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	02/08/2025

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46117 Based on record review and interviews for one of three sampled residents (Resident #42) reviewed for accidents, the facility failed to ensure the resident was free from injury resulting from an instant hot pack. The findings include: Resident #42's diagnoses included dementia, ulcerative colitis, liver cancer, brain cancer, and colon cancer. The quarterly MDS assessment dated [DATE] identified Resident #42 had intact cognition (BIMS of 15), was totally dependent on staff for transfers, toileting, hygiene, and dressing, and utilized a manual wheelchair for mobility. The Resident Care Plan (RCP) dated 11/15/24 identified Resident #42 had a recall, memory impairment and impaired decision making related to dementia. Care plan interventions directed to use short and simple sentences, allow time to respond when speaking to the resident, when confused or forgetful offer gentle reminders, and if the resident does not understand, please state in simple terms. The physician's orders for the month of November 2024 directed the resident required a two person assist with bed mobility and transfers via a Hoyer lift The nurse's note dated 1/12/25 at 2:52 PM identified Resident #42 sustained a burn to the right outer knee from an instant hot pack. The skin assessment identified the area was dry, red and measured 4.0 cm in length and 1.5 cm in width. The Situation, Background, Assessment, Recommendation (SBAR) nurse's note written by LPN #1 dated 1/12/24 at 3:47 PM identified NA #1 reported Resident #42 was noted to have a hot pack applied directly to the right knee without a barrier between the skin and hot pack. Resident #42 identified that someone entered his/her room and applied the hot pack directly to his/her right knee. The note further identified Resident #42 had a burn to the right outer knee. The note also identified that the family, APRN and nursing supervisor were updated. (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 0689 Level of Harm - Actual harm Residents Affected - Few	The initial wound evaluation dated 1/15/25 at 4:48 PM identified Resident #42 had a new first degree burn to the right lateral knee. The wound size was documented as 4.0 cm in length by 2.0 cm in width and 0.1 cm in depth. The wound base was 100 percent epithelization with scant amount of serosanguineous drainage. The treatment plan directed to apply Xeroform (a type of gauze dressing) to the base of the wound and secure with a dry clean dressing, to be changed every other day and as needed. The weekly wound evaluation dated 1/29/25 at 6:10 AM identified that the first degree burn to the right lateral knee had worsened due to the presence of slough (dead tissue) in the wound bed. The wound size was documented as 4.0 cm in length by 1.5 cm in width and 0.1 cm in depth. The wound base was 75 percent epithelization, 25 percent slough and with scant amount of serosanguineous drainage. The treatment plan directed to apply Santyl (chemical debridement) followed by Xeroform to the base of the wound and secure with a dry clean dressing to be completed every other day and as needed. Interview with NA #1 on 2/6/25 at 1:50 PM identified that on the day she found the burn, Resident #42 was lying in bed, and she went in the room to provide incontinent care. She noted that she removed the blanket, and saw a hot pack applied to the right knee without a barrier between the right knee and the instant heat pack. She immediately removed the hot pack and reported to the nurse. She further identified that the hot pack was from the facility's supply and was located opposite the nursing station. She also identified that the nurse aides and nurses have access to the supply closet. Additionally, NA #1 identified that she had not applied the hot pack to Resident #42 and would notify the nurse if a resident requested a hot pack. She identified that she had not received training regarding the use of the hot packs nor was she aware of a protocol regarding the use of instant hot packs. She noted that she knows that she cannot apply a hot pack to a resident. Interview with the DNS on 2/7/25 at 8:00 AM identified that LPN #1 notified her that Resident #42 had a burn to the right knee cause by the instant hot pack. She identified that the nursing staff noticed that the hot pack was directly applied to the resident's skin. She further noted that the nursing staff should follow the manufacturer's instructions related to not applying the hot pack directly to the skin because it could cause an injury. She also identified that she was unable to determine who applied the hot pack to Resident #42's right knee, and noted Resident #42 was total care