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	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Kimberly Hall North	1 Emerson Dr Windsor, CT 06095

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 48792 Based on observations of the noon meal and staff interview for 1 of 4 units (memory unit) residents were served their noon meal on dietary trays, the facility failed to provide a home like environment. The findings include: Observations on 9/15/24 at 12:00 PM on 9/16/24 at 9:00 AM and again at 12:00 PM identified 30 residents on memory unit dining room served their lunch meals on dietary trays. Interview with Administrator on 9/16/24 at 2:30 PM identified residents on the memory unit meals are on trays to act as a barrier to deter other residents from taking other resident's food.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 37721 Based on clinical record reviews, observation, facility documentation, facility policy and interviews for 2 of 6 sampled residents (Resident #76) reviewed for abuse, the facility failed to ensure a resident was free from physical mistreatment by another resident (Resident #139) and for Resident # 122 , the facility failed to ensure the resident was free from physical abuse by Resident # 10. The findings included: 1. Resident #76's diagnoses included Alzheimer's disease and anxiety disorder. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #76 as severely cognitively impaired, required assistance with activities of daily living (ADL), and was independent with ambulation. The Resident Care Plan (RCP) dated 7/1/24 identified Resident #76 at risk for elopement, wandering/pacing and tended to ambulate quickly. Interventions directed to reside on a secured unit and, redirect near exits/doorways and encourage resident to slow down when ambulating. 2. Resident #139's diagnoses that included Alzheimer's disease, depression and aphasia. The quarterly MDS assessment dated [DATE] identified Resident #139 required assistance with Activities of Daily Living (ADL) skills and was independent with ambulation. The RCP dated 7/22/24 identified Resident #139 exhibited wandering behaviors, had the potential to exhibit physical behaviors such as biting, aggression, grabbing related to dementia and had a history of past resident mistreatment. Interventions directed to divert to alternate activities, redirect from peers if observed to be agitated and ambulating in the hallway. An observation on 9/17/24 at 2:07 PM identified Resident #139 pacing up and down the halls on a secured memory care unit. Resident #139 went into a resident room that two residents were occupying at the time and where s/he did not reside. Nurse Aide, NA #4 who was standing just outside the dining common area, immediately attempted to redirect Resident #139 out of the room who was initially resistive but eventually exited into the hallway. Resident #139 then grabbed a hair product from NA #4's hand and threw it on the floor before continuing to quickly resume pacing down the hall. NA #4 then returned to the dining/common area and stood just outside the door. At 2:15 PM Resident #139 was observed pacing the hallway along with other residents that included Resident #76. Both Resident #76 and Resident #139 were ambulating in the same direction down the hall walking past the medication cart at the same time. NA #4 stated, S/he (Resident #139) just hit (Resident #76) in the back!. Registered Nurse, RN #5, who was with the medication cart at the time immediately directed staff to take Resident #76 to her/his room, called for assistance and remained with Resident #139. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility Reportable Event dated 9/17/24 at 3:41 PM on 9/17/24 at 2:15 PM identified staff, (NA #4) reported observing Resident #139 hit Resident #76 in the back while walking by in the hallway on unit. Staff immediately intervened and separated both residents. Both residents were ambulating independently in the hallway on unit. Resident #139 was immediately placed on 1:1 observation. The physician, family and local police were notified. A body audit was completed for Resident #76 no injury noted. An interview with RN #5 on 9/18/24 10:16 AM identified she was administering medications when she observed Resident #139 walk up to Resident #76 and then walk side by side. RN #5 looked away momentarily and then heard NA #4 say Resident #76 was hit in the back by Resident #139. RN #5 immediately separated the two residents, called for another nurse and initiate 1:1 supervision for Resident #139. RN #5 further identified Resident #139, had aphasia, any speech was disorganized, and staff had to anticipate her/his needs. Resident #139 was agitated earlier in the shift before lunch, ambulating quickly in the hall. RN #5 called in Resident #139's family member who came to the facility to assist and bring her/his outside and Resident #139 seemed calm when returning to the unit. RN #5 identified she was not aware Resident #139 was agitated and was throwing objects just prior to the event and would have had staff well known to Resident #139 intervene or provided a medication used as needed for agitation. An interview with NA #4 on 9/18/24 11:00 AM identified she was routinely assigned to the unit and was familiar with Resident #139's behavior. NA #4 identified minutes before the incident, Resident #139 was observed entering another resident(s) room and was redirected out. Resident #139 was agitated and grabbed a hair product NA #4 was holding and threw it on the floor before continuing down the hall. NA #4 identified that when Resident #139 begins throwing things, she notifies the nurse but did not during this occasion as the nurse was nearby and NA #4 thought she would have observed the incident. NA #4 identified minutes later, Resident #139 was ambulating down the hall behind, and then alongside Resident #76 who both were walking around the medication cart. Resident #139 hit Resident #76 in the back