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	05/05/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation/policy and interviews for one (1) of three (3) sampled residents (Resident #1) reviewed for neglect, the facility failed to notify the State Agency (SA) of an allegation of neglect related to the turning and repositioning of a dependent resident with existing facility acquired pressure injuries to the posterior scalp (back of head) within two (2) hours as required. The findings include:Resident #1?s diagnoses included bilateral paralytic syndrome following cerebral infarction (a condition involving paralysis on both sides of the body due to stroke-related brain damage), type II diabetes mellitus with diabetic neuropathy (complication of diabetes, characterized by nerve damage), chronic pain syndrome, muscle weakness and anxiety disorder.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Staff Assessment for Mental Status conducted which identified short-term and long-term memory problems and severely impaired cognition. The MDS identified Resident #1 required substantial assistance for bed mobility, was dependent on staff for personal hygiene and transfers and was at risk for pressure injuries but had no current skin abnormalities.The Resident Care Plan (RCP) dated 3/26/26 identified Resident #1 was at risk for skin breakdown related to quadriplegia (paralysis affecting all four limbs and the torso) with contractures, decreased activity, impaired cognition, bowel and bladder incontinence, dependence on staff for bed mobility, transfers, and toileting and had a history of healed pressure injuries. Interventions included the use of a low air loss mattress, turning and/or repositioning and checking the skin four (4) times per shift as determined by tissue tolerance, observing skin condition daily with care and reporting abnormalities and completing a Weekly Skin Check by a licensed nurse.A nurse's note by RN #1 dated 4/7/26 at 3:00 PM identified she assessed Resident #1 in response to a concern from the responsible party (Person #4) regarding a change in skin integrity to the scalp after Person #4 had Resident #1's head shaved due to severely matted hair. The back of Resident #1's head had a cluster of five (5) lesions, including two (2) distal (farther away from the midline) lesions that were closed/resolved and of the other three (3), 2 had adherent fibrinous tissue (a yellowish moist or dry layer of necrotic material composed of dead cells and debris) covering the wounds and the other lesion had a pink wound bed. The entire cluster measured 6 centimeters (cm) by 5 cm. The surrounding scalp was unremarkable and although the wound beds were moist, there was no active drainage and Resident #1 denied pain. The severely matted hair contributed to pressure on the scalp and Person #4 planned to keep the hair length short moving forward. RN #1 educated Person #4 on caring for ethnic hair and he/she verbalized understanding. The provider was notified and a new order for calcium alginate (a highly absorbent wound dressing used for managing moderate to heavily draining wounds) to be applied to the wound bed was obtained and Resident #1 would be followed during weekly wound rounds.The wound physician note by MD #2 dated 4/10/26 identified Resident #1 was seen and evaluated for a wound to the back of the head. The posterior scalp (back of the head) wound was a full thickness cluster wound measuring 4.5 cm by 3.5 cm by 0.1 cm with twenty (20) percent (%) thick adherent devitalized necrotic tissue (dead tissue that acts as a physical barrier to healing), with no drainage and no signs and symptoms of pain or (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	infection although Resident #1 was anxious. The etiology (cause/reason) of the wounds were undetermined/unknown and the treatment plan included applying Santyl to the wound beds followed by a dry protective dressing once daily for thirty (30) days. A facility Grievance Form dated 4/12/26 by Person #4 identified there was a customer service concern regarding the repositioning and turning of Resident #1 and reported one-to-one education was provided to NA #4 for Resident #1's reposition plan of four (4) times per shift.Review of the April 2026 Documentation Survey Report identified all assigned tasks on the 11:00 PM to 7:00 AM shift on 4/11/26 were not documented, including the turning and repositioning of Resident #1.A Disciplinary Action Form identified from 4/11/26 to 4/12/26 NA #4 failed to complete assigned tasks including documentation and it was her responsibility to ensure all resident needs are met in a timely manner. NA #4 was re-educated to provide care per the RCP, frequent rounding, and completing required documentation of care provided.The wound physician note by MD #2 dated 5/4/26 identified the posterior scalp wound measured 4.8 cm by 1.2 cm by 0.1 cm and no longer required Santyl. The wound bed consisted of fifty (50) % granulation tissue (new connective tissue that forms on the surface of a wound during the healing process). Interview with Person #4 on 5/4/26 at 11:09 AM identified in 2024 he/she shaved Resident #1's head and discovered wounds to the back of the head. At that time the facility contributed the wounds to barrettes that he/she put in Resident #1's hair and was told to no longer do so. Person #4 reported there was a live camera in the room and numerous times where no one entered the room to reposition Resident #1 for over four (4) hours and suspected the wounds were caused from pressure related to Resident #1 no being repositioned.Observation of Resident #1 on 5/5/26 at 8:45 AM identified Resident #1 turned to the right side with a positioning wedge in place to the right and the head of bed elevated to approximately forty-five (45) degrees. The touch pad call-bell was hanging on the back wall, out of reach.Interview and observation of Resident #1 with NA #1 on 5/5/26 at 8:46 AM identified Resident #1's call bell hanging on the back wall out of reach. NA #1 reported she had not yet been in the room since the start of her shift because there was no help and ignored the request to place the call-bell within reach of Resident #1. NA #1 continued to pass drinks for breakfast in the hallway and did not go into Resident #1's room to replace the call-bell or reposition Resident #1.Subsequent to surveyor inquiry, at 9:08 AM (20-minutes after notification to NA #1), LPN #1 and RN #1 placed Resident #1's call bell within reach and turned and repositioned Resident #1 in bed.Interview with MD #2 on 5/5/26 at 10:24 AM identified he was initially unsure of the etiology