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	02/17/2026

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of the clinical record, facility policy, facility documentation, and interviews for 1 of 6 residents (Resident #127) observed for medication administration, the facility failed to ensure the medication error rate was not 5 percent (%) or greater (the error rate was 6.9%). The findings include: Resident #127 had diagnoses that included major depression, diabetes, heart failure, hypertension, and anemia. The quarterly MDS dated [DATE] identified Resident #127 had intact cognition. Resident #127 had pain occasionally on average 2 out of the last 5 days, and received antipsychotic, antidepressant, diuretic, opioid, antiplatelet, and hypoglycemic medications during the last 7 days or since admission.The RCP care plan dated 11/28/25 identified Resident #127 received psychotropic medications. Interventions directed to administer medications as ordered by the physician.The physician's order dated 2/9/26 directed to administer Aspirin (medication used to thin blood) 81 milligrams (mg) chewable daily, Plavix (prevents blood clots) 75 mg daily, Cymbalta (used to treat depression, anxiety, and chronic pain) 60 mg, Abilify (used to treat several mental health conditions) 10 mg daily, Losartan Potassium (lowers blood pressure) 25 mg daily, Singular (used to prevent asthma attacks and treat allergies) 10 mg daily, Steglatro (used to lower blood sugar) 15 mg daily, Torsemide (used to treat fluid retention) 20 mg twice a day, and Percocet (a narcotic pain medication) 10-325 mg tablet every 6 hours as needed. Observation of medication administration on 2/10/26 at 9:20 AM, for Resident #127 by LPN #6 removed the resident's medications, placed them into a plastic medication cup, approached the resident, and administered the following medications: Aspirin 81 mg chewable tablet (1 tablet), Plavix 75 mg (1 tablet), Losartan Potassium 25 mg (1 tablet), Steglatro 15 mg (1 tablet), Singulair 10 mg (1 tablet), and Torsemide 20 mg (1 tablet). LPN #6 asked Resident #127 if he/she was experiencing pain, Resident #127 stated yes and requested pain medication. LPN #6 searched the medication cart and stated that Abilify and Cymbalta were not available in the cart and that she would need to check the medication room. LPN #6 indicated she would go to the supervisor and check the emergency medication to obtain Percocet. At 9:40 AM LPN #6 and the supervisor removed one tablet of Percocet 5-325 mg. LPN #6 then approached Resident #127 and administered one tablet of Percocet 5-325 mg. LPN #6 stated she completed Resident #127 medication administration and was moving on to the next resident. Review of the Medication Administration Record (MAR) identified on 2/10/26 at 9:00 AM, LPN #6 signed off she administered Cymbalta 60 mg and Abilify 10 mg. Review of the MAR dated identified on 2/10/26 at 9:40 AM, LPN #6 did not sign off that she administered the Percocet 5-325 mg in accordance with physician orders. Interview and clinical record with LPN #6 on 2/10/26 at 10:00 AM revealed that she did not administer Cymbalta 60 mg or Abilify 10 mg to Resident #127 because they were not in the medication cart. After reviewing the MAR dated 2/10/26, LPN #6 stated that she had documented both medications as given but stated she should not have done so because they were not administered. LPN #6 stated that because she had already signed off the Cymbalta and Abilify as administered, she would not have returned to look for or give those medications if the surveyor had not reconciled the MAR and brought it to her attention. LPN #6 stated she had forgotten to go to the medication room to locate the Cymbalta and Abilify earlier in the medication pass. LPN #6 further stated that, had the surveyor not identified the (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	discrepancy, she would not have returned to administer the medications.Subsequent to surveyor inquiry, on 2/10/26 at 10:05 AM LPN #6 administered Cymbalta 60 mg and Abilify 10 mg to Resident #127. Interview with the DNS on 2/10/26 at 10:08 AM identified nurses are required to prepare medications, administer them to the residents, and sign off only the medications actually given. The DNS stated that if medication is not available at the scheduled time, the charge nurse must notify the supervisor and must not document the medication as administered. The DNS identified that if a medication is not signed off, it appears highlighted in pink in the electronic MAR as a reminder that it remains unaddressed. The DNS also stated pain medication removed from the emergency box (e-box) must be documented on the MAR. The DNS identified that charge nurses are required to follow physician orders and notify the supervisor if unable to do so, so the provider can be contacted. The DNS stated that LPN #6 should have signed off only the medications she administered to Resident #127 on the MAR. The DNS stated that LPN #6 should have signed off only the medications she administered to Resident #127 and should have documented on the MAR when she administered Percocet to Resident #127. Review of the Medication Error Policy identified medication error means the observed or identified preparation or administered of medications or biologicals which is not in accordance with the prescriber's order; manufacturer's specifications regarding the preparation and administration of the medication; or accepted professional standards and principles which apply to professionals providing services. The facility shall ensure medications will be administered as follows: according to physician's orders and in accordance with standards and principles which apply to professionals providing services. The facility must ensure that it is free of medication error rates of 5% or greater as well as significant medication error events. To prevent medication errors the following procedures will be initiated: Right medication, dose, route, and time of administration and right resident and right documentation. The medication error rate was 6.9% based on the medication administration observation task.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual 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** Based on clinical record review, facility documentation review, facility policy review, and interviews for 1 of 6 residents (Resident #2) reviewed for medication administration, the facility failed to ensure the clinical record was accurate to include timely documentation when medications were administered, and for 1 of 3 residents (Resident #42) reviewed for wound care, the facility failed to ensure the clinical record was complete and accurate to include documentation of wound care provided. The findings included:1.Resident #2 had diagnoses that included neuromuscular dysfunction of the bladder, osteoarthritis, deep vein chronic embolism and thrombosis, and diabetes. The RCP dated 12/5/25 identified Resident #2 has pain related to osteoarthritis with interventions that directed to administer pain medications per physician's orders. The physician's order dated 12/31/25 directed to administer Tylenol 1000 milligrams (mg) three times a day for pain, Eliquis (medication to prevent and treat blood clots) 5 mg twice a day, Vasotec (lowers blood pressure and treats heart failure) 20 mg daily, Atorvastatin Calcium (lowers cholesterol) 10 mg daily, Insulin Glargine (medication used to lower blood sugar) 100 units subcutaneously twice a day, Lispro (lowers blood sugar)100 units per 1ml sliding scale based on blood sugar taken before meals and bedtime, Pregabalin (used to treat seizure and nerve pain) 50 mg capsule three times a day, and Pro-stat (liquid protein supplement) 30 ml twice a day, and monitor pain on every shift. a. Review of the Medication Administration Record (MAR) identified on 1/6/26 at 9:00 AM, LPN #5 did not sign off that she administered Tylenol 1000 mg, Eliquis 5 mg, Vasotec 20 mg, Atorvastatin Calcium 10 mg daily, Insulin Glargine 100 units subcutaneously, Pregabalin 50 mg capsule, and Pro-stat 30 ml twice a day in accordance with physician's orders. b. Review of the MAR identified on 1/6/26 at 11:30 AM, LPN #5 did not sign off she administered Lispro (lowers blood sugar)100 units per 1ml sliding scale based on blood sugar reading in accordance with physician