STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075270	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Groton Regency LLC	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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46117 Based on observation, review of facility documentation, review of facility policy, and interviews, the facility failed to ensure the Main ([NAME]) dining room was open and utilized for resident dining consistently on the weekends. The findings include: Observation of the resident dining on 3/21/24 at 12:30 PM identified approximately 30 residents eating in the [NAME] dining room. The Resident Council Interview on 3/25/24 at 1:00 PM with Resident #6, Resident #10, Resident #64, Resident #72, and Resident #102 identified that the [NAME] dining room had been closed on the weekend for several weeks. Interview with Dietary Aide (DA) #1 and Dietary Aide #2 on 3/26/24 at 12:00 PM identified that the [NAME] dining room was closed on weekends. The residents' meals are delivered to the residents' rooms on the weekends. DA #1 and DA #2 identified that the [NAME] dining room had been closed on the weekends for several weeks. They further identified that the nursing staff did not have enough staff to transport the residents to the [NAME] dining room on the weekend. Interview with the Food Service Director (FSD) on 3/26/24 at 1:00 PM identified that the [NAME] dining room was closed on weekends. She further identified that dietary utilized tray service and delivered meals to the residents' rooms on weekends. She also identified that the nursing staff did not have enough staff on the weekends to transport the residents to the [NAME] dining room. Further, The FSD identified that she and the nursing department had collaborated and decided to close the [NAME] dining room on the weekends. Interview with NA #1 on 3/26/24 at 1:35 PM identified she worked on 3/24/24 (Sunday) on the 7AM -3PM shift on the E and F unit (dementia unit). She identified that the E and F unit had the residents listed at the nurses' station who were supposed to be transported to the [NAME] dining room for meals. She further identified that she had not transported any residents to the [NAME] dining room on 3/24/24 because it was closed. Interview with LPN #1 (charge nurse) on 3/26/24 at 2:15 PM identified the [NAME] dining room was closed on the weekends. She identified that the FSD notified the nursing department that the [NAME] dining room would be closed on the weekends due to the staffing shortage. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075270	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Groton Regency LLC	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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the DNS on 3/27/24 at 10:00 AM identified that the [NAME] dining room was available to the residents every day; however, she identified that the [NAME] dining room had a low participation rate from the residents on the weekends. She further identified the facility had started a QAPI to increase the resident participation utilizing the [NAME] dining room on the weekends. The facility Quality Assurance (QA) and Performance Improvement (PI) documentation dated 2/20/24 identified the issue of re-opening the [NAME] dining room on the weekends. The goal was to re-open the dining room by 5/1/24. The facility plan of action was to reach safe staffing levels by holding nurses' aides (NA) classes and training new NAs for dining procedures and transport. Review of the facility QAPI materials with the DNS on 3/27/24 at 11:00 AM identified the facility problem was re-opening of the [NAME] dining room on the weekends and their action plan was safe staffing levels by holding NA class and to train NAs on the dining procedure and transport. She denied that the facility had a staffing shortage on the weekends after reviewing the QAPI for the re-opening of the [NAME] dining room. She further identified that the facility had not opened the [NAME] dining room on the weekends because the facility had until 5/1/24 to meet their goal. The Promoting and Maintaining Resident Dignity During Mealtime policy identified that the facility would treat each resident with respect and/or dignity and care for each resident in an environment that maintains or enhances the residents' quality of life.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075270	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/27/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Groton Regency LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0637 Level of Harm - Potential for minimal harm Residents Affected - Some	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46117 Based on clinical record review and interviews for one sample resident (Resident #12) reviewed for hospice care, the facility failed to complete a Significant Change in Status MDS assessment when the resident was admitted to hospice. The findings include: Resident #12's diagnoses included dementia, adult failure to thrive, bipolar disorder and malignant neoplasm of the colon. The quarterly MDS assessment dated [DATE] identified Resident #12 had severe cognitive impairment, required extensive assistance with toileting, hygiene, dressing, transfers, and was non-ambulatory. The physician's order dated 6/27/23 directed to refer Resident #12 for hospice services and treatment as appropriate for late-stage dementia. Review of the electronic health record (resident census) identified Resident #12 was admitted to hospice on 6/28/23. The Resident Care Plan (RCP) dated 6/28/23 identified Resident #12 was admitted to hospice care with interventions that identified: recognize and respect resident decision of no tube feeding and/or intravenous fluid, provide companionship and activities of daily living (ADL) support, do not resuscitate (DNR) advance directive, and bereavement services provided by hospice. Review of Resident #12's MDS record from 6/28/23 to 7/11/23 failed to identify that a significant change MDS assessment was completed when the resident was admitted to hospice. Interview