of the wounds to the back of Resident #1's head during his 4/10/26 visit and thought they could have been malignant (chronic, non-healing skin lesions caused by cancer cells in the skin) so documented them as non-pressure wounds. Since 4/10/26 the wounds improved. The wounds would not have improved if they were malignant, therefore, there was no need to biopsy the wounds and he determined they were caused by pressure due to the back of the head location. Review of in-room camera footage with Person #4 on 5/5/26 at 1:57 PM identified staff last repositioned Resident #1 on 5/5/26 at 5:18 AM and Resident #1 was not again turned and repositioned until 9:08 AM by LPN #1 and RN #1 subsequent to surveyor inquiry (almost 4 hours later) despite the plan of care directing Resident #1 be turned and repositioned at least four (4) times per shift (every 2-hours). Person #4 reported he/she was going to immediately show the DON the 5/5/26 camera footage.Interview with the DON on 5/5/26 at 2:27 PM identified Person #4 showed her the camera footage which identified Resident #1 had not been turned or repositioned from 5:18 AM until 9:08 AM.Subsequent to surveyor inquiry, review of the Connecticut Department of Public Health Facility Licensing and Investigations Section portal on 5/6/26 failed to identify the 5/5/26 allegation of neglect by Person #4 was reported to the SA as required.Review of the Abuse, Neglect and Exploitation policy dated 7/1/24 directed, in part, the facility is to report all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: immediately, but not later than 2 hours after the allegation is made, if the events that caused the allegation involved abuse.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation/policy and interviews for one (1) of three (3) sampled residents (Resident #1) reviewed for neglect, the facility failed to ensure an allegation of neglect related to the discovery of several pressure injuries to the posterior scalp (back of head) of a dependent resident was thoroughly investigated and statements were obtained from all staff who were in contact with the resident for the prior 72 hours after the discovery of the pressure injuries. The findings include:Resident #1?s diagnoses included bilateral paralytic syndrome following cerebral infarction (a condition involving paralysis on both sides of the body due to stroke-related brain damage), type II diabetes mellitus with diabetic neuropathy (complication of diabetes, characterized by nerve damage), chronic pain syndrome, muscle weakness and anxiety disorder.A Nursing readmission assessment by RN #2 dated 3/10/26 identified a full body skin assessment was completed, skin was intact and no open areas were noted.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Staff Assessment for Mental Status conducted which identified short-term and long-term memory problems and severely impaired cognition. The MDS identified Resident #1 required substantial assistance for bed mobility, was dependent on staff for personal hygiene and transfers and was at risk for pressure injuries but had no current skin abnormalities.Weekly Skin Checks completed by RN #2 on 3/17/26 and 3/25/26 identified a skin check was performed and no skin injury/wounds were noted.The Resident Care Plan (RCP) dated 3/26/26 identified Resident #1 was at risk for skin breakdown related to quadriplegia (paralysis affecting all four limbs and the torso) with contractures, decreased activity, impaired cognition, bowel and bladder incontinence, dependence on staff for bed mobility, transfers, and toileting and had a history of healed pressure injuries. Interventions included the use of a low air loss mattress, turning and/or repositioning and checking the skin four (4) times per shift as determined by tissue tolerance, observing skin condition daily with care and reporting abnormalities and completing a Weekly Skin Check by a licensed nurse.A Weekly Skin Check by RN #2 on 4/2/26 identified a skin check was performed and no skin injury/wounds were noted.A nurse's note by RN #1 dated 4/7/26 at 3:00 PM identified she assessed Resident #1 in response to a concern from the responsible party (Person #4) regarding a change in skin integrity to the scalp after Person #4 had Resident #1's head shaved due to severely matted hair. The back of Resident #1's head had a cluster of five (5) lesions, including two (2) distal (farther away from the midline) lesions that were closed/resolved and of the other three (3), 2 had adherent fibrinous tissue (a yellowish moist or dry layer of necrotic material composed of dead cells and debris) covering the wounds and the other lesion had a pink wound bed. The entire cluster measured 6 centimeters (cm) by 5 cm. The surrounding scalp was unremarkable and although the wound beds were moist, there was no active drainage and Resident #1 denied pain. The severely matted hair contributed to pressure on the scalp and Person #4 planned to keep the hair length short moving forward. RN #1 educated Person #4 on caring for ethnic hair and he/she verbalized understanding. The provider was notified and a new order for calcium alginate (a highly absorbent wound dressing used for managing moderate to heavily draining wounds) to be applied to the wound bed was obtained and Resident #1 would be followed during weekly wound rounds.A facility Reportable Event (RE) dated 4/8/26 identified at 10:45 AM Person #4 reported a concern regarding Resident #1's hair hygiene and believed Resident #1 was neglected due to hair at the base of the scalp being knotted resulting in irritation to the scalp and back of the head. Resident #1 was a total assist of two (2) for care and transfers and a full body skin assessment was completed and no changes were noted to skin integrity. The provider and the police were notified, an investigation was initiated and an alternate style pillow was provided for better tissue tolerance.Review of the facility schedules dated 4/5/26, 4/6/26 and 4/7/26 identified RN #2, RN #4, LPN #1, LPN #4, NA #1, NA #2, NA #3, NA #4, NA #5, NA #9, NA #10, NA #11 and NA #12 had been assigned to work on Resident #1's (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	unit.Review of the facility Accident and Investigation / Incident (A & I) documents for Resident #1 failed to identify statements were obtained from RN #2, RN #4, LPN #4, NA #4 and NA #10.Interview with the DON on 5/4/26 at 1:49 PM identified the wounds discovered to the back of the head should have been investigated as an injury of unknown origin and statements should have been obtained from all staff who worked with Resident #1 and on Resident #1's