STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075279	A. Building B. Wing	05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Kimberly Hall North	1 Emerson Dr Windsor, CT 06095

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41223 Based on clinical record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #1) reviewed for abuse or neglect, the facility failed to ensure staff comments within hearing of the resident were with respectful. The findings include: Resident #1 was admitted with diagnoses that included loss of movement on both sides of the body after a stroke, dementia. A quarterly MDS assessment dated [DATE] identified Resident #1 had severe cognitive impairment and sometimes understood others. The RCP dated 3/28/2024 identified Resident #1 had impaired communication due to cognitive loss and dementia. Interventions directed to explain all procedures one step at a time and the reason for performing care, speak clearly and slowly while making eye contact and use short phrases that required yes or no answers. A facility grievance form dated 4/18/2024 identified Resident #1's conservator had questioned a comment made by a MD #1 observed on room video. The grievance indicated on 4/22/2024 the results of the investigation were provided to the family member and indicated MD #1 was not speaking to Resident #1 when he made the comments but was discussing with staff about the signage that was posted in the room. The form indicated staff education was provided regarding resident rights and dignity, professional conduct and language, and details of the situation regarding the signage in the room. Resident #1's conservator requested MD #1 no longer be assigned to care for Resident #1, agreed that MD #1's comments did not reference Resident #1, and was satisfied with the results of the investigation. Interview with the Administrator on 5/8/2024 at 10:56 AM identified that on 4/17/2024, Resident #1's conservator reported MD #1 made a comment when in Resident #1's room. The Administrator reviewed the room video and initiated a grievance. The Administrator stated a sign posted in the room that informed staff a camera was in use in the room, and blocking or obstructing the camera would result in discipline. MD #1 was observed to read the sign and spoke to someone out of view of the camera (out of the resident's view); the comment included a reference to getting a trashing or spanking in regard to the discipline verbiage on the sign and staff nearby laughed at MD #1's comment. The Administrator stated MD #1's comments were unprofessional and should not have been made in a resident's room. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and facility documentation review with MD #1 on 5/8/2024 at 11:00 AM identified on 4/17/2024 as he was about to provide care for Resident #1, he noticed signage on the back wall of the room near the foot of Resident #1's bed. The sign had information about the room camera and referenced discipline for staff if the camera was covered and MD #1 indicated he found the sign offensive. MD #1 stated he turned and addressed Person #1 (vendor) who was in the hallway outside the room and commented to him about the sign, what were they going to do, would it be a thrashing or a spanking. MD #1 further indicated that he thought the sign was inappropriate towards the staff and realized that he should not have made the comment in a resident room. MD #1 stated after the comments were made, he provided care for Resident #1 with no unusual behaviors noted. The DON was unavailable for interview during the survey, Review of the facility Residents [NAME] of Rights Policy dated 5/2021 directed in part, that residents have the right to be treated with respect and dignity. Review of facility documentation identified staff education was initiated on 4/17/2024 regarding professional conduct, language, resident respect and dignity, and the sign posted in Resident #1's room, with audits and a QAPI meeting was held on 4/18/2024. Based on review of facility documentation, no additional incidents were identified, and past non-compliance was identified.

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 41223 Based on clinical record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #2) reviewed for abuse, the facility failed ensure the resident was free from mistreatment. The findings include: Resident #2 was admitted with diagnoses that included anxiety, and major depression. A quarterly MDS assessment dated [DATE] identified Resident #2 was alert and oriented and was independent for ambulation. The RCP dated 8/9/2022 identified Resident #2 as at risk for distressed, fluctuating mood due to sadness, depression and anxiety caused by family discourse and estrangement. Interventions directed to monitor for behavior changes, to provide empathy, support and to encourage Resident #2 to seek support from staff for distressed mood. A facility investigation report dated 9/1/2022 at 8:30 AM identified an allegation of staff to resident abuse without injury. Resident #2 reported that NA #1 told him/her they were a troublemaker and that's why he/she was here. NA #1 was placed on administrative leave pending investigation. The facility investigation summary dated 9/10/2022 identified NA #1 had a disagreement about the linen hamper with Resident #1 on 9/1/2022 at 7:10 AM. Later that morning NA #1 heard Resident #1 having a conversation with NA #2 in the hallway and walked up to NA #2 and Resident #2 and accused Resident #2 of telling lies about NA #1. NA #1 later approached Resident #2 when he/she was talking to LPN #1 and NA #1 alleged Resident #2 of making things up to cause trouble. NA #1 then addressed Resident #2 stating This is why you are here because you are a troublemaker. The summary further indicated due to the results of the investigation, NA #1's employment was terminated. Interview with NA #1 on 5/8/2024 at 12:19 PM identified on 9/1/2022 at about 8:15 AM during a conversation with Resident #2, Resident #2 indicated NA #2 would not let him/her put dirty linen in the facility and NA #2 approached them saying that Resident #1 was lying and making stuff up. NA #1 tried to explain to NA #2 what they were talking about, but NA #2 walked away. Resident #1 started to cry saying that NA #1 had told Resident #1 that because Resident #1 had tried to run away, her/his family had placed Resident #1 in the facility. Resident #1 then went over to LPN #1 who was at the medication cart and began to tell LPN #1 what he/she had just reported to NA #1. Interview with LPN #1 on 5/8/2024 at 1:00 PM identified about 8:30 AM Resident #1 came to speak with LPN #1. Resident #1 was crying, saying that NA #1 told her Resident #2 that he/she was a liar. As LPN #1 began to ask Resident #1 what happened, NA #1 approached and told Resident #1 to stop lying and told Resident #1 that he/she was a liar and that was why he/she was placed at the facility. LPN #1 then directed NA #1 to the nurse's station, notified the supervisor, and she escorted Resident #1 to his/her room and provided support. LPN #1 indicated NA #1 was sent home. LPN #1 stated NA #1 should not have made the comments to Resident #1 and did not know why NA #1 acted that way. Facility documentation review and interview with RN #1 on 5/8/2024 identified the facility investigation of the incident on 9/1/2022 substantiated the allegation of abuse and NA #1's employment was terminated. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility Abuse, Neglect and Misappropriation Policy dated 5/2021, directed in part, verbal abuse means the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents. Metal abuse is defined as humiliation and harassment. The Policy further directed that residents would be free from abuse.