before continuing down the hall. RN #5 intervened and separated the residents. NA #4 further identified that although Resident #139 had previously been the alleged aggressor in a previous resident to resident altercation, s/he did not normally attack other residents. An interview with the Director of Nursing Services, DNS on 9/18/24 at 12:18 PM identified Resident #139 was involved in a separate resident to resident altercation where s/he was the aggressor and had difficulty being redirected at times when agitated. Resident #139's family member was occasionally called in to assist by removing Resident #139 from the unit which had been effective in the past. The DNS identified she would expect staff to inform the nurse right away if efforts to redirect were ineffective and expect that residents be free from any mistreatment. A review of the facility policy for Abuse given during the survey for the incident directs the facility to provide protections for the health welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect and exploitation including physical abuse. 3. Resident #122's diagnoses included dementia, anxiety, and depression. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The admission MDS assessment dated [DATE] identified Resident #122 as severely cognitively impaired and exhibited wandering behaviors. Additionally, the MDS assessment noted wandering behavior that significantly intruded on privacy or activities of others. A care plan dated 9/24/2023 identified Resident #122 had the potential to exhibit behaviors such as entering others' rooms, making beds, and attempting to help residents. Interventions included: to provide activities to keep the resident occupied, such as a cleaning kit, a duster, and items to fold and sort. An Accident and Incident (A&I) Report dated 6/13/2023 indicated Resident #122 was in the hallway by a rest bench. Resident #122 was observed by NA # 14 holding on to Resident #10's wheelchair. Resident #10 turned around, held Resident #122's right hand, and bit Resident #122's right forearm. A nursing note dated 6/13/2023 identified Resident #122 was bitten on the right forearm by Resident # 10 and both residents were immediately separated. A care plan dated 6/16/2023 identified Resident #122 as a recipient of a resident-resident altercation and at risk for mood alteration. Interventions included redirecting the resident away from other residents when seen wandering in the hallway and gently guiding the resident away from potential conflict. An A&I Report dated 6/25/2023 identified staff observed Resident #10 on top of Resident #122 on the floor in the doorway of Resident #10's room. The A&I also indicated Resident #10 reported to staff Resident #122 had come into Resident #10's room and refused to leave. Resident #10 indicated s/he then hit Resident #122 when the resident refused to leave. A nursing note dated 6/25/2023 indicated Resident #122 was knocked down by Resident #10 and developed a bruise on the right forearm. The note also indicated Resident #122 did not remember what happened. 4. Resident #10's diagnoses included dementia, schizoaffective disorder, and impulse disorder. The MDS assessment dated [DATE] indicated Resident #10 with moderate cognitive impairment and noted the resident did not exhibit physical or verbal behaviors directed toward others. A nursing note dated 6/13/2024 indicated that Resident #10 bit Resident #122 on the right arm after Resident #122 touched Resident #10 on the arm. A psychiatric evaluation dated 6/15/2023 identified the resident was oriented to self, place, and time. The evaluation further indicated facility staff had reported that Resident #10 had bitten their peer when the peer entered Resident #10's room. Additionally, the evaluation indicated the resident expressed frustration with fell ow residents on the nursing unit. The evaluation also identified the resident was easily frustrated by dementia-associated behaviors. A nursing note dated 6/25/2023 indicated Resident #122 walked by Resident #10's room. The nursing notes further indicated Resident #10 transferred from the bed to a wheelchair, rolled over to the doorway, got out of the wheelchair, and jumped on Resident #122, knocking both to the ground. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/17/2024 at 1:21 PM an interview with NA #2 identified s/he could not recall the 6/13/2023 or 6/25/2023 incidents. NA #2 indicated Resident #122 walked around the unit going into other residents' rooms and making the beds. NA #2 also indicated many residents would attempt to go to Resident #10's room, but as soon as a resident was in the doorway, Resident #10 would tell them to go away. In an interview on 9/18/2024 at 11:28 AM, NA #1 indicated she could not recall the details of the incident on 6/25/2023 but indicated Resident #122 liked going into other residents' rooms to fold clothes. NA #1 identified Resident #10 was oriented and made her/his needs known in 2023. NA #1 indicated Resident #10 may have complained about residents going into his/her room and thought that was why Resident #10 was in a private room. NA #1 further indicated there were no stop signs in use for Resident #10's room at the time of the incident. On 9/18/2024 at 11:59 AM, an interview with the Director of Nursing Services (DNS) indicated the incident on 6/25/2023 occurred at the doorway of Resident #10's room; the DNS indicated that when the residents were found, they were half in the hallway and half in the room. The DNS indicated stop signs used to deter wandering residents were not in use at the time because Resident #122 would remove the signs and still go into other residents' room. The facility believed supervising and redirecting Resident #122 was the most effective intervention. The DNS also indicated the incident occurred at 2:14 PM, which is close to the change of shift, and that staff did not witness the incident because staff were probably in other rooms providing care. 48880