unit for at least the prior 72-hours from the discovery of the wounds. She reported she reviewed the schedules and put each staff members name on blank statement sheets going back beyond 72-hours but then went on vacation, and the nursing supervisors should have ensured the statements were obtained. The DON identified she should have ensured all the statements were obtained when she returned from vacation to ensure a complete investigation, especially from RN #2 who was the nurse that completed all Weekly Skin Checks leading up to the incident. The DON was unable to produce statements from RN #2, RN #4, LPN #4, NA #4 and NA #10.Review of the Abuse, Neglect and Exploitation policy dated 7/1/24 directed, in part, an immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. Written procedures for investigations include: Identifying staff responsible for the investigation; Exercising caution in handling evidence that could be used in a criminal investigation (e.g., not tampering or destroying evidence); Investigating different types of alleged violations; Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and providing complete and thorough documentation of the investigation. Taking all necessary actions as a result if the investigation, which may include, but are not limited to, the following: Analyzing the occurrence(s) to determine why abuse, neglect, misappropriation of resident property or exploitation occurred, and what changes are needed to prevent further occurrences; Defining how care provision will be changed and/or improved to protect residents receiving services; Training of staff on changes made and demonstration of staff competency after training is implemented; Identification of staff responsible for implementation of corrective actions; The expected date for implementation; and identification of staff responsible for monitoring the implementation of the plan.

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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/policy and interviews for one (1) of three (3) residents (Resident #1) reviewed for neglect, the facility failed to ensure Resident #1 was turned and repositioned per the plan of care to prevent pressure-related skin breakdown, resulting in the development of several posterior scalp (back of head) pressure injuries. The findings include:Resident #1?s diagnoses included bilateral paralytic syndrome following cerebral infarction (a condition involving paralysis on both sides of the body due to stroke-related brain damage), type II diabetes mellitus with diabetic neuropathy (complication of diabetes, characterized by nerve damage), chronic pain syndrome, muscle weakness and anxiety disorder.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Staff Assessment for Mental Status conducted which identified short-term and long-term memory problems and severely impaired cognition. The MDS identified Resident #1 required substantial assistance for bed mobility, was dependent on staff for personal hygiene and transfers and was at risk for pressure injuries but had no current skin abnormalities.Weekly Skin Checks completed by RN #2 on 3/17/26 and 3/25/26 identified a skin check was performed and no skin injury/wounds were noted.The Resident Care Plan (RCP) dated 3/26/26 identified Resident #1 was at risk for skin breakdown related to quadriplegia (paralysis affecting all four limbs and the torso) with contractures, decreased activity, impaired cognition, bowel and bladder incontinence, dependence on staff for bed mobility, transfers, and toileting and had a history of healed pressure injuries. Interventions included the use of a low air loss mattress, turning and/or repositioning and checking the skin four (4) times per shift as determined by tissue tolerance, observing skin condition daily with care and reporting abnormalities and completing a Weekly Skin Check by a licensed nurse.A Braden Scale assessment dated [DATE] identified Resident #1 was at moderate risk for developing pressure injuries.The April 2026 Documentation Survey Report identified NA #1 gave Resident #1 a shower on 4/1/26 and documented the skin observation as Not Applicable (N/A).A Weekly Skin Check by RN #2 on 4/2/26 identified a skin check was performed and no skin injury/wounds were noted. Review of the Kardex in effect on 4/6/26 directed NA's to monitor for skin redness/irritation and report as indicated, observe skin condition daily with Activities of Daily Living (ADL) care and report abnormalities and continue to encourage every two (2) hour repositioning. A nurse's note by RN #1 dated 4/7/26 at 3:00 PM identified she assessed Resident #1 in response to a concern from the responsible party (Person #4) regarding a change in skin integrity to the scalp after Person #4 had Resident #1's head shaved due to severely matted hair. The back of Resident #1's head had a cluster of five (5) lesions, including two (2) distal (farther away from the midline) lesions that were closed/resolved and of the other three (3), 2 had adherent fibrinous tissue (a yellowish moist or dry layer of necrotic material composed of dead cells and debris) covering the wounds and the other lesion had a pink wound bed. The entire cluster measured 6 centimeters (cm) by 5 cm. The surrounding scalp was unremarkable and although the wound beds were moist, there was no active drainage and Resident #1 denied pain. The severely matted hair contributed to pressure on the scalp and Person #4 planned to keep the hair length short moving forward. RN #1 educated Person #4 on caring for ethnic hair and he/she verbalized understanding. The provider was notified and a new order for calcium alginate (a highly absorbent wound dressing used for managing moderate to heavily draining wounds) to be applied to the wound bed was obtained and Resident #1 would be followed during weekly wound rounds.A facility Reportable Event (RE) dated 4/8/26 identified at 10:45 AM Person #4 reported a concern regarding Resident #1's hair hygiene and believed Resident #1 was neglected due to hair at the base of the scalp being knotted resulting in irritation to the scalp and back of the head. Resident #1 was a total assist of two (2) for care and transfers and a full body skin assessment was completed and no (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	changes were noted to skin integrity. The provider and the police were notified, an investigation was initiated and an alternate style pillow was provided for better tissue tolerance. The wound physician note by MD #2 dated 4/10/26 identified Resident #1 was seen and evaluated for a wound to the back of the head. The