STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075240	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Glendale	4 Hazel Ave Naugatuck, CT 06770

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, interviews, facility documentation and facility policy for one (1) of three (3) residents (Resident #1) reviewed for a change of condition, the facility failed to notify the resident's family of a critical lab value result. The findings included: Resident #1 was admitted to the facility in March of 2025 with diagnoses that included cervicalgia, other spondylosis, and subluxation of the T2/T3 thoracic vertebra. The comprehensive Minimum Data Set assessment (MDS) dated [DATE] identified Resident #1 was moderately cognitively impaired (Brief Interview for Mental Status (BIMS) score of 11), required set-up assistance with eating and oral hygiene, and required supervision with personal hygiene. The Resident Care Plan (RCP) dated 3/18/25 identified a risk for malnutrition related to hyponatremia, dehydration, intravenous fluids, variable oral intake, mechanically altered diet, and oral nutritional supplements. Interventions directed to monitor for signs of dehydration and monitor weights and labs as available. Lab results dated 4/16/25 at 2:53 PM identified a critical serum sodium level of 99. Nursing notes dated 4/16/25 at 3:54 PM identified Resident #1 was seen by MD #1 and APRN #1, new orders for a KUB (kidney, ureter, bladder x-ray) and an ultrasound to bilateral upper extremities, and that Person #1 was aware of all new orders, however failed to indicate Person #1 was informed of the critical sodium level of 99. Nursing notes dated 4/16/25 at 6:55 PM identified a peripheral intravenous line was inserted into Resident #1's left hand and that a one (1) liter normal saline infusion was initiated at 50 milliliters per hour, however failed to indicate Person #1 was informed of the critical sodium level of 99. Nursing notes dated 4/17/25 at 3:50 PM identified a STAT BMP (basal metabolic panel) was ordered for Resident #1, intravenous hydration was completed, and Person #1 was aware of all new orders. Review of the Notification of Changes policy directed to promptly inform the resident, consult with the resident's physician, and notify, consistent with his/her authority, the resident's representative when there was a change requiring such notification which included circumstances that required a need to alter treatment, such as a new treatment or discontinuation of current treatment due to adverse consequences, acute condition, or exacerbation of a chronic condition. (continued on next page)

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
	075240	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Glendale	4 Hazel Ave Naugatuck, CT 06770

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	075240	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Glendale	4 Hazel Ave Naugatuck, CT 06770

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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 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 clinical records, interviews, facility documentation and facility policy for one (1) of three (3) residents (Resident #1) reviewed for a change of condition, the facility failed to ensure follow-up labs were drawn in a timely manner for a resident with critical lab values. The findings included: Resident #1 was admitted to the facility with diagnoses that included cervicalgia, other spondylosis, and subluxation of the T2/T3 thoracic vertebra. The comprehensive Minimum Data Set assessment (MDS) dated [DATE] identified Resident #1 was moderately cognitively impaired (Brief Interview for Mental Status (BIMS) score of 11), required set-up assistance with eating and oral hygiene, and required supervision with personal hygiene. The Resident Care Plan (RCP) dated 3/18/25 identified a risk for malnutrition related to hyponatremia, dehydration, intravenous fluids, variable oral intake, mechanically altered diet, and oral nutritional supplements. Interventions directed to monitor for signs of dehydration and monitor weights and labs as available. Review of the hospital discharge records dated 3/12/25 identified Resident #1 was hyponatremic with a serum sodium level of 128, was treated with gentle fluid hydration, and his/her sodium level improved to 131 prior to discharge. Lab results dated 4/16/25 identified a critical serum sodium level of 99. Provider's orders dated 4/16/25 at 3:49 PM directed a Basic Metabolic Panel (BMP) (blood test that measures levels in the blood to assess metabolism, kidney function, blood sugar, and electrolyte balance) with a requested service date of 4/17/25. Review of the clinical record identified the order was canceled the morning of 4/17/25 and replaced with an order for a STAT (immediate) BMP at 11:15 AM. The BMP results dated 4/17/25 identified Resident #1's blood was drawn on 4/17/25 at 9:26 PM, was received by the lab for processing on 4/18/25 at 12:54 AM, and resulted on 4/18/25 at 2:02 AM with a critical serum sodium level of 103. APRN #2's (On-Call APRN) note dated 4/18/25 at 2:34 AM identified he/she was informed of Resident #1's abnormal sodium result of 103, Resident #1 was unarousable upon exam, Resident #1's condition was critical and directed Resident #1 be sent to the hospital. The 4/18/25 hospital record identified Resident #1 was diagnosed with hyponatremia, hypokalemia, hypomagnesemia, acute respiratory failure with hypoxia, hypovolemia, altered mental status, and was admitted into the critical care unit. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with APRN #1 on 5/13/25 at 11:20 AM identified an order for a BMP (which included a serum sodium level) was initially ordered on 4/16/25 at 3:49 PM, with a service date of 4/17/25. APRN #1 further indicated the lab results should have been available by the time he/she arrived at the facility on the morning of 4/17/25 and after identifying the labs were not drawn, placed a new order at 11:15 AM for a STAT BMP. APRN #1 indicated he/she immediately informed LPN #1, who was assigned to care for Resident #1 during the 7:00 AM to 3:00 PM shift on 4/17/25, of the STAT order. The order was entered into the lab portal at 12:45 PM (one hour and thirty minutes after the order was entered). Interview with MD #1 on 5/13/25 at 12:09 PM identified he/she was aware of the critical sodium level of 99 on 4/16/25 and ordered one (1) liter of normal saline to be administered at 50 milliliters per hour, Lasix 40 milligrams daily for treatment of hyponatremia, and a follow-up lab draw for 4/17/25 to re check Resident #1's sodium level. MD #1 further indicated the follow up sodium level of 103 was not an adequate response to the interventions ordered and required transfer to the hospital. A confirmation for the lab order dated 4/16/25 (with a service date of 4/17/25) was requested, however, the facility was unable to provide verification that the lab was ordered. Interview with APRN #1 on 5/13/25 at 4:00 PM identified he/she was not informed of any issue with the initial BMP order (entered on 4/16/25) and was never told lab orders needed to be entered as STAT to be drawn on a non-routine lab day (4/17/25). Interview with LPN #1 on 5/14/25 at 9:42 AM identified an order entered as STAT should be carried out immediately after completing essential in progress tasks. The process to enter a STAT lab order required the order to be entered into the electronic lab portal and to place a phone call to the lab service provider to directly notify the lab of the STAT order. Interview with the Director of Nurses (DON) on 5/14/25 at 10:30 AM identified the facility failed to process the BMP ordered by APRN #1 on 4/16/25. The DON further identified that both the charge nurse and nurse supervisor were responsible for checking pending orders in the electronic medical record (EMR) which is where the lab order would have been entered by the provider for facility processing. Interview with Person #1 (lab service provider) on 5/14/25 at 2:48 PM identified labs ordered for non-routine lab draw days (4/17/25) would need to be entered STAT for the lab to be scheduled and drawn and that the lab technician would be dispatched to fulfill the order within eight (8) hours after the order was placed. Person #1 further indicated that if a lab order needed to be drawn more expediently, the facility should have entered specifications in the comment field of the order screen. Person #1 identified the comment field for the lab order dated 4/17/25 was blank.