for transfers and bed mobility and was unable to obtain a hot pack without staff knowledge or self-apply a hot pack. She further identified that the usage of the hot pack was a nursing measure and indicated that only the licensed nurses were allowed to apply the hot pack. Interview with APRN #2 on 2/7/25 at 1:40 PM identified that she was notified of Resident #42's burn to the right knee on 1/12/25. She could not recall whether or not she received a picture from the charge nurse but noted that she did not order a treatment because it was conveyed that the skin was intact, with no redness, or injury noted. She identified that she instructed the nursing staff to monitor the right knee area. She further identified that her expectation of monitoring would include monitoring for redness, warmth, and/or drainage from the right knee burn for three days. Interview with the Wound Specialist (APRN) on 2/7/24 at 2:00 PM identified that her initial encounter with Resident #42's right knee burn was on 1/15/25. She diagnosed the right knee wound as a first degree burn because her initial encounter noted the area was dry and red, so she ordered Xeroform to keep the wound area moist. She further noted the wound had worsened because of the development of slough to the wound bed and changed the treatment to Santyl to remove the dead skin in the wound bed. She further noted that the development of the slough to the wound bed was typically a part of the normal healing process for any type of burn wound. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interview with the DNS on 2/8/24 at 10:45 AM identified that the facility did not have a written protocol or policy related to the use of the hot packs, and that the staff should follow the manufacture's guidance at the back of the hot pack. She further identified that the nursing staff should have been educated regarding who was allowed to apply the hot pack to a resident and education regarding not applying the hot packs directly to the skin. The DNS noted that she did not have documentation of education provided to the staff regarding the use of the hot packs. Review of the Dynarex instant hot pack manufacturer's warning identified that the hot pack should not be applied directly to unprotected skin. The hot pack should be wrapped in a soft cloth before prior to applying the hot pack directly to the skin and that not applying the cloth could result in burn injuries.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47489 Based on observations, review of the clinical record, review of facility policy/procedures and interviews for one of two sampled residents (Resident #252) reviewed for respiratory care, the facility failed to ensure a physician order was in place for a resident who required oxygen therapy. The findings included: Resident #252 was admitted to the facility on [DATE] with diagnoses included dementia, without behavioral disturbance, psychotic disturbance, mood disturbance anxiety, and dyspnea. The hospital discharge summary dated 1/29/25 identified Resident #252 was administered oxygen via nasal cannula at 2 lpm (liters per minute) while in the hospital. The nursing admission assessment dated [DATE] at 11:05 AM identified Resident #252 was admitted to the facility with diminished lung sounds, exhibited shortness of breath (SOB) with exertion, utilized oxygen, and had diagnoses of asthma, and chronic obstructive pulmonary disease (COPD) The baseline care plan dated 1/29/25 identified Resident #252 received respiratory treatment with interventions that included oxygen and O2 sats as ordered, suction as ordered, head of bed elevated to comfort level, lung sounds as ordered, watch for increased cough, congestion, wheeze, edema, and shortness of breath. Th physician's orders dated 1/29/25 directed to change and label the oxygen (O2) set up every Saturday on the night shift. The nurse's note dated 1/29/25 at 12:25 PM identified Resident #252's O2 saturation was 95% on 5 liters of oxygen. The nurse's note dated 1/30/25 at 3:05 PM identified Resident #252's O2 saturation was 97% on 5 liters of oxygen. The occupational therapy evaluation and plan of treatment dated 1/30/25 identified the short-term goal for care to improve standing tolerance by 2 minutes with no shortness of breath on 2 liters of O2. Review of the clinical record identified nursing notes dated 1/31/25, 2/1/2, 2/2/25 and 2/6/25 that identified Resident #252 had oxygen in place. Observation on 2/6/25 at 11:33 AM identified Resident #252 had oxygen in place via nasal canula and the oxygen level was set at 0.5 liters per minute. Observation on 2/8/25 at 7:37 AM identified Resident #252 sleeping in bed with nasal canula in place and oxygen set and flowing at 2 liters per minute. (continued on next page)

