STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075270	A. BUILDING _____ B. WING _____	09/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GROTON REGENCY CENTER	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 -** Few	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation, review of facility documentation, facility policy and staff interviews, the facility failed to maintain an accurate record of the dishwasher temperatures. The findings include: Observation in the kitchen on 9/6/20 at 9:27 AM with Registered Nurse (RN) #1 identified the September 2020 dishwasher temperature log had been completed for the dates of 9/1/20 through 9/6/20 for the morning, noon and evening. Interview on 9/6/20 at 9:28 AM with Dietary Aide #1 indicated s/he was not aware that the dishwasher log had been filled out policy through 9/6/20. Dietary Aide #1 stated s/he completed the log on 9/5/20 without paying attention to the date. Interview on 9/6/20 at 9:34 AM with Account Manager #1 identified s/he was not aware that the dishwasher log had been completed through the evening of 9/6/20. The Account Manager indicated that staff should not have filled out the form ahead of time. S/he indicated the kitchen staff would be immediately provided in-service education. Subsequent to surveyor inquiry, the Account Manager replaced the dishwasher log and in-serviced the kitchen staff regarding the required protocol for checking and recording dishwasher temperatures. Review of the facility's sanitizing policy identified that food and nutrition services employees clean and sanitize all dishware after each use/meal. The policy indicated that the dishwasher is used for machine warewashing, and a high temperature or low temperature machine is acceptable for use. The protocol further identified that the Director of Dining Services or a designee records temperatures on the Warewashing Sanitizing Log at a minimum of daily with the parts per million (PPM) of sanitizer on the dish surface if a low temperature machine is used. Completed logs are to be maintained for thirty days and reviewed with the chemical supply service representative when issues arise.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide and implement an infection prevention and control program.** Based on observations, review of facility documentation, facility policies and staff interviews for five of six sampled residents (Residents #1, 2, #3, #4 and #5) located on the C, E, and F wings, the facility failed to ensure appropriate cohorting of the residents to prevent the transmission of COVID-19. The findings include: Interview with the Director of Nursing on 9/6/20 at 9:20 AM identified a facility capacity of 162 with a census of 117 on 9/6/20. Observations, review of facility documentation and interview with the Director of Nursing during a tour of the facility which commenced on 9/6/20 at 9:40 AM identified the following: 1. Interview with the Director of Nursing identified that the second floor F wing was designated for residents who were negative for COVID-19. Review of facility documentation and observation during the tour with the Director of Nursing on 9/6/20 identified that Resident #1 who was residing on the F wing had been recently admitted to the facility and required transmission-based precautions. 2. Observations and interviews with the Director of Nursing on the third floor C wing which was designated for residents who were negative for COVID-19 identified the following: a. Observation indicated that transmission-based precautions had been implemented for Resident #4 and Resident #5 who shared a room. Interview with the Director of Nursing during the tour of 9/6/20 indicated that the precautions were implemented for both residents after Resident #4 experienced an elevated temperature b. Further observation on the third floor C wing identified that Resident #3 who resided on C wing required transmission-based precautions. Interview with the Director of Nursing indicated that the resident had been recently readmitted to the facility. c. Observation identified that Resident #2 who resided on C wing required transmission based precautions. Interview with the Director of Nursing indicated that the resident had been recently admitted to the facility. Review of the facility roster on 9/6/20 identified that the facility's A wing on the first floor had been designated as a unit for residents with possible exposure to COVID-19. Interview with Registered Nurse (RN) #1 and review of the facility's cohorting strategy on 9/6/20 at 2:00 PM identified the A wing, had been designated as the unit for persons who were under investigation (PUI) for COVID-19 due to possible exposure. S/he stated that residents who were negative as well as residents who required transmission-based precautions were located on C wing as well as E and F wings. RN #1 indicated that residents who required transmission-based precautions would be located on the A wing. Interview and review of the facility's cohorting strategy on 9/6/20 at 2:15 PM with the Director of Nursing identified that A wing had been designated as the PUI (quarantine) wing although residents who required transmission-based precautions were also located on three other wings (i.e. C-wing and E and F wings) that had been designated for residents who were negative for COVID-19. Review of the facility's supplemental policy regarding the placement of admissions and readmissions identified the corporation had adopted additional clinical screening criteria for reviewing every referral for possible admission. The supplemental policy indicated that the purpose was to identify patients who presented with symptoms that have the potential to be consistent with COVID-19 prior to admission. Review of the facility's placement of readmission policy identified that when patients are admitted or readmitted from home or the hospital, the highest priority is to prevent the transmission of infection to a Covid-naive unit. The readmission policy further identified that the policy applied to all patients who are being readmitted regardless of their time out of the facility. The facility's COVID-negative or screening-negative readmission policy identified that just as new admissions from the hospital may have been exposed to coronavirus and may be asymptomatic but contagious, readmissions who may be COVID-negative or who are screening-negative and have not been tested should be admitted to the AOU (admission observation unit) for fourteen days prior to the resident's return to his/her original room if available. The facility failed to ensure appropriate cohorting of residents who had been recently admitted or readmitted to the facility to prevent the transmission of infection. The facility further failed to implement the necessary measures to prevent any further transmission of infection to a resident when a roommate experienced an elevated temperature.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE