

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 07/14/2026
NAME OF PROVIDER OR SUPPLIER Complete Care at Harrington Court		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0697 Level of Harm - 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 documentation, facility policy, and staff interviews for one (1) of three (3) sampled residents (Resident #1) reviewed for suicidal ideation, the facility failed to ensure that when Resident #1 continued to experience pain after administration of scheduled analgesics, licensed nursing staff assessed the ongoing pain and implemented available interventions, including review of the Medication Administration Record (MAR) and timely administration of ordered PRN pain medication. As a result, Resident #1's pain remained unrelieved, contributing to the escalation of distress and self-harm behaviors. The findings include:Resident #1's diagnoses included nondisplaced oblique fracture of the shaft of the right femur (a diagonal break in the thighbone that remains aligned), periprosthetic fracture around internal prosthetic right hip joint (broken bone that occurs in the area surrounding a surgically implanted joint), pain due to internal orthopedic prosthetic devices (hardware), major depressive disorder, bipolar disorder with mild depression and anxiety disorder.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had moderately impaired cognition (Brief Interview for Mental Status (BIMS) score of 11), and required setup assistance for eating, bed mobility and transfers and was independent with ambulation.The Resident Care Plan (RCP) dated 6/9/26 identified Resident #1 exhibited or was at risk for alterations in comfort related to a periprosthetic fracture of the right hip. Interventions included utilizing the pain scale, medicating the resident as ordered for pain, monitoring for effectiveness and side effects and reporting to the provider as needed.A nurse's note by RN #4 dated 6/9/26 at 3:02 PM identified, in part, Resident #1 was readmitted to the facility with a diagnosis of a periprosthetic fracture around internal prosthetic of the right hip joint. Two (2) dressings were intact to the right hip with an order for dressings to stay in place for seven (7) to ten (10) days. Resident #1 arrived with a foley catheter for urinary retention (inability to fully or partially empty the bladder). Acetaminophen and tramadol were ordered for pain.A physician's order dated 6/9/26 directed to administer acetaminophen 325 milligrams (mg), give two (2) tablets by mouth every eight (8) hours for pain for fourteen (14) days.A physician's order dated 6/9/26 directed to administer tramadol 100 mg, give one (1) tablet by mouth every six (6) hours as needed for severe pain for fourteen (14) days.The facility Accident and Investigation (A & I) form dated 6/13/26 identified at 4:51 AM Resident #1 was found with a sheet wrapped around his/her neck, witnessed by both RN #1 and LPN #1. The on-call provider was notified, and Resident #1 was transferred to the Emergency Department (ED) for evaluation. Prior to the incident, Resident #1 was confused and complained of pain.A Situation, Background, Assessment and Recommendation (SBAR) note by RN #1 dated 6/13/26 at 4:51 AM identified Resident #1 had a change in condition related to behavioral symptoms, was a danger to self and/or others and was experiencing pain. Resident #1's behavior seemed to be in response to pain, but to err on the side of caution, Resident #1 was transferred to the ED for evaluation by a psychiatric provider.Review of the (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 075253	Facility ID: 075253 If continuation sheet Page 1 of 5

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Medication Administration Record (MAR) identified prior to the 6/13/26 incident, Resident #1 was administered scheduled acetaminophen at 12:00 AM by LPN #1. The administration did not require subsequent evaluation of the effectiveness of the acetaminophen. Additionally, the MAR identified Resident #1 was administered Tramadol 100 mg at 3:38 AM, however, the Controlled Substance Disposition form for tramadol 50 mg tablets dated 5/20/26 identified one (1) 50 mg tablet was borrowed for Resident #1 on 6/13/26 at 4:00 AM, despite a physician's order for tramadol 100 mg. Review of the clinical record dated 6/13/26 failed to identify documentation regarding pain or interventions offered or administered. Interview with Resident #1 on 7/13/26 at 11:39 AM identified he/she was slightly confused on 6/13/26 and recalled having severe pain to the right leg and groin with no relief which caused him/her to tie a sheet around his/her neck for relief. Interview with NA #1 on 7/13/26 at 12:20 PM identified on 6/12/26, Resident #1 started to ring the call bell and complain of pain at around 11:50 PM. NA #1 notified LPN #1 immediately and repositioned Resident #1 several times with the assistance LPN #1 but Resident #1 remained awake and continued to ring the call bell numerous times complaining of pain and discomfort. Interview with RN #1 on 7/13/26 at 1:45 PM identified LPN #1 notified her just before 4:00 AM on 6/13/26 that Resident #1 had been complaining of pain. Resident #1 reported issues with urinating and feeling as if something was stuck in his/her rectum. RN #1 assessed Resident #1's abdomen, which was not distended, but Resident #1 yelled out and grimaced on palpation. LPN #1 reported a bladder scan yielded fifteen (15) milliliters (mL) of urine. RN #1 reviewed the MAR and confirmed PRN tramadol was available. She helped LPN #1 locate the tramadol but could not recall where it was obtained and identified if it were not sent from the pharmacy for Resident #1, it should have been obtained from the Pyxis (automated medication dispensing machine of an emergency stock of medications). When they