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	075111	A. Building B. Wing	02/08/2025

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 2/8/25 at 8:01 AM with RN#3 identified that residents receiving oxygen therapy should have a physician's order in place directing the use of oxygen and the level the oxygen should be set at. Review of the clinical record with RN #3 failed to identify an oxygen order for Resident #252. Interview on 2/8/25 at 10:00 AM with the DNS, Administrator, RN#4, and RN#8, identified there should be a doctor's order in place directing the use of oxygen. Additionally, the DNS identified there was not a policy related to the monitoring of a resident that utilizes continuous oxygen therapy. Interview with RN #2 on 2/8/25 at 2:33 PM identified that she completed the admission paperwork for Resident #252 and noted orders for oxygen were not noted on the W10, so they were not included on the admission orders for the facility. An unsuccessful attempt was made to interview MD #1 on 2/8/25 at 2:41 PM regarding the lack of oxygen therapy orders for Resident #252. The nasal cannula oxygen administration policy identified that the procedure for oxygen administration contained verification of the physician's order and review of the patient chart to familiarize yourself with the patient history and directed use of a humidifier bottle if flow is greater than 4 LPM. Additionally, the policy directed to record the start of oxygen in the patient's chart.

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	075111	A. Building B. Wing	02/08/2025

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47489 Based on observations, review of facility documentation, review of facility policy/procedures and interviews, the facility failed to establish a system of records of receipt and disposition of all controlled medications in sufficient detail to enable an accurate reconciliation and failed to have a system in place to keep an accurate accounting of controlled medications. The findings include: Observation on [DATE] at 11:35 AM identified the DNS office contained a binder that held the yellow Controlled Substance Disposition Records (CSDR), the CSDR sheets were organized alphabetically. Additionally, some of the yellow CSDR sheets were from 2023 and had not yet been reconciled with the white CSDR nor were the medications identified as having been destructed. The book did not contain audit sheets for 2024 and the last signed off narcotic audit was [DATE] Interview on [DATE] at 11:45 AM with the DNS and RN#8 identified that the DNS is responsible for narcotic reconciliation in the facility and completed an audit on [DATE]. The DNS indicated that she doesn't use the audit sign off sheets to log the audits and signs the yellow Controlled Substance Disposition Record (CSDR) sheet to identify when an audit of that medication was completed. The DNS indicated the audits should be completed twice a month, but she sometimes runs out of time. The DNS was not able to demonstrate that narcotics were reconciled regularly or in some cases, at all. The DNS noted that sometimes when a resident is discharged , they are discharged with the medication, and she does not know what happens to the white CSDR that was with the medication in the med cart. The DNS further identified that the white sheets may go with the chart to the records department. When asked how the medications were reconciled without having the white CSDR sheets match up against the yellow CSDR sheets, the DNS did not answer but indicated that she was trying to implement a better system. Interview on [DATE] at 11:55 AM with RN#4 and RN#8 identified that narcotic audits should be completed two times per month and that the audit signature sheets are provided to keep track of the audits. Interview on [DATE] at 12:13 PM with RN#3 identified that the white CSDR sheets are turned into the DNS if the resident is discharged with the remaining medication after it is zeroed out. RN#3 indicated that the DNS takes the unused narcotics from the unit carts if a resident dies and/or if the medication is discontinued or changed, or the resident leaves without it. Observation and interview on [DATE] at 12:33 PM with the DNS identified she attempted to reconcile 10 CSDR sheets and the audit identified that only two of the ten controlled medications remained in the medication cart. The DNS indicated she was going to check the destruction bin and the records department. She identified that the nurses sometimes discharge residents and place the white copies of the CSDRs into the chart and the records department takes them. The DNS identified she would like to receive the white copies, but nursing doesn't give them to her. Interview on [DATE] at 1:09 PM with the DNS identified that she found the white CSDR sheets, and they were in the records department from discharged residents, two of the residents were deceased residents and the white CSDRs and medications were in the DNS office. (continued on next page)

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	075111	A. Building B. Wing	02/08/2025

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy for medication administration identified narcotics and controlled substances must be double-locked and counted per facility protocol and that medication reconciliation should be done upon resident admission, transfer and discharge.

