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	01/29/2026

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 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 clinical records, review of facility documentation, review of facility policy, and interviews for one of six sampled residents (Residents #98) reviewed for resident-to-resident abuse, the facility failed to ensure the resident was free from abuse. The findings include:Resident #15's diagnoses included schizoaffective disorder bipolar type, pseudobulbar affect, and post-traumatic stress disorder. The quarterly MDS assessment dated [DATE] identified Resident #15 was cognitively intact, had hallucinations, and delusions, exhibited verbal behavioral symptoms directed towards others and other behavioral symptoms not directed toward others. The assessment further identified Resident #15 required moderate assistance with toileting hygiene, lower body dressing, clean-up assistance with personal hygiene, was non-ambulatory and independently utilize a manual wheelchair. The care plan dated 2/19/25 identified Resident #15 exhibited or had the potential to demonstrate verbal behaviors related to cognitive loss/dementia, history of verbal outburst such as yelling out, and swearing with interventions that included provide consistent, trusted caregiver, provide structured daily routine when possible, evaluate need or provide psychiatric/behavioral health consultation and provide a calm quiet well-lit environment. Review of the physician's orders for the period of February 2025 through March 2025 identified an order to monitor Resident #15 for the targeted behaviors of hallucinations and delusions. Resident #130's was admitted to the facility in February of 2025 with diagnoses that included Alzheimer's disease, anxiety disorder, and cognitive communication deficit. The admission MDS assessment dated [DATE] identified Resident #130 had severely impaired cognition, had delusions, displayed physical behavioral symptoms directed towards others, verbal behavioral symptoms directed towards others, and rejection of care. The assessment further identified Resident #130 required maximal assistance with toileting hygiene, dressing, and was able to ambulate 10 to 50 feet with moderate assistance utilizing a walker. The care plan dated 2/20/25 identified Resident #130 was resistive to care related to difficulty adjusting to facility, cognitive loss/dementia, refusal of care, use of assistive devices, physical/verbal aggressive behaviors, yells, has delusions, hits, and has incessant pacing. Interventions included: if resident becomes combative or resistive postpone care/activity and allow resident time to regain composure, monitor and report laboratory test results to physician, monitor for anxiety, verbal/physical aggression and delusions. Review of the physician's orders from February 2025 through March 2025 identified an order to monitor Resident #130 for the targeted behaviors of delusions, physical aggressive to staff, resident, and verbal aggressive to staff, resident.The Reportable Event Report dated 3/21/25 at 12:30 PM identified Resident #15 was in the bathroom in his/her room, when Resident #130 entered the bathroom and was instructed to get out by Resident #15. The report further identified that Resident #130 proceeded to slap Resident #15 on the left cheek with an open hand. The reportable event report further identified Resident #15 had no injuries, distress or discomfort and noted the actions taken included a neurological (continued on next page)

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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessment and vital signs, follow-up with psychiatric evaluation and social services, and to place a stop sign on across Resident #15's doorway. The Psychiatric evaluation and consultation dated 3/21/25 identified Resident #130 was on antibiotics for an infection and was a poor historian related to dementia and appears unaware that the incident occurred. The evaluation further identified Resident #130 was likely confused and wandered into Resident #15's bathroom and responded to the other resident telling him/her to leave the bathroom.The care plan dated 3/21/25 identified Resident #130 exhibits or has the potential to exhibit physical behaviors related to cognitive loss/dementia, negative interaction with another resident. The care plan further identified that the resident used to work in a prison and is triggered when he/she is told no. Interventions included evaluating the need for psychiatric/behavioral health consult, social service visit to provide support as needed or requested, diverting resident by giving alternative objects or activities, remove the resident from the environment if needed, observe for non-verbal signs of physical aggression and evaluate the nature and circumstances of physical behavior. The care plan did not address the possibility of Resident #130 wandering into other residents' rooms. The nurse's note dated 3/21/25 at 5:16 PM identified Resident #130 hit staff and threw a cup of juice into staff member's face after attempts to redirect. The nurse's note dated 3/29/25 at 12:16 AM identified Resident #130 was verbally aggressive toward staff, refused to use walker, refused to stop wandering into residents' room and refused to be redirected.The nursing note dated 3/31/25 at 9:00 PM identified Resident #130 was agitated, refused care, was aggravating other residents and was not easily redirected. Resident #98 was admitted to the facility in March 2025 and had diagnoses that included Alzheimer's disease, anxiety disorder and bilateral hearing loss. The admission MDS assessment dated [DATE] identified Resident #98 had moderate cognitive impairment, required setup or clean-up assistance with dressing, personal hygiene, was independent with bed mobility and ambulation. The care plan dated 4/8/25 identified Resident #98 had exhibit or had the potential to exhibit physical behaviors related to cognitive loss/dementia with a history of combative behavior in the community, lacked personal space boundaries and had the behavior of yelling with interventions that included social service visits to provide support as needed and or as requested, evaluate the need for psychiatric/behavioral health consult, remove resident from environment if needed and gently guide the resident from the environment while speaking in a calm reassuring voice. Review of Resident #98's physician's order dated 4/1/25 directed to monitor the target behavior of paranoia every shift. The Reportable Event Report dated 4/4/25 at 10:00 AM identified Resident #130 entered Resident #98's room and slapped the resident on the left side of the face and grabbed the resident's right upper arm. The report further identified that actions taken included a stop sign at the doorway, a neurological assessment, vital signs and an examination of the face and arm. The Unit Manager's (RN #5) note dated 4/4/25 at 2:14 PM identified he was called to Resident #98's room at around 10:15 AM when the resident reported that another resident entered the room and asked him/her something and then slapped him/her on the left side of the face. The nurse's note further noted the resident had pinkness to the left side of the face, resident denied pain and was alert and oriented to person and place. The note further noted that a stop sign was placed in the doorway to Resident #98's room. Interview with Resident #98 on 1/29/26 at 2:36 PM identified he/she was slapped in the face by a resident that is no longer at the facility. Resident #98 identified at the time of the incident he/she was upset but got over it quickly.The psychiatric evaluation and consultation dated 4/4/25 identified Resident #98 reported being hit in the face by another resident in the morning, and thinks the resident was confused and wanted him/her to go with him/her but once he/she declined, Resident #98 struck him/her. The Reportable Event Report dated 4/4/25 at 10:00 AM identified Resident (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#130 went into another resident's room (Resident #98) yelled at the resident, demanded them to do what he/she asks, slapped the resident and grabbed them on the right upper forearm. The report further identified Resident #130 was placed on one-to-one supervision following the incident. The Psychiatric evaluation and consultation dated 4/4/25 identified Resident #130 entered another resident's room and the other resident reported that Resident #130 hit her in the face with an open hand. The evaluation further identified Resident #130 had a previous resident to resident incident which occurred on 3/21/25 wherein Resident #130 went into another resident's bathroom and the other resident yelled at him/her and Resident #130 hit the other resident and Resident #130 was worked up for infection and there was no evidence of an active infection. In addition, the evaluation further identified based on recent episodes of physical aggression with no evidence of infection, Resident #130 should remain on one-to-one supervision and should be sent to a psychiatric facility for treatment. Review of the nurses' notes from 4/4/25 to 4/8/25 identified that the resident remained on one-to-one observation. The physician's progress note dated 4/8/25 identified the resident was transferred to an inpatient psychiatric hospital. Review of the Abuse, Neglect and Exploitation policy identified that this 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, exploitation and misappropriation of resident property. The facility failed to implement effective interventions for Resident #130, who displayed wandering, verbal and physical aggression and was not easily redirected. These failures contributed to an incident of resident-to-resident abuse.