview on [DATE] at 9:15 AM the Director of Social Services identified no evaluation had been submitted since the 30ˆday exemption expired on [DATE]. She stated that an evaluation should have been submitted and was unsure why it had not been completed. She also identified she was responsible for overseeing submission requests for evaluations.After inquiry an assessment evaluation was submitted on [DATE] at 10:37 AM. 2.Resident #79's diagnoses include bipolar disorder, depression, and Type 2 diabetes mellitus.The admission MDS assessment dated [DATE] indicated the resident is cognitively intact, requires setup assistance for eating, requires substantial assistance for toileting hygiene, and is dependent with bed mobility.The care plan dated [DATE] identified Resident #79 is at risk for falls due to cognitive loss and lack of safety awareness.A physician's order dated [DATE] directed staff to administer 1 tablet of 10 Milligrams (MG) Aripiprazole (Abilify) by mouth once daily for bipolar disorder, 3 mg capsule of Vraylar for bipolar disorder, and a 10 mg Fluoxetine (Prozac) HCl tablet for depression.The facility was unable to provide documentation to support that a PASRR Level I or Level II assessment had been completed for Resident #79.During an interview with the Director of Social Services on [DATE] at 9:15 AM identified Resident #79 had a 7ˆday approval (expired on [DATE]). Based on their records, a referral request for evaluation was attempted on [DATE]; however, it was not accepted due to being submitted too soon after the initial approval (resident approved on [DATE], with a new request attempted on [DATE]). The Director of Social Services stated that although the request was rejected, another evaluation request should have been submitted on or before [DATE]. She was unsure why this was not completed and reported that she was responsible for ensuring all referrals are submitted timely. After inquiry, a PASRR assessment evaluation was submitted on [DATE] at 10:13 AM.The facility's Resident Assessment - Coordination with PASARR Program policy, revised [DATE], states in part: All applicants to this facility will be screened for serious mental health or intellectual disabilities and related conditions. A record of the pre-screening shall be maintained in the resident's medical record. The policy further states: If a resident who was not screened due to an exception remains in the facility longer than 30 days: (A) The facility must screen the individual using the state Level I screening process.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, review of facility policy for 1 of 1 resident (Resident # 119) reviewed for bowel and bladder, the facility failed to ensure a resident's bowel regimen was followed as ordered. The findings include: Resident #119 was admitted on [DATE] with diagnoses that included muscle weakness and cognitive communication deficit. A physician's orders dated 2/7/2026 directed the following: Administer 30 milliliters (mL) of milk of magnesia suspension (a medication for constipation) 400 milligrams (mg)/5mL every 24 hours as needed for constipation if the resident had no bowel movement in 3 days; administer 17 grams (g) of Miralax powder (a medication for constipation) every 24 hours as needed for constipation if the resident had no bowel movement in 72 hours; and administer a dulcolax suppository (a medication for constipation) 10mg every 24 hours as needed if no result was obtained from milk of magnesia or Miralax by the next shift. The admission MDS assessment dated [DATE] identified Resident #119 had severe cognitive impairment and required substantial/maximal assistance for toileting. On 2/24/2026 at 3:07 PM, during a screening interview, Resident #119 indicated she/he had not had a bowel movement in weeks. Person #2, who was accompanying Resident #119 in the room, identified Resident #119 had no bowel movement in a week and that Resident #119 had received an enema in the afternoon. A review of the bowel documentation in the electronic medical record and in the Bowel Movement book identified Resident #119's last bowel movement was on 2/17/2025. A review of the Medication Administration Record(MAR) identified Resident #119 had received 17 g of Miralax powder on 2/20/2026 at 9:45 AM (3 days after the last bowel movement). On 2/22/2026 at 8:42 AM, Resident #119 received 30 mL of magnesia milk (2 days after having received Miralax powder and 5 days after the last bowel movement). The MAR failed to identify that any bowel regimen medication was administered on 2/21/2026 or 2/23/2026. Additionally, the MAR failed to identify any administration of a Dulcolax suppository. On 3/2/2026 at 11:48 AM, an interview with LPN#5 indicated she administered Miralax powder on 2/20/2026 because Resident #119 was complaining of nausea and noted the resident had not had a bowel movement in 3 days. LPN#5 indicated Resident #119 did not have a bowel movement during the 7 :00 AM to 3:00 PM shift and she reported to the 