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	075279	A. Building B. Wing	09/19/2024

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46046 Based on clinical record review and staff interviews for the 1 resident reviewed for pressure ulcers(Resident #39) the facility failed to ensure staff updated the care plan when there was a change in the resident's wound status. The findings include: Resident #39's diagnosis include pressure ulcer of the sacral region, stage 4. The Nursing Admission assessment dated [DATE] at 9:12 PM indicated Resident #39 had a stage 3 pressure ulcer on the coccyx (later known as sacral). The Initial Wound Evaluation and Management Summary form dated 2/14/2024 completed by the consulting wound physician indicated Resident #39's sacral pressure ulcer was staged as an unstageable pressure ulcer due to necrosis, noted the wound was debrided during the visit and indicated the wound would eventually deteriorate to a stage 4 pressure ulcer wound then fill in with granulation tissue. A nursing progress note dated 2/15/2024 at 8:43 AM indicated in part Resident #39 had an unstageable Deep Tissue injury to the sacrum which was debrided during the consulting wound physician visit on 2/14/2024. The admission Minimum Data set (MDS) assessment dated [DATE] indicated Resident #39 as severely cognitively impaired and noted a stage 4 pressure ulcer present on admission. The Wound evaluation and management summary note dated 2/21/2024 completed by the consulting wound physician indicated at this visit the pressure ulcer of the sacrum after debridement during this visit was a stage 4 pressure ulcer. The summary note further indicated the correct staging of the pressure ulcer at the last visit (2/14/2024) after debridement was a stage 3. The care plan initiated 2/21/2024 indicated Resident #39 was at risk for skin breakdown and had a present on admission (POA) stage 4 pressure ulcer of the sacrum. Interventions included : to provide wound care as ordered, turn and reposition 4 times per shift as tolerated, a low air loss mattress on bed and weekly skin check by a licensed nurse. A nursing progress note dated 2/15/2024 at 8:43 AM indicated in part Resident #39 had an unstageable Deep Tissue injury to the sacrum which was debrided during the consulting wound physician visit on 2/14/2024. Review of the facility resident Matrix on 9/16/24 at 8:47 AM indicated Resident #39 had a stage 4 pressure ulcer pressure ulcer not present on admission. A record review and interview with the ADNS/IP/wound nurse on 9/17/2024 at 1:30 PM indicated the sacral wound was a stage 3 on admission and the wound MD after debriding the wound on 2/21/2024 declined to a stage 4 pressure ulcer. The ADNS indicated now the wound is a facility acquired pressure ulcer and was no longer considered a wound that was present on admission. (continued on next page)

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	075279	A. Building B. Wing	09/19/2024

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review and interview with RN # 4 MDS nurse at 3:19 PM indicated the hospital at discharge staged the coccyx (Sacral) wound as a stage 3, review of the admission notes and wound physician notes through 2/21/2024 indicated the sacral wound deteriorated from a stage 3 (2/14/2024) to a stage 4 pressure ulcer as noted on the 2/21/2024 consulting wound physician visit note. The consulting wound visit also noted the wound could no longer be considered a Present on Admission pressure ulcer. RN #4 indicated although Resident #39 had other wounds on admission, the only stage 4 documented on all the MDS assessments was the sacral wound indicating it was present on admission (POA). RN# 4 indicated the care plan would need to be updated as it also indicated the pressure ulcer was present on admission. 48792

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	075279	A. Building B. Wing	09/19/2024

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48792 Based on observations, review of the clinical record, facility policy and interviews for 1 of 30 residents (Resident #67) reviewed for dinning, the facility failed to provide adaptive equipment at mealtime per care plan. The findings include: Resident #67's diagnoses included dementia, muscle weakness, and Alzheimer's disease. A dietician's note dated 3/7/24 at 11:56 AM identified resident feeds self with the help of adaptive equipment. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #67 as severely cognitively impaired and required supervision with transfers, bed mobility, and was independent with eating. The Resident Care Plan with update on 8/8/24 identified Resident #67 would be able to feed self with the help of adaptive equipment. Interventions included to provide a Kennedy cup (added to care plan on 6/26/23). A physician's order dated 8/18/24 indicated resident to be on a no salt packet diet, ground texture. A meal ticket dated 9/15/24 identified resident required adaptive equipment, a Kennedy cup for meals. Observation on 9/15/24 at 12:00 PM, identified resident was drinking out of a regular cup and did not have a Kennedy cup on his/her tray. Interview with NA #1 on 9/15/24 at 12:00 PM identified the resident did not have a Kennedy cup even though Resident # 67's meal ticket indicated a Kennedy cup should be provided. NA #1 also indicated the kitchen provides the adaptive equipment. Interview with the Director of Dietary on 9/15/24 at 1:00 PM indicated the kitchen provides the adaptive equipment, and s/he was unsure why the resident did not have a Kennedy cup on her/his tray. Dinning observation on 9/16/24 at 9:00 AM identified Resident # 67 was provide a Kennedy cup after surveyor inquiry. Review of the current Food and Nutrition Services policy dated 10/2019 directed, in part, nursing staff will ensure that assistive devices are available to residents as needed.

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	075279	A. Building B. Wing	09/19/2024

