STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075253	A. Building B. Wing	07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Harrington Court	59 Harrington CT Colchester, CT 06415

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29050 Based on clinical record reviews and interviews for 1 of 1 sampled resident (Resident #391) reviewed for constipation/diarrhea, the facility failed to ensure a baseline care plan was completed to address the resident's constipation. The findings include. Resident #391's diagnoses included polyneuropathy chronic pain syndrome, atrial fibrillation, deep vein thrombosis and Urinary Tract Infection (UTI). A physician's order dated 6/30/2023 at 8:50 PM directed to provide Senna (a stool softener) 8.6. Milligrams (MG) 2 tablets by mouth daily for constipation. A physician's order dated 6/30/23 at 8:57 PM directed to administer Macrobid (an antibiotic) 100 MG orally twice daily for UTI. A physician order dated 6/30/23 at 9:21 PM directed to provide Oxycodone Hydrochloride (a narcotic analgesic) 10 MG tablet one tablet by mouth every 8 hours as needed for pain. Physician orders dated 6/30/23 at 9:22 PM directed to provide Oxycontin 40 MG (narcotic analgesic) extended release every 12 hours one tablet twice daily for chronic pain. A physician's order dated 6/30/2023 at 9:30 PM directed to provide Glycolax powder (an osmotic laxative)17 grams by mouth once daily for constipation for 3 days. The care plan dated 7/1/2023 identified Resident # 391 required assistance for activities of daily living related in part to toileting. An intervention includes providing supervision with toileting. The care plan further indicated Resident #391 was at risk for alterations in comfort related to chronic pain and polyneuropathy. Interventions included utilizing the pain scale, advising the resident to request pain medication before pain becomes severe, to medicate resident as ordered for pain and monitor for effectiveness and side effects. A physician's note dated 7/4/2023 at 0:00 notes in part Resident #931 is highly anxious and changes subjects frequently and can be easily agitated. The admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #391 was cognitively intact and required extensive assistance of one person for toileting. (continued on next page)

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

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physicians note dated 7/7/2023 at 6:26:01 AM indicated a diagnosis of constipation with a new order for Movantik 25 Mg one tablet daily and indicated Resident #391 describes manually dis-impacting stool and indicated the constipation was likely due to medication induced since Resident # 931 has a long history of prescription narcotic medication use. A physician's order dated 7/7/2023 directed to provide Movantik 25 mg orally once daily for constipation. On 7/11/2023 at 1:45 PM interview with the MDS Coordinator Licensed Practical Nurse (LPN # 9) indicated she/he had looked at the bowel documentation from the nurse aides and the resident was admitted on [DATE] was noted with 2 bowel movements on 7/1/23 and another on 7/5/23. LPN #1 indicated s/he coded the MDS based on the Resident Assessment Instrument Manual guidelines for coding and constipation was not present. On 7/11/23 at 1:50 PM interview with RN MDS Director Registered Nurse (RN #10) indicated the MDS nurses look at the resident as a whole when reviewing medications, diagnosis treatment and in part, looks at the nurse's notes, hospital notes, assessments, and physician orders. MDS Director RN #10 further indicated that the baseline care plan on admission is started by the nurse completing the admission or the supervisor on duty then the next day, the MDS nurses check the care plan to be sure it is complete. On 7/11/2023 at 11:52 PM MDS nurse MDS Director RN #10 indicated s/he makes sure the baseline care plan addresses the medications, Activity of daily living, potential or actual skin breakdown, pain falls and bleeding risk. MDS Director RN #10 also indicated although Resident #391 was not constipated the resident was taking medications to prevent constipation from admission through the MDS lookback period and s/he was unaware of the physician progress note dated 7/7/2023. MDS Director RN#10 indicated that s/he would add a care plan related to preventing constipation. Subsequent to inquiry, on 7/11/2023 to address Resident #391 at risk for constipation related to narcotic use and decreased mobility. Interventions included: to follow the bowel protocol for bowel management, monitoring medications for side effects of constipation and to keep the physician informed of any concerns, and to document and report the signs and symptoms related to constipation.

