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	12/08/2025

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 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. (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 0657 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 #1) reviewed for Activities of Daily Living (ADLs), the facility failed to review and revise the plan of care to include the resident's refusal of showers and implement alternative interventions. The findings include:Resident #1's diagnoses included adult failure to thrive, anorexia, type II diabetes mellitus, muscle weakness and lack of coordination. The admission Record dated 8/13/25 identified a family member was named Power of Attorney for medical, care conference person, and authorized HIPPA contact. The Nursing admission assessment dated [DATE] identified Resident #1 was alert and oriented to person, place, time and situation, required extensive assistance with bed mobility and was totally dependent on staff for transfers, personal hygiene and bathing. The Resident Care Plan dated 8/14/25 identified Resident #1 was at risk for decreased ability to perform ADLs related to limited range of motion and limited mobility. Interventions directed to provide the resident with extensive assistance of one (1) for personal hygiene and bathing. Review of the Care Plan Meeting documentation dated 11/25/25 at 2:51 PM identified Resident #1's family had requested a care conference to discuss concerns. The documentation identified they discussed showering and the facility offered to meet regularly and call the family with updates when Resident #1 refused care. Review of the Documentation Survey Report (Nurse Aide documentation) for August 2025 through November 2025 identified Resident #1 was not provided a shower on 8/14/25, 8/18/25, 8/21/25, 9/4/25, 9/11/25, 9/22/25, 9/25/25, 9/29/25, 10/2/25, 10/6/25, 10/13/25, 10/16/25, 10/23/25, 10/30/25, 11/6/25, 11/10/25, 11/13/25, 11/17/25 or 11/24/25 and there was no follow-up documentation as to why the showers were not provided or if Resident #1 had refused to be showered. The documentation failed to identify what shift the showers were scheduled for. Review of the shower schedule identified Resident #1 was scheduled for showers on the 7AM-3PM shift on Tuesdays. Review of the revised care plan dated 11/26/25 identified Resident #1 refused ADL care at times. Interventions included explaining all care, including procedures and the reason for performing the care before initiating, and evaluating the nature and circumstances of the resistive behavior with the resident and/or resident representative and discuss the findings with the resident and family members and adjust care delivery appropriately. Interview with nurse aides, Nurse Aide (NA) #1 and NA #2, on 12/8/25 identified although Resident #1 had been refusing showers since his/her admission, Resident #1 would agree to a bed bath instead and they would notify the charge nurse when Resident #1 refused. Interview with the 3-11PM nursing supervisor, Registered Nurse (RN) #1, on 12/8/25 at 1:15 PM identified on 11/18/25 Resident #1's family member approached her and reported Resident #1 had not been showered and requested to see documentation regarding showering. RN #1 indicated she reviewed the documentation and identified although Resident #1 had not received a shower in several weeks Resident #1 did receive a bed bath on the day shift on 11/18/25. RN #1 identified she offered to have the nurse aide shower Resident #1, but both Resident #1 and the family member declined and stated the shower could wait until another day. Interview with the Director of Nursing (DON) on 12/8/25 at 12:30 PM identified during the 11/25/25 care plan meeting with Resident #1's family, the family voiced concerns with Resident #1 being showered. The DON explained, through staff interviews she identified Resident #1 had been refusing showers but allowing bed baths and the nurse aides had been notifying the charge nurses and nursing supervisors however they did not document the refusals, revise the care plan to include refusal of care and showering, or initiate targeted behavior monitoring as they should have when the behaviors were first observed so interventions could have been put into place and the behaviors could be monitored. The DON identified a care plan was developed after the 11/25/25 meeting and when she reviewed the nurse aide documentation, the showering documentation did not match up to the unit shower schedule. The DON stated the schedule should have been customized to identify which shift and day of the week the shower was scheduled for and she was unsure why the shower was scheduled for every shift multiple days a week, which made it confusing to follow. Review of the Comprehensive Care Plans policy dated 07/01/23 directed, in part, that the facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychological needs and all services that are identified in the resident's comprehensive assessment and meet professional standards of quality. Other factors identified by the interdisciplinary team, or in accordance with the residents' preferences, will also be addressed in the plan

