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	07/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Havencare at Litchfield Woods	255 Roberts St Torrington, CT 06790

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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 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** Based on review of the clinical record, facility documentation, facility policy and staff interviews for 1 of 5 residents reviewed for accidents (Resident #72), the facility failed to provide transfer assistance per the physician's order which resulted in a fall with a fracture. The findings include:Resident #72's diagnosis included dementia, hemiplegia (paralysis) and hemiparesis (weakness) affecting the left dominant side, and right proximal humerus fracture.Review of the resident care card dated 10/18/24 indicated that Resident #72 was an assist of 1 for transfers with a rolling walker (RW)/four wheeled walker (FWW). A fall risk evaluation dated 11/16/24 identified Resident #72 was a moderate to high fall risk with a score of 10.The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #72 was severely cognitively impaired and required partial/moderate assistance with bed mobility, and substantial/maximal assistance with toileting and transfers. The MDS indicated Resident #72 had not had any falls since admission/entry or reentry or on the prior assessment.The Resident Care Plan (RCP) dated 12/9/24 identified Resident #72 had left sided hemiplegia and required help with activities of daily living (ADL's) due to generalized weakness and had a risk for falls. Interventions included assistance of 1 with RW for transfers and toileting and to provide assistance with activities of daily living (ADL's). A physician's order dated 1/1/25 directed transfers with an assist of 1 and FWW for Resident #72.A Reportable Event form (RE) completed by Licensed Practical Nurse (LPN) #2 and dated 1/30/25 identified Resident #72 was being transferred to a shower chair and was lowered to the floor by Nurse Aide (NA) #4. The RE indicated the incident occurred on 1/30/25 at 7:30 AM in the shower room, NA #4 was a witness and an investigation was initiated.A nursing progress note written by RN #2 and dated 1/30/25 at 8:10 AM identified Resident #72 fell in the shower while being transferred from a wheelchair to a shower chair. The progress note indicated NA #4 stated he was transferring Resident #72, turned to move the wheelchair and the resident lost his/her balance and fell onto the floor. An In-service Attendance Sheet dated 1/30/25 identified NA #4 was educated on following a resident's transfer status and care plan when transporting a resident. The content of the in-service was indicated as It is important to follow policy when transferring a resident. Always check the care card prior to transferring a resident as their needs change constantly. The in-service attendance sheet was signed by NA #4 on 2/3/25.An Advanced Practice Registered Nurse (APRN) progress note dated 1/31/25 at 10:06 AM identified Resident #72 was status post (s/p) fall with x-ray of the pelvis and hip ordered. X-rays revealed no acute abnormality seen and the hip pain was resolved.An APRN progress note dated 2/1/25 at 7:54 AM identified Resident #72 had developed new bruising to his/her right medial arm at the elbow and an order for right arm x-rays was obtained to rule out a fracture were obtained.Review of Resident #72's clinical record identified a right shoulder/right forearm x-ray was completed on 2/1/25 with results indicating a right humeral neck non-displaced impact fracture. A nursing progress note dated 2/1/25 at 1:00 PM identified Resident #72 was observed to have a large area of bruising to his/her right inner arm proximal to the elbow and the resident had pain upon movement of his/her right arm. The progress note indicated Resident #72 was status post (s/p fall) on 1/30/25 and the APRN was (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0689 Level of Harm - Actual harm Residents Affected - Few	notified, and x-rays were ordered and results indicated a non-displaced fracture of the humeral head. An investigation statement, written and signed by NA #4, dated 2/3/25 for a date of occurrence of 1/30/25, identified he took Resident #72 to the bathroom for a shower and when transferring the resident from the wheelchair to the shower chair NA #4 was standing behind the resident holding him/her by the waist. NA #4 indicated he took his right hand off the resident to push the wheelchair out of the way and while holding the resident with only his left-hand, Resident #72 began to lean to the left and fell onto the floor.A consultant report from the Orthopedist dated 2/5/25 identified Resident #72 had a right proximal humerus fracture and was placed in a right [NAME] brace (a rigid, plastic shell type of brace used to treat a fracture of the upper arm bone). The brace was to be left on and could be removed for hygiene purposes daily.Interview and review of the clinical record with the DNS on 7/18/25 at 10:45 AM identified Resident #72 was an assist of 1 for transfers and on 1/30/25 when transferring the resident from a wheelchair to a shower chair, NA #4 should have always had both hands on the resident. The DNS indicated NA #4 was re-educated after the incident due to not following procedure which led to Resident #72's fall and subsequently identified fracture. Interview and review of the clinical record with the nursing supervisor (RN #2) on 7/18/25 at 2:20 PM identified she recalled Resident #72's fall on 1/30/25 and was called to the floor after the incident. RN #2 reviewed NA #4's statement and indicated that NA #4 should not have taken his hand off Resident #72 because as a transfer assist of 1 the NA should have kept both hands on the resident during the transfer. RN #2 identified that NA #4 did not follow procedure and was re-educated after the incident. Interview and review of the clinical record with the Administrator on 7/21/25 at 9:55 AM indicated Resident #72 was an assist of 1 for transfers and on 1/30/25 when transferring the resident from a wheelchair to a shower chair, NA #4 should not have taken his hand off the resident during the transfer and in doing so he caused the resident to fall. The Administrator identified that NA #4 did not follow procedure and was re-educated after the incident. Additionally, the Administrator was notified of the surveyor's inability to contact NA #4 by the means provided and the Administrator indicated NA #4 was out of the country.Interview and review of the clinical record with the Director of Rehab (PT #1) on 7/21/25 at 11:00 AM identified an assist of 1 transfer order meant one staff person assisted the resident and the staff should always have both hands on the resident during the transfer. After review of the 1/30/25 incident documents, PT #1 indicated NA #4 should not have taken one hand off Resident #72 while transferring the resident from a wheelchair to a shower chair. Per PT #1, doing so left Resident #72 without full support on both sides of his/her waist which caused the resident to fall towards his/her weakened left side and onto the shower room floor. PT #1 indicated he regularly provided education to the NA staff on resident transfers and would plan to do another training soon.Multiple attempts to interview NA #4 and were unsuccessful.Review of the facility policy, Activities of Daily Living, directed for each resident a program of assistance and instruction in ADL skills is developed and implemented based on the individual's evaluation to encourage the highest level of function.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observations, interviews, facility documentation, and facility policy, the facility failed to ensure food served appeared appetizing, at appropriate temperatures and was palatable. The findings include: 1. Interview with Resident #135 on 7/15/25 at 10:00 AM identified the food was either undercooked or overcooked.Interview with the Director of Dining Services (DDS) on 7/15/25 at 10:17 AM identified that the facility used a point of service, steam table, system for meal service with breakfast items placed in the steam tray at 7:00 AM for service beginning at 7:30 AM, lunch items placed in the steam table at 11:00 AM for service beginning at 11:30 AM, and dinner items placed in the steam table at 4:30 PM for service beginning at 5:00 PM.Interview with Resident #136 on 7/15/25 at 10:20 AM identified the food was cold and the portions were small.Interview with Resident #145 on 7/15/25 at 10:38 AM identified the food was cold at times.Observation in the first-floor resident dining room on 7/15/25 at 11:47 AM identified that meals were portioned from a steam table plugged in for temperature maintenance, and ceramic plates were observed stacked without a warming device. Food was plated by a dietary aide, using a printed meal ticket for reference, onto the ceramic plates covered by clear plastic covers with a circular hole in the center. A second dietary aide then confirmed plated items and provided the prepared food plates to a nurse aide for delivery to the residents. Interview with the DDS on 7/17/25 at 12:42 PM identified that the facility does