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F 0686 Level of Harm - Minimal harm or potential for 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** 47460 Based on clinical record reviews, observations, facility documentation review, facility policy review, and interviews for one of three residents (Resident #50) reviewed for wound prevention and healing, the facility failed to follow the residents plan of care and the physician's orders to off load/float heels when the resident was identified with wounds on both heels and for one of three residents (Resident # 5) at risk for pressure ulcer development, the facility failed to ensure the resident's air mattress was set according to the plan of care. The findings included: 1. Resident #50's diagnoses included diabetes, osteomyelitis, malnutrition, pressure ulcer, malignant neoplasm of lung, disc degeneration lumbar region and chronic pain syndrome. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #50 had intact cognition, was at risk of developing pressure ulcer/injury, had one or more unhealed pressure ulcers/injuries and required extensive assistance with bed mobility, transfer, locomotion, and personal hygiene. A physician's order dated 6/27/23 directed to encourage the resident to offload heels as tolerated in bed every shift for prevention. The Resident Care Plan dated 6/29/23 identified Resident #50 was at risk for skin breakdown related to decreased mobility and or has actual skin breakdown. Interventions directed to off load/float heels while in bed with pillows and to observe verbal and nonverbal signs of pain related to wound or wound treatment and medication as ordered. The Change in Condition Evaluation dated 7/5/23 at 8:00 AM identified Resident #50's right heel discoloration measuring 1 centimeter (cm) x 0.7 cm, non-blanchable intact skin. Further review identified left heel discoloration measuring 1 cm x 1 cm non-blanchable intact skin. Recommendations included to always apply skin prep daily and to off load heels when the resident is in bed. Skin Integrity Report dated 7/5/23 identified intact left heel, with no pain, measuring 1 cm x 1 cm with healthy surrounding tissues. Further review identified right heel with intact, measuring 1 cm x 0.7 cm, no drainage with healthy surrounding tissue. Observation with Nurse Aide (NA #2) on 7/5/23 at 12:23 PM identified Resident #50 was lying on his/her bed, legs uncovered and visible from the hallway. A thin flatbed pillow was positioned under the resident's knees without the benefit of providing pressure relief to both heels that were making visible indentation into the mattress. Resident #50 identified that both heels were sore and sometimes when his/her legs were digging into the mattress, his/her heels hurt so he/she tried to move them. The resident was observed trying to push the pillow down from under his/her calves with his/her reacher. Interview with NA #2 on 7/5/23 at 12:40 PM identified although Resident #50's Visual/Bedside Kardex Report directed to off load/float heels while in bed with pillows, she was not aware that the resident's heels should be offloaded, nobody told me, and she had no time to review the kardex, since she came to work at 8:00 AM and it was breakfast time. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and clinical record review with RN #2 on 7/5/23 at 1:48 PM identified Resident #50 previously had a scab on right heel which was indicated as healed on 5/9/23. RN #2 further identified that she assessed the resident's wounds and offloaded the resident's heels with pillow in the morning, but the resident pushed the pillow down so his/her heels were not offloaded. Review of the resident's care plan identified the resident was resistive to care related to lack of motivation but noncompliance with offloading heels was not documented and no alternatives were offered. RN #2 identified it was important for the resident's heels with diabetic wounds to be offloaded to reduce pressure and to promote healing. The wound consultant evaluation by Medical Doctor (MD #2) dated 7/6/23 identified Resident #50 with diabetic wound of the right heel measuring 1.2 cm x 1.4 cm with unmeasurable depth due to presence of dried fibrinous exudate (scab). Further review identified diabetic wound of the left heel partial thickness measuring 1.2 cm x 1.5 cm with unmeasurable depth due to presence of dried fibrinous exudate (scab). Recommendations included to elevate legs, float heels in bed off-load wound and reposition per facility protocol and to apply skin prep once daily for 30 days. Interview with wound consultant MD #2 on 7/6/23 at 11:42 AM identified Resident #50 was able to move his/her feet off the pillow. MD #2 further