orders. c. Review of the Medication Administration Record (MAR) identified on 1/6/26 at 1:00 PM, LPN #5 did not sign off that she administered Tylenol 1000 mg in accordance with physician orders. d. Review of the MAR identified on 1/11/26 at 9:00 AM, LPN #5 did not sign off that she administered Tylenol 1000 mg, Eliquis 5 mg, Vasotec 20 mg, Atorvastatin Calcium 10 mg daily, Insulin Glargine 100 units subcutaneously, Pregabalin 50 mg capsule, and Pro-stat 30 ml twice a day in accordance with physician's orders. e. Review of the MAR identified on 1/11/26 at 11:30 AM, LPN #5 did not sign off she administered Lispro (lowers blood sugar)100 units per 1ml sliding scale based on blood sugar reading in accordance with physician orders. f. Review of the Medication Administration Record (MAR) identified on 1/11/26 at 1:00 PM, LPN #5 did not sign off that she administered Tylenol 1000 mg in accordance with physician orders. e. Review of the Medication Administration Record (MAR) identified on 2/8/26 at 9:00 AM, LPN #5 did not sign off that she administered Tylenol 1000 mg, Eliquis 5 mg, Vasotec 20 mg, Atorvastatin (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Calcium 10 mg daily, Insulin Glargine 100 units subcutaneously, Pregabalin 50 mg capsule, and Pro-stat 30 ml twice a day in accordance with physician's orders. f. Review of the MAR identified on 2/8/26 at 11:30 AM, LPN #5 did not sign off she administered Lispro (lowers blood sugar)100 units per 1ml sliding scale based on blood sugar reading in accordance with physician orders. g. Review of the Medication Administration Record (MAR) identified on 1/6/26 at 1:00 PM, LPN #5 did not sign off that she administered Tylenol 1000 mg in accordance with physician orders. A Disciplinary Action Form dated 1/13/26 identified LPN #5 was disciplined because she did not sign off on medications she had administered. Interview with APRN #1 on 2/10/26 at 2:14 PM identified Resident #2 has chronic pain and prescribed scheduled Tylenol. APRN #1 stated the nurses should sign the MAR/medical record when a medication was administered. Interview with LPN #5 on 2/11/26 at 12:40 PM, identified she was the assigned nurse for Resident #2 on 1/6/26, 1/11/26, and 2/8/26 during the 7 AM to 3 PM shifts. LPN #5 indicated on 1/6/26, 1/11/26, and 2/8/26 she thought she signed off the MARs after she administered Resident #2's medications per the physician's orders. LPN #5 stated the DNS disciplined her for not signing off Resident #2's MARs but does not recall when she received the education. LPN #5 stated she believes the issue may be computer-related, as the system sometimes logs her out during medication passes, and interruptions from residents contribute to missed signoffs on the MARs. LPN #5 indicated she requested IT assistance but has not met with anyone. LPN #5 stated that unlike previous places she had worked the supervisors at this facility do not verify end-of-day medication signoffs. Interview with the DNS on 2/11/26 at 1:33 PM identified nurses must sign the MAR/medical record when they administer any medication. The DNS could not explain why Resident #2's medications were not signed off as administered on 1/6/26, 1/11/26, and 2/8/26 by LPN #5. The DNS identified on 1/13/26 LPN #5 for failing to sign Resident #2's MAR on 1/6/26 and 1/11/26 after medication administration. The DNS stated LPN #5 should have signed the MAR immediately after administering the medications. The DNS further stated charge nurses are responsible at the end of each shift for ensuring all medications are administered and documented. Review of the facility Medication Administration Policy identified medications are administered as ordered by a licensed nurse in accordance with professional standards of practice, in a manner to prevent contamination or infection. Keep medication cart clean and adequately stocked. Ensure that the 6 rights of medication administration are followed: right resident, right drug, right dosage, right route, right time, and right documentation. Once medications are prepared observe resident consume the medications. Sign the MAR after administration. If the medication is a controlled substance (Percocet) sign the narcotic book. Correct any discrepancies and report to the nurse manager. 2. Resident #42 had diagnoses that included peripheral vascular disease, severe protein-calorie malnutrition, and generalized muscle weakness. The quarterly MDS dated [DATE] identified Resident #42 had a Brief Interview for Mental Status (BIMS) score of fifteen out of fifteen (15/15) indicative of intact cognition, was always incontinent of bowel, dependent on staff for all ADLs, including bed mobility, and transfers, non-ambulatory, at risk (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	for developing pressure ulcers, and had one unhealed stage 4 pressure ulcer. The RCP dated 12/19/2025 identified Resident #42 was at risk for skin breakdown and had actual skin breakdown/wounds pressure ulcer to the left hip and discolored areas to the bilateral heels. Interventions directed to offload heels while in bed, place resident on pressure reducing air mattress, provide wound care per orders, and monitor closely for redness, warmth, swelling, drainage, or any other signs of infection. a. The physician orders dated 1/20/2026 directed to irrigate left heel with normal saline, apply Calcium Alginate AG (wound dressing containing silver), followed by a dry clean dressing (DCD), daily on every day shift and as needed for soiling , accidental removal, increased drainage and irrigate the left ischium with normal saline, apply collagen powder (medication used to promote tissue regeneration and accelerates healing), followed by Calcium Alginate AG, and DCD, daily on every day shift and as needed for soiling , accidental removal, and increased drainage. Review of the Treatment Administration Record (TAR) dated 1/27/2026, 1/28/2026, 1/29/2026, 1/30/2026, 2/2/2026, and 2/3/2026 on the 7 AM to 3 PM shift, identified LPN #5 did not sign off that she administered Resident #42's wound treatments to his/her left heel and left ischium in accordance with physician's orders. Interview with LPN #5 on 2/17/2026 at 1:00 P.M. identified she was the charge nurse for Resident #42 on 1/27/2026, 1/28/2026, 1/29/2026, 1/30/2026, 2/2/2026, and 2/3/2026, from 7:00 A.M. to 3:00 P.M. LPN #5 indicated she administered Resident #42's wound treatments to his/her left heel and left ischium per the physician's orders on 1/27/2026, 1/28/2026, 1/29/2026, 1/30/2026, 2/2/2026, and 2/3/2026. LPN #5 stated due to computer issues on 1/27/2026, 1/28/2026, 1/29/2026, 1/30/2026, 2/2/2026, and 2/3/2026 she was not successful in signing off on Resident #42's TARs to indicate she administered the wound treatments. b. The physician orders dated 1/20/2026 directed to irrigate left heel with normal saline, apply Calcium Alginate AG (wound dressing containing silver), followed by a dry clean dressing (DCD), daily on every day shift and as needed for soiling , accidental removal, increased drainage and irrigate the left ischium with normal saline, apply collagen powder (medication used to promote tissue regeneration and accelerates healing), followed by Calcium Alginate AG, and DCD, daily on every day shift and as needed for soiling , accidental removal, and increased drainage. Review of the Treatment Administration Record (TAR) dated 2/4/2026 for the 7 AM to 3 PM shift, identified LPN #3 did not sign off that she administered Resident #42's wound treatments to his/her left heel and left ischium in accordance with physician's orders. Interview with LPN #3 on 2/17/2026 at 1:08 P.M. identified she was the charge nurse for Resident #42 on 2/4/2026, from 7:00 A.M. to 3:00 P.M. LPN #3 indicated she administered Resident #42's wound treatments to his/her left heel and left ischium per the physician's orders on 2/4/2026. LPN #3 identified on 2/4/2026 she did not document on Resident # 42's TAR at the time she administered Resident #42's wound treatments because she left early on 2/4/2026. c. The physician orders dated 1/20/2026 directed to irrigate left heel with normal saline, apply Calcium Alginate AG (wound dressing containing silver), followed by a dry clean dressing (DCD), daily on every day shift and as needed for soiling , accidental removal, increased drainage and irrigate the (continued on next page)

