

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075240	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/03/2026
NAME OF PROVIDER OR SUPPLIER  Complete Care at Glendale		STREET ADDRESS, CITY, STATE, ZIP CODE  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 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** Based on review of the clinical record, facility documentation/policies, and staff interviews, for one (1) of three (3) sampled residents (Resident #1) who required staff assistance for daily living skills, the facility failed to develop and implement a comprehensive care plan and physician orders to address the required use of a left arm sling following a humerus fracture. The findings included: Resident #1's diagnoses included fracture of the left humerus, chronic kidney disease, and type two diabetes. Review of the hospital discharge documents dated 11/21/25 identified Resident #1 was fitted for a left arm sling due to a humerus fracture. Review of physician's orders from 11/21/25 through 12/2/25 failed to identify an order for a left arm sling. The five (5) day Minimum Data Set assessment dated [DATE] identified Resident #1 was cognitively intact (Brief Interview for Mental Status (BIMS) score of 13) and was dependent on staff for dressing and transfers in and out of the bed and chair. The Resident Care Plan (RCP) dated 11/27/25 identified Resident #1 had a self-care deficit and was at risk for falls. Interventions directed assistance of one (1) with dressing. The RCP failed to identify use of a sling and interventions for the left arm fracture. Review of the nurse aide care card failed to identify instructions for Resident #1 to wear a sling at all times to the left arm. Review of a complaint filed on 1/2/26 identified when the complainant visited Resident #1 on 12/3/25, Resident #1 did not have his/her left arm sling on. Interview with LPN #1 (the 7 AM to 3 PM charge nurse) on 2/3/26 at 1:29 PM identified she recalled Resident #1 had a sling that was to be worn all the time and that directions for sling use would have been either on the physician's order or the RCP. Interview with NA #1 (the 7AM to 3 PM nurse aide) on 2/3/26 at 1:47 PM identified she provided care for Resident #1 every time she worked. NA #1 identified Resident #1 wore the sling all the time except when he/she was being changed. NA #1 further identified she was aware of the directions for sling use because the therapist instructed her on the use of the sling and the directions were on the care card. NA #1 further identified that although Resident #1 did not actively take his/her sling off, it would come off sometimes with independent movement. Interview with the Certified Occupational Therapist Assistant (COTA) on 2/3/26 at 2:19 PM identified she was made aware of Resident #1's sling orders from the OT (Occupational Therapist) that did the initial evaluation. The COTA further identified the orders for the sling should have been on the physician's orders, RCP, and NA care card. Interview with the DON (Director of Nursing) on 2/3/26 at 2:30 PM identified directions for sling use should have either been on the physician's orders or on the RCP and that the facility failed to follow the Care Plan Policy. Review of the Facility Care Plan Policy identified in part the facility will develop and implement a care plan that includes instructions needed to provide effective and person-centered care of the residents that meets professional standards of quality care. The Policy further identified the care plan should contain any services and treatments to be administered by the facility staff. Although attempted, unable to reach the complainant.		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 075240
		If continuation sheet Page 1 of 1