

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075279	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/17/2026
NAME OF PROVIDER OR SUPPLIER Complete Care at Kimberly Hall North		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - 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 clinical record reviews, review of facility documentation, review of facility policy and staff interviews for 1 of 6 residents reviewed for abuse (Resident #87), the facility failed to ensure a resident was free from abuse, which resulted in a vulnerable resident being physically abused by a staff member and for (Resident #85) reviewed for abuse, the facility failed to prevent a physical injury during a resident-to-resident altercation. The findings included: 1.Resident #87's diagnoses included dementia, anxiety, muscle weakness, and cerebral vascular disease.The quarterly MDS assessment dated [DATE] identified Resident #87 had short-term and long-term memory problems. The MDS further indicated Resident #87 had not exhibited behavioral symptoms or rejection of care. The MDS also identified that Resident #87 was dependent for toileting and personal hygiene and required substantial to maximal assistance for bed mobility and transfers.A Resident Care Plan revised on 4/6/2026 identified Resident #87 had an impaired/decline in cognitive function related to dementia, interventions included: observing for changes in cognitive status and communicating with short phrases. The care plan also identified that Resident #87 was at risk for decreased ability to perform activities of daily living related to dementia. Interventions included: providing assistance from one staff member for bed mobility, eating, toileting, and bathing.A physician's order dated 6/15/2026 identified Resident #87 directed administration of the following medications: trazodone 100 mg by mouth once daily for anxiety; Aricept 10 mg by mouth at bedtime for dementia; Zolof 100 mg by mouth at bedtime for anxiety; and buspirone 10 mg by mouth twice daily for anxiety.A nursing note by LPN#6 dated 6/24/2026 indicated that a Nurse Aide (NA # 6) approached the nurses' station to report an incident involving NA # 7 and a resident. The note also indicated that no visible injuries were noted.A nursing note by the nursing supervisor (RN#3) dated 6/24/2026 indicated the LPN # 6 had reported Resident #87 had been slapped by a nursing aide. The note indicated that an RN assessment had been completed, and no injuries had been noted.An Advanced Practice Registered Nurse (APRN) note dated 6/24/2026 identified Resident #87 had been involved in an altercation with a nursing aide during morning care. The note indicated that during the altercation Resident #87 had struck the nursing aide in the face and the nursing aide struck the resident back. Resident #87 remained confused at baseline, with stable vital signs and no visible or reported injuries.A facility Incident Report and investigation dated 6/24/2026 and a summary dated 6/26/2026 identified that on 6/24/2026, during morning care, NA#6 observed Resident #87 push NA#7 on her face, and then NA#7 slapped Resident #87 across the resident's face. The local police were called and made aware of the incident. During the facility investigation, NA#7 did not dispute the allegation and indicated that she reacted impulsively with no intent to harm the resident. NA#7 was placed on leave. Resident #87 was evaluated by psychiatry, who reported Resident #87 had no recollection of the incident.NA#7's written (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 - Actual harm Residents Affected - Few	statement identified that after NA#6, an orientee, removed the pillows, Resident #87 became agitated. NA#7 then approached Resident #87's bedside and asked what the problem was. Resident #87 struck NA#7 in the face, after which NA#7 reactively hit Resident #87 back. NA#7's statement did not indicate where she had struck Resident #87. NA#6's written statement identified she was preparing to provide care to Resident #87 and Resident #87 did not want to take off her/his blanket. NA#7 then walked into the room and went to Resident #87's bedside and began wrestling Resident #87 for the blanket yelling at the resident and saying, what is your problem. Resident #87 then released the blanket, reached up, and pushed NA#7's face away. NA#7 then slapped Resident #87 hard across the resident's face and mouth. NA#7 then yelled at the resident, saying, Don't you dare touch my face and try to break my \$500 glasses. NA#6 then walked out of the room and informed the nurse what had happened. RN#3's written statement identified he was the supervisor on duty in the morning of 6/24/2026. He was informed Resident #87 had slapped NA#7 across the face, and that NA#7 had retaliated, although the location of where NA#7 had slapped Resident #87 was not specified. A statement by the facility administrator dated 6/24/2026 indicated the administrator had spoken to NA#7, who indicated that she had