not use a plate warmer or insulated cover system.Observation of the tray line on 7/17/25 at 12:42 PM identified the ground-floor meal delivery cart was brought down the hall from the kitchen to the ground-floor nursing unit. All meal trays were plated by dietary staff and then delivered to the residents by nurse's aide staff on the unit. The test tray was the last tray plated in the nursing unit kitchenette at 12:53 PM and the following temperatures were obtained by the surveyor and DDS:The Shepherd's pie was 164.1 degrees Fahrenheit (F) with the surveyor's thermometer and 165 degrees F with the DDS thermometer; the Herbed baked fish was 127.9 degrees F with the surveyor's thermometer and 126 degrees F with the DDS thermometer. The string beans were temped at 151 degrees F with the surveyor thermometer and 149 degrees F with the DDS thermometer.Interview with DDS on 7/17/25 at 12:54 PM identified the food temperatures were low for the herb baked fish and further identified the temperature should be at or above 135 degrees (F) for hot hold temperature, 145 degrees (F) for cooked temperature.Review of documentation provided by the DDS included the following:Daily Temperature Log, dated 7/17/25, with recorded entree temperatures for each steam table indicated that the alternate entree of fish was placed into table 1 at 140 degrees (F) and table 2 at 137 degrees (F), with cook #1 initials on the log. Based on an interview with DDS on 7/17/2025 at 12:54 PM and review of the dining services staff training, this was below the acceptable internal temperature for fish.Dining Services Staff Training, revised February 2005, described the minimum safe internal cooking temperatures for all food types. Fish required an internal temperature of 145 degrees (F).Inservice Attendance from 6/2/25 regarding temperature logs, included content about completion of temperature logs daily including documentation of food temperatures.A page titled Holding Food from ServSafe Manager (facility reference) identified hot food should be held at a temperature of 135 degrees (F) or higher.2. Interview with Resident #86 on 7/15/25 at 10:38 AM identified the food was terrible.Observation in the first-floor resident dining room on 7/15/25 at 11:47 AM for lunch service identified the menu being served included herbed pork, polenta, carrots, and strawberry cake. The herb pork and polenta being served appeared visibly dry in texture/consistency.Interview with Resident #145 on 7/15/25 at 12:45 PM identified the food was tasteless at times.Interview with Resident #10 on 7/15/25 at 3:01 PM identified there was limited fresh fruit and he/she would love to have an apple every day, but they don't have them, and he/she stated there were limited diabetic food options.Observation of lunch service in the ground floor resident dining room on 7/17/25 at 12:42 PM identified a lunch menu of shepherd's pie, string beans and baked fish. The baked fish appeared to be heavily seasoned with a excessively thick layer of seasoning coating the fish.A food tray for tasting (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	was conducted. The tray was delivered 7/17/25 at 12:55 PM, identified excessive and overly seasoned mashed potatoes used for the shepherd's pie, and further identified an unappealing visual consistency of the string beans (mushy).Interview with DDS on 7/17/25 at 1:21 PM identified that recipes were not routinely followed for food preparation and reported no formal policy to follow recipes. DDS identified [NAME] #1 had prepared the food for the day. DDS identified he tasted only the beef for the shepherd's pie prepared for lunch. DDS further identified there was no formal recipe for the herb baked fish served for the day and subsequently provided a recipe for the shepherd's pie and lemon baked fish as requested.Interview with [NAME] #1 on 7/18/25 at 9:46 AM, with the DDS present, identified that recipes were not routinely used to prepare food, and not all food items had a recipe in the recipe book available. When a recipe was not available, she stated that she googled heart healthy/low carb recipes for preparation or asked the DDS about preparation.Cook #1 described how the shepherd's pie was prepared, stating that she used Adobo seasoning for the mashed potatoes that had been identified as excessively seasoned the day before. She identified that when preparing the baked fish, she accidentally opened the incorrect side of the seasoning container resulting in more seasoning covering the fish than intended, which she then attempted to correct with limited result. She indicated that typically when she was unsure of preparation or there were any errors in preparation, the DDS was consulted for assistance, however on 7/17/25, she did not want to interrupt the DDS who she felt was busy throughout the building that day.Interview with DDS 7/18/25 at 9:46 AM identified that the cooks have been instructed to use recipes moving forward for all meal preparations to ensure consistency in preparation, and to seek his assistance whenever needed. Additionally, the DDS indicated that he will be testing a souffle cup of each food item before distribution to the residents to verify taste and consistency.Although requested, policies for food committee process and content, food preparation process, recording food temperatures were not provided. Per the DDS formal polices were not available, instead dining services staff training and in-services were provided as evidence of education about expected practices/procedures.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, facility documentation, and facility policy, the facility failed to ensure that refrigerator/freezers out of range temperatures in 3 of 3 kitchenettes were identified and reported to the Director of Dining Services and failed to identify/recognize when low temperatures were displayed on the dial during the dishwasher cycle. The findings include: During a kitchen tour and interview with the Director of Dietary Services (DDS) on 7/15/25 at 10:17 AM it was identified that the dietary service department cooks completed the Daily Temperature Log for all refrigerators in the kitchen and the refrigerator logs that were on the resident units in the kitchenettes. The cooks also checked expiration dates for refrigerator contents while the Infection Control Nurse verified the expiration dates as well.On 7/15/25 at 12:40 PM, observation of the kitchenette area/nourishment room located within the 1st floor dining room, identified the refrigerator, located within the kitchenette, was observed to be at 38 degrees Fahrenheit (F) and to include the following items inside: (4) Lactaid bottles; (3) 1/2 cups of yogurt; (1) 1 oz. Sour Cream; (2) 4 oz. containers of nectar thick water; (1) 4oz. containers of nectar thick orange juice; (1) 24 oz. jar of pickles - resident labeled; (8) oz. containers of apple sauce; (1) resident takeout container of Thai food; (3) additional takeout containers of resident food; (1) 1/8 container of resident food; (1) resident fruit container; (1) resident takeout container of fettucine1.Review of the Nourishment Room Refrigerator/Freezer Temperature Logs for the first-floor refrigerator/freezer indicated that in July 2025, 10 of 15 recorded temperatures and in June 2025, 17 of 30 recorded temperatures were out of range. According to the log, acceptable ranges for the refrigerator were 35-41 degrees and the freezer was 0 degrees or less. The log instructed the reporter to report all temps out of range. Interview with the DDS on 7/15/25 at 12:40 PM indicated that the DDS to reviews the logs and explained what Report All Temps Out of Range meant. The DDS indicated that this meant that any abnormal temperatures should be reported to him, but identified he was not made aware of the out of range temperatures for June 2025 and July 2025. The DDS indicated that the cook who recorded the temperatures was present on the unit at that time, would verify with [NAME] #1 and return with copies of the logs. Upon return at 12:45 PM, The DDS reported that the [NAME] #1 informed him that she took the temp and twice got low readings, so adjusted the dial in the fridge herself to accommodate the issue, but didn't notify anyone. Observation on 7/16/25 at 3:00 PM of the second-floor resident kitchenette area/nourishment room which was located to the side of the resident dining room. The refrigerator, located within the kitchenette, was observed to be at 30 degrees (F) and to include the following items inside: (12) 1/2 cups of yogurt; (1) snack pack; (8) 4 oz. containers of nectar thick water; (7) 4 oz. containers of nectar thick apple juice; (1) chocolate syrup container; (9) 8 oz. containers of apple sauce; (1) Italian Dressing; (1) 1/4 full 2% milk; (3) covered jugs of orange juice; (1) resident ham and cheese sandwich dated; (1) resident salad dated; (3) 2 full and 1 partially full covered jugs of cranberry juice; (4) 3 full and 1 partially full covered jugs of milk; (1) 1/4 full whole milk; Freezer - (1) box popsicles; (1) box magic cups; (1) box regular ice cream 2. A review of the Nourishment Room Refrigerator/Freezer Temperature Logs for the second-floor refrigerator/freezer indicated that in July 2025, 10 of 15 recorded temperatures and in June 2025, 17 of 30 recorded temperatures were out of range According to the log, acceptable ranges for the refrigerator were 35-41 degrees (F) and the freezer was 0 degrees (F) or less. The log instructed the reporter to report all temps out of range.Interview with DDS on 7/16/225 at 3:18 PM indicated that he was not made aware of the multiple dates with out-of-range temperatures recorded on the second-floor resident Nourishment Room Refrigerator/Freezer Temperature Logs. The DDS indicated that subsequent to surveyor identification, he held an inservice with all cooks on 7/16/25 to review how to properly complete these logs as a manner of remediation for the observed issues reported. This inservice included notification criteria anytime out-of-range temperatures were obtained. Additionally, the DDS ordered new thermometers for all refrigerators and freezers, ten in (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	total.An interview with [NAME] #1 on 7/17/25 at 9:41 AM regarding out of range temperatures from the resident nourishment room refrigerator/freezer indicated that she did not do anything about the out-of-range temperatures at the time she took them and that she was confused by the log [instructions]. 