identified that it was important to offload the resident's heels to prevent skin injury and staff should assist as needed. Observation with LPN #4 on 7/7/23 at 6:09 AM identified the resident lying in bed with pillow partially under ankles and calves, feet partially off loaded with left heel resting on the mattress and right heels offloaded. LPN #4 immediately readjusted the pillow and stated heels should be floating. Observation with NA #3 on 7/7/23 at 1:20 PM identified Resident #50 heels resting on top of his/her pillow without the benefit of being offloaded. NA #3 identified she thought that the resident's wounds on both heels were healed. NA #3 further identified that the resident refused to have his/her heels offloaded and wanted to rest them on top of the pillow. NA #3 with resident's permission offloaded his/her heels with his/her pillow. Resident #50 stated at the same time I was not thinking about them not being elevated, I was only thinking about the pillow being under my feet. Interview with DNS on 7/7/23 at 2:30 PM identified Resident #50's heels should have been offloaded to promote healing and to prevent any further skin injury. The DNS further identified that she would replace the bed pillow with heel lift booties to offload the resident's heels, she will review the new intervention with the wound doctor MD #2 and will update the resident's care plan as required. Review of facility Complete Care Skin Integrity-Foot Care Policy directed in part, Interventions will be based on specific factors identified in the risk assessment, skin assessment, and assessment of any foot ulcers. Appropriate offloading or orthopedic devices, diabetic shoes, or pressure-relieving devices will be utilized. The policy further identified that interventions will be modified in a resident's plan of care as needed. Considerations for need modifications include resident non-compliance. 2. Resident # 5's diagnoses included, obstructive hypertrophic cardiomyopathy, pleural effusion, metabolic encephalopathy, severe protein-calorie malnutrition anxiety and stage 4 pressure ulcer on the sacrum. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The readmission MDS assessment dated [DATE] identified the resident was severely cognitively impaired, required total dependence two persons assistance for bed mobility, transfers, and toileting. The assessment also noted the resident needed total dependence one person assist for personal hygiene, incontinent of bladder and bowel and noted one stage 4 pressure ulcer. The RCP for at risk for skin breakdown related to decrease mobility and has stage 4 sacrum Moisture -Associated Skin Damage (MASD) dated 6/21/23. Interventions included: to provide wound treatment as ordered, weekly wound assessment to include measurements and description of wound status, to observe skin condition daily during ADL care, turn and reposition and check skin every two hours as tolerated and to a pressure redistribution surface bed as per guideline: Low Air Loss (LAL) mattress. The Health Status note dated 6/21/23 at 11:46 AM identified Resident # 5 was seen by Wound MD and RN unit manager for weekly wound rounds 6/20/23. The sacrum stage 4 pressure wound measured 0.8 cm x 1.1 cm x 0.3 cm. Moderate serous drainage. 10% slough, 90% granulation tissue and note no change. Surgically debrided by wound doctor. Non pressure wound to sacrum MASD 1.4 cm x 1.3 cm x 0.1 cm. Light Serous drainage. 100 % (Dermis) with no change. Treatment orders in place. The resident tolerated dressing changes without distress. The physician's orders 4/24/23 to 7/13/23 directed Low airloss mattress to be setting 80-160 lbs Normal pressure alternating every shift and directed staff to check setting and function every shift. The Treatment Administration Record for July 2023 directed LAL to bed 80-160 lb. setting. Observation on 7/6/23 at 1:40 PM identified the resident lying in bed with air mattress set at 400. Observation on 7/12/23 at 3:25 PM with the RN # 2- (Supervisor) identified the resident lying in bed with air mattress set at 400. Interview with RN # 2 Supervisor on 7/12/23 at 4:15 PM identified the resident's air mattress should not be set at 400 and reviewed the physician's order for the air mattress to be set at 80 160 lbs. Subsequent to inquiry, RN # 2 change the setting of the air mattress to the physician's orders.