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	07/29/2025

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 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. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0550 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 ADL's, the facility failed to ensure a resident who was dependent on staff for feeding was fed in a dignified manner. The findings include:Resident #1 had diagnoses that included dementia, dysphagia oropharyngeal phase, mood disorder, lack of coordination, and difficulty walking. 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, transfers, was non ambulatory, dependent on staff for mobility in the wheelchair, and on a mechanically altered diet.The Resident Care Plan (RCP) dated 5/30/2025 identified Resident #1 was at risk for impaired swallowing related to dementia. Interventions directed to provide dysphagia puree consistency diet as ordered, sit upright for all oral intake and medications, feed slowly, small bites/sips via cup, alternate liquids and solids, if coughing occurs no food/liquids until coughing resolves, and monitor for signs and symptoms of aspiration coughing during/after meals, watery eyes, choking, moist sounding voice, or increased temperature.The Resident Care Card directed to assist or feed Resident #1 at mealtimes, provide slow approach and cues while feeding, provide a dysphagia puree consistency diet with nectar thick liquids, if coughing occurs no food/liquids until coughing resolves, and monitor for signs and symptoms of aspiration, coughing during/after meals, watery eyes, choking, moist sounding voice, feed slowly small bites/sips, alternate liquids and solids.Review of the documentation survey report dated 7/12/2025 for the 7:00 A.M. to 3:00 P.M. shift identified NA #1 signed off the eating task at 1:00 P.M. indicating the task was completed. Interview with Person #2 on 7/12/2025 at 9:56 A.M. identified video footage dated 7/12/2025 at approximately 9:40 A.M. captured Resident #1 being fed breakfast by NA #1. Person #2 identified h/she sent the video footage to the facility on 7/13/2025. Review of the one-minute video footage on 7/29/2025 identified the video was dated 7/12/2025 during the breakfast meal. NA #1 was sitting in a chair spoon feeding Resident #1. NA #1 proceeded to place a full spoonful of oatmeal with a piece of scrambled egg to Resident #1's lips then partially inserted the spoon into Resident #1's mouth. NA #1 stated to Resident #1 open with the spoon still at Resident #1's mouth, Resident #1 lifted h/her left hand and moved it towards h/her mouth. NA #1 took the spoon away from Resident #1's mouth. NA #1 then opened a sugar packet, added it to the oatmeal, and stirred it slightly. NA #1 took the bowl of oatmeal placed it under Resident #1's chin and stated to Resident #1 try this one. NA #1 proceeded to put two heaping spoonful's of oatmeal into Resident #1's mouth with oatmeal dripping off the spoon onto Resident #1's chin. NA #1 used the spoon to remove the oatmeal from Resident #1's chin and stated, you doing good, then proceeded to place another heaping spoonful of oatmeal into Resident #1's mouth.Interview with NA #1 on 7/29/2025 at 11:16 A.M. identified prior to 7/12/2025 she received education on feeding residents and passed the competency titled Feeding the Resident. NA #1 identified that on 7/12/2025 she was aware Resident #1 needed to be fed slowly and did not realize how fast she was feeding Resident #1. NA #1 identified she should have ensured Resident #1 swallowed each spoonful of oatmeal before inserting an additional spoonful into Resident #1's mouth. Interview with the DNS on 7/29/2025 at 12:35 P.M. identified that based on video footage dated 7/12/2025, NA #1 was feeding Resident #1 too fast. The DNS identified that staff should feed residents slowly and ensure the resident swallows food in their mouth before feeding another spoonful of food. The DNS identified that NA #1 should have paused between each spoonful of oatmeal and not fed Resident #1 one spoonful after another.Review of the facility's Resident Rights policy dated 7/1/2024; in part, identified the resident has the right to a dignified experience.