3.A review of the Nourishment Room Refrigerator/Freezer Temperature Logs for the ground-floor refrigerator/freezer indicated that in June 2025, 10 of 30 recorded temperatures were out of range with 2 missing recorded temperatures and in May 2025, 18 of 31 recorded temperatures were out of range. According to the log, acceptable ranges for the refrigerator were 35-41 degrees (F) and the freezer was 0 degrees (F) or less. The log instructed the reporter to report all temps out of range. This review was shared with the DDS. 4. The facility utilized a 3-bay sink with pre-diluted sanitizer, that was used primarily for soaking large pans only. The DDS indicated that all pots and dishes can fit into the high heat dishwasher, and therefore the dishwasher was used for most items.On 7/15/25 at 10:00 AM, the DDS indicated that the dishwasher temperatures were supposed to be 160 degrees (F) for the wash cycle and 180 degrees (F) for the rinse cycle, and that the temperatures were recorded on the Daily Temperature Log by the morning and evening cooks.Observation of a dishwasher cycle on 7/17/25 at 10:03 AM with the DDS, and observing Dietary Aide (DA) #1 and Dietary Aide (DA) # 2 in the dishwasher area processing dishes from breakfast service. DA #1 handled the dirty dishes exclusively and DA #2 handled the clean dishes exclusively. One (1) tray of 16 plates and one (1) tray of plate covers, approximately 8-10 covers, were passed through the dishwasher, however during surveyor observation of this cycle, the wash temperature was 129 degrees (F) and rinse temperature was 143 degrees (F), below the required 160 and 180 degrees (F) respectively. DA #1 and DA #2 did not identify low wash/rinse temperatures, did not view the wash/rinse cycle and continued passing the racks of dinnerware/plate covers through the machine. The plates and covers previously run through the dishwasher at below temperature range were put on a cart by DA #2 to be placed in circulation due to DA #1 and DA #2 not identifying low wash/rinse temperatures.The Director of Dining Services was immediately notified of the temperature by the surveyor, and came out to observed the dishwasher cycle. Subsequent to surveyor inquiry, the DDS instructions DA #2 to be put the plate covers and plates through the dishwasher again once it reached the appropriate temperature per the DDS direction.Interviews of DA #1 and DA #2 on 7/17/25 at 10:05 AM identified neither had checked the temperature of the dishwasher during the cycle because they were not aware to do so and therefore did not notice below normal wash/rinse temperatures. DA #1 stated he did not check the temperature between passing racks through the dishwasher because the machine was usually at 180 degrees (F) and he does not double check the temperature between passes. The Director of Dining Services indicated that the machine should be160 degrees (F) for the wash cycle and 180 degrees (F) for the rinse cycle.The Director of Maintenance was contacted by the DDS at 10:08 AM and reported that the storage tank for kitchen water, which he indicated was a separate tank from resident water, was checked every morning and was 172 degrees (F) the same morning. Prior to coming to the kitchen, the tank was at 142 degrees (F), indicating that a large amount of hot water had been used, or that some other potential problem was occurring with the dishwasher. The Director of Maintenance also reported that the dishwasher typically ranges between 158-162 degrees (F) and that he had contacted the vendor to check both the storage tank and the dishwasher for any other mechanical causes of the low temperatures.Review of the Daily Temperature Log for 7/17/25, completed by [NAME] #1 in the early morning at approximately 5:30 AM indicated that the dishwasher temperatures were 170 degrees (F) for the wash cycle and 180 degrees (F) for the rinse cycle.Interview with the DDS on 7/17/25 at 10:10 AM indicated that there was no written policy about checking that the dishwasher temperatures were at expected levels between wash cycles, but that this was a verbal policy, with the dietary staff being aware that each was to notify the DDS if the temperatures were not as expected.Although requested, policies were not received to illustrate refrigerator temperature recording (requested 7/15/2025) and verification of dishwasher wash/rinse cycle temperatures (requested 7/17/25). Per the DDS formal (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	written policies are not in place, instead verbal instruction and dining services training and in-services were provided as evidence of education about expected practices/procedures.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for 1 of 2 residents (Resident #78) reviewed for Pre-admission Screening and Resident Review (PASRR), the facility failed ensure a Level 2 PASRR evaluation was completed after a new post-admission diagnosis of major depression. The findings include:Resident #78's diagnoses included major depression, post-traumatic stress disorder (PTSD) and anxiety disorder. An annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #78 was cognitively intact, and independent with toileting, transfers and bed mobility. Additionally, the MDS identified a diagnosis of depression, post-traumatic stress disorder (PTSD), and anxiety disorder despite being coded as 0 or No for PASRR 2/serious mental illness.The Resident Care Plan (RCP) dated 5/21/25 identified Resident #78 was at risk for behavior problems, verbal outbursts, refusals of daily care, and trouble sleeping due to diagnoses of depression, PTSD and anxiety with the use of psychotropic medications. Interventions included to monitor sleep, appetite, and level of participation and to redirect/explain/reinforce when the resident's behavior was inappropriate/unacceptable and to intervene as necessary to protect the rights and safety of others with psychiatric follow-up as needed/indicated. Interview and review of the clinical record with the Director of Social Work (SW #1) on 7/17/25 at 10:45 AM indicated Resident #78 had a negative Level 1 PASRR completed in January 2020 and while a resident of the facility in August 2023, Resident #78 was diagnosed with a major depressive disorder. SW #1 identified that although Resident #78 should have been referred for the completion of Level 2 PASRR in August 2023, the referral was not made, and she was not sure of the reason it was not done. SW #1 indicated it would have been the Social Service departments responsibility to ensure the Level 2 PASRR was requested and completed in August 2023.Subsequent to surveyor inquiry, on 7/17/25 at 12:55 PM, SW #1 provided a copy of the referral made on 7/17/25 for the completion of a Level 2 PASRR screening for Resident #78. The referral identified the resident had never had a Level 2 PASRR evaluation and showed signs and symptoms that indicated he/she may have a PASRR condition with mental health diagnoses of current major depression and current anxiety disorder.Review of the facility policy, PASRR Policy and Procedure, undated, directed that a new Level 2 PASRR screen will be completed by the social service staff when a resident experiences a significant change in status which indicates a worsening PASRR condition or the presence of a PASRR condition that was not previously identified.