returned to Resident #1's room with the tramadol, Resident #1 had a sheet tied around his/her neck and stated, If you care, take it down, but if not, then leave it. Resident #1 had no apparent injuries, was placed on one-to-one observation, was administered the PRN tramadol, and sent to the ED for evaluation. RN #1 identified Resident #1 appeared to attempt self-harm to draw attention to his/her pain. She was unaware Resident #1 had been complaining of pain since around 11:50 PM and identified LPN #1 should have medicated Resident #1 with PRN tramadol within one (1) hour of the acetaminophen administration when pain was unrelieved. Interview with LPN #1 on 7/13/26 at 3:19 PM identified on 6/12/26 at around 11:50 PM, Resident #1 began complaining of groin pain. She administered the scheduled acetaminophen at 12:00 AM on 6/13/26. After 45-60 minutes, Resident #1 rang the call bell again and continued to complain of pain. LPN #1 performed a bladder scan, which identified 15 mL of urine in the bladder. Resident #1 appeared to be in pain and seemed confused so was repositioned without effect. LPN #1 reported she did not notify RN #1 of the ongoing pain until around 3:30 AM. She was unaware that Resident #1 had a PRN tramadol order. She acknowledged she should have reviewed the MAR when the pain was unrelieved after the acetaminophen administration and repositioning, and that she should have administered the PRN tramadol. She identified she was busy that shift and notified RN #1 when she got the chance. LPN #1 could not recall where the tramadol was obtained from. Interview with the DON on 7/14/26 at 10:24 AM identified LPN #1 should have reviewed the MAR and administered PRN tramadol within one (1) hour of the acetaminophen administration when pain remained unrelieved. Licensed nurses were required to follow physician's orders and administering the incorrect dose of tramadol was a medication error. LPN #1 should have ensured Resident #1 was administered tramadol 100 mg as the order directed. Completing a pain assessment within 1-hour of administering the scheduled acetaminophen and administering the PRN tramadol timely following the continued pain and per physician's order may have prevented the self-harm incident. Interview with (continued on next page)		

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F 0697 Level of Harm - Actual harm Residents Affected - Few	APRN #1 on 7/14/26 at 10:47 AM identified following the administration of pain medication, a resident should be reevaluated for pain within the hour. If a PRN medication is available, the pain level should be assessed and documented and the medication should be administered as soon as able. Licensed staff are responsible for following physician's orders and administering the correct dose as ordered. Review of the Pain Management policy dated 9/1/24 directed, in part, staff must identify when pain is present or anticipated, evaluate pain at admission and with any change in condition, and use both verbal and non-verbal indicators to recognize discomfort. Once pain is identified, the licensed nurse is responsible for timely assessment, documentation, and implementation of appropriate interventions consistent with the resident's care plan, professional standards of practice, and the resident's goals. Licensed nurses are to use appropriate pain assessment tools; gather detailed information on the resident's pain history, characteristics, precipitating factors, and impact on quality of life; review prescribed pain medications, including PRNs, and administer them as ordered when pain is not controlled; reassess pain within one hour after administering pain medication, document effectiveness, and revise treatment as needed; notify the provider when pain remains uncontrolled and ensure correct dosing of all analgesics, including opioids. When pain persists or worsens, staff are to reassess, document findings, and adjust the care plan or medications accordingly. Failure to follow the physician's orders for PRN pain medication or failure to reassess within the required time frame places the resident at risk for unmanaged pain, decreased quality of life, and behavioral or psychosocial decline.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for one (1) of three (3) sampled residents (Resident #1) reviewed for behaviors, the facility failed to ensure controlled substances were obtained, stored, and administered according to policy and federal requirements. Specifically, staff borrowed a controlled substance from another resident's supply and failed to administer the controlled medication according to the physician's order. The findind include:Resident #1's diagnoses included nondisplaced oblique fracture of the shaft of the right femur, periprosthetic fracture around the internal prosthetic right hip joint, pain due to internal orthopedic prosthetic devices, major depressive disorder, bipolar disorder with mild depression, and anxiety disorder.