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	075111	A. Building B. Wing	02/08/2025

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 47489 Based on observations, review of facility policy/procedures and interviews, the facility failed to ensure the medication administration cart was appropriately secured during the medication administration pass while not within the line of sight of the nurse. The findings include: Observations of medication administration on 2/6/25 at 9:31 AM identified LPN #2 was able to access the medications without using a key to unlock the medication cart. She used her fingers to pull the lock out and was able to open the drawers containing the medications. LPN #2 prepared Resident #45's medications and then pushed the lock in on the cart and entered the resident's room and pulled the privacy curtain. The medication cart was not within LPN #2's line of sight. LPN #2 returned to the cart and was able to pull the locking mechanism out and without using a key, was able to access medications. At 9:52 AM, LPN #2 prepared medications for Resident #250, LPN#2 pushed the locking mechanism on the med cart, entered the room, and pulled the privacy curtain closed. The medication cart was not within LPN #2's line of sight. Interview on 2/6/25 at 10:00 AM with LPN#2 identified that if the cart was in the resident's doorway and the nurse was in the room, the cart did not have to be secured with the key. Interview on 2/7/25 at 10:14 AM with the DNS identified that the medication cart must be locked when the nurse walks away from it. The DNS indicated that if the cart was visible, and the nurse was close by, then it may be okay to not use the key. Additionally, the DNS identified that the locks will be checked because they should not be able to be opened when in the locked position without a key. Facility policy on medication storage and administration identified that medication administration carts are locked when not visible to the nurse or qualified staff, and that the nurse or qualified staff should stay with resident until medications have been taken.

