| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 075261 | A. Building<br>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<br>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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**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<br>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<br>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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>**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 |