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	02/04/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47826 Based on clinical record reviews, facility documentation, facility policies and interviews for one (1) of three (3) sampled residents (Resident #1) who were reviewed for a fall, the facility failed to ensure the hallway was free of environmental hazards to prevent a resident from tripping which resulted in the resident falling and sustaining a laceration to the lip. The findings include: Resident #1's diagnoses included Alzheimer's Disease and abnormal gait and mobility. The physical therapy discharge summary dated 7/13/24 identified Resident #1 was independent with transfers and ambulating. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 was unable to complete the Brief Interview for Mental Status indicating poor memory recall and was independent with transfers and ambulating. The Resident Care Plan dated 10/22/24 identified Resident #1 was at risk for falls due to dementia. Interventions directed to keep areas clutter free and provide handheld assistance of one (1) when redirecting. The nurse's note dated 1/14/25 at 1:45 PM identified the Unit Manager, Registered Nurse (RN) #1, assessed Resident #1 in response to a staff member's observation at 11:30 AM on 1/14/25 of Resident #1 tripping on a cord in the hallway and falling forward. The note identified Resident #1 had a moderate amount of bleeding from the inner lower lip and gums which stopped when pressure was applied. The Advanced Practice Registered Nurse (APRN) was present to assess Resident #1 and directed to transfer Resident #1 to the Emergency Department (ED) for further evaluation and treatment. The nurse's note dated 1/16/25 at 3:30 PM identified Resident #1 returned to the facility with three (3) dissolvable sutures to the inner lip, a CT scan of the head and spine and an x-ray of the pelvis and bilateral femurs were conducted and were negative and a physical therapy evaluation was ordered. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The hospital record dated 1/16/25 identified Resident #1's lower lip laceration measured two (2) centimeters (cm) long by three (3) cm deep and was repaired with three (3) sutures and a physical therapy evaluation identified Resident #1 initially ambulated with handheld assistance and then progressed to stand by assist only. Review of the summary report dated 1/17/25 indicated on 1/14/25 a 7AM-3PM nurse aide witnessed Resident #1 ambulating independently in the hallway and although there were caution signs placed around the electrical cord Resident #1 tripped over the cord falling forward. Interview with the Unit Manager, RN #1, on 2/4/25 at 11:40 AM identified she responded when Resident #1 had fallen on 1/14/25. RN #1 identified she noted there were four (4) wet floor caution signs placed in the hallway, an electrical cord was running across the hall in the vicinity of where Resident #1 fell and housekeeping staff (Housekeeper #1) was in the vicinity of the area. RN #1 identified Resident #1 was independent with ambulating and staff would hold Resident #1's hand if the resident needed redirection. Interview with the housekeeper, Housekeeper #1, on 2/4/25 at 12:15 PM identified on 1/14/25 he was buffing individual resident rooms and had plugged the cord to the machine in a hallway outlet, he had placed four (4) wet floor signs in the hallway and was going back and forth across the hall to the different rooms. Housekeeper #1 indicated the electrical cord was running across the hallway and when he was in one of the rooms, he heard one of the signs fall, he proceeded to go out into the hall and found Resident #1 lying on the ground. Housekeeper #1 indicated going forward the cord will be plugged in an outlet in the individual resident rooms. An interview with the Director of Housekeeping on 2/4/25 at 12:20 PM identified the facility safety policy for floor cleaning directed to keep machines that are required to be plugged into an outlet on the side of the hallway the staff is working on to prevent a tripping hazard. The Director of Housekeeping indicated Resident #1 tripped and fell over the cord because the cord was running across the hall. The Director of Housekeeping identified she provided an in-service to staff on 6/11/24 on this topic and Housekeeper #1 was present at that in-service. Review of facility policy for Floor Care identified, in part, not to stretch any equipment cords across any open common areas in a manner that creates an unnecessary trip hazard.