posterior scalp (back of the head) wound was a full thickness cluster wound measuring 4.5 cm by 3.5 cm by 0.1 cm with twenty (20) percent (%) thick adherent devitalized necrotic tissue (dead tissue that acts as a physical barrier to healing), with no drainage and no signs and symptoms of pain or infection although Resident #1 was anxious. The etiology (cause/reason) of the wounds were undetermined/unknown and the treatment plan included applying Santyl to the wound beds followed by a dry protective dressing once daily for thirty (30) days. A facility Grievance Form dated 4/12/26 by Person #4 identified there was a customer service concern regarding the repositioning and turning of Resident #1 and reported one-to-one education was provided to NA #4 for Resident #1's reposition plan of four (4) times per shift.Review of the April 2026 Documentation Survey Report identified all assigned tasks on the 11:00 PM to 7:00 AM shift on 4/11/26 were not documented, including the turning and repositioning of Resident #1.A Disciplinary Action Form identified from 4/11/26 to 4/12/26 NA #4 failed to complete assigned tasks including documentation and it was her responsibility to ensure all resident needs are met in a timely manner. NA #4 was re-educated to provide care per the RCP, frequent rounding, and completing required documentation of care provided. Interview with Person #4 on 5/4/26 at 11:09 AM identified in 2024 he/she shaved Resident #1's head and discovered wounds to the back of the head. At that time the facility contributed the wounds to barrettes that he/she put in Resident #1's hair and was told to no longer do so. Person #4 identified on or around 4/6/26, LPN #1 asked if Person #4 was going to shave Resident #1's head again. He/she thought the request was odd because the hair was only about three (3) inches long and Resident #1 always wore a hair cover. Person #4 identified he/she then noticed blood on Resident #1's pillow and reported the hair had an odor. On 4/7/26, Person #4 brought clippers to shave Resident #1's head. Upon inspection of the hair, the back of the head was severely matted. Person #4 reported he/she requested NA #2's assistance with shaving and when they shaved the hair, multiple pink areas and scabbed areas were observed to the back of the head. Person #4 identified he/she never had Resident #1 go to the hairdresser because staff reported they washed the hair weekly and never reported issues with the hair. Person #4 reported there was a live camera in the room and numerous times where no one entered the room to reposition Resident #1 for over four (4) hours. Person #4 filed a grievance 4/12/26 which reported no staff entered the room to turn and reposition Resident #1 from around 9:20 PM on 4/11/26 until around 5:20 AM on 4/12/26 (eight hours) and suspected the wounds were caused from pressure related to Resident #1 not being repositioned. Observation of Resident #1 on 5/5/26 at 8:45 AM identified Resident #1 turned to the right side with a positioning wedge in place to the right and the head of bed elevated to approximately forty-five (45) degrees. The touch pad call-bell was hanging on the back wall, out of reach.Interview and observation of Resident #1 with NA #1 on 5/5/26 at 8:46 AM identified Resident #1's call bell hanging on the back wall out of reach. NA #1 reported she had not yet been in the room since the start of her shift because there was no help and ignored the request to place the call-bell within reach of Resident #1. NA #1 continued to pass drinks for breakfast in the hallway and did not go into Resident #1's room to replace the call-bell or reposition Resident #1.Subsequent to surveyor inquiry, at 9:08 AM (20-minutes after notification to NA #1), LPN #1 and RN #1 placed Resident #1's call bell within reach and turned and repositioned Resident #1 in bed. Interview with MD #2 on 5/5/26 at 10:24 AM identified he was initially unsure of the etiology of the wounds to the back of Resident #1's head during his 4/10/26 visit and thought they could have been malignant (chronic, non-healing skin lesions caused by cancer cells in the skin) so documented them as non-pressure wounds. Since 4/10/26 the wounds improved. The wounds would not have improved if they were malignant, therefore, there was no need to biopsy the wounds and he determined they were caused by pressure due to the back of the head location. MD #2 reported if the back of the head been offloaded consistently, the area most likely would not have (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	developed. Interview with the Rehab Director on 5/5/26 at 11:38 AM identified she evaluated Resident #1 following the discovery of the wounds and determined the wounds were not caused from the wheelchair headrest and Resident #1 was never in the wheelchair longer than three (3) hours at a time daily. Following the evaluation, the wheelchair headrest was removed and Resident #1's positioning was still aligned. Resident #1 reported being comfortable without the headrest, so it was left off to allow time to heal. She reported the wounds were most likely due to positioning in bed but was unable to identify an exact cause. A contouring pillow was ordered to relieve pressure.Interview with the DON on 5/5/26 at 12:45 PM identified NA staff were responsible for turning and repositioning residents per their plan of care and Resident #1 was to be turned and repositioned four (4) times every shift per the plan of care.Review of in-room camera footage with Person #4 on 5/5/26 at 1:57 PM identified staff last repositioned Resident #1 on 5/5/26 at 5:18 AM and Resident #1 was not again turned and repositioned until 9:08 AM by LPN #1 and RN #1 subsequent to surveyor inquiry (almost 4 hours later) despite the plan of care directing Resident #1 be turned and repositioned at least four (4) times per shift (every 2-hours). Although attempted, an interview with NA #4 was not obtained.Review of the Turning and Repositioning policy dated 7/1/24 directed, in part, all residents at risk of, or with existing pressure injuries, will be turned and repositioned, unless it is contraindicated due to a medical condition. Turning and repositioning is a primary responsibility of nursing assistants, however, all nursing staff are expected to assist with turning and repositioning. The frequency of turning and repositioning will be documented in the resident's plan of care and will be determined by the resident's: tissue tolerance, level of activity and mobility, skin condition, overall medical condition, treatment goals, type of pressure redistribution support surface in use, comfort levels and resident preferences. Use the appropriate number of staff to perform the tasks safely.Review of the Comprehensive Care Plan policy dated 4/1/25 directed, in part, it is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and all services that are identified in the resident's comprehensive assessment and meet professional standards of quality. The comprehensive care plan will describe, at a minimum, the following: The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, resident specific interventions that reflect the resident's needs and preferences and align with the resident's cultural identity, as indicated. The objectives will be utilized to monitor the resident's progress. Alternative interventions will be documented, as needed. Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made.

