

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075105	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025
NAME OF PROVIDER OR SUPPLIER Torrington Center for Nursing & Rehabilitation LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40172</p> <p>Based on review of the clinical record, facility documentation, facility policy, and interviews for one (1) of four (4) residents (Resident #3) reviewed for change in condition, the facility failed to notify the physician when a resident was exhibiting behaviors that included agitation, anxiety, and aggression. The findings include:</p> <p>Resident #3 had diagnoses that included paranoid schizophrenia, antisocial personality disorder, conversion disorder with seizures or convulsion, and unspecified dementia with severe anxiety.</p> <p>A physician's order dated 10/7/24 directed to administer trazodone (a medication used for anxiety, depression, and insomnia) 50 milligrams (mg) every 6 hours as needed for anxiety.</p> <p>The 5-day MDS dated [DATE] identified Resident #3 had a Brief Interview for Mental Status (BIMS) score of eleven (11) indicative of moderately impaired cognition with verbal behavioral symptoms directed towards others, and during the last 7 days Resident #3 was taking high-risk drugs which included antipsychotics and antidepressants.</p> <p>The care plan dated 10/14/24 identified that Resident #3 has a potential alteration in mood due to diagnoses of antisocial personality disorder, paranoid schizophrenia, and anxiety with interventions that directed to monitor and document changes in mood and behavior.</p> <p>A review of APRN #2's (psych) note dated 10/14/24 at 1:30 P.M. identified Resident #3 continues trazodone as needed as ordered. APRN #2 identified Resident #3 shared that h/she is reticent to PRN [as needed] trazodone. APRN #2 indicated she provided Resident #3 with medication education, Resident #3 was encouraged to let the nursing staff know if h/she feels like h/she is having increased anxiety, and h/she will notify nursing staff if h/she is experiencing increased anxiety.</p> <p>The nurse's note dated 10/15/24 at 3:31 A.M. written by Licensed Practical Nurse (LPN) #2 identified that Resident #3's behaviors continued, and Resident #3 was throwing staff's personnel belongings on the floor. The resident was re-directed and educated Resident #3 multiple times during the shift, and Resident #3 responded with vulgar language.</p> <p>The nurse's note dated 10/15/24 at 10:13 P.M. written by LPN #4 identified Resident #3 continues with behaviors, Resident #3 is verbally aggressive towards staff and other residents. LPN #4 identified Resident #3 was not easily redirected.</p> <p>(continued on next page)</p>

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: 075105	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025
NAME OF PROVIDER OR SUPPLIER Torrington Center for Nursing & Rehabilitation LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The nurse's note dated 10/16/24 at 6:49 A.M. written by LPN #6 identified Resident #3 was self-propelling in h/her wheelchair with a very rapid on the unit. LPN #6 identified Resident #3 sat and stared at her using side-to-side hand gestures across h/her throat while pointing at her using threatening comments and foul language. LPN #6 identified Resident #3 was talking to h/herself with a rapid voice and directing anger at staff. LPN #6 identified Resident #3 turned up the volume on the television to the point it was waking neighboring residents. LPN # 6 indicated when she requested that Resident #3 turn the volume down Resident #3 attempted to hit her. LPN #6 identified during the shift Resident #3 had numerous confrontations with staff and when attempts were made to educate Resident #3 h/she would curse.</p> <p>The nurse's note dated 10/16/24 at 9:55 A.M. written by Registered Nurse (RN) RN #1 identified Resident #3 had a verbal and physical altercation with another resident and was placed on one to one supervision. RN #1 identified Resident #3 continued with agitation and aggression was sent to the emergency room .</p> <p>A review of Resident #3's Medication Administration Records dated 10/15/24 and 10/16/24 revealed Resident #3 did not receive as needed trazodone 50 mg for anxiety.</p> <p>An interview with APRN #2 on 2/27/25 at 2:00 P.M. identified on 10/15/24 and 10/16/24 when Resident #3 was verbally aggressive, using vulgar language, threatening staff, and throwing items on the floor she was not notified. APRN #2 identified her expectation is when a resident is exhibiting these types of behaviors she is notified. APRN #2 identified on 10/15/24 and 10/16/24 when Resident #3 had changes in h/her behaviors she should have been notified.