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on resident and staff interviews, facility tours, and review of facility policy for snacks, the facility failed to ensure adequate snacks were available and also distributed/offered to residents who were unable to request. The findings include: Interview with Resident #43 on 7/15/25 at 10:15 AM identified that the facility took all our snacks away, and our only option for snacks is saltines. During the kitchen tour on 7/15/25 at 10:17 AM, the Director of Dining Services (DDS) indicated that nourishments were available on each unit, including crackers, cookies, fruit, and sandwiches. The DDS indicated that these were stocked twice daily at 1:00 PM and by the night cook after dinner.Interview with Resident #136 on 7/15/25 at 10:20 AM identified that there were no snacks anymore.Interview with Resident #120 on 7/15/25 at 10:35 AM identified that snacks were not available unless you ask, and there were not many available.Observations on 7/15/25 at 12:40 PM on the first-floor kitchenette indicated that there were what appeared to be lock mechanisms attached to the refrigerator, freezer, and microwave. These appliances were not locked at any time during the survey period, however multiple staff reported that these were previously locked with padlocks as directed by an independent nurse consultant. There were no non-perishable items/food items in the cabinets of the kitchenette.Interview with Resident #10 on 7/15/25 at 3:01 PM identified that the facility limited snack choices now you have to ask for them, and anything good was gone by the time you get to something.Observation and review on 7/16/25 at 3:00 PM appear to indicate restricted access to snacks. Review 7/16/25 at 3:00 PM of the second-floor kitchenette refrigerator temperature logs from July 2025 noted that on 7/4/25, 7/5/25, 7/6/25 and 7/9/25 the freezer temperature was recorded as locked. Additionally, there was a sign on this refrigerator that stated: soda no longer kept in fridge, ask RN. Interview with the DDS on 7/17/25 at 9:41 AM identified that cabinets in each kitchenette were not stocked because some residents took multiple snacks, therefore non-perishable snacks, such as crackers, have been moved behind the nurse's station. The DDS indicated that since the new company acquired the facility, snack order options have been limited to graham crackers and saltines, versus the prior orders that included items such as cookies and cheese flavored crackers that residents enjoyed. The DDS indicated that any leftover sandwiches from the cold carts from lunch were stocked in the unit refrigerators (but that was not observed), and additional cold sandwiches were brought to the units after dinner service. Interview with Nurse Aide (NA) #5 on 7/17/25 at 3:25 PM identified that snacks were kept in the clean utility room, behind the nurse's station and not accessible to residents. NA #5 indicated that previously there were more options for snacks, but these had been reduced. She reported that she distributed snacks at approximately 8:00 PM nightly to the residents on her assignment, when she was able, however when she gets too busy she relied on the residents putting on a call light to request a snack. She was unable to quantify how often she was able to distribute snacks.A Resident Council Meeting, held on 7/17/25 at 2:34 PM, indicated feedback from residents that included Resident #135 reporting that graham crackers and saltines were the only available snacks, that snacks were not offered anymore, and that there were locks on the refrigerator.Review of the Policy and Procedure Manual dated August 2015, page two, titled Snacks, directed, in part the following: Snacks will be made available to residents/patients at designated times and whenever requested; Diabetic residents who have HS snacks recommended by Dietitian and Physician will have snacks documented on MAR by a licensed nurse. Subsequent to surveyor inquiry, the DDS provided a copy of a new HS Snack Sign-In on 7/18/25 at 10:00 AM, indicating that this process was instituted for the dietary staff to complete when distributing evening snacks with a signature from the unit nurse receiving the snacks to ensure these are delivered to each unit.

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Havencare at Litchfield Woods	255 Roberts St Torrington, CT 06790

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and staff interviews for 1 of 5 residents (Resident #72) reviewed for accidents, the facility failed to notify a resident's responsible party of a fall. The findings include: Resident #72's diagnosis included dementia, hemiplegia (paralysis) and hemiparesis (weakness) affecting the left dominant side, and right proximal humerus fracture. The annual comprehensive Minimum Data Set (MDS) assessment dated [DATE] identified Resident #72 was severely cognitively impaired and required partial/moderate assistance with bed mobility, and substantial/maximal assistance with toileting and transfers. The MDS indicated Resident #72 had not had any falls since admission/entry or reentry or on the prior assessment. The Resident Care Plan (RCP) dated 12/9/24 identified Resident #72 had left sided hemiplegia and required help with activities of daily living (ADL's) due to generalized weakness and had a risk for falls. Interventions included assistance of 1 with a rolling walker (RW) for transfers and toileting and to provide assistance with ADL's. A nursing progress note (RN #2) dated 1/30/25 at 8:10 AM identified Resident #72 fell in the shower while being transferred from the wheelchair to a shower chair. The progress note indicated NA #4 stated he was transferring the resident and he turned to move the wheelchair and the resident lost her balance and fell onto the floor. The progress note failed to indicate if the resident's responsible party had been notified of the fall. A nursing progress note (LPN #2) dated 1/30/25 at 8:20 AM identified Resident #72 was observed on the floor in the bathroom on 1/30/25 at 7:30 AM with a NA in the room and after the fall the resident complained of left hip pain and an x-ray was ordered. The progress note failed to indicate if the resident's responsible party had been notified of the fall. A Reportable Event Form (REF) completed by LPN #2 and dated 1/30/25 identified Resident #72 was being transferred to a shower chair and was lowered to the floor by NA #4. The REF indicated No for Family Notification and self was written below the No box. An interview with Person #3 on 7/18/25 at 9:53 AM identified he was emergency contact #2 for Resident #72. Person #3 indicated he did not recall being notified of Resident #72's fall on 1/30/25 and that the facility likely called Person #1 first. An interview with Person #1 on 7/18/25 at 9:56 AM identified he was the responsible party (RP) and emergency contact #1 for Resident #72. Person #1 indicated that he was unsure if he was notified of Resident #72's fall on 1/30/25 and would need to check his phone records. Another interview with Person #1 on 7/18/25 at 10:15 AM identified that he reviewed his phone records and did not have a call from the facility until 2/3/25. Person #1 indicated he was not notified of Resident #72's fall on 1/30/25 but he did recall being notified on 2/3/25 about the resident's subsequent fracture due to the fall. Interview and review of the clinical record with the DNS on 7/18/25 at 10:45 AM indicated it would have been the charge nurse or nursing supervisor's responsibility to inform Resident #72's RP of his/her fall on 1/30/25. The DNS was unsure why LPN #2 indicated No and self on the REF and review of RN #2 and LPN #2's progress notes for 1/30/25 failed to identify that Resident #72's RP was notified of the fall. The DNS indicated she was unable to find documentation which reflected Resident #72 was her own responsible party on 1/30/25 and that she would need to provide further education to RN #2 and LPN #2. Interview and review of the clinical record with LPN #2 on 7/18/25 at 2:05 PM identified she recalled the incident with Resident #72 on 1/30/25 and agreed with her documentation on the REF. LPN #2 indicated that since the REF and her progress note failed to identify that she had notified Resident #72's RP of the fall, then she did not notify the RP of the incident and she was not sure why. LPN #2 indicated that it would have been her or the nursing supervisor's responsibility to notify Resident #72's responsible party after the residents fall on 1/30/25. LPN #2 further identified Resident #72 was not her own responsible party and that she had made a mistake and checked No and wrote self on the REF in error. Interview and review of the clinical record with the nursing supervisor (RN #2) on 7/18/25 at 2:20 PM identified she (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	recalled the incident on 1/30/25 and after review of her progress note which failed to indicate notification of Resident #72's RP, she stated if I did not note it, then I did not do it. RN #2 identified that it would have been her responsibility to notify Resident #72's RP of the fall on 1/30/25 and she was unsure why she did not do so. Review of the facility policy, Condition/Significant Change, undated, directed the responsible party will be notified by the nurse in the event of change in condition and this notification shall be documented in the clinical record. Review of the facility policy, Accident and Incident State Specific Reporting Department of Public Health (DPH)/Department of Health (DOH) Reportable Event, dated 4/2015, directed that accidents and incidents that occur in the facility will be reported in accordance with the requirements of the DPH. The Administrator, Director of Nursing or their designee assumes responsibility for the immediate VERBAL notification of the incident to the resident's conservator/responsible party.

