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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075192	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/04/2024
NAME OF PROVIDER OR SUPPLIER: Complete Care at Meriden, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 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** 46046 Based on a record reviews, review of policy and interviews for 1 of 1 resident (Resident # 28) reviewed for dementia care, the facility failed to ensure a resident with a diagnosis of dementia was reflected in the resident care plan and for 1 of 6 residents (Resident #212) reviewed for accidents, the facility failed to ensure a care plan was developed to include a facial hematoma present on admission. The findings included. 1. Resident #28's diagnosis included dementia and Alzheimer's disease. The Minimum Data Set (MDS) assessment dated [DATE] identified Resident #28 had cognitive loss. The care plan dated 3/11/2024 indicated in part Resident #28 had behaviors such as yelling and striking out at staff, resistant to care. Interventions included: to have two staff members at all times while providing care, explaining all care before initiating and providing psychiatric consult/care as needed. The care plan did not mention dementia or Alzheimer's disease. An interview and record review with RN#4 on 4/02/24 at 8:50 AM indicated Resident #28's care plan did not reflect the diagnosis of dementia or Alzheimer's disease and further indicated the MDS Coordinator is responsible for adding care plans on admission and the ADNS or nurses add any care plans if there are changes. An interview on 4/2/2024 at 9:50 AM with RN #3 indicated there was no care plan for Resident #28 regarding dementia and s/he would add one at this time to the care plan. Subsequent inquiry on 4/2/2024 a care plan was written indicating Resident #28 had impaired cognitive function. Dementia or impaired thought processes related to Alzheimer's disease with interventions inducing in part to administer medications as ordered, communicate with the resident/family/caregivers regarding the resident's needs and capabilities, to provide communication techniques including using preferred name, identify self with interactions and face the resident when speaking and make eye contact., reduce distractions and to provide any necessary cues and to stop if resident becomes agitated .Additionally, interventions also included to keep routine and care givers consistent. The facility policy labeled Care Plan Comprehensive, Person Centered (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated in part the facility will develop and implement a care plan for each resident including measurable objectives and timetables to meet each resident's physical, psychological and functional needs. The policy further indicated the care plan is derived by a thorough analysis of the information gathered as part of the comprehensive assessment (which included diagnosis). 2. Resident #212's diagnosis included heart failure and diabetes mellitus. The Nursing Admission/Readmission/Annual/Significant Change assessment-V7 dated 3/21/2024 at 11:17 PM indicated the only skin impairment on admission was a Stage 2 pressure ulcer of the coccyx. The assessment also noted Resident #212 had a fall with a fracture in the last 6 months. A physician's order dated 3/22/2024 at 3:00PM directed to monitor hematoma on the left temporal area status post fall every shift. The care plan dated 3/22/2024 indicated Resident #212 was at risk for falls related to cognitive loss, lack of safety awareness impaired mobility and history of falls. Interventions included in part to assess for changes in medical status, provide verbal cues, assist with toileting needs, remind to use call light, and report any changes to the physician. On 4/1/2024 at 3:06 PM an interview and record review with the ADNS and RN # 4 indicated Resident #212 was admitted with facial hematoma as seen in the identification picture in the electronic record. RN#4 was able to locate results of a scan done while in the hospital which indicated Resident #212 had a soft tissue hematoma overlying the frontal bone of the face with a mildly displaced nasal fracture. An interview and record review on 4/02/24 at 8:45 with the ADNS and RN #4 indicated Resident #212's care plan should have reflected the facial hematoma/bruising since a physician order was in place to monitor the area. The ADNS further indicated the Minimum Data set (MDS) Coordinator, and the nurses write the baseline care plans on admission and if there are any changes to the care plan nursing, MDS or the ADNS would add as needed. Although a facility policy for baseline care plans was requested one was not provided.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46046 Based on review of the clinical record and interviews for 1 of 6 residents (Resident #28) reviewed for accidents, the facility failed to revise the resident care plan regarding utilization of side rails timely. The findings include: Resident #28's diagnosis included dementia and Alzheimer's disease. The Minimum Data Set (MDS) assessment dated [DATE] identified Resident #28 had cognitive loss. The care plan dated 3/11/2024 indicated Resident # 28 was at risk for falls due to impaired mobility, cognitive loss, and lack of safety awareness. Interventions included, in part to keep the bed in a low position and tie the side rails in the down position to prevent Resident #28 from putting arms through the rails. An observation on 4/3/204 at 2;40 PM identified 2 half siderails on Resident # 28's bed. An observation with RN #7 on 4/4/2024 at 10:40 AM indicated 2 half side rails up on the sides of Resident#28's bed which was in the low position. An interview and record review on 4/4/2024 at 11:14 AM with the DNS indicated the care plan intervention for side rails for Resident #28 had not been revised since 2020. The DNS also indicated the care plan did not include an indication for use or a physicians' order. After inquiry, the DNS indicated the care plan would be updated to address the side rail usage as it pertains to physician's orders.

