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	11/13/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, facility documentation, facility policy and interviews for one (1) of three (3) sampled residents (Resident #2) who had targeted behaviors, the facility failed to ensure a comprehensive care plan was developed and interventions implemented to address the resident's behaviors which included the tendency to transfer him/herself without assistance. The findings include:Resident #2's diagnoses included dementia without behavioral disturbances, depression, anxiety disorder, obsessive compulsive disorder and insomnia. A physician's order dated 9/16/25 directed Resident #2 was non-weight bearing to the right lower extremity every shift. The nurse's note dated 9/16/25 at 9:31 PM identified Resident #2 was admitted to the facility following a right third toe amputation. The note indicated Resident #2 was confused, restless, displayed poor safety awareness, required close observation for safety due to non-weight bearing status to the right foot, required assistance of two (2) for transfers. The Resident Care Plan dated 9/17/25 identified Resident #2 was at risk for complications related to the use of psychotropic, antipsychotic for OCD, antianxiety for depression, and antidepressant for insomnia. Interventions directed to complete the behavior monitoring flow sheet as indicated, monitor for changes in mental status and functional level and report to the physician, and monitor for continued need of medication as related to behavior and mood. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had a Brief Interview for Mental Status (BIMS) score of four (4) out of fifteen (15) indicating poor memory recall, was dependent on staff for transfers in and out of the bed and chair, and received antipsychotic, antianxiety, and antidepressant medications on a routine basis. Review of the October 2025 Treatment Administration Record (TAR) identified Resident #2's targeted behavior was wandering and insomnia. The TAR failed to include restless, obsessive-compulsive behaviors and non-compliant with transfers. The nurse's note dated 10/10/25 at 11:09 AM identified around 12:15 AM Resident #2 was observed seated in his/her wheelchair next to the roommate's bed and the roommate reported Resident #2 had come to his/her bedside, removed the bed linens, pulled up his/her clothing and touched him/her inappropriately. The note indicated Resident #2 was immediately taken to the nurse's station and placed on one-to-one (1-1) observations and the provider and resident representative were notified of the incident. Review of the care plan dated 10/10/25, following the 10/10/25 allegation the care plan was revised to address Resident #2's potential for changes in mood, behavior and psychosocial well-being related to dementia and signs and symptoms of depression. Interview with Resident #2's roommate, Resident #1, on 11/13/25 at 8:18 AM identified prior to the 10/10/25 incident, Resident #2 would often get out of bed unassisted into the wheelchair, rummage through his/her (Resident #1's) belongings on the bedside table and often sit on his/her (Resident #1's) bed. Resident #1 reported that although he/she had not formally complained about Resident #2's behavior, it bothered Resident #1, and he/she identified the staff had observed Resident #2's behavior numerous times. Interview with a 7AM-3PM nurse aide, Nurse Aide (NA) #3, on 11/13/25 at 8:25 AM identified Resident #2 required assistance for transfers, resided in a window bed and would sometimes transfer him/herself and be found sitting close to or on Resident #1's bed. NA #3 explained when she observed this, she would redirect Resident #2, assist him/her back to the wheelchair, attempt to meet his/her needs and bring him/her to the nurse's station. NA #3 indicated Resident #2 had also been observed standing at the nurse's station. Interview with a 3-11PM nurse aide, NA #1, on 11/13/25 at 11:57 AM identified she worked on 10/9/25. NA #1 explained she put Resident #2 to bed just after 9:00 PM and observed Resident #2 in bed with his/her eyes closed around 10:30 PM when she did her last rounds. NA #1 indicated Resident #2 was calm and displayed no behaviors that night, Resident #2 did not use the call-bell and had a history of getting out of bed unassisted and self-transferring and needed to be checked-in on frequently. Interview with a 11PM-7AM nurse aide, NA #2, on 11/13/25 at 12:08 PM identified that she worked the 11PM-7AM shift the night of the accusation, reporting that although she last saw Resident #2 in bed around 11:20 PM she was unsure when Resident #2 got out of bed and into the wheelchair, as observed at 12:15 AM. NA #2 identified Resident #2 had a history of getting out of bed unassisted several times nightly. Interview with the 11PM-7AM nursing supervisor, Registered Nurse (RN) #1, on 11/13/25 at 12:19 PM identified Resident #2 had a history of getting up unassisted and wandering around his/her room on the 11PM-7AM shift. RN #1 indicated Resident #1 had complained to her about the behavior previously of how Resident #2 had been taking Resident #1's stuff. RN #1 identified when the behaviors were noted staff would redirect Resident #2 and would keep Resident #2 at the nurse's station