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **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) sampled residents (Resident #1) reviewed for neglect, the facility failed to ensure a severely cognitively impaired resident who was dependent on staff for hygiene care and was identified as at risk for pressure injuries received ongoing skin monitoring, hair care, thorough head to toe skin assessments (Weekly Skin Checks) and repositioning necessary to prevent pressure-related skin breakdown resulting in unrecognized posterior scalp pressure injuries progressing to necrotic wounds requiring an enzymatic debridement treatment after discovery by the resident representative when the residents head was shaved for closer observation due to odor and severely matted hair. The findings include:Resident #1?s diagnoses included bilateral paralytic syndrome following cerebral infarction (a condition involving paralysis on both sides of the body due to stroke-related brain damage), type II diabetes mellitus with diabetic neuropathy (complication of diabetes, characterized by nerve damage), chronic pain syndrome, muscle weakness and anxiety disorder.A Nursing readmission assessment by RN #2 dated 3/10/26 identified a full body skin assessment was completed, skin was intact and no open areas were noted.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Staff Assessment for Mental Status conducted which identified short-term and long-term memory problems and severely impaired cognition. The MDS identified Resident #1 required substantial assistance for bed mobility, was dependent on staff for personal hygiene and transfers and was at risk for pressure injuries but had no current skin abnormalities.Weekly Skin Checks completed by RN #2 on 3/17/26 and 3/25/26 identified a skin check was performed and no skin injury/wounds were noted.The Resident Care Plan (RCP) dated 3/26/26 identified Resident #1 was at risk for skin breakdown related to quadriplegia (paralysis affecting all four limbs and the torso) with contractures, decreased activity, impaired cognition, bowel and bladder incontinence, dependence on staff for bed mobility, transfers, and toileting and had a history of healed pressure injuries. Interventions included the use of a low air loss mattress, turning and/or repositioning and checking the skin four (4) times per shift as determined by tissue tolerance, observing skin condition daily with care and reporting abnormalities and completing a Weekly Skin Check by a licensed nurse.A Braden Scale assessment dated [DATE] identified Resident #1 was at moderate risk for developing pressure injuries.The April 2026 Documentation Survey Report identified NA #1 gave Resident #1 a shower on 4/1/26 and documented the skin observation as Not Applicable (N/A).A Weekly Skin Check by RN #2 on 4/2/26 identified a skin check was performed and no skin injury/wounds were noted.Review of the Kardex in effect on 4/6/26 directed NA's to monitor for skin redness/irritation and report as indicated, observe skin condition daily with Activities of Daily Living (ADL) care and report abnormalities and continue to encourage every two (2) hour repositioning.A nurse's note by RN #1 dated 4/7/26 at 3:00 PM identified she assessed Resident #1 in response to a concern from the responsible party (Person #4) regarding a change in skin integrity to the scalp after Person #4 had Resident #1's head shaved due to severely matted hair. The back of Resident #1's head had a cluster of five (5) lesions, including two (2) distal (farther away from the midline) lesions that were closed/resolved and of the other three (3), 2 had adherent fibrinous tissue (a yellowish moist or dry layer of necrotic material composed of dead cells and debris) covering the wounds and the other lesion had a pink wound bed. The entire cluster measured 6 centimeters (cm) by 5 cm. The surrounding scalp was unremarkable and although the wound beds were moist, there was no active drainage and Resident #1 denied pain. The severely matted hair contributed to pressure on the scalp and Person #4 planned to keep the hair length short moving forward. RN #1 educated Person #4 on caring for ethnic hair and he/she verbalized understanding. The provider was notified and a new order for calcium alginate (a highly absorbent wound dressing used for managing moderate to heavily draining wounds) to be applied to the wound (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	bed was obtained and Resident #1 would be followed during weekly wound rounds.Review of the RCP failed to identify a preference or request for Person #4 to provide care for Resident #1's hair or any identified abnormalities with Resident #1's hair.A facility Reportable Event (RE) dated 4/8/26 identified at 10:45 AM Person #4 reported a concern regarding Resident #1's hair hygiene and believed Resident #1 was neglected due to hair at the base of the scalp being knotted resulting in irritation to the scalp and back of the head. Resident #1 was a total assist of two (2) for care and transfers and a full body skin assessment was completed and no changes were noted to skin integrity. The provider and the police were notified, an investigation was initiated and an alternate style pillow was provided for better tissue tolerance.A note by APRN #1 dated 4/9/26 identified she was asked to see Resident #1 for reports of wounds to the back of the head. Resident #1 was awake and alert, had no indicators of pain, was afebrile (without a fever) and the wound dressing was in place with no drainage on the dressing. She ordered Santyl (enzymatic debriding agent) to the open clustered skin wounds to the back of head daily followed by a clean dry dressing. Staff were to monitor Resident #1's pain level and follow up with the wound physician for signs and symptoms of infection.The wound physician