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47491 Based on clinical record reviews, facility policy and interview for 1 of 2 sampled residents (Resident #389) reviewed for hydration, the facility failed to maintain fluid intake per physician's order. The findings included: Resident #389's diagnoses included chronic diastolic Congestive Heart Failure (CHF), dyspnea, and hypertensive urgency. A physician's order dated 6/6/2023 directed to monitor a daily fluid restriction total of 1500ml per day. The admission Minimum Data Set assessment dated [DATE] identified Resident #389 as cognitively intact, requiring extensive assistance with toileting and personal hygiene and indicated independent with eating. The Resident's Care Plan dated 6/22/23, revised on 7/7/2023, identified the resident was at risk for dehydration as evidenced by fluid restriction/insufficient intake. An intervention directs to monitor intake and output per protocol. The nurse's note and certified nursing assistant's fluid intake/output documentation dated 6/13/23 through 7/11/23 identified twenty-three days of total fluid intake below the daily 1500ml fluid restriction and four days of total fluid intake above the daily 1500ml fluid restriction. Interview with Director of Nursing Services (DNS) on 7/13/23 at 1:10 PM identified her expectation is that staff follow the physician's order for monitoring daily fluid intake. The DNS also indicated the daily intake and output policy directs staff to ensure daily intake and output are recorded and maintained for residents who need it. The DNS was unable to explain why the physician's order was not followed. Review of the Intake and Output Policy notes daily Intake/Output record would be implemented by the physician or nurse practitioner physician's order and directed staff to record the resident's food and fluid intake within the designated shift periods.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 47460 Based on observation and staff interview, the facility failed to ensure nurse and nurse aide staffing information posted was accurate and up to date. The findings include: Observation on 7/5/23 identified the staffing information posted at the entrance receptionist desk area, and in the entrance foyer lounge area was dated 6/30/23. Interview and observation on 7/5/23 at 1:30 PM with the DNS identified that Human Resources was responsible for changing the staffing posting. Interview on 7/5/23 at 1:31 PM with the DNS and Human Resources identified the scheduler was normally responsible for the posting, however that individual was on vacation. Additionally, the DNS indicated Human Resources would be responsible for changing and updating the nurse staffing form. Subsequent to inquiry, on 7/5/23 the staff posting was updated and the 7/5/23 nurse staffing form was posted.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 47460 Based on observations of the dietary tray line, and review of facility documentation and interview, the facility failed to provide food at an appetizing temperature and failed to indicate holding temperature of sweet potatoes. The findings included: 1a. Observation of the dietary tray line and a test tray with Food Service Director of the lunch meal on 7/11/23 began at 11:23 AM identified the last cart left the kitchen at 12:46 PM and arrived at 600's wing at 12:48 PM, serving began at 12:52 PM, and the last resident tray was served to Resident #32 at 1:04 PM. A review of the food test tray with the surveyor in the presence of the Food Service Director on 7/11/23 at 1:04 PM identified the following food temperatures surveyor/ Food Service Director: the main meal item (ham with a temperature (in degrees Fahrenheit) of 103.5/103.4, sweet potatoes at 117/116, creamed spinach at 117. 7/116.6, and fruit cup at 63.8/63.3. Interview with the Food Service Director at time of the observation identified the food should be held at 135 or greater. b. Review of Facility documentation of Holding Temperatures prior to the tray line on 7/11/23 for the lunch meal indicated ham at 160 degrees, sweet potatoes log failed to indicate temperature for sweet potato temperature, creamed spinach at 154 degrees and fruit cup at 47 degrees Fahrenheit. Interview with Food Service Director on 7/13/23 at 11:33 AM identified that the Holding Temperature log for 7/11/23 staff failed to record the temperature of the sweet potatoes served on 7/11/23.