STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075237	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Kimberly Hall-South	1 Emerson Drive Windsor, CT 06095

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for one (1) of three (3) residents (Resident #2) reviewed for falls, the facility failed to complete and document neurological checks after an unwitnessed fall per facility policy. The findings include: Resident #2 was admitted to the facility with diagnoses that included encephalopathy, dementia and adult failure to thrive. The nursing admission assessment dated [DATE] identified Resident #2 was verbally incomprehensible, was only orientated to person, required extensive assistance with activities of daily living (ADL'S). The admission minimum data set MDS assessment dated [DATE] identified Resident #2 had moderately impaired cognition (Brief Interview for Mental Status (BIMS) score of 8) and had one fall with no injury since admission. The care plan dated 4/5/24 identified Resident #2 was at risk for falls secondary to dementia with forgetfulness and impulsive behavior. Interventions included to assist Resident #2 to organize belongings for a clutter free environment, therapy/rehab services as indicated and approved by hospice, after meals recline Resident #2 in chair for comfort and bring Resident #2 to a common area to observe when restless. A nursing change in condition note dated 4/23/24 at 12:41 AM identified Resident #2 had an unwitnessed fall and was found on his/her buttocks with a skin tear on his/her left arm. It identified the plan was to notify a provider of any change in condition, fall precautions per facility protocol, assess pain per protocol and monitor with neuro checks per protocol. A physician's order dated 4/23/24 directed to notify a provider of any change in condition, fall precautions per facility protocol, assess pain per protocol and monitor with neuro checks per protocol. Review of the accident & incident form dated 4/23/24 and medical record failed to identify neurological checks were completed. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nursing change in condition note dated 4/24/24 at 1:57 AM identified Resident #2 had an unwitnessed fall, was found on the floor sitting on his/her buttocks by the bed and could not recall what happened. It identified the plan was to notify a provider of any change in condition, fall precautions per facility protocol, assess pain per protocol and monitor with neuro checks per protocol. A physician's order dated 4/24/24 directed to notify a provider of any change in condition, fall precautions per facility protocol, assess pain per protocol and monitor with neuro checks per protocol. Review of the accident & incident form dated 4/23/24 and medical record failed to identify neurological checks were completed. Although requested, the DNS was unable to produce Resident #2's neurological checks for 4/23/24 and 4/24/24. Review of the neurological assessment policy directed neurological assessment are completed to assess neurological status after an un-witnessed fall. Neurological assessments will be completed as follows: every fifteen minutes for the first hour, every thirty minutes for the next two hours, every hour for the next two hours, every shift for the next seventy two hours and then as the primary healthcare provider orders.

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for one (1) of three (3) residents (Resident #2) reviewed for hospice, the facility failed to administer prescribed morphine during the dying process, for a prolonged period of time, after an ineffecive dose was administered. The findings include: Resident #2 was admitted to the facility with diagnoses that included encephalopathy, dementia and adult failure to thrive. A provider order dated 3/28/24 directed do not resuscitate. A provider order dated 4/5/24 directed morphine .25 ml by mouth every two (2) hours as needed for pain. The admission minimum data set (MDS) assessment dated [DATE] identified Resident #2 had moderately impaired cognition (Brief Interview for Mental Status (BIMS) score of 8) and received hospice care while a resident. The Resident Care Plan (RCP) dated 4/23/24 identified hospice services began 4/11/24 due to an end stage diagnosis of dementia and failure to thrive. Interventions included to assess for pain, restlessness, agitation and other signs of discomfort, medicate as ordered and evaluate effectiveness and provide non-pharmacological approaches to aid in decreasing comfort. The RCP further directed to provide emotional and social support to the patient and family to address anticipatory grief and end of life wishes. The RCP identified Resident #2 was at risk for alterations in comfort. Interventions included to medicate Resident #2 as ordered for