</p> <p>An interview with the Director of Nursing Services (DNS) on 2/27/25 at 2:30 P.M. identified her expectations are when a resident is exhibiting any changes in mood or behaviors the provider is notified. The DNS identified on 10/15/24 and 10/14 when Resident #3 was verbally aggressive, using vulgar language, threatening staff, and throwing items on the floor APRN #2 should have been notified.</p> <p>Although attempted, interviews with LPN #2, LPN #4, and LPN #6 were not obtained.</p> <p>Review of facility change in condition policy dated 9/16/2018 identified it is the policy to ensure that changes in residents' conditions are reported to the providers and families and the facility must immediately inform the resident, consult with the resident's physician when there is a significant change in the resident's physical, mental, or psychosocial status.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075105	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025
NAME OF PROVIDER OR SUPPLIER Torrington Center for Nursing & Rehabilitation LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40172</p> <p>Based on review of the clinical record, facility documentation, facility policy, and interviews for one (1) of four (4) residents (Resident #4) reviewed for abuse, the facility failed to ensure a resident who was exhibiting verbal and physical behaviors did not physically abuse another resident. The findings include:</p> <p>1. Resident #3 had diagnoses that included paranoid schizophrenia, antisocial personality disorder, conversion disorder with seizures or convulsion, and unspecified dementia with severe anxiety. The 5-day MDS dated [DATE] identified Resident #3 had a Brief Interview for Mental Status (BIMS) score of eleven (11) indicative of moderately impaired cognition with verbal behavioral symptoms directed towards others, and during the last 7 days was taking high-risk drugs that included antipsychotics and antidepressants. The care plan dated 10/14/24 identified that Resident #3 has a potential alteration in mood due to diagnoses of antisocial personality disorder, paranoid schizophrenia, and anxiety with interventions that directed to monitor and document changes in mood and behavior.</p> <p>The nurse's note dated 10/15/24 at 3:31 A.M. written by Licensed Practical Nurse (LPN) #2 identified that Resident #3's behaviors continued, and Resident #3 was throwing staff's personnel belongings on the floor. The resident was re-directed and educated Resident #3 multiple times during the shift, and Resident #3 responded with vulgar language.</p> <p>The nurse's note dated 10/15/24 at 10:13 P.M. written by LPN #4 identified Resident #3 continues with behaviors, Resident #3 is verbally aggressive towards staff and other residents. LPN #4 identified Resident #3 was not easily redirected.</p> <p>The nurse's note dated 10/16/24 at 6:49 A.M. written by LPN #6 identified Resident #3 was self-propelling in h/her wheelchair with a very rapid on the unit. LPN #6 identified Resident #3 sat and stared at her using side-to-side hand gestures across h/her throat while pointing at her using threatening comments and foul language. LPN #6 identified Resident #3 was talking to h/herself with a rapid voice and directing anger at staff. LPN #6 identified Resident #3 turned up the volume on the television to the point it was waking neighboring residents. LPN# 6 indicated when she requested that Resident #3 turn the volume down Resident #3 attempted to hit her. LPN #6 identified during the shift Resident #3 had numerous confrontations with staff and when attempts were made to educate Resident #3 h/she would curse.</p> <p>The nurse's note dated 10/15/24 at 3:31 A.M. written by Licensed Practical Nurse (LPN) #2 identified that Resident #3's behaviors continued, and Resident #3 was throwing staff's personnel belongings on the floor. The resident was re-directed and educated Resident #3 multiple times during the shift, and Resident #3 responded with vulgar language.</p> <p>The nurse's note dated 10/15/24 at 10:13 P.M. written by LPN #4 identified Resident #3 continues with behaviors, Resident #3 is verbally aggressive towards staff and other residents. LPN #4 identified Resident #3 was not easily redirected.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075105	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025
