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	03/28/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48879 Based on review of the clinical record, facility documentation, facility policy and interviews for two (2) of thirteen (13) residents (Resident #1 and Resident #10) reviewed for abuse, the facility failed to ensure the residents were free from abuse. The findings include: 1. Resident #1's diagnoses included cerebral infarction (when blood flow to the brain is interrupted, causing brain tissue damage), legal blindness, anxiety disorder and depression. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Mental Interview for Mental Status (BIMS) of fifteen (15) indicative of intact cognition and required moderate assistance with bed mobility and transfers. Additionally, the MDS identified Resident #1 ' s hearing was adequate with no difficulties. The Resident Care Plan (RCP) dated 3/6/25 identified Resident #1 had the potential to be verbally aggressive related to ineffective coping skills, poor impulse control and poor anger management and Resident #1 alleged a staff to resident incident. Interventions included providing supportive care as needed and when Resident #1 becomes agitated, intervene before agitation escalates, guide away from the source of distress, engage calmly in conversation and if the response is aggressive, staff is to walk away calmly and approach later. The facility Accident and Investigation report (A & I) dated 3/6/25 identified that at 2:10 PM Resident #1 alleged LPN #1 called him/her a f***ing a***ole (profanity), the police and Advance Practice Registered Nurse (APRN) were notified, and LPN #1 was suspended immediately pending the investigation. The A & I identified that social services was to follow up with Resident #1, staff re-education was initiated for residents rights and allegations of abuse, and random audits would be conducted on staff to resident interactions. A social service note dated 3/6/25 at 3:16 PM identified that Social Worker (SW) #1 met with Resident #1 regarding the staff to resident allegation and Resident #1 identified that the staff member called him/her an inappropriate name, which resulted in Resident #1 getting upset. The note identified that at the time of the visit, Resident #1 ' s mood was labile (unpredictable, uncontrollable and rapid shifts in emotions) but after redirection, Resident #1 calmed down. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Situation, Background, Assessment and Recommendation (SBAR) note dated 3/6/25 at 4:24 PM identified there was a staff to resident verbal altercation that was witnessed by another staff member but that no changes were observed with Resident #1 and psych services and social services would follow-up with Resident #1. Review of the facility Summary Report dated 3/11/25 identified that LPN #1 denied calling Resident #1 a profanity and that she turned away, walked approximately five (5) feet and mumbled under her breath that Resident #1 was a pain in the a**. The report identified that NA #1 was present, and she reported that LPN #1 mumbled that Resident #1 was a pain in the a** but that Resident #1 was already on the way back to his/her room. The report identified that the comment made by LPN #1 was not directed towards Resident #1 and was not consistent with the statement that Resident #1 reported. Interview with Resident #1 on 3/28/25 at 9:03 AM identified that on 3/6/25 he/she came out of their room and into the hallway to the nursing station to request that a NA assist him/her with incontinent care. Resident #1 reported that he/she couldn't locate a NA, so he/she asked LPN #1 for assistance, and LPN #1 dismissed him/her, began arguing with him/her and then called him/her a profanity. Resident #1 identified that although legally blind, LPN #1 was not five (5) feet away, as he/she could feel her in his/her personal space, and indicated his/her hearing is good and he/she did not misunderstand what LPN #1 said. Resident #1 reported that he/she was initially calm and respectful when he/she approached LPN #1 but stated LPN #1 quickly became mean which angered him/her. Resident #1 indicated LPN #1 was unprofessional, so he/she yelled obscenities back at LPN #1. Resident #1 reported that LPN #1 has cared for him/her since the incident but indicated there had been no additional incidents. Interview with LPN #1 on 3/28/25 at 11:11 AM identified that on 3/6/25 around 2:10 PM, she was at her medication cart in front of the West-unit nursing station when Resident #1 approached her and stated he/she had to go to the bathroom. LPN #1 identified Resident #1 shared too many details regarding what he/she needed to do in the bathroom. She identified NA #1 was behind her at the nursing station feeding Resident #14, so she told Resident #1 to wait until they found additional assistance and Resident #1 became loud, accused her of not wanting to help him/her and called her prejudiced. LPN #1 denied calling Resident #1 a profanity but further identified she became frustrated