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	08/01/2025

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 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** Based on review of the clinical record, facility documentation, facility policy and interviews for 1 of 3 residents reviewed for abuse (Resident # 92), the facility failed to ensure the resident was free from physical abuse. The findings include:Resident #92's diagnoses included vascular dementia, anxiety, cognitive impairment and hypertension. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #92 was cognitively impaired, requires maximal assistance with sit-to-stand transfers and personal hygiene and noted dependent on staff for lower body dressing. The care plan dated 4/22/24 identified Need for Continued Safety and Appropriate for Skilled Nursing Facility (SNF) level of care in the facility. Interventions included providing information to family at meetings as needed.A nurse's note dated 6/29/24 at 2:58 PM identified an incident was witnessed by charge nurse- sitting in hallway. Resident #92 was arm's length away from Resident #134 who turned to Resident #92 and punched him/her in the face. The residents were immediately separated to another area of the hallway and assessed for injury. No injury was observed and Resident #92 denied any pain and stated that man hit me but within a short period of time had no recollection of the incident. All parties were notified by the Director of Nursing Services (DNS), third eye provider, family and the local police. A nurse's note dated 6/30/24 at 1:16 PM indicated no adverse signs or symptoms post- incident. Resident #134 stated Resident #92 kicked his/her chair and that is why he/she punched him/her. The physical altercation was witnessed by a charge nurse whose statement identified Resident #92 never kicked Residents #134's chair. Attempts were made to interview the Licensed Practical Nurse (LPN) charge nurse who witnessed the incident but were unsuccessful An interview with DNS on 7/31/25 at 10:27 AM indicated that once an allegation of abuse occurs, residents are removed from any danger, investigation is initiated, affected residents are seen by psychological services and social workers and all key personnel are informed. Interview with the Social Worker (SW #2) on 7/31/2025 at 10:50 AM identified once there are any altercations involving residents, the social worker would follow up as soon as informed and for 3 days after the incident. SW #2 was unable to recall details of the incident, however, reported Resident #92 is not usually aggressive towards other residents. SW#2 documentation indicated SW#2 was informed on 7/8/25 about the incident. Facility Abuse Policy and procedure (revised 1/2023) indicated in part Residents have the rights to be free from abuse.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075261	A. Building B. Wing	08/01/2025

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for 1 of 3 residents reviewed for abuse (Resident # 92), the facility failed to notify the social work department of a resident-to-resident altercation to ensure timely follow up per facility practice. The findings include:Resident #92's diagnoses included vascular dementia, anxiety, cognitive impairment and hypertension. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #92 was cognitively impaired, requires maximal assistance with sit-to-stand transfers and personal hygiene and noted dependent on staff for lower body dressing. The care plan dated 4/22/24 identified Need for Continued Safety and Appropriate for Skilled Nursing Facility (SNF) level of care in the facility. Interventions included providing information to family at meetings as needed.A nurse's note dated 6/29/24 at 2:58 PM identified an incident was witnessed by charge nurse- sitting in hallway. Resident #92 was arm's length away from Resident #134 who turned to Resident #92 and punched him/her in the face. The residents were immediately separated to another area of the hallway and assessed for injury. No injury was observed and Resident #92 denied any pain and stated that man hit me but within a short period of time had no recollection of the incident. All parties were notified by the Director of Nursing Services (DNS), third eye provider, family and the local police. Interview with the Social Worker (SW #2) on 7/31/2025 at 10:50 AM indicated once there are any altercations involving residents, social workers would follow up as soon as informed and for 3 days prior after incident. SW #2 was unable to recall details of the incident. However, SW # 2 reported Resident #92 is usually not aggressive towards other residents and denied any other altercations. SW#2 documentation indicated SW#2 was informed of the altercation on 7/8/24 (7 days later). Interview with Social Worker (SW #1) on 7/31/2025 at 11:09 AM identified secondary to the late notification of the resident-to-resident altercation with Resident # 92 and Resident # 134 on 6/29/24. SW #1 further indicated the social services department oversees timely reporting incidents. Interview with DNS and RN #1 on 8/1/2025 at 11:43 AM indicated the resident to resident between Resident # 92 and Resident # 134 was discussed at the Monday morning report (7/1/24). However, at that time she/he did not notice there was no social work representative present. The DNS further indicated she/he was unsure when the social work department was notified of the resident-to-resident altercation. Interview with and Registered Nurse (RN #1) on 8/01/2025 at 11:43 AM identified as a result of miscommunication, the facility has re-educated staff, conducted audits and reported the facility was back into compliance as of 12/31/24. Plan of Correction1.Social Service immediately notified to complete psychosocial assessment follow up; investigation completed and documented per policy.2. All managers re-educated on abuse investigation protocols to include immediate notification to social worker.3. Social Worker to maintain daily communication with nursing supervisor4. Social Worker to complete any audits on any resident-to-resident altercations beginning July 2024 to December 2024 to ensure that the social service department was notified timely.5. All resident to resident to altercation in AM report and Quality Assurance and Performance Improvement (QAPI).6. Social Worker has access to Facility Licensing and Investigations Section Reporting line7 Email notification to administrator / Social Worker and Director of Nursing Services Resident to Resident altercations.8. Review results monthly in QAPI. Date of Completion 12-31-24

