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 01/14/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, facility documentation, facility policy, and interviews, the facility failed to ensure dry storage items were stored under sanitary conditions; and failed to ensure that the sanitizing solution was monitored for appropriate sanitizing levels; and failed to ensure food temperatures were monitored and logged for every meal; and failed to ensure that the nourishment refrigerator temperatures were checked and logged daily. The findings include:Observation on 1/11/26 at 8:24 AM during an initial tour of the kitchen with the Dietary Director in the dry food storage area identified a large, prepackaged bag that contained corn flake type cereal. The bag was not labeled or dated and there was a large tear in the bag (approximately 3 inches) with cereal open to the air. Additionally, a box of powered liquid thickener was observed fully opened at the top and had been placed in a plastic bag. The bag was open and nonsealable. Observation of the red sanitizing buckets identified that 2 of 3 buckets tested at 150 PPM. The Dietary Director identified these levels were low for the quaternary solution used by the facility and should have been tested between 200-400 PPM. Interview with the Dietary Director immediately following these observations identified he only started working at the facility 2 weeks prior and had identified issues with the kitchen, sanitization, and the debris around the grease trap. The Dietary Director failed to provide any additional information related to what these issues were. Following these observations, a request was made to review the sanitizing solution manufacturer directions, and the solution testing logs for 10/25, 11/25, 12/25 and 1/2026. Observations on 1/12/26 at 7:41 AM with the Dietary Director identified an open package of white sliced bread in the dry storage area. During this observation, 2 live flying insects, which appeared to be fruit flies, were observed within the dry storage area. Dietary Director reported that all dry food items within the kitchen should be stored securely with closed packaging.Following this observation, a request was made to review the food temperature logs for all meals from 10/25, 11/25, 12/25 and 1/2026. An additional request was also made to the Dietary Director to provide the sanitizing solution manufacturer directions, and the solution testing logs for 10/25, 11/25, 12/25 and 1/2026 previously requested. Observations on 1/12/26 at 1 PM of the two facility nourishment refrigerators identified temperature logs posted for 1/26. The logs failed to identify any documentation of the freezer temperatures and failed to identify the staff who completed the temperature checks. Interview on 1/13/26 at 7:05 AM with the Dietary Director identified he was unable to provide any documentation or instructions related to the sanitizing solution issues. The Dietary Director identified that the facility had not utilized any kind of system to track or document the sanitizing solution used throughout the kitchen and identified that this was something that he could implement in the future. Interview on 1/13/26 at 7:10 AM with Dietary [NAME] #1 and Dietary Aide #3 identified that the facility kitchen staff did not routinely test the sanitizing solution used in the kitchen or track the test strip results. Dietary [NAME] #1 identified that the previous dietary director had implemented the use of log sheets for a couple of months in 2025 however the sheets were only used sporadically by dietary staff and eventually they went away. Dietary [NAME] #1 identified she was a full time cook in the kitchen and regularly used the test strips when she used new sanitizing solution. Dietary [NAME] #1 identified that throughout 2025 there were several issues (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
	075240	A. Building B. Wing	01/14/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with the sanitizing solution testing being above 400 PPM so she was surprised that the levels were low during survey. Review of facility documentation and interview with the Dietary Director beginning at 1/13/26 at 11 AM identified issues with the prior nourishment refrigerator cleaning and temperature logs. The Dietary Director identified following taking over the role, he decided to utilize a new form beginning 1/26. The Dietary Director identified he did not realize the form did not include documentation of the freezer temperatures and he would correct this. The Dietary Director provided the nourishment refrigerator cleaning and temperature logs for 12/25. Review of the 12/25 temperature logs failed to identify any recorded temperatures from 12/23/25 - 12/29/25 or on 12/31/25. The Dietary Director identified that he was unable to locate any additional nourishment refrigerator cleaning or temperature logs for any other months in 2025. During this interview the Dietary Director also provided food temperature logs labeled Hot Food Temperature Log sheet for 1/26 for review. Review of the logs with the Dietary Director identified that the forms did not include any cold items, did not include any documentation related to the time or specific meal that the temperatures were recorded for, or the dietary staff who recorded the temperatures. The Dietary Director identified that in addition to the issues with the 1/26 food temperature logs, he was unable to locate any prior logs and could not provide any documentation of any food temperatures for 2025. Despite multiple requests, the facility failed to provide any documentation related to the quaternary solution used for sanitizing throughout the kitchen of the facility. Although requested, the facility failed to provide a policy on sanitizing solution use in the kitchen. Although requested, the facility failed to provide a policy on the resident nourishment refrigerators. Although requested, the facility failed to provide a policy on food temperature logs for residents' meals. The facility policy on food safety requirements directed that food would be stored, prepared, distributed, and served in accordance with professional standards for food service safety. The policy also directed that food safety practices would be followed throughout the facilities entire food handling process and elements of the process included:Storage of food in a manner that helped prevent deterioration or contamination of the food including the growth of organisms.Preparation of food including cooking, cooling, holding, and reheating.Equipment used in the handling of food, including dishes, utensils, mixers, grinders, and other equipment that comes in contact with food.The policy also directed that refrigerated food storage included monitoring the function of refrigerated equipment daily and at routine intervals during all hours of operation. The policy further directed that when preparing food cooked food should be prepared until recommended temperatures for specific foods were reached and staff should monitor food temperatures to ensure proper hot and cold holding temperatures were maintained. The policy also directed that all equipment used in handling food should be clean and sanitized and handled in a manner to prevent contamination and staff should follow facility procedures for cleaning fixed cooking equipment. The facility policy on sanitation inspection directed that it was the policy of the facility to conduct inspections to ensure food service areas were clean, sanitary and in compliance with applicable state and federal regulations.

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for 3 residents (Resident #7, 117 and 119) reviewed for hospitalization and/or discharge, the facility failed to ensure the Office of the State Long-Term Care Ombudsman was notified in a timely manner when the residents were was transferred and admitted to the hospital and when a resident had left against medical advice (AMA). The findings include: 1. Resident #7 was admitted to the facility in February 2021 with diagnoses that included epilepsy, traumatic brain injury, and acute embolism. Review of the census form identified Resident #7 was transferred to the hospital and admitted on [DATE]. A nurse's note dated 6/9/25 at 8:26 PM identified Resident #7 was readmitted to the facility at 7:00 PM alert, nonverbal, and calm. Review of a notification details form dated 10/2/25 identified the routine monthly resident transfers dated between 6/1/25 – 6/30/25 were sent to the Office of the State Long-term Ombudsman (4 months late). Review of an action summary report dated 10/2/25 failed to reflect Resident #7's transfer to the hospital on 6/3/25 and failed to reflect notification to the Office of the State Long-term Ombudsman of the hospital transfer. Interview with the Business Office Manager on 1/13/26 at 8:35 AM identified she was not aware she was required to notify the Office of the State Long-term Ombudsman when residents were transferred to the hospital. The Business Office Manager indicated that in October 2025, she submitted a resident discharge lists for June 2025, July 2025, August 2025, and September 2025 to the Office of the State Long-term Ombudsman. The Business Office Manager indicated she did not include residents who had been transferred to the hospital. 2. Resident #117 was admitted to the facility in May 2025 with diagnoses that included congestive heart failure (CHF), stage 5 chronic kidney disease, and bladder cancer. The 5-day MDS dated [DATE] identified Resident #117 had intact cognition. Review of the clinical record identified Resident #117 was transferred to the hospital on 6/22/25 and returned on 6/26/25. Additionally, Resident #117 was transferred to the hospital on 6/29/25 and returned on 7/5/25. Review of facility documentation identified the Office of the State Long-Term Care Ombudsman was not notified of the resident's hospitalizations of 6/22/25 or 6/29/25 until 10/2/25. Interview with the Business office Manager (BOM) on 1/12/26 at 9:50 AM identified there was confusion related to a new process she had been instructed to complete related to the Ombudsman's (continued on next page)

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

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	office and confused the process with replacing the Ombudsman notifications. The BOM identified that she realized that she should be reporting transfers/discharges monthly and reported the hospitalizations of 6/22/25 and 6/29/25 to the Office of the State Long-Term Care Ombudsman via the portal on 10/2/25. The facility policy on transfers and discharges directed that the facility would provide transfer/discharge notice to the resident/representative and Ombudsman as indicated. 3. Resident #119 was admitted to the facility on [DATE] with diagnoses that included low back pain, diabetes, pneumonia, and abnormalities of gait and mobility. Review of the census form identified Resident #119 had left the facility against medical advice (AMA) on 8/31/25. A nurse's note by the DNS dated 8/31/25 at 4:06 PM identified Resident #119 was expected to transfer to another room because the resident's roommate tested positive for Covid-19. Resident #119 and his/her resident's representative and the new roommates were notified of the room change. Review of the voluntary discharge against medical advice form dated 8/31/25 identified Resident #119 signed the form on 8/31/25 at 5:30 PM and LPN #4 signed as the witness. Review of the nurse's note dated 8/31/25 at 5:14 PM through 9/1/25 at 1:25 AM failed to reflect documentation that Resident #119 had left the facility against medical advice (AMA) on 8/31/25 at 5:30 PM. Additionally, documentation failed to reflect that the resident representative was notified that Resident #119 had left the facility against medical advice (AMA). Review of the action summary report dated 10/2/25 identified Resident #119 left against medical advice, or discontinued care on 8/31/25 at 6:09 PM. The action summary report failed to reflect the Office of the State Long-term Ombudsman had been notified that Resident #119 left on 8/31/25 against medical advice in a timely manner. Review of the notification details form dated 10/2/25 identified the routine monthly resident transfers for 8/1/25 – 8/31/25 were sent to the Office of the State Long-term Ombudsman (2 months late). Interview with the Business Office Manager on 1/12/26 at 9:35 AM identified she has been employed with the facility for approximately 2 years. The Business Office Manager indicated last year in 2025 she attended a webinar regarding notice of intent to discharge. The Business Office Manager indicated that the monthly resident discharge notifications to the Office of the State Long-term Ombudsman were discontinued and the new form, notice of intent to discharge, was to be sent to the Office of the State Long-term Ombudsman daily. The Business Office Manager indicated in October 2025, she submitted the resident discharge lists for June 2025, July 2025, August 2025, and September 2025 to the Office of the State Long-term Ombudsman. Interview with the Administrator on 1/12/26 at 9:50 AM identified she was not aware that notification to the Office of the State Long-term Ombudsman of resident discharges and hospital transfers were not timely and/or done. The Administrator indicated the issue was brought to her attention by the Ombudsman. The Administrator indicated the Business Office Manager is responsible for submitting the list of resident discharges and transfers to hospital to the Office of the State Long-term (continued on next page)