NAME OF PROVIDER OR SUPPLIER Torrington Center for Nursing & Rehabilitation LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The nurse's note dated 10/16/24 at 6:49 A.M. written by LPN #6 identified Resident #3 was self-propelling in h/her wheelchair with a very rapid on the unit. LPN #6 identified Resident #3 sat and stared at her using side-to-side hand gestures across h/her throat while pointing at her using threatening comments and foul language. LPN #6 identified Resident #3 was talking to h/herself with a rapid voice and directing anger at staff. LPN #6 identified Resident #3 turned up the volume on the television to the point it was waking neighboring residents. LPN# 6 indicated when she requested that Resident #3 turn the volume down Resident #3 attempted to hit her. LPN #6 identified during the shift Resident #3 had numerous confrontations with staff and when attempts were made to educate Resident #3 h/she would curse.</p> <p>A review of Resident #3's Medication Administration Records dated 10/15/24 and 10/16/24 revealed Resident #3 did not receive as needed trazodone 50 mg for anxiety or that the physician was notified of the residents aforementioned behaviors.</p> <p>The nurse's note dated 10/16/24 at 9:55 A.M. written by Registered Nurse (RN) RN #1 identified Resident #3 had a verbal and physical altercation with another resident and was placed on one to one supervision. RN #1 identified Resident #3 continued with agitation and aggression was sent to the emergency room .</p> <p>A nurse's note dated 10/16/24 at 9:55 A.M. written by RN #1 identified Resident #3 had a verbal and physical altercation with another resident and was placed on one to one. RN #1 identified Resident #3 continued with agitation and aggression was sent to the emergency room .</p> <p>2. Resident #4 had diagnoses that included borderline personality disorder, delusional disorder, anxiety, and major depressive disorder. The annual MDS dated [DATE] identified Resident #4 had a Brief Interview for Mental Status (BIMS) score of fourteen (14) indicative of intact cognition and during the last 7 days was taking high-risk drugs that included antipsychotics, antidepressants, antianxiety. The care plan dated 9/26/24 identified Resident #4 at potential risk of an alteration in mood state as evidenced by depressive symptoms and mental health conditions with interventions that directed to monitor for verbal expressions of distress and observe mood, behavior, appetite and sleep pattern document any changes, psych services as needed, and social worker to provide additional support as appropriate.</p> <p>The nurse's note dated 10/16/24 at 7:59 A.M. written by RN #1 identified Resident #4 was involved in an altercation with Resident #3. RN #1 identified Resident #4 was hit in the right shoulder with an open hand as Resident #3 yelled at Resident #4 for h/her to move. RN #1 indicated Resident #4 denied any pain and no injuries were noted.</p> <p>Review of the facility's accident and incident report dated 10/16/24 at 9:24 A.M. identified at 7:45 A.M. an incident of resident-to-resident abuse without injury occurred in the lobby between Resident #3 and Resident #4. The Speech Therapist (SLP) #1 witnessed Resident #3 hit Resident #4 with an open hand on the shoulder, the residents were immediately separated, Resident #4 was placed on one-to-one monitoring and transferred to the emergency room for evaluation. The facility summary dated 10/21/24 identified on 10/16/24 when Resident #3 tried to enter the therapy gym early in the morning, it was closed, due to not being able to use the gym Resident #3 became agitated and Resident #3 approached Resident #4 striking h/her on the shoulder with an open hand in the lobby, Resident #3 and Resident #4 did not have a prior history of altercations with each other. The facility identified that abuse was substantiated.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075105	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025
NAME OF PROVIDER OR SUPPLIER Torrington Center for Nursing & Rehabilitation LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with SLP #1 on 2/27/25 at 10:25 A.M. identified on 10/16/24 at approximately 7:45 A.M. Resident #3 and Resident #4 were sitting in their wheelchairs in the lobby in front of the doors to the gym. SLP #1 identified Resident #3 tried to enter the gym, but the doors were locked. SLP #1 identified Resident #3 said something to Resident #4 and as Resident #4 went to move out of to move out of Resident #3's way, Resident #3 with an open hand struck Resident #4 on h/her left shoulder. SLP #1 indicated she immediately separated the residents and notified RN #1.</p> <p>Interview with RN #1 on 2/27/25 at 11:45 A.M. identified on 10/16/24 she was notified by SLP #1 that Resident #3 hit Resident #4 with an open hand on h/her shoulder by the doors to the gym in the lobby. RN #1 indicated she assessed Resident #4 no injuries were noted, and Resident #4 denied any pain. RN #1 indicated Resident #3 was placed on one-to-one monitoring until the ambulance arrived and transported Resident #3 to the hospital.