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37721 Based on review of the clinical records, observations, facility policy, and interviews for 1 of 5 residents (Resident # 75) reviewed for unnecessary medications, the facility failed to monitor the behaviors associated with psychotropic medications as directed in the physician's orders and professional standards and for for 1 of 2 resident (Resident #98) reviewed for positioning and mobility, the facility failed to apply a knee brace per physician order and for 1 sampled resident (Resident #113) reviewed for edema, the facility failed to ensure therapeutic management to reduce swelling for a resident with edema was implemented in accordance with physician orders. The findings included: 1. Resident #75's diagnoses included major depressive disorder, history of suicidal ideation, and cerebral vascular disease. The care plan dated 6/19/24 identified a concern with the use of psychotropic drugs Interventions included: to compete the behavior monitoring flow sheet, gradual reduction as ordered, monitor for changes in mental status and functional level and report to physician, as well as to monitor for continued need of medication as indicated. The quarterly MDS assessment dated [DATE] identified Resident #75 had severely impaired cognition and noted a diagnosis of non-Alzheimer's dementia, was able to walk 10 feet once standing, and able to wheel his/her manual wheelchair at least 150 feet in a corridor or similar space. A physician's order dated 9/1/24 directed to give Seroquel 50 Milligrams (mg) by mouth 3 times daily for vascular dementia with anxiety. Give Seroquel 25mg by mouth every 6 hours as needed for agitation. The physician order dated 9/5/24 directed to give Trazodone 50mg (give 0.5 tablet) every 6 hours as needed for anxiety, agitation, and restlessness for 14 days. The physician order dated 9/11/24 directed to give Lorazepam Intensol Oral Concentrate 2mg/ml (Lorazepam) 0.5 ml by mouth every 2 hours as needed for comfort for 30 days/give 0.5 ml sublingually every 2 hours as needed for agitation and restlessness. A previous physician's order dated 8/20/24 directed to give Lorazepam Oral Concentrate 2mg/ml (Lorazepam) 0.5 ml sublingually every 2 hours as needed for agitation with a stop date of 9/11/24. The MAR with physician's order dated 9/1/24 directed to monitor the behavior of negative statements at the end of each shift with no behaviors identified for the month of September 2024, with omissions identified on 9/7/24 on the 11:00PM-7:00AM shift and an omission on 9/17/24 on the 7:00AM-3:00PM shift. The Medication Administration Record (MAR) with physician's orders dated 9/1/24 directed to generically monitor Resident #75 behavior every shift with no behaviors identified thru 9/17/24, an omission on 9/7/24 on the 11:00PM-7:00AM shift and an omission on 9/17/24 on the 7:00AM-3:00PM shift. The Electronic Medical Record (EMR) identified psychotropics were administered on the following dates in September 2024 with no behaviors identified: (continued on next page)

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	075279	A. Building B. Wing	09/19/2024

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Lorazepam 0.5 ml was administered on an as needed basis on 9/5/24 at 9:08PM Lorazepam 0.5 ml was administered on an as needed basis on 9/9/24 at 7:00PM Lorazepam 0.5 ml was administered on an as needed basis on 9/9/24 at 9:00PM Lorazepam 0.5 ml was administered on an as needed basis on 9/13/24 at 8:49AM Seroquel 25mg was administered on an as needed basis on 9/3/24 at 9:29PM Seroquel 25mg was administered on an as needed basis on 9/3/24 at 9:27PM Seroquel 25mg was administered on an as needed basis on 9/5/24 at 1:33PM Seroquel 25mg was administered on an as needed basis on 9/9/24 at 4:30PM Seroquel 25mg was administered on an as needed basis on 9/9/24 at 8:00PM Trazodone 50mg (0.5 tablet) was administered on an as needed basis at 9/3/24 at 5:46PM Trazodone 50mg (0.5 tablet) was administered on an as needed basis at 9/7/24 at 3:24PM, Trazodone 50mg (0.5 tablet) was administered on an as needed basis at 9/9/24 at 6:00PM Trazodone 50mg (0.5 tablet) was administered on an as needed basis at 9/10/24 at 8:00PM Trazodone 50mg (0.5 tablet) was administered on an as needed basis at 9/11/24 at 7:30PM Trazodone 50mg (0.5 tablet) was administered on an as needed basis at 9/12/24 at 7:30PM Trazodone 50mg (0.5 tablet) was administered on an as needed basis at 9/13/24 at 5:30PM Interview with the Psychiatric Advanced Practiced Registered Nurse (APRN #2) identified she relies on the resident record for documented behaviors as well as input from the nursing staff. When questioned regarding the lack of documentation in the EMR regarding behaviors she indicated it is her expectation the behaviors are documented per nursing protocol. Interview and clinical record review with the DNS on 9/19/24 at 12:05PM identified the behavior monitoring sheet indicated Resident #75 did not exhibit any behaviors for the month of September 2024, yet as needed psychotropics were administered. The DNS's initial response was Resident #75 consistently tries to get up from his/her wheelchair and when questioned if the psychotropics are to prevent the resident from standing, she indicated they were not prescribed for that reason. The DNS failed to identify any documented behaviors attributing to the administration of the psychotropic medications either in the behavior section of Resident #75 EMR or in the nurse's notes for the days of psychotropic medication administration for September 2024. The DNS later identified it is her expectation that nurses document the behavior(s) exhibited prior to the administration of the psychotropic medication for a behavior and indicate a nurse's note with the behavior. (continued on next page)