pain, monitor for effectiveness, monitor for side effects and report to the physician as indicated. A nursing note by RN #2 dated 4/28/24 at 12:00 PM identified the unit nurse called her stating Resident #2 was sleeping and did not respond when called. Resident #2's family member was informed of Resident #2's status, did not want him/her to be hospitalized and would go in to the facility to see him/her. Review of the mediation administration record (MAR) dated 4/28/24 identified morphine .25 ml was administered by LPN #1 at 9:45 AM and was documented as ineffective. The medical record failed to identify what interventions were done, if any, for Resident #2's ineffective morphine dose. The vital signs dated 4/28/24 at 1:40 PM identified Resident #2's heart rate was 123 beats per minute (BPM) (normal range is 60-100 BPM), respirations were 22 breaths per minute (normal range is 12-20 breaths per minute), and oxygenation of 81% on room air (normal range is 95-100%). A physician's order dated 4/28/24 at 3:15 PM directed morphine .25 ml by mouth every one (1) hour as needed for pain. A nursing note by RN #2 dated 4/28/24 at 3:22 PM identified Resident #2's family members questioned the unit nurse several times about his/her morphine medication, which was every two hours as needed. They requested it be increased to every hour. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the MAR on 4/28/24 identified morphine .25 ml was administered by RN #1 at 3:45 PM (effectiveness was unknown, 6 hours after the last dose of morphine was administered), 5:00 PM (effectiveness was unknown), 6:00 PM (effective) and 7:00 PM (effective). A nursing note by LPN #1 dated 4/28/24 at 3:53 PM identified Resident #2 was responsive to physical stimuli and noted with labored breathing. Oxygen was administered at 2 liters/minute and family asked if oxygen could be removed and LPN #1 explained it should be kept on due to oxygen levels. Resident #2's family members were at the bedside and constantly requesting Morphine. Resident #2 was resting with no signs of pain/discomfort. An RN death pronouncement dated 4/28/24 identified Resident #2's date and time of death was 4/28/24 at 7:27 PM. Interview with Person #1 (Resident #2's family member and health care representative) on 5/1/25 at 12:30 PM identified she went to visit Resident #1 at approximately 10:00 AM on 4/28/24 and Resident #2 was agitated, air hungry, had rapid/shallow respirations and was sweating. She identified the nurse told her Resident #2 just received morphine, so Person #1 requested the morphine dose be changed to hourly. Person #1 identified the nurse told her she would contact the physician, and no further doses of morphine were administered. Person #1 identified that at around 2:00 PM, the nurse went into Resident #2's room and asked if everyone was okay, but did not assess Resident #2. Person #1 identified that at 3:00 PM, she went out of the room to find a nurse and requested Resident #2 receive a dose of morphine. She further identified that due to a change of shift, the nurse did not return to the room until 3:40 PM and the nurse indicated she had to complete her medication pass for the other residents on the unit before administering Resident #2's morphine. Person #1 requested the supervisor and the supervisor identified the morphine dose had been changed from every two (2) hours to every one (1) hour. The supervisor took over medication administration for Resident #2 and Resident #2 received a morphine dose at 3:45 PM (approximately six (6) hours after the previous administration). Interview with LPN #1 (administered morphine on 4/28/24 at 9:45 AM) on 5/1/25 at 12:42 PM identified she could not remember Resident #2. However, LPN #1 identified if an as needed medication is administered and ineffective, she would notify the physician, the hospice team and document in the medical record. She was unable to speak to why there were no follow up interventions to Resident #2's ineffective morphine dose at 9:45 AM and why no further doses were administered. Review of the coordination of hospice services policy directed that the plan of care will include directives for managing pain and other uncomfortable symptoms and will be revised and updated as necessary. Review of the pain management policy directed that facility staff will observe nonverbal indicator which may indicated the presence of pain such as change in vital signs (increased heart rate, respirations and/or blood pressure) and perspiration. It identified to reassess and adjust the medication dose to optimize the resident's pain relief while monitoring the effectiveness of the medication and work the minimize or manage side effects. Facility staff will notify the practitioner if the resident's pain is not controlled by the current treatment regimen.