3:00 PM to 11:00 PM shift Resident #119 was due to be reevaluated for a bowel movement after the administration of Miralax powder. LPN#5 indicated that, based on the bowel protocol, residents should be evaluated by the end of the next shift to determine if they needed additional medications such as milk of magnesia or a suppository. On 3/2/2026 at 12:18 PM, an interview with the nursing supervisor (RN #5) indicated the facility had a bowel protocol that indicated when residents should be evaluated after receiving an as-needed bowel medication. RN#5 indicated that re-evaluations were based on 8-hour shifts and that if a medication is not effective by the end of the next shift, it should have been readdressed. On 3/3/2026 at 10:39 AM, an interview with Advanced Practiced Registered Nurse (APRN #1) identified that she ordered an enema for Resident #119 on 2/24/2026 because when she assessed the resident on a routine visit, Resident #119 complained of constipation, and she/he noted Resident #119 had not had a bowel movement in the prior three days. APRN #1 further indicated that a 7-day period between bowel movements is considered too long and that residents should have a bowel movement at least every 3 days. A review of Resident #119's orders with APRN#1 identified that after administration of Miralax powder or milk of magnesia, the next shift would need to assess for effectiveness based on the orders and the facility's bowel protocol. APRN #1 further indicated that administration would be able to provide the specifics of the bowel protocol. Although requested, the facility was unable to provide a specific bowel regimen protocol and provided batch order sets for bowel regimen medications for providers' selection during order entry.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on clinical record review and staff interview for 1 of 3 residents reviewed for nutrition (Resident # 125) review for nutrition, the facility failed to ensure the resident was re-weighed when there was a change in the resident's weight per facility practice. The findings include: Resident # 125 diagnoses included hypertension, depression and dysphagia.A review of the resident's weight record identified a weight of 113 pounds on 12/21/25 and on 12/23/25 weigh 118 pounds (indicating a weight gain of 2 pounds in 2 days.The physician's orders dated 12/24/25 directed to weigh every shift weekly time 4 and then every day for one month.However, further review of Resident # 125 weight record on 3/2/26 identified on 1/8/26 a weight of 112 pounds (reweigh 15 days later).Record review and interview with RN #2 on 3/2/26 at 12:45 PM identified the facility practice is to conduct a reweigh for 3 pounds or more and indicated that the weight on 12/23/25 may be a mistake. RN #2 further indicated the dietician reviews residents' weights and will send a notice for a reweight. However, she could not explain why a reweight was not conducted before 1/8/26 but would follow up.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record reviews facility policy the facility failed to ensure staff stored clean linen in a sanitary manner, maintained specimen refrigerators with thermometers and temperature monitoring and for 1of 1 resident on contact precautions (Resident # 25), the facility failed to ensure a room of a resident on contact precautions was set up with appropriate equipment. The findings included: 1. An observation on 2/25/2026 at 5:30 AM identified the front flap of the linen cart on the south wing to be open revealing clean linen and with the linen was a Monster beverage with a plastic cup covering the opening and a closed personal water bottle. An Interview with the charge nurse (LPN #2) indicated the Nurse Aide (NA #1) was not available due to taking care of a resident at that time and stated s/he was pretty sure the beverages should not have been inside the clean linen cart while removing both beverages. An attempt to interview NA #1was unsuccessful. 2. An observation on 2/25/2026 at 5:46 AM of the north wing soiled utility room identified 2 trash bins with no covers containing closed bags of trash. A specimen refrigerator located on high shelf on the left side of the room identified no lock, a thermometer, but no temperature log and 2 specimens awaiting pick up. Numerous pillows were kept on the shelf within the dirty utility room. 3. An observation on 2/25/2026 0 at 5:49 AM clean utility room with lift pads hanging vertically on the right side of the wall with the lower portion of each of the pads touching the floor. Also noted were 2 closed bags of pillows on the floor, a small linen cart uncovered and an open brief bag in the sink. 3. On 2/25/2026 5:53 AM an observation with the Regional Dietary Manager who took pictures of the concerns identified the south dirty utility room without covers for bagged garbage, the specimen with a thermometer but no logbook. Further observation of the clean utility room identified mechanical lift pads hanging vertically on