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	08/01/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, review of facility policy and staff interviews for 1 of 3 residents (Resident # 85) reviewed for pain management, the facility failed to ensure that licensed staff used the correct formation of a medication as per physician orders to meet professional standards. The findings include: Resident #85's diagnoses included Alzheimer's disease, dementia, and anxiety. A quarterly MDS assessment dated [DATE] identified Resident #85 had severe cognitive impairment. A physician's order dated 7/1/2025 directed to admit Resident #85 to hospice care. A physician's order dated 7/2/2025 directed to administer a 0.5 milligram (mg) tablet of lorazepam (a medication for anxiety) every one hour by mouth as needed for 14 days. The significant change MDS assessment dated [DATE] identified Resident #85 had severe short-term and long-term memory problems and noted severely impaired cognitive skills for daily decision making. The significant change MDS assessment also identified that Resident #85 was receiving hospice services. On 7/15/2025, the physician's order for lorazepam (anti-anxiety) tablets was discontinued. A physician's order dated 7/15/2025 directed to administer 0.5mg of lorazepam 2 mg/1 ml concentrate (a liquid form) every one hour by mouth as needed for 14 days. A care plan, last reviewed 7/28/2025, identified Resident #85 had a behavior problem of agitation. Interventions included administering medications as ordered. On 7/31/2025, a review of the controlled substance disposition record for lorazepam 0.5 mg tablets identified tablets were removed for administration after the discontinued date. One tablet was removed on 7/16/2025, 7/18/2025, and 7/21/2025, and the disposition record was signed by Licensed Practical Nurse (LPN#7). A review of nursing notes and the Medication Administration Record (MAR) from 7/1/2025 through 7/31/2025 failed to indicate Resident #85 received lorazepam 0.5 mg tablets on 7/16/2025, 7/18/2025, and 7/21/2025. The MAR indicated that Resident #85 received lorazepam 0.5 mg concentrate on 7/22/2025, 7/23/2025, and 7/24/2025. A review of the controlled substance disposition record for lorazepam 2 mg/1 ml concentrate was received by the facility on 7/4/2025. On 7/31/2025 at 1:14 PM, an interview with Advanced Practiced Registered Nurse (APRN #1) indicated that she was asked to evaluate Resident #85 for renewal of as-needed medications. APRN #1 indicated she ordered the as-needed administration of 0.5mg of lorazepam 2mg/1ml concentrate because the resident was receiving hospice care and hospice had recommended liquid medications. APRN#1 indicated there would be no adverse effects from receiving 0.5 mg of liquid lorazepam versus 0.5 mg in tablet form as long as a resident is able to swallow. On 7/31/2025 at 2:56 PM, an interview with LPN#7 identified she administered lorazepam 0.5 tablets to Resident #85 on 7/16/2025, 7/18/2025, and 7/21/2025. LPN#7 indicated that at that time she was not aware the order for lorazepam had been changed from tablet to liquid formulary. LPN#7 indicated she had not checked the MAR prior to administration of the lorazepam tablets and indicated she could not recall if she had attempted to document the administration in the MAR after administering. LPN#7 further indicated she had been made aware after 7/21/2025 by a day shift nurse the formulary for lorazepam had been changed. On 7/31/2025 at 3:30 PM, an interview with the Regional Nurse (RN #1) indicated LPN#7 should have notified the DNS when LPN#7 found out that she had administered tablets of lorazepam instead of the ordered concentrate. A review of the facility policy for Medication Pass identified that when as-needed medications are administered, documentation should include date and time of administration, medication, dose, and route. Additionally, the policy indicated that staff were to remember the six rights of medication pass, which included administering the right dosage form of a medication.