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37721 Based on clinical record review, facility documentation, facility policy and interviews for 1 of 1 sampled resident, (Resident #104) reviewed for discharge, the facility failed to ensure a discharge transition plan was provided to the responsible party for a resident who was discharge Against Medical Advice (AMA). The findings Include: Resident #104's diagnoses included cerebral vascular disease and mild cognitive impairment. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #104 was severely cognitively impaired, independent with bed mobility, transfers and ambulation and required moderate assistance with toileting. The Resident Care Plan dated 12/30/23 identified Resident #104 had cognitive loss and had preferences for customary routines. Interventions directed to evaluate behavioral symptoms, provide morning care, and create opportunities to choose clothing for the day. A nurse's note dated 12/31/23 at 10:41 AM identified Resident #104's responsible party came to visit and decided to bring h/her home. The Advanced Practice Registered Nurse, APRN was informed, and the family signed Resident #104 out AMA. Medication and instruction were provided to the family along with belongings. An interview with the Director of Nursing on 4/02/24 at 11:26 AM identified for any discharge of a resident would include education on the pros and cons of leaving AMA. If the resident still wishes to leave, orders will be obtained, and community referrals provided to the resident along with a discharge summary. An interview with Registered Nurse, RN #6 on 4/02/24 at 2:32 PM identified he was working on 12/31/23 during the 7:00 AM to 3:00 PM shift when he was notified by Resident #104's responsible party that they wished to sign h/her out AMA. RN #6 could not recall discussing a discharge plan and living arrangements with the responsible party, nor did he provide a discharge transition plan to the family upon discharge from the facility. A review of the facility policy for Discharge Against Medical Advice Directs AMA discharges will be processed in accordance with the patient/ representative to arrange for a safe discharge. A Discharge Transition Plan will be provided to the resident/representative and efforts will be made to make referrals to the community resources and agencies to the extent time permits. Documentation will be made in the medical record that details the discharge including persons/agencies notified, statement of the reason for discharge, explanation of remaining at the center, explanation of risks, benefits and consequences of leaving, data and time of discharge, mode of transportation and by whom.

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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** 37721 Based on clinical record reviews, facility documentation, facility policy and interviews for 1 of 3 sampled residents (Resident #87) reviewed for accidents, the facility failed to ensure a resident reporting new pain following a recent fall was assessed. The findings include: Resident #87's diagnoses included end stage renal disease, hypertension, chronic pain syndrome, anxiety, and morbid obesity. A Fall Risk assessment dated [DATE] identified a score of 7 indicating Resident #87 was at moderate risk for falls. A quarterly Nursing assessment dated [DATE] identified two half side rails were in place for safety and to promote independence with bed mobility. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #87 as cognitively intact, required substantial maximal assist with bed mobility, total two person assist with transfers and had no reported falls. The Resident Care Plan (RCP) dated 3/14/24 identified Resident #87 was at risk for decreased ability to perform activities of daily living (ADL) and at risk for falls. Interventions directed Resident #87 was dependent with bed mobility, provide assist with morning and evening care and arrange resident environment as much as possible to facilitate ADL performance. A Physical Therapy Discharge Summary dated 3/14/24 identified Resident #87 required partial to moderate assist with rolling from a lying position on the back to the left or right side and then returning to lying on the back. The Medication Administration Record (MAR) dated 3/1/24 through 3/17/24 identified Resident #87 as free from pain and received Tylenol for mild pain on two occasions with good effect. A nurse's note dated 3/18/24 at 11:06 AM identified Resident #87 was receiving morning care when Nurse Aide, NA #2 noted an open area on the left buttocks. NA #2 had Resident #87 positioned on h/her left side when she exited the room to inform the nurse of the open area at which time the resident subsequently rolled out of bed. No injuries or pain were noted at the time of the fall. The Advanced Practice Registered Nurse, APRN #1 was notified of the fall. Maintenance checked the bed and side rails for safety. An Occupational Therapy Treatment Encounter note dated 3/18/24 identified Resident #87 sustained a fall out of bed just prior to therapy and was cleared by nursing to attend. Resident #87 was unable to engage in functional transitional training due increased right hip pain. The nursing staff were informed and administered pain medication during the therapy session. A specialized Service Treatment Flow Sheet dated 3/18/24 at 3:00 PM identified Resident #87 reported a fall to the floor with a head strike at the nursing home which was unreported by nursing staff. Heparin (anticoagulant) was withheld. Resident #87 refused to go to the Emergency Department (ER). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A subsequent Service Treatment Flow Sheet dated 3/18/24 at 5:40 PM identified Resident #87 was transferred to the Emergency Department post treatment. An APRN progress note dated 3/18/24 identified Resident #87 had a complaint of acute right hip pain following a fall. An x-ray was ordered. Resident #87 was sent to the Emergency Department from an outside community setting while receiving specialized services, so the x-ray was not able to be obtained. An x-ray (obtained at the hospital) of the right hip and pelvis dated 3/18/24 identified no acute fracture. Resident #87 was admitted for an unrelated incidental finding of cholecystitis and discharged back to the facility on [DATE]. An interview with Licensed Practical Nurse, LPN #2 on 4/03/24 at 12:50 PM identified Resident #87 was medicated just prior to therapy. The therapist later reported Resident #87 was experiencing pain which was reported to Registered Nurse, RN #9 and an order for an x ray was obtained. Resident #87 left the facility for an outside appointment before the x-ray could be obtained. An interview with RN #9 on 4/03/24 at 1:13 PM identified she was working on 3/18/24 during the 7:00 AM to 3:00 PM shift as the nursing supervisor when she was notified Resident #18 sustained a fall. RN #9 assessed Resident #87 at the time of the fall who had no complaints of pain and was able to move all extremities. RN #9 determined there were no obvious signs of injury at the time of the fall but was later notified by the rehabilitation therapist Resident #87 was experiencing pain and LPN #2 administered pain medication. RN #9 further identified she did not re- assess Resident #87 following the report of pain as she attributed the pain to be chronic in nature. An interview with the Director of Nursing Services (DNS) on 4/03/24 at 2:56 PM identified RN #9 should have reassessed Resident #87 with reported pain after a recent history of a fall. An interview with the Advanced Practice Registered Nurse, APRN# on 4/04/24 at 10:51 AM identified Resident #87 did not have any pain at the time of the fall. APRN #1 later received a call from RN #9 reporting new pain. APRN #1 differentiated this new onset of pain from Resident #87's chronic pain due to it being more than usual and due to a recent fall history. An x-ray was ordered. However, Resident #87 was subsequently transferred from an outside facility before the x-ray could be obtained at the facility. Although requested, a policy for RN assessments was not provided.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37721 Based on clinical record review, facility documentation, facility policy and interviews for 1 of 3 sample residents (Resident # 87), reviewed for accidents, the facility failed to prevent an accident hazard for a resident who sustained a fall after being left in an unsafe position with the bed in a high position. The findings include: Resident #87's diagnoses included end stage renal disease, hypertension, chronic pain syndrome, anxiety, and morbid obesity. A bed rail inspection dated 1/21/22 identified the bed designated for room [ROOM NUMBER] A 'Passed' inspection. A Fall Risk assessment dated [DATE] identified a score of 7 indicating Resident #87 was at moderate risk for falls. A quarterly Nursing assessment dated [DATE] identified two half side rails were in place for safety and to promote independence with bed mobility. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #87 as cognitively intact, required substantial maximal assist with bed mobility, total two person assist with transfers and had no reported falls. The Resident Care Plan (RCP) dated 3/14/24 identified Resident #87 was at risk for decreased ability to perform activities of daily living (ADL) and at risk for falls. Interventions directed that Resident #87 was dependent with bed mobility, to assist with morning and evening care and arrange resident environment as much as possible to facilitate ADL performance. A Physical Therapy Discharge Summary dated 3/14/24 identified Resident #87 required partial to moderate assist with rolling from a lying position on the back to the left or right side and then returning to lying on the back. A nurse's note dated 3/18/24 at 11:06 AM identified Resident #87 was receiving morning care when Nurse Aide, NA #2 noted an open area on the left buttocks. NA #2 had Resident #87 positioned on h/her left side when she exited the room to inform the nurse of the open area and the resident subsequently rolled out of bed. No injuries or pain were noted at the time of the fall. The Advanced Practice Registered Nurse, APRN #1 was notified of the fall. Maintenance checked the bed and side rails for safety. An Occupational Therapy Treatment Encounter note dated 3/18/24 identified Resident #87 sustained a fall out of bed just prior to therapy and was cleared by nursing to attend. Resident #87 was unable to engage in functional transitional training due to increased right hip pain. The nursing staff were informed and administered pain medication during the therapy session. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A specialized Service Treatment Flow Sheet dated 3/18/24 at 3:00 PM identified Resident #87 reported a fall to the floor with a head strike at the nursing home which was unreported by nursing staff. Heparin (anticoagulant) was withheld. Resident #87 refused to go to the Emergency Department (ER) for an evaluation following the fall. A nurse's note dated 3/18/24 at 3:02 PM identified Resident #87 as complaining of right hip pain following a fall. An x-ray was ordered. The technician came in, however Resident #87 was at an outside community setting receiving specialized services. A subsequent Service Treatment Flow Sheet dated 3/18/24 at 5:40 PM identified Resident #87 was transferred to the Emergency Department post specialized treatment. An x-ray (obtained at the hospital) of the right hip and pelvis dated 3/18/24 identified no acute fracture. Resident #87 was admitted for an unrelated incidental finding of cholecystitis and discharged back to the facility on [DATE] with medications that included Hydromorphone 4 mg every four hours as needed for severe pain which was unclear if the medication was for hip pain. An interview with Resident #87 on 4/3/24 at 10:10 AM identified beginning Friday evening, 3/15/24, s/he noticed there was no rail on the left side and reported it to nurse aide staff periodically throughout the weekend. Resident #87 learned over the weekend there was no maintenance and was told the matter would be addressed on the following Monday (3/18/24). On 3/18/24 during morning care, Resident #87 identified s/he was left on h/his left side for approximately ten minutes while NA #2 exited the room. Resident #87 did not have the bed rail to grab to hold him/herself up and subsequently rolled off the bed and onto the floor. Resident #87 identified s/he would have used the rail to hold him/herself in position to prevent from falling. According to Resident #87, no other interventions were put in place for safety over the weekend, and s/he did not observe maintenance staff come to fix the rail until after the fall. An interview with the Director of Maintenance on 4/3/24 at 10:25 AM identified he or the Administrator should be notified of any maintenance related issues after hours. The Director of Maintenance further identified he was not notified at any time over the weekend of the broken rail. Once notified on 3/18/24, the Director of Maintenance fixed the rail. An interview on 4/3/24 at 10:36 AM, after surveyor inquiry, the Director of Maintenance identified the bed rail was fixed at 7:00 AM prior to the fall. An interview with the Director of Nursing on 4/3/24 at 10:28 AM identified she was informed care was being provided. NA #2 needed assistance and walked away to get help when Resident # 87 fell . Resident #87 was left on h/his left side with the bed in a high position and should not have been left that way. The DNS identified she was unaware that the bed rail was previously broken but was informed by the Director of Maintenance, subsequent to surveyor inquiry the bed was fixed at 7:00 AM before the fall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with NA #2 on 4/3/24 at 10:40 AM identified she was the assigned nurse aide for Resident #87 on 3/18/23 during the 7:00 AM to 3:00 PM shift. NA #2 identified she had provided morning care to Resident #87 and left the room