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	04/10/2026

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for two (2) of two (2) sampled residents (Residents #4 and #5) reviewed for abuse, the facility failed to ensure residents were protected from sexual abuse. Both residents had cognitive impairment which limited their ability to consent to or understand the interaction, and the facility failed to implement adequate supervision and interventions to prevent the incident. The findings include:1. Resident #4 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's dementia and dementia with behavioral disturbance. Resident #4's family member was Resident #4's responsible party for medical care. The Nursing admission assessment dated [DATE] identified Resident #4 was independent with bed mobility, transfers and required supervision for dressing. The Physician's orders dated 3/28/26 directed Donepezil 10 mg at bedtime for dementia, Quetiapine Fumarate 100 mg in the evening for agitation and Sertraline 150 mg once a day for depression.The Brief Mental Interview for Mental Status (BIMS) interview dated 3/30/26 identified Resident #4 scored five (5), indicative of severely impaired cognition.The Resident Care Plan (RCP) dated 3/30/36 identified Resident #4 had impaired/decline in cognitive function and impaired thought processes related to dementia. Interventions included to allow Resident #4 to make daily decisions, use verbal cues, gestures and demonstrations to assist in decision making, break down tasks to support short-term memory deficits and re-direct Resident #4 using external cues as needed.The Psychiatric Evaluation dated 3/31/26 identified Resident #4 was alert and orientated to self only with cognitive deficits evident. The Physician's order dated 4/1/26 directed Lorazepam 0.5 mg in the morning for anxiety.2. Resident #5 was admitted to the facility on [DATE] with diagnoses that included frontotemporal neurocognitive disorder and dementia. The Court of Probate document dated 4/24/25 identified Resident #5 had a conservator of person.The Physician's order dated 1/29/26 directed Venlafaxine 100 mg once a day for anxiety.The Quarterly Minimum Data Set (MDS) dated [DATE] identified Resident #5 had a Brief Mental Interview for Mental Status (BIMS) of six (6) indicative of severely impaired cognition. The Quarterly Nursing admission assessment dated [DATE] identified Resident #5 was independent with bed mobility, transfers, dressing and toileting. The Brief Mental Interview for Mental Status (BIMS) interview dated 3/30/26 identified Resident #4 scored five (5), indicative of severely impaired cognition.The Resident Care Plan (RCP) dated 2/23/26 identified Resident #5 was at risk for elopement and wandering related to cognitive impairments. Interventions included to engage Resident #5 with tailored recreation activities based on his/her interests, intervene and re-direct when wandering, exit seeking or behaviors become intrusive or affect peers, monitor and document target behaviors and divert Resident #5 by giving alternative objects or activities. The care plan further identified Resident #5 had impaired/decline in cognitive function and impaired thought processes related to dementia. Interventions included to observe and evaluate the types of changes in cognitive status and notify the physician as needed, speak in a normal-tones voice, clearly and slowly while making eye contact, stress key words and present just one thought at a time and use short phrases that require yes or no answers.The Psychiatric Evaluation dated 4/3/26 identified Resident #5 was (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	alert to self only and was unable to accurately state day, month, year. Resident #5 previously was without mood or behavior concerns since the last evaluation (3/17/26) but nursing reports increased anxiety. She identified to renew Clonazepam 0.5 mg every twelve (12) hours as needed for anxiety for fourteen days.The Physician's order dated 4/4/26 directed Clonazepam 0.5 mg every eight (8) hours as needed for increased anxiety, agitated behaviors for fourteen (14) days. The Reportable Event form by the DNS dated 4/7/26 at 10:00 AM identified Resident #4 and #5 reside on a locked dementia unit and are not responsible for themselves. Resident #5 was observed in Resident #4's room and Resident #4 and Resident #5 were lying prone in bed partially clothed. The residents were immediately separated. Skin checks were completed for both residents with no injuries noted. Resident #4 was placed on every 15-minute