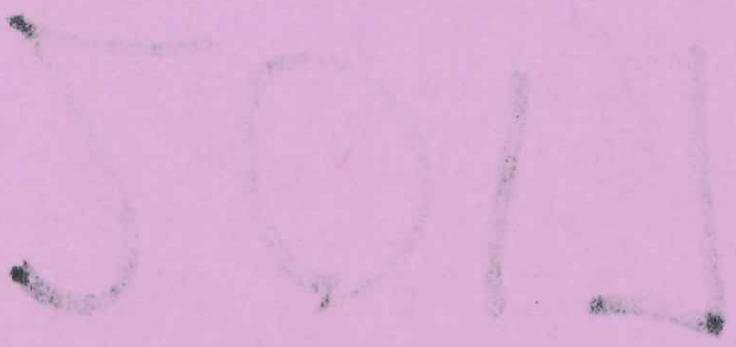
2017



STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
FACILITY LICENSING AND INVESTIGATIONS SECTION

LICENSING INSPECTION REPORT

D/B/A Name and Address of Entity	*Signature of Survey Staff*	
Groton Regency RCH	**Kibby M. Phillips**	**Generalist/Surveyor**
1145 Poquonnock Rd.		
Groton, CT 06340		

Licensure Category:	Licensed Bed/Bassinet Capacity:	Census:
__ RCH_____	**___81_____**	**_54___**

Date(s) of onsite inspection: _____1/31/17 & Fire Safety Inspection _____

Date(s) additional information obtained: _____

Personnel contacted: _____ Diane Thomas, Person in Charge & Monique Terelak, Staff Person in Charge _

REVIEW/FINDINGS/PROCESS (Complete all applicable categories)

[X] Licensing Inspection [ ] *Initial* [X] *Renewal* [ ] *Other*: (e.g. Strike)_____

[ ] Visit **OR** Revisit for the purpose of _____

[ ] See Complaint Investigation # _____

[X] Violations of the General Statutes of Connecticut and/or regulations of Connecticut State Agencies **were** identified at the time of this inspection. See attached violation letter dated 2/15/17

[ ] Desk Audit _____ [ ] Amended Letter date: _____

[ ] Citation # _____ was issued to this facility as a result of this inspection.

[ ] Violations of the General Statutes of Connecticut and/or the regulations of Connecticut State Agencies **were not** identified at the time of this inspection.

[ ] Citation # _____was/was not verified as corrected. See attached narrative report.

[ ] Narrative report/additional information attached.

[ ] See Certification File.

[ ] Referred to: _____.

REPORT SUBMITTED BY: _Kibby M. Phillips_____ DATE OF REPORT: ____2/1/17_____

[✓] Approval for issuance of license granted by: Karen Gwarek RN BSN C **DATE:** 2/15/17
Supervisor/Title

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

Healthcare Quality And Safety Branch

February 15, 2017

Diane Thomas, Person-in-Charge
Groton Regency Center
1145 Poquonnock Road
Groton, CT 06340

Dear Ms Thomas:

An unannounced visit was made to Groton Regency Center on January 31, 2017 by a representative of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting a licensure inspection.

Attached are the violations of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which were noted during the course of the visit.

You may wish to dispute the violations and you may be provided with the opportunity to be heard. If the violations are not responded to by March 1, 2017 or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

Please address each violation with a prospective plan of correction which includes the following components within fourteen days of the date of this letter:

1. Measures to prevent the recurrence of the identified violation, (e.g., policy/procedure, inservice program, repairs, etc.);

2. Date corrective measure will be effected;

3. The institution's plan to monitor its quality assessment and performance improvement functions to ensure that the corrective measure or systemic change is sustained; and

Identify the staff member, by title, who has been designated the responsibility for monitoring the individual plan of correction submitted for each violation.

If there are any questions, please do not hesitate to contact this office at (860) 509-7400.

Respectfully,

Karen Gworek RN SNC
Karen Gworek, RN, SNC
Supervising Nurse Consultant
Facility Licensing and Investigations Section

KEG:mb
cc: Nancy Shaffer

Connecticut Department of Public Health

Phone: (860) 509-7400 • Fax: (860) 509-7543
410 Capitol Avenue, P.O. Box 340308
Hartford, Connecticut 06134-0308
www.ct.gov/dph

DATE(S) OF VISIT: January 31, 2017

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following are a violation of the Regulations of Connecticut General Statutes 19a-550 and/or Section 19-13-D6 (c) Administration (1).

1. Based on a review of resident records and interview, the facility failed to ensure a copy of the resident rights had been provided to the residents. The findings include:
   a. On 1/31/17, review of Residents #1 through #27's clinical records failed to reflect documentation that a copy of Resident Rights had been provided upon admission. Interview with the Person-in-Charge identified the problem.

The following are a violation of the Regulations of Connecticut State Agencies Section 19-13-D6 (c) Administration (1) and/or (4)(A)(B).

2. Based on review of personnel files, the facility failed to ensure yearly performance evaluations were completed on the employees of the facility. The findings include:
   a. On 1/31/17, review of personnel files for Staff Persons #1 through #13 failed to reflect documentation that a performance evaluation was completed in the year of 2016. Interview with the Person-in-Charge identified the problem.

The following are a violation of the Regulations of Connecticut State Agencies Section 19-13-D6 (h) General conditions (5).

3. Based on observations and interview, the facility failed to post and/or provide a system of communication that was sufficient to meet to needs of the residents and the requirements of the state health department. The findings include:
   a. On 1/31/17, during the tour of the facility, observations identified that a copy of the patient's Bill of Resident Rights information was posted in the facility. Interview with the Person-in-Charge identified the problem.

The following are a violation of the Regulations of Connecticut State Agencies Section 19-13-D6 (c) Administration (1) and/or (c) Administration (5)and/or (h) General Conditions(3).

4. Based on review of facility records and interview, the facility failed to report an incident and/or within seventy-two hours to the State Department of Public Health. The findings:
   a. On 1/8/17, Resident #29 fell in her room and experienced right shoulder pain, was transferred to the Emergency Department for an evaluation, the resident sustained a fracture. Review of facility documentation identified the facility contacted the resident's family and police but did inform the State Public Health Department of the incident.

DATE(S) OF VISIT: January 31, 2017

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

On 1/14/17, Resident #28 fell on floor at the facility while walking in the hallway. The resident experienced right shoulder pain, was transferred to the Emergency Department for an evaluation, the resident sustained a fracture. Review of facility documentation identified the facility notified the Conservator however, the facility failed to inform the State Public Health Department of the incident. Interview with the Person-in-Charge identified the problem.