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. (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 0726 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 ADL's, the facility failed to ensure a resident who was dependent on staff for feeding, was fed using the proper feeding technique. The findings included:Resident #1 had diagnoses that included dementia, dysphagia oropharyngeal phase, mood disorder, lack of coordination, and difficulty walking.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, transfers, was non ambulatory, dependent on staff for mobility in the wheelchair, and on a mechanically altered diet.The Resident Care Plan (RCP) dated 5/30/2025 identified Resident #1 was at risk for impaired swallowing related to dementia. Interventions directed to provide dysphagia puree consistency diet as ordered, sit upright for all oral intake and medications, feed slowly, small bites/sips via cup, alternate liquids and solids, if coughing occurs no food/liquids until coughing resolves, and monitor for signs and symptoms of aspiration coughing during/after meals, watery eyes, choking, moist sounding voice, or increased temperature.The Resident Care Card directed to assist or feed Resident #1 at mealtimes, provide slow approach and cues while feeding, provide a dysphagia puree consistency diet with nectar thick liquids, if coughing occurs no food/liquids until coughing resolves, and monitor for signs and symptoms of aspiration, coughing during/after meals, watery eyes, choking, moist sounding voice, feed slowly small bites/sips, alternate liquids and solids.Review of NA #1's clinical competency validation dated 6/27/2025 on Feeding the Resident identified that NA #1 passed the Feeding the Resident competency.Review of the documentation survey report dated 7/12/2025 for the 7:00 A.M. to 3:00 P.M. shift identified NA #1 signed off the eating task at 1:00 P.M. indicating the task was completed.Interview with Person #2 on 7/12/2025 at 9:56 A.M. identified video footage dated 7/12/2025 at approximately 9:40 A.M. captured Resident #1 being fed breakfast by NA #1. Person #2 identified h/she sent the video footage to the facility on 7/13/2025. Review of the one-minute video footage on 7/29/2025 identified the video was dated 7/12/2025 during the breakfast meal. NA #1 was sitting in a chair spoon feeding Resident #1. NA #1 proceeded to place a full spoonful of oatmeal with a piece of scrambled egg to Resident #1's lips then partially inserted the spoon into Resident #1's mouth. NA #1 stated to Resident #1 open with the spoon still at Resident #1's mouth, Resident #1 lifted h/her left hand and moved it towards h/her mouth. NA #1 took the spoon away from Resident #1's mouth. NA #1 then opened a sugar packet, added it to the oatmeal, and stirred it slightly. NA #1 took the bowl of oatmeal placed it under Resident #1's chin and stated to Resident #1 try this one. NA #1 proceeded to put two heaping spoonful's of oatmeal into Resident #1's mouth with oatmeal dripping off the spoon onto Resident #1's chin. NA #1 used the spoon to remove the oatmeal from Resident #1's chin and stated, you doing good, then proceeded to place another heaping spoonful of oatmeal into Resident #1's mouth. Interview with NA #1 on 7/29/2025 at 11:16 A.M. identified prior to 7/12/2025 she received education on feeding residents and passed the competency titled Feeding the Resident. NA #1 identified that on 7/12/2025 she was aware Resident #1 needed to be fed slowly and did not realize how fast she was feeding Resident #1. NA #1 identified she should have ensured Resident #1 swallowed each spoonful of oatmeal before inserting an additional spoonful into Resident #1's mouth.Interview and review of the video footage with Speech and Language Pathologist (SLP) #1 on 7/29/2025 at 11:30 A.M. identified based on the video footage dated 7/12/2025, NA #1 was feeding Resident #1 too fast. SLP #1 identified that Resident #1 needed to be fed slowly, and NA #1 should have paused between each bite of oatmeal.Interview with the DNS on 7/29/2025 at 12:35 P.M. identified that based on video footage dated 7/12/2025, NA #1 was feeding Resident #1 too fast. The DNS identified that staff should feed residents slowly and ensure the resident swallows food in their mouth before feeding another spoonful of food. The DNS identified that NA #1 should have paused between each spoonful of oatmeal and not fed Resident #1 one spoonful after another.Review of the facility's Feeding the Resident clinical competency validation form identified; in part, the critical elements directed to offer the food in bite-size pieces, make sure the resident's mouth is empty before the next bite, and wipe food from the resident's mouth and hands as necessary.Although requested, a facility policy for feeding residents was not provided.