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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 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** Based on observation, review of the clinical record, facility documentation, facility policy and interviews for the 3 sampled residents (Resident #56, Resident #86 and Resident #109) reviewed for respiratory care, the facility failed to ensure the portable oxygen E-tanks (tall steel tank) were safely stored in resident rooms. 1. Resident #56 had diagnoses that included diabetes, heart failure, and anemia.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #56 was cognitively intact, required oxygen therapy, setup or clean-up assistance with eating, supervision or touching assistance with transfers, and was independent with walking 10 feet.The Resident Care Plan (RCP) dated 6/18/25 identified Resident #56 had anemia. Interventions included signs of anemia may include pallor, shortness of breath, fatigue, weakness, general malaise, palpitations or chest pain. The RCP failed to identify Resident #56 received oxygen therapy.An Interdisciplinary Care Plan Meeting form dated 6/18/25 at 10:45 AM identified Resident #56 required oxygen therapy at 2 liters per minute via nasal cannula tubing.Observation in Resident #56's room on 7/18/25 at 6:26 AM identified a freestanding oxygen E-tank by the room entry doorway that was not in a holder/stand.Observation in Resident #56's room on 7/18/25 at 7:45 AM identified the oxygen E-tank was no longer visible in the room.2. Resident #86 had diagnoses that included chronic obstructive pulmonary disease (COPD), bipolar disorder, and transient cerebral ischemic attack.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #86 was cognitively intact, required oxygen therapy, setup and clean-up assistance with eating, and was independent with transfers and walking.The Resident Care Plan (RCP) dated 4/21/25 identified Resident #86 had oxygen therapy related to COPD. Interventions included to provide extension tubing or portable oxygen apparatus. A physician order from April 2025 and currently in effect directed to administer oxygen via nasal cannula at 2 liters per minute (lpm) for oxygen saturation less than 92%.Review of the Resident Care Card dated 6/18/25 failed to identify Resident #86 was on oxygen and subsequently did not include directions for nursing staff related to care and storage of the portable oxygen tank for Resident #86.Observation in Resident #86's room on 7/16/25 at 11:43 AM and on 7/18/25 at 10:21 AM identified a full portable oxygen E-tank (needle in the green on the gauge) inside a transport bag. The oxygen tank was standing upright on floor leaning against the side of a chair and the wall. The oxygen tank was not secured inside a stand.Observation and interview with Nurse Aide (NA) #3 on 7/18/25 at 11:30 AM identified Resident #86 was provided a portable oxygen E-tank for use when he/she left the unit. NA #3 identified the 11:00 PM to 7:00 AM shift would go around in the morning and ensure everyone's portable oxygen tanks were full and they would leave the tanks in the room. NA #3 identified when Resident #86 wasn't using his/her portable oxygen tank, it was stored in it's current position (upright on the floor next to the chair and leaning against the wall) where Resident #86 could easily reach it.Observation in Resident #86's room on 7/21/25 10:21 AM identified a full portable oxygen E-tank (needle in the green on the gauge) inside a transport bag. The oxygen tank was standing upright on floor leaning against the side of a chair and the wall. The oxygen tank was not secured inside a stand.3. Resident #109 had diagnoses that included heart failure, chronic obstructive pulmonary disease (COPD), and anemia.The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #109 was severely cognitively impaired and used a manual wheelchair. The MDS assessment further identified Resident #109 required oxygen therapy, setup or clean-up assistance with eating, partial/moderate assistance with chair/bed transfers, and substantial/maximal assistance with manual wheelchair mobility.The Resident Care Plan (RCP) dated 6/9/25 identified Resident #109 had COPD. Interventions included oxygen therapy via nasal cannula at 2-4 liters per minute (lpm) and change oxygen tubing weekly.A physician order dated 9/27/22 and currently in effect directed to administer oxygen via nasal cannula at 2 liters/pm.A physician order dated 8/24/23 and currently in effect directed to check and fill portable oxygen every shift. (portable (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	oxygen tanks are no longer filled by staff and are instead pre-filled E-tanks)Observation in Resident #109's room on 7/18/25 at 6:26 AM identified a freestanding oxygen E-tank next to a wheelchair, that was not in a holder/stand.Observation in Resident #109's room on 7/18/25 at 7:45 AM identified the oxygen E-tank was secured in a holder on the back of the wheelchair.Interview with Licensed Practical Nurse (LPN) #1 on 7/18/25 at 9:40 AM identified that sometimes the portable oxygen E-tanks were stored in resident's rooms when not in use and there were rolling stands that the tanks could be placed in for storage in the room, but there were only approximately 5 of those stands available so some residents didn't have a stand and the oxygen tank would be placed next to a chair for support against the wall.Review of facility documentation obtained 7/21/25 identified In-service Attendance form(s) dated 5/14/25 for in-service topic oxygen portable tanks. The forms identified staff were provided demonstration of how to use the new oxygen cylinder regulators, use of the travel caddy, and use of the oxygen bag for attaching the oxygen tank/cylinder to the wheelchair and/or walker. The forms identified 57 staff members were provided education. The forms failed to identify LPN #1 had attended the in-service. Review of the Oxygen Administration policy directed, in part, the procedure for administering low-flow oxygen included the equipment of high-pressure oxygen cylinder. The policy directed proper handling and storage of oxygen tanks was crucial to prevent accidents and ensure resident safety. The policy further identified for storage to use a cart or stand designed for oxygen tanks to prevent them from falling and to handle tanks with care to avoid dropping or damaging them.