momentarily to notify the nurse of a new skin integrity issue and to report the left side rail was broken, in the down position. NA #2 exited the room leaving Resident #87 on h/his left side to go to the nurse's station (approximately eighteen feet) to notify the nurse. Licensed Practical Nurse, LPN #2. Resident #87 subsequently fell off the bed when NA #2 exited the room. An interview with LPN #2 on 4/3/24 at 10:55 AM identified she was at the nurse's station when NA #2 reported Resident #87's bed rail was broken. As she and NA #2 were going towards Resident #87's room, they were informed by another aide Resident #87 was on the floor. When LPN #2 entered the room, she noted the rail was in a fixed down position and that the bed was in a high position. After the fall, LPN #2 completed a work order (no date or time) and submitted it to maintenance who then came up right away to fix the rail. LPN #2 identified she was not previously made aware that there was any issue with Resident #87's side rail prior to the fall. An interview with NA #3 on 4/03/24 at 11:44 AM identified he worked during the 3:00 PM to 11:00 PM shift on 3/15/24. Although NA #3 could not specifically recall if he were assigned to Resident #87, he did recall Resident #87 reported, and he observed that the left side rail was broken. NA #3 did not report the broken rail to anyone as Resident #87 had indicated he had been reporting the broken rail to staff. NA #3 further indicated that there would be no available maintenance staff to address the issue over the weekend. An interview with the Rehabilitation Director on 4/3/24 at 1:30 PM identified s/he did have strong upper body strength. If left in an unstable position, Resident #87 could utilize the rail to stabilize him/herself. A subsequent interview with the Director of Maintenance on 4/3/24 at 2:05 PM identified he had not completed a bed rail inspection for Resident #87's bed since 1/21/22 because he had not yet gotten around to it. A subsequent interview with the DNS on 4/03/24 at 2:56 PM identified that although bed rails in general do not prevent falls, staff should have notified the Administrator or maintenance at the time the rail was noted to be malfunctioning and the bed rail inspection completed according to policy. A subsequent interview with Resident #87 on and 4/03/24 at 4:00 PM identified the maintenance staff (Director of Maintenance) came up right away for the first time after the fall to assess the broken rail and then return a short time later to replace the entire rail. Interview with the Director of Maintenance on 4/3/24 at 6:00 PM identified the first time he repaired the side rails on the day of the fall he only needed to replace one of the two pin attachments to the bed. As a result of the investigation the facility failed to ensure a resident (Resident # 87) who previously reported a siderail malfunction and subsequently sustained a fall after being left in an unsafe position with the bed in a high position without the use of the bed rail requiring transfer to an acute care facility resulting in immediate jeopardy. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Medical Director on 4/9/24 at 11:07 AM identified Resident #87 should have never been left in an unsafe position with the bed in a higher position and proper notifications if equipment is malfunctioning. The Medical Director further indicated he would expect bed rail inspections to be completed for all residents according to policy. The facility submitted plan on 4-3-24 at 6:15 PM that identified the following: All direct care staff to be educated not to leave residents unattended in an unsafe position. Direct Care staff were educated on notifying maintenance if an issue with equipment was identified as a risk to patient safety, will be removed from service. Education will be provided prior to the employee working. Preventative maintenance will be completed on side rails according to facility policy and manufacturer guidelines. Audits were conducted for all residents capable of answering if there were any issues with the side rails, with none identified. An in-house audit of all resident side rails was assessed by maintenance for functionality with no issues identified on 4/3/24. In-house audits of side rails will be completed weekly for four weeks and then monthly for two months. An entrapment zone audit of all facility beds was completed by maintenance staff on 4/4/24 with no issues identified. In-house audits of staff knowledge on what to do if a piece of equipment was not functioning will be completed weekly for four weeks, then monthly for two months. A Performance Review committee was held on 4/3/24 to review the event and interventions. The findings will be discussed at future QAPI (Quality Assurance/Performance Improvement) meetings for a minimum of three months or until a pattern of compliance is obtained. The Director of Nursing will be responsible for overseeing this plan of correction. After surveyor inquiry, a Bed Rail Inspection dated 2/16/23 identified as 'passed' was provided. A review of the Bed Rail Policy directed if a side rail is to be used, the facility will ensure the correct installation, use and maintenance. Although a policy for Accident prevention was requested, none was provided.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37721 Based on clinical record reviews, facility documentation, facility policy and interviews for 1 of 1 of 3 residents, (Resident #87) reviewed for accidents, the facility failed ensure a recent fall was communicated to community center for a resident who subsequently required transfer to the Emergency Department (ED) while receiving specialized services. The findings include: Resident #87's diagnoses included end stage renal disease, hypertension, chronic pain syndrome, anxiety, and morbid obesity. A quarterly Nursing assessment dated [DATE] identified two half side rails were in place for safety and to promote independence with bed mobility. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #87 as cognitively intact, required substantial maximal assist with bed mobility, total two person assist with transfers and had no reported falls. The Resident Care Plan (RCP) dated 3/14/24 identified Resident #87 was at risk for decreased ability to perform activities of daily living (ADL) and at risk for falls. Interventions directed Resident #87 was dependent with bed mobility, to assist with morning and evening care and arrange resident environment as much as possible to facilitate ADL performance. A Physical Therapy Discharge Summary dated 3/14/24 identified Resident #87 required partial to moderate assist with rolling from a lying position on the back to the left or right side and then returning to lying on the back. A nurse's note dated 3/18/24 at 11:06 AM identified Resident #87 was receiving morning care when Nurse Aide, NA #2 noted an open area on the left buttocks. NA #2 had Resident #87 positioned on h/her left side when she exited the room to inform the nurse of the open area at which time