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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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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ombudsman on a monthly basis. The Administrator indicated she will educate the Business Office Manager to submit a list of all discharges which will include all hospital transfers on a monthly basis. Review of the facility transfer and discharge (including AMA) policy identified the facility to permit each resident to remain in the facility and not transfer or discharge the resident from the facility, except in limited circumstances. This policy applies to all residents regardless of their payment source. The facility will maintain evidence that the notice was sent to the Ombudsman. The facility will provide transfer/discharge notice to the resident/representative and Ombudsman as indicated. The social services director, or designee, will provide copies of notices for emergency transfers to the Ombudsman, but they may be sent when practicable, such as in a list of residents on a monthly basis, as long as the list meets all requirements for content of such notices. Discharge against medical advice (AMA): Documentation of this notification should be entered in the nurse's notes by the nursing department. Notify adult protection services, or other entity as appropriate, if self-neglect is suspected, and document accordingly.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for 1 of 3 residents (Resident #1) reviewed for abuse, the facility failed to revise the care plan with interventions to reduce future injury after the resident sustained an injury of unknown origin. The findings include:Resident #1 was admitted to the facility in 6/2022 with diagnoses that included atherosclerosis of the native arteries, peripheral vascular disease (PVD) and dementia.The annual MDS dated [DATE] identified Resident #1 was moderately cognitively impaired, independent with bed mobility and required one person assist with transfers, toileting and locomotion using a wheelchair/walker. The care plan dated 11/18/25 identified Resident #1 had impaired cognition, was independent with transfers and ambulation with a walker, received antiplatelet therapy (medication used for PVD management that may increase risk for bleeding) and was at risk for skin breakdown. Interventions included to cue, supervise as needed, monitor for adverse reactions to antiplatelet therapy and observe skin for signs of breakdown.a. A weekly skin assessment dated [DATE] identified no skin injury/wound(s) were noted.Nure's note dated 12/24/25 at 2:30 AM identified Resident #1 sustained a skin tear to the right shin without pain. The note did not identify a documented measurement, description or origin of the injury. The physician was notified, and treatment was initiated for the skin tear per facility wound care protocol.b. A weekly skin assessment dated [DATE] identified no skin injury/wound(s) were noted.Nurse's note dated 1/7/26 at 2:38 AM identified an area of discoloration to the lower right back and right outer thigh area that was observed by the nurse aide during rounds. No pain or discomfort was noted. There was no documented measurement, description or origin of the injury. The physician was notified, with no new orders.Skin injury report dated 1/7/26 at 2:45 AM identified Resident #1 had an area of discoloration described as a bruise to right lower back and right thigh. Resident #1 was alert, confused and ambulated independently. Resident #1 reported that he/she probably bumped into it with no other information regarding where the injury occurred and no documented measurement or description.A reportable event form dated 1/7/26 identified a skin discoloration to the right hip and thigh described as a bruise with no further documented measurement, description, origin of the injury or any interventions to prevent further injuries. The care plan dated 1/8/26 identified skin discoloration to the right hip and buttocks without interventions to prevent further injury.Nurse's note dated 1/12/26 at 8:33 PM identified that Resident #1 had discoloration to the right lower back and thigh. Resident #14 denied pain, known injury or mistreatment and the finding was not suspicious in nature. Resident #1 took prescribed medication which may have contributed to bruising and had dementia with poor safety awareness. Resident #14 self- transferred in and out of bed and on/off toilet independently, did not consistently use a walker and probably bumped it. Resident #14 had a history of falls with the last known fall to have occurred on 11/28/25. The incident was reviewed by the interdisciplinary team, and the care plan was updated. Care plan dated 1/12/26 identified skin discoloration to the right hip and buttocks with interventions to monitor the discolored areas for increase and report findings to the APRN. The care plan did not include interventions to reduc future injury.Interview with RN #3 on 1 13 26 at 8:19 AM identified she was responsible for wound management at the facility. On 1/8/26, she assessed the area and noted discoloration to the right hip and buttocks which was not consistent with a pressure injury. RN #3 indicated she updated the care plan to include the skin discoloration but did not include any interventions. Interview and clinical record review with the Director of Rehabilitation on 1/13/26 at 9:19 AM identified Resident #1 was independent with ambulation but based on current functional level, would not be able to get up on his/her own after a fall. The Rehabilitation Director indicated residents would be referred for screening by nursing when a resident sustained an injury of unknown origin. The Director of Rehabilitation further identified Resident #1 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was last seen in October 2025 for services and she had not received a referral for a screen to determine if anything environmental could have caused repeated injuries.Interview, clinical record and facility documentation review with the DNS on 1/13/26 at 1:22 PM identified for any injury of unknown origin, the resident would be interviewed if possible. If unable to explain the injury due to cognitive impairment, staff statements were relied upon and the care plan updated. The DNS identified a reportable event form had not been completed for the skin tear because completing a form for every skin tear in the facility with no known cause would be excessive.Subsequent interview, clinical record and facility documentation review with the DNS on 1/13/26 3:21 PM identified Resident #1's bruising was discussed at a risk management meeting, but she could not recall an outcome of the discussions, and she did not have documentation supporting preventative measures had been put in place to reduce future injury.Interview with RN #6, the MDS coordinator on 1/14/26 at 6:56 AM identified the interdisciplinary team was responsible for the revision of the care plan for any change of condition. RN #6 identified on 1/12/26, 5 days after the discovery of the skin discoloration, she updated the care plan to include the skin discoloration but did not include preventative interventions to reduce the risk of future injury as she did not know what they would be. RN #6 further identified interventions would need to be discussed.The policy for Care Plan Revisions Upon Status Change directs that the care plan will be revised as necessary when a resident experiences a status change. Upon identification of a change in status, the interdisciplinary team will discuss the resident condition and collaborate on intervention options. The team discussion will be documented in the progress notes, and the care plan will be updated with new or modified interventions that reflect the resident's needs.The policy for Abuse, Neglect and Exploitation defines possible indicators of abuse as any physical mark such as bruises or patterned appearances such as a handprint, belt or ring mark on a resident's body and any physical injury of unknown source. Allegations must be reported to the overseeing state agency immediately, but not later than two hours after an allegation is made if the allegation involves abuse or results in serious bodily injury. Or 24 hours if events do not involve abuse or serious bodily injury. Connecticut Public Health Code directs that all reportable events, which have occurred in the facility, shall be reviewed monthly by the administrator and director of nurses. All situations which have potential for risk shall be identified. A determination shall be made as to what preventative measures shall be implemented by the facility staff.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on observation, review of the clinical record, facility policies, and interviews for 1 of 5 residents (Resident #121) reviewed for accidents, the facility failed to ensure an RN assessment was completed timely following a change in the residents condition and failed to ensure antibiotics were administered timely after an x ray identified pneumonia. The findings include:Resident #121 was admitted to the facility in 12/2025 with diagnoses that included metabolic encephalopathy, neurocognitive disorder with Lewy Bodies, type 2 diabetes mellitus, Parkinson's Disease, and dysphagia.The physician's orders dated 12/15/25 directed for a cardiac, carbohydrate-controlled diet, dysphagia puree texture, honey consistency and directed for the administration of Albuterol Sulfate Inhalation Solution (2.5mg/3ml) 0.083% (a bronchodilator which works to relax the muscles of the airway to make breathing easier) 3ml inhale orally, via nebulizer every 6 hours, for shortness of breath or wheezing. The admission MDS dated [DATE] identified Resident #121 had had severely impaired cognition, required supervision or touching assistance with eating, had the following signs and symptoms of a swallowing disorder: holding food in mouth/cheeks or residual food in mouth after meals and coughing or choking during meals or when shallowing medications, and required the following nutritional approaches: a mechanically altered diet and a therapeutic diet.The care plan dated 1/5/26 identified Resident #121 exhibited or was at risk for impaired swallowing related to history or cerebral vascular accident (CVA), with interventions that included providing modified diet and liquid consistencies as ordered, encouraging small sip/bites and cue as needed, encouraging resident to alternate liquids and solids, monitoring for signs and symptoms of aspiration ie: coughing, watery eyes, choking, moist sounding voice, and if coughing occurs, no food/liquids until coughing resolves. The nurse aide kardex identified Resident #121 required an extensive assist for self-feeding and directed to monitor adherence to fluid restriction; 2000ml daily, monitoring for signs and symptoms of aspiration, providing modified consistency diet and liquids as ordered, and if coughing occurs, no food/liquids until coughing resolves. Observation on 1/11/26 at 9:40 AM identified Resident #121 sitting up in bed coughing, the cough was noted to sound wet.Observation on 1/11/26 at 11:45 AM through 12:00 PM identified Resident #121 was seated for lunch in the parlor and was noted to have a consistent wet cough. Interview with LPN #1 on 1/11/26 at 12:00 PM identified that Resident #121 would sometimes cough during meals, as he/she was not tolerating food or drinks well, due to his/her Parkinson's which the SLP had educated that the disease process was likely to worsen the dysphagia. LPN #1 indicated that Resident #121 was working with the SLP, was on a puree diet, honey thickened liquids, and the family had declined placement of a feeding tube. The Medication Administration Record (MAR) dated 1/11/26 at 12:28 PM identified Albuterol Sulfate Inhalation Solution (2.5mg/3ml) 0.083% was administered, via nebulizer. a. The LPN's Change in Condition note dated 1/11/26 at 1:52 PM identified Resident #121 was noted to be coughing especially after eating or drinking, the resident was on puree diet and honey thick liquids, a congested cough was noted, and rhonchi lung sounds. The primary care provider was notified, and a chest x-ray was ordered. Recommendations included Mucinex, nebulizer treatments, and supplemental oxygen therapy at 2 liters. Resident #121's blood pressure: 118/66, heart rate: 92, respiratory rate: 18, temperature: 97.3 , and pulse oximetry 92% on room air.The change in condition follow-up note, written by the LPN, dated 1/11/26 at 9:48 PM identified there was no change in condition, Resident #121 was observed coughing, frequently-gargling, positive for pneumonia, on honey thickened liquids, on a puree diet and intravenous (IV) antibiotics. The LPN's change in condition follow-up note dated 1/12/26 at (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7:35 AM identified Resident #121's condition was improved. Resident #121 was coughing, oxygen saturation was below 80% (normal range 95-100%), he/she was started on 2 liters of oxygen, bloodwork was done, and the resident has pneumonia. Will start IV antibiotics today. With nasal cannula, Resident #121's oxygen level was above 95%. Resident #121 was resting in bed with the head of the bed up, call bell was within reach.Review of the nurse's notes dated 1/11/26 through 1/12/26 failed to identify an RN assessment of the resident's condition had been completed after the residents change in respiratory status including the diagnosis of pneumonia. Review of the clinical record with the 7:00 AM - 3:00 PM RN Supervisor (RN #2) and the Infection Control Nurse (RN #3) on 1/12/26 at 10:59 AM failed to identify that an RN assessment was completed following Resident #121's change in condition, on 1/11/26. During an interview with RN #2 and RN #3 on 1/12/26 at 10:59 AM, RN #2 identified that LPN #1 had come to her sometime during the afternoon on 1/11/26 to notify her that he had placed a call to the medical APRN and that a chest x-ray was ordered for Resident #121 due to his/her congested cough. RN #2 could not recall the time that she was notified of Resident #121's change in condition, and she would look further into the documentation to see if an RN assessment had been completed. RN #3 indicated that she had just learned of Resident #121's cough and treatment plan, earlier this morning, and had planned to follow-up and complete an assessment, this morning. RN #3 further indicated that while the medical provider and family were notified of the change of condition, she would also have expected an RN assessment to have been completed and documented, as soon as the congested cough was identified and the first PRN nebulizer treatments was administered on 1/11/26 at 12:28 PM. Review of the clinical record with the DNS and the Regional Director Resource Nurse (RN #8) on 1/14/26 at 10:00 AM failed to identify that a timely RN assessment was completed following Resident #121's change in condition, on 1/11/26.During an interview with the DNS and RN #8 on 1/14/26 at 10:00 AM, the DNS identified that she would have expected an RN assessment to have been completed on Resident #121 once the congested cough was identified because this was an observed change in his/her condition. b. Radiology Results Report dated 1/11/26 at 3:16 PM identified a single view chest x-ray was completed on Resident #121 on 1/11/26 at 2:42 PM. The findings identified normal heart size and configuration. The mediastinum was normal without adenopathy. There were modest right lower lobe and modest left lower lobe infiltrates. There was no venous congestion. The osseous structures were unremarkable. Impressions: modest bilateral lower lobe pneumonia. Electronically signed by the physician on 1/11/26 at 3:16 PM. A physician's order dated 1/11/26 (and discontinued on 1/12/26) directed to administer Cefpodoxime Proxetel 200mg (antibiotic used to treat respiratory bacterial infections) give 1 tablet by mouth, every 12 hours for pneumonia, for 7 days.The Medication Administration Record (MAR) dated 1/11/26 failed to identify Resident #121 received Cefpodoxime Proxetel 200mg.A physician's order dated 1/12/26 directed to administer Ceftriaxone Sodium Intravenous Solution 1 gram (gm) (antibiotic used to treat bacterial infections such as pneumonia) use 1 gm intravenously once daily for pneumonia, for 5 days.The Medication Administration Record (MAR) dated 1/12/26 failed to identify Resident #121 received Ceftriaxone Sodium Intravenous Solution 1gm.Clinical record review with the 7:00 AM - 3:00 PM nurse (LPN #9) on 1/12/26 at 9:40 AM identified that the medical provider had ordered Ceftriaxone on 1/12/26 around 1:00 AM and Resident #121's first dose of IV Ceftriaxone was scheduled for 1/12/26 at 6:00 AM.Interview with LPN #9 on 1/12/26 at 9:40 AM identified that Resident #121 had a chest x-ray that was reviewed by the medical provider on 1/11/26 at 3:15 PM, and the resident had IV Ceftriaxone scheduled for administration on 1/12/26 at 6:00 AM. LPN #9 identified that the Ceftriaxone should have been administered, but she could not speak to why it had not been administered by the 11:00 PM - 7:00 AM nurse.Subsequent to surveyor inquiry, the RN note dated 1/12/26 at 9:55 AM identified that the APRN was updated that Resident #121 had not yet received IV Ceftriaxone. A new order directed to change time of administration to 10:00 AM and give the Ceftriaxone. IV Ceftriaxone started running without difficulty and was tolerated well.Review of the clinical record with the 7:00 AM - 3:00 PM RN Supervisor (RN #2) and the Infection Control Nurse (RN (continued on next page)