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, facility policy and interviews for 1 of 3 residents (Resident #66) observed for medication administration, the facility failed to ensure the medication error rate was not greater than 5% (error rate was 6.9%). The findings include:Resident #66 had diagnoses that included chronic kidney disease, acute and chronic respiratory failure with hypoxia, and diabetes.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #66 was cognitively intact, required setup or clean-up assistance with eating, partial/moderate assistance with bed mobility, and was dependent for transfers.The Resident Care Plan (RCP) dated 4/29/25 identified Resident #66 had a diagnosis of chronic obstructive pulmonary disease (COPD). Interventions included to elevate the head of bed to assist and maintain maximal lung expansion. The RCP further identified Resident #66 was incontinent of bowel and/or bladder with interventions that included to offer toilet assistance every 2 hours and as needed.a. A physician order dated 7/1/25 directed to administer Bethanechol Chloride (a medication to help stimulate bladder function and emptying) 25 milligrams (mg) by mouth 3 times a day for urinary retention.The Medication Administration Record (MAR) for July 2025 identified Bethanechol Chloride 25 mg was ordered for administration at 9:00 AM, 2:00 PM, and 9:00 PM. Observation of medication administration on 7/17/25 at 9:35 AM identified Registered Nurse (RN) #3 poured Bethanechol Chloride 25 mg for administration to Resident #66. The pharmacy label instructions directed to take on an empty stomach. Resident #66 stated he/she had already eaten breakfast that morning (consisting of toast with cream of wheat cereal). RN #3 was observed to set the medication cup in front of Resident #66 (which contained Bethanechol Chloride 25 mg), administered an inhaler to Resident #66, and as Resident #66 went to pick up the medication cup to take his/her medication, surveyor requested to talk to RN #3 and to bring the medication cup with him prior to Resident #66 consuming medication. Interview and record review with RN #3 on 7/17/25 at 9:50 AM identified the Bethanechol Chloride 25 mg tablet had directions on the pharmacy label which directed to take on an empty stomach. RN #3 identified he had not seen the pharmacy directions to take on an empty stomach. RN #3 could not identify how long Resident #66 had received this medication at the 9:00 AM time. RN #3 removed the Bethanechol Chloride 25 mg tablet from the medication cup and identified he would contact the Advanced Practice Registered Nurse (APRN) for further instructions on whether she wanted to change the administration times for the medication or approve administration with food.Subsequent to surveyor inquiry, an interview with RN #3 on 7/17/25 at 2:50 PM identified APRN #1 had ordered to change the administration times for Bethanechol Chloride to 6:00 AM, 2:00 PM, and 10:00 PM to avoid administration directly after a meal.Physician order dated 7/17/25 directed to administer Bethanechol Chloride 25 milligrams (mg) by mouth 3 times a day for urinary retention and give on an empty stomach.b. A physician order dated 7/1/25 directed to administer Guaifenesin extended release 12 hour 600 mg (medication for chest congestion) 2 tablets (1200mg total dose) by mouth 2 times a day for cough/congestion.The Medication Administration Record (MAR) for July 2025 identified Guaifenesin extended release 12 hour 600 mg 2 tablets was ordered for administration at 9:00 AM and 9:00 PM.Observation of medication administration with RN #3 on 7/17/25 at 9:52 AM identified he had administered 2 tablets of Guaifenesin 600mg/dextromethorphan 30 mg extended release to Resident #66.Interview with RN #3 on 7/21/25 at 9:40 AM identified he had not realized the Guaifenesin 600mg/dextromethorphan 30 mg extended release medication in his medication cart was not the same as the Guaifenesin extended release 12 hour 600 mg tablet, and he then obtained a box of the correct medication (Guaifenesin extended release 12 hour 600 mg tablets) for his medication cart.Interview with DNS on 7/21/25 at 12:35 PM identified Guaifenesin 600mg/Dextromethorphan 30 mg extended release was not interchangeable with Guaifenesin extended release 12 hour 600 mg and that the boxes were different colors which should alert the nurse that it wasn't the same medication. The DNS (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	identified the nurses should verify the over the counter medications with the physician order before administration. DNS further identified that medications with pharmacy instructions to take on an empty stomach should not be administered after breakfast during the 7:00 AM to 3:00 PM morning medication pass at 9:00 AM.Review of the Medication Administration and Documentation-General Policy #PHNE69 directed, in part, the licensed nurse would compare the medication name, strength, route, and dosage schedule on the medication administration record against the prescription label.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff/resident interview, observations, review of facility documentation and facility policy for 1 of 1 sampled resident (Resident #65) reviewed for dental, the facility failed to assist Resident #65 to arrange a consultation with the dentist to discuss treatment options. The findings include: Resident #65's diagnosis included chronic obstructive pulmonary disease, depression, anxiety and dysphagia. Review of the face sheet in the clinical record identified Resident #65's payor source was Medicaid. An annual Minimum Data Set (MDS) dated [DATE] identified Resident #65 had intact cognition, required set up assistance with eating, oral hygiene, and was independent with transfers. The MDS further identified Resident #65 required partial/moderate assistance with toileting, bathing and personal hygiene. Although Resident #65 was observed to have broken teeth, the MDS failed to identify broken teeth. A Resident Care Plan dated 1/25/25 identified a problem with being on a mechanical soft diet and being at risk for weight fluctuations. Interventions included to monitor for signs of dehydration, encourage the intake of foods/fluids and assist with meals as needed. An Advanced Practice Registered Nurse (APRN) order dated 3/30/25 directed a dental consult for teeth removal. A nursing note dated 4/1/25 at 5:25 PM identified the scheduler was notified to set up an appointment for a dental consultation as per the APRN order (from 3/30/25). An APRN order dated 4/11/25 directed a dental appointment for 4/28/25. An APRN order dated 5/8/25 directed a dental consultation regarding broken teeth, the need for extractions and dentures. A nursing note dated 5/19/25 at 2:41PM identified Resident #65 had left for a scheduled dental appointment and returned to the facility. Also, identifying the consultation identified Resident #65 needed extractions followed by dentures. Further, identifying the APRN reviewed the consultation report, and the resident was made aware. Results from the dental consultation report dated 5/19/25 identified recommendations for the extraction of Resident #65's remaining teeth and root tips. Also identifying the next step was dentures. Nursing note dated 5/22/25 at 3:15 PM and written by Registered Nurse (RN) # 2 identified that the dentist had called explaining that he agreed that Resident #65's teeth needed to be extracted and were rotten with roots exposed but felt Resident #65 was not a good candidate for dentures as the resident's mouth was too dry. Also identifying RN #2 provided information to the resident regarding the phone call she had from the dentist. Further identifying Resident #65 still wanted to explore the option of getting dentures. RN #2 gave Resident #65 the dentist's contact information and stated to give him a call to discuss the options and did not assist Resident #65 with contacting the dentist. An Advanced Practical Registered Nurse (APRN) order dated 5/23/25 directed to assist the patient in getting an insurance quote for dentures and a follow up appointment, he/she does not have the executive function to do this task him/herself. On 7/16/25 at 10:28 AM, Resident #65 was observed with many missing teeth and identified that he/she would like dentures. An interview with RN #2 on 7/17/25 at 9:28 AM identified Resident #65 did not have a follow up appointment with the dentist for dentures or teeth extractions. Also identifying nursing was responsible for assisting with this and it was an oversight. An interview with the DNS on 7/18/25 at 11:25 AM identified Resident #65 would be provided assistance with a follow-up phone call to the dentist and a follow-up appointment should have been made within 2 weeks of the appointment on May 19, 25. Also identifying she was unsure of the reason it wasn't completed timely. Follow up interview with Resident #65 on 7/18/25 at 11:45 AM noted the Assistant Director of Nursing (ADNS) having Resident #65 write a statement regarding the follow-up for the dentist. Resident #65 identified she/he was assisted with a phone call to dentist by a staff member but could not remember the staff member's name. Also identified Resident #65 told the staff member she/he wanted another opinion about having dentures, but no follow-up appointment was made at the time. Subsequent to the surveyor, inquiry the ADNS on 7/18/25 at 12:00 PM identified Resident #65 had a follow-up appointment scheduled for extractions and dentures on 9/12/25. Also identified the staff member at the time should have made a (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	follow-up appointment for the resident for a second opinion as requested by the resident. Review of the facility policy for Resident Right's outlines the fundamental rights of all residents, ensuring that they are treated with dignity, respect, and compassion and that their individual needs and preferences are honored in accordance with federal and state regulations. Residents have the right to autonomy and self-determination to make informed choices about their care and services.