the resident subsequently rolled out of bed. No injuries or pain were noted at the time of the fall. The Advanced Practice Registered Nurse, APRN #1 was notified of the fall. Maintenance checked the bed and side rails for safety. The Communication Record dated 3/18/24 identified there was no documented communication to the Specialty Service Center regarding Resident #87's recent fall. A specialized Service Treatment Flow Sheet dated 3/18/24 at 3:00 PM identified Resident #87 reported a fall to the floor with a head strike at the nursing home which was unreported by nursing staff. Heparin (anticoagulant) was withheld. Resident #87 refused to go to the Emergency Department (ER). A subsequent Service Treatment Flow Sheet dated 3/18/24 at 5:40 PM identified Resident #87 was transferred to the Emergency Department post treatment. An interview with Licensed Practical Nurse, LPN #2 on 4/03/24 at 12:50 PM identified she did not document information regarding Resident #87's recent fall in the communication book prior to sending the book with Resident #87 into the community to receive specialized services. (continued on next page)

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

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Director of Nursing Services on 4/03/24 at 2:56 PM identified she would expect nursing staff to report any change in resident condition to an outside community center that provides specialty services for that resident. A review of the facility policy for Specialized Treatment Communication Form directed to ensure the completion of the communication form which accompanies the resident on treatment days to communicate resident information and coordinate care between the center and facility.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37721 Based on clinical record reviews, facility documentation, facility policy and interviews for 6 of 6 residents, (Residents # 27, # 28 , # 34, # 87 # 212 and # 215) reviewed for bed rails, the facility failed to acquire consent and physician's orders prior to the initiation of a bed rails, explain risk and benefits and failed to assess the function and perform maintenance to the bed rail according to facility policy. The findings included: 1. Resident #27 was admitted on [DATE] with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD), dementia, and bipolar disorder. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #27 was cognitively intact and dependent for personal hygiene, bathing, and toileting. The nursing quarterly assessment dated [DATE] identified Resident #27 had side rails on each side of the bed which were indicated for safety and to promote independence with bed mobility. After surveyor inquiry, a consent for use of bed rails dated 4/4/24 identified the use and risk of bed rails and the resident has the right to refuse them. Additionally, an order for bed rails dated 4/4/24 directed the use of bed rails as an enabler for turning and repositioning in bed. An interview on 4/4/24 at 12:47 PM with the DNS and the Director of Operations indicated consents and physician's orders for side rails were obtained on 4/4/24 and that the nursing staff should have obtained them on admission to the facility. The DNS and Director of Operations further indicated they were educating staff on this requirement at the time of the interview. 2. Resident #28's diagnosis included dementia and Alzheimer's disease. The Minimum Data Set (MDS) assessment dated [DATE] identified Resident #28 had cognitive loss. Resident #28's care plan dated 3/11/2024 indicated Resident # 28 was at risk for falls due to impaired mobility, cognitive loss, and lack of safety awareness. Interventions included, in part to keep the bed in a low position and to tie the side rails in the down position to prevent Resident #28 from putting arms through the rails. An observation on 4/3/204 at 2:40 PM identified 2 half siderails on Resident #28's bed. An observation with RN #7 on 4/4/2024 at 10:40 AM identified 2 half side rails up on the sides of Resident#28's bed which was in the low position. After surveyor inquiry on 4/4/2024 at 11:23 AM a physician's order was obtained for 1/4 bedrails as an enabler for turning and repositioning in bed and verbal consent for use was obtained on 4/4/2024 from the responsible party/family. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Resident #34's diagnoses included Type 1 diabetes mellitus, falls, and muscle weakness. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #34 as severely cognitively impaired and required maximum assistance with toileting, showering and dressing. The Resident Care Plan with a revision date of 3/19/24 identified Resident #34 had an actual fall with no injury. Interventions included toileting the resident on last rounds, offering a snack followed by toileting when awake on the 11;00 PM - 7:00 AM shift. Further the Resident Care Plan identified Resident #34 at risk for falls. Interventions included reinforcing call bell use, placing call light within reach, and monitoring for and assisting with toileting needs. A quarterly nursing assessment dated [DATE] at 12:40 PM indicated Resident #34 had bed rails. On 4/3/24 at 2:00 PM an interview with the Director of Maintenance identified bed rails should be inspected annually. The Director of Maintenance identified that he had a log, and the Bed Rail Inspection Report for Resident #34 was dated 1/21/22. He indicated the last time the rails were inspected was 1/21/22. Further, The Director of Maintenance stated that he has not gotten a chance to inspect them. After surveyor inquiry a Bed Rail Inspection Report was produced on 4/4/24 with the inspection date of 2/16/23. A physician's order dated 4/4/24, after surveyor inquiry, directed for use of 1/4 bed rails as an enabler for turning and repositioning in bed. A consent for use of bed rails, dated 4/4/24, after surveyor inquiry, identified the use, risk, and benefits for use of bed rails. 4. Resident #87's diagnoses included end stage renal disease, hypertension, chronic pain syndrome, anxiety, and morbid obesity. A bed rail inspection dated 1/21/22 identified the bed designated for room [ROOM NUMBER] A as a 'Passed' inspection. A quarterly Nursing assessment dated [DATE] identified two half side rails were in place for safety and to promote independence with bed mobility. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #87 as cognitively intact, required substantial maximal assist with bed mobility, total two person assist with transfers and had no reported falls. The Resident Care Plan (RCP) dated 3/14/24 identified Resident #87 was at risk for decreased ability to perform activities of daily living (ADL) and at risk for falls. Interventions directed Resident #87 was dependent with bed, assist with morning and evening care and arrange resident environment as much as possible to facilitate ADL performance. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility resident obtained consents and physician's orders identified there was no documented consent or physician's order for the use of the resident bed rails. Further, there was no documented updated annual bed rail inspection completed for Resident #87's bed. An interview with the Director of Maintenance on 4/3/24 at 2:05 PM identified he had not completed a bed rail inspection for Resident #87's bed since 1/21/22 because he had not yet gotten around to it. After surveyor inquiry, a Bed Rail Inspection dated 2/16/23 was provided. An interview with the Director of Nursing on 4/3/24 at 2:56 PM identified she would expect bed rail assessment to be performed according to policy. An interview with the Medical Director on 4/9/24 at 11:07 AM identified he was not aware that consents and physician's orders were not being obtained for the use of bed rails and their use should be implemented according to policy. A review of the facility policy for Side Rails directed upon admission, each resident will be assessed for the need of either half side rails or bed bars, consent /education will be obtained prior to installation and maintenance staff will complete an annual review of the condition and conduct any necessary maintenance. Consent for the use of bed rails and physician orders dated 4/4/24 were obtained after surveyor inquiry. 5. Resident #212's diagnosis included heart failure and diabetes mellitus. The Nursing Admission/Readmission/Annual/Significant Change assessment-V7 dated 3/21/2024 at 11:17 PM indicated half side rails on both sides of the bed were in place with no indication for use and no consent obtained. The care plan dated 3/22/2024 indicated Resident #212 was at risk of falling due to cognitive loss. Interventions included in part to provide verbal cues for safety. 6. Resident #215 diagnosis included fracture of the proximal phalanx of the left great toe, fall and dementia. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #212 was severely cognitively impaired. The Nursing quarterly assessment-V5 dated 11/16/2023 indicated both half side rails were in place to promote independence with bed mobility but no consent for use. The care plan dated 11/28/2023 indicated Resident #215 was at risk for falls. Interventions include in part to provide verbal cues for safety and to place call bell in reach. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview and review of facility documentation on 4/3/2024 at 2:10 PM indicated the last side rail inspection completed on the bed in room [ROOM NUMBER]-B (Resident #215's bed) was completed on 1/20/2022. The Maintenance Director further indicated side rail inspections should be completed annually but he/she has not been able to complete that task since. An interview with the DNS on 4/4/2024 at 11:14 AM indicated she and the Regional Nurse were currently completing an audit of all residents for side rail use and consent. Interview on 4/4/2024 at 12:10 AM with the DNS indicated unable to find physician's orders, siderail assessments and consent with indication for use of side rails on all residents including Resident #28, #212 and #215. 46046 48792 48880

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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** 46046 Based on clinical record reviews, review of facility documentation, review of policy and interviews for 2 of 5 residents (Residents # 27 and #28) reviewed for unnecessary medications, the facility failed to ensure a pharmacy recommendation regarding a needed stop date for a medication was reviewed by the physician timely. The findings included. 1.Resident #27 was admitted on [DATE] with a diagnosis that included Chronic Obstructive Pulmonary Disease (COPD), dementia, and bipolar disorder. The care plan dated 6/2/23 identified Resident #27 as at risk for impaired swallowing related to an overall decline in medical condition. Interventions included providing thin-consistency liquids, assisting with feeding, and alternate small bites and sips. A pharmacy note dated 6/26/23 indicated the resident's medication regimen was reviewed and recommendations were made to the prescriber. The pharmacy notes further directed staff to see the medication regimen review report. A Drug Regimen Review report dated 6/26/23 recommended that if the resident has difficulty swallowing, alternative medications for divalproex (a medication for seizures) and pantoprazole (a medication for acid reflux) should be considered. Additionally, the report recommended clarifying medication administration directions for potassium chloride (a potassium supplement for low potassium). The report failed to identify a physician response to indicate review or followed up. A physician order dated 8/1/23 directed the administration of Protonix (pantoprazole) delayed release 40 milligrams in the morning and Divalproex delayed release 750 milligrams. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #27 as cognitively intact and was dependent for personal hygiene, bathing, and toileting. Additionally, the MDS identified Resident #27 as taking an antipsychotic, antidepressant, diuretic, and opioid. A physician's order dated 1/30/24 directed staff to provide a regular texture diet. An interview with the DNS on 4/3/24 at 12:40 PM indicated she could not locate all the pharmacy recommendations requested by the surveyor secondary to not being in the medical record. A follow-up interview with the DNS on 4/3/24 at 1:30 PM indicated she had emailed the pharmacy and that the only pharmacy recommendation for which there was no follow-up was the Drug Regimen Review dated 6/26/23. The DNS was unable to identify a reason for the missing follow-up. A review of the facility policy on Medication Regimen Review indicated notes written communications from the pharmacist should become a permanent part of the resident's medical record and facility staff shall act upon all recommendations according to procedures for addressing medication regimen review irregularities. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #28's diagnoses included dementia, Alzheimer's disease, and delusional disorders. The physician's order dated 11/22/2023 directed to administer Lorazepam oral Tablet 0.5 mg by mouth every 4 hours as needed for anxiety and restlessness. A pharmacy consultant document dated 11/28/2023, labeled Drug Regimen Review: Physician Referrals/Findings identified the current order for lorazepam PRN (as needed) had no stop date and CMS guidelines do not allow maintaining open ended orders for PRN psychotropics on medication profiles. The pharmacy consultant document recommended to evaluate and consider discontinuation of the medication if appropriate. A pharmacy consultant document dated 1/30/2024 labeled Drug Regimen Review: Physician Referrals/Findings indicated the current order for lorazepam PRN (as needed) had no stop date and CMS guidelines do not allow maintaining open ended orders for PRN psychotropics on medication profiles. The pharmacy consultant document recommended to evaluate and consider discontinuation of the medication if appropriate. The APRN indicated on the form on 2/1/2024 he/she agreed with the recommendation. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #28 had moderate cognitive impairment and was utilizing antipsychotic medication. The care plan dated 3/11/2024 indicated Resident #28 was at risk for complications related to the use of psychotropic medications. Intervention in part direct to administer the smallest most effective dose without side effects. An interview with the DNS on 4/2/2024 at 2:15 PM identified s/he could not explain why the pharmacy recommendation dated 11/28/2023 was not addressed timely resulting in a second pharmacy recommendation for the same concern resubmitted was on 1/30/2024 (30 days later). The facility policy labeled Medication Regimen Review dated 7/1/2023 indicated in part; the medication regimen review is a thorough evaluation of the medication regimen of a resident with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication. The policy further indicated the consultant pharmacist would schedule at least one monthly visit to the facility and communicated any recommendations and identified irregularities via written communication within in 10 working days of the review at which time the facility will act upon all recommendations according to procedures for addressing medication regimen review irregularities. 48880

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 46046 Based on tour of the kitchen, observations, facility policy and interviews, the facility failed to ensure food items in the dry storage were kept sealed from the environment and non-food items (detergent and open box of unused scrub pads) were not stored in the dry food storage and failed to ensure that daily food meal temperatures were consistently documented and failed to ensure the cook during plating food properly handle hamburger roll and the nourishment room ice machines was free from build up and pink build up on the ice outlet and the one machine was free from water overflow dish that overflowed onto the floor. The findings included: 1. Observation of the kitchen during the survey 4/1/24 with the Food Service Director of the dry storage area identified a large box with a bag of chocolate chips left open. The Food Service Director at the time of the observation indicated brownies were made 2 days ago, and immediately closed and knotted the bag while stating the bag should have been closed after use. Further observation of the kitchen identified 2 bottles of dishwashing detergent and an open box of new green scrub pads were found on a shelf in the dry food storage in the presence of the Dietary Manger who indicated which the items should not be there, immediately removed and could not explain the items were in the dry storage area. 2. A kitchen review on 4/1/2024 at 9:15 AM with the Food Service Director identified the March food temperature log kept by the cook had no breakfast temperatures logged for 3/3/2024 and on 3/11 and 3/31/2024 no food temperatures were documented on the temperature log for dinner The Food Service Manager indicated temperature should have been taken and recorded and there was no other location where the temperatures could have been written. 3, On 4/1/2024 while arriving on the 300/400 unit with the steam table observation identified with the Dietary Manager the nourishment room ice machine tray was full of water which dripped onto the floor. The Dietary Manager removed the catch tray from the ice machine, emptied the water from the tray and returned the tray to the machine. 4. Observation 4/1/2024 at 11:40 AM while plating food from the steam table on the 300/400 unit Cook #2 reached into the hamburger roll bag with bare hands (not utilizing gloves or utensil) and plated a hamburger roll open to accept a hamburger handing to Cook #1. The Dietary Manager indicated the staff was told not to use gloves while serving on the units and went to the kitchen and returned with a pair of tongs and directed Cook #2 to use the tongs to pick up the rolls out of the bag to plate the roll. Cook #2 repeated what the Dietary Manger said to him/her and proceeded to access the hamburger rolls out of the bag and plate it with the use of the tongs. Cook #1 who plated the hamburger on the roll utilized tongs to hold the hamburger and roll while slicing it into quarters with a knife. The Dietary Manager further indicated he/she would expect tongs to be used when handling hamburger rolls. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	5. Observations and interview on 4/02/24 at 12:30 PM with the Maintenance Director and review of the facility logs for cleaning noted completed monthly and noted no indication of any scale or buildup of pink debris on the ice outlet. The Maintenance Director further indicated the last cleaning was mid-March about 2 weeks ago. Observation of the 100/200-unit ice machine revealed a thick pink buildup of debris on the ice outlet which the Maintenance Director indicated was due to obtaining ice in cups and pitchers that already had juice in them. The Maintenance Director further indicated the cleaning schedule could be adjusted and proceeded to the 300/400 unit with the surveyor to observe the ice machine. Observation of the nourishment room revealed wet floor signs and water on the floor in the nourishment room and foot tracks from the nourishment room into the hallway. The Maintenance Director indicated the ice machine catch tray needs to be manually emptied or it overflows as this ice machine also gives water. After asking 2 nurse aids in the nourishment room if they called housekeeping to mop the water on the floor both (indicted no). The Maintenance Director indicated he/she would empty the catch tray as it was everyone's responsibility and would call housekeeping. On 4/2/2024 at 12:40 PM an interview and observation with Housekeeper #1 with (Maintenance Director in attendance) indicated his/her job duties in the 300/400 nourishment room is to wipe down the areas and ice machine, mop the floors and empty the collection tray further indicated he/she empties 3 times herself during the shift and does not know how many times other staff empty it during the shift. An observation on 4/03/24 at 12:49 PM identified the ice machine on 300/400 out of order/service and the tray removed from the machine. The facility policy labeled Food Storage: Dry Goods dated as revised 2/2023 indicated in part all packaged and canned food items will be kept clean, dry, and properly sealed, and date marked as appropriate. The facility policy labeled Storage: Chemicals dated 2/2023 indicated in part all chemicals will be in a separate/secure area labeled and in original containers. The facility policy labeled Meal Distribution dated revised on 2/2023 indicated in part meals are transported to the dining locations in a manner that ensures proper temperature maintenance, protects against contamination, and delivered in a timely and accurate manner with proper food handling techniques to prevent contamination and temperature maintenance controls will be used for point of service dining.