checks and currently remains on every 15-minute checks. Resident #5 was placed on 1:1 observation and currently remains on 1:1 observation. Resident #5's room was moved further away as they previously had close proximity to each other.Resident #4's Assessment of Resident Capacity to Consent to Sexual Activity form dated 4/7/26 identified the Social Worker and DNS met with Resident #4's family member who is Resident #4's emergency contact. Resident #4's family member did not consent to sexual activity for Resident #4 with other residents.Resident #5's Assessment of Resident Capacity to Consent to Sexual Activity form dated 4/7/26 identified the Social Worker and DNS met with Resident #5's conservator of person via the phone. No consent was given for Resident #5 to participate in sexual activity with other residents.NA #2's statement dated 4/7/26 identified on 4/7/26 she entered into Resident #4's room to feed the resident and saw Resident #4 on top of Resident #5. Resident #5's pants and undergarments were on the bottom of the bed. Resident #4's pants were open and unzipped. NA #2 immediately called for the nurse.Interview with COTA #1 on 4/9/26 at 12:18 PM identified on 4/7/26 during breakfast time, she was next door to Resident #4's room feeding a resident who just received breakfast. She could not identify the estimated time. She identified she heard ruckus in the hallway and it appeared like NA #2 needed assistance. She then went into Resident #4's room and observed Resident #4 in Resident #5's bedroom. Resident #4 had a shirt on but no pants or underwear. Resident #5 had a shirt on and his/her pants and underwear were pulled down. She identified Resident #4 was on top of Resident #5. She identified she pulled Resident #4 off Resident #5 with his/her belt on his/her pants and Resident #5 sat in his/her room chair. Resident #4 proceeded to dress him/herself and more staff arrived in the room.Interview with RN #1 on 4/9/26 at 2:30 PM identified she was the RN on the dementia unit on 4/7/26 during the 7:00 AM - 3:00 PM shift. She identified she last saw Resident #4 in the dining room for breakfast around 8:30 AM. She identified Resident #5 ate breakfast in his/her room. She identified a page was announced for the RN supervisor to the floor and went to Resident #4's room. She identified Resident #4 and Resident #5 were already separated. Resident #4 and Resident #5's were assessed and no injuries were found. Resident #4 was placed on every 15-minute checks and Resident #5 was placed on 1:1 observation.Interview with APRN #3 on 4/9/26 at 12:30 PM identified Resident #4 was alert and orientated to self but not the day, time or place. Resident #4 had no previous behavioral concerns. She identified Resident #4 did not recall the incident on 4/7/26. Resident #5 was alert and orientated to self, day, place but had severe cognitive impairments. Resident #5 had recent previous behaviors of refusal of care but no sexual disinhibition behaviors. She identified Resident #5 thought Resident #4 was someone from his/her past and they were rekindling a relationship.Interview with the Regional Clinical Nurse and DNS on 4/9/26 at 12:00 PM identified the incident occurred after breakfast, which is served from 8:30 AM - 9:00 AM. Resident #4's and Resident #5's breakfast trays were already picked up (around 9:15 AM - 9:30 AM) when NA #2 was assisting with feeding another resident when she identified Resident #4's door was closed. The estimated time between when the residents were last observed to the time of the incident (9:50 AM) is 15 - 20 minutes.Review of the Sexual Expression of Residents policy directed to respect the right of residents to express themselves sexually, as long as it does not violate the rights of other residents. The policy applies to individuals who exhibit intact cognitive decision-making capacity. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PAST NON-COMPLIANCE The facility presented a corrective action plan dated 4/7/26 which included:Staff education dated 4/7/26 to include: Policies on sexual expression, resident's rights and reporting requirements.Audits of residents on the dementia unit evaluated for any behaviors of inappropriate affection towards other residents. Audits of staff knowledge on what to do if they observe residents displaying inappropriate affection towards each other and what steps they should takeQAPI meeting was held reviewing the event and the plan of correction.The corrective action plan for past noncompliance was accepted by the state agency during an onsite visit on 4/9/26.