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F 0568 Level of Harm - Potential for minimal harm Residents Affected - Some	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record and policy review for 1 of 2 sampled residents (Resident #70) reviewed for personal funds, the facility failed to provide Resident #70 and multiple other residents with quarterly statements for the period of 1/1/25 to 3/31/25.Resident #70's diagnoses included heart failure, diabetes mellitus and anxiety disorder.The quarterly Minimum Data Set assessment dated [DATE] identified Resident #70 was cognitively intact.On 7/15/25 at 11:29 AM an interview with Resident #70 identified he/she had not received a quarterly statement even though funds were kept in a trust account with the facility.An interview with the Accounts Receivable Assistant ([NAME]) on 7/18/25 at 12:42 PM identified Resident #70 had a $30.21 balance in the Resident Trust Account, and it was facility policy to provide residents and/or their responsible parties with patient trust fund quarterly statements every quarter and upon request. Additionally, she was responsible for generating/sending out the statements and kept track of quarterly statements generated by providing the residents and/or the responsible parties with a receipt that was signed and returned to her. (The [NAME] could not procure a log or tracking sheet identifying patient trust statements sent or received). An interview and record review with the [NAME] on 7/21/25 at 9:47 AM identified 23 personal trust accounts received quarterly statements for the period of 1/1/25 to 3/31/25. She identified there were 99 patient trust fund accounts eligible to receive quarterly statements and 130 total active patient trust fund accounts that quarter. However, 33 were not eligible to receive quarterly statement due to representative payee status, which meant the resident was unable to manage their funds, money was owed to the facility or the family/conservator stated they did not wish to receive statements. The accounts receivable assistant could not identify where the other receipts were, or the reason the receipts were not available on request.A review of the personal fund policy directed in part that a copy of the quarterly statement will be submitted to the resident or the resident's designated representative (if the resident is unable to comprehend or has requested that the statement be sent to the representative) on a quarterly basis and or the request of the resident or designated representative.

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	075319	A. Building B. Wing	07/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Havencare at Litchfield Woods	255 Roberts St Torrington, CT 06790

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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 0584 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of Resident Council minutes, resident/staff interviews and policy review for 2 of 3 resident lounge areas observed, the facility failed ensure wheelchairs were not stored in a resident area (lounges) and for 6 sampled residents (Resident #54, Resident #55, Resident #111, Resident #118, Resident #135, and Resident #153) , the facility failed to ensure personal laundry was returned and laundered appropriately. Additionally, the facility failed to ensure facility provided linens were not left in the washing machine, causing them to be odorous and stained. The findings include:1.Observations were made on 7/16/25 at 10:28 AM, 7/17/25 at 10:30 AM, and 7/18/25 at 10:15 AM of three wheelchairs and one geri-recliner being stored in the 1st floor resident lounge. For all observations, Resident #9 was seated in a wheelchair in the 1st floor resident lounge with a visitor completing a puzzle. Two of the wheelchairs were electric but not charging/plugged in and one wheelchair was a custom standard wheelchair. The geri-recliner was facing the window and blocked access to other chairs and furniture in the lounge.Observations were made on 7/17/25 at 10:35 AM and 7/18/25 at 10:30 AM of three wheelchairs being stored in the 2nd floor resident lounge (labeled chapel/lounge). Two of the wheelchairs were electric and not charging/plugged in and one of the wheelchairs was a custom standard wheelchair.Observation and interview with Resident #9 on 7/21/25 at 10:15 AM identified he/she completed puzzles in the 1st floor resident lounge daily, often in the company of visitors and other residents. Resident #9 indicated the wheelchairs and other equipment were kept in the 1st floor resident lounge all the time and he/she was not sure why. Resident #9 stated they use this room as a storage room and due to that, he/she often had trouble gaining access to the table in order to work on the puzzle.Observation and Interview on 7/21/25 at 10:20 AM with LPN #3 identified the 1st floor resident lounge is a resident area which is often utilized by residents and their families. LPN #3 indicated the wheelchairs were stored in the room all the time and she was unsure why the electric wheelchairs were in there and were not charging/plugged in. LPN #3 was unsure if there was another area on the unit where the equipment could be stored and she would need to check with the nursing supervisor about it.Observation and interview with Resident #90 in the 2nd floor resident lounge on 7/21/25 at 10:30AM identified he/she was seated in a wheelchair at the puzzle table and there were three wheelchairs (2 electric and not charging/plugged in and 1 custom standard wheelchair) being stored in the room. Resident #90 indicated the wheelchairs were always in the 2nd floor lounge and were being stored by the facility in that location. Resident #90 identified he/she frequently worked on puzzles in the lounge alone and with visitors and the room often felt cluttered due to the wheelchairs being stored in there. Interview with the Administrator on 7/21/25 at 12:16 PM identified he was aware that three wheelchairs and a geri-recliner were being stored in the 1st floor resident lounge and that three wheelchairs were being stored in the 2nd floor resident lounge. The Administrator indicated the 1st and 2nd floor resident lounges were frequently utilized by residents and visitors and the electric wheelchairs were not always being charged when stored in the lounges. The Administrator further identified the wheelchairs and geri-recliner should not have been stored in the 1st and 2nd floor lounges because they are resident areas and that he would have them removed and find an alternative location for them to be stored. Although requested, a policy on the storage of durable medical equipment was not provided. 2. Resident Council meeting minutes (20 residents were in attendance) dated 1/16/25 identified that laundry services was down a dryer and so turnaround time for laundry could be longer than usual. Resident Council meeting minutes (12 residents were in attendance) dated 3/20/25 identified residents were reminded that laundry was down a dryer and turnaround time could be longer for laundry services. Resident Council meeting minutes (38 residents in attendance) dated 5/29/25 identified there was still only 1 dryer working and several residents (5 rooms) were very upset about (continued on next page)

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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 0584 Level of Harm - Potential for minimal harm Residents Affected - Some	their clothing being missing. Resident Council meeting minutes (28 residents in attendance) dated 6/19/25 identified there was still only 1 dryer working and the equipment company had been out to the facility 2 times to do repairs. The minutes further identified several residents stated they were still not receiving their personal clothing back in a decent amount of time. The residents were reminded that the new company was looking into getting more dryers which would help with the turnaround of laundry. A Resident Council meeting was held with the State Agency on 7/17/25 at 2:34 PM with 13 residents present and had the following issues:Resident #54 had lost clothing in the facility laundry 3 times and after Resident #54 and the Social Worker going to the laundry department, clothing was not found except for a sweatshirt (labeled with Resident #54's name), which was returned months later. The Resident Council meeting further identified Resident #55 stated he/she had put 4 expensive pairs of jeans and sweaters to be washed by the facility laundry department and all items were returned bleached. When Resident #55 reported the bleaching, the facility provided no assistance to rectify the matter and Resident #55 stated he/she now washes his/her own clothing. Additionally, Resident #55 identified the bed sheets in the facility smell offensive and were returned from the in house laundry stained.The Resident Council meeting also