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	075279	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The policy for Psychotropic Medication Use given during the survey notes antipsychotic medications may be considered for residents with dementia but only after medical, physical, functional, psychological, emotional psychiatric, social and environmental causes of behavioral symptoms have been identified and addressed. The policy also notes residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective. 2. Resident #98's diagnoses included polyosteorarthritis, pain in right knee, and dementia. A physician's order dated 4/8/24 directed to apply knee brace after morning care and remove before evening care. In-service forms dated 4/4/24 and 4/8/24 identified the nursing staff and Nurse Aides (NA) were trained to donning and doffing Resident #98's knee brace. A physical Therapy noted dated 4/8/24 identified nursing staff and NAs were trained to donning and doffing Resident #98's knee brace. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #98 as severely cognitively impaired and required 2-person assistance for toileting, transferring and was independent with eating. The Resident Care Plan dated 9/6/24 identified the resident as at risk for alterations in comfort related to osteoarthritis. Interventions included to evaluate pain and medicate as needed. Observations of resident on 9/15/24 at 11:45 AM and 1:45 PM and on 9/16/24 at 8:45 am and 9/17/24 at 12:10 PM identified Resident # 98 was not wearing a knee brace. Interview on 9/17/24 at 12:11PM with NA #3 identified Resident #98 had a knee brace, but the resident removes it all the time, so it was discontinued. Interview with MDS RN #4 Coordinator on 9/18/24 at 9:10 AM identified the care plan should have included resident's refusal to wear the knee brace. Further RN # 4 identified the knee brace was discontinued on 9/17/24. The discontinuation was after surveyor inquiry. Interview and record review on 9/18/24 at 11:10 AM with ADNS identified she would expect any refusals of a resident to wear a knee brace would be reported to the physician. Further the ADNS identified the refusals should be care planned. The ADNS stated the application of the brace should be on the NA Kardex. Upon review of the record, it was not included on the Kardex or the care plan. The ADNS identified the order was written incorrectly therefore it did not flow to the Kardex or the Treatment Administration Record (TAR). The ADNS stated the nurse reviewing the order should have ensured it was written properly. (continued on next page)

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	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Kimberly Hall North	1 Emerson Dr Windsor, CT 06095

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 9/18/24 at 2:00 PM with Physical Therapy (PT #1) identified she is no longer employed by facility but recalls the resident. She remembers ordering the knee brace for the resident. Her expectations would have been that staff would have applied the brace initially until such time that resident had a comfort and could tolerate it. Once she was confident that the resident could tolerate it, she would educate the nursing staff (including NAs) to don and doff the brace. PT # 1 indicated after the training; she would enter the order into facility software. PT#1 also stated her expectation would be, once the order is entered, the nursing staff/NAs would apply the brace as ordered. If the resident is not tolerating the brace, she would expect to be notified at which time she would discontinue the order. Although requested, a policy for assistive devices was not provided. 3. Resident #113's diagnoses included localized edema (swelling in the lower extremities) and hypertension. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #113 as severely cognitively impaired and dependent with activities of daily living, independent with ambulation. The Resident Care Plan dated 7/19/24 identified Resident #113 was at risk for skin breakdown related lower leg edema and had behaviors that included refusal of TEDs (compression stockings). Interventions directed to place ACE wraps to bilateral lower extremities according to physician orders and postpone care/activity to allow time for to regain composure if combative or resistive. The physician's orders dated 9/1/24 directed Ace wrap both lower extremities starting from feet to calf daily during 7-3 PM shift. An observation on 9/15/24 at 2:46 PM identified Resident #113 had edematous lower extremities bilaterally, in bare feet with no Ace wrap in place. A second observation with Nurse Aide, NA #5 on 9/17/24 at 1:36 PM identified Resident #113 wearing socks and without Ace wraps to both lower extremities. A subsequent observation on 9/17/24 at 2:52 PM identified Resident #113 without Ace wraps and Registered Nurse, RN #5 counting medicating with the oncoming nurse for the following shift. A review of the MAR and nursing progress notes dated 9/1/24 through 9/16/24 identified Resident #113 had Ace wraps applied daily with no documented refusals. The MAR and nursing progress notes dated 9/17/24 identified Resident #113 did not have Ace wraps applied to the lower extremities with no documented rationale. An interview with RN #5 on 9/18/24 at 10:32 AM identified nursing was responsible for applying the Ace wraps during the 7:00 AM to 3:00 PM shift. RN #5 identified she had not applied the Ace wraps to Resident #113 at any time during the shift on 9/17/24. RN #5 identified she had realized she did not have the supplies and intended to obtain them. Additionally, RN #5 needed the assistance of the nurse aide staff to apply the Ace wrap. Other matters were prioritized during the remainder of the shift and RN #5 did not complete the task as an oversight. (continued on next page)

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	075279	A. Building B. Wing	09/19/2024

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Director of Nursing Services, DNS on 9/18/24 at 12:31 PM identified she would expect nursing staff to apply the Ace wrap according to physician orders. Although requested, a policy for implementing therapeutic interventions or management of a resident with edema were not provided. 43032

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	075279	A. Building B. Wing	09/19/2024