note by MD #2 dated 4/10/26 identified Resident #1 was seen and evaluated for a wound to the back of the head. The posterior scalp (back of the head) wound was a full thickness cluster wound measuring 4.5 cm by 3.5 cm by 0.1 cm with twenty (20) percent (%) thick adherent devitalized necrotic tissue (dead tissue that acts as a physical barrier to healing), with no drainage and no signs and symptoms of pain or infection although Resident #1 was anxious. The etiology (cause/reason) of the wounds were undetermined/unknown and the treatment plan included applying Santyl to the wound beds followed by a dry protective dressing once daily for thirty (30) days.A facility Grievance Form dated 4/12/26 by Person #4 identified there was a customer service concern regarding the repositioning and turning of Resident #1 and reported one-to-one education was provided to NA #4 for Resident #1's reposition plan of four (4) times per shift.Review of the April 2026 Documentation Survey Report identified all assigned tasks on the 11:00 PM to 7:00 AM shift on 4/11/26 were not documented, including the turning and repositioning of Resident #1.A Disciplinary Action Form identified from 4/11/26 to 4/12/26 NA #4 failed to complete assigned tasks including documentation and it was her responsibility to ensure all resident needs are met in a timely manner. NA #4 was re-educated to provide care per the RCP, frequent rounding, and completing required documentation of care provided.The wound physician note by MD #2 dated 5/4/26 identified the posterior scalp wound measured 4.8 cm by 1.2 cm by 0.1 cm and no longer required Santyl. The wound bed consisted of fifty (50) % granulation tissue (new connective tissue that forms on the surface of a wound during the healing process).Interview with Person #4 on 5/4/26 at 11:09 AM identified in 2024 he/she shaved Resident #1's head and discovered wounds to the back of the head. At that time the facility contributed the wounds to barrettes that he/she put in Resident #1's hair and was told to no longer do so. Person #4 identified on or around 4/6/26, LPN #1 asked if Person #4 was going to shave Resident #1's head again. He/she thought the request was odd because the hair was only about three (3) inches long and Resident #1 always wore a hair cover. Person #4 identified he/she then noticed blood on Resident #1's pillow and reported the hair had an odor. On 4/7/26, Person #4 brought clippers to shave Resident #1's head. Upon inspection of the hair, the back of the head was severely matted. Person #4 reported he/she requested NA #2's assistance with shaving and when they shaved the hair, multiple pink areas and scabbed areas were observed to the back of the head. Person #4 identified he/she never had Resident #1 go to the hairdresser because staff reported they washed the hair weekly and never reported issues with the hair. Person #4 reported there was a live camera in the room and numerous times where no one entered the room to reposition Resident #1 for over four (4) hours. Person #4 filed a grievance 4/12/26 which reported no staff entered the room to turn and reposition Resident #1 from around 9:20 PM on 4/11/26 until around 5:20 AM on 4/12/26 (eight hours) and suspected the wounds were caused from pressure related to Resident #1 not being repositioned.Interview with LPN #1 on 5/4/26 at 12:03 PM identified she frequently provided care for (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Resident #1 on the 7:00 AM to 3:00 PM shift and had not noticed matted hair to the back of the head, scabbing, wounds or drainage. LPN #1 reported she asked Person #4 if he/she was going to shave Resident #1's head because the weather was getting warmer.Interview with NA #1 on 5/4/26 at 12:59 PM identified she frequently provided care for Resident #1 on the 3:00 PM to 11:00 PM shift. On 4/1/26 she gave Resident #1 a shower but did not notice matted hair and did not look at the scalp. She identified Resident #1 usually wore a hair cover but after a full bed bath or shower, she would comb Resident #1's hair, including the back. She was unable to identify if she combed from the base of the scalp outwards and identified the hair to the back of the head was thicker, but she did not think it was matted.Interview with RN #2 on 5/5/26 at 8:37 AM identified she normally worked the 3:00 PM to 11:00 PM shift and completed the Weekly Skin Checks for Resident #1 while in bed on 3/10/26, 3/17/26, 3/25/26 accompanied by an NA, but the back of the head was difficult to see, even with two (2) staff. She identified she did the best assessment she could and did not notice matted hair to the back of the head or skin abnormalities to the scalp. RN #2 identified that on 4/2/26, she performed the Weekly Skin Check independently and did her best to check the head but may have missed an area. She identified she should have had another staff present for assistance. She was unable to identify why the Weekly Skin Check had not occurred the previous day (4/1/26) when NA #1 documented a shower.Observation of Resident #1 on 5/5/26 at 8:45 AM identified Resident #1 turned to the right side with a positioning wedge in place to the right and the head of bed elevated to approximately forty-five (45) degrees. The touch pad call-bell was hanging on the back wall, out of reach.Interview and observation of Resident #1 with NA #1 on 5/5/26 at 8:46 AM identified Resident #1's call bell hanging on the back wall out of reach. NA #1 reported she had not yet been in the room since the start of her shift because there was no help and ignored the request to place the call-bell within reach of Resident #1. NA #1 continued to pass drinks for breakfast in the hallway and did not go into Resident #1's room to replace the call-bell or reposition Resident #1.Subsequent to surveyor inquiry, at 9:08 AM (20-minutes after notification to NA #1), LPN #1 and RN #1 placed Resident #1's call bell within reach and turned and repositioned Resident #1 in bed.Interview with MD #2 on 5/5/26 at 10:24 AM identified he was initially unsure of the etiology of the wounds to the back of Resident #1's head during his 4/10/26 visit and thought they could have been malignant (chronic, non-healing skin lesions caused by cancer cells in the skin) so documented them as non-pressure wounds. Since 4/10/26 the wounds improved. The wounds would not have improved if they were malignant, therefore, there was no need to biopsy the wounds and he determined they were caused by pressure due to the back of the head location. MD #2 reported if the back of the head been offloaded consistently, the area most likely would not have developed. He