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	075192	A. Building B. Wing	02/17/2026

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	left ischium with normal saline, apply collagen powder (medication used to promote tissue regeneration and accelerates healing), followed by Calcium Alginate AG, and DCD, daily on every day shift and as needed for soiling , accidental removal, and increased drainage. Review of the Treatment Administration Record (TAR) dated 2/5/2026 for the 7 AM to 3 PM shift, identified the ADNS did not sign off that she administered Resident #42's wound treatments to his/her left heel and left ischium in accordance with physician's orders. Interview with the ADNS on 2/17/2026 at 1:12 P.M. identified she was the charge nurse for Resident #42 on 2/5/2026, from 7:00 A.M. to 3:00 P.M. The ADNS indicated on 2/5/2026 she administered Resident #42's wound treatments to his/her left heel and left ischium per the physician's orders. The ADNS stated on 2/5/2026 she forgot to sign off on Resident #42's TAR to identify she administered the wound treatments. Interview with the DNS on 2/17/2026 at 1:25 P.M. identified she would expect that any wound treatment administered to a resident would be signed off in the TAR at the time the wound treatment was administered by the nurse. The DNS was unable to explain why on 1/27/2026, 1/28/2026, 1/29/2026, 1/30/2026, 2/2/2026, 2/3/2026, 2/4/2026, and 2/5/2026 the nurses did not sign off on Resident #42's TAR to reflect that his/her wound treatments were administered. Review of facility Documentation of Wound Treatment policy dated 9/1/2025 directed, in part, wound treatments are documented at the time of each treatment.

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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** Based on review of the clinical record, facility documentation, facility policy, observation, and interviews for 1 resident (Resident #2) reviewed for indwelling urinary catheter, the facility failed to ensure a urinary drainage bag was maintained in a manner that protected the resident's privacy and dignity. The findings include:Resident #2 had diagnoses that included urgency of urination, neuromuscular dysfunction of the bladder, and diabetes. The Resident Care Plan (RCP) dated 12/5/25 identified Resident #2 requires an indwelling catheter due to neurogenic bladder. Interventions included providing privacy and comfort, catheter care per physician orders and as needed, keeping catheter off floor, and providing a privacy bag.The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had moderately impaired cognition, was frequently incontinent of bowel, presence of an indwelling foley catheter, required moderate assistance with personal hygiene and dependent on staff for toileting, and dressing.The physician's order dated 1/15/26 directed a 16 French foley catheter with a 10 cubic centimeter (cc) balloon to bedside drainage, perform catheter care on every day shift, every evening shift, and as needed, and empty the catheter drainage system at least every 8 hours, when it is 1/4 to 2/3 full, and as needed. Observations on 2/5/26 at 11:00 AM and 2:20 PM identified Resident #2 was lying in bed with a urinary drainage bag attached to right side foot portion of the bed frame, visible from the hallway without a privacy cover. Observations on 2/9/26 at 10:30 AM and 1:05 PM identified Resident #2 was lying in bed with a urinary drainage bag attached to right side foot portion of the bed frame, visible from the hallway without a privacy cover.Observation on 2/10/26 at 10:30 AM identified Resident #2 was lying in bed with a urinary drainage bag attached to right side foot portion of the bed frame, visible from the hallway without a privacy cover. Observation on 2/10/26 at 2:30 PM identified Resident #2 was lying in bed with the urinary drainage bag attached to the foot portion of the bed frame, visible from the hallway without a privacy cover. The urinary drainage bag was approximately half full of yellow liquid.Interview and observation with the Assistant Director of Nurses (ADNS) on 2/10/26 at 2:41 PM identified Resident #2's urinary drainage bag, half full of a yellow liquid, was visible from the hallway. The ADNS identified that all urinary drainage bags must always be covered to protect the residents' dignity and privacy. The ADNS stated if a urinary drainage bag does not have a privacy cover, the nurse aide or charge nurse is responsible for obtaining a privacy cover immediately. The ADNS stated if she had been informed Resident #2 needed privacy cover, she would have obtained one immediately.Interview with the Director of Nurses (DNS) on 2/10/26 at 3:00 PM identified any residents with urinary drainage bags must always have a privacy cover in place to maintain the resident's dignity and privacy.Review of the facility Catheter policy identified it is the policy of the facility to ensure that residents with indwelling catheters receive appropriate catheter care and maintain their dignity and privacy when indwelling catheters are in use. Privacy bags will be available and catheter drainage bags will be covered while in use.Review of the facility Resident Rights policy identified, in part, the resident has the right to a dignified existence and self-determination.

