STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075261	A. Building B. Wing	07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency House Nursing and Rehabilitation Center	181 E Main St Wallingford, CT 06492

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48879 Based on review of the clinical record, facility documentation, facility policy and interviews for the one (1) of three (3) residents, (Resident #1), reviewed for accidents, the facility failed to notify a provider timely of a change in condition. The findings include: Resident #1's diagnoses included vascular dementia with behavioral disturbances, anxiety disorder, age-related osteoporosis without current pathological fracture (loss of bone), unequal limb length, and muscle weakness. The Resident Care Plan (RCP) dated 4/2/24 identified that Resident #1 had a self-care performance deficit due to dementia with interventions that included a low bed, extensive assistance of one (1) staff for personal hygiene, toileting, and dressing. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 was severely cognitively impaired, required moderate assistance with bed mobility, extensive assistance with transfers and toileting, and required setup assistance with eating. A change in condition progress note dated 7/1/24 at 10:49 PM identified that Resident #1's left lower extremity was warm to touch with noted redness and edema, however with normal range of motion, staff was able to bend left lower extremity without difficulties, and no pain was noted. APRN #1 was notified, and a new order was obtained for a STAT (immediate) venous doppler ultrasound to the left lower extremity. Review of the clinical record failed to identify that the STAT doppler was completed (please refer to F 684). A medical progress note dated 7/2/24 at 3:41 PM identified that APRN #1 had assessed Resident #1 due to nursing reports that the left lower extremity was red, warm, edematous, and the resident was calling out in pain with palpation. It indicated that the resident was alert and responsive earlier in the morning, but nursing reported altered mental status, and staff having to assist with breakfast. She indicated she was called urgently to the resident's room later in the day per request of a family member, as the resident was lethargic, would not open his/her eyes, and was unable to follow directions. The resident's family member requested that they were sent to the ED. (continued on next page)

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility Accident and Investigation (A & I) documentation dated 7/3/24 identified that the facility sent Resident #1 to the Emergency Department (ED) on 7/2/24 to be evaluated for stroke-like symptoms and received a phone call on 7/3/24 at 3:19 PM from Resident #1's family member reporting that the resident had a left tibial fracture. It reported the facility was not aware of a recent fall. Interview with NA #1 on 7/24/24 at 12:10 PM identified that she worked the 7:00 AM to 3:00 PM shift on 7/1/24. She indentified that she received in report from NA #8 that Resident #1 was restless and awake all night. She reported she went to go see the resident who wasn't eating breakfast so NA#1 had to feed the resident, (the resident usually feeds h/herself after set-up). When NA#1 attempted to bring the resident to the dining room for lunch in the wheelchair, he/she wouldn't lift h/her feet to be pushed in the wheelchair. At that point, she notified LPN #2 about the residents unusual behavior, who stated, he/she probably has a Urinary Tract Infection (UTI) and then LPN #2 proceeded to feed the resident lunch. NA #1 identified that after lunch she brought Resident #1 into the bathroom as she always does and cued him/her to grab the bar and stand so she could change him/her, the resident could not stand so she put him/her back in the wheelchair, transferred him/her into bed and changed h/[NAME] the bed. She indicated she did not notice any signs and symptoms of pain and did not notice any redness or swelling to his/her left extremity. She could not recall if LPN #2 went in to see the resident after she put him/her back to bed. Interview with LPN #2 on 7/24/24 at 12:25 PM identified that she worked the 7:00 AM to 3:00 PM shift on 7/1/24. She indicated that she received in report from LPN #3 that Resident #1 was awake all night, which was out of the ordinary for him/her. She indicated that NA #1 reported that the resident was having difficulty eating and she had to assist him/her with breakfast, but she attributed it to the resident being tired from being up all night. She reported that Resident #1 also required assistance with lunch, and she fed him/her, but the resident did not appear to be in pain and she didn't notice any other changes so did not feel that it needed to be reported. Review of the clinical record on Resident #1 from 6/30/24 to 7/1/24 failed to show documentation from LPN #3 or LPN #2 regarding a change in condition or communication with NA #1. Interview with LPN #3 on 7/24/24 at 9:04 AM identified that she worked the 11:00 PM to 7:00 AM shift on 6/30/24 and the resident didn't sleep well and was awake a majority of the night but she appeared comfortable and the NA didn't report anything out of the ordinary. She indicated she also worked the 3:00 PM to 11:00 PM shift on 7/1/24 and prior to dinner, NA #4 came to her and requested she come take a look at Resident #1. She stated that she was in bed and appeared comfortable but below her left knee to her ankle was red and swollen, and she couldn't find his/her pedal (foot) pulse so she notified RN #8 right away, identifying RN #8 assessed her and got an order for a doppler ultrasound to the left leg to rule out a blood clot. She reported they kept him in bed that night and did not transfer her to the wheelchair. