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

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observations, review of facility documentation and interviews for two of three nursing units (C/D and E/F), the facility failed to ensure resident areas were kept in good repair. The findings include:Observations on all days of the survey, 1/21/26, 1/22/26, 1/27/26, 1/28/26 and 1/29/26 identified that many of the resident rooms on the C/D and E/F nursing units were noted with following:The frames of the drop ceilings contained an excessive amount of what appeared to be rust stains. The wallpaper and wallpaper borders at the top of the walls appeared discolored, ripped and/or hanging off the wall.Ceiling tiles that were bowed, bulged, or broken.Cove base molding that was not adhered to the wall and with dirt, debris or black growth observed behind the moldingThe thresholds to some resident rooms were missing.Chipped flooring tiles A tour of the nursing units with the Regional Maintenance Director on 1/28/26 and 1/29/26 identified that he wrote the specific rooms and areas where the environmental concerns were noted. Interview with the Regional Maintenance Director on 1/21/26 at 2:30 PM identified that the rooms throughout the facility were being redone and that there is a QAPI (Quality assurance project) outlining the plan. Review of the QAPI plan dated 10/21/25 identified a plan to address the environment on the A/B nursing unit and noted that resident rooms would be renovated. Further review of the plan failed to identify that the environment on the C/D and the E/F units would be addressed. Interview with the Administrator on 1/21/26 at 2:45 PM identified facility environmental rounds paperwork and QAPI plan dated 10/21/25 which addressed the topic Homelike Environment and renovation plans for Units A and B and projected repairs were for the 31 resident rooms on those 2 units. There was no information provided regarding repairs on the C, D, E or F unit. Interview with the ADNS on 1/22/2026 at 3:25 PM identified that she was responsible for environmental rounds with a focus on infection control and indicated she does not focus on the maintenance or repair of items unless it affects infection control. Interview with the Director of Housekeeping and the District Manager for Environmental Services (EVS) on 1/22/2026 at 3:31 PM identified EVS environmental rounds were focused on cleanliness of the areas but indicated if something was in grave disrepair it would be noted. Interview with the Maintenance Supervisor on 1/22/2026 at 3:36 PM identified that he reviews a reporting system that staff can put in maintenance requests and completes repairs to the facility based on the reporting system requests. When asked if there was a general maintenance audit or list with items that needed upkeep or if there was a system in place for general upkeep, the Maintenance Director identified that he had not completed a building audit and indicated the rooms are looked at when the maintenance staff are in the rooms to complete work. The Maintenance Director identified that when the rooms are empty and available they are looked at. He presented maintenance and housekeeping rounds dated 5/7/25, 6/11/25, 6/18/25, 6/25/25, 7/2/25, 7/9/25, 7/16/25, 7/23/25 and 7/3025 which identified items on the E/F unit for cleaning and an audit for repairs and room improvements that the Maintenance Director identified was primarily initiated by the E/F unit coordinator and indicated he did not have the same paperwork for the C/D unit. Interview with the E/F Unit Manager on 1/28/2026 at 7:56 AM identified that as he does daily rounds he notes if something needs to be repaired and puts that request for repair in the computer system so that maintenance is notified. Interview with the (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administrator on 1/28/2026 at 11:07 AM identified that he received quotes for flooring throughout the building but did not have a timeline or a plan for implementation of the plan. The Administrator indicated he was aware that repairs needed to be completed but noted he did not have a written plan. The Administrator identified that the facility had completed repairs concentrated on the A/B unit because it was identified in a previous survey. Following surveyor inquiry, the Regional Maintenance Director submitted a prioritized plan for room repairs for resident rooms and identified the facility will complete corrections on A/B and move throughout the remaining units based on need and prioritization.