identified that when he first evaluated the areas, they did not appear new and appeared to have been existing at least one (1) to two (2) weeks or longer. He identified the wounds should have been discovered and reported immediately before becoming necrotic. Interview with RN #1 on 5/5/26 at 11:08 AM reported she had not seen the back of Resident #1's hair or head prior to being shaved on 4/7/26 but all the wounds were open or necrotic which identified they were not new wounds and were existing prior to being first discovered. She identified the wounds appeared to have been caused by matted hair which created a solid mass and caused pressure to the back of the head. RN #1 identified staff should have identified the matted hair while providing hair care and Weekly Skin Checks. She reported if the hair was not matted, the wounds to Resident #1's head could have been identified by NA's and licensed nursing staff before becoming necrotic.Interview with the Rehab Director on 5/5/26 at 11:38 AM identified she evaluated Resident #1 following the discovery of the wounds and determined the wounds were not caused from the wheelchair headrest and Resident #1 was never in the wheelchair longer than three (3) hours at a time daily. Following the evaluation, the wheelchair headrest was removed and Resident #1's positioning was still aligned. Resident #1 reported being comfortable without the headrest, so it was left off to allow time to heal. She reported the wounds were most likely due to positioning in bed but was unable to identify an exact cause. A contouring pillow was (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	ordered to relieve pressure.Interview with the DON on 5/5/26 at 12:45 PM identified licensed nurses are expected to perform complete head to toe skin checks (Weekly Skin Checks) at least weekly and Resident #1 was a two (2) person assist for care so the Weekly Skin Check should not have been performed without assistance. She reported NA's should have brushed/combed Resident #1's hair at least daily with care and observed the skin every shift with care. She identified if staff removed Resident #1's hair cover, provided hair care, checked the skin every shift, and turned and repositioned Resident #1 four (4) times every shift per the plan of care, the matted hair and/or wounds could have been identified timely.Interview with NA #2 on 5/5/26 at 1:19 PM identified on 4/7/26, she provided care to Resident #1 in bed, not including hair care and once she assisted Resident #1 out of bed and into the wheelchair, she braided the top portion of Resident #1's hair. NA #2 reported she did not inspect the bottom portion of Resident #1's hair nor braid the bottom portion of the hair because Resident #1's head was too close to the headrest on the wheelchair, and she could not see it. She identified later in the day, Person #4 came to her requesting assistance with shaving Resident #1's head. She reported Resident #1 was not usually on her assignment so was unsure of what Resident #1's hair usually looked like. Person #4 removed the headrest on the wheelchair and the back of Resident #1's head had an area that was much thicker than the rest of the hair. She reported she gently shaved the hair to that area, which revealed several dark, scabbed areas and identified she notified LPN #1 immediately, and RN #1 assessed the area. Review of in-room camera footage with Person #4 on 5/5/26 at 1:57 PM identified staff last repositioned Resident #1 on 5/5/26 at 5:18 AM and Resident #1 was not again turned and repositioned until 9:08 AM by LPN #1 and RN #1 subsequent to surveyor inquiry (almost 4 hours later) despite the plan of care directing Resident #1 be turned and repositioned at least four (4) times per shift (every 2-hours). Although attempted, an interview with NA #4 was not obtained.Review of the Pressure Injury Prevention and Management policy dated 7/1/25 directed, in part, the facility is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injuries. Pressure Ulcer/Injury refers to localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. Avoidable means that the resident developed a pressure ulcer/injury and that the facility did not do one or more of the following: evaluate the resident's clinical condition and risk factors; define and implement interventions that are consistent with resident needs, resident goals, and professional standards of practice; monitor and evaluate the impact of the interventions; or revise the interventions as appropriate. The facility shall establish and utilize a systematic approach for pressure injury prevention and management, including prompt assessment and treatment; intervening to stabilize, reduce or remove underlying risk factors; monitoring the impact of the interventions; and modifying the interventions as appropriate. Licensed nurses will conduct a full body skin assessment on all residents upon admission/re-admission, weekly, and after any newly identified pressure injury. Findings will be documented in the medical record. Assessments of pressure injuries will be performed by a licensed nurse and documented. The staging of pressure injuries will be clearly identified to ensure correct coding on the MDS. Nursing assistants will inspect skin during bath and will report any concerns to the resident's nurse immediately after the task. Training in the completion of the pressure injury risk assessment, full body skin assessment, and pressure injury assessment will be provided as needed.Review of the Turning and Repositioning policy dated 7/1/24 directed, in part, all residents at risk of, or with existing pressure injuries, will be turned and repositioned, unless it is contraindicated due to a medical condition. Turning and repositioning is a primary responsibility of nursing assistants, however, all nursing staff are expected to assist with turning and repositioning. The frequency of turning and repositioning will be documented in the resident's plan of care and will be determined by the resident's: tissue tolerance, level of activity and mobility, skin condition, overall medical condition, treatment goals, type of pressure redistribution support surface in use, comfort levels and (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	resident preferences. Use the appropriate number of staff to perform the tasks safely.Review of the Activities of Daily Living (ADLs) policy dated 7/1/24 directed, in part, a resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming and personal and oral hygiene.