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DNS and RN #1 (Unit Manager) on 7/24/24 at 12:46 PM identified that they were not made aware or notified of a change in condition on Resident #1 prior to the change in condition regarding the redness and swelling to the left lower extremity that was documented on 7/1/24 at 10:49 PM by RN #8. The DNS indicated that she had interviewed LPN #2 and NA #1 as part of the investigation for Resident #1, but that they had not reported any change in condition in their statements at that time. They identified that they have a whole protocol for a resident change in condition, and if a RN had been notified of the change, they would have assessed the resident immediately, reported their findings to the provider, obtained orders if indicated, notified the responsible party, documented in the change in condition communication form, and could have put in a therapy screen if it was warranted. Review of the Change of Condition Notification policy dated 4/2023 directed, in part, that staff will identify a change of condition and notify the licensed nurse, who will per state regulations conduct a complete physical/mental evaluation and document the findings in the medical record. The licensed nurse will notify the resident, the attending physician, and the family/responsible party of the change in condition

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48879 Based on review of the clinical record, facility documentation, facility policy and interviews for the one (1) of three (3) residents (Resident #1) reviewed for abuse, the facility failed to ensure that a full investigation was conducted related to an injury of unknown origin. The findings include: Resident #1's diagnoses included left tibial fracture (shin bone), age-related osteoporosis without current pathological fracture (loss of bone), unequal limb length, muscle weakness, and vascular dementia with behavioral disturbances. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 was severely cognitively impaired and required moderate assistance with bed mobility, extensive assistance with transfers and toileting, and required setup assistance with eating. A nurse's change in condition note dated 7/1/24 at 10:49 PM identified that Resident #1's left lower extremity was warm to touch with noted redness and pitting edema, but had normal range of motion, staff was able to bend left lower extremity without difficulties, and no pain was noted. APRN #1 was notified, and a new order was obtained for a STAT (immediate) venous doppler ultrasound to the left lower extremity. A medical progress note dated 7/2/24 at 3:41 PM identified that APRN #1 had assessed Resident #1 due to nursing reports that the left lower extremity was red, warm, edematous, and the resident was calling out in pain with palpation. It indicated that the resident was also noted with an episode of hypertension the previous evening. The resident was alert and responsive earlier in the morning, but nursing reported altered mental status, and staff having to assist with breakfast. She indicated she was called urgently to the resident's room later in the day per request of a family member, as the resident was lethargic, would not open his/her eyes, and was unable to follow directions. The resident's family member requested that they were sent to the ED. A physician's order dated 7/2/24 directed that Resident #1 was sent to the ED for further evaluation. A nurse's note dated 7/3/24 at 5:20 PM identified that the facility received a call from Resident #1's family reporting hospital findings of a left tibial fracture. Review of the facility Accident and Investigation (A & I) documentation dated 7/3/24 identified that the facility sent Resident #1 to the Emergency Department (ED) on 7/2/24 to be evaluated for stroke-like symptoms and the facility received a phone call on 7/3/24 at 3:19 PM from Resident #1's family member reporting that the resident had a left tibial fracture. It reported the facility was not aware of a recent fall. Review of the facility schedules from the 3:00 PM to 11:00 PM shift on 6/28/24 (72 hours prior to the discovered change in condition) through the 3:00 PM to 11:00 PM shift on 7/1/24 (the initial change in condition) identified 12 staff members with direct contact with Resident #1 (RN#1, RN #2, RN #3, RN #8, LPN #2, LPN #3, LPN #4, LPN #5, NA #1, NA #2, NA #3, NA#8). For that time period, only 5 out of 12 statements were obtained (42%). (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DNS on 7/23/24 at 11:30 AM identified she wasn't notified that Resident #1 had a fracture until 7/3/24. She indicated she reported the incident to the state agency immediately and then started her investigation, identifying she interviewed and obtained statements from the staff going back 72 hours from the date the fracture was reported (7/3/24), not 72 hours from when the resident was first noted to have redness and swelling to the left lower extremity (7/1/24), which she indicated she should have done. She reported that the resident had not left the facility, and after investigation the facility could not determine how the fracture had occurred, identifying that there were no reports of falls or injuries. Review of the Accident/Incident policy dated 6/2024 directed, in part, that the licensed nurse will complete an investigation for accidents/incidents. The investigation will include written statements from staff members caring for the resident and from people having knowledge of the event. If the occurrence is an injury of unknown origin, statements from staff members on the unit will be taken to try and determine the cause of the injury. Statements may need to continue for the previous 24-72 hours or more if needed and cease once the cause is identified. The Director of Nursing reviews the events to ensure accurate and complete documentation of the incident, and to determine if there is credible evidence to substantiate the allegations of abuse, neglect, or mistreatment.