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#3) on 1/12/26 at 10:59 AM failed to identify Resident #121 received antibiotics in a timely manner.During an interview with RN #2 and RN #3 on 1/12/26 at 10:59 AM, RN #3 identified that LPN #9 had notified her, just prior to 10:00 AM, that Resident #121's antibiotics had not been started. RN #3 indicated that she notified the resident representative and the medical APRN of the delay, and the Ceftriaxone was administered on 1/12/26 at 10:00 AM. RN #3 identified that the medical APRN's original order was for Cefpodoxime Proxetil 200 mg, 1 tablet by mouth every 12 hours, and that antibiotic was not available at the facility. When the pharmacy delivered the order in the evening, Resident #121 was not able to swallow the tablet so an order for IV Ceftriaxone was obtained and an peripheral IV line was placed on 1/11/26 at 11:12 PM. RN #3 further indicated that IV Ceftriaxone was available in the facility's emergency box and should have been administered after obtaining IV access, ideally before midnight. RN #3 identified that Resident #121 received his/her first dose of antibiotics on 1/12/26 at 10:00 AM, when LPN #9 brought the concern to her attention, subsequent to surveyor inquiry. Review of the clinical record with the DNS and the Regional Director Resource Nurse (RN #8) on 1/14/26 at 10:00 AM failed to identify Resident #121 received antibiotics for the treatment of pneumonia, in a timely manner.During an interview with the DNS and RN #8 on 1/14/26 at 10:00 AM, the DNS identified that, during her investigation of why the administration of Resident #121's antibiotics were delayed, the 11:00 PM - 7:00 AM LPN indicated she could not find the saline to reconstitute the Ceftriaxone. The DNS indicated that the RN Supervisor was notified and took the LPN's word for it that the saline was not available. The APRN was notified, but she did not want to modify the order to IM (intramuscular). The DNS could not identify if the saline unavailability and delay of the antibiotic administration was communicated to the 7:00AM - 3:00PM (LPN #9) nurse during shift report, as none of this information had been documented in the clinical record, and she was relying on information from interviews obtained during her investigation. The DNS identified that the saline must have been available at the facility because LPN #9 was able to administer the medication as soon as it was identified that the antibiotic had not been given. The DNS indicated that she would have expected Resident #121 to have received the IV Ceftriaxone following the insertion of the peripheral line and would have expected the RN Supervisor to look for the saline, not take the LPN's word for it that it was not available. The DNS further identified that she would expect the reason for the delay in the antibiotic administration to be documented in Resident #121's clinical record. The Verbal Orders policy directs that physician orders may be received by telephone, by a licensed or registered health care specialist who is legally authorized to do so and to follow through with orders by making appropriate contact or notification.The Medication Administration policy directs medications are to be administered by licensed staff, as ordered by the physician and in accordance with professional standards of practice; ensuring that the six rights of medication administration are followed: the right resident, drug, dosage, route, time, and documentation. The policy further directs that medications are to be administered within 60 minutes prior to or after scheduled times unless otherwise ordered by the physician.

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NAME OF PROVIDER OR SUPPLIER Complete Care at Glendale		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, facility policies, and interviews for 1 of 4 residents (Resident #12) reviewed for pressure ulcers, the facility failed to complete a nutritional assessment for a resident with a newly re-opened pressure injury in a timely manner, and for 2 of 4 residents (Residents #60 and 121) reviewed for pressure ulcers, the facility failed to ensure a specialty mattress was set in accordance with a physician's order, and for Resident #121, the facility failed to ensure a comprehensive pressure ulcer assessment was completed on admission. The findings include: Resident #12 was admitted in 4/2025 with diagnoses that included Type II diabetes and atrial fibrillation. The quarterly MDS dated [DATE] identified Resident #12 had severely impaired cognition, required one person assist for bed mobility, transfers, was dependent for toileting needs, had no unhealed pressure ulcers and was at risk for developing a pressure ulcer. The care plan dated 10/22/25 identified Resident #12 had was at risk for malnutrition and skin breakdown. Interventions included provide supplements as ordered and observe for signs and symptoms of skin breakdown. A wound consult dated 12/2/25 identified Resident #12 had a previously opened stage II pressure injury to the left buttocks that was resolved. Recommendations included continuing current skin care and breakdown prevention and discontinue supplements. Physician's order dated 12/2/25 directed to cleanse skin to buttocks and apply Calazime ointment every shift. A dietary progress note dated 12/29/25 identified a stage II pressure wound on the left buttock resolved 12/2/25, with moisture associated skin damage, (MASD) to the buttocks remaining. Recommendations included to discontinue Pro-stat (protein supplementation beneficial for wound healing) related to resolved pressure injury. Nurse's note dated 12/29/25 at 8:00 AM identified Resident #1 was seen by the certified wound nurse for a skin assessment of the buttocks. Resident #1 had MASD with open excoriations present to the left and right buttock. Skin was blanchable. Physician's order dated 12/2/25 directed to cleanse skin to bilateral buttocks and apply Calazime ointment every shift and cleanse wound with wound cleanser, pat dry, apply calcium followed by calcium alginate and cover with foam dressing in the evening. A wound consult dated 12/30/25 identified Resident #12 was being evaluated for an unstageable pressure wound on the left buttock measuring 5cm x 4.5cm x 3cm, 100% eschar (black necrotic tissue). The area was debrided, ultrasound mist therapy applied and new daily wound treatments initiated. A wound tracking dated 12/30/25 did not include the newly identified pressure ulcer to the left buttock. (continued on next page)

