STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075105	A. Building B. Wing	03/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Torrington Center for Nursing & Rehabilitation LLC	80 Fern Dr Torrington, CT 06790

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 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** 41223 Based on observations, clinical record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #1) reviewed for abuse, the facility failed ensure the resident was free from mistreatment. The findings include: 1. Resident #1 was admitted with diagnoses that included schizoaffective disorder/bipolar (psychiatric/mood disorder) and muscle weakness. A quarterly MDS assessment dated [DATE] identified that Resident #1 was alert and oriented, and was independent for transfers and mobility with a walker. A Resident Dare Plan (RCP) dated 8/3/2023 identified Resident #1 had behavioral symptoms with a potential for altered thought process/adjustment to new situations and was a fall risk due to decline in mobility. Interventions directed to support as needed, maintain a clam environment, calm approach to resident and complete a fall risk assessment quarterly. Record review identified Resident #1 was conserved. Observations identified Resident #1's room was located on the North wing. 2. Resident #2 was admitted with diagnoses that included autism, Parkinson's disease, schizoaffective disorder/bipolar, depression and anxiety. A readmission MDS assessment dated [DATE] identified Resident #1 was severely cognitively impaired and required substantial assistance for bed mobility, moderate assistance for transfer, and partial assistance for mobility in a wheelchair. A RCP dated 9/1/2023 identified Resident #2 wandered, had behavioral symptoms such as refusals of care, screaming, yelling, shouting, and combativeness towards staff. Interventions directed to monitor for changes in mood, redirect to the common area if attempting to elope and reapproach if refused care. Record review identified Resident #2 had a power of attorney for financial and healthcare decisions. Observations identified Resident #2's room was located on the North wing, four (4) rooms away from Resident #1 and on the same side of the hallway. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility incident report dated 2/14/2024 at 5:00 PM identified an incident of resident-to-resident abuse without injury: Resident #2 punched Resident #1 in the stomach and the residents were immediately separated. Resident #2 was observed to approach Resident #1, punch him/her in the stomach, hit his/her leg and grabbed Resident #1's walker. Resident #2 was placed on one to one (1:1) supervision and was sent to the hospital for evaluation. Notifications were completed as per facility policy. A facility interview with LPN #1 dated 2/14/2024 identified on 2/24/2024 at 5:00 PM, she had observed Resident #2 physically strike out with his hands and fist, pummeling Resident #1 who was cornered at the end of the hallway of the middle unit by the emergency door (the north wing and the middle unit meet at a corner by room [ROOM NUMBER] and the emergency exit). The statement further indicated Resident #2 had positioned his/her wheelchair to pin Resident #1 so he/she could not move. Facility summary dated 2/19/2024 identified Resident #1 had no injury from the incident, and the residents had no previous altercations. Resident #2's RCP was updated on 2/14/2024 and directed to educate and remind Resident #2 to keep hands to him/herself, to redirect resident when anxious, speak in a calm quiet manner and to offer to ambulate resident when increased agitation is noted. APRN progress note dated 2/15/2024 identified Resident #1 was evaluated after the incident and had no physical harm. Resident #1 received Hydroxyzine HCL (antihistamine with anxiety reduction effects) 25 milligrams (mg) for increased anxiety last evening. Provided emotional support and will continue Hydroxyzine HCL every 6 hours as needed for anxiety. APRN progress note dated 2/15/2024 identified Resident #2 was seen after readmission back to facility. Resident #2 was not a harm to self or others. A stat valproic acid level was ordered. Interview with LPN # 2 on 3/11/2024 at 11:00 AM identified on 2/14/2024 she observed Resident #2 punch Resident #1 in the stomach using both fists, and she immediately separated the residents. Interview with NA #1 on 3/11/2024 at 11:10 AM identified on 2/14/2024 she observed Resident #2, without any provocation, hit Resident #1 in the stomach and attempt to pull Resident #1's walker away. a. A facility accident and investigation report dated 2/16/2024 (2 days after the 1st incident) at 1:15 PM identified a second alleged incident of resident-to-resident abuse without injury. Resident #1 alleged that Resident #2 came up to him/her in their wheelchair and pulled his/her arm in a downward motion resulting in Resident #1 falling to the floor. Residents were immediately separated, and Resident #2 was placed on a 1:1 monitoring and sent to the hospital for evaluation. Notifications were completed as per facility policy. APRN #1's progress note dated 2/16/2024 identified the incident was reviewed with the DON, and Resident #2 was experiencing increased impulsivity. Resident #2 had grabbed another Resident #1 throwing him/her to the ground, and Resident #2 indicated he/she was physically aggressive because he/she wanted to. Ativan increased adding an additional 0.5 mg scheduled dose with an as need dose between 12 AM and 4 AM if needed and Depakote was also increased. APRN #1's progress note dated 2/16/2024 that Resident #1 has mild anxiety, indicating he/she did not know why Resident #2 is fixated on him/her. No changes to the current treatment plan recommended. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview, facility documentation review and clinical record review with the DON on 3/11/2024 at 2:30 PM identified Resident #1 was heard calling Resident #2 names prior to the incidents. The DON further indicated the interactions between Resident #1 and Resident #2 were inappropriate. The facility Resident Abuse, Mistreatment, Neglect, Exploitation, Misappropriation of Resident's Property and Retaliation Policy dated 9/16/2018, directed in part, to ensure residents are free from abuse. The facility Resident Rights Policy dated April 4, 2018, directed in part, residents have the right to be free from verbal or physical abuse.