STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075319	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Litchfield Woods Health Care Center	255 Roberts 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41223 Based on clinical record review, facility documentation review, facility policy review, and interviews for one of two residents (Resident #1), reviewed for medication administration, the facility failed to ensure medications were administered in accordance with physician orders which resulted in a medication error. The findings include: The facility admitted Resident #1 with diagnoses that included chronic obstructive pulmonary disease (COPD), chronic kidney disease stage 2, and anxiety. A resident care plan dated 1/30/2025 identified Resident #1 was at risk for dehydration due to chronic kidney disease and had episodes of anxiety. Interventions directed adequate fluid intake. An admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated he/she was alert and oriented. A facility reportable event report dated 2/7/2025 identified a medication error of clinical significance. LPN #1 reported at 11:30 AM she had given Resident #1 the medications that were scheduled to be administered to Resident #2, and no injury was identified. LPN #1 reported that she was feeling overwhelmed and was behind in her morning medication pass and did not accurately verify Resident #1's identity prior to administering medications. LPN #1 written statement dated 2/7/2025 identified it was her first time working 7 AM to 3 PM and she was feeling overwhelmed and behind with the medication pass. LPN #1's statement indicated she failed to properly verify the patient's identification before administering medication and gave the wrong medications to Resident #1. Nursing note dated 2/7/2025 at 11:30 AM identified Resident #1 was given the wrong medications including beta blockers, diuretics, anti-seizure and antidiabetic medications. The APRN was notified, evaluated Resident #1 at the bedside and ordered to transfer Resident #1 to the hospital for evaluation. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075319	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Litchfield Woods Health Care Center	255 Roberts 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing note written, by the ADON, dated 2/7/2025 at 3:05 PM identified the APRN assessed Resident #1 after the resident was administered another resident's medications. Resident #1 was alert and oriented, had no word slurring, no anxious mood, denied any chest pain palpitations, difficulty breathing, dizziness or nausea. Initial vital signs were within normal limits and 911 was activated. Subsequent vital signs were: blood pressure 110/52, pulse 95, respirations 16; at 11:37 AM, blood pressure was 94/74, pulse 99; at 11:45 AM blood pressure was 86/46; and 11:50 blood pressure was 80/48 with pulse 102. EMS arrived and Resident #1 was transferred to the hospital. Record review identified Resident #1 was administered the following medications in error on 2/7/2025 (the medications were scheduled to be administered to Resident #2): 1. Sertraline Hydrochloride (treat depression) 75 milligrams (mg) 2. Hydroxyzine (treat anxiety) 50 mg tablet 3. Entresto (strengthen heart pumping) 24-26 mg 4. Keppra (treat seizures) 500 mg 5. Gabapentin (treat nerve pain) 400 mg 6. Metoprolol (treat high blood pressure) extended release 25 mg sprinkles 7. Senna (treat constipation) 8.6 mg 8. Spironolactone (treat high blood pressure and swelling) 12.5 mg 9. Lasix (treat swelling) 40 mg 10. Jardiance (treat diabetes) 10 mg 11. Januvia (treat diabetes) 100 mg 12. Metformin (treat diabetes) 1000 mg 13. Aspirin (prevent blood clots) delayed release 81 mg 14. Ticagrelor (prevent blood clots) 15. Multivitamin one tablet 16. Potassium (electrolyte replacement) chloride extended release 20 milliequivalents 17. Vitamin B12 (Cyanocobalamin)1 mg 18. Folic Acid (Vitamin B9)1 mg 19. Vitamin B1 (Thiamine) 100 mg (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075319	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Litchfield Woods Health Care Center	255 Roberts 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	20. Vitamin D3 (Cholecalciferol) 1000 units. 21. Fluticasone Furoate-Vilanterol Inhalation Aerosol Powder (treats COPD) one (1) puff A hospital discharge summary dated 2/7/2025 identified that upon assessment Resident #1 was negative for any congestion, SOB, chest pain, myalgias or rash. The resident was not in acute distress, not diaphoretic, lung and heart sounds were normal, skin was warm, and mental status was alert and oriented to person, place and time, with no behavioral issues. The residents' blood work showed baseline results. Nursing note dated 2/7/2025 at 10:24 PM identified Resident #1 returned from the hospital with no adverse effects identified and new orders. A facility summary dated 2/20/2024 identified Resident #1 was immediately assessed after the medication error with no injury, distress or discomfort identified. Allergies were evaluated and compared with the incorrect medications received and resident did not have any known allergies that correlated with the medications administered in error. Resident #1 returned from the hospital on 2/7/2025 at 11:02 PM and was discharged home as per prior plan, on 2/8/2025. Interview and record review with Pharmacist #1 on 2/27/2025 at 10:15 AM identified that Resident #1 received medications in error, and they would not cause a significant issue or lasting effects. Interview with MD #1 on 2/27/2025 at 12:48PM identified Resident #1 did not appear to have had any significant ill effects from the error and was discharged home as scheduled on 2/8/2025. Interview and review of the facility investigation with the DON on 2/27/2025 at 2:00 PM identified that LPN #1 was a newly graduated nurse, hired on 12/2/204 and completed her orientation to the facility on [DATE] . LPN #1's usual shift to work was 11 PM to 7 AM, and she had picked up 2/7/2025 to work as an extra shift. LPN #1 had not worked any day shifts previously. The DON stated LPN #1 did not verify Resident #1's identify prior to administering the medications; she did not verify the photo in the electronic medical record and LPN #1 did not check Resident #1's identification (ID) band prior to providing the medications. LPN #1 called Resident #1 by his/her first name only (Resident #1 and Resident #2 had the same first name) and then administered Resident #2's medications to Resident #1. When LPN #1 returned to her medication cart, she realized the error and she immediately reported it to the supervisor. The DON stated all nurses should check the resident's identification bracelet (or identification photo in the EMR) prior to administering medications. LPN #1 identified that she was behind with the medication pass, felt overwhelmed, did not ask for help when she was behind with the medication pass. Multiple attempts to contact LPN #1 were unsuccessful during the survey. The facility policy Medication administration-oral dated June 2015, directed in part, when administering medications the Resident should be identified. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075319	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Litchfield Woods Health Care Center	255 Roberts 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility documentation review identified staff education was initiated on 2/7/2025 regarding administering medications as prescribed to the right resident and a review of safe administration of medications. A QAPI meeting was held on 2/7/2025 to include correctly identifying residents when administering medications. Audits were initiated on 2/8/2025. Based on review of facility documentation, past non-compliance was identified on 2/8/2025.