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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 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 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 (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 #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 (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, review of facility documentation, review of facility policy/procedures and interviews for 2 of 6 residents (Resident #4 and Resident #73) reviewed for involuntary seclusion, the facility failed to ensure the comprehensive care plan was reviewed and revised to reflect each resident's changing goals, preferences and needs of the resident including placement and continued placement on a secured unit. The findings included:Review of resident roster for the E/F secured nursing unit on 1/21/26 at 11:00 AM identified Resident #4 resided on the secured unit.Review of the clinical record on 1/22/26 identified a consent form for the secured unit (E/F) that identified Resident #4 had dementia and was a wandering risk and would only be allowed to leave the unit with supervision. The form identified that verbal consent was obtained from Resident #4's responsible party on 10/30/25 and was signed by facility staff.The physician's orders dated 1/26/26 directed Resident #4 directed to monitor the target behaviors of agitation, and insomnia. Interview with Resident #4's Responsible Party on 1/29/26 at 8:48 AM identified she did not have any concerns with Resident#4's placement on the secured unit due to wandering behaviors, confusion and safety decline.Interview with the Unit Manager (E/F) (RN# 10) on 1/29/26 at 10:35 AM identified Resident #4 was a resident on the secured unit and indicated that admission to the secured unit is interdisciplinary and that the social worker is responsible for updating the care plan to reflect the resident residing on a secured unit.Interview with Social Services Director on 1/29/26 at 1:15 PM identified Resident #4's care plan failed to identify interventions implemented related to the resident being on a secured unit. The facility policy for Comprehensive Care Plans identified the comprehensive care plan should describe, at a minimum, the following: the services that are to be furnished to attain or maintain the residents' highest practicable physical, mental, and psychosocial well-being, and resident specific interventions that reflect the residents' needs.The Secure Dementia Care Unit Policy identified that the interdisciplinary team conducts quarterly and periodical reviews on patients residing on the secured unit to assess for ongoing appropriateness of residing on the unit.The policy indicated that the comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment and indicated that alternative interventions will be documented and identified that qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made. Resident #73's diagnoses included hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominant side, Alzheimer's disease and vascular dementia with other behavioral disturbances. The quarterly MDS assessment dated [DATE] identified Resident #73 had moderately impaired cognition, did not exhibit behaviors, was dependent on staff for position changes, transfers and mobility and did not utilize any alarms or restraints. Review of facility unit roster for E/F secured unit on 1/21/26 at 11:00 AM identified Resident #73 resided on the secured unit. Memory unit program physician authorization dated 1/6/26 and signed by the Medical Director identified Resident #4 would benefit from a structured program including the provision of a secured residence/neighborhood based on Resident #4's diagnosis of Alzheimer's disease.Facility documentation for E/F secure unit with dementia features consent signed 1/6/26 identified Resident #73's conservator gave verbal permission for secured unit placement over the phone. Observation of Resident #73 on 1/21/26 at 2:16 PM identified Resident #73 resided in a resident room on the secured unit and indicated he/she could not leave the unit without permission. The physician's orders dated 1/26/26 directed to monitor for target behaviors of yelling/screaming, and sad affect/weeping. The care plan dated 1/28/26 identified Resident #73 had the potential to exhibit behaviors of irritability and restlessness secondary to a diagnosis of depression, swearing, yelling at staff and forgetting when care provided (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with interventions to explain all care including procedures, and the reason for performing the care before initiating, provide consistent, trusted caregiver and structured daily routine, when possible, remove resident from environment, if needed and gently guide the resident from the environment while speaking in a calm, reassuring voice, provide a calm, quiet, well-lit environment. The care plan did not identify Resident #4 resided on a secure unit.Interview with the Unit Manager (E/F) (RN# 10) on 1/29/26 at 10:35 AM identified Resident #73 was a resident on the secured unit and indicated that admission to the secured unit is interdisciplinary and that the social worker is responsible for updating the care plan to reflect the resident residing on a secured unit.Interview with Social Services Director on 1/29/26 at 1:15 PM identified the care plan failed to address Resident #73's residence on the secure unit and/or interventions to direct the resident specific care on the unit. The facility policy for Comprehensive Care Plans identified the comprehensive care plan should describe, at a minimum, the following: the services that are to be furnished to attain or maintain the residents' highest practicable physical, mental, and psychosocial well-being, and resident specific interventions that