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	08/01/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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	08/01/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, review of facility documentation, review of facility policy and staff interviews for 2 of 3 residents (Residents # 7 and Resident # 85) reviewed for pain management and medication documentation, the facility failed to ensure that administration of as-needed medications was documented in the medical record. The findings included: 1.Resident #7 was admitted on [DATE] to the facility, The resident's diagnoses included gangrene (death of body tissue due to a lack of blood supply) and amputation of left and right toes. A physician's order dated 7/5/2025 directed to administer 2 milligrams (mg) of hydromorphone (an opioid pain medication) every four hours as needed for severe or moderate pain. A care plan dated 7/6/2025 identified Resident #7 had a potential for pain related to peripheral vascular disease, wounds, and neuropathy. Interventions included administering medications per physician's orders. The admission MDS assessment dated [DATE] identified that Resident #7 was cognitively intact, had a recent surgery requiring a stay in a skilled nursing facility, and had experienced occasional pain. On 7/29/2025 at 11:21 AM, during resident screening, Resident #7 indicated although she/he had no issues receiving her/his pain medications, there was one night where she/he had to wait a long time. Resident #7 indicated this occurred three to four weeks ago but was unable to recall the length of time she/he had to wait. Resident #7 indicated she/he told the day nurse but did not recall the name of the staff member. On 7/30/2025, an interview with LPN#3 indicated she had not received any complaints from Resident #7 regarding getting her/his pain medications timely. LPN #3 indicated the resident was able to get hydromorphone every four hours as needed and the resident would call when she/he need the medication. A review of the hydromorphone blister pack (where the medication is package) identified the correct number of tablets compared to the controlled substance disposition record. LPN#3 indicated older disposition records would be located with the DNS. A review of facility-controlled substance disposition records and the MAR from 7/5/2025 through 7/28/2025 identified hydromorphone 2mg tablets were removed on 7/13/2025 at 8:00 AM, 1:00 PM, and 8:00 PM and the disposition record was signed by LPN#4; however, the MAR failed to identify corresponding administration for the tablets removed. On 7/14/2025, the controlled substance disposition record identified that hydromorphone 2mg tablets were removed at 7:15 AM and signed with an illegible signature. Tablets were also removed at 4:00 PM and 8:00 PM by LPN#4. The MAR failed to identify a corresponding administration for the tablets removed. On 7/24/2025, the controlled substance disposition record indicated hydromorphone 2mg tablets were removed at 1:00 PM and signed with an illegible signature. Tablets were also removed at 4:45 PM and 8:40 PM by LPN#4. The MAR failed to identify a corresponding administration for the tablets removed. On 7/26/2025, the controlled substance disposition record indicated hydromorphone 2mg tablets were removed at 10:00 AM and 2:00 PM by LPN#4 and at 8:00 PM by LPN#8. The MAR failed to identify a corresponding administration for the tablets removed. On 7/30/2025 at 3:25 PM, an interview with the DNS identified controlled substance disposition records are reconciled every two weeks. The DNS indicated there was no formal process for reconciling the controlled substance disposition record with the documentation in the MAR. On 7/30/2025 at 3:30 PM, an interview and record review with the Regional Nurse (RN#1) identified there were additional scattered days where hydromorphone 2mg tablets were removed but did not have corresponding documentation in the MAR. Additionally, RN #1 indicated the MAR would be audited only if irregularities were noted. RN#1 indicated that the facility would conduct an audit of the administration of hydromorphone 2mg tablets for Resident #7, including an interview with the resident. On 7/31/2025 at 10:00 AM an interview with RN #1 identified the facility had reviewed Resident #7 and other residents on the same unit and residents taken care of by LPN#4. The DNS indicated that although they had not identified irregularities in the management of controlled substances the facility determined that staff had not been consistently documenting as needed medications in the MAR and she/he would start education of all licensed staff. On 7/31/2025 at 10:52 AM, an interview with LPN#4 indicated she had administered hydromorphone 2mg tablets to Resident #7, but indicated that she does not always documented the administrations in the MAR. LPN#4 indicated she sometimes gets focused on providing care and forgets to document as-needed medications in the MAR. LPN#4 further indicated that for determining when a resident is due for as-needed medications, she would not always look in the MAR but would look at the controlled substance disposition record instead. LPN#4 further indicated she knew that as-needed medications should have been documented in the MAR. 2. Resident #85's diagnoses included Alzheimer's disease, dementia

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	08/01/2025

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 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on review of facility documents and staff interviews, the facility failed to ensure weekend staffing was reported correctly to the Payroll Based Journal (PBJ) for quarters 3 and 4 in 2024. The findings include:The PBJ Staffing Data Report labeled Fiscal Year (FY)Quarter 3, 2024 (4/1/2024-6/30/2024) and FY Quarter 4 (7/1/2024 -9/30/2024) indicated the staffing reported by the facility for quarter 3 and 4 in the year of 2024 was considered Excessively Low Weekend Staffing.An interview with the Administrator on 7/28/2025 at 10:20 AM indicated corporate managers submit the facility's PBJ staffing and had been focused on finding the reason(s) why weekend staffing as reported for quarter 3 and 4 were considered by the PBJ system as Excessively Low Weekend Staffing. The Administrator further indicated that when there is a staffing need the facility offers a bonus to cover call outs and meet the staffing levels.An interview on 7/31/2025 at with the Corporate Director #1 indicated Quarters 3 and 4 of 2024 were found to have correct staffing but the staff who worked were not placed in the appropriate classification when reported, causing the PBJ to not accurately reflect weekend staffing for Quarters 3 and 4 in 2024.