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Risk management meeting minutes dated 12/31/25 identified Resident #12 had an in-house acquired deep tissue injury to the left buttock. A wound consult dated 1/6/26 identified weekly evaluation and treatment for an unstageable pressure wound to the left buttocks measuring 5.5 x 4 x 0.4cm. The area was partially debrided, then non-contact ultrasound therapy was provided with new wound treatment recommendations. A wound tracking dated 1/6/26 identified Resident #12 was being treated for a facility acquired unstageable pressure ulcer to the left buttock. A dietary progress note dated 1/12/26 at 1:05 PM, completed twelve days after the discovery of the newly reopened pressure wound on 12/30/25, identified Resident #12 had a previously resolved wound as of last assessment and was now being evaluated for a pressure wound to the left buttock per 1/6/26 wound note. Recommendations include Pro-stat AWC daily to promote wound healing. Interview with Dietitian #1 on 1/13/26 at 9:54 AM identified she routinely monitored residents with wounds and completed nutritional assessments of newly identified or recurrent wounds. Dietitian #1 indicated she obtained information through morning report, reviewing wound notes and by a weekly wound tracking report provided by the wound nurse. Dietitian #1 further identified she did not assess Resident #12 before 1/12/26 and would typically review a wound within one month of identification, as she was onsite three days weekly. Dietitian #1 was unable to recall being present at morning report or risk management when Resident #12's newly re-opened wound was discussed prior to 1/6/26. Interview with the Regional Dietitian on 1/13/26 at 11:06 AM identified Resident #12's newly identified wound should have been assessed by the dietitian as soon as possible after its discovery. Interview with APRN #1 on 1/13/26 at 12:07 PM identified that while she did not provide routine services for Resident #12, any resident with a pressure-related wound should be nutritionally assessed no more than five days after the discovery of a new wound. Interview with the DNS on 1/13/26 at 1:10 PM DNS identified new wounds were communicated during morning report, in a weekly wound report and at-risk management meetings. The DNS further identified that although there was no specific policy, a nutritional assessment should be completed for any resident with a new wound discussed at risk management within a week. Interview with RN #3 on 1/13/26 at 2:56 PM identified she was responsible for wound management at the facility. RN #3 indicated she completed a weekly wound tracking report listing all the residents with wounds in the facility and disseminated electronically to the interdisciplinary team. On 12/30/25, RN #3 completed rounds with the wound specialist where Resident #12's new wound was identified. RN #3 identified she completed the weekly wound tracking after rounds but did not include information regarding Resident #12's new wound as an oversight. RN #3 further identified, however, that she was present when Resident #12's wound was discussed during morning report and later at a scheduled risk management meeting on 12/31/25 confirming Dietitian #1 was present during both meetings. Dietary staff punch detail dated 12/30/25 through 1/12/26 identified a nutritionist was on-site six days, including on 12/31/25, before a nutritional assessment with new recommendations had been completed on 1/12/26. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility policy for Nutritional Management directs that a comprehensive assessment will be completed within 72 hours of admission, annually and upon a significant change of condition and follow-up assessments as needed. Components of the assessment may include any physical and medical conditions and monitored/revised on an ongoing basis. 2. Resident #60 was admitted to the facility in 10/2022 with diagnoses that included Parkinson's Disease, difficulty in walking, spinal stenosis, and adult failure to thrive. The quarterly MDS dated [DATE] identified Resident #60 had intact cognition, required substantial/maximal assistance with rolling left and right, sitting to lying, sitting to standing, and toilet transfers, was at risk for developing pressure ulcers/injuries, and required a pressure reducing device for the chair and bed. A physician's order dated 6/26/25 directed to provide a low air loss mattress to the bed set to 160 lbs. and check settings and functions every shift. The care plan dated 1/7/26 identified Resident #60 was at risk for skin breakdown related to limited mobility, incontinence, fragile skin, anticoagulation use, and failure to thrive. Interventions included a low air loss mattress to the bed set to 160 lbs. and to observe skin daily for any localized skin problems. Observation on 1/11/26 at 8:30 AM identified the specialty mattress was set to 400 lbs. and a sticker on the face of the pump unit directed the mattress to be set at 160 lbs. Observation with RN #6 on 1/11/26 at 9:49 AM identified the specialty mattress was set to 400 lbs. RN #6 adjusted the setting to 160 lbs. Interview with RN #6 on 1/11/26 at 9:50 AM identified that Resident #60's specialty mattress was not set to the setting that was directed by the sticker on the pump unit, and that Resident #60's specialty mattress setting was observed all the way up. RN #6 identified that it was the responsibility of the charge nurse to check the specialty mattress settings every shift, but she occasionally would make rounds on the unit and check specialty mattress settings. Interview with LPN #1 on 1/11/26 at 9:51 AM identified that he was the nurse assigned to Resident #60 from 7:00 AM - 3:00 PM and that his/her specialty mattress setting should be set according to the physician's order. LPN #1 indicated it was the responsibility of the charge nurse to ensure specialty mattresses are functioning and set correctly, each shift. LPN #1 identified that he had not yet checked Resident #60's mattress settings for the day shift but had done so during his shift the day before and was not aware that the specialty mattress had been set to 400 lbs. Interview with the Wound Nurse (RN #3) on 1/12/26 at 8:03 AM identified that Resident #60 currently did not have a pressure ulcer but had a history of a stage 3 pressure ulcer to his/her back. RN #3 indicated that Resident #60 had a history of kyphosis (excessive outward curvature of the spine) which put him/her at risk for developing pressure injuries to that area so as a preventative measure the specialty mattress remained in place as an intervention. RN #3 further indicated that it was the responsibility of the charge nurse to evaluate the specialty mattress function and settings every shift; in addition, she completed audits of all specialty mattress settings, every Monday. RN #3 identified that it was important to ensure specialty mattresses are set in accordance with the physician's order (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	because a mattress that was too firm defeats the purpose of the interventions and won't relieve pressure. 3. Resident #121 was admitted to the facility in 12/2025 with diagnoses that included metabolic encephalopathy, neurocognitive disorder with Lewy Bodies, chronic systolic heart failure, and type 2 diabetes mellitus. The Nursing admission assessment dated [DATE] at 1:23 PM identified that Resident #121 had a pressure injury/ulcer to the coccyx, MASD to the groin, and his/her right and left heels were dry and scaly. The Nursing admission Assessment failed to identify wound measurements and/or staging of the coccyx pressure injury/ulcer. The Braden score identified Resident #121 was at high risk for developing pressure injuries. The nurse's note dated 12/16/25 at 10:13 AM identified Resident #121 had been seen by the wound specialist for a weekly wound assessment. A stage 4 pressure wound to the sacrum/coccyx that measured 1.5 x 1.4 x 0.4, wound bed is 25% granulation, 75% non-ran/necrosis, edges were macerated, moderate serosanguinous drainage, surrounding skin color and temperature were within defined limits. The wound was cleansed and treatment applied, tolerated well. Refer to wound physician note for full visit details. The admission MDS dated [DATE] identified Resident #121 had had severely impaired cognition, required substantial/maximal assistance with rolling left and right, sitting to lying, lying to sitting, was dependent with sitting to standing and toilet transfers, had 1 stage 4 pressure ulcer, and required the following pressure ulcer/injury treatments: pressure reducing device for bed and chair, nutrition or hydration intervention to manage skin problems, and pressure ulcer/injury care. A physician's order dated 12/17/25 directed to provide a low air loss mattress to the bed, one time only for 1 day, bed safety check and hand check set up, and end every shift setting 170, check settings and functions every shift The care plan dated 1/5/26 identified Resident #121 was at risk for skin breakdown related to impaired mobility, incontinence, increased risk for wound worsening related to poor oral intake and decline, actual coccyx pressure ulcer. Interventions included a low air loss mattress set to 170 lbs. and weekly skin checks by licensed nurse. Observation on 1/11/26 at 8:30 AM identified Resident #121's specialty mattress was set to 350, a sticker on the face of the pump unit identified the mattress setting should be set to 130 (physician's order directs for setting of 170). Observation with RN #6 on 1/11/26 at 9:48 AM identified Resident #121's specialty mattress was set to 350; RN #6 adjusted the setting to 130. Interview with RN #6 on 1/11/26 at 9:50 AM identified that Resident #121's specialty mattress was not set to the setting that was indicated by the sticker on the pump unit, and that Resident #121's specialty mattress had been set at 350. RN #6 identified that it was the responsibility of the charge nurse to check the specialty mattress settings every shift, but she occasionally would make rounds on the unit and check specialty mattress settings. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LPN #1 on 1/11/26 at 9:51 AM identified that he was the nurse assigned to Resident #121 from 7:00 AM - 3:00 PM and that his/her specialty mattress setting should be set to the physician's order, and he would have to confirm Resident #121's mattress setting with the physician's order. LPN #1 indicated that it was the responsibility of the charge nurse to ensure specialty mattresses were functioning and set correctly, each shift. LPN #1 identified that he had not yet checked Resident #121's mattress settings for the day shift but had done so the day before and was not aware that the specialty mattress was set to 350. Interview with the Wound Nurse (RN #3) on 1/12/26 at 8:03 AM identified that Resident #121 was admitted with a stage 4 pressure ulcer, which was almost healed, but that Resident #121 was very deconditioned. RN #3 further indicated that it was the responsibility of the charge nurse to evaluate the specialty mattress function and settings every shift and in addition she completed audits of the specialty mattress settings every Monday. RN #3 identified that it was important to ensure specialty mattresses were set in accordance with the physician's order because a mattress that was too firm defeats the purpose of the interventions and won't relieve pressure. Clinical record review with the Wound Nurse (RN #3) and the Regional Clinical Resource Nurse (RN #5) on 1/3/26 at 12:50 PM failed to identify a comprehensive assessment, including wound measurements and staging, was completed on admission, 12/12/25, or prior to 12/16/25 (4 days), of Resident #121's pressure ulcer to the coccyx. During an interview with RN #3 and RN #5 on 1/3/26 at 12:50 PM, RN #3 identified that she was not in the facility when Resident #121 was admitted on [DATE], but she had rounded with the Wound Specialist on 12/16/25 and documented a comprehensive wound assessment. RN #3 indicated that prior to her wound assessment, which was completed during wound rounds, there was no documentation in Resident #121's clinical record that the coccyx pressure ulcer had been measured or staged. RN #3 further indicated that pressure ulcers that were present on admission should be measured, staged, and documented by the admitting nurse. During an interview with the DNS and the Regional Director of Resource Nurses (RN #8) on 1/14/26 at 9:59 AM, the DNS identified that it was the responsibility of the nurse to confirm specialty mattress settings were set according to the physician's order and should be documented in the clinical record. The DNS indicated that the Wound Nurse also completed weekly audits of the specialty mattress settings, and RN #8 identified that the physician's order and the specialty mattress setting should match. The DNS indicated that it was the expectation that documentation of a pressure ulcer that was present on admission would be documented in the clinical record and would include a description, measurements, and staging of the pressure injury, and it was the responsibility of the RN Supervisor to ensure that assessment was completed. The Use of Support Surfaces policy directs support services will be used in accordance with evidence-based practice for residents with or at risk for pressure injuries. Support surfaces will be chosen by matching the potential therapeutic benefit with the resident's specific situation. Considerations for utilizing specialized support services: medical condition, size and weight, mobility and activity levels, need for moisture control or shear reduction, presence of pressure injuries including severity and location, risk for developing a pressure injury or at high risk for additional pressure injuries, pain or discomfort, bottoms out on current surface. Except for the facility's standard mattresses and wheelchair cushions support services will be utilized in accordance with the physician's order. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Pressure Injury Prevention and Management policy directs the facility to establish and utilize a systemic approach for pressure injury prevention and management, including prompt assessment and treatment; intervening to stabilize, reduce or remove underlying risk factors; monitoring the impact of the interventions; and modifying the interventions as appropriate. After completing a thorough assessment/evaluation, the interdisciplinary team shall develop a relevant care plan that includes measurable goals for prevention and management of pressure injuries with appropriate interventions. Interventions will be based on specific factors identified in the risk assessment, skin assessment, and any pressure injury assessment. Evidence-based treatments in accordance with current standards of practice will be provided for all residents who have pressure injury present. Pressure injuries will be differentiated from non-pressure injuries, such as arterial, venous, diabetic, moisture or incontinence related skin damage. Treatment decisions will be based on the characteristics of the wound, including the stage, size, exudate if present, presence of pain, signs of infection, wound bed, wound edge and surrounding tissues characteristics. The Documentation of Wound Treatments policy directs the facility to complete accurate documentation of wound assessments and treatments, including response to treatment, change in condition, and change in treatment. Wound assessments are documented upon admission, weekly, and as needed if the resident or wound condition deteriorates. The following elements are documented as part of a complete wound assessment: type of wound and anatomical location, stage of the wound, if pressure injury or the degree of skin loss if non-pressure, measurements including height, width, depth, undermining, and tunneling, and description of wound characteristics.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, facility documentation, facility policies, and interview for 1 of 5 residents (Resident #121) reviewed for accidents, the facility failed to ensure a resident at risk for aspiration was supervised during a meal. The findings include: Resident #121, during admission to an acute care hospital on [DATE], had a Clinical Bedside Swallow Evaluation. The Clinical Bedside Swallow Evaluation identified Resident #121 had mild oral phase dysphagia complicated by prolonged oral transit time/bolus manipulation across trial consistencies. No overt signs and symptoms (s/s) or airway compromise was noted at this time and no retention in the oral cavity post-swallow. Recommendations included the following: diet: puree/IDDSI-4 and mildly thick liquids/IDDSI-2, liquid administration via: cup and straw, supervision: total assist with feeding, compensation/maneuvers: slow rate, small bites/sips and check for pocketing, environmental considerations: upright 90 degrees and upright 30 minutes after meals. Resident #121 was admitted to the facility in 12/2025 with diagnoses that included metabolic encephalopathy, neurocognitive disorder with Lewy Bodies, chronic systolic heart failure, type 2 diabetes mellitus, Parkinson's Disease, and dysphagia.The Speech Language Pathologist (SLP) Evaluation and Plan of Treatment dated 12/15/25 identified Resident #121 participated in a bedside swallowing evaluation which revealed moderate oral and severe pharyngeal stage dysphagia. Of note, the resident was positioned upright in bed and pushing against bed, head in lordosis position, significant difficulty with achieving head in midline position. The resident was unable to follow directions even with modeling, tactile, and verbal cues therefore the evaluation and oral mechanism exam was limited. The resident was dependent for feeding. Oral stage remarkable for reduced manipulation of bolus, mild to moderate residue requiring extra swallows and liquid wash to clear. Pharyngeal stage remarkable for moderately delayed swallow onset sporadically and sporadic absent swallow, wet cough noted for 40% of puree, 90% of nectar thick liquid, and delayed wet cough for 10% of honey thickened liquid. No significant change in signs and symptoms of aspiration with straw versus cup sips. However, of note, improved oral management and swallowing initiation timing with straw sips. However, the resident with intermittent recognition of straw resulting in inconsistent use. The resident was at high risk for aspiration across all consistencies, no significant change with temperature changes, verbal, and tactile cues. The resident was at high risk for malnutrition and dehydration. Discussed evaluation results and recommendations with the APRN, nursing, social worker, and two family members. The family declined alternative means of nutrition and hydration at this time, family considering palliative/hospice options. Recommended to continue puree diet, discontinue nectar thick liquid changed to honey thick liquid. The physician's order dated 12/15/25 directed for a cardiac, carbohydrate-controlled diet, dysphagia puree texture, honey consistency.The admission MDS dated [DATE] identified Resident #121 had had severely impaired cognition, required supervision or touching assistance with eating, had the following signs and symptoms of a swallowing disorder: holding food in mouth/cheeks or residual food in mouth after meals and coughing or choking during meals or when shallowing medications, and required the following nutritional approaches: a mechanically altered diet and a therapeutic diet.The SLP progress note dated 12/29/25 at 5:08 PM identified Resident #121 had demonstrated persistent signs and symptoms of aspiration across consistencies, over the treatment. However, slightly reduced signs and symptoms of aspiration from initial evaluation, no change with slow rate, small bites/sips, cued swallow, and unable to demonstrate a hard swallow. Resident #121 had increased cough this session and reduced oral intake. The resident was pushing away food reporting he/she was not hungry. Aspiration risk persists across consistencies, additional development of safe swallow strategies and training indicated. The family continues to decline alternate means of nutrition, the family was provided extensive education regarding aspiration risk, malnutrition risk, and clinical level of (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	functioning, good comprehension and in agreement with current goals and plan of care.The care plan dated 1/5/26 identified Resident #121 exhibited or was at risk for impaired swallowing related to history of cerebral vascular accident (CVA), with interventions that included providing modified diet and liquid consistencies as ordered, encouraging small sip/bites and cue as needed, encouraging resident to alternate liquids and solids, monitoring for signs and symptoms of aspiration ie: coughing, watery eyes, choking, moist sounding voice, and if coughing occurs, no food/liquids until coughing resolves. The current nurse aide kardex identified Resident #121 required an extensive assist for self-feeding and directed to monitor adherence to fluid restriction; 2000ml daily, monitoring for signs and symptoms of aspiration, providing modified consistency diet and liquids as ordered, and if coughing occurs, no food/liquids until coughing resolves. Observation on 1/11/26 at 9:40 AM identified Resident #121 sitting up in bed coughing, which sounded wet.Observation on 1/11/26 at 11:45 AM through 12:00 PM identified Resident #121 was seated for lunch in the Parlor and was noted to have a consistent wet cough. Interview with LPN #1 on 1/11/26 at 12:00 PM identified that Resident #121 would sometimes cough during meals, as he/she was not tolerating food or drinks well due to Parkinson's which the SLP indicated was likely to worsen the dysphagia. LPN #1 indicated that Resident #121 was working with the SLP, was on a puree diet, honey thickened liquids, and the family had declined placement of a feeding tube. Subsequent to surveyor inquiry, the Change in Condition note dated 1/11/26 at 1:52 PM identified Resident #121 was noted to be coughing especially after eating or drinking, the resident was on puree diet and honey thick liquids, a congested cough was noted, and rhonchi lung sounds. The primary care provider was notified, a chest x-ray was ordered, and recommendations were made for Mucinex, nebulizer treatments, and supplemental oxygen therapy at 2 liters. Resident #121's blood pressure: 118/66, heart rate: 92, respiratory rate: 18, temperature: 97.3 , and pulse oximetry 92% on room air.The single view chest x-ray dated 1/11/26 at 3:16 PM identified modest right lower lobe and modest left lower lobe infiltrates and no venous congestion. Impression: modest bilateral lower lobe pneumonia. Observation on 1/12/26 at 12:06 PM identified Resident #121 alone in his/her room sitting up in a chair with a lunch tray and cranberry juice on the bedside table in front of the resident. A straw that contained residual of a red fluid like substance was hanging from his/her mouth. Observation with LPN #9 on 1/12/26 at 12:08 PM identified Resident #121 was alone in his/her room sitting up in a chair with a lunch tray and cranberry juice on the bedside table in front of him/her and a straw on his/her lap. LPN #9 indicated that Resident #121 should not have a lunch tray and drink placed in front of him/her; Resident #121 was not able to self-feed and required an assist with feeding. LPN #9 indicated that the SLP had identified that Resident #121 was likely to be aspirating during meals.Resident #121's meal ticket failed to identify he/she was at risk for aspiration.Interview with NA #5 on 1/12/26 at 12:15 PM identified that she had mixed Resident #121's cranberry juice with thickener to create a honey consistency and left the straw in the cup, accidentally. (NA #5 Clinical Competency Validations for Feeding the Resident and Obstructed Airway were identified as met on 12/22/25).During an interview with the Speech Language Pathologist (SLP #1) and the Directory of Rehabilitation on 1/12/26 at 12:28 PM, SLP #1 identified Resident #121 had been evaluated by SLP therapy services on 12/15/25, and a swallowing assessment and cognitive communication assessment were completed; at that time it was determined that Resident #121 was having moderate oral and severe pharyngal dysphagia, and he/she was having signs and symptoms of aspiration across all consistencies. SLP #1 indicated that she had discussed the evaluation results and her recommendations with the medical APRN, nursing staff, the social worker, and 2 family members. SLP #1 identified that Resident #121's family had declined alternate means of hydration and nutrition and at that time were considering palliative/hospice options. SLP #1 further indicated that Resident #121 was downgraded to honey thick liquids but kept puree diet consistency. SLP #1 indicated that Resident #121 had reached his/her maximum potential and benefit from SLP therapy services, and due to his/her progressive neuro-degenerative disease, the dysphagia would likely worsen, and anything that Resident #121 eats (continued on next page)

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Complete Care at Glendale	4 Hazel Ave Naugatuck, CT 06770

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	or drinks would be risky, but the nursing staff was educated with the compensatory strategies needed to assist Resident #121 with meals and the strategies were outlined in the care plan. SLP #1 indicated that residents identified for being at risk for aspiration have their compensatory strategies and aspiration monitoring outlined in the care plan, and that she does not believe that there was any notation on the resident's meal ticket to notify dietary staff when a resident had aspiration risk or required a specific level of meal supervision. SLP #1 identified that the plan moving forward was to continue Resident #121 with the current compensatory strategies and the current diet and liquid consistencies. Interview with APRN #1 on 1/13/26 at 12:12 PM identified that although she was not the facility's primary medical APRN, was covering and not familiar with Resident #121, she would expect a resident identified by speech for being at risk for aspiration would have an order for aspiration precautions. APRN #1 indicated she would enter a new order. Interview with NA #4 on 1/13/26 at 12:35 PM identified that she was not Resident #121's primary nurse aide, but she had occasionally provided care for the resident. NA #4 indicated that Resident #121 was on thickened liquids and a puree diet, and she was aware that he/she was an aspiration risk because she had been informed by the nurses, LPN #1 and LPN #9. NA #4 indicated that for residents requiring supervision with meals, she would push their tray table away from where the residents were seated or away from the bed to ensure the dietary aides didn't put the meal tray within their reach, and she would provide assistance with meals for the appropriate residents, depending on information provided by the nurse and the resident's care card. NA #4 identified that the last time she was assigned to Resident #121, he/she required supervision during the meal, was to be seated at 90 degrees, alternated bites and sips, and was aware that she needed to notify the nurse if Resident #121 had s/s of aspiration, including coughing. Interview with NA #6 on 1/13/26 at 12:40 PM identified that she was Resident #121's primary day shift nurse aide, and that prior to Sunday, when she noticed that the resident was coughing during breakfast, she would set him/her up for breakfast in his/her room but not remain in the room to supervise, as Resident #121 could feed him/herself. NA #6 indicated she would listen from another room in close proximity while feeding another resident. NA #6 indicated that on Sunday she noticed Resident #121 was coughing, so she remained with him/her during breakfast and notified LPN #1 at approximately 8:30 AM, and she was told to stop the feeding. LPN #1 came into evaluate Resident #121. NA #6 identified that she believed Resident #121 was at risk for aspiration because any resident on a thickener would be at risk. NA #6 indicated that education to alternate sips and bites for Resident #121 was not communicated to her, and that she did not feel that Resident #121 had the cognition to alternate sips and bites, while self-feeding. NA #6 indicated that Resident #121 went to the parlor for lunch on most days, and that room had nursing supervision. (NA #6 Clinical Competency Validations for Feeding the Resident and Obstructed Airway were identified as met on 12/30/25).Interview with Dietary Aide #2 on 1/13/26 at 12:50 PM identified that the dietary aides deliver the meal trays, and the nurse aides deliver the drinks to the residents. The SLP or nurses would notify the kitchen staff of any changes in diet or consistency, and that would be reflected on the meal ticket, but a resident at risk for aspiration would not be identified on the meal ticket. Dietary Aide #2 identified that she just remembers which residents are at risk and for aspiration, and she would drop their meal tray on their dresser or out of their reach, so the nurse aides could set them up and feed them. Dietary Aide #2 indicated that she was aware that Resident #121 was at risk for aspiration, but she could not recall if she was the dietary aide that placed the lunch tray in front of him/her, the day before. Dietary Aide #2 further indicated that a new process was put into place, starting today; meals for residents requiring feeding assistance would be delivered on a separate cart and the nurses and nurse aides would distribute the trays. Interview with the Dietary Director on 1/13/26 at 12:58 PM identified that the dietary aides pass meals to the residents and the nurse aides pass the drinks. The SLP would update new diet or consistency orders into the resident's electronic health record and that would automatically update the kitchen's ticketing system, additionally the SLP and RD also fill out diet request forms to communicate updates and verbally communicate (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	changes. The Dietary Director indicated that he was unable to answer if residents at risk for aspiration should be identified on the meal ticket, and he would have to circle back with an answer. The Dietary Director indicated that a new process was put into place starting today; a master list was created of all residents with an aspiration risk, and a separate cart would go out with those resident's meals and be handed off directly to the nursing staff for delivery. Interview with the Regional Director of Dietary on 1/13/26 at 1:07 PM identified that he did not know the exact process at this facility, for communicating to dietary staff a resident that was on aspiration precautions. Interview with Dietary Aide #3 on 1/13/26 at 1:12 PM identified residents at risk for aspiration were not identified on the meal ticket, but she knew which residents were at risk because the nurses communicate that information to them, additionally she would notice a change in a diet or consistency order on a resident's meal ticket and then seek out clarification, however, she was not sure how a new dietary aide or dietary aide not familiar with the residents would know who was at risk for aspiration. Interview with the DNS and the Regional Director Resource Nurse (RN #8) on 1/14/26 at 10:04 AM identified that Resident #121's care plan identified him/her as requiring an extensive assist for self-feeding, and that it was the DNS's understanding that Resident #121 could manage the hand to mouth movements to self-feed but staff were expected to remain in the room to monitor for signs and symptoms of aspiration, provide cues, and remind the resident to alternate sips and bites per the interventions listed on the care plan; if Resident #121 started to cough, the meal should be stopped and nurse should be notified. The DNS further indicated that her understanding, based off conversations with the SLP and the interdisciplinary team, was that Resident #121 would remain someone who coughs while eating, the silent aspiration would not improve, and that the family agreed with the current plan of care. The DNS and RN #8 both indicated that it was their expectation that staff would be in the room while Resident #121 was eating. Interview with the Medical Director (MD #1) on 1/14/26 at 12:15 PM identified that while the nursing staff should attempt to supervise Resident #121 during meals due to his/her disease progression there was not much that could be done to stop him/her from aspirating. MD #1 indicated that since the family had declined artificial nutrition, the next step would be a conversation to discuss hospice. MD #1 further indicated that he thought there was an aspiration policy as he would expect the facility to have one in place. MD #1 identified that if a resident continues to aspirate and the family does not want artificial nutrition then a conversation about palliative care and hospices services should be discussed, hospice goals are designed to support the family and to allow the patient to be comfortable, even allowing the resident's diet to be liberalized as long as the family consents and understands the process. Although requested, an Aspiration policy was not provided. The Therapeutic Diet Orders policy directs the facility to provide all residents with food in the appropriate form and/or the appropriate nutritive content as prescribed by a physician, and/or assessed by the interdisciplinary team to support the resident's treatment/plan of care, in accordance with his/her rules and preferences. Therapeutic diets, including mechanically altered diets where appropriate, will be based on the resident's individual needs as determined by the resident's assessment. Therapeutic diets may be considered in certain situations, such as, but not limited to: inadequate nutrition, nutritional deficits, weight loss, medical conditions, and swallowing difficulty. The reason for therapeutic diet is to be documented in the medical record and/or indicated on the resident's comprehensive plan of care. All diet orders are to be communicated to the dietary department in accordance with facility procedures.The facility's Meal Supervision and Assistance policy directs that the resident will be prepared for a well-balanced meal in a calm environment, location of his/her preference and with adequate supervision and assistance to prevent accidents, provide adequate nutrition, and assure an enjoyable event. This includes identifying hazards and risks, evaluating and analyzing hazards and risks, implementing interventions to reduce hazards and risks and monitoring for effectiveness and modifying interventions when necessary. The facility will utilize a systemic approach to ensure safety throughout the residence environment and among all staff. Compliance guidelines identified, in part, include: the facility will develop and (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	implement an individualized plan of care based on the Resident Assessment Instrument to address the resident's needs and goals, and to monitor the results of the planned interventions such as adequate supervision during meal time, the resident should be positioned so his or her head and upper body are as upright as possible and with the head tipped slightly forward, if the resident is served his or her meal in bed, use wedges and pillows to achieve an upright position, alternate food and liquids as desired and needed, in order to cleanse the mouth of food, be careful to provide portions of food easy for the resident to chew, feed slowly allowing plenty of time between bites, and encourage the resident to participate in his/her meal as much as possible.The Comprehensive Care Plans policy directs the facility to develop and implement a comprehensive person centered care plan for each resident, consistent with resident rights, that includes measurable objectives and time frames to meet a resident's medical, nursing and mental and psychosocial needs and all services that are identified in the resident's comprehensive assessment and meet professional standards of quality. The comprehensive care plan will describe at a minimum the following: services that are to be furnished to attain or maintain the residence highest practicable physical, mental and psychosocial well-being, resident specific interventions that reflect the resident's needs and preferences and align with the resident's cultural identity as indicated. The comprehensive care plan will be prepared by the interdisciplinary team that includes but is not limited to: the attending physician or non-physician practitioner designee involved in the resident's care, a registered nurse with responsibility for the resident, a nurse aide with responsibility for the resident, a member of the food and nutrition services staff, the resident and the resident's representative, other staff or professionals and disciplines as determined by the residents needs or as requested by the resident. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment.