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37721 Based on clinical record reviews, facility documentation, facility policy and interviews for 2 of 4 sampled residents, (Resident #156 and Resident #159) reviewed for abuse, the facility failed maintain a complete and accurate clinical record for residents involved in alleged physical mistreatment. The findings included: 1. Resident #156's diagnoses included dementia and muscle weakness. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #156 as severely cognitively impaired and required one person assist with bed mobility, toileting, and two persons for transfer. The Resident Care Plan dated 11/1/22 identified Resident #156 required assistance with activities of daily living (ADL) and had preferences with daily routines. Interventions directed to assist with morning and evening care, provide assistance of two when transferring out of bed to the wheelchair using a mechanical lift and allow to choose when to go to bed. 2. Resident #159's diagnoses included aneurysm of the artery of the lower extremity. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #159 was moderately cognitively impaired and required one person assist with bed mobility, transfers, and locomotion on the unit. The Resident care Plan dated 11/8/22 identified Resident #159 was at risk for or was experiencing adjustment issues related to change in lifestyle /routines and difficulty accepting placement. Interventions directed to encourage the resident to make independent decisions and encourage expression of feelings related to change in routines. A facility Reportable Event dated 11/3/22 at 9:30 AM identified on 11/2/22 between 8:45 PM and 9:00 PM, the roommate of Resident #156, Resident #159 allegedly heard Resident #156 tell the nurse aide, NA #3 that s/he did not want to go to bed. Resident #159 pulled the curtain back and observed NA #3 with both hands-on Resident #156's johnny telling Resident #156 s/he was going to bed while overhearing Resident #156 stating, You are hurting me. The APRN, responsible party and police were notified. NA #3 remained out of the building pending investigation. A review of the clinical record for Resident #156 and Resident #159 did not include any documentation of the alleged incident. (continued on next page)

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	An interview with Registered Nurse, RN #2 on 04/01/24 9:49 AM identified she was the assigned nursing supervisor on 11/2/22 during the 3:00 PM to 11:00 PM shift. RN 2 #was notified of an altercation on the unit. Upon arrival, RN #2 observed Resident #159 kicking NA #3 who was attempting to hold Resident #159's wrists to prevent further assault. RN #2 intervened to allow NA #3 to get out of the room. RN #2 identified she learned Resident #159 had expressed concerns Resident #156 was not cared for properly. A skin check was completed for Resident #156 after the concern of abuse and the Director of Nursing Services, DNS was notified. RN #2 further identified an account of the events that should have been documented in Resident #156 and Resident #159's chart. An interview with the Director of Nursing Services, DNS on 4/01/24 at 10:47 AM identified the alleged incident should have been documented in Resident #156's and Resident 159's clinical record. A review of the facility policy for Charting and Documentation dated 10/2019 directed that any change in the resident's medical, physical, functional, or psychological condition shall be documented in the resident record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075192	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Meriden, LLC	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 0851 Level of Harm - Potential for minimal harm Residents Affected - Some	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 48880 Based on review of Payroll Based Journal (PBJ) submissions for Quarter 4 of 2023, Quarter 3 of 2023, Quarter 2 of 2023, and Quarter 1 of 2023 and staff interview, the facility failed to ensure that PBJ data was complete and accurate. The findings include: The PBJ submissions for Quarter 4 of 2023 (July 1 through September 30), Quarter 3 of 2023 (April 1 through June 30), Quarter 2 of 2023 (January 1 through March 31), and Quarter 1 of 2023 (October 1 through December 31) identified excessively low weekend staffing. On 4/2/24 at 10:35 AM, an interview with the Administrator identified that data for the PBJ is inputted automatically through payroll and the facility did not capture the hours worked by agency or shared staff. Additionally, the Administrator indicated that agency staff do not punch in, and the issue had been fixed for 2024. A review of the facility policy for Nursing Services and Sufficient Staff identified that the facility is responsible for submitting timely and accurate staffing data through the CMS Payroll-Based Journal system.

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	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Meriden, LLC	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 0868 Level of Harm - Potential for minimal harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 48880 Based on review of facility documentation and interview, the facility failed to have a Quality Assessment and Assurance (QAA) committee consisting of the minimum required members. The findings include: The Quality Assurance and Performance Improvement (QAPI) meeting sign-in sheet dated 1/25/24 identified the Administrator, Director of Nursing Services (DNS), and six other staff members who attended the meeting. The Medical Director and the Infection Preventionist were not in attendance at the meeting. The QAPI meeting sign-in sheet dated 2/26/24 identified the Administrator, DNS, and nine other staff members who attended the meeting. However, the Medical Director and Infection Preventionist were not in attendance at the meeting. The QAPI meeting sign-in sheet dated 3/22/24 identified the Administrator, DNS, and seven other staff members who attended the meeting. The Medical Director and Infection Preventionist were not in attendance at the meeting. On 4/4/24 at 3:00 PM, an interview with the Administrator and DNS identified the Medical Director does not attend the monthly QAPI meeting but attends the quarterly medical staff meetings. The DNS and Administrator indicated the quarterly medical staff meetings are different than the monthly QAPI meetings, but that QAPI items are brought forth in the quarterly medical staff meetings. Additionally, the DNS and Administrator indicated that the Infection Control Nurse does not attend QAPI meetings or the medical staff meetings since she is a corporate nurse and is at the facility three days a week. Additionally, the corporate Infection Control Nurse does not work on Fridays, the day the QAPI and medical staff meetings occur.