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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 observations, interviews, review of the clinical record, and facility policy for 1 of 1 sampled resident identified to self-administer medication (Resident #91), the facility failed to assess Resident #91's ability to safely self-administer medication. The findings include:Resident #91 had diagnoses that included hypertension, hepatitis C, kidney disease, and pruritus (chronic itchiness). The RCP dated 2/3/26 identified Resident #91 had itching and was at risk for decreased ability to perform personal care tasks (ADL's). Interventions directed to administer medications as ordered, document effectiveness, and update the physician as necessary with any changes. The admission MDS dated [DATE], identified Resident #91 was cognitively intact, required the application of ointments/medications other than to his/her feet and was supervised or provided touching assistance for toileting, standing/transferring and bed mobility.Observation and interview on 2/5/26 at 10:38 AM identified Resident #91 was noted to have a 2-ounce tube of Hydrocortisone 1 % cream on the bedside table in his/her room. The tube was not in its original box and did not contain a pharmacy label or an opened dated indicating when the medication was dispensed or first opened.Interview with Resident #91 on 2/5/26 at 10:38 AM, identified Resident #91 indicated the Hydrocortisone 1 % cream was provided by the nursing staff and routinely left at the bedside. Resident #91 stated the cream does nothing to relieve the itch. A second observation on 2/9/2026 at 10:38 AM, Resident #91 was observed in his/her room with Person #1, and the 2-ounce tube of Hydrocortisone 1% cream was noted lying on Resident #91's bedside table. The tube was not in its original box and did not contain a pharmacy label or an opened date indicating when the medication was dispensed or first opened.Interview with Resident #91 and Person #1 on 2/9/26 at 10:38 AM identified Resident #91 and Person #1 both stated the Hydrocortisone 1% cream was provided by the facility. Person #1 stated that no medications or ointments had been brought from home for Resident #91. Person #1 identified he/she informed the facility Resident #91 had previously used another ointment at home. Resident #91 stated he/she was unable to recall which staff member provided him/her the Hydrocortisone cream and when he/she was provided with Hydrocortisone 1% cream.Review of the clinical record on 2/5/26 failed to identify Resident #91 had been assessed for self-administration of medication. Interview and clinical record review with the DNS on 2/9/26 at 11:08 AM, indicated that the DNS was not aware that Resident #91 was keeping Hydrocortisone 1% cream at the bedside or that he/she was self-administering. Additionally, review of the clinical record with the DNS failed to reflect that Resident #91 had been assessed for self-administration of medications. The DNS stated Resident #91 should have been assessed to identify if he/she could self-administer medication safely. Review of facility Resident Self-Administration of Medication policy dated 7/1/2024 directed that a resident may only self-administer medications after the facility's interdisciplinary team has determined which medication may be self-administered safely. Each resident is offered the opportunity to self-administer medications during routine assessments by the facilities interdisciplinary team. The residents' preferences will be documented on the appropriate form and placed in the medical record. Also, the care plan must reflect resident self-administration and storage arrangements for each such medication.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews record review, interviews for 1 of 3 residents (Resident #127) reviewed for Advance Directives, the facility failed to ensure an advanced directives form was completed according to the resident's expressed wishes. The findings include:Resident #127 had diagnoses that included Type 2 Diabetes Meletus, congestive heart failure, and osteomyelitisThe Resident Care Plan (RCP) dated 11/20/2025 identified Resident #127 had established advanced directives and was a Full Code. Interventions directed to activate resident's advanced directive as indicated, inform resident and/or healthcare decision-makers of any changes in status or care needs, and allow opportunities for expression of feelings and ask questions.A physician's order dated 11/21/2025 directed a Full Code (all life saving measures).The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #127 had a Brief Interview of Mental Status (BIMS) score of 15 indicating intact cognition. of intact cognition.Interview and clinical record review with Licensed Practical Nurse (LPN) #1 on 2/9/2026 at 11:41 AM identified an unsigned and incomplete advanced directives form in Resident #127's paper chart. Further clinical record review with LPN #1 identified there were no signed advanced directives in the paper chart or scanned into the Electronic Medical Record (EMR). LPN #1 stated the admitting nurse and Registered Nurse (RN) supervisor are responsible for ensuring advanced directive forms are completed during the admission process.Interview and clinical record review with RN #4 (nursing manager) on 2/9/2026 at 11:50 AM identified Resident #127 did not have completed advanced directives. RN #4 stated in the event of a code, staff must ensure the code status in the paper chart and EMR match; otherwise, staff would treat the resident as Full Code. RN #4 identified although Resident #127's EMR indicated he/she a Full Code, she could not confirm whether this reflected Resident #127's current wishes without a signed advanced directive. RN #4 stated she would need to verify with Resident #127 that he/she wished to be a Full Code. RN #4 could explain why Resident #127's advanced directives had not been completed. Interview with the DNS on 2/9/2026 at 2:15 PM identified nurses are responsible for ensuring advance directives are completed for every resident on day of admission. The DNS stated in the event of a code, nurses are expected to check both the paper chart and the EMR to verify the resident's code status. The DNS could not explain why Resident #127's advance directives had not been completed.Review of the facility Resident Rights Regarding Treatment and Advanced Directives policy identified, in part, upon admission the facility will determine if the resident has executed an advanced directive, and if not determine whether the resident would like to formulate an advanced directive. Upon admission, should the resident have an advanced directive, copies will be made and placed in the chart as well as communicated to staff.