identified Resident #111 stated the facility no longer laundered his/her laundry because he/she had lost thousands of dollars worth of clothing (which was labeled prior to sending down to the laundry), and didn't assist with rectifying the situation.Resident #135 stated he/she had been at the facility for 3 months and had to go out to do laundry (which costs $10.00 per week) because of the poor condition his/her clothes came back from the in house laundry, had reported the laundry issue to the Social Service department, but nothing had been done.Resident #153 stated he/she had lost a lot of shirts and pants when his/her clothes were sent to the facility laundry. Resident #153 noted he/she spoke with the Director of Environmental Services who was unable to locate the missing shirts/pants in the laundry. Also identifying he/she had colored clothing that was returned bleached. Resident #153 also identified the facility had an issue with the dryer not working for over a year.Interview with Nurse Aide (NA) #1 on 7/17/25 at 3:07 PM identified she frequently did not have personal clothes for the residents on her assignment to get them dressed when she worked on the 7:00 AM to 3:00 PM shift. NA #1 noted that she would go to the laundry room to see if there were any clean clothes for her residents to wear, but they were either not laundered or were missing. NA #1 identified the residents would get upset because they didn't have clothes to wear. Observation of the soiled laundry room on 7/18/25 at 6:00 AM identified 2 large rolling plastic bins overflowing with soiled laundry. Additionally, 1 large rolling bin and 2 medium rolling bins were identified as sorted laundry, that rose above the level of the bins. Laundry Aide (LA) #3 identified it was difficult to catch up on the laundry because only 1 of the 5 dryers and 2 of the 4 washers were working). Interview with LA #3 on 7/18/25 at 8:30 AM identified he dried laundry left inside the washers and sitting in the laundry baskets from the previous day when he arrived in the early morning. Additionally, he stated his focus each day was washing the linens first and when the linens were adequately stocked, he would try to get to the residents' personal clothes, but that he would often be asked for more linens so he would stop washing the personal clothes. Review of the Residents' Personal Clothing policy directed, in party that the facility would make every effort to safeguard the belonging of its residents. The policy directed that the facility would treat all residents' property in a respectful manner, and return clean clothing to the correct unit, room and closet. The policy failed to identify a timeline for the return of residents' personal clothing. Although requested, a policy for laundry services was not provided. 3.Resident#118's was admitted to the facility on [DATE] with diagnoses that included dementia, congestive heart failure, and anxiety.An annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #118 was severely cognitively impaired, was dependent on bathing, toileting, and personal hygiene. Also identified Resident #118 required maximal assistance for eating, oral hygiene, dressing and transfers.The Resident Care Plan (RCP) dated 5/21/25 identified Resident #118 had an activities of daily living deficit related to cognitive loss and dementia. Interventions included assisting the resident with (continued on next page)

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F 0584 Level of Harm - Potential for minimal harm Residents Affected - Some	gathering and setting up clothing, toiletries and equipment, to keep the call bell and needed items within reach of the resident.An interview with Person #2 on 7/15/25 at 11:21 AM identified Resident #118 had numerous missing items since admission although all items were labeled with the resident's name in permanent black marker. Person #2 reported that she/he had purchased a new comforter set for a Christmas gift for Resident #118 and it went missing shortly after. Also identifying Resident #118 was missing numerous clothing along with a pair of shoes. Further identifying in May of 2025, Person #2 purchased a new blanket for Resident #118, and it went missing after one week. Person #2 reported the missing items to Social Worker (SW) #2 when all these items went missing. An interview with SW #2 on 7/17/25 at 10:30AM identified Person #2 had reported the missing shoes, clothing, comforter set and blanket when these items went missing but could not provide any documentation of the missing items or what was done to resolve the issue. Also identified that the policy for missing items was to go to the department and for her to speak to the department head regarding the missing items. Further identified the items were not found, no one followed up with Person #2 and SW #2 was responsible for the follow-up. An interview with the Environmental Director on 7/17/25 at 10:48 AM identified he was aware of Resident #118 missing clothing items but not aware of the missing comforter, blanket, and shoes. When the Environmental Director identified the labeling with a permanent marker was not permanent as it usually washes out. Additionally stating the facility has an iron on label maker for personal items and residents were directed to ensure the items were marked with an iron on label. Also identifying that admissions or the front desk would explain to families about this process and then items were brought to laundry to have an iron on identification label placed on the items. Further identifying the laundry has 8 large black bags filled with unidentified laundry. Although a policy for labeling laundry items was requested from the Environmental Director, one was not provided.

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F 0585 Level of Harm - Potential for minimal harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the Grievance Log, staff and resident interviews, observations and facility policy regarding missing laundry items (Resident #118), the facility failed to resolve grievances regarding missing items. The findings include:Resident#118's was admitted to the facility on [DATE] with diagnoses that included dementia, congestive heart failure, and anxiety. An annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #118 was severely cognitively impaired, was dependent on bathing, toileting, and personal hygiene. Also identified Resident #118 required maximal assistance for eating, oral hygiene, dressing and transfers. The Resident Care Plan (RCP) dated 5/21/25 identified Resident #118 had an activities of daily living deficit related to cognitive loss and dementia. Interventions included assisting the resident with gathering and setting up clothing, toiletries and equipment, to keep the call bell and needed items within reach of the resident. An interview with Person #2 on 7/15/25 at 11:21 AM identified Resident #118 had numerous missing items since admission although all items were labeled with the resident's name in permanent black marker. Person #2 reported that she/he had purchased a new comforter set for a Christmas gift for Resident #118 and it went missing shortly after. Also identifying Resident #118 was missing numerous clothing along with a pair of shoes. Further identifying in May of 2025, Person #2 purchased a new blanket for Resident #118, and it went missing after one week. Person #2 reported the missing items to Social Worker (SW) #2 (but couldn't identify when) when all these items went missing. An interview with SW #2 on 7/17/25 at 10:30AM identified Person #2 had reported the missing shoes, clothing, comforter set and blanket when these items went missing but could not provide any documentation of the missing items or what was done to resolve the issue. Also identified that the policy for missing items was to go to the department and for her to speak to the department head regarding the missing items. Further identified the items were not found, no one followed up with Person #2 and SW #2 was responsible for the follow-up. An interview with the Environmental Director on 7/17/25 at 10:48 AM identified he was aware of Resident #118 missing clothing items but not aware of the missing comforter, blanket, and shoes. When the Environmental Director identified the labeling with a permanent marker was not permanent as it usually washes out. Additionally stating the facility has an iron on label maker for personal items and residents were directed to ensure the items were marked with an iron on label. Also identifying that admissions or the front desk would explain to families about this process and then items were brought to laundry to have an iron on identification label placed on the items. Further identifying the laundry has 8 large black bags filled with unidentified laundry. Although a policy for labeling laundry items was requested from the Environmental Director, one was not provided.