the wall each touching the floor, 3 closed bags of pillows on the floor against the wall and the sink with the small linen cart cover on top of it along with a folded sheet and a bottle of shampoo/body wash on it. The Regional Dietary Manager observed the north wing clean and dirty utility rooms along with the surveyor to share the findings noted earlier and indicated s/he would obtain a thermometer to place in the south wing specimen refrigerator.An interview on 2/25/2026 at 6:05 AM with the nursing Supervisor RN #1 with the Regional Dietary Manager present identified she/he was not sure if the specimen refrigerators needed to be locked if specimens were inside. On 2/25/2026 6:15 AM observations and interview with the Director of Nursing Services (DNS) who was made aware of the infection control concerns in the clean and dirty utility rooms and observed the mechanical lift pads hanging on the walls and touching the floors on both units and the bags of pillows on the floor of the dirty utility rooms. The DNS indicated nothing should be touching the floors and the problem would be corrected. The DNS also observed the refrigerators in the dirty utility rooms without temperature logs and the north specimen refrigerator had 2 specimens and the south none. It was also noted that the entry doors to the soiled utility rooms had no locks. A policy and procedure for storage of staff beverages and belongings, specimen refrigerator maintenance, storage of staff beverages/belongings were not provided.The facility policy labeled Handling Clean Linen indicated facility linen is considered hygienically clean (handled to prevent re-contamination with dust and dirt). Linen shall be delivered to the units on covered linen carts with the cover down and only rolled bags used for linen transport are to be kept on the carts in its designated pockets. Clean linen will be stored in a separate designated room with a closed door to reduce the risk of accidental contamination which can occur with pathogens from contact with intact skin or body substances or from environmental contaminants. The policy further indicated clean linens are not to be placed on the floor or other contaminated surfaces.The facility policy labeled Specimen collection indicated to place the collected specimen into a biohazard transport bag and send to the laboratory with the request form. The policy failed to provide how staff was to safely and correctly store laboratory specimens collected until the laboratory arrived to pick them up.4. Resident #25 ?s diagnoses included Sepsis and C. Diff (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075183	A. Building B. Wing	03/03/2026

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(Clostridioides difficile, a highly contagious bacterium that causes diarrhea and colitis).The admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #25 was cognitively intact and being treated with antibiotics. A laboratory specimen result dated 2/22/2026 at 8:55 AM indicated a specimen sent to the laboratory on 2/20/2026 was positive for C. Diff. Resident #25's care plan revised on 2/24/2026 indicated he had a C. Diff infection with interventions including providing Contact Precautions, administering medication as ordered, encouraging fluids and assist Resident #25 with hand hygiene as needed. An observation on 2/25/2026 at 06:45 6:55 AM identified RN #1 conducting a blood sugar reading using a glucometer for Resident #25 while doffing of Personal Protective Equipment (PPE) after hand hygiene, including gloves, and a gown as required per the posted signage for contact precautions. After entering the room, completing the procedure, and moving toward the door no trash receptacle was noted for doffing used PPE a small individual trash container was noted at the bedsides of Resident #25 and his/her roommate. The Dietary Regional Manager passing by in the hall was alerted to the situation and a nurse provided a trash receptacle for the present moment.On 2/25/2026 at 7:00 AM the Director of Nursing Services (DNS) was at reception desk and indicated s/he was in-servicing staff members at this time as they entered the building to start work to be aware of the need for receptable specifically for used PPE in the room of a resident with contact precautions. The DNS further indicated a trash receptacle should have been located just inside the room's doorway. The DNS also indicated she/he did not know why there was not one there and she/he would have someone complete rounds to ensure all other rooms involved had trash receptacles. The facility labeled Transmission Based Precautions indicated Contact precautions refers to measures intended to prevent transmission of infectious agents spread through direct or indirect contact with the resident and the environment. Although the facility policy indicated PPE (gloves and a gown) would be donned prior to entering the room, the policy made no mention of how to correctly dispose of used PPE after doffing(removing).