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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** 48879 Based on review of the clinical record, facility documentation, facility policy and interviews for the one (1) of three (3) residents, (Resident #1), reviewed for abuse, the facility failed to follow a physician's order related to a STAT (to be done immediately) doppler ultrasound and failed to supervise a resident while on the toilet. The findings include: 1) Resident #1's diagnoses included vascular dementia with behavioral disturbances, anxiety disorder, age-related osteoporosis without current pathological fracture (loss of bone), unequal limb length, and muscle weakness. The Resident Care Plan (RCP) dated 4/2/24 identified that Resident #1 had a self-care performance deficit due to dementia. Interventions included a low bed, extensive assistance of 1 staff for personal hygiene, toileting, and dressing. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 was severely cognitively impaired and required moderate assistance with bed mobility, extensive assistance with transfers and toileting, and required setup assistance with eating. a. A nurse's change in condition note dated 7/1/24 at 10:49 PM identified that Resident #1's left lower extremity was warm to touch with noted redness and pitting edema, but had normal range of motion, staff was able to bend the left lower extremity without difficulties, and no pain was noted. APRN #1 was notified, and a new order was obtained for a STAT (immediate) venous doppler ultrasound to the left lower extremity. A physician's order dated 7/1/24 directed to obtain a STAT Venous Doppler to the left lower extremity due to redness and warmth to rule out a deep vein thrombosis (blood clot). Review of the clinical record from 7/1-7/3/24 failed to identify that the venous doppler had been obtained STAT on Resident #1. Interview with the contracted X-ray company #2 on 7/23/24 at 3:20 PM identified that the facility called in the order for the venous doppler to the left lower extremity for Resident #1 on 7/1/24 at 5:45 PM but indicated that they had not been ordered to be a STAT exam and that the notes in their system did not communicate that. She stated that they do complete STAT venous dopplers, and that they try to come out within 3 hours. She reported that the facility was alerted that the doppler would not be done until the next day when they first called in the order, as they don't offer 24-hour services and the technician was already booked until his 8:00 PM end of shift that day, 7/1/24. She identified that if an exam is not booked STAT, the ultrasound technician completes all of the abdominal ultrasounds that are ordered first, as residents are to be nothing by mouth, and when those are completed, they will then prioritize and complete the remaining orders, usually in the afternoon. She indicated if they had been aware that the order was STAT, they would have moved their schedule around sent the technician in the early morning. Further, she reported that the technician called the facility at around 2:00 PM on 7/2/24 to request that they had the resident ready in bed and that they were on their way, but the technician was told that they wanted to cancel the exam, so the technician never arrived at the facility. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nurse's note dated 7/2/24 at 3:07 PM identified that Resident #1 was transferred to the hospital emergency department for evaluation after new noted lethargy. It noted the family accompanied the resident. Interview with RN #1 (Unit Manager) on 7/24/24 at 10:40 AM identified that she called the diagnostic company on 7/2/24 inquiring when they would arrive to complete the venous doppler on Resident #1 after she was notified of the order in morning report. She indicated that they reported the order had been called in, but that they were still waiting for a technician to be assigned and gave no timeframe as to when someone would be out to complete it. Further, she identified that she did not inquire about the order being STAT, as she was not aware at that time that it was ordered STAT. Interview with RN #8 on 7/24/24 at 11:53 AM identified that she was aware that the order for the venous doppler was STAT, as she obtained the order from APRN #1 on 7/1/24. She reported that she was almost certain she called it in STAT and stated she could not recall them indicating that they would not be out until the next day. She identified they had not arrived by the end of her 3:00 PM to 11:00 AM shift, so she passed it on in report, but did not call to follow up with the diagnostic company. Although requested, policies on following physician's orders and outside vendors were not obtained. b. Review of facility statements from the 7/3/24 Accident and Investigation on Resident #1 identified that on 7/2/24, the 7:00 to 3:00 PM nurse, LPN #1, indicated that it was communicated on report from the 11:00 PM to 