</p> <p>Interview with the Director of Nursing on 2/27/25 at 2:30 P.M. identified that her expectations are when a resident is exhibiting any changes in mood or behaviors the provider is notified. The DNS identified on 10/15/24 and 10/14 when Resident #3 was verbally aggressive, using vulgar language, threatening staff, and throwing items on the floor APRN #2 should have been notified. On 10/16/24 SLP #1 witnessed Resident #3 with an open hand hit Resident #4 on h/her left shoulder. The DNS indicated the residents were immediately separated; Resident #3 was placed on one to one until h/she was transferred to the hospital. The DNS indicated Resident #4 had no injuries, and Resident #4 denied any pain. The DNS identified based on the investigation the allegation of resident-to-resident abuse was substantiated Resident #3 did hit Resident #4 on h/her left shoulder without being provoked.</p> <p>Review of facility abuse policy dated 9/16/18 identified; in part; it is the policy of the facility to ensure residents are free from abuse, mistreatment, neglect, exploitation, misappropriation, and retaliation. Physical abuse is the intentional infliction of physical pain, bodily harm, or physical coercion.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075105	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025
NAME OF PROVIDER OR SUPPLIER Torrington Center for Nursing & Rehabilitation LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40172</p> <p>Based on review of the clinical record, facility documentation, facility policy, and interviews for one (1) of three (3) residents (Resident #3) reviewed for behaviors, the facility failed to ensure a comprehensive care plan with appropriate interventions was implemented for a resident who exhibited physical and verbal behaviors. The findings include:</p> <p>Resident #3 had diagnoses that included paranoid schizophrenia, antisocial personality disorder, conversion disorder, and unspecified dementia with severe anxiety.</p> <p>A physician's order dated 10/1/24 directed to monitor target behavior at the end of each shift marking the frequency and intensity.</p> <p>Review of a nurse's note dated 10/8/24 at 10:45 A.M. written Licensed Practical Nurse (LPN) #5 identified she heard yelling coming from Resident #3's room. LPN #5 indicated Resident #3 was cursing to h/herself because h/she lost remote to the television. LPN #5 identified when assisting Resident #3 h/she threatened to kill and strangle her. LPN #5 indicated Resident #3 was placed on a one-to-one at this time for safety.</p> <p>Review of a nurse's note dated 10/8/24 at 10:48 A.M. written by LPN #5 identified Resident #3 declined to take as needed trazodone during and after the event and redirection was ineffective.</p> <p>Review of a nurse's note dated 10/8/24 at 10:55 A.M. written by LPN #5 identified 911 was activated due to Resident #3's threats and the police were requested.</p> <p>Review of a nurse's note dated 10/8/24 at 11:28 A.M. written by Registered Nurse (RN) #2 identified Resident #3 was agitated, threatening staff and remained one to one supervision. RN #2 identified 911 was activated and Resident #3 was transported to the emergency room .</p> <p>Review of a nurse's note dated 10/8/24 at 7:09 P.M. written by RN #3 identified Resident #3 returned from the emergency department with a no harm letter and Resident #3 is not considered a danger to self or others.</p> <p>The care plan dated 10/10/24 identified that Resident #3 had a potential alteration in mood due to diagnoses of antisocial personality disorder, paranoid schizophrenia, and anxiety with interventions that directed to monitor and document changes in mood and behavior. The care plan failed to identify a concern related to Resident #3's behaviors and include personalized interventions to manage behaviors.</p> <p>Review of a nurse's note dated 10/10/24 at 7:54 A.M. written by LPN #2 identified Resident #3 has increased behaviors was aggressive and hitting staff. LPN #2 identified while Resident #3 passed by her h/she was making gestures of cutting someone's throat. LPN #2 indicated she redirected Resident #3 and put Resident #3 in the psych book.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075105	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025