struck Resident #87 back and she had reacted to being struck. A psychiatry note dated 6/24/2026 identified Resident #87 was oriented to self only, consistent with advanced dementia. The note identified that the resident's speech was clear, pleasant, and engaging, and the resident denied feelings of depression and anxiety. Additionally, the note indicated that Resident #87 had no agitation, aggression, emotional distress, or behavioral disturbance and appeared consistent with baseline. A local police report signed 7/2/2026 identified on 7/2/2026, the police had spoken to NA#7, who indicated that when she arrived in Resident #87's room, Resident #87 was awake and agitated. NA#7 walked over to Resident #87 and asked Resident # 87 what was wrong and tried to calm the resident down. Resident #87 swung at NA#7 and hit NA#7 on the left corner of the left eye at which time NA#7 slapped Resident #87 on the hand. A supplementary police report signed 7/11/2026 identified that NA#7 was arrested on 7/11/2026 for charges including breach of peace second degree and reckless endangerment second degree. On 7/15/2026 at 3:02 PM, an interview with NA#6 indicated she was on her first day of orientation and had started preparing Resident #87 for care by removing the pillows. When she attempted to remove the resident's blanket, the resident refused by saying no and holding on to the blanket with both hands. NA#6 then indicated she moved to the foot of the bed, and NA#7 walked in. NA#6 indicated that she told NA#7 Resident #87 was refusing care. NA#7 then went to the resident's left side of the bed and attempted to remove Resident #87's blanket. Resident #87 and NA#7 struggled with each other for the blanket while NA#7 was yelling at Resident #87, Why are you doing this? Resident #87 then released the blanket and pushed NA#7's face by the mouth and nose area using her/his palm. NA#7 then used both of her hands to push away Resident #87's hand and then slapped the resident across the right side of the face. From the slap, the resident's head went sideways towards the resident's left side towards NA#7. NA#6 indicated that the privacy curtain had been drawn closed, there was no other staff member in the room, and that Resident #87's roommate appeared to have been sleeping the whole time. NA#6 further indicated that she left the room and told the nurse about the incident. On 7/16/2026 at 10:32 AM, an interview with LPN#6 identified she was the first person to respond to the incident after NA#6 had told her about the incident. LPN#6 indicated she went to Resident #87's room and saw NA#7 still in the room finishing up care by putting sheets on Resident #87. LPN#6 indicated that NA#7 confirmed that she had slapped the resident, and LPN#6 asked NA#7 to stop what she was doing and leave. LPN#6 indicated she did not ask NA#7 where exactly she had slapped Resident #87 but indicated that NA#7 may have written it in her statement. LPN#6 further indicated she did not observe any injuries on Resident #87 and the (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	resident appeared calm. On 7/16/2026 at 1:00 PM, attempts to interview Resident #87 and her/his roommate were unsuccessful due to both residents' severe cognitive impairment. On 7/16/2026 at 2:12 PM, an interview with the DNS, Administrator, RN#7, and Person #2 identified that the Administrator and Person #2 had spoken on the phone with NA#7 after the incident, and NA#7 indicated that she had struck Resident #87 back after getting hit in the face. Person #2 and the Administrator indicated that they could not recall if they had asked NA#7 where she had struck Resident #87. The DNS and RN#7 indicated after the incident, they initiated an investigation and substantiated the allegation. The facility also provided education on abuse prevention to staff and completed a facility-wide evaluation of residents via interviews or body audits to ensure no other resident had been affected. On 7/17/2026 at 1:53 PM, an interview with RN #3 indicated that he was the supervisor on the day of the incident. RN #3 indicated he was informed of the incident by the charge nurse, and he suspended NA#7 and assessed Resident #87, including a full skin audit, including hands and face. RN#3 indicated that Resident #87 had no injuries. Multiple attempts were made to interview NA#7 without success. A review of NA#7's employee record identified that she had been terminated from the facility on 6/30/2026. Additional information provided to the state agency on 7/28/26 and 7/29/26 identified the following for abuse prevention : The facility alleged Past Non-Compliance Daily audits to monitor and ensure that all staff are visible in hallways, dining room and activity area at peak behavior time Staff to monitor any noise, clutter, crowding and to identify any additional triggers To monitor residents with increased behaviors and interventions provided. Date of Compliance 6-26-26 A review of the facility policy titled Abuse, Neglect, and Exploitation, last reviewed on 6/17/2026, identified that abuse was defined as the willful infliction of injury, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Additionally, the policy indicated that instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. 