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	02/17/2026

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, facility documentation, facility policy, and interviews for 1 of 1 resident (Resident #11) reviewed for dignity, the facility failed to ensure a resident with respiratory concerns had a clean and sanitary homelike environment. The findings include:Resident #11 had diagnoses that included chronic respiratory failure with hypoxia, tracheotomy, chronic obstructive pulmonary disease, stroke, and gastrostomy (g-tube) related to dysphagia. The quarterly MDS dated [DATE] identified Resident #11 had intact cognition and was independent with ADLs. The physician's order dated 1/8/26 directed to administrator eternal tube feeding of 474 milliliters via g-tube bolus twice a day, perform tracheostomy care twice a day and as needed, and enhanced barrier precautions related to Extended-Spectrum Beta-Lactamases (bacteria resistant to a variety of commonly used antibiotics) in the secretions of the tracheostomy. The RCP dated 2/4/26 identified Resident #11 had a tracheostomy in place. Interventions directed tracheostomy care twice a day and as needed for extra secretions and change the tracheostomy tube per physician's orders. Observation on 2/5/26 at 1:20 PM identified Resident #11 was seated in a standard wheelchair in his/her room. The wheelchair had visible dirt buildup on the seat, legs, and wheels; and the back right wheel was torn and shredded. The room only contained a bed for seating, and three rusty soiled overbed tables used for meals, respiratory equipment, and computers. The room walls and radiators had hardened brown drippings. The floor had brown spots and dirt built up along edges and corners. A red rolling walker near the doorway was soiled with brown debris.Observation on 2/9/26 at 2:00 PM identified Resident #11 was seated in a standard wheelchair in his/her room. The wheelchair had visible dirt buildup on the seat, legs, and wheels; and the back right wheel was torn and shredded. The room only contained a bed for seating, and three rusty soiled overbed tables used for meals, respiratory equipment, and computers. The room walls and radiators had hardened brown drippings. The floor had brown spots and dirt built up along edges and corners.Observation on 2/11/26 at 2:00 PM identified Resident #11 was seated in a standard wheelchair in his/her room. The wheelchair had visible dirt buildup on the seat, legs, and wheels; and the back right wheel was torn and shredded. The room only contained a bed for seating, and three rusty soiled overbed tables used for meals, respiratory equipment, and computers. The room walls and radiators had hardened brown drippings. The floor had brown spots and dirt built up along edges and corners. Interview and observations with the Administrator and DNS on 2/17/26 at 8:55 AM identified Resident #11 was lying on top of the bed in his/her room. The Administrator acknowledged dirt and food build on the room floor and Resident #11's wheelchair. The Administrator stated it took a long time for food and dirt to accumulate. The Administrator identified housekeeping follows a cleaning schedule, but Resident #11's wheelchair was not maintained. The Administrator stated Resident #11 needed a bedside chair. The Administrator indicated she was unaware of Resident #11's rusty overbed tables. The Administrator identified she would have expected staff to clean the wheelchair and floor. The Administrator stated Resident #11's room required deep cleaning. The Administrator was unable to explain why Resident #11's wheelchair and room had not been cleaned. Interview with the Director of Housekeeping on 2/17/26 at 11:50 AM identified he was the interim director from a contracted agency. The Director of Housekeeping stated Resident #11's room was scheduled for monthly deep cleaning, but he could not verify when or if it had been completed. The Director of Housekeeping identified on 2/16/26 Resident #11's room was scheduled for cleaning, but housekeeping staff did not complete it. The Director of Housekeeping indicated the wheelchair cleaning rotates weekly by unit. The Director of Housekeeping identified he was unable to locate the rosters for wheelchair cleaning. The Director of Housekeeping stated he Director of Housekeeping identified he was unable to locate the rosters for the wheelchairs on the 400-unit. The Director of Housekeeping stated he could not verify if Resident #11's wheelchair had (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	been washed in the last 6 months. Review of the facility Safe and Homelike Environment policy identified in accordance with resident rights, the facility will provide a safe, clean, comfortable homelike environment. Sanitary means preventing the spread of disease-causing organisms by keeping resident care equipment clean and properly stored. Resident care equipment includes equipment used in the completion of the activities of daily living. Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly, and comfortable environment. Report any furniture in disrepair to maintenance promptly. Report any unresolved environmental concerns to the Administrator. Review of the facility Routine Cleaning and Disinfectant policy identified the facility was to ensure the provision of routine cleaning and disinfection to provide a safe, sanitary environment and to prevent the development and transmission of infections to the extent possible.

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	075192	A. Building B. Wing	02/17/2026

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 2 residents (Resident #96) reviewed for abuse, the facility failed to file a grievance for a resident who voiced concerns regarding treatment by a staff member. The findings include:Resident #96 had diagnoses that included overactive bladder, repeated falls, and congestive heart failure. Review of facility Grievance forms dated 1/1/2025 through 2/5/2026 failed to identify any grievances for Resident #96 regarding inappropriate staff behavior.The annual MDS assessment dated [DATE] identified Resident #96 had a Brief Interview of Mental Status (BIMS) score of 15, indicative of intact cognition, did not exhibit delusions or behavioral symptoms towards others, and was dependent with toileting hygiene and chair/bed-to-chair transfers.The RCP dated 11/4/2025 identified Resident #96 required assistance with activities of daily living. Interventions included assistance of two using a mechanical lift, assist of two for bed mobility, and dependent with toileting. The RCP further identified Resident #96 was resistive to care and fabricated stories. Interventions included providing consistent, trusted caregivers, and structured daily routine when possible.Interview with Resident #96 on 2/5/2026 at 10:16 AM identified he/she had experienced negative interactions with an aide on day shift. Resident #96 stated the aide does not treat me well and stated he/she felt humiliated when requesting assistance with toileting. Resident #96 indicated the aide spoke in a rude tone and had rolled her eyes at him/her from the hallway on multiple occasions. Resident #96 stated he/she had told several nurses about the aide's behavior, and the aide was not removed from his/her assignment. Resident #96 declined to identify the aide by name because he/she was afraid of retaliation.Interview with LPN #4 on 2/10/2026 at 12:57 PM, LPN #4 stated Resident #96 had voiced a grievance to her in the past about not being treated kindly by an aide. LPN #4 indicated Resident #96 had not voiced the name of the aide. LPN #4 stated she did not report Resident #96's complaint to her supervisor or anyone else because she believed Resident #96 wouldn't talk to her supervisor if the complaint were reported. LPN #4 stated Resident #96 acted like he/she wanted it dropped.On 2/10/2026 at 1:50 PM, the state surveyor notified the DNS of Resident #96's grievance.Review of Facility reportable event dated 2/10/2026 at 4:57 P.M. identified Nurse Aide (NA) #3 as the alleged perpetrator of Resident #96's grievance. Interview with NA #3 on 2/11/2026 at 9:32 AM identified she had cared for Resident #96 for several years and had not received any complaints about the care she provided. NA #3 stated she had never rolled her eyes at Resident #96 or made any negative comments to Resident #96 while providing care.Interview with the DNS on 2/11/2026 at 12:12 PM identified she was unaware of Resident #96's concerns regarding treatment prior to surveyor inquiry on 2/10/2026. The DNS identified her expectations are that staff report grievances as soon as the grievance is made. The DNS stated when Resident #96 initially voiced concerns related to treatment by a staff member a grievance should have been completed. Review of the facility's Resident and Family Grievances policy identified, in part, that a resident or family member may voice grievances with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and other residents, and other concerns regarding their facility stay. Grievances may be voiced as a verbal complaint to a staff member or Grievance Official. The staff member receiving the grievance will record the nature and specifics of the grievance on the designated grievance form and forward the grievance form to the Grievance Official as soon as practicable. The facility will take appropriate action in accordance with State law if an alleged violation of resident's rights is confirmed by the facility or an outside agency, such as the State Survey Agency. The facility will make prompt efforts to resolve grievances.