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 31357 Based on review of the facility Payroll Based Journal (PBJ) records, interview, and review of facility policy for 4 out of 4 quarters reviewed, the facility failed to maintain weekend staffing at a level that was above excessively low, and for 2 of 4 quarters, failed to ensure the facility did not receive a 1 star rating for staffing. The findings include: Review of the Payroll Based Journal records for the second, third, fourth and first fiscal quarters of 2022 identified that during the second quarter, (January 1 through March 31), the third quarter, (April 1 through June 30), the fourth quarter, (July 1 through September 30) and first quarter, (October 1 through December 31, 2022), the facility electronically reported excessively low weekend staffing. Additionally, during the third and fourth quarters, the facility had a 1 star rating for staffing. Interview with RN # 12 the corporate nurse on 7/13/23 at 1:40 PM identified that the facility did not actually have excessively low weekend staffing but, according to RN # 12, who had conducted extensive research into the PBJ system, the facility had failed to accurately report staffing into the PBJ system. Additionally, RN # 12 indicated that, according to RN # 5 there may have been a problem including agency staff in the facility reporting and that RN # 5 would be better able to explain the problem. Subsequent to surveyor inquiry, RN # 5 indicated that she would provide staffing records to negate the inaccurate recording of facility staffing but staffing records were no available. Review of the facility Nursing Services and Sufficient Staff policy dated 7/1/23 identified, in part, that the facility is responsible for submitting timely and accurate staffing data through the CMS Payroll Based Journal (PBJ) system. Review of the facility Payroll Based Journal policy dated 7/1/23 referencing the Centers for Medicare & Medicaid Services (CMS) electronic staffing data submission PBJ Long Term Care Facility Policy Manual (June 2022) directed, in part, that the facility would ensure that all staffing data entered in the Payroll Based Journal system was auditable and able to be verified through either payroll, invoices, and/or tied back to a contract. The he facility would utilize the current submission guidelines as described in the CMS Electronic Staffing Data Submission Payroll Based Journal Policy Manual. The Administrator, Human Resource Director and director of Nursing were responsible for verifying the accuracy of the staffing data that is submitted to CMS using various facility audit forms and/or payroll vendor reports. The Business Office Manage was responsible for verifying the accuracy of census data and collaborating the Minimum Data Set (MDS) Coordinator or any correction and reports were available through CASPER to assist with verification of data. Lastly, the Administrator was responsible for reviewing validation reports and ensuring that any needed corrections were made prior to the quarterly deadline.

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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** 47460 Based on observations, clinical record review, staff interviews, policy review, and facility documentation, for 1 of 1 sampled resident (Resident #65), reviewed for respiratory care, and for 1 of 1 sampled resident, (Resident #439), reviewed for infection prevention, the facility failed to ensure that infection prevention practices were followed and for one of six units, the facility failed to ensure bed pans were properly labeled and stored according to facility policy. The findings included: 1. Resident #65's diagnoses included chronic obstructive pulmonary disease, heart failure, atrial fibrillation, diabetes mellitus, and dementia. An Annual MDS assessment dated [DATE] identified Resident #65 was alert and cognitively intact, and required total dependence of one for toilet use, personal hygiene, extensive assistance of two with bed mobility, extensive assistance of one with dressing, and independence with set-up for meals. A Resident Care Plan revised dated 4/3/23 identified the resident required oxygen therapy was at risk for poor oxygen absorption, and shortness of breath. Interventions included monitoring for respiratory distress, positioning for lung expansion and improved air exchange, monitoring for difficulty breathing, and anxiety, confusion, restlessness, shortness of breath at rest, cyanosis (bluish discoloration of skin), or somnolence (excess sleepiness) due to respiratory insufficiency. Observation and interview on 7/5/23 at 1:19 PM with NA #1, identified while the resident was lying in his/her bed, the resident's oxygen nasal cannula was on the floor next to his/her bed. NA #1 picked up the oxygen nasal cannula off the floor and was about to put the oxygen nasal cannula back on the resident. Subsequent to inquiry NA #1 stopped and did not apply the oxygen and indicated s/he needed to get the nurse. Observation and interview on 7/5/23 at 1:21 PM with LPN #1, identified NA #1 went out of the room to get the nurse who return with a new oxygen cannula. LPN #1 further indicated when oxygen equipment is found on the floor staff is responsible for obtaining a new oxygen cannula for resident. Interview with DNS on 7/5/23 at 1:35 PM indicated that she would expect the nurse aide to tell the nurse to change a resident's nasal cannula/tubing if the tubing is found on the floor. A Medication Administration Record dated 6/1/23 to 7/10/23 directed nursing to check every shift the resident's oxygen is infusing at 2 liters/minute via nasal cannula continuously. A Resident Care Card for the resident failed to include monitoring or reporting for respiratory care concerns or ensuring oxygen in place. 