STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075253	A. Building B. Wing	02/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Harrington Court	59 Harrington CT Colchester, CT 06415

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, interviews, and review of facility policies for one (1) of three (3) residents (Resident #1) reviewed for accidents, the facility failed to ensure a resident's treatment order was entered correctly to ensure timely initiation of the practitioner's directive. The findings included the following: Resident #1 had diagnoses which included lymphedema, atherosclerotic heart disease, and adjustment order with anxiety. Review of Resident #1's Care Plan dated 1/7/25 identified the resident was at risk for skin breakdown related to reduced mobility and has actual skin breakdown and bilateral lower extremity lymphedema with interventions that directed to ace wraps as ordered for lymphedema. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Mental Interview for Mental Status (BIMS) of thirteen (13) indicative of intact cognition. The MDS further identified Resident #1 was dependent with bathing and toileting hygiene, and required substantial assistance with personal hygiene. Review of the 1/7/25 Advanced Practice Registered Nurse (APRN) #1's note on 1/7/25 at 2:57 PM identified Resident #1 was seen for increased confusion and lower extremity edema. The note the instructed to elevate Resident #1's lower extremities while in bed and start ace wraps to the lower extremities with application at 6:00 AM and removal at 6:00 PM. Review of the Medication Administration Report (MAR) dated January 2025 identified an order to wrap lower legs with ace wraps at 6:00 AM and remove at 6:00 PM daily one time a day for edema was not initiated until 1/12/25, (five days following the APRN's instruction). Interview with the Director of Nursing Services (DNS) on 2/21/25 at 3:30 PM identified the order to wrap Resident #1's legs with ace wraps was entered into Resident #1's medical record on 1/7/25, however the order was entered incorrectly (as an ancillary order - without a schedule), which prevented the order from appearing on the MAR with a scheduled times. The DNS further identified the standard of practice was for the nursing supervisor to confirm new orders that were entered into the electronic medical record; however, he/she had failed to realize the treatment schedule was missing from the order until 1/11/25, which caused the delay in initiating the resident's treatment unit; 1/12/25.

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: 075253	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/21/2025
NAME OF PROVIDER OR SUPPLIER Complete Care at Harrington Court		STREET ADDRESS, CITY, STATE, ZIP CODE 59 Harrington CT Colchester, CT 06415	

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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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, interviews, and review of facility policies for one (1) of three (3) residents (Resident #1) reviewed for accidents, the facility failed to ensure that a resident was not provided an allergen at meal time. The findings included the following: Resident #1 had diagnoses which included dysphagia, atherosclerotic heart disease, and adjustment order with anxiety. Review of Resident #1's Care Plan dated 1/6/25 identified a risk for allergic reaction related to known allergy to cephalexin, erythromycin, sulfa antibiotics, pineapple, and shellfish with interventions that directed to note allergy in Point Click Care (the resident's electronic medical record) and to notify the physician of any signs and symptoms of an allergic reaction. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Mental Interview for Mental Status (BIMS) of thirteen (13) indicative of intact cognition. The MDS further identified Resident #1 was dependent with bathing and toileting hygiene, and required substantial assistance with personal hygiene. Review of RN #1's nursing noted dated 1/13/25 at 6:28 PM identified Resident #1 was given pineapple for dinner and that he/she had an allergy to pineapple. RN #1 further indicated that at the time of this writing, the resident showed no signs of having an allergic reaction, had pulse oximetry (a device which reads oxygen levels in the blood) reading of 95%, was on two (2) liters of oxygen, had diminished lungs sounds throughout, was without rash and wheezing, an order for Benedryl 25 milligrams by mouth every six (6) hours as needed was in place, and he/she would continue to monitor the resident. Interview with the Food Services Director (FSD) on 2/21/25 at 1:58 PM identified he/she was aware of that pineapple was served to the resident with a known allergy to pineapple. The FSD further identified the facility had now instituted a color-coded meal ticket for residents with known allergies and/or special diets to avoid this situation from happening again and that staff was in-serviced on meal safety/checks as well. Interview with Dietary Aide #1 on 2/21/25 at 3:00 PM identified he/she had observed a bowl of pineapple pieces on Resident #1's dinner tray and had removed it because of the allergy, however, was distracted when another nurse's aide had requested a food item for another resident. Kitchen Aide #1 indicated he/she inadvertently rested the bowl of pineapple pieces back onto Resident #1's tray to assist the nurse's aide with his/her request and forgot to remove it prior to placing it onto the food cart for delivery. (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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with RN #1 on 2/21/25 at 2:30 PM identified Resident #1 did ingest what appeared to be a small amount of pineapple with his/her dinner on 1/13/25 and was informed by Person #1 that a rash would result when the resident would consume pineapple. RN #1 indicated he/she contacted dietary regarding the mistake, had taken Resident #1's vitals twice, twenty (20) minutes apart, which were non-concerning (within normal limits) on both occasions, did not observe any signs or symptoms of an allergic reaction/anaphylactic shock at all, and had educated Person #1 to monitor for shortness of breath, wheezing, and/or dizziness, and instituted fifteen (15) minute checks to ensure patient safety. Interview with NA #1 on 2/21/25 at 3:16 PM identified he/she failed to check the items on Resident #1's dinner tray with the meal ticket prior to giving it to the resident. NA #1 identified that she would normally check the residents food prior food prior to serving and notify the nurse if something was not correct. NA #1 further identified it was his/her responsibility to check the dinner tray and meal ticket prior to serving the resident. NA #1 indicated he/she didn't ensure the meal matched the meal ticket as he/she thought Person #1 (family member), who was with Resident #1 during dinner that day, would check the meal ticket with the resident. Review of dierary and nursing policies identified that the dietary staff must check the meal tickets for allergies while working the tray lines and checked prior to being served to the resident by nursing staff.