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	075192	A. Building B. Wing	02/17/2026

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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, facility documentation, and interviews for 1 of 5 residents (Resident #8) reviewed for Preadmission Screening and Resident Review (PASRR), the facility failed to submit a request for a Level II screen subsequent to Resident #8's new psychiatric diagnoses. The findings include:Resident #8 had diagnoses that included paranoid personality disorder, anxiety, depression, and dementia.A PASRR Level 1 Screen dated 5/24/24 identified Resident #8 had no diagnosis of any mental illness and no diagnosis of dementia. The Level 1 screen indicated Resident #8 was approved for long term care.Review of Resident #8's clinical record identified on 6/24/24 diagnosis of paranoid personality disorder was added.A PASRR Level 1 Screen outcome dated 6/26/24 submitted by SW #2 dated identified Resident #8 had diagnoses of anxiety and dementia. The Level 1 outcome did not identify Resident #8's diagnoses of paranoid personality disorder and depression. The outcome from the assessment indicated long term care for a nursing facility level of care with no status change. The PASRR Level 1 Screen further identified Resident #8's approval remained valid for the duration of his/her stay and that no additional screening was required unless Resident #8 was suspected of having a serious mental illness or an intellectual or developmental disability and exhibited a significant change in treatment needs.Review of Resident #8's clinical record identified on 6/27/24 diagnosis of anxiety disorder was added.The admission MDS dated [DATE] identified Resident #8 had severely impaired cognition, diagnoses of paranoid personality disorder, anxiety, depression, and dementia. The MDS further identified antipsychotic and antidepressant medications were administered. The physician's order dated 6/27/24 directed to administer Lexapro (antidepressant) 5 mg at bedtime, Trazodone (for anxiety) 50 mg every 8 hours as needed for agitation, and Risperidone (antipsychotic) 0.25 mg every 12 hours as needed for behavioral disturbances. A Psychiatric Evaluation and Consultation note dated 6/27/24 identified Resident #8 was seen for evaluation of his/her mood and behaviors related to insomnia, anxiety, depression, agitation, dementia, and paranoid personality disorder.The RCP dated 6/28/24 identified Resident #8 had a mood problem related to agitation, anxiety, depression, insomnia, paranoia and confusion. Interventions directed to administer medications as ordered.A Psychiatric Evaluation and Consultation note dated 7/8/24 identified Resident #8 was seen for evaluation of his/her mood and behaviors related to insomnia, anxiety, depression, agitation, dementia, and paranoid personality disorder.A Psychiatric Evaluation and Consultation note dated 7/17/24 identified Resident #8 was seen for evaluation of his/her mood and behaviors related to insomnia, anxiety, depression, agitation, dementia, and paranoid personality disorder.Review of the clinical record failed to identify the PASSR contracted agency was notified of the new psychiatric diagnoses of paranoid personality disorder and anxiety disorder from 6/27/24 through 2/9/26 in order to conduct an additional Level 1 and Level 2 screen.Interview with SW #1 (Director of Social Services) on 2/9/26 at 12:24 PM identified he was responsible for updating the PASRR contracted agency when there is a new psychiatric diagnosis. Subsequent to surveyor inquiry, SW #1 reviewed the clinical record, identified Resident #8 had diagnoses of paranoid personality disorder, anxiety, and dementia which occurred after Resident #8's admission to the facility and had not been communicated to the PASRR contracted agency. SW #1 indicated it had been missed by SW #2 and was unable to identify the reason SW #2 had not updated the PASRR contracted agency with the new diagnoses of paranoid personality disorder, anxiety, and dementia. SW #1 stated Resident #8's PASRR should have been resubmitted at the time of the new psychiatric diagnoses.Interview with SW #2 on 2/9/26 at 12:45 PM identified she submitted Resident #8's PASRR on 6/21/24 with and received the outcome on 6/26/24. SW #2 indicated when she reviewed Resident #8's psychiatric notes she just looked at the diagnosis in bold type and did not read all the diagnosis. SW #2 stated she missed Resident #8's diagnoses of depression and paranoid (continued on next page)

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	075192	A. Building B. Wing	02/17/2026