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46046 Based on clinical record reviews, observations, and staff interviews for 6 of 6 residents observed during dining, (Resident #9 #32, #44, #107, #116, #135), the facility failed to ensure supervision was provided while residents were still eating. The findings include: 1. Resident #9's diagnosis' included dementia, diabetes mellitus and Gastroesophageal Reflux. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #9 as severely cognitively impaired and required supervision and set up for eating. The care plan dated 7/12/2024 indicated Resident #9 required set up with eating and assistance of one person for ambulation with an assistive devise. The care plan further indicated Resident #9 required assistance with meals related to dementia. Interventions included : to provide assistance with meals as needed, noted the resident was on a liberalized diet and to encourage oral intake. 2. Resident #32's diagnosis included diabetes mellitus, dementia, Alzheimer's disease and syncope and collapse. The quarterly MDS assessment dated [DATE] indicated Resident #32 as severely cognitively impaired, received a therapeutic diet (no added salt) and set up for eating. The care plan dated 8/29/2024 indicated Resident #32 required assistance with activities of daily living (ADL). Intervention included assistance of one person for transfers and to encourage the resident to attend meals in the dining room. 3. Resident #44's diagnosis included mild cognitive impairment and failure to thrive. The annual Minimum Data Set (MDS) assessment indicated Resident #44 as cognitively intact and required supervision for eating. The care plan date 8/19/2024 indicated Resident #44 had nutritional concerns with interventions including to assist with meals as needed. 4. Resident #107's diagnosis included dementia and protein calorie malnutrition. The annual Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #107 had moderate cognitive impairment and required set up assistance for eating. The care plan dated 7/25/2024 indicated Resident #107 at risk for decline in ADL. Intervention include assistance of 1 person for eating as needed. 5. Resident #116 diagnosis included Gastro- Esophageal Reflux (GERD). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #116 as severely cognitively impaired and required extensive assistance of one person for eating. The care plan dated 6/18/2024 indicated Resident #116 was dependent for ADL with interventions including dependent on staff for eating. 6. Resident #135's diagnosis included diabetes mellitus, dementia and Alzheimer's disease. The quarterly Minimum Data Set (MDS) assessment dated [DATE] had moderate cognitive impairment, was on a therapeutic diet and required set up for eating. The care plan dated 8/2/2024 identified Resident #135 at risk for decline in ADL but was independent with eating. An observation on 9/15/2024 at 12:50 PM identified 6 residents seated at tables in the main dining area. Resident #116 was seated at a table with food on the table and the resident was holding a bowl with food inside of the bowl. Seated next to Resident #116 was Resident #9 with some eaten food items on his/her plates on the table. At another table Residents #32 and #135 were seated together both with some uneaten food items on the table in front of them. Residents #44 and #107 were seated at another table both with their lunch items mostly eaten and one drinking a beverage. No staff members were in the area as surveyor waited for staff recreation staff arrived to take Resident #32 and #135 back to their rooms at this time The surveyor noted a licensed nurse up the hallway at a medication cart at the nurse's station (LPN #1) who indicated he/she was assigned to supervise the main dining room but had to leave to return to the unit to ensure resident medications were administered timely. LPN #1 further indicted only one resident was still eating when he/she left the main dining room. Upon returning to the main dining room [ROOM NUMBER] residents were still remaining Residents #32, #135 and #9 and #116 with no staff present but recreation staff returned to transport Residents #9 and #135 from the dining room. On 9/15/2024 at 1:16 PM the attention of RN #3 was obtained and during observation and interview. RN # 3 identified residents should not have been left unsupervised in the dining room and went to find a nurse aide to stay with the remaining residents until all residents were done eating. On 9/15/2024 an interview with the ADNS at 1:45 PM indicated there was a rotating schedule of for charge nurses on each unit who are assigned to supervise the main dining room. Sometimes the supervisor or manager on duty will supervise the dining room as well and indicated the resident should not have been left alone. An interview on 9/19/2024 at 9:30 AM with Resident #116 indicated he/she ate in the dining room regularly and if no staff was in attendance. Resident # 116 indicated in an emergency he/she would yell for help.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37721 Based on clinical record review, review of facility documentation, observation, facility policy and staff interviews, the facility failed to ensure staff competencies were current for the provision of Intravenous Therapy (IV) and for 1 of 3 residents (Resident #39) reviewed for at risk for pressure ulcer, the facility failed to ensure facility nursing staff were trained in the use, settings and maintenance of Low Air Loss (ALA) mattresses. The findings included: 1. A review of staff competencies for the management of Intravenous Therapy (IV) identified there were no documented competencies for IV Therapy for 17 of 47 licensed staff. An interview and facility documentation review with the Assistant Director of Nursing Services ADNS on 9/17/24 at 12:35 PM identified she reviewed competencies for IV therapy with the assigned licensed staff at the time any resident was prescribed IV therapy. A review of the Facility Assessment identified staff competencies for IV therapy were required to be completed upon hire and then annually for all licensed staff. 2. Resident #39's diagnosis include pressure ulcer of the sacral region, stage 4. A physicians order dated 2/15/2024 10:00 directed to provide a Low Air Loss (LAL) mattress as of 2/13/2024, to hand check upon set up and every shift including settings to soft and low and check functioning every shift. The quarterly Minimum Data set (MDS) assessment dated [DATE] indicated Resident #39 as severely cognitively impaired and noted a stage 4 pressure ulcer present on admission. The care plan dated 8/19/24 indicated Resident #39 was at risk for skin breakdown and had a pressure ulcer on admission (POA) stage 4 pressure ulcer of the sacrum. Interventions included in part to provide wound care as ordered, turn and reposition 4 times per shift as tolerated, a low air loss mattress on the bed and a weekly skin check by a licensed nurse. An observation on 9/17/2024 at 11:07 AM during set up for wound care identified the low air loss mattress noted to be set to 260 lbs. and low. At conclusion of wound care RN #4 verified the setting at 260 pounds and low and indicated s/he would need to check the physician's orders. On 9/17/2024 at 12:15 PM an interview and record review with Unit manager RN #4 with LPN #2 in attendance, indicated after looking at the physician order for the Low Air Loss (LAL) mattress the staff needed to call for assistance. They were told the instructions for setting the LAL mattress were in the care plan. RN#4 identified the care plan directed to set the mattress to the resident's weight. RN #4 reviewed the clinical record and Resident #39's weight was 80 pounds, and the air mattress was not set at the correct setting and should be set to 80 pounds. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/17/2024 at 12:20 PM an interview and observation with LPN #2 indicated the last facility s/he worked at the settings were in the physician order and the order was not clear. Observation of the LAL mattress with LPN #2 indicated the setting was at 250 pounds s/he had not adjusted the setting during the beginning of the shift at 7:00AM and a dial which noted soft on the left and firm on the right and the center identified pounds. LPN #2 agreed Resident #39 did not look 250 pounds (actually 80 pounds) but indicated if the mattress is set too low the resident could bottom out and touch the mattress, On 9/18/24 at 12:19 PM an interview and review of the facility documents with the ADNS indicated there were no in servicing found or training with staff on how to use the LAL mattress with the physician's orders, set the settings and maintain them. After surveyor inquiry, a current in-service training on low air loss mattress training was done. Although, the training the facility provided was the facility policy regarding Support Surface Guidelines that did not include information on the use of the particular low air loss mattress being used in the facility. The ADNS indicated the in-servicing did not include the manufacturer guidelines. Regional Clinical Managers, RNs #3 and #10, were present and review the manufacturer guidelines provided as the LAL mattress is use at the facility did not indicate to set the mattress to the resident's weight but to adjust the setting to a comfortable setting from soft to firm which contradicted the care plan. RN #10 indicated an air mattress should be checked to ensure it is not bottoming out under the resident. The ADNS was unable to provide staff training or a facility policy/procedure containing low air loss air mattress information. RN #10 further indicated a new in-service would need to be completed with the staff. The facility policy labeled Prevention of Pressure Ulcers/Injuries indicated in part to select appropriate support surfaces based on the resident's mobility, continence, skin moisture and perfusion, body size, weight and overall risk factors. The manufacturer guidelines/user manual for the Selectis Alternating Pressure Pump and Mattress indicated in part the pump and mattress are intended to reduce the incidence of pressure ulcers while optimizing patient comfort in home care and long-term care settings. 46046

