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	05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Havencare at Litchfield Woods	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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation, facility policies, and interviews for one of three residents (Resident #1) reviewed for abuse, the facility failed to ensure the resident was free from misappropriation and controlled substances were properly accounted for and safeguarded from misappropriation. The findings include: Resident #1's diagnoses included intervertebral disc degeneration and chronic pain syndrome. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of fifteen out of fifteen (15/15), indicative of being cognitively intact and received opioids in the prior seven (7) days. The Resident Care Plan (RCP) dated 2/9/26 identified pain medication therapy related to chronic pain. Interventions include administering analgesic medications as ordered by the physician. Physician orders dated 2/28/26 for Resident #1 directed to administer Morphine Sulfate Oral Solution 20mg/5mL, every four (4) hours, as needed for pain. The Facility Reportable Event (RE) form dated 4/1/2026 at 1:40 PM identified an allegation of misappropriation of Resident #1's Morphine (used to treat pain). Additional information identified Morphine 15 milliliters (mL) was missing, and the Morphine was still an active order for Resident #1. The medication had been delivered on 3/25/2026 and was last observed during the shift count on 4/1/2026. The facility RE Summary dated 4/11/2026 identified on 04/01/26, during the change of shift narcotic count between the off going 11-7 nurse and oncoming 7-3 nurse, it was noted that the liquid Morphine for Resident #1 was incorrect by 15 mL. The current physician order directed Morphine Sulfate oral solution 20mg/5mL, give 5 mL by mouth every four (4) hours as needed for pain. The 11-7 nurse signed out Two (2) doses of the medication (4/1/26 at 1:35 AM and at 6:30 AM). The count record went from 125 mL to 120 mL after the first dose, then from 120 mL to 115 mL after the second dose. At the time of the change of shift narcotic count, the count was noted to be 100 mL remaining in the bottle (off by 15 mL). Interview with Resident #1 identified he/she did not receive any Morhpine at 1:35, and did receive a dose at 6:30 AM. Facility investigation identified a suspected nurse, and the accused nurse denied the allegation. the accused nurse stated the count may have been off because she tilted the bottle when reading it (for counting) and state she should have placed the bottle on a level surface for better accuracy. Record review of the Controlled Substance Disposition Record for Resident #1's Morphine Sulfate oral solution (20 mg/5 mL) identified RN #1 documented administration of two PRN (as needed) doses on 4/1/26, at 1:35 AM and 6:30 AM. Although the documentation reflected the remaining volume decreased correctly to 115 mL, the documentation did not explain why the shift count was 100 mg at the end of the shift (off by 15 mL). Further review identified an additional entry dated 4/01/26 indicating a count correction, with a line drawn through the amount left column and the remaining volume documented as 100 mL, accompanied by a nurse signature. This entry reflects a 15 mL discrepancy from the expected remaining balance of 115 mL, with no corresponding documentation to account for the variance. Review of the Medication Administration Record/Treatment Administration Record (MAR/TAR) for Resident #1 identified no documentation of the 1:35 and 6:30 AM PRN Morphine administrations reportedly provided by RN #1 on 4/01/26. The MAR/TAR lacked corresponding entries for these administrations. Interview with RN #2 on 5/5/26 at 11:45 AM (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	identified the facility's process for controlled substance accountability includes completion of a narcotic count at each shift change for all residents receiving scheduled or PRN controlled medications. RN #2 reported that the off-going and oncoming nurses jointly verify the count for each medication, and upon completion, the off-going nurse transfers the medication cart keys to the oncoming nurse. RN #2 stated that on 4/1/26, while completing the change-of-shift narcotic count with RN #1 for their assigned medication cart, a discrepancy was identified involving Resident #1's morphine sulfate oral solution, with 15 mL unaccounted for. RN #2 reported that upon identification of the discrepancy, RN #1 did not provide an explanation or otherwise acknowledge the discrepancy and proceeded with her assigned duties. RN #2 reported the discrepancy to the RN Supervisor/Administration immediately following identification and continued with her assigned shift responsibilities. RN #2 further reported that Resident #1 did not exhibit increased complaints of pain and did not report concerns related to pain management during or immediately following the shift in question. Interview with RN #1 on 5/5/26 at 1:05 PM identified that at the beginning of her assigned shift (11:00 PM to 7:00 AM), she performed rounds on all assigned residents. RN #1 reported that prior to assuming responsibility for the medication cart, she completed a change-of-shift narcotic count with RN #3. RN #1 stated that RN #3 read aloud the expected controlled substance amounts from the count sheet, and RN #1 visually verified the remaining quantities in each medication container. RN #1 acknowledged that, although she agreed with the count at that time, she does not believe she performed a thorough verification of the morphine volume for Resident #1. RN #1 reported that following completion of the narcotic count, she met with Resident #1 to review PRN pain medication needs and provided education regarding the ordered frequency of administration. RN #1 stated that during her shift, she maintained possession of the medication cart keys at all times and did not provide access to other staff. RN #1 denied any incidents of spillage, leakage, or other events that could account for a 15 mL discrepancy in Resident #1's morphine sulfate oral solution. RN #1 described her medication administration process as withdrawing the prescribed dose into a syringe, transferring the medication into a medication cup, and administering it to the resident. RN #1 stated that she did not re-verify the remaining volume of the controlled substance following each PRN administration. RN #1 stated she was unable to provide an explanation for the 15 mL discrepancy and attributed the issue to a lack of thoroughness in completing the narcotic count verification, and denied diverting Resident #1's Morphine. Interview with the DON on 5/5/26 at 2:35 PM identified that on 4/1/26, the facility was notified by nursing staff of a narcotic discrepancy involving Resident #1, specifically an unaccounted loss of 15 mL of Morphine Sulfate oral solution identified during