STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075192	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Meriden	845 Paddock Ave Meriden, CT 06450

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 - Few	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** 47460 Based on clinical record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #1) reviewed for abuse, the facility failed to ensure the resident was treated with respect and dignity. The findings include: Resident #1's diagnoses included depressive episodes, anxiety, delusional disorders and auditory hallucinations. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of thirteen out of fifteen, required assistance with ADLs, and had no behaviors. The Resident Care Plan (RCP) dated 2/22/2025 or last CP review completed dated 3/11/2025 identified a decreased ability to perform ADLs. Interventions directed to assist with ADLs. Review of Facility Reportable Events form dated 3/15/2025 at 1:30 PM identified according to witnesses (LPN #1 and Dietary Aide #1) Resident #1 and Nurse Aide (NA) #1 exchanged harsh words, Resident #1 became upset, claiming NA #1 had yelled at him/her first which and then Resident #1 shouted back, and used foul language directed at NA #1 (told NA #1 to shut the ***k up. The form indicated witnesses reported NA #1 responded to Resident #1 using foul language and repeated the same phrase to Resident #1. Resident #1 reported the exchange to RN #1. Interview and witness statement review with Dietary Aide #1 on 4/8/2025 at 11:48 AM identified she was standing in the hall directly across from Resident #1's room when she heard a NA saying in a loud voice to Resident #1, how do you not know how to clean yourself up and not know how to use a ***king napkin. Dietary Aide #1 stated LPN #1 was in the same hallway, she notified LPN #1 and LPN #1 went into the resident's room. Dietary Aide #1 stated she did not hear Resident #1 speaking, and she spoke to LPN #1 and LPN #1 entered Resident #1's room. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and review of witness statement on 4/8/2025 at 12:07 PM with LPN #1 identified Dietary Aide #1 did not notify her; she was standing at the medication cart in the nearby (lateral) hallway when she heard Resident #1 and NA #1 talking in loud voices that she described as screaming at each other. When she arrived at the room, NA #1 told her the kitchen always gives Resident #1 too much ice cream and pudding. LPN #1 reported there was pudding and ice cream on the resident and on the floor and NA #1 stated Resident #1 does that all the time. NA #1 said she was trying to give Resident #1 a wash cloth to wash his/her hands and face, and the resident did not want to do it. NA #1 indicated Resident #1 said it's your ***king job to do it, so you clean it up, and NA #1 responded yes, I clean up everything else, we are trying to get you to . but Resident #1 interrupted and told NA #1 to shut the ***k up. LPN #1 stated NA #1 spoke to Resident #1 in a raised tone, a raised voice volume and said right back at you to Resident #1, but NA #1 did not use foul language; did not use the f-word. On 4/8/2025 at 12:59 PM interview, review of clinical record and facility documentation with RN #1/RN supervisor identified Dietary Aide #1 notified him that she overheard a verbal exchange between a resident and a NA. RN #1 began an investigation, spoke with Resident #1, LPN #1, Dietary Aide #1, and NA #1. RN #1 stated NA #1 may have been offended by comments the resident made, however, NA #1 should not have behaved in that manner and it was unprofessional. Interview and review of witness statement on 4/8/2025 at 1:16 PM with NA #1 indicated Resident #1 had never spoken to her like that before, ice cream was everywhere and Resident #1 started swearing at her and said, shut the ***k up. NA #1 stated she did not swear back at the resident, but repeated back to the resident asking, why did you tell me to shut the *** up? NA #1 indicated that she did not swear at the resident and denied speaking in a loud volume level or raised voice. Interview, clinical record and facility documentation review on 4/8/2025 at 2:22 PM with the DNS identified Dietary Aide #1 and LPN #1 both overheard NA #1 speaking with Resident #1, and when LPN #1 entered the room, he observed spilled yogurt and ice cream on the resident's clothes. NA #1 handed a towel to Resident #1 to clean up the food, the resident became upset and told NA #1 shut the ***k up. NA #1 responded by saying why did you say shut the ***k up to me? NA #1's voice was overheard as she was speaking too loud to Resident #1. The DNS stated that NA #1 should not have spoken loudly, in that tone or volume or repeated the sentence back to the resident. NA #1 should not have asked the resident why he/she said it, and NA #1 should have just gone about doing what she needed to do. Review of the facility Resident Rights Policy directed in part, the resident has a right to be treated with respect and dignity. Review of Employee Relations, code of conduct directed in part the Company considers professional conduct and compliance with Company's policies and procedures to be an essential responsibility of an employee's job.