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47402 Based on review of the clinical record, review of facility policy/procedures and interviews for 1 of 5 sampled residents (Resident #18) reviewed for unnecessary medication, the facility failed to ensure monthly pharmacy medication regimen review recommendations were part of the clinical record. The findings include: Resident #1's diagnoses included anxiety disorder, bipolar disorder, and dementia. The annual MDS assessment dated [DATE] identified Resident #18 was severely cognitively impaired, had no behaviors, was independent with bed mobility, transfers, dressings and personal hygiene. The care plan dated 10/28/23 identified Resident #18 utilized antipsychotic medication and antidepressant medication for management of bipolar disorder and dementia w/behavioral disturbance with interventions that included be aware of movements of the mouth, trunk or extremities, and be aware of medication changes. The consultant pharmacist's monthly regiment review dated 12/14/23 identified there were recommendations made. Interview with the DNS on 2/8/25 at 12:30 PM identified that Consultant Pharmacist's recommendation could not be located. Interview with the Staff Development RN on 2/8/25 at 1:00 PM identified she could print the Consultant Pharmacist's report of the recommendations made. Review of the Pharmacist's recommendation dated 12/14/23 identified Resident #18's as needed order for Melatonin had not been used within the previous 90 days with a recommendation to discontinue the Melatonin due to lack of use. Interview with the DNS and the Administrator on 2/8/25 at 8:42 AM identified that the Pharmacist's recommendations are faxed to the facility, then placed in the provider book to be reviewed and a decision noted to accept or decline the recommendation. Once the recommendations are reviewed and a decision made a copy is given to the DNS and a copy is placed in the resident's physical clinical record. The DNS could not explain why the recommendation was not placed in Resident #18's clinical record. Review of the Medication Regimen Review policy identified the facility should maintain readily available copies of the consultant pharmacists reports on file in the facility and as a part of the resident's permanent record.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47900 Based on review of clinical records, review of facility policy, review of facility documentation, and interviews for two of five sampled residents (Resident #4 and Resident #5), reviewed for immunizations, the facility failed to ensure that the pneumococcal vaccine was administered as requested by the resident upon admission. The findings include: 1. Resident #4 was admitted to the facility in September of 2024 with diagnoses that included dementia, type 2 diabetes mellitus, anemia, and atrial fibrillation. The admission MDS assessment dated [DATE] identified Resident #4 had moderately impaired cognition. Review of the Pneumococcal Vaccine Consent form identified Resident #4 responsible party gave the facility permission to administer the pneumococcal based on the guidance provided on current pneumococcal vaccine schedule per the Centers for Disease Control and Prevention (CDC) in collaboration with the provider oversight on 10/9/24. Review of Resident #4 clinical records on 2/6/25 failed to identify that he/she received the vaccination or documentation that the resident refused the vaccine. Interview with the Regional Director of Nursing Services (RN #4) and the Infection Preventionist (IP) Nurse (RN #5) on 2/7/25 at 9:14 AM identified she was responsible for ensuring the resident was administered the pneumococcal vaccine as requested, however she was trying to administer the COVID-19, influenza vaccine, dealing with outbreaks and monitoring vaccine reaction. IP identified COVID-19 outbreak was in September of 2024 and December of 2024, and gastrointestinal outbreak in January of 2024. The IP further indicated the vaccine should be administered when requested but had to check historical immunization prior to administration, however the vaccine was not administered to the resident at the time when it was requested. 2. Resident #5 was admitted to the facility in January of 2024 with diagnoses that included dementia, chronic obstructive pulmonary disease, and pulmonary fibrosis. The admission MDS assessment dated [DATE] identified Resident #5 had moderately impaired cognition. Review of the Pneumococcal Consent Form (PCV 23), (PVC 20) and (PVC 15) identified Resident #5's responsible party gave the facility permission to administer the pneumococcal on 1/30/24. Review of another Pneumococcal Vaccine Consent form identified Resident #4 responsible party gave the facility permission again to administer the pneumococcal based on the guidance provided on current pneumococcal vaccine schedule per the Centers for Disease Control and Prevention (CDC) in collaboration with the provider oversight on 10/8/24. Review of Resident #5 clinical records on 2/6/25 for January and February of 2024 and October of 2024 all failed to identify that he/she was administered the vaccination. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Person #2 on 2/8/24 at 10:57 AM identified he/she had given the facility permission to administer the pneumococcal vaccine to Resident #5 in quite a while now and had assumed it was automatic administered after the consent is signed, but it seem as it was not administered as the facility called him/her on 2/7/25 stating Resident #5 was not feeling well hence they were unable to administer the pneumococcal vaccine on 2/7/25. Interview with the Regional Director of Nursing Services (RN #4) and the Infection Preventionist (IP) Nurse (RN #5) on 2/7/25 at 9:14 AM identified she was responsible for ensuring the resident had received the pneumococcal vaccine as required, however indicated she was not the IP at the time when the Resident #5's pneumococcal consent was first signed in January of 2024. Interview with the RN #4 and RN #5 on 2/7/25 at 10:42 AM identified that on admission residents are assessed and offered the pneumococcal vaccination. RN #5 identified the process for administering vaccine to the resident, a consent is received from the resident/the resident responsible party to administer the vaccine, then a physician's order is obtained, and the vaccine is administered by the IP nurse or the nurse on the unit. Both RN #4 and RN #5 identified that the pneumococcal vaccine should have been administered when requested by the resident/resident representative and currently in the process to ensure all residents are updated with their pneumococcal vaccination. They further identified that Resident #4 and Resident #5 are eligible for PCV 20 and will be receiving the vaccine. Review of the Pneumococcal policy identified residents, or their responsible party will be offered the pneumococcal vaccine according to their specific eligibility that aligns with the current Center for Disease Control (CDC) Adult immunization schedule upon admission. The facility should obtain historical pneumococcal vaccination history and collaborate with the MD to determines appropriate vaccine needs. The policy further identified the facility would document date and location of injection site, refusal and re-offer and historical pneumococcal vaccine administration in the medical record if given in the community.