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had moderately impaired cognition (Brief Interview for Mental Status (BIMS) score of 11), required setup assistance for eating, bed mobility, and transfers, and was independent with ambulation.The Resident Care Plan (RCP) dated 6/9/26 identified Resident #1 exhibited or was at risk for alterations in comfort related to a periprosthetic fracture of the right hip. Interventions included medicating the resident as ordered, reviewing pain medications, and monitoring for effectiveness.A physician's order dated 6/9/26 directed tramadol 100 milligrams (mg), give one (1) tablet by mouth every six (6) hours as needed for severe pain.Review of the Medication Administration Record (MAR) identified Resident #1 was administered tramadol 100 mg at 3:38 AM on 6/13/26 by LPN #1.Review of the Controlled Substance Disposition form for Resident #6's tramadol 50 mg tablets dated 5/20/26 identified one (1) 50 mg tablet was borrowed for Resident #1 on 6/13/26 at 4:00 AM, despite Resident #1 having a physician's order for tramadol 100 mg. The disposition form was signed by RN #1 and LPN #2.Interview with RN #1 on 7/13/26 at 1:45 PM identified medications are to be administered per physician's orders. RN #1 reported helping LPN #1 locate tramadol for Resident #1 but could not recall where it was obtained, adding that if it was not sent from the pharmacy for Resident #1, it should have been obtained from the Pyxis.Interview with LPN #1 on 7/13/26 at 3:19 PM identified she could not recall where the tramadol was obtained and stated that if the medication was not available in Resident #1's supply, it should have been accessed from the Pyxis, though she reported she had difficulty accessing the Pyxis on 6/13/26. LPN #1 acknowledged that controlled medications must be administered according to the physician's order.Interview with the Director of Nursing (DON) on 7/14/26 at 10:24 AM identified that controlled substances are not to be borrowed from another resident's supply and must be obtained through approved systems such as the Pyxis. The DON identified she learned on 7/14/26 that both RN #1 and LPN #1 were unable to access the Pyxis on 6/13/26 and instead borrowed tramadol from Resident #6. The DON stated LPN #1 should have ensured Resident #1 received tramadol 100 mg as ordered.Interview with APRN #1 on 7/14/26 at 10:47 AM identified licensed nurses are responsible for following physician's orders and administering controlled substances in the correct dose.Review of the Controlled Substance Administration & Accountability policy dated 7/1/24 directed that controlled substances are to be stored securely, obtained only through approved dispensing systems, documented accurately, and administered exactly as ordered. Borrowing controlled substances from another resident's supply and administering a dose different from the physician's order does not comply with facility policy or federal requirements.		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **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 were reviewed for behaviors, the facility failed to ensure targeted behavior monitoring was initiated for an anti-psychotic medication. The findings include: Resident #1's diagnoses included major depressive disorder, bipolar disorder with mild depression and anxiety disorder. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had moderately impaired cognition (Brief Interview for Mental Status (BIMS) score of 11), required setup assistance for eating, bed mobility and transfers and was independent with ambulation. The Resident Care Plan (RCP) dated 6/9/26 identified Resident #1 had the potential for changes in mood, behavior and psychosocial well-being due to a history of alcohol abuse, depression and was recently widowed. Interventions included administering medication per order, monitoring for therapeutic effects and side effects of medications and completing behavior monitoring. A physician's order dated 6/9/26 directed to complete generic behavior monitoring every shift. The facility Accident and Investigation (A & I) form dated 6/13/26 identified at 4:51 AM Resident #1 was found with a sheet wrapped around his/her neck, witnessed by both RN #1 and LPN #1. The on-call provider was notified, and Resident #1 was transferred to the Emergency Department (ED) for evaluation. Prior to the incident, Resident #1 was noted to be confused and complaining of pain. A psychiatric APRN note by APRN #2 dated 6/15/26 identified she was asked to see Resident #1 urgently following return from the Emergency Department (ED) after an emergent hospitalization for psychiatric concerns. Resident #1 reported continued delusions and at times, hallucinations, which primarily occurred in the evening. Resident #1 also reported mood lability as well as having a hard time getting ahold of his/her emotions at times. Recommendations included starting Seroquel 25 milligrams (mg) daily at bedtime for delusions and visual hallucinations and monitoring for change of mood, appetite and sleep. A physician's order dated 6/15/26 directed to administer Seroquel 25 mg, give one (1) tablet by mouth at bedtime for bipolar disorder, visual disturbances and hallucinations. Review of physician's orders from 6/15/26 through 7/13/26 failed to identify that targeted behavior monitoring was initiated to include delusions and visual hallucinations. Interview with the DON on 7/13/26 at 2:25 PM identified upon initiation of antipsychotic medications, targeted behavior monitoring is to be completed every shift while the medication is utilized. For Resident #1 the targeted behaviors for the Seroquel should have included monitoring for delusions and visual hallucinations. She was unsure why an order for the targeted behaviors was not initiated when the new order for the Seroquel was entered, reporting it must have been missed. Review of the Use of Psychotropic Medications policy dated 4/1/25 directed, in part, that psychotropic medications are to be used only when clinically indicated and after appropriate non-pharmacological interventions have been considered or attempted, unless contraindicated. Ongoing behavior monitoring by requiring assessment of the resident's physical, behavioral, mental, and psychosocial signs and symptoms before initiating, changing, or discontinuing medication. The policy further requires continuous monitoring and documentation of the resident's response to treatment, including progress toward treatment goals, the presence or absence of adverse effects, and regular physician, nursing, pharmacist, and interdisciplinary reviews to ensure medications remain appropriate, effective, and used at the lowest effective dose.		