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interviews for 1 of 2 residents reviewed for environment (Resident #14), the facility failed to ensure a resident's bathroom call bell was functioning properly and failed to implement an appropriate alternative method of calling. The findings include: Resident #14 was admitted on [DATE] with diagnoses that included left knee replacement and muscle weakness. A nursing admission assessment dated [DATE] identified Resident #14 was oriented to person, place, and time and was totally dependent for transfers and toilet use. Additionally, the admission assessment indicated Resident #14 was continent of bowel and bladder. On 2/24/2026 at 10:55 AM, an interview with Resident #14 indicated the emergency call cord in the bathroom did not work. Resident #14 indicated staff was aware shortly after her/his admission and indicated when staff came to evaluate emergency call cord, they indicated the problem was with the wiring. Resident #14 indicated that sometimes staff have stayed outside the bathroom or outside the room to make sure they were okay, and other times they would have her/his roommate ring their call bell to alert staff that Resident #114 was finished using the bathroom. On 2/27/2026 at 2:18 PM, an interview with NA#3 indicated Resident #14 required assistance to ambulate with a walker to the bathroom. NA#3 indicated that since Resident #14 was oriented, staff did not need to stay in the room while Resident #14 used the bathroom. NA#3 indicated she was aware Resident #14's bathroom call bell did not work and that sometimes staff would stay outside the room in case Resident #14 needed assistance. In other instances, Resident #14 would tell Resident #119 to push their call bell to alert staff that she/he had fished using the bathroom. An observation with NA#3 identified Resident #14's bathroom call bell was not functioning. NA#3 indicated that maintenance and the nursing supervisor were aware of the malfunctioning call bell and were not aware of any alternative method for Resident #14 to call staff. On 2/27/2026 at 2:31 PM, an interview with the DNS identified she was not aware of Resident #14's malfunctioning bathroom call bell and if she had known, she would have ensured the resident's bathroom had a hand bell as a temporary communication method. On 2/27/2026 at 2:36 PM, an interview with the Director of Maintenance indicated he was informed of Resident #14's malfunctioning bathroom call bell on 2/14/2026, and after troubleshooting, he concluded that it was an issue with wiring inside the wall. The Director of Maintenance indicated he contacted an outside vendor on 2/14/2026 for repair of the call bell but had not yet received a date for repair of the call bell. A review of the facility policy for Call Lights identified that staff would report problems with the call lights and provide immediate or alternative solutions until the problem could be fixed.

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F 0804 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observations, review of the clinical record, facility documentation, facility policy and interviews for residents reviewed for food, the facility failed to provide a palatable lunch. The findings include: 1. During initial pool interviews on 2/24/26 Residents #8, # 50, # 51, 70, 75, 75, 83, 89, 91, 108 and # 123 identified concerns with the taste of the food and/ or temperature with a particular focus on the lunch.A food test tray was conducted on 2/26/26 at 12:43 PM of the noon meal. The meal consisted of 1 Italian sausage, sauteed spinach with garlic and parmesan noodles, dinner roll, peach and coffee/ or tea. The alternative was grilled cheese sandwich, sliced carrots and oven roasted potatoes.Observation of the pasta with identified the meal lacking flavor, pasta was bland and spinach was soggy and the potatoes were hard in the middle.Interview with Food Director on 3/2/26 at 1:58 PM indicated that the kitchen staff were unable to put seasoning on the meal because they need to accommodate all residents. She further indicated residents have made suggestions in the food committee which they are trying to implement. A request for the facility Food and Nutrition policy was not provided.