2. Resident #85's diagnoses included irritability and anger, visual hallucinations, and dementia with psychotic disturbance. The quarterly MDS assessment dated [DATE] identified Resident #85 was severely cognitively impaired, had the presence of physical and verbal behaviors directed towards others, and other behaviors not directed towards others. Resident #85 was independent with bed mobility, dependent with personal hygiene and dressing. The assessment further identified the resident ambulated independently. The care plan dated 6/4/26 identified Resident #85 was at risk for resident directed violence related to cognitive impairment or confusion. Interventions included: assessing possible triggers and offering diversional activities when restlessness. Resident #116's diagnoses included dementia with other behavioral disturbances, polyarthropathy (inflammation of the joints), and hypertension. The admission assessment dated [DATE] identified Resident #116 was severely cognitively impaired, noted the presence of physical and verbal behaviors directed towards others, and behaviors not directed towards others. Resident #116 was independent with bed mobility, supervision with personal hygiene and dressing. The assessment further identified the resident ambulated independently. The care plan dated 4/22/26 identified Resident #116 exhibits or has the potential to exhibit physical behaviors related to cognitive loss/dementia, physical aggression- striking out at staff. Interventions included : to bring resident to courtyard to de-escalate, offer and provide resident a cup of coffee, evaluate the nature and circumstances of behavior with resident/patient/or patient representative, evaluate need for psychiatric/behavioral health consult. The nurse's note for Resident #85 dated 6/26/26 at 12:17 PM from RN#6 identified Resident #85 was assessed following a resident-to-resident altercation where Resident #85 was pushed out of the door of the resident room where she/he hit his/her head on the door frame resulting in a skin tear to the right forehead. The social worker notes for Resident (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	#116 dated 6/26/26 at 11:10AM identified Resident #116 pushed Resident #85 out of the room. Resident #116 was put on a 1:1 monitoring until cleared by psychiatry. The Reportable Event form dated 6/26/26 and an investigation identified Resident #116 pushed Resident #85 out of the resident's room resulting in a skin tear measuring 0.5 Centimeters (CM) x 0.5 CM to the forehead. Psychiatric evaluations were completed on both residents and Resident #85 was moved into a new room. Review of NA#5 statement dated 6/26/26 identified NA#5 was in the hallway witnessed Resident #116 opened the door and pushed Resident #85 out into the hallway. Review of the skin integrity report dated 6/26/26 identified a skin tear measuring 0.5CM x 0.5 CM resulting from the incident on Resident #85's forehead. Interview with NA#5 on 7/17/26 at 10:03AM identified she was the witness to the incident between the residents on 6/26/26. Resident #116 pushed Resident #85 out of the room with one hand and Resident #85 may have hit his/her head on the door jam. Resident #85 likes to organize her/his space and thinks the whole space is her/his. NA#5 identified she was in the hallway at the time of the incident. Per NA#5 Resident #85 did not fall. Interview with RN#6 on 7/17/26 at 11:15AM identified she was called to the area following the resident-to-resident altercation. At the time of assessment Resident #85 was noted with a skin tear above the right eyebrow with a small amount of blood present. RN#6 identified she was informed by NA#5 Resident #116 pushed Resident #85 out of the room and Resident #85 hit his/her head on the door jam. Neither Resident #85 nor Resident #116 could recall the incident. RN#6 notified the APRN and believes she/he placed some sort of dressing on the area. However, she could not recall specifically what was put on the forehead. Interview with the DNS on 7/17/26 at 2:00PM identified from her investigation Resident #116 pushed Resident #85 resulting in Resident #85 receiving a small area on the side of her/his head. The DNS further identified Resident #116 likes to organize her/his things and Resident #85 likes to walk around a lot. Resident #116 may have wanted Resident #85 out of her/his space. There was a room change made for Resident #116 following the incident. A review of the facility policy titled Abuse, Neglect, and Exploitation, last reviewed on 6/17/2026, identified abuse was defined as the willful infliction of injury, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Additionally, the policy indicated that instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish.		