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	personality disorder.Subsequent to surveyor inquiry, a PASRR submission request dated 2/10/26 was made to the PASSR contracted agency to report that Resident #8 had a new diagnosis of paranoid personality disorder which may trigger a Level II PASRR. Review of the Resident Assessment Coordination with PASRR Program policy directed, in part, the facility coordinates assessments with the preadmission screening and resident review (PASRR) program under Medicaid to ensure that individuals with a mental health disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs. The facility will only admit residents with a mental health disorder or intellectual disability who the state mental health authority has determined as appropriate for admission. The social services director will be responsible for keeping track of each resident's PASRR screening status and referring to the appropriate authority. The policy further identified any resident who exhibits a newly evident or possible serious mental health disorder or related condition will be referred promptly to the state mental health authority for a Level 2 review.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the observation, review of the clinical record review, facility documentation, facility policy, and interviews for 1 of 1 sampled resident (Resident #91) reviewed for medication storage, the facility failed to properly secure medication, and for 1 of 1 sampled resident (Resident #91) reviewed for medication administration the facility to ensure obtain physician's order prior to providing a resident with medication. The findings included:Resident #91 had diagnoses that included hypertension, hepatitis C, kidney disease, and pruritus (chronic itchiness). The RCP dated 2/3/26 identified Resident #91 had itching and was at risk for decreased ability to perform personal care tasks (ADL's). Interventions directed to administer medications as ordered, document effectiveness, and update the physician as necessary with any changes. The admission MDS dated [DATE], identified Resident #91 was cognitively intact, required the application of ointments/medications other than to his/her feet and was supervised or provided touching assistance for toileting, standing/transferring and bed mobility.a. Observation and interview on 2/5/26 at 10:38 AM identified Resident #91 was noted to have a 2-ounce tube of Hydrocortisone 1 % cream on the bedside table in his/her room. The tube was not in its original box and did not contain a pharmacy label or an opened dated indicating when the medication was dispensed or first opened.Interview with Resident #91 on 2/5/26 at 10:38 AM, identified Resident #91 indicated the Hydrocortisone 1 % cream was provided by the nursing staff and routinely left at the bedside. Resident #91 stated the cream does nothing to relieve the itch. A second observation on 2/9/2026 at 10:38 AM, Resident #91 was observed in his/her room with Person #1, and the 2-ounce tube of Hydrocortisone 1% cream was noted lying on Resident #91's bedside table. The tube was not in its original box and did not contain a pharmacy label or an opened date indicating when the medication was dispensed or first opened.Interview with Resident #91 and Person #1 on 2/9/26 at 10:38 AM identified both Resident #91 and Person #1 stated the Hydrocortisone cream was provided by the facility. Person #1 stated that no medications or ointments had been brought from home for Resident #91. Person #1 identified he/she informed the facility Resident #91 had previously used another ointment at home. Resident #91 stated he/she was unable to recall which staff member provided him/her the Hydrocortisone cream.b. Review of Resident #91's clinical record on 2/5/26 failed to identify a physician's order for Hydrocortisone 1% cream. Subsequent to surveyor inquiry on 2/5/26, a physician's order was obtained directing to apply hydrocortisone 1% cream topically to trunk and bilateral arms every day and night shift for itch, for 14 days. An interview and observation on 2/9/2026 at 11:08 AM with the DNS identified a tube of Hydrocortisone 1 % cream was noted on Resident #91's bedside table. The DNS stated that the Hydrocortisone 1% cream should not have been left at the resident's bedside. The DNS stated the Hydrocortisone 1% cream was facility house stock and removed it from Resident #91's bedside table at that time. The DNS stated a physician order is required prior to administering any medications including house stock. Review of facility Medication Storage policy dated 7/1/2024, directed in part, it is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security.Review of facility Medication Orders policy dated 7/1/2024, directed in part, directed medications should be administered only upon the signed order from a person lawfully authorized to prescribe.

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	075192	A. Building B. Wing	02/17/2026

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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, review of the clinical record, facility documentation, facility policy, and interviews for 1 of 3 residents (Resident #42) reviewed for pressure ulcers, the facility failed to maintain proper infection control during wound care and perform hand hygiene between glove changes and for 2 of 3 residents (Resident #53 and Resident #127) reviewed Enhanced Barrier Precautions (EBP) the facility to wear appropriate Personal Protective Equipment (PPE) during care. The findings include:1.Resident #42 had diagnoses that included severe protein-calorie malnutrition, osteoarthritis, colonized MRSA, and peripheral vascular disease. The quarterly MDS assessment dated [DATE] identified Resident #42 had intact cognition, dependent on staff for all ADLs including bed mobility and transfers. The MDS identified a stage 4 pressure ulcer was present. The RCP dated 12/26/25 identified Resident #42 was non complaint with offloading heels, had a stage 4 pressure ulcer to the left hip, and discolored areas to the bilateral heels. Interventions directed to educate resident on why heels must be elevated to prevent pressure injury and maintain skin integrity and provide wound care per physician's orders. The physician's order dated 2/8/26 directed to apply Dakins 1/4 strength solution to left heel topically once a day for a deep tissue injury and irrigate the left heel with Dakins 1/4 strength solution, apply calcium alginate with silver (AG) followed by a dry clean dressing daily and as needed, and irrigate the left ischium with normal saline followed by calcium alginate and dry clean dressing daily and as needed. Observation of Resident #42's wound care on 2/11/26 at 2:30 PM with the ADNS (wound nurse) and LPN #5 identified LPN #5 collected all the necessary supplies for the dressing changes before entering the room. LPN #5 and the ADNS donned PPE (gown and gloves) before entering the resident's room. LPN #5 placed a box of gloves and a bottle of hand sanitizer on the foot of Resident #42's bed. LPN #5 poured Dakins 1/4 solution into a plastic cup and placed it on Resident #42's bedside table without the benefit of cleansing the tabletop or placing a barrier on the tabletop surface. LPN #5 removed the dressing from Resident #42's left hip and discarded it into the garbage. LPN #5 removed the soiled gloves and without performing hand hygiene donned a new pair of gloves. LPN #5 poured Dakins 1/4 strength solution from the plastic cup on to gauze pads, cleansed the wound, and packed the wound with the Dakins 1/4 strength gauze pads she used to cleanse. LPN #5 removed the soiled gloves and without performing hand hygiene donned a new pair of gloves. LPN #5 then placed a piece of calcium alginate with silver over the Dakins 1/4 strength gauze pads. The ADNS intervened and directed LPN #5 to remove the gauze pads from the wound bed and then apply the calcium alginate with silver to the wound bed. LPN #5 removed the calcium alginate with silver and Dakins 1/4 solution gauze pads packing form the wound. LPN #5 removed the soiled gloves and without performing hand hygiene donned a new pair of gloves. LPN #5 took the same piece of calcium alginate with silver that she removed, placed it over the wound, and followed by a bordered gauze dressing . LPN #5 removed the soiled gloves and without performing hand hygiene donned a new pair of gloves. LPN #5 removed the dressing from the left heel, discarded the dressing, removed her gloves, and without performing hand hygiene, donned a new pair of gloves. Following this LPN #5 poured Dakins 1/4 strength solution from the plastic cup on to gauze pads, cleansed the left heel wound and discarded the gauze pad, and with the same gloves on she applied a piece of calcium alginate with silver to the wound bed, and placed bordered gauze dressing over the wound. LPN #5 removed the (continued on next page)