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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 policy, and interviews for 1 of 2 residents (Resident #33) reviewed for pain management, the facility failed to ensure pain assessments per the physician's order. The findings include: Resident #33 was admitted to the facility in April 2022 with diagnoses that included headache, polyosteoarthritis, chronic pain, schizoaffective disorder, borderline personality disorder, and repeated falls. A physician's order dated 5/1/24 directed to administer Acetaminophen 325mg, 2 tablets by mouth, every 4 hours as needed for mild pain. A physician's order dated 5/13/25 directed to administer Topiramate (an anticonvulsant also used to prevent migraines) 100mg, 1 tablet by mouth, twice daily for migraines, The quarterly MDS dated [DATE] identified Resident #33 had intact cognition and reported pain that rarely interfered with therapy activities, occasionally effected sleep and day-to-day activities, and over the past 5 days his/her worst pain rating was 3 (on a scale of 0 through 10). The MDS further identified that Resident #33 had taken an opioid in the past 7 days and an indication for use was noted. The care plan dated 11/13/25 identified that Resident #33 was at risk for alterations in comfort related to chronic pain, bilateral shoulder osteoarthritis, neuropathy, neuritis, lower back pain, and a history of migraines with interventions that included completing pain assessments per protocol, utilizing the pain scale, and monitoring for non-verbal signs and symptoms of pain. Physician's orders for December 2025 (original date 1/19/22) directed pain monitoring every shift, (are you free of pain, if no indicate response), if new or change in pain, complete a pain evaluation. Additionally, physician's order for December 2025 (original date 10/3/25) directed to administer Tramadol HCL (medication for moderate to severe pain) 50 mg, 1 tablet every 6 hours as needed (prn) for moderate pain and 2 tablets every 6 hours prn for severe pain, and limit Acetaminophen to twice weekly. Review of the December 2025 MAR identified Resident #33 was free of pain on all shifts, all month despite receiving pain medication on 12/3, 12/6, 12/10, 12/11, 12/14, 12/15 twice, and 12/17/25. In different areas of the MAR, documentation included the following:On 12/3/25 at 9:37 PM, Tramadol 50mg was administered for a pain level of X (a numeric value was not identified).On 12/6/25 at 8:00 PM pain level was documented as X.On 12/10/25 at 12:10 PM pain level was documented as X.On 12/11/25 at 10:15 PM pain level was documented as X.On 12/15/25 at 7:35 AM pain level was documented as X.On 12/15/25 at 8:05 PM pain level was documented as X.On 12/17/25 at 8:06 pm pain level was documented as X. The nurse's notes dated 12/1/25 through 12/31/25 failed to identify the location of the pain when pain medication was administered except for 12/14/25 at 2:23 PM when Resident #33 he/she bumped his/her head against a chair and reported a pain level of 3. The January 2026 MAR dated 1/1/26 through 1/13/26 identified Resident #33 was free of pain or hurting on all shifts despite receiving pain medication on 1/5/26 at 9:06 PM for a pain level of X, on 1/6/26 at 4:03 AM for a pain level X, on 1/7/26 at 8:37 PM for a pain level X, on 1/12/26 at 8:02 PM for a pain level X, and on 1/8/26 at 10:36 PM for a pain level X. Interview with Resident #33 on 1/11/26 at 9:53 AM identified that he/she gets migraines, especially at night, and that there is a medication (could not recall the name) that he/she usually requests around 8:30 at night for the migraine, but the nurse doesn't always bring it.Interview with LPN #9 on 1/12/26 at 9:49 AM identified that Resident #33 had a history of migraines and had a comprehensive plan that was developed by the neurologist which included a few different treatments, but his/her migraine pain was also treated with a limited dose of Acetaminophen, as needed. LPN #9 further indicated that Resident #33 had leg pain because of prior leg surgery and the formation of scar tissue, and Tramadol was used to treat leg pain. LPN #9 identified that Resident #33 usually doesn't request pain medication during the day shift, when she works, but when she administers a pain medication she would complete a pain evaluation, which would include obtaining a pain rating on a scale of 0-10, the location of the pain, quality and description of the pain, and if the pain was a new or chronic pain. LPN #9 further identified she would document the evaluation in a progress note or administration (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	note; if the reported pain was not a chronic pain, then she would also report the new onset of pain to the RN Supervisor and APRN.Review of the clinical record with the DNS and the Director of Resource Nurses (RN #8) on 1/14/26 at 9:46 AM failed to identify that pain evaluations were being completed prior to Resident #33 receiving Tramadol.During an interview with the DNS and RN #8 on 1/14/26 at 9:46 AM, RN #8 identified that the clinical record only contained documentation that the Tramadol had been effective, following administration. RN #8 indicated that he would expect to see a pain scale rating and location of the resident's pain, and if a resident was not able to communicate pain verbally, he would expect qualitative data to be used to complete a pain evaluation. RN #8 further indicated that he had updated the electronic Medication Administration Record to trigger the nurse to enter a numerical pain scale value when administering Tramadol.The facility's Pain Management policy directs the facility to utilize a systematic approach for recognition, assessment, treatment, and monitoring of pain. To help a resident attain or maintain his/her highest practicable level of physical, mental and psychosocial well-being and to prevent or manage pain, the facility will recognize when the resident is experiencing pain and identify circumstances when the pain can be anticipated, evaluate the resident for pain and the cause upon admission, during ongoing scheduled assessments, and when a significant change in condition or status occurs, and manage or prevent pain, consistent with the comprehensive assessment and plan of care, current professional standards of practice, and the residence goals and preferences. The policy further directs that the facility will use a pain assessment tool, which is appropriate for the resident's cognitive status, to assist staff in consistent assessments of a resident's pain. Based on professional standards of practice, an assessment or evaluation of pain by the appropriate members of the interdisciplinary team may necessitate gathering the following information, as applicable to the resident: history of pain and its treatment, asking the patient to rate the intensity of his her pain using numerical scale, a verbal or visual descriptor that is appropriate and preferred by the resident, reviewing the resident's current medical conditions, and identifying key characteristics of pain including duration of pain, frequency, location, timing, pattern, and radiation of pain.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, facility documentation, facility policy, and interviews for 1 of 5 residents (Resident #37) reviewed for unnecessary medications, the facility failed to ensure that a pharmacy recommendation was reviewed and addressed by the APRN/Physician. The findings include:Resident #37 was admitted to the facility on [DATE] with diagnoses that included Parkinson's disease, hypertension, and dementia.The quarterly MDS dated [DATE] identified Resident #37 had severely impaired cognition, was frequently incontinent of bowel, occasionally incontinent of bladder, and required supervision by facility staff with toileting, bathing, and dressing.The care plan dated 3/10/25 identified Resident #37 had altered cardiovascular status due to hypertension. Interventions included administering cardiac medications as ordered.A physician's order dated 5/15/25 directed for Metoprolol Tartrate (a medication for hypertension) 37.5 mg once daily.A pharmacy recommendation form dated 5/23/25 identified a recommendation to consider switching to Metoprolol Succinate (a long acting version of the medication). Review of the form failed to identify any physician or prescriber response addressing the recommendation.Review of the clinical record failed to identify any documentation that the 5/23/25 pharmacy recommendation was reviewed or addressed by Resident #37's APRN or physician.Interview with RN #8 (Regional Director of Resource Nurses) on 1/14/26 at 11:00 AM identified he was unable to locate any documentation at the 5/23/25 pharmacy recommendation was given to and reviewed by the provider. Interview with the DNS and RN #8 at 11:22 AM identified that the pharmacy recommendations were emailed to the DNS and the RN unit managers. The DNS identified that the unit manager would print the recommendation for the APRN and once the recommendation was reviewed, the DNS received the signed and completed recommendation, reviewed them and then provided them to medical records and the receptionist to upload to the resident's clinical record. The DNS identified that while she did spot check to ensure that the recommendations were reviewed, addressed, and signed off, she was unable to locate a few of them but did not quantify the number missing. Subsequent to surveyor inquiry and following this interview, the facility provided 2 undated signed pharmacy recommendation forms. The forms included the 5/23/25 form and a 10/15/25 pharmacy recommendation form. Review of the 5/23/25 form identified the provider disagreed with the recommendation to switch to a long acting version of Metoprolol without a rationale. Although requested, the facility failed to provide a policy related to pharmacy recommendations. The facility policy on pharmacy services directed that it was the policy of the facility to ensure that pharmaceutical services were provided to meet the needs of each resident and reflected the current standards of practice. The policy also directed that pharmaceutical services included the process of identifying, evaluating, and addressing medication related issues. The policy further directed that the licensed pharmacist would collaborate with the facility leadership and staff to coordinate pharmacy services within the facility.