reflect the residents' needs.The Secure Dementia Care Unit Policy identified that the interdisciplinary team conducts quarterly and periodical reviews on patients residing on the secured unit to assess for ongoing appropriateness of residing on the unit.The policy indicated that the comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment and indicated that alternative interventions will be documented and identified that qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of clinical records, review of facility policy, review of facility documentation, and interviews for one of three residents (Resident #23) reviewed for pressure ulcer/injury, the facility failed to appropriately track and place a resident with an open wound on Enhanced Barrier Precautions (EBP) to ensure the appropriate PPE was utilized when providing wound care. The findings include:Resident #23's diagnoses included vascular dementia, non-pressure chronic ulcer of skin of other sites with fat layer exposed, anxiety disorder.The quarterly MDS assessment dated [DATE] identified Resident #23 had severely impaired cognition, was dependent on staff for bed mobility, personal hygiene, dressing, eating, transfers and was non-ambulatory. The assessment further identified Resident #23 had treatments for skin and ulcer/injury for pressure reducing device for chair and bed, application of non-surgical dressing other than to feet and applications of ointment/medications other than feet.The care plan dated 1/24/26 identified Resident #23 was at risk for skin breakdown related to fragile skin, incontinent of bowel and bladder, end stage failure with interventions that included low air mattress related to sacral wound and for pressure reduction, setting per manufacturer guidelines, treatment per provider order, weekly wound assessment to include measurements and description of wound status.The physician's order dated 12/4/25 directed to cleanse sacrum with wound cleanser, pat dry, apply xeroform followed by dry protective dressing as needed for soiled or dislodged monitor for placement and every day shift wound care.The wound evaluation and management summary dated 12/18/25 written by the Wound physician (MD #2) identified Resident #23 had an end stage skin failure to sacrum full thickness measuring 3 centimeter (cm) in length, 0.8 cm in width, and 0.2 cm in depth with moderate serosanguinous exudate.The wound evaluation and management summary dated 1/22/26 written by the Wound physician (MD #2) identified Resident #23 had an end stage skin failure to sacrum full thickness measuring 0.5 cm in length, 0.8 cm in width, and 0.2 cm in depth with moderate serosanguinous exudate.Observation on 1/27/26 at 2:00PM identified posted signage that identified the need for Enhanced Barrier Precautions (EBP) which noted the need for everyone to perform hand hygiene before entering and when leaving the room, providers, and staff to wear gloves and a gown for high-contact resident care activities such as dressing, bathing, showering, device care or care of a urinary catheter.Interview with NA #1 on 1/27/26 at 2:00 PM identified the EBP signage posted outside Resident #23's room was for the roommate as the resident has a foley catheter. She identified that staff is aware of who is on EBP by the sign placed outside of the room and if they have questions, they can ask the nurse.Review of the facility's EBP list dated 1/13/26 with the Infection Preventionist (RN #1) in the presence of the Clinical Manager RN #3 on 1/28/26 at 10:49 AM failed to reflect that Resident #23 was placed on the EBP list.Interview with the Infection Preventionist (RN #1) in the presence of the Clinical Manager RN #3 on 1/28/26 at 10:49 AM identified any resident with an open wound even if it is small is placed on EBP. RN #1 identified that staff is aware that a resident is on EBP by the signage placed on the outside of the room, the nurse aide care card, the resident care plan, the physician's order, and a list is placed at the nurse's station. RN #1 identified that Resident #23 should be on EBP due to the open wound on the sacrum. She identified that it was her responsibility to place the resident on EBP and add them to the list as he/she did have an open wound to the sacrum.Observation of wound care treatment for Resident #23 on 1/29/26 at 9:28 AM identified LPN #2 cleaned the treatment cart, performed hand hygiene, brought the cart to the room, donned gloves, gathered supplies of wound cleanser, xeroform dressing, dry protective dressing, gauzes, scissors, and marker. LPN #2 requested NA #1 to assist with positioning the resident during the wound care treatment. LPN #2 brought supplies to the beside while NA #1 repositioned Resident #23 on the left side exposing the affected area which was open and red, and proceeded to complete the treatment as directed by the physician. LPN #2 and NA #1 donned gloves but failed to wear a gown when providing (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and assisting with the wound care treatment.Interview with LPN #2 on 1/29/26 at 9:40 AM identified she did not wear the required PPE while administering the wound care treatment because the resident was not on EBP. She identified that the EBP signage outside of the room was for the roommate who had a foley catheter and would require EBP. LPN #2 further noted that when a resident is on EBP there is a physician's order in the chart, a care plan, a note in the special instructions banner, and his/her name would be listed on the EBP/MDRO list at the nursing station. A review of all the locations described failed to reflect that Resident #23 was on EBP. Interview with the Unit Manager (LPN #1) on 1/29/26 at 9:49 AM identified the resident was not on EBP and should have been on EBP precautions after reviewing the wound notes and LPN #2 identifying it was an open wound.Interview with the Wound Nurse (RN #4) on 1/29/26 at 9:59 AM identified Resident #23 should be on EBP due to the open wound to sacrum. She identified it was her responsibility to ensure that the resident was on EBP, as this resident is seen by the wound provider weekly.Review of the Enhanced Barrier Precautions identifies an order for enhanced barrier precautions will be obtained for residents with any of the following: wounds (example chronic wounds such as pressure ulcers, diabetic ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and indwelling medical devices (example central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheter, PICC lines, midlines) even if the resident is not known to be infected or colonized with a MDRO.