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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 clinical records, facility documentation/policy, and interviews for one (1) of three (3) sampled residents (Resident #1) reviewed for medication administration, the facility failed to ensure medications were administered within acceptable time frames and documented at the time of administration, resulting in a pattern of medication administration errors, including the administration of time-sensitive medications outside the facility's established one (1) hour before to one (1) hour after window. The findings included:Resident #1 was admitted to the facility in February 2024 with diagnoses which included seizure disorder, anxiety, and dementia.The comprehensive Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 as severely cognitively impaired (Brief Mental Interview for Mental Status (BIMS) score of 3) and required moderate assistance with toileting, bathing, and personal hygiene. The Resident Care Plan (RCP) dated 1/2/26 identified Resident #2 as at risk for seizure activity related to a history of seizure disorder. Interventions directed to medicate as ordered and monitor for effectiveness and side effects, and report to the physician as needed.1.A physician's order directed two (2) tablets of gabapentin, 100 milligrams, to be administered every eight (8) hours for neuropathy.A physician's order directed two (2) tablets of acetaminophen, 500 milligrams, to be administered every eight (8) hours for pain management.The March 2026 Medication Administration Report identified Resident #2 was not given his/her 2:00 PM scheduled 200 milligrams of gabapentin and 1000 milligrams of acetaminophen on 3/2/26.Interview with RN #1 (nurse supervisor of the 7:00 AM to 3:00 PM shift on 3/2/26) on 4/6/26 at 2:26 PM identified he/she administered Resident #2's 200 milligrams of gabapentin and 1000 milligrams of acetaminophen at 2:00 PM on 3/2/26, however, failed to document the medications were administered. RN #1 further identified facility policy directed staff to document medications were administered at the time they were administered.2.The following 9:00 AM scheduled medications were documented as administered to Resident #1 by RN #2 on 3/1/26 at 1:32 PM (four (4) hours and thirty-two (32) minutes past the scheduled time):-Brivaracetam Oral Solution, 10 milligrams/milliliter (for seizures)-Ferrous Sulfate, 325 milligrams (for anemia)-Baclofen, 5 milligrams (for muscle spasms)-Carvedilol, 12.5 milligrams (for hypertension)-Losartan Potassium, 50 milligrams (for hypertension)-Apixaban, 2.5 milligrams (for atrial fibrillation)-Amlodipine, 10 milligrams (for hypertension)-Duloxetine, 20 milligrams (for depression)-Senna, 8.6/50 milligrams (for constipation)-Lorazepam, 0.5 milligrams (for seizure disorder)The following 9:00 PM scheduled medications were administered to Resident #1 by RN #3 on 3/1/26 at 6:32 PM (two (2) hours and twenty-eight (28) minutes before schedule):-Brivaracetam Oral Solution, 10 milligrams/milliliter (for seizures)-Diclofenac Sodium External Gel, 1% ointment (for pain)-Baclofen, 5 milligrams (for muscle spasms)The following 9:00 PM scheduled medications were administered to resident #1 by RN #3 on 3/1/26 at 6:33 PM (two (2) hours and twenty-seven (27) minutes before schedule):-Melatonin, 5 milligrams (for insomnia)-Apixaban. 2.5 milligrams (for atrial fibrillation)-Mirtazapine, 7.5 milligrams (for depression)-Lorazepam, 0.5 milligrams (for seizure disorder)-Acetaminophen, 1000 milligrams (for pain management)The following 10:00 PM scheduled medications were administered to resident #1 by RN #3 on 3/1/26 at 6:34 PM (three (3) hours and twenty-six (26) minutes before schedule):-Gabapentin, 200 milligrams (for neuropathy)Interview with RN #2 on 4/7/26 at 10:29 AM identified he/she documented medications were administered after all his/her assigned residents were administered their medications due to issues with uploading data into the electronic medical record, requiring him/her to restart his/her computer and wait for the system to reload. RN #2 further indicated he/she would also wait until all his/her assigned residents were administered their medications before documenting they were given to avoid delayed administration due to a challenging workload. Although attempted, an interview with RN #3 was not obtained.Interview with the Director (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of Nursing Services (DNS) on 4/7/26 at 11:08 AM identified the facility's standard of practice was for medications to be administered up to one hour before to one hour after the scheduled medication administration time. The DNS further identified once medication(s) were administered to a resident, the nurse was to immediately document the administration in the resident's medical record. The Medication Administration policy directed to ensure the six rights of medication administration were followed, which included right documentation, and to sign the medication administration record after medication(s) were administered.