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F 0883 Level of Harm - Potential for minimal harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, policy review and staff interviews, for 3 of 5 residents reviewed for immunizations (Residents #12, # 17, and # 57), the facility failed to ensure the residents' clinical records included documentation that the resident or representative was provided education related to the influenza vaccine. The findings included:1.Resident #12's diagnosis includes Multiple Sclerosis. An influenza immunization informed consent form dated 10/11/2024 identified Resident #12 consented to receive the influenza vaccine annually. The quarterly MDS assessment dated [DATE] indicated Resident #12 was cognitively intact. An immunization record with a date range of 10/1/2025 through 3/31/2026 identified on 10/23/2025, Resident #12 received an influenza vaccine to the right deltoid. Neither the immunization record nor the electronic medical record identified what education was provided to Resident #12 prior to being given the influenza vaccine for the 2025-2026 season. 2. Resident #17's diagnoses included epilepsy and muscle weakness. An influenza immunization informed consent form dated 9/26/2024 identified Resident #17's healthcare decision maker consented to receive the influenza vaccine annually. The quarterly MDS assessment dated [DATE] indicated Resident #12 was cognitively intact. Facility documentation dated 10/13/2025 identified that Resident #17's responsible party was emailed a letter indicating that influenza vaccines would be administered, along with a copy of the vaccination information sheet (VIS). An immunization record with a date range of 10/1/2025 through 3/31/2026 identified on 10/23/2025, Resident #17 received an influenza vaccine to the right deltoid. Neither the immunization record nor the electronic medical record identified what education was provided to Resident #17 or responsible party prior to being given the influenza vaccine for the 2025-2026 season. 3. Resident #57's diagnoses included dementia and delusional disorders. An influenza immunization informed consent form dated 9/26/2024 identified Resident #57 had consented to receive the influenza vaccine annually. The quarterly MDS assessment dated [DATE] indicated Resident #57 was moderately cognitively impaired. An immunization record with a date range of 10/1/2025 to 3/31/2026 identified on 10/23/2025, Resident #57 received an influenza vaccine to the left deltoid. Neither the immunization record nor the electronic medical record identified what education was provided to Resident #57 or their conservator prior to Resident #57 being given the influenza vaccine for the 2025-2026 season. On 2/27/2026 at 10:49 AM, an interview and record review with the Infection Control Nurse (RN#3) and Regional Infection Control nurse (RN#4) identified the facility uses a blanket consent form for the influenza vaccine, where residents or their representatives consent to ongoing annual vaccinations for influenza. RN#3indicated that residents who have a healthcare decision maker (responsible party), the decision maker was either mailed or emailed a letter in August 2025 indicating that vaccines would be administered for the 2025-2026 season, along with a vaccine information sheet (VIS), and that they could contact the facility with questions or concerns. RN#3 indicated that when she was administering the vaccine to residents who were able to consent themselves, she explained to them the side effects of the vaccine and that residents had the option to refuse vaccination. RN#3 indicated that she did not document the education provided in the residents' medical records. A review of the facility policy for Influenza Vaccination identified that prior to administration of the influenza vaccine, the person receiving the immunization or their legal representative would be provided with a copy of the Centers for Disease Control (CDC)'s current vaccine information statement. The policy further indicated that the resident's medical record would include documentation that the resident and/or the resident's representative were provided education regarding the benefits and potential side effects of immunization.