2. Resident #439's diagnoses included diabetes mellitus, fracture of the femur, and pain. A physician's order dated 7/1/23 directed staff to obtain blood glucose levels before meals and at bedtime. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 7/10/23 at 11:39 AM identified LPN #1 checking Resident #439's glucose level with the glucometer. LPN #1 then used Microdot disinfectant wipes which had an expiration date of 2/2023. Interview with LPN #1 on 7/10/23 at 11:42 AM, indicated she had failed to check the expiration date because she was unaware the Microdot disinfectant wipes had expiration dates. LPN #1 further indicated had she known the Microdot wipes had an expiration date, she would have checked to ensure the wipes were within the expiration date and that checking for expiration dates was the responsibility of all licensed nurses. Subsequent to inquiry, LPN #1 identified she would obtain new wipes and properly disinfect the glucometer. Interview with RN # 12 Corporate Nurse, on 7/11/23 at 10:00 AM identified the facility had begun educating staff to ensure disinfecting products were within expiration dates prior to use. Review of the Cleaning and Disinfecting Non-Critical Resident care items, policy dated 1/2019 directed, in part, that reusable items (stethoscopes, durable medical equipment) were to be cleaned and disinfected or sterilized between residents according to manufacturer recommendations. 3. Observation and interview with RN #7 on 7/13/23 at 3:43 PM identified the following: 1. room [ROOM NUMBER]'s shared bathroom contained a bed pan that was in a plastic bag and tied to the grab bar on the right side of the toilet without a label. 2. room [ROOM NUMBER]'s shared bathroom contained a bed pan that was unlabeled, in a plastic bag and tied to the grab bar on the right side of the toilet. room [ROOM NUMBER]'s shared bathroom also contained a urinal that was unlabeled and uncovered, hanging from the grab bar. Interview with RN #7 on 7/13/23 at 3:43 PM identified the nursing staff was responsible for ensuring bed pans and urinals were cleaned, covered, and stored in the bedside table following use and indicated she could not explain why this was not done. Interview with DNS on 7/13/23 at 9:49 AM failed to identify the bed pan policy. Review of the cleaning of bedpans and urinals policy indicated to store bedpans and urinals in the resident's bedside cabinet or drawer after placing in a plastic bag. 48335

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075253	A. Building B. Wing	07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Harrington Court	59 Harrington CT Colchester, CT 06415

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 29050 Based on observations of the kitchen, facility documentation and interview, the facility failed to properly store food in sanitary conditions. The findings include: During the initial kitchen tour with the District Food Manager on 7/5/2023 beginning at 10:38 AM identified the following: The ice maker was noted to be filled with ice with outside scoop on wall in closed container. Further observation identified the inside of ice maker on the top right and left interior above the ready to be used ice with several dark black patches. Interview on 7/5/23 at 11:51 AM with District Food Manager identified the black patches as mold. She further indicated that the cleaning schedule is monthly and was last done in June 2023 and was not done correctly. Observation of facility documentation indicated that the ice maker was last cleaned on 6/27/23 and further identified the ice maker cleaning log was not signed off as cleaned in the month of May 2023. Manufacturer specifications for the Ice Maker's vendor notes interior of the bin is lined with antimicrobial-treated polyurethane, which helps slow down the growth of mold and slime, but it will not eliminate it altogether. Additionally, the manufacturer specifications identified the best way to keep these growths out of your ice bin is to disinfect and sanitize it regularly. Subsequent to inquiry, the District Manager indicated she plans to educate her staff to look at the top of the ice machines going forward to ensure cleanliness. The District Manager also indicated she would follow up to ensure the ice machine black patches area was cleaned.