STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075111	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wolcott Hall Nursing Center Inc	215 Forest St 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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, interviews, and review of facility documentation and policies for one (1) of three (3) residents reviewed for fluid status, the facility failed to complete dehydration evaluations in accordance with facility policy and failed to notify the provider with the results of a dehydration evaluation timely. The findings included: Resident #1 had diagnoses that included adjustment disorder with depressed mood, peripheral vascular disease, and unspecified congestive heart failure. Review of the Nursing admission assessment dated [DATE] identified Resident #1 had a very poor food intake pattern, Resident #1 never ate a complete meal, rarely ate more than one-third of any food offered, ate two (2) servings or less of protein (meat or dairy products) per day, and took fluids poorly. Review of the Comprehensive Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Mental Interview for Mental Status (BIMS) of five (5) indicative of severely impaired cognition. The MDS further identified Resident #1 required moderate assistance with oral and personal hygiene and set-up assistance with eating. Review of Resident #1's Care Plan dated 12/26/24 identified the Resident #1 was exhibiting signs and symptoms of Corona Virus and had the potential for nutritional decline related to poor appetite interventions directed to encourage fluids up to fluid restriction, if applicable, to prevent dehydration, and to record intake and output as ordered. Review of the Resident #1's Nutritional assessment dated [DATE] identified Resident #1 had an estimated daily fluid need of 1445 milliliters to 1740 milliliters. Review of Resident #1's Fluid Intake Chart dated 12/30/24 through 1/12/25 identified the following: -A fluid intake of 580 milliliters on 12/30/24. -A fluid intake of 720 milliliters on 12/31/24. -A fluid intake of 650 milliliters on 1/1/25. -A fluid intake of 960 milliliters on 1/2/25. (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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-A fluid intake of 980 milliliters on 1/3/25. -A fluid intake of 1080 milliliters on 1/4/25. -A fluid intake of 960 milliliters on 1/5/25. -A fluid intake of 1020 milliliters on 1/6/25. -A fluid intake of 860 milliliters on 1/7/25. -A fluid intake of 760 milliliters on 1/8/25. -A fluid intake of 480 milliliters on 1/9/25. -A fluid intake of 380 milliliters on 1/10/25. -A fluid intake of 600 milliliters on 1/11/25. -A fluid intake of 640 milliliters on 1/12/25. Intake for the 14 days were all below the residents minimum daily fluid needs of 1445 milliliters. a) Review of Resident #1's Dehydration Evaluations identified evaluations were completed on 12/31/24, 1/3/25, 1/6/25, and 1/11/25 which indicated dark urine, decreased skin turgor, dry tongue, and dry mucous membranes. The evaluations identified that the practioner was notified on 12/31/24, 1/3/25, and 1/6/25. Interview with the Director of Nursing Services (DNS) on 3/5/25 at 3:10 PM identified that a Dehydration Evaluation should be completed when a resident's fluid intake was below his/her fluid goal for three (3) consecutive days and that Resident #1 should have had a Dehydration Evaluation. The DNS further identified that although the dehydration assessments were completed in accordance with facility policy on 12/31/24, 1/3/25, and 1/6/25, a Dehydration Assessment should have been completed on 1/9/25 instead of 1/11/25 (2 days late) as his/her fluid intake did not meet the established parameters on 1/6/25, 1/7/25, and 1/8/25. b. Review of the 1/11/25 Dehydration Evaluation identified Resident #1 had dark urine, decreased skin turgor, dry tongue and mucous membranes, and that APRN #1 was notified of the findings. Review of LPN #2's SBAR (Situation, Background, Assessment, Recommendation) dated 1/13/25 at 7:53 PM identified Resident #1 with increased lethargy, had mental status changes, was not eating or drinking, and that the family requested the resident be sent to the emergency room. Review of the hospital paperwork dated 1/13/25 identified that the resident was dehydrated and required Intravenous (IV) fluid resuscitation. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LPN #1 (who performed the 1/11/25 Dehydration Evaluation) on 3/6/25 at 2:55 PM identified she did not call the provider on January 11, 2025 she placed the Dehydration Evaluation into the Advanced Practice Registered Nurse (APRN) binder for review, however, the physician/APRN should have been called regarding Resident #1's 1/11/25 Dehydration Evaluation results and decreased fluid intake because January 11, 2025 was a Saturday and it was not guaranteed that a provider would be at the facility on that day. Interview with APRN #1 on 3/5/25 at 3:00 PM identified that he/she was not made aware of the 1/11/25 Dehydration Evaluation findings until 1/13/25 (Monday) when he/she was at the facility and would expect to have been called on 1/11/25 (Saturday) if the resident was at risk for dehydration. Interview with the DNS on 3/5/25 at 3:10 PM identified it was acceptable practice to place Dehydration Evaluations in the APRN binder during the week (Monday through Friday) as the physician/ APRN were in the facility on a regular basis, however if the evaluation was completed over the week-end (1/11/25 was a Saturday),and the assessment identified signs of dehydration the physician/APRN should have be called regarding findings/concerns on 1/11/25. The DNS further identified at risk residents should be seen within 24 hours of their Dehydration Evaluation if signs of dehydration are identified. The facility did not have a Dehydration Evaluation policy to provide. Review of the Hydration Protocol directed new patients would have a daily fluid goal of 1500 milliliters unless otherwise ordered by the physician. Review of the Intake/Output policy directed to ensure adequate hydration and prevent dehydration to the extent possible based on each resident's individualized care needs and choices. Review of the Hydration Protocol directed all residents will receive sufficient fluids to maintain proper hydration and health.