NAME OF PROVIDER OR SUPPLIER Torrington Center for Nursing & Rehabilitation LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a nurse's note dated 10/10/24 at 9:35 P.M. written by LPN #7 identified Resident #3 continues with verbally abusing staff and residents.</p> <p>A review of APRN #2's (psych) note dated 10/10/24 at 2:00 P.M. identified she collaborated with LPN #3 who reported Resident #3 has been exhibiting recent aggressive behaviors, hitting staff, making gestures towards staff of cutting someone's throat as h/she passed by the nursing staff in the hallway on 10/10/24. APRN #2 identified Resident #3 endorses h/she has random anxiety with aggression and acknowledges that h/she has not been coping effectively. APRN #2 identified the plan for Resident #3 was to continue to monitor mood, anxiety, sleep, appetite, promote adaptive coping, and provide emotional support.</p> <p>The 5-day MDS dated [DATE] identified Resident #3 had a Brief Interview for Mental Status (BIMS) score of eleven (11) indicative of moderately impaired cognition with verbal behavioral symptoms directed towards others, and during the last 7 days was taking high-risk drugs which included antipsychotics and antidepressants.</p> <p>A review of APRN #2's (psych) note dated 10/14/24 at 1:30 P.M. identified RN #3 asked her to see Resident #3 related to recent anxiety and aggression with a concern as to whether Resident #3 is exhibiting psychosis. APRN #2 identified Resident #3 endorsed mild anxiety at the time of evaluation and acknowledged h/she has random agitation and aggression associated with anxiety. APRN #2 indicated Resident #3 agreed to let nursing staff know if h/she is experiencing random anxiety.</p> <p>A review of a nurse's note dated 10/15/24 at 10:13 P.M. written by LPN #4 identified Resident #3 continues with behaviors, Resident #3 is verbally aggressive towards staff and other residents. LPN #4 identified Resident #3 was not easily redirected.</p> <p>Review of a nurse's note dated 10/16/24 at 6:49 A.M. written by LPN #6 identified Resident #3 was self-propelling in h/her wheelchair with a very rapid on the unit. LPN #6 identified Resident #3 was sitting and staring at her using side-to-side hand gestures across h/her throat while pointing at her using threatening comments and foul language. LPN #6 indicated Resident #3 was talking to h/herself with a rapid voice and directing anger at staff. LPN #6 indicated Resident #3 turned up the volume on the television to the point it was waking neighboring residents. LPN# 6 identified when she requested that Resident #3 turn the volume down Resident #3 attempted to hit her. LPN #6 identified during the shift Resident #3 had numerous confrontations with staff and when attempts were made to educate Resident #3 h/she would curse.</p> <p>Review of a nurse's note dated 10/16/24 at 9:55 A.M. written by RN #1 identified Resident #3 had a verbal and physical altercation with another resident and was placed on one to one. RN #1 identified Resident #3 continued with agitation and aggression was sent to the emergency room .</p> <p>Interview and clinical record review with LPN #8 (MDS Coordinator) on 2/27/25 at 12:45 P.M. was unable to provide documentation to reflect that Resident #3 had a comprehensive care plan implemented with appropriate interventions to manage behaviors. The MDS Coordinator indicated for when a resident has behaviors there should be an intervention implemented to manage the behaviors. Additionally, the MDS Coordinator could not identify why Resident #3 did not have a comprehensive care plan implemented to address h/her behaviors.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075105	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025
NAME OF PROVIDER OR SUPPLIER Torrington Center for Nursing & Rehabilitation LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview and clinical record review with the Director of Nursing Services (DNS) on 2/27/25 at 2:30 P.M. identified her expectation when a resident has behaviors is that a comprehensive care plan is implemented with person centered interventions. The DNS was unable to provide documentation to reflect that Resident #3 had a comprehensive care plan implemented for behaviors. The DNS identified Resident #3 should have had a comprehensive care plan in place to identify and address Resident #3's behaviors. The DNS further identified the MDS Coordinator and nursing supervisors can update and oversee the care plans. The DNS was unable to explain why Resident #3 did not have a comprehensive care plan implemented.</p> <p>Review of facility comprehensive care plan policy dated 9/16/2018 identified it is the policy that the interdisciplinary team in conjunction with the resident develops a comprehensive, person-centered care plan that includes measurable objectives to meet the resident's physical, psychosocial, and functional needs and implemented for each resident and care plan interventions are chosen only after careful data gathering, proper sequencing of events, and careful consideration of the relationship between the resident's problem areas and their causes.</p>		