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. (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 0692 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 #1) who was at risk for weight loss, the facility failed to ensure weekly weights were obtained per the physician's order and failed to ensure a re-weight was obtained at the time a significant weight loss was identified and not wait one (1) week. The findings include:Resident #1's diagnoses included adult failure to thrive, anorexia, dysphagia (difficulty swallowing) and type II diabetes mellitus. The Nursing admission assessment dated [DATE] identified Resident #1 was alert and oriented to person, place, time and situation, required full dentures but did not wear them and was independent with eating. A physician's order dated 8/14/25 directed to obtain the resident's weight every day shift every Thursday for four (4) weeks. The Resident Care Plan dated 8/14/25 identified Resident #1 met the criteria for moderate protein calorie malnutrition diagnosis due to weight loss and inadequate oral intakes. Interventions directed to monitor the resident's weight and laboratory results as available. The Medical Nutrition Therapy assessment dated [DATE] identified, in part, Resident #1 was admitted from the hospital, Resident #1's appetite and intakes were poor and a low albumin (a type of protein in the blood) level was noted. The assessment identified Resident #1 was a risk for malnutrition related to poor intakes, low albumin, need for oral nutritional supplements, and the plan and interventions included eight (8) ounces of Glucerna twice daily, continue current diet, honor food preferences as able, weekly weights for four (4) weeks, monitor all nutrition parameters and follow-up for nutrition plan of care as needed. A physician's order dated 8/19/25 directed to obtain the resident's weight every day shift every Tuesday for four (4) weeks. A physician's order dated 9/22/25 directed to obtain the resident's weight every evening shift every Monday for four (4) weeks and then every evening shift once a month starting on the 10/20/25. Review of the August and September 2025 Medication Administration Records identified weights were scheduled to be obtained on Resident #1 on 8/19/25, 8/26/25, 9/2/25, 9/9/25, and 9/16/25. Upon further review, although the weights were signed off on the Medication Administration Record as being obtained on 8/19/25, 8/26/25, 9/2/25, 9/9/25, and 9/16/25, no weights were recorded in the clinical record on those dates. Review of the September 2025 Medication Administration Record identified on 9/22/25 Resident #1 weighed 154.6 pounds and on 9/29/25 Resident #1 weighed 129.4 pounds showing a twenty-six (26.2) pound weight loss in one (1) week. Upon further review, the Medication Administration Record failed to reflect documentation Resident #1 was re-weighed to ensure accuracy of the 9/29/25 weight. An Advanced Practice Registered Nurse (APRN) note dated 10/1/25 identified she was requested by nursing to evaluate Resident #1 for weight loss, reporting Resident #1's weight was currently 129.4 pounds and directed to continue with a regular diet ground texture, encourage by mouth intake, continue working with speech therapy and continue to monitor weights. Review of the clinical record failed to identify a re-weight was obtained on Resident #1 until 10/6/25, seven (7) days after a weight loss of 26.2 pounds was documented. The weight on 10/6/25 was documented as 127.6 pounds, a two (2) pound further weight loss from the 9/29/25 weight. Review of the clinical record identified the Dietician did not follow-up with Resident #1's significant weight loss until 10/9/25, ten (10) days later. The dietary note dated 10/9/25 at 1:31 PM identified Resident #1 presented with a significant unplanned weight loss of 28 pounds loss related to decreased intake and overall decline and chronic conditions with cirrhosis of the liver (late stage liver disease characterized by scarring to the liver tissue). The note indicated the provider was aware and interventions were added and there was a pending discussion on goals of care and possible transition to hospice. The note identified Resident #1 remained at risk for malnutrition and the dietician will continue to monitor labs, intakes, mediations, skin and weights as needed. Interview with the Regional Dietician on 12/8/25 at 11:53 AM identified although the dietician was responsible for tracking weights for residents at risk for weight loss, they do not implement any new interventions or meet with the resident until the weight was confirmed as accurate and the 9/29/25 weight on Resident #1 was not confirmed with a re-weight until 10/6/25. The Regional Dietician stated the facility did not have a policy on re-weights and was unable to identify when a re-weight should have been obtained on Resident #1 after the significant weight loss was documented on 9/29/25. Interview with the APRN on 12/8/25 at 12:15 PM identified weights should have been obtained weekly on Resident #1 per physician's orders and a re-weight should have been obtained within one (1) day of the documented significant weight change on 9/29/25 to confirm the accuracy. Interview with a charge nurse, Licensed Practical Nurse (LPN) #1, on 12/8/25 at 2:15 PM identified that