a change-of-shift count. The DON reported he conducted an interview with Resident #1, who stated he/she received only one of the two doses documented by RN #1 on the Controlled Substance Disposition Record. The DON stated that upon identification of the discrepancy and concern for potential misappropriation, the facility initiated required notifications to appropriate regulatory and law enforcement agencies, including the Connecticut Department of Public Health, the Drug Enforcement Administration, and local law enforcement, and initiated an internal investigation. The DON stated Drug Enforcement Administration conducted an interview with RN #1; however, details of the interview were not disclosed to the facility. The DON further reported that RN #1 declined to provide a statement as part of the facility's internal investigation and indicated she would communicate only with state and federal agencies. The DON concluded that, although the facility was unable to substantiate that RN #1 directly misappropriated the medication, the investigation determined that 15 mL of Resident #1's Morphine was unaccounted for and therefore considered misappropriation. Although attempted, interview with RN #3 was unable to be obtained. Review of the undated facility Abuse, Neglect, and Exploitation Policy directed the facility will provide protections and prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. Misappropriation was defined as the means of deliberate misplacement, exploitation, or wrongful, temporary or permanent, used of a resident's belongings or money without the resident's consent.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on clinical record reviews, facility documentation, facility policies, and interviews for one of three residents (Resident #1) reviewed for abuse, the facility failed to ensure a complete and accurate record to include accurate documentation of the resident's controlled medication administration record. The findings include: Resident #1's diagnoses included intervertebral disc degeneration and chronic pain syndrome. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of fifteen out of fifteen (15/15), indicative of being cognitively intact and received opioids in the prior seven (7) days. The Resident Care Plan (RCP) dated 2/9/26 identified pain medication therapy related to chronic pain. Interventions include administering analgesic medications as ordered by the physician. Physician orders dated 2/28/26 for Resident #1 directed to administer Morphine Sulfate Oral Solution 20mg/5mL, every four (4) hours, as needed for pain. The Facility Reportable Event (RE) form dated 4/1/2026 at 1:40 PM identified an allegation of misappropriation of Resident #1's Morphine (used to treat pain). Additional information identified Morphine 15 milliliters (mL) was missing, and the Morphine was still an active order for Resident #1. The medication had been delivered on 3/25/2026 and was last observed during the shift count on 4/1/2026. The facility RE Summary dated 4/11/2026 identified on 04/01/26, during the change of shift narcotic count between the off going 11-7 nurse and oncoming 7-3 nurse, it was noted that the liquid Morphine for Resident #1 was incorrect by 15 mL. The current physician order directed Morphine Sulfate oral solution 20mg/5mL, give 5 mL by mouth every four (4) hours as needed for pain. The 11-7 nurse signed out Two (2) doses of the medication (4/1/26 at 1:35 AM and at 6:30 AM). The count record went from 125 mL to 120 mL after the first dose, then from 120 mL to 115 mL after the second dose. At the time of the change of shift narcotic count, the count was noted to be 100 mL remaining in the bottle (off by 15 mL). Interview with Resident #1 identified he/she did not receive any Morhpine at 1:35, and did receive a dose at 6:30 AM. Facility investigation identified a suspected nurse, and the accused nurse denied the allegation. the accused nurse stated the count may have been off because she tilted the bottle when reading it (for counting) and state she should have placed the bottle on a level surface for better accuracy. Record review of the Controlled Substance Disposition Record for Resident #1's Morphine Sulfate oral solution (20 mg/5 mL) identified RN #1 documented administration of two PRN (as needed) doses on 4/1/26, at 1:35 AM and 6:30 AM. Although the documentation reflected the remaining volume decreased correctly to 115 mL, the documentation did not explain why the shift count was 100 mg at the end of the shift (off by 15 mL). Further review identified an additional entry dated 4/01/26 indicating a count correction, with a line drawn through the amount left column and the remaining volume documented as 100 mL, accompanied by a nurse signature. This entry reflects a 15 mL discrepancy from the expected remaining balance of 115 mL, with no corresponding documentation to account for the variance. Review of the Medication Administration Record/Treatment Administration Record (MAR/TAR) for Resident #1 identified no documentation of the 1:35 and 6:30 AM PRN Morphine administrations reportedly provided by RN #1 on 4/01/26. The MAR/TAR lacked corresponding entries for these administrations. Interview with RN #1 on 5/5/26 at 1:05 PM identified she did not document the administration of Resident #1's PRN morphine doses in the Medication Administration Record/Treatment Administration Record (MAR/TAR) during the 11:00 PM to 7:00 AM shift. RN #1 stated the shift was very busy and reported prioritizing medication administration over documentation, indicating she did not return to complete the required charting, and stated the care needs of multiple residents limited her ability to complete documentation in a timely manner. RN #1 stated all medication administrations are required to be documented in the MAR/TAR and confirmed that failure to do so was not consistent with facility policy or professional standards, and she should (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	have completed the documentation. Interview with the DON on 5/5/26 at 2:35 PM identified RN #1 failed to document two (2) PRN Morphine administrations on the electronic Medication Administration Record/Treatment Administration Record (MAR/TAR), contributing to the inability to reconcile the controlled substance count. The DON stated RN #1 should have documented when the medication was administered. Review of facility Controlled Substance Handling Policy directed in part, immediately after a dose is administered, the licensed nurse administering the drug enters the date and time of administration, the dose administered, the signature of the nurse administering the dose. Review of the Policy failed to identify the Policy directed to record an accurate count after the dose was removed from the supply. Additional review failed to identify the policy directed the nurse to reconcile the count, or accurately count and record the amount of controlled substances remaining.