and although she should not have, she turned, started to walk away, and under her breath called Resident #1 a pain in the a**. LPN #1 identified she did not intend for Resident #1 to hear what she said. LPN #1 identified that SW #1 was in the hallway when the incident occurred, but did not hear the incident. LPN #1 identified SW #1 spoke with Resident #1 and blew the incident out of proportion, by reporting her to administration and she was subsequently suspended. LPN #1 reported she should not have made the comment to Resident #1, instead, she should have walked away and not called Resident #1 a pain in the a**. She identified that she cared for Resident #1 since the 3/6/25 incident with no issues. Interview with SW #1 on 3/28/25 at 11:34 AM identified that on 3/6/25 she observed NA #1 pushing Resident #1 in his/her wheelchair away from the nurse's station and Resident #1 was loud and visibly upset, yelling b**ch. She reported that she immediately met with Resident #1 who stated he/she was upset and reported that LPN #1 called him/her a profanity when he/she requested assistance in the bathroom. SW #1 identified that NA #1 initially reported that LPN #1 called Resident #1 a profanity and then changed her statement to say that LPN #1 mumbled Resident #1 was a pain in the a**. SW #1 identified that LPN #1 should not have made either of those comments. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of NA #1's statement dated 3/6/25 identified that Resident #1 came out of his/her room asking for help to get changed and to call his/her mother and LPN #1 told Resident #1 that she did not care about the whole story and that he/she was giving too many details and that he/she could have just asked for help. The statement identified there was a back and forth verbal exchange between Resident #1 and LPN #1 so NA #1 encouraged Resident #1 to turn around and head back to his/her room and NA #1 would be with him/her shortly and that Resident #1 followed the direction by NA #1 and then LPN #1 mumbled, You're being a pain in the a**, which Resident #1 heard, causing an escalation in the interaction, and Resident #1 began to call LPN #1 names. Interview with NA #1 (accompanied by the Administrator and DNS) on 3/28/25 at 11:42 AM identified that on 3/6/25, Resident #1 approached the nurse's station from the orange room and requested help with the bathroom and the urinal. NA #1 identified that she told Resident #1 she would assist him/her when she was done feeding Resident #14 but LPN #1 interfered and told Resident #1 that he/she was giving too many details regarding what he/she needed. NA #1 further identified she was surprised at how dismissive and rude LPN #1 was towards Resident #1 for no apparent reason. NA #1 identified she heard LPN #1 tell Resident #1 he/she was a pain in the a** and that he/she was being an a***ole and is a pain in the a**, loud enough for Resident #1 to hear. NA #1 indicated Resident #1 clearly heard the statements made by LPN #1 which caused an escalation in Resident #1 ' s behavior and he/she in return began calling LPN #1 names. NA #1 identified she finished feeding Resident #14 and then redirected Resident #1 back to his/her room. NA #1 identified that LPN #1 approached her in the hall after the incident and asked her why she reported her and accused her of not being truthful. NA #1 indicated she did tell the truth. She identified that Resident #1 continued to bring up the incident days after it took place and asked if LPN #1 was working. NA #1 indicated she had additionally witnessed LPN #1 speak in a rude tone to other residents within the facility. Interview with the Administrator and DNS on 3/28/25 11:51 AM identified that NA #1 reported LPN #1 called Resident #1 a profanity which LPN #1 denied, both LPN #1 and NA #1 previously reported the comment was not made towards Resident #1. Both the Administrator and the DNS identified that LPN #1 should not have mumbled or called any resident names, whether it was meant for a resident to hear or not. They identified that they were unaware that LPN #1 was rude to other residents and indicated they would conduct interviews with residents regarding being treated with dignity and respect. They identified that following the allegation, they educated LPN #1, and all staff, on abuse, residents rights and professionalism, and conducted staff to resident observation audits weekly. 2. Resident #10's diagnoses included anxiety disorder and schizoaffective disorder (psychotic symptoms including hallucinations, delusions and disorganized thinking and speech), bipolar type (both manic and depressive episodes). The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #10 had a Brief Mental Interview for Mental Status (BIMS) of fifteen (15) indicative of intact cognition and required maximal assistance with bed mobility, transfers and ambulation. The Resident Care Plan (RCP) dated 3/28/25 identified Resident #10 was involved in an incident with a staff member. Interventions included monitoring Resident #10 for emotional distress as ordered, behavior monitoring as ordered, social services to follow-up post incident and evaluation by a psychiatric provider. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 3/28/25 at 2:00 PM identified NA #4 sitting at the East wing nursing station, seated at the computer closest to the 200 wing, speaking loudly in a harsh tone to Resident #10 who was sitting in his/her wheelchair in front of the cafe about 50 feet away. NA #4 stated to Resident #10, you've asked for water a million times today, can you just stop and give me five minutes to sit down, and further stated Resident #10 was being needy. Resident #13 was sitting in his/her wheelchair against the opposite wall from Resident #10 and NA #5 was standing next to NA #4 against the wall behind the nursing station. When the surveyor was identified, NA #4 quickly stood up, approached Resident #10 and loudly stated, (Resident #10), give me your cup! then took Resident #10 ' s mug off the table, brought it into the cafe, then placed the mug back onto the table over Resident #10 and returned to sit at the nursing station. Observation on 3/28/25 at 2:03 PM, identified NA #4 loudly state (with Resident #10 and Resident #13 within hearing range) that she was frustrated, that the facility is consistently short staffed and that she always has Resident #10 on her assignment because no one else will take care of him/her or help her with Resident #10. She indicated that Resident #10 was demanding all day, had been calling her a c*nt all shift and she was sick of it. NA #4 then asked, Where are my rights? During an interview with NA #4 on 3/28/25 at 2:03 PM, NA #4 stated You have no idea how it is here, it's so bad, I'm ready to quit and be done. NA #4 then stood up and reported to RN #2 that she was going outside to smoke and then exited the main entrance. Subsequent to surveyor report at 2:03 PM, the Administrator immediately sent SW #1 to speak with Resident #10 and to conduct interviews and the DNS identified that NA #4 was suspended pending an investigation and that NA #4 told the DNS that she quit and exited the building. A Situation, Background, Assessment and Recommendation (SBAR) note dated 3/28/25 at 2:03 PM identified that a visitor observed a verbal staff to resident incident and that the provider was notified of the incident at 2:10 PM and recommended that a psychiatric evaluation be obtained, social services was to follow up and staff was to monitor Resident #10 for emotional distress following the incident. Interview with the Administrator and SW #2 (Director of Social Services) on 3/28/25 at 2:15 PM identified that NA #4 should not have spoken to Resident #10 the way she did and identified the incident as abuse. They identified Resident #10 had a history of significant behaviors and had an appointment on 3/27/25, where he/she was given bad news which he/she was struggling with. A social services note dated 3/28/25 at 3:16 PM identified Resident #10 verbalized a staff member was being inappropriate towards him/her and felt it was a misunderstanding. The note identified that Resident #10 shared that he/she received news of a new diagnosis and was feeling down about it. The note identified support was offered to and Resident #10 ' s mood appeared to be down, but no observable signs of distress were noted. Interview with Resident #10 on 3/28/25 at 4:00 PM identified that NA #4 was mean to him/her all day and refused to get him/her out of bed until he/she quieted down, NA #4 further identified he/she was not assisted out of bed to the wheelchair until after 1 PM by NA #1. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Abuse, Neglect and Exploitation policy dated 7/1/24 directed, in part, that abuse means the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse and mental abuse. Verbal abuse means the use of oral, written or gestured communication or sounds that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend or disability. It identified that the facility must not use verbal, mental, sexual or physical abuse. Review of the Professionalism- Customer Service policy dated 7/1/24 directed, in part, that it is the policy of the facility to provide professional, courteous service to their customers. Every employee is accountable for conducting themselves in a professional manner at all times, and the facility strives to create an environment where the residents always come first. It identified that each resident will be treated with compassion and respect at all times, remove negative language, and when a resident makes a request staff will respond positively. It also identified that staff is to do whatever is necessary to support their residents based on their individual needs and preferences and to protect and uphold residents' rights at all times. Staff is not to argue or [NAME] with the residents that they care for and if they feel they are becoming angry or confrontational, they are to step away from the situation at the moment and ask a co-worker or supervisor to assist as needed.