| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 075105 | A. Building<br>B. Wing | 05/11/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Torrington Center for Nursing & Rehabilitation LLC | 80 Fern Dr<br>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 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.<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 1of 4 resident (Resident #2) reviewed for accidents, the facility failed to ensure a grievance was completed when the resident reported a delay in care and call bell response time. The findings include:Resident #2's diagnosis included conversion disorder with mixed symptoms, neuralgia, and hypertension.The admission Minimum Data Set (MDS) dated [DATE] identified Resident #2 had intact cognition, was frequently incontinent of bowel and bladder, and required substantial assistance with personal hygiene, and dependent with transfers and toileting.The Resident Care Plan (RCP) dated 4/12/26 identified Resident #2 was frequently incontinent of bowel/bladder function. Interventions included providing incontinence care, incontinence care products as needed, and monitoring changes in continent status.Interview with Resident #2 on 5/4/2026 at 12:50 PM identified on 4/17/26 he/she experienced issues with Nurse Aide (NA) #2 during the 3:00 PM-11:00 PM shift. Resident #2 identified two nurse aides are required to transfer him/her to the commode. Resident #2 indicated after ringing the call bell for toileting assistance, NA #2 did not respond promptly, but NA #2 finally came to the doorway and said she was assisting another resident and would return afterward. Resident #2 indicated when NA #2 finally returned he/she was on a virtual appointment and asked NA #2 to return after the appointment ended. Resident #2 indicated he/she became incontinent while waiting for assistance form NA #2. Resident #2 indicated the supervisor, Registered Nurse #5 (RN), who worked the 3:00 PM-11:00 PM shift on 4/17/26, was made aware he/she had to call NA #2 multiple times for assistance with care. Resident #2 identified RN #5 and NA #2 offered care, but he/she was upset and declined care from both, so RN #5 sent NA #3 to provide care, which Resident #2 accepted.Interview with NA #3 on 5/6/2026 at 3:07 PM identified RN #5 called him to the unit to assist with Resident #2's care on 4/17/26 during the 3:00 PM to 11:00 PM shift. NA #3 indicated he did not know the reason for the call at that time. NA #3 identified Resident #2 had been incontinent, and he provided care to the resident.Interview with NA #2 on 5/6/2026 at 3:15 PM identified on 4/17/26 when Resident #2 rang the call bell she was assisting another resident. NA #2 indicated she went to Resident #2's room and informed the resident that she would return after finishing care for the other resident. NA #2 indicated when she returned, Resident #2 was on a virtual appointment and became upset, requesting assistance from another nurse aide. NA #2 indicated she informed RN #5 about the situation, and both she and RN #5 offered care to Resident #2. NA #2 indicated Resident #2 refused care from them and accepted care from NA #3.Interviews with the Director of Nursing Services (DNS) and the Administrator on 5/6/2026 at 3:44 PM indicated that they were unaware of any incident involving Resident #2 and NA #2 on 4/16/26 or 4/17/26. The DNS and Administrator identified staff should have completed documentation, including a grievance report, notified the DNS of the incident, and changed the NA assignment.Interview with RN #5 on 5/6/2026 at 4:31 PM identified on 4/17/26 Resident #2 was upset about the care received from NA #2 due to delayed responses to the call bell. RN #5 identified she did not file a grievance or report the incident to the Administrator or Director of Nursing Services (DNS) because she changed Resident #2's assignment that evening and believed<br>(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 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | that action was sufficient. RN #5 identified she knows the policy and should have filed a grievance, documented the incident, and reported it to the DNS.Review of the Grievance log indicated there was no grievance on file dated 4/17/26 for Resident #2.Subsequent to surveyor inquiry, the DNS and Administrator initiated an accident and incident investigation.Review of facility Grievance Policy dated 1/19/18 directed, in part, all resident and responsible parties have a right to voice their grievances and to make recommendations for changes in services and/or policies (verbally or in writing) to administration, medical, nursing, or ancillary departments. Grievance is federally defined as a complaint regarding treatment, care, management of funds, lost clothing, and violation of rights. These communications are generally held confidentially and are investigated without fear or reprisal. Responses to expressed concerns are made in an orderly and timely process and are documented.Review of facility Supervisor Communication Protocol policy dated 1/19/28 directed, in part, that the RN Supervisor shall promptly report significant resident care, operational, staffing, regulatory, safety, and clinical concerns to appropriate leadership to ensure timely intervention, regulatory compliance, resident safety, and continuity of care. Any event, issue, condition, or occurrence that may negatively impact resident safety, resident rights, quality of care, staffing operations, regulatory compliance, or facility operations. The RN Supervisor shall immediately notify appropriate leadership of concerns that exceed routine nursing management responsibilities or require escalation of interventions, investigation, or regulatory reporting. The RN Supervisor shall report resident voiced concerns and will immediately notify the DNS, Administrator, and appropriate state agencies as directed by the facility policy. The RN supervisor shall document nature of concern, date, time identified, assessment findings, individuals notified, time of notifications, interventions implemented, follow-up actions, and resident outcomes. |