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 01/14/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 review of the clinical record, facility documentation, facility policy, and interviews for 1 resident (Resident #119) reviewed for discharge, the facility failed to ensure nursing staff documented when a resident left the facility against medical advice (AMA). The findings include: Resident #119 was admitted to the facility on [DATE] with diagnoses that included low back pain, diabetes, pneumonia, and abnormalities of gait and mobility.The nurse's note dated 8/29/25 at 9:57 PM identified Resident #119 arrived at the facility and was alert and oriented. Prior to admission Resident #119 had weakness and pain to the lower back and radiating to the left leg. Resident #119 denied shortness of breath and difficulty breathing. No edema noted to bilateral lower extremities. Resident #119 was on Levofloxacin 500mg every 48 hours for 5 days.Review of the census form identified Resident #119 had left the facility against medical advice (AMA) on 8/31/25.A nurse's note by the DNS dated 8/31/25 at 4:06 PM identified Resident #119 was expected to transfer to another room due to the resident's roommate testing positive for Covid-19. Resident #119, the resident's representative, the affected, and the new roommates were notified of the room change.Review of the voluntary discharge against medical advice form dated 8/31/25 identified Resident #119 signed the form on 8/31/25 at 5:30 PM and LPN #4 signed as the witness. A physician's order dated 8/31/25 directed to discharge against medical advice (AMA) with medications.Review of the nurse's note dated 8/31/25 at 5:14 PM through 9/1/25 at 1:25 AM failed to reflect documentation that Resident #119 had left the facility against medical advice (AMA) on 8/31/25 at 5:30 PM. Additionally, documentation failed to reflect that the resident representative was notified that Resident #119 had left the facility against medical advice (AMA). Interview and clinical record review with the Administrator on 1/12/26 at 8:46 AM identified the clinical record failed to reflect that Resident #119 had left the facility against medical advice. The Administrator indicated it is the expectation of the facility that nursing and social service staff would have documented that Resident #119 had left against medical advice. The Administrator indicated staff education would be provided to nursing and social services regarding documentation. Interview and clinical record review with the Director of Social Service on 1/12/25 at 8:54 AM identified she has been employed by the facility for approximately 4 years. The Director of Social Service indicated Resident #119 was admitted to the facility on a Friday, late in the evening, after her shift had ended. The Director of Social Service indicated Resident #119 left the facility against medical advice (AMA) on the following Sunday and she was not working. The Director of Social Service indicated the nursing department should have documented the residents discharge AMA in the clinical record.Interview and clinical record review with the DNS on 1/12/26 at 9:23 AM failed to provide documentation to reflect that Resident #119 had left the facility AMA. The DNS indicated on 8/31/25 at 5:36 PM she had notified APRN #2 that Resident #119 was leaving the facility AMA and obtained an order for the resident to leave with medications. The DNS indicated the expectation is that staff document in the clinical record when a resident leaves AMA.Although attempted, an interview with RN #4, and LPN #4 was not obtained.Review of the facility notification of change policy identified the purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification. Circumstances that require a need to alter treatment. This may include transfer or discharge of the resident from the facility. Contact information of the resident's legal representative or family member must be recorded and periodically updated.Review of the facility transfer and discharge (including AMA) policy identified the facility to permit each resident to remain in the facility and not transfer or discharge the resident from the facility, except in limited circumstances. This policy applies to all residents regardless of their payment source. The facility will maintain evidence that the notice was sent to the Ombudsman. The (continued on next page)

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

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility will provide transfer/discharge notice to the resident/representative and Ombudsman as indicated. The social services director, or designee, will provide copies of notices for emergency transfers to the Ombudsman, but they may be sent when practicable, such as in a list of residents on a monthly basis, as long as the list meets all requirements for content of such notices.Discharge against medical advice (AMA): Documentation of this notification should be entered in the nurse's notes by the nursing department. Notify adult protection services, or other entity as appropriate, if self-neglect is suspected. Document accordingly.

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Complete Care at Glendale	4 Hazel Ave Naugatuck, CT 06770

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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 observation, clinical reviews, facility documentation, facility policy and interviews for 1of 4 residents (Resident #12) reviewed for pressure ulcers, the facility failed to ensure hand hygiene was performed in accordance with infection control practices during wound care. The findings include:Resident #12 was admitted in 4/2025 with diagnoses that included Type II diabetes and atrial fibrillation and recent multidrug resistant organism (MDRO) of the urine.The quarterly MDS dated [DATE] identified Resident #12 was severely cognitively impaired and required one person assist for bed mobility, transfers, was dependent for toileting needs, had no unhealed pressure ulcers and was at risk for developing a pressure ulcer. The care plan dated 10/22/25 identified Resident #12 had an ADL deficit, actual moisture associated skin damage (MASD) and placed on enhanced barrier precautions after just completing treatment for a multidrug resistant organism in the urine. Interventions included dependent (two person) assist for bed mobility, transfers and conduct weekly wound assessments.Physician orders dated 1/6/26 directed cleansing of the left buttock with wound cleanser, apply skin prep to the peri wound then apply Santyl ointment (medication that removes damaged tissue to aid in wound healing) to wound bed, cover with calcium alginate (wound dressing that absorbs moisture) followed by a superabsorbent bordered foam dressing.Observation on 1/12/26 at 1:06 PM identified LPN #12 in Resident #12's room at the bedside wearing gloves and gown setting up wound supplies and barrier on the bedside table. LPN #12 instructed Resident #12 she was going to lower the head of the bed to begin wound care. Using her right hand, she operated the bed remote control and placed it by the rail. LPN #12 assisted the nurse aide in positioning the resident on the left side, exposing the left buttock. Using the left hand, LPN #12 then sprayed wound cleanser on a gauze pad held by the opposite hand, then reached toward the wound with the same right hand previously used to set up supplies and handle the remote control, without first removing gloves, performing hand hygiene and donning a new pair of gloves. The task was interrupted, hand hygiene performed, and a new pair of gloves were donned. LPN #12 proceeded to cleanse the wound to the left buttock with a gauze pad, discard the soiled gauze, remove both gloves then don a new pair of gloves without first performing hand hygiene. LPN #12 opened a skin barrier and reached for the peri wound. The task was interrupted. Interview with LPN #1 on 1/12/26 at 1:06 PM identified she should have removed the gloves, performed hand hygiene and put on a new pair of gloves between tasks, when beginning wound care and after cleansing of the wound but did not as an oversight as she was nervous.The task was subsequently completed by RN #3, the infection preventionist/wound nurse.Interview with RN #3 on 1/12/26 at 1:40 PM identified she was responsible for education for the use of personal protection equipment (PPE) and performing hand hygiene between dirty and clean tasks. RN #3 indicated staff compliance remained a challenge and that education was ongoing.Interview with the DNS on 1/13/26 at 3:44 PM identified she would expect hand hygiene to be performed between tasks and between removing and replacing gloves.A review of the facility policy for hand hygiene directs that all staff perform proper hand hygiene (using soap and water or alcohol-based hand rub) procedures to prevent the spread of infection to other personnel, residents and visitors. If the task requires gloves, perform hand hygiene prior to donning gloves and immediately after removing gloves. Hand hygiene is to be performed after handling contaminated objects, before and after removing PPE including gloves, before and after handling clean or soiled dressings, linens, etc., after handling items potentially contaminated with blood, body fluids, secretions or excretions and when moving from a contaminated body site to a clean body site.

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

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observations, facility documentation, facility policy, and interviews, the facility failed to ensure that the kitchen was free of flying insects. The findings include: Observations on 1/11/26 at 8:24 AM during an initial tour of the kitchen with the Dietary Director identified 2 live flying insects at the interior entryway of the kitchen area. The insects appeared to be fruit flies. Additional observations of the grease trap area, also located near the interior entryway of the kitchen area, identified a significant amount of food debris and multiple dead winged insects directly on top of the grease trap, the gap between the wall and the grease trap, and along the wall surface directly next to the grease trap. The winged insects also appeared to be fruit flies. Interview with the Dietary Director immediately following these observations identified he only started working at the facility 2 weeks prior and had identified issues with the kitchen, sanitization, and the debris around the grease trap but had not noticed any active pest activity during that time. The Dietary Director failed to provide any additional information related to what these issues were. Observations on 1/12/26 at 7:41 AM with the Dietary Director identified an open package of white sliced bread in the dry storage area. During this observation, 2 live flying insects, which appeared to be fruit flies, were observed within the dry storage area. Dietary Director reported that all dry food items within the kitchen should be stored securely with closed packaging.Interview on 1/12/26 at 10:55 AM with the Regional Facilities Director identified he has only just been notified of the issue with flying insects by the Dietary Director during the survey. The Regional Facilities Director identified he would be placing traps and had already requested pest control come into the facility that day. He would also be addressing issues related to food items being sealed and cleanliness in the kitchen. Observations on 1/13/26 at 7:05 AM with the Dietary Director identified 3 live flying insects which appeared to be fruit flies flying near the range hood. Interview on 1/13/26 at 7:10 AM with Dietary [NAME] #1 and Dietary Aide #3 identified that there had been issues with fruit fly activity in the kitchen for several months, with heavy activity in the summer months. Dietary [NAME] #1 and Dietary Aide #3 identified since the weather change the insect activity had decreased but they were still present throughout the kitchen area. Review of pest control service reports provided by the facility identified that the kitchen area was treated for crawling insects on 10/27/25, 11/30/25, and 12/30/25.Although requested, the facility failed to provide any documentation that pest control services related to the flying insects had been completed on 1/12, 1/13, or 1/14/26.The facility policy on the pest control program directed that the facility would maintain an effective pest control program that eradicated and contained most common household pests and rodents. The policy further directed that the facility would maintain a report system of issues that might arise in between scheduled visits with the outside pest service provider and treat as indicated, and that the facility would utilize a variety of methods and controlling certain seasonal pests which would involve indoor and outdoor methods that were deemed appropriate by the outside pest service and state and federal regulations.The facility policy on sanitation inspection directed that it was the policy of the facility to conduct inspections to ensure food service areas were clean, sanitary and in compliance with applicable state and federal regulations. The policy further directed that all food service areas would be kept clean, sanitary, free from litter, rubbish and protected from rodents, roaches, flies and other insects.