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, review of facility documentation, review of facility policy/procedures, and interviews for 1 of 5 residents (Resident #4) reviewed for immunizations, the facility failed to ensure that the COVID-19 booster vaccination was offered or history assessed. The findings include:Resident #4's diagnoses included dementia, atrial fibrillation, and anxiety disorder. The quarterly MDS assessment dated [DATE] identified Resident #4 had severely impaired cognition. The assessment further identified that Resident #4 was not up to date with the COVID-19 vaccination.Review of the COVID-19 Vaccine Administration and Consent Form with the Infection Preventionist (RN #1) in the presence of the Clinical Manager (RN #3) on 1/28/26 at 10:49 AM identified Resident #4 Power of Attorney (POA) gave the facility permission on 10/20/25 to administer the COVID-19 vaccine and boosters. Further review of Resident #4 physician's orders, preventative health care report and progress notes with RN #1 and RN #3 failed to reflect that Resident #4 had received the COVID-19 booster vaccine for 2025-2026 as requested or had refused the vaccine when attempted to administer. Interview with RN #1 on 1/29/26 at 10:34 AM identified she had seen the previous COVID-19 consent that was signed in August of 2025 for refusal but did not see the new consent that was signed in October of 2025. She further indicated that the resident should have received the vaccine as the facility had started administering the vaccine to residents at that time. RN #1 identified she had spoken to the POA, and he/she still wants the resident to offer the vaccine. Review of the COVID-19 Vaccination policy identifies the facility to minimize the risk of acquiring, transmitting or experiencing complications from COVID-19 (SARS-CoV-2) by educating and offering our resident and staff the COVID-19 vaccine.

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

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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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, review of facility documentation, and interviews for one of two sampled residents (Residents #15) reviewed for Preadmission Screening and Resident Reviews (PASRR), the facility failed to ensure the comprehensive assessments were accurately coded to reflect the resident's positive Level II PASRR status and for three of three sample residents (Resident #12, Resident #14, and Resident #44) reviewed for resident assessment, the facility failed to ensure the Brief Interview for Mental Status (BIMS) (a screening tool to assess resident's cognitive function) was completed. The findings include: Resident #15's diagnoses included schizoaffective disorder bipolar type, pseudobulbar affect, and post-traumatic stress disorder. The PASRR level II screening dated 2/7/2023 identified Resident #15 had a positive level II PASRR. The annual MDS assessment dated [DATE] identified under the Preadmission Screening and Resident Review (PASRR) section a response of no to the question that asks if the resident was currently considered by the level II PASRR process to have a serious mental illness and or intellectual disability or a related condition. The correct response should have been yes because the resident has a positive Level II assessment and a yes would have led to more questions that pertain to why the resident has a Level II PASRR assessment. Interview on 1/27/26 at 11:30 AM with the Director of Social Services (SW #1) identified that the social workers are responsible for completing section A1500 on the admission, annual, and significant change in status MDS assessments. SW #1 identified he started working at the facility in August of 2025 and during that initial orientation phase, a per diem MDS Coordinator was completing the PASRR section of the MDS assessments. He further identified Resident #15 had a positive level 2 PASRR assessment and the MDS should have been coded accurately to reflect the positive level 2 PASRR assessment. Interview on 1/28/26 at 2:00 PM with the MDS Coordinator (RN #2) identified she was responsible for coding the PASRR section of the MDS assessment dated [DATE]. She identified that she obtained information from the electronic record system to complete the assessment and at the time of the review she saw a document entitled level of care in the miscellaneous section of Resident #15's record but did not open the document. RN #2 identified that the assessment was coded incorrectly, and she had submitted a correction as it is the policy that MDS assessments should be coded accurately. Review of the Conducting an Accurate Resident Assessment identifies the purpose of this policy is to ensure that all residents receive an accurate assessment, reflective of the resident's status at the time of the assessment, by staff qualified to assess relevant care areas. The policy further identified each individual who completes a portion of the assessment will sign and certify the accuracy of that portion of the