with RN #1 (MDS Coordinator) and LPN #1 on 3/25/24 at 10:00 AM identified they were responsible for the scheduling and completion of the MDS assessments. They both identified that a resident who was admitted to the hospice program should have a significant change MDS assessment completed within 14 days of being admitted to hospice. They identified that they started working at the facility in July of 2023 and identified that the facility did not have an MDS Coordinator at that time. They further identified that Resident #12 should have had a significant change MDS assessment completed by 7/12/23. Interview with the DNS on 3/25/24 at 10:15 AM identified that the facility did not have an MDS Coordinator at the time Resident #12 was admitted to hospice. The Resident Assessment Instrument (RAI) 3.0 manual identified that a (SCSA) must be completed after a resident's enrollment in a hospice program. The Assessment Reference Date (ARD) must be set within 14 days from the effective date of the hospice election.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075270	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/27/2024
NAME OF PROVIDER OR SUPPLIER: Complete Care at Groton Regency LLC		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46117 Based on review of facility documentation, and interviews, the facility failed to ensure staff was available to transport residents to the [NAME] dining room on the weekends. The findings include: The Resident Council Interview on 3/25/24 at 1:00 PM with Resident #6, Resident #10, Resident #64, Resident #72, and Resident #102 identified that the [NAME] dining room had been closed on the weekend for several weeks. The facility Quality Assurance (QA) and Performance Improvement (PI) documentation dated 2/20/24 identified the issue of re-opening the [NAME] dining on the weekends and point of service. The goal was to re-open the [NAME] dining room by 5/1/24. The facility plan of action was to reach safe staffing levels by holding NA classes and training new NAs for dining procedures and transport. Review of staffing schedules on 3/16/24 (Saturday) identified there was 6 licensed nurses and 10 NA for the 7-3 shift and on 3/24/24 (Sunday) there was 6 licensed nurses and 9 NAs for the 7-3 shift. Interview with Dietary Aide (DA) #1 and Dietary Aide #2 on 3/26/24 at 12:00 PM identified that the [NAME] dining room was closed on weekends. The residents' meals are delivered to the residents' rooms on the weekends. DA #1 and DA #2 identified that the [NAME] dining room had been closed on the weekends for several weeks. They further identified that the nursing staff did not have enough staff to transport the residents to the [NAME] dining room on the weekend. Interview with the Food Service Director (FSD) on 3/26/24 at 1:00 PM identified that the [NAME] dining room was closed on weekends. She further identified that dietary utilized tray service and delivered meals to the residents' rooms on weekends. She also identified that the nursing staff did not have enough staff on the weekends to transport the residents to the [NAME] dining room. Further, The FSD identified that she and the nursing department had collaborated and decided to close the [NAME] dining room on the weekends. Interview with NA #1 on 3/26/24 at 1:35 PM identified she worked on 3/24/24 (Sunday) on the 7AM -3PM shift on the E and F unit (dementia unit). She identified that the E and F unit had the residents listed at the nurses' station who were supposed to be transported to the [NAME] dining room for meals. She further identified that she had not transported any residents to the [NAME] dining room on 3/24/24 because it was closed. Interview with LPN #1 (charge nurse) on 3/26/24 at 2:15 PM identified the [NAME] dining room was closed on the weekends. She identified that the FSD notified the nursing department that the [NAME] dining room would be closed on the weekends due to the staffing shortage. Interview with the DNS on 3/27/24 at 10:00 AM identified that the [NAME] dining room was available to the residents every day; however, she identified that the [NAME] dining room had a low participation rate from the residents on the weekends. She further identified the facility had started a QAPI to increase the resident participation utilizing the [NAME] dining room on the weekends. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075270	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Groton Regency LLC	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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility QAPI materials with the DNS on 3/27/24 at 11:00 AM identified the facility problem was re-opening of the [NAME] dining room on the weekends and their action plan was safe staffing levels by holding NA class and to train NAs on the dining procedure and transport. She denied that the facility had a staffing shortage on the weekends after reviewing the QAPI for the re-opening of the [NAME] dining room. She further identified that the facility had not opened the [NAME] dining room on the weekends because the facility had until 5/1/24 to meet their goal. Interview with RN #2 (unit Manager) on 3/27/24 at 1:00 PM identified that E and F (dementia unit) had residents who were encouraged to go to the [NAME] dining room for meals. He further noted that the nursing staff, recreation department and the administration personnel assist to transport residents to the [NAME] dining room during the week days but he identified that he could not speak for the weekends because he does not work on the weekends. Interview with the Scheduler on 3/27/24 at 1:50 PM identified that she was responsible for scheduling the staff for the facility. She identified that the facility staffing level would depend on the resident census and noted for a resident census of 122, she was instructed to staff the facility for 6 licensed nurses for 7-3 shift and 3-11 shift and 4 licensed nurses for the 11-7 shift. The facility would have 13 to 14 NAs for the 7-3 shift, 11 NAs for 3-11 shift, and 7 NAs for 11-7 shift. She further identified that the facility was short staffed on 3/16/24 and 3/24/24 due to staff call outs and noted facility administration was aware of the short staffing. Interview with the Administrator on 3/27/24 at 2:20 PM identified that other staff members are available to transport residents to the [NAME] dining room during the week days; however, staffing on the weekends is limited to the nursing staff making the transport more difficult and that is why it was a QAPI was developed to address the issue of the dining room being closed on the weekend related to having enough staff to transport the residents on the weekends.