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	075279	A. Building B. Wing	09/19/2024

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48792 Based on clinical record review, observations, facility policy and interviews for 1 of 30 residents (Resident #141) reviewed for dinning, the facility failed to ensure that food was served in the correct form for a resident on a mechanically altered diet. The findings include: Resident #141's diagnoses included Alzheimer's disease, dysphagia, and hypertension. A physician's order dated 7/30/24 directed to provide a regular diet, chopped texture and thin consistency. The admission Minimum Data Set assessment dated [DATE] identified Resident #141 as severely cognitively impaired and required maximum assistance with showering, toileting, and set up assistance for eating. The Resident Care Plan dated 8/15/24 identified Resident #141 had an altered diet texture due to dysphagia. Interventions included to provide diet as ordered. A dietician's note dated 8/27/24 at 12:50 PM identified the resident is on a regular diet with chopped texture. An observation of the lunch meal on 9/17/24 12:15 PM identified Resident #141 was on a chopped diet as per his/her lunch ticket however he/she was given a dinner roll. Interview on 9/17/24 at 12:15 PM with NA#2 identified s/he had no idea which foods were allowed on a chopped diet. NA 3 2 further stated s/he just serves the food from the kitchen. NA # 2 also indicated s/he assumed what is on the resident's tray is the correct food for their diet. When asked what s/he would do if s/he noticed the food on the tray did not match the meal ticket, NA #2 stated nothing, when I notify the kitchen, they just send back the same tray. Observation with the dietician on 9/17/24 at 12:30 PM identified the resident was observed with a dinner roll on his/her plate that was not cut up and the resident was on a chopped diet, the dietician stated s/he did not think that was part of the chopped diet. Interview with Food Service Director on 9/17/24 at 12:57 PM identified a dinner roll is not allowed on a chopped diet. When asked the process to ensure residents received the correct diets and choices, s/he identified the last person on the tray line in the kitchen double and triple checks the food on the tray to the ticket and notes food preferences and special/therapeutic diets. The Food Service Director indicated s/he was not sure why the resident did not get the correct food items. (continued on next page)

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	075279	A. Building B. Wing	09/19/2024

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Complete Care at Kimberly Hall North	1 Emerson Dr Windsor, CT 06095

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 9/19/24 at 9:48 AM with Speech Language Pathologist (SLP #1) identified that a dinner roll was not allowed on a chopped diet and Resident #141 should not have received a dinner roll with his/her meal. SLP #1 stated s/he conducts in-service monthly for all of staff and specific residents, as well as notify the Food Service Director with any changes in diet via a dietary slip. SLP #1 further indicated s/he SPL # 1 would expect the nurse aides to know what is on the specific diets and to ensure residents receive the correct diet. A copy of the chopped diet guidelines identified notes a dinner roll was not allowed on a chopped diet. A copy of the menu for a chopped diet included crustless bread quartered. Review of the current Food and Nutrition Services policy dated 10/2019 directed, in part, food and nutrition services staff will inspect food trays to ensure that the correct meal is provided to each resident.