7:00 AM shift that the resident was tired, had bruising and warmth noted to the left lower extremity, and they were waiting for a doppler to be completed. She reported that later in the morning, there was a new order to obtain a urine from the resident, so she had put him/her on the toilet to obtain the urine but the resident had a bowel movement in the collection hat so she stepped out to get help from NA #5. NA #5 helped LPN #1 stand the resident and they replaced the soiled collection hat with a new one. LPN31 stepped out of the bathroom again, and waited a few minutes and was listening to hear if the resident urinated. She indicated that there was nothing in the orders stating that Resident #1 could not be left alone in the bathroom and that the resident was safe. Review of the July 2024 monthly orders identified a physician's order dated 12/19/22 directing that Resident #1 was a staff assist of 1 for all activities of daily living. A medical progress note dated 7/2/24 at 3:41 PM identified that APRN #1 had assessed Resident #1 due to nursing reports that the left lower extremity was red, warm, edematous, and the resident was calling out in pain with palpation. It indicated that the resident was alert and responsive earlier in the morning, but nursing reported altered mental status, and staff having to assist with breakfast. She indicated she was called urgently to the resident's room later in the day per request of a family member, as the resident was lethargic, would not open his/her eyes, and was unable to follow directions. The resident's family member requested that they were sent to the ED. Interview with PTA #1 (Rehab Director) on 7/23/24 at 12:24 PM identified that Resident #1 had last been on therapy services from 3/6/24 to 3/26/24. She indicated that prior to the resident being transferred to the hospital on 7/2/24, he/she was a 1 person assist for bed mobility, transfers and toileting and should not have been left unattended on the toilet for safety concerns. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LPN #1 on 7/23/24 at 12:35 PM identified that Resident #1's left lower extremity had been bruised and was warm to touch when she first saw her the morning of 7/2/24, indicating she was waiting for the technician to show up to perform the doppler ultrasound. She also reported that the resident was alert, but sleepy. She identified that after lunch, she put the resident on the toilet to obtain a urine that had been ordered, but that he/she had a bowel movement in the collection hat, so she ran across the hall to get a clean collection hat and notify the NA that she required assistance. She reported that she thought it was okay to leave him/her on the toilet because he/she couldn't physically get up on their own and she only left the resident briefly, but identified that the resident had cognitive deficits and could have fallen off the toilet. Interview with Person #1 on 7/23/24 at 12:57 PM identified that when she arrived on the unit to visit Resident #1 on 7/2/24, Person #1 walked into the room with NA #7 who had just come back from break, and they found Resident #1 on the toilet, slumped back with her eyes closed, unattended. She reported that the resident called her the wrong name, and that NA #7 was not able to get him/her off the toilet, because h/she was so weak. She identified that this incident was not the first time that she has found the resident in the bathroom unattended. Interview with NA #5 on 7/23/24 at 1:38 PM identified that she assisted LPN #1 on 7/2/24 in getting Resident #1 off the toilet. She indicated that LPN #1 had asked her to switch out a collection hat with a clean one while she stood the resident, so that she could obtain a urine. She reported after she switched the hat, she left the bathroom and then later, she heard NA #7 calling her name, requesting her assistance in getting him/her off the toilet, as he/she was weak and confused. She identified that they both stood her up, got her in the wheelchair and then transferred her back to bed. Interview with NA #7 on 7/23/24 at 1:51 PM identified that on 7/2/24, she came back from her lunch break after 1:00 PM and she walked into the resident's bathroom with Person #1 and Resident #1 was slumped over on the toilet unattended. She indicated the resident was so weak, she couldn't get her off the toilet, so she yelled to NA #5 to come help her. She reported that with NA #5's assistance, they were able to get him/her into a wheelchair and then from the wheelchair into bed. She identified that Resident #1 was an assist of 1 and was not safe to be left unattended in the bathroom. Interview with the DNS on 7/24/24 at 12:40 PM identified that LPN #1 should not have left Resident #1 on the toilet unattended, especially when he/she was experiencing a change in condition. She indicated she spoke with LPN #1 regarding not leaving a resident who requires assistance and has a change in condition on the toilet unattended.