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075270	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Groton Regency LLC	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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47402 Based on observations, review of facility policy and interviews, the facility failed to ensure expired food was dated and removed from the refrigerator. The findings include: Observation during the initial tour of the dietary department with the Food Service Director (FSD #2) on [DATE] at 9:54 AM identified 2 large plastic zip bags full of sliced ham with the date ,d+[DATE] handwritten on both bags. Two peaches in a plastic produce bag with two slices out of them that was undated. Interview with FSD #2 on [DATE] at 10:10 AM identified the two bags of sliced ham would be good for three days past the labeled date then should be discarded. The FSD #2 further identified that he did not know why the peaches were in an undated bag in the fridge. Interview with the Food Service Director (FSD #1) on [DATE] at 11:50 AM identified FSD #2 had told her about the expired foods, and she identified the ham would be good for seven days past the labeled date of [DATE]. She noted that the ham should have been discarded by [DATE]. She also could not explain why the peaches had been in an undated plastic bag in the fridge. FSD #1 further identified that she and/or the Dietary Manager in Training were responsible for going through the refrigerator daily and discarding outdated foods and noted that missing the ham and peaches were an oversight. Review of the Food Storage and Retention Guide directed ready to eat prepared foods that are edible without additional preparation to achieve food safety to be stored in the refrigerator up to 7 days with Day 1 as the day of preparation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075270	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/27/2024
NAME OF PROVIDER OR SUPPLIER: Complete Care at Groton Regency LLC		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47900 Based on clinical record review, review of facility policy, and interviews for one of two sampled residents (Resident #119) reviewed for advanced directives, the facility failed to ensure the clinical record contained accurate documentation pertaining to advanced directives. The findings include: Resident #119's diagnoses included cerebrovascular disease, type 2 diabetes mellitus, and aphasia. The admission MDS assessment dated [DATE] identified Resident #119 had intact cognition, required moderate assistance with bed mobility, toileting hygiene, lower body dressing, was non-ambulatory, and utilized a wheelchair for mobility. The care plan dated 12/26/23 identified the resident's cardiopulmonary status as full code (if a person's heart stopped beating and/or they stopped breathing, all resuscitation procedures will be provided to keep them alive) with interventions that included activate resident's advance directive as indicated. The physician's order dated 12/21/23 directed Resident #119 had full code status. Review of Resident #119's clinical record failed to identify a completed Resident/Patient Health Care Instructions form identifying the resident's election of full code status. The record did contain Resident #379's Resident/Patient Health Care Instructions form which indicated a do not resuscitate (DNR) code status. Interview and clinical record review with the Unit Manager (RN #3) on 3/21/24 at 11:45 AM identified that Resident #379 was discharged from the facility and his/her records should not have been in Resident #119's clinical records. RN#3 also indicated that a copy of the resident's advanced directive consents are kept in the chart with a physician's order in the computer. She further noted Resident #119 had a completed Resident/Patient Health Care Instructions form that indicated Full Code which was found in Resident #379's chart. RN #3 further identified that the forms are filed by the unit coordinator. Interview with the Unit Coordinator on 3/21/24 at 2:20 PM identified that she is responsible for filing and scanning records into the computer and noted that the nurses also file documents at times. The Unit Coordinator further indicated that when she removes records from the resident's chart, and scans them into the computer, she does not check the names because she is taking the information directly from the resident's chart and assumes the records in the chart belong to that resident. Interview with the DNS on 3/26/24 at 10:15 AM identified that it is the responsibility of the nurse, unit manager, and the unit coordinator to file documents. The DNS identified that after the consent is obtained it is flagged in the chart for the provider to sign, then it is scanned into the electronic health record. The DNS further identified that the resident's name should be double checked especially if the names are similar prior to filling a document into the resident's records and a copy of the resident's advanced directives consent form should be kept in the resident's physical chart. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075270	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Groton Regency LLC	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 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	The Maintenance of Clinical Record policy identified that the facility must maintain medical records on each resident that are completely and accurately documented.