STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075270	A. Building B. Wing	11/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Groton Regency	1145 Poquonnock Rd Groton, CT 06340

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, interviews, facility documentation and policies for one (1) of three (3) residents (Resident #1) reviewed for resident rights, the facility failed to ensure the resident was treated with respect during medication administration. The findings included:Resident #1 was admitted to the facility in October of 2025 with diagnoses which included congestive heart disease, anxiety, and Type 2 diabetes mellitus.Review of the Nursing admission assessment dated [DATE] identified Resident #1 was alert and oriented to person, place, time, and situation, was verbally appropriate, and required extensive assistance with personal hygiene, bed mobility, and transfers.The Resident Care Plan (RCP) dated 10/25/25 identified Resident #1 required assistance/was dependent for activities of daily living which included bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, and toileting related to a recent hospitalization which resulted in fatigue, activity intolerance, and confusion. Interventions included to monitor medications, especially new/changed/discontinued medications, for side effects and responses contributing to cognitive loss/dementia.The Department of Public Health Reportable Event Summary Report dated 10/24/25 identified Resident #1 alleged a staff member went into his/her room at 6:00 AM on 10/24/25 to administer medications, Resident #1 informed the staff member that he/she could not take medications without applesauce and Resident #1 heard the staff member state Jesus Christ before leaving the room.A Nursing note dated 10/25/25 at 12:06 PM identified Resident #1 alleged RN #1 used inappropriate language and demeanor during an interaction.A Disciplinary Action Form dated 10/26/25 identified RN #1 was cited for unprofessional conduct and failed to maintain professional demeanor during an interaction with a resident. RN #1 was educated on professionalism and customer service.Interview on 11/14/25 at 9:15 AM with RN #1 (11:00 PM to 7:00 AM nurse supervisor) identified he/she was assigned to provide care for Resident #1 on 10/24/25. RN #1 identified that during the morning medication pass, Resident #1 informed him/her that he/she took medication(s) with applesauce. Upon returning from the kitchen with applesauce, RN #1 indicated Resident #1 was fumbling with the remote control to his/her bed and that prior to taking the remote from Resident #1, had uttered Jesus Christ under his/her breath. RN #1 identified Resident #1 did not react to what he/she said at that time and further indicated that he/she was uncertain as to why it was even said. RN #1 further indicated he/she apologized to Resident #1 approximately thirty (30) minutes following the incident.Interview with the Director of Nursing Services (DNS) on 11/14/25 at 2:20 PM identified that uttering Jesus Christ was poor bedside manner and indicated the language was offensive. The DNS further identified that it was the facility's standard of practice for staff to maintain professionalism and respect at all times. Review of the Resident Rights policy dated 7/1/24 directed residents had a right to be treated with respect and dignity.

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
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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, interviews, facility documentation and policies for one (1) of three (3) residents (Resident #1) reviewed for medication administration, the facility failed to ensure the resident was not left unattended with administered medications. The findings included:Resident #1 was admitted to the facility in October of 2025 with diagnoses which included congestive heart disease, anxiety, and Type 2 diabetes mellitus.Review of the Nursing admission assessment dated [DATE] identified Resident #1 was alert and oriented to person, place, time, and situation, was verbally appropriate, and required extensive assistance with personal hygiene, bed mobility, and transfers.The Resident Care Plan (RCP) dated 10/25/25 identified Resident #1 required assistance/was dependent for activities of daily living which included bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, and toileting related to a recent hospitalization which resulted in fatigue, activity intolerance, and confusion. Interventions directed to monitor medications, especially new/changed/discontinued, for side effects and responses contributing to cognitive loss/dementia, drug interactions, adverse drug reactions, drug toxicity, or errors. A physician's order dated 10/25/25 directed to administer fifteen (15) grams of sodium polystyrene sulfonate powder by mouth daily for hyperkalemia (elevated serum potassium levels) mixed in sixty (60) milliliters of fluid of choice. A nurse's note dated 10/29/25 at 3:05 PM identified Resident #1 was found lying prone (on his/her stomach) on the floor, with copious wet marks on the right side of his/her shirt and right pant leg, and when asked what happened, Resident #1 responded the nurse gave me liquid that tasted horrible and I started to vomit. Then, you found me.Interview with LPN #1 on 11/13/25 at 12:22 PM identified on the morning of 10/29/25, Resident #1 was seated in his/her wheelchair during the medication pass. LPN #1 indicated he/she administered half of Resident #1's medications before Resident #1 requested additional applesauce. LPN #1 identified when he/she went to the med cart to retrieve more applesauce he/she took the remaining pills to the med cart, however, left the half-filled cup of sodium polystyrene sulfonate mixture on the bedside table positioned in front of the Resident #1. LPN #1 further identified upon reaching the medication cart (stationed at the doorway of Resident #1's room), he/she heard a loud noise behind him/her and turned to find Resident #1 lying on the floor. Interview with LPN #1 on 11/14/25 at 9:50 AM identified the remaining sodium polystyrene sulfonate mixture should not have been left on Resident #1's bedside table. LPN #1 further indicated he/she was unsure if Resident #1 consumed the remaining sodium polystyrene sulfonate mixture prior to the fall.Interview with the Director of Nurses on 11/14/25 at 2:20 PM identified facility practice was to watch residents take their medication(s) in entirety prior to leaving the resident or their room. Review of the Medication Administration policy dated 1/18/24 directed medications were administered by licensed nurses, or other staff who were legally authorized to do so in this state, as ordered by the physician, and in accordance with professional standards of practice in a manner to prevent contamination or infection. The policy further directed staff to observe resident consumption of medication.