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	06/27/2025

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 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. (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 0600 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 review of the clinical record, facility documentation, facility policy, and interviews for one (1) of three (3) residents (Resident #1) reviewed for abuse, the facility failed to ensure that a resident, who was being fed by facility staff, was free from abuse. The findings include:Resident #1 had diagnoses that included dementia, dysphagia oropharyngeal phase, mood disorder, lack of coordination, and difficulty walking.The Resident Care Card dated 5/1/2025 directed to assist or feed Resident #1 at mealtimes as needed, provide slow approach and cues while feeding, encourage Resident #1 to consume all fluids during meals, and if Resident #1 becomes combative or resistive, postpone care/activity and allow h/her time to regain composure, and redirect as necessary. Physician's orders dated 5/9/2025 directed to provide a regular dysphagia puree texture diet with nectar thick liquids. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had short-term and long-term memory impairment, severely impaired cognitive skills for daily decision making, was frequently incontinent of bowel and bladder, dependent on staff for all ADLs including eating, bed mobility, and transfers, was non ambulatory and dependent on staff for mobility in the wheelchair.The Resident Care Plan (RCP) dated 5/30/2025 identified Resident #1 was at risk for a decreased ability to perform ADLs. Interventions directed to provide assistance for eating as needed, provide slow approach and cues while feeding, Resident #1 could be resistive to care at times and nursing staff should re-approach Resident #1 for breakfast and dinner after 1st attempt. Review of the documentation survey report dated 6/3/2025 for the 7:00 A.M. to 3:00 P.M. shift identified NA #1 signed off the eating task at 8:00 A.M. and at 12:00 P.M. indicating the tasks were completed. Interview with Person #1 on 6/27/2025 identified video footage dated 6/3/2025 at approximately 9:30 A.M. identified Resident #1 being fed breakfast by NA #1. Person #1 gave consent for the video footage to be viewed by facility staff. Interview and review of the video footage on 6/27/2025 at 9:50 A.M. with the Director of Nursing (DNS), Administrator, RN #1 (regional nurse), and RN #4 (Regional Director of Clinical) identified during the breakfast meal NA #1 was sitting in a chair spoon feeding Resident #1, and as NA #1 puts the spoon towards Resident #1's mouth, Resident #1 put h/her hands up in attempt to block h/her face. NA #1 moved Resident #1's hands away and proceeded to place a spoonful of oatmeal into Resident #1's mouth. NA #1 stood up with the spoon still in the Resident #1's mouth while pushing the spoon further into Resident #1's mouth causing Resident #1's head to jerk to the right. NA #1 stated to Resident #1 stop kicking, I am done, although in the video footage, Resident #1 was not kicking. NA #1 then threw the spoon on the meal tray, placed the plastic cover on the oatmeal, and left the room. The DNS identified that when NA #1 started to feed Resident #1 and Resident #1 put h/her hands up, NA #1 should have stopped feeding Resident #1, tried to redirect Resident #1, gave Resident #1 time, and then reapproached Resident #1. An interview with RN #1 (regional nurse) on 6/27/2025 at 11:01 A.M. identified that based on the video footage dated 6/3/2025, NA #1's actions toward Resident #1 could not be rebutted. RN #1 indicated NA #1 would be terminated for mistreating Resident #1. Subsequent to viewing the video footage dated 6/3/2025 the DNS and Administrator identified they would initiate a class B accident and incident report with an event type of staff to resident abuse without injury and NA #1 was suspended pending the outcome of the investigation. Although attempted, interviews with LPN #1 and NA #1 were not obtained. Review of facility Abuse, Neglect, and Exploitation policy dated 7/1/2024; in part, identified the facility will provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, abuse means the willful infliction of injury, intimidation resulting in physical harm, pain or mental anguish which can include staff to resident abuse, and employees receive annual training through planned in-services and as needed.

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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	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **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) residents (Resident #1) reviewed for abuse, the facility failed to ensure interventions were implemented for a resident who is dependent on staff for eating. The findings include:Resident #1 had diagnoses that included dementia, dysphagia oropharyngeal phase, mood disorder, lack of coordination, and difficulty waking.The Kardex Report dated 5/1/2025 directed to assist or feed Resident #1 at mealtimes as needed, provide slow approach and cues while feeding, encourage Resident #1 to consume all fluids during meals, and if Resident #1 becomes combative or resistive, postpone care/activity and allow h/her time to regain composure, and redirect as necessary. The physician's orders dated 5/9/2025 directed to provide a regular dysphagia puree texture diet with nectar thick liquids. The quarterly [NAME] Data Set (MDS) dated [DATE] identified Resident #1 had short-term and long-term memory impairment (not capable of completing a brief interview for mental status exam), severely impaired cognitive skills for daily decision making, was frequently incontinent of bowel and bladder, dependent on staff for all ADLs, including eating, bed mobility, and transfers, was non ambulatory and dependent on staff for mobility in the wheelchair.The Resident Care Plan dated 5/30/2025 identified Resident #1 at risk for decreased ability to perform ADLs. Interventions directed to provide assist for eating as needed, provide slow approach and cues while feeding, Resident #1 can be resistive at care at times, nursing should re-approach Resident #1 for breakfast and dinner after 1st attempt. Interview and review of the video footage on 6/27/2025 at 9:50 A.M. with the Director of Nursing (DNS), Administrator, Registered Nurse (RN#1 regional nurse), and RN #4 (Regional Director of Clinical) identified the date of the video was 6/3/2025 which showed NA #1 sitting in a chair feeding Resident #1 with a spoon as NA #1 puts the spoon towards Resident #1's mouth Resident #1 put h/her hands up in attempt to block h/her face, NA #1 moved Resident #1's hands away, proceeded to place a spoonful of oatmeal into Resident #1's mouth, NA #1 stood up with the spoon still in the Resident #1's mouth pushing the spoon further into Resident #1's mouth causing Resident #1's head to jerk to the right NA #1 stated to Resident #1 stop kicking I am done, although in the video footage Resident #1 was not kicking, NA #1 then throws the spoon on the meal tray, places the plastic cover on the oatmeal, and leaves the room. The DNS identified on 6/3/2025 when NA #1 started to feed Resident #1 the resident put h/her hands up NA #1 should have stopped feeding Resident #1, tried to redirect Resident #1, and gave Resident #1 time, and then reapproached Resident #1. Although attempted, interviews with LPN #1 and NA #1 were not obtained. Review of the facility Comprehensive Care plan policy dated 4/1/2025; in part, identified the facility will develop and implement a comprehensive person-centered care plan for each resident to meet a resident's medical, nursing, and mental psychosocial needs to meet professional standards of quality.