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility policy and interviews for one (1) of three (3) residents (Resident #1) reviewed for neglect, the facility failed to ensure Resident #1's call bell was consistently accessible and within reach, resulting in a dependent resident with limited verbal communication being unable to independently request assistance. The findings include:Resident #1?s diagnoses included bilateral paralytic syndrome following cerebral infarction (a condition involving paralysis on both sides of the body due to stroke-related brain damage), type II diabetes mellitus with diabetic neuropathy (complication of diabetes, characterized by nerve damage), chronic pain syndrome, muscle weakness and anxiety disorder.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Staff Assessment for Mental Status conducted which identified short-term and long-term memory problems and severely impaired cognition. The MDS identified Resident #1 required substantial assistance for bed mobility, was dependent on staff for personal hygiene and transfers and was at risk for pressure injuries but had no current skin abnormalities.The Resident Care Plan (RCP) dated 3/26/26 identified Resident #1 was dependent for Activities of Daily Living (ADL) care in all ADL's related to history of a stroke, spasticity, cognitive impairment, limited range of motion and limited mobility, was at risk for falls and was at risk for respiratory complications related to Chronic Obstructive Pulmonary Disease (COPD), chronic respiratory failure, shortness of breath and had a tracheotomy with increased respiratory secretions putting the resident at risk for aspiration of enteral feeding. Interventions included anticipating and meeting the resident's needs, being sure the resident's call light was within reach and encouraging the resident to use the call light for assistance as needed. The RCP further indicated Resident #1 needed prompt response to all requests for assistance.A facility Reportable Event (RE) dated 4/8/26 identified at 10:45 AM Person #4 reported a concern regarding Resident #1's hair hygiene and believed Resident #1 was neglected due to hair at the base of the scalp being knotted resulting in irritation to the scalp and back of the head. Resident #1 was a total assist of two (2) for care and transfers and a full body skin assessment was completed and no changes were noted to skin integrity. The provider and the police were notified, an investigation was initiated and an alternate style pillow was provided for better tissue tolerance.A nurse's note by the DON dated 4/8/26 at 12:16 PM identified Resident #1's responsible party (Person #4) reported a concern regarding hair hygiene. The APRN and police were notified, a skin assessment was completed and no changes to skin integrity were noted. An alternate style pillow was provided for better tissue tolerance and Person #4 was updated.A. Observations on 5/4/26 at 11:33 AM identified Resident #1 in bed, on his/her back with tears running down his/her face. Resident #1 was unable to verbally communicate but when asked if he/she was okay, Resident #1 shook his/her head no. A moderate amount of pink secretions were noted to the gauze under Resident #1's tracheostomy site and the touch pad call bell was noted to be hanging on the oxygen concentrator that was against the back wall about three (3) feet away from the head of Resident #1's bed, not within reach of Resident #1.Observation and interview with LPN #1 on 5/4/26 at 11:37 AM identified the touch pad call bell to not be within reach of Resident #1. LPN #1 performed tracheostomy care for Resident #1, changed the dressing to the back of Resident #1's head as ordered and then at 12:03 PM placed the call bell on the bed next to Resident #1's right hand and clipped it to the bed. LPN #1 identified she was unsure why the call bell was not in place and within reach of Resident #1, as Resident #1 had recently received personal care from NA #3. She reported Resident #1 had use of his/her right hand and was able to use the call bell and the call bell should have been within reach to utilize as needed. Moments later, the call system was noted to be lit up outside of Resident #1's room and LPN #1 responded.Interview with NA #3 on 5/4/26 at 12:20 PM identified after performing personal care for Resident #1 approximately one (1) hour earlier, she forgot to place the call bell back in Resident #1's reach, and she should have ensured the call bell was within reach prior to leaving the room.B. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of Resident #1 on 5/5/26 at 8:45 AM identified Resident #1 turned to the right side with the positioning wedge in place to the right and the head of bed elevated to approximately forty-five (45) degrees. The touch pad call bell was noted to be hanging on the back wall, not within reach of Resident #1. Resident #1 was noted with a minimal amount of pink secretions to the gauze under the tracheostomy site but did not appear to be in distress but when asked if he/she was okay, Resident #1 did not shake his/her yes or no but instead raised his/her right fist in the air.Interview and observation of Resident #1 with NA #1 on 5/5/26 at 8:46 AM identified Resident #1's call bell hanging on the back wall out of reach. NA #1 reported she had not yet been in the room since the start of her shift because there was no help and ignored the request to place the call-bell within reach of Resident #1. NA #1 continued to pass drinks for breakfast in the hallway and did not go into Resident #1's room to replace the call-bell or reposition Resident #1. Subsequent to surveyor inquiry, at 9:08 AM (20-minutes after notification to NA #1), LPN #1 and RN #1 placed Resident #1's call bell within reach and turned and repositioned Resident #1 in bed. Interview with the DON on 5/5/26 at 9:11 AM identified after providing care for residents, both NA's and licensed nurses should ensure the call bell is within reach of the resident prior to leaving the room. She reported if NA #1 was not providing care to another resident at the time she was notified the call bell was not within reach for Resident #1, she should have responded immediately when notified, and placed the call bell within reach of Resident #1.Review of the Call Lights: Accessibility and Timely Response policy dated 9/1/24 directed, in part, all staff will be educated in the proper use of the resident call system, including how the system works and ensuring residents have access to the call light. Staff will ensure the call light is within reach of each resident and secured, as needed. The call system will be accessible to residents while in their bed or other sleeping accommodations within the resident's room.