assessment, whether the MDS assessments are manually completed, or computer-generated following data entry, each individual assessor is responsible for certifying the accuracy of responses relative to the resident's condition and discharge or entry status. Resident #12's diagnoses included vascular dementia, anxiety, and type 2 diabetes mellitus. (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	The quarterly MDS assessment dated [DATE] identified Resident #12's cognitive assessment in (section C) was not assessed, meaning the BIMS was not completed nor was the cognition assessed by the staff, which is supposed to be done when the resident is unable to complete the brief interview for mental status. Interview with the Director of Social Work (SW #1) on 1/22/26 at 1:25 PM identified that the social worker is responsible for conducting the BIMS and completing the section C of the MDS (this is the part pertaining to the assessment of cognition). He identified that section C is completed during the seven-day look back period of the MDS assessment. He further identified that not assessed means the BIMS nor alternate staff assessment of the cognition were completed. He could not provide a reason why the interviews or the staff assessments were not completed for Resident #12, Resident #14, and Resident #44. Interview with the MDS Coordinator (RN#2) on 1/28/26 at 2:10 PM identified that the social worker is responsible for conducting the BIMS in section C of the MDS to assess the resident's cognition. She identified that she coded not assessed in section C because there was no BIMS completed during the seven day look back period. She identified that she works per diem as the MDS Coordinator. She noted that she did explore why the cognitive function of the resident was not assessed. The Resident Assessment of Cognitive Patterns policy identified that the facility completes section C of the MDS to determine the resident's attention, orientation, and ability to register and recall new information. Each resident's cognitive functioning will be assessed and documented in section C of the MDS assessment. Resident #14's diagnoses included bipolar disorder, post-traumatic stress disorder (PTSD), type 2 diabetes mellitus. The annual MDS assessment dated [DATE] identified Resident #14's cognitive assessment in section C was marked off as not assessed meaning the BIMS was not completed nor was the cognition assessed by the staff, which is supposed to be done when the resident is unable to complete the brief interview for mental status. Interview with the Director of Social Work (SW #1) on 1/22/26 at 1:25 PM identified that the social worker is responsible for conducting the BIMS and completing the section C of the MDS (this is the part pertaining to the assessment of cognition). He identified that section C is completed during the seven-day look back period of the MDS assessment. He further identified that not assessed means the BIMS nor alternate staff assessment of the cognition were completed. He could not provide a reason why the interviews or the staff assessments were not completed for Resident #12, Resident #14, and Resident #44. Interview with the MDS Coordinator (RN#2) on 1/28/26 at 2:10 PM identified that the social worker is responsible for conducting the BIMS in section C of the MDS to assess the resident's cognition. She identified that she coded not assessed in section C because there was no BIMS completed during the seven day look back period. She identified that she works per diem as the MDS Coordinator. She noted that she did explore why the cognitive function of the resident was not assessed. The Resident Assessment of Cognitive Patterns policy identified that the facility completes section C of the MDS to determine the resident's attention, orientation, and ability to register and recall new (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	information. Each resident's cognitive functioning will be assessed and documented in section C of the MDS assessment. Resident #44's diagnoses included heart failure, atrial fibrillation, and spinal stenosis. The quarterly MDS assessment dated [DATE] identified Resident #44 cognitive assessment in section C was marked off as not assessed meaning the BIMS was not completed nor was the cognition assessed by the staff, which is supposed to be done when the resident is unable to complete the brief interview for mental status. Interview with the Director of Social Work (SW #1) on 1/22/26 at 1:25 PM identified that the social worker is responsible for conducting the BIMS and completing the section C of the MDS (this is the part pertaining to the assessment of cognition). He identified that section C is completed during the seven-day look back period of the MDS assessment. He further identified that not assessed means the BIMS nor alternate staff assessment of the cognition were completed. He could not provide a reason why the interviews or the staff assessments were not completed for Resident #12, Resident #14, and Resident #44. Interview with the MDS Coordinator (RN#2) on 1/28/26 at 2:10 PM identified that the social worker is responsible for conducting the BIMS in section C of the MDS to assess the resident's cognition. She identified that she coded not assessed in section C because there was no BIMS completed during the seven day look back period. She identified that she works per diem as the MDS Coordinator. She noted that she did explore why the cognitive function of the resident was not assessed. The Resident Assessment of Cognitive Patterns policy identified that the facility completes section C of the MDS to determine the resident's attention, orientation, and ability to register and recall new information. Each resident's cognitive functioning will be assessed and documented in section C of the MDS assessment.