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	075192	A. Building B. Wing	02/17/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	soiled gloves and without performing hand hygiene, donned a new pair of gloves. LPN #5 proceeded to apply skin prep to the right heel and placed a bordered gauze dressing over the heel. LPN #5 removed her soiled gloves and discarded them in the waste bin. LPN #5 then washed her hands in the resident bathroom. Interview with the DNS on 2/11/26 at 3:11 PM identified that for all wound care, nurses should ensure a clean environment for use as a surface for supplies, such as a bedside table, and not place supplies on a resident's bed. The DNS stated that all nurses are to perform hand hygiene before initiating a dressing change and between all glove changes. Interview with the ADNS (wound nurse) on 2/17/26 at 10:30 AM identified during dressing changes all nurses are to perform hand hygiene between all glove changes. Review of the facility Hand Hygiene Policy identified all staff will perform proper hand hygiene to prevent the spread of infection to other personnel, residents, and visitors. Hand hygiene will be performed by washing your hands vigorously for at least 20 seconds or alcohol-based hand rub for 20 seconds covering all surfaces of hands and fingers. The use of gloves does not replace hand hygiene. If your task requires glove perform hand hygiene before you put gloves on and after you remove the gloves. Hand hygiene table identifies hand hygiene must be done before and after handling clean or soiled dressings. Review of the facility Clean Dressing Change Policy identified it is the policy of the facility to provide wound care in a manner to decrease potential for infection and/or cross contamination. Physician's orders will specify type of dressing and frequency of changes. Wound care supplies will be dated and initialed when they are opened. Each wound will be treated individually. When multiple wounds are being addressed, the dressings will be changed in the order of least contaminated to most contaminated. The dressing with infected wounds will be changed last. Set up the field on the overbed table with needed supplies for wound cleaning and dressing applications, wash hands and put on gloves once wound supplies are prepared. Loosen the dressing and remove the existing dressing. Remove gloves by pulling the glove inside out over the old dressing Discard into receptacle. Wash hands and put on clean gloves. Cleanse the wound as ordered and pat dry with gauze. Wash hands and put on clean gloves. Apply topical ointments or creams and dress the wound per physician order. Secure dressing and mark with initials and date. Discard disposable items and gloves into appropriate trash receptacles and wash hands. 2. Resident #53's had diagnoses that included dementia, Diabetes Meletus, and a Stage 2 pressure ulcer. The annual MDS assessment dated [DATE] identified Resident #53 had a Brief Interview of Mental Status (BIMS) score of 5 indicating severe cognitive impairment, was dependent on staff with personal hygiene and required maximal assistance with rolling left and right. The RCP dated 1/21/2026 identified Resident #53 had a stage 2 pressure ulcer. Interventions included provide turning and repositioning as tolerated, apply treatment as ordered, and monitor for signs and symptoms of infection. The RCP failed to include that he/she was on EBP. A review of Physician's orders on 2/05/2026 failed to identify an order directing EBP. (continued on next page)

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	02/17/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of Resident #53's room on 2/09/2026 at 1:27 PM identified an Enhanced Barrier Precautions (EBP) sign posted outside Resident #53's door directing providers and staff gown and gloves must be worn for high contact activities. Observation and interview with NA #2 on 2/09/2026 at 1:27 PM identified NA #2 started to roll Resident #53 from his/her back to his/her side in preparation to receive wound care and provide incontinent care without the benefit of wearing a gown or gloves. NA #2 stated when providing care to a resident on EBP she should have donned a gown and gloves, but she did not think of it. Observation of wound care on 2/09/2026 at 1:29 PM with LPN #1 identified an open wound Resident #53's coccyx that measured 1 centimeter (cm) X 1.5 cm with a medium pink colored base. Subsequent to surveyor inquiry, a physician's order dated 2/09/2026 at 3:00 PM directed Enhanced Barrier Precautions related to increased risk of transmission to/from due to a chronic wound. 3. Resident #127 had diagnoses that included Type 2 Diabetes Meletus, congestive heart failure, and osteomyelitis. The quarterly MDS assessment dated [DATE] identified Resident #127 had a Brief Interview of Mental Status (BIMS) score of 15 indicative of intact cognitive, and required supervision with personal hygiene, rolling left and right and chair/bed to chair transfers. The RCP dated 12/15/2025 identified Resident #127 was at risk for skin breakdown and had moisture-associated skin damage (MASD) to the bilateral buttocks. Interventions directed to provide treatment per medical doctor order, weekly wound assessments, and observe skin for signs/symptoms of skin breakdown. The RCP failed to identify that he/she was on EBP. The Wound care provider notes dated 1/30/2026 through 2/2/2026 identified Resident #127 had a stage 2 pressure ulcer on the left buttock with partial thickness skin loss. A review of Physician's orders on 2/05/2026 failed to identify an order directing EBP. Observation of Resident #127's room on 2/09/2026 at 12:59 PM identified an Enhanced Barrier Precautions (EBP) sign posted outside Resident #127's door directing providers and staff gown and gloves must be worn for high contact activities. Observation and interview with the ADNS on 2/09/2026 at 12:59 PM identified the ADNS administered Resident #127's wound care without the benefit of wearing a gown. The ADNS identified she did not put a gown on prior to administering wound care because she felt very rushed and had a lot of medications to pass. The ADNS stated she should have put a gown on according to the facility policy. Interview on 2/09/2026 at 1:51 PM with Registered Nurse (RN) #4 (nursing manager) staff should wear appropriate PPE when providing care to residents on EBP residents, including during incontinence care and wound care. RN #4 stated NA #2 and the ADNS should have worn PPE when providing care to the residents on EBP. RN #4 could not explain why NA #2 and the ADNS failed to don appropriate PPE. Interview on 2/09/2026 at 2:15 PM with the Director of Nursing Services (DNS) identified all staff should wear a gown and gloves when providing hands on care to any residents on EBP. The DNS (continued on next page)

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	075192	A. Building B. Wing	02/17/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated NA #2 and the ADNS should have donned the appropriate PPE prior to providing the residents with care. Review of the facility Enhanced Barrier Precautions policy identified in part an order for EBP will be obtained for residents with wounds (e.g. Chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers) even if the resident is not known to be infected or colonized with a Multi Drug Resistant Organism. PPE for EBP is necessary when performing high-contact care activities including dressing, bathing, transferring, providing hygiene, changing linens, and wound care.