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	075279	A. Building B. Wing	09/19/2024

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48792 Based on clinical record review, observation, facility policy and interviews for 1 of 30 residents (Resident #90) reviewed for dining, the facility failed to honor resident's food preference. The findings include: Resident #90's diagnoses included dementia, hypertension, and muscle weakness. The Resident Care Plan (RCP) dated 6/10/24 identified diagnosis of dementia which sometimes affects weight and/or appetite. Interventions included to provide the resident with food and beverage choices as available. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #90 as severely cognitively impaired and required substantial assistance with toileting, showering, and noted the resident was independent with eating. A physician's order dated 8/18/24 directed to provide a regular diet with regular texture. Observations on 9/15/24 at 12:00 PM, identified Resident # 90's lunch ticket did not match the meal the resident was served. The lunch ticket indicated Resident # 90 should have received assorted cold cereals. The meal served to Resident # 90 at time of the observation was an egg salad sandwich and macaroni salad. There was no cereal on his/her tray Interview with Nurse Aide (NA #1) on 9/15/24 at 12:30 PM identified the trays come up from the kitchen prepared and Nurse Aides do not have to add anything to the trays, they serve them as they are. Interview with NA #1 on 9/17/24 at 12:15 PM indicated s/he serves the dietary trays as they come up from the kitchen. S/he doesn't match the ticket with the meal. NA #1 further indicated if s/he notified the kitchen, they would just send the same meal. Interview with the Director of Dietary on 9/17/24 at 12:57 PM identified there is a staff member at the end of the tray line who ensures meals served meets all dietary restrictions and preferences as outlined on the meal ticket before the food is placed on the meal trucks. Review of the current Food and Nutrition Services policy dated 10/2019, directed, in part, food and nutrition staff will inspect food trays to ensure the correct meal is provided to each resident. Review of the current Nutrition Assessments policy dated 5/2/2021, directed, in part, the facility will conduct an interview with the resident/family for the following: food allergies, food preferences, previous diet modifications, and feeding ability/adaptive utensils are part of the nutritional assessment.

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	075279	A. Building B. Wing	09/19/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46046 Based on clinical record review, observations, review of policy and interviews and for 1 resident (Resident #39), reviewed for pressure ulcer, the facility failed to ensure staff followed procedure for enhanced barrier precautions, hand hygiene and handling of trash and clean wound items. The finding include: 1. a. Resident #39's diagnosis include pressure ulcer of the sacral region, stage 4. The quarterly Minimum Data set (MDS) assessment dated [DATE] indicated Resident #39 was severely cognitively impaired and noted a stage 4 pressure ulcer present on admission. The care plan dated 8/19/2024 indicated Resident #39 at risk for skin breakdown and had a pressure ulcer on admission (POA) stage 4 pressure ulcer of the sacrum. Interventions included in part to provide wound care as ordered, turn and reposition 4 times per shift as tolerated, provide a low air loss mattress on bed and to conduct weekly skin check by a licensed nurse. During an observation of wound care on 9/17/24 at 11:07 AM with charge nurse LPN #2 and unit manager RN #6 identified LPN #2 after removing Resident # 39's old dressing from the sacral wound placing the dressing on the resident's top sheet, then into the prepared trash bag at the bedside. With dirty gloves LPN #2 handled Resident #39's plastic zip lock wound supply bag with dirty gloves after noting a specific xeroform dressing was needed. RN #6 directed LPN #2 to wash hands and apply new gloves before proceeding. LPN #2 proceeded to conduct hand washing and apply clean gloves. The wound was cleansed with normal saline, hand hygiene was completed, a clean pair of gloves donned. A xeroform dressing followed by a foam dressing was applied to the wound. LPN #2 then gathered the trash bag placed it on the television stand on top of an open nonsterile package of 4x4 dressings went to the sink to wash hands. On 9/17/24 at 11:30 AM an interview with RN #4 indicated the trash and clean dressing should not have been handled with dirty gloves and then placed onto the television stand. RN #4 indicated both items should have been discarded. b. On 9/17/2024 at 11:35 AM during observation and interview with the ADNS/IP/wound nurse indicated Resident #39 is on enhanced barrier precautions and a gown should have been worn by the staff providing wound care. The ADNS/IP/wound nurse further indicated a sign is posted outside to the side of Resident #39's door, no cart outside the room but Personal Protective Equipment (PPE) carts located in the hall with supplies shared for all residents requiring PPE. On 9/17/24 11:48 AM an interview with RN #4 and LPN #2 indicated they did not see the sign outside Resident #39's door requiring enhanced barrier precautions. RN #4 indicated gowns should have been worn during the procedure and LPN #2 indicated s/he did not know a gown was needed. The ADNS provided recent training completed by LPN #2 and RN #4 regarding enhanced barrier precautions. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy labeled Hand Hygiene indicated in part use of an alcohol-based hand rub for routinely decontaminating hands should be used before putting on a new pair of gloves. If hands are not visibly dirty and if alcohol-based hand rub is not available hands may be washed with antimicrobial soap and water for enhanced barrier precautions (EBP). The facility policy labeled Enhanced Barrier Precautions indicated in part gowns and gloves need to be immediately available near or outside the resident's room and PPE is only required when conducting high contact care activities including wound care.