

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075332	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/02/2025
NAME OF PROVIDER OR SUPPLIER Havencare at Valerie Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 1360 Tarringford 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)
<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation, and staff interviews for one of three residents (Resident #1) reviewed for abuse, the facility failed to ensure the resident was free from physical restraints. The findings include:</p> <p>Resident #1 had a diagnosis of dementia and muscle weakness. An annual Minimum Data Set (MDS) dated [DATE] identified Resident #1 had a Brief Interview Mental Status (BIMS) score of two (2) indicating severely impaired cognition and used a walker and a manual wheelchair. The Resident Care Plan dated 11/15/2024 identified impaired cognition, required cueing for ambulation, and risk for falls. Interventions directed one (1) staff assist for transfers and ambulation, and speak slowly, clearly, and explain procedures.</p> <p>Physician order dated 9/24/2024 directed assist of one (1) for ambulation with rolling walker.</p> <p>Facility reportable event incident report dated 12/9/2024 at 12:21 PM identified Resident #1 was alert, confused, required assist of one (1) staff for transfers and one (1) staff for ambulation with rolling walker. The report further indicated the facility became aware on 12/9/2024 at 9 AM (3 hours and 21 minutes before the report was submitted) that it was reported that a staff member used a gait belt to restrict a resident's movement in a wheelchair on 12/5/2024 at 11:05 PM; the resident was confined to a wheelchair using the gait belt. No physical or emotional injuries were noted. After a comprehensive investigation that included interviews, and collection of statements from employees both directly and indirectly connected to the incident, it was determined that the employees' actions or lack of action did in fact demonstrate a failure to follow the facility policy or protocol on restraint use. The facility separated employment with those employees directly involved in the incident.</p> <p>The facility incident summary dated 12/13/2024 identified on 12/9/2024 it was reported that on 12/5/2024 at 11:05 PM during the change of shift NA #2 restricted Resident #1 from getting up from a wheelchair using a gait belt. The facility summary identified the employee's actions or lack of action demonstrated a failure to follow the facility policy on restraint use, and the facility separated employment with the employees directly involved with the incident.</p> <p>APRN note dated 12/10/2024 at 10:07 AM identified the resident had no recollection of the event, in his/her usual mental state, denied pain, and no signs of injury.</p> <p>(continued on next page)</p>

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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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Social Services note dated 12/11/2024 at 8:37 PM identified Resident #1 had no complaints, no behavioral issues noted, no recollection of the event, and no emotional distress.</p> <p>Interview with NA #1 on 1/2/2025 at 11:34 AM identified on 12/5/2024 she started her shift at 11 PM (worked 11 PM to 7 AM shift) and during her initial walking rounds with NA #2 they observed Resident #1 in his/her closet. NA #2 put Resident #1 in a wheelchair and brought him/her to the common area and placed Resident #1 at a table. NA #1 stated she witnessed NA #2 place a gait belt around the wheelchair and clip the resident in, with the clip part being within the residents reach. NA #1 stated she did not know if Resident #1 could unclip the gait belt him/herself, and she was unsure if a gait belt was supposed to be used to prevent the resident from standing.</p> <p>Interview with NA #2 on 1/2/2025 at 11:59 AM identified on 12/5/2024 she worked on from 3 to 11 PM and had Resident #1 on her assignment. NA #2 was doing walking rounds with NA #1 and found Resident #1 in his/her closet. Resident #1 was then placed in a wheelchair and brought to the common area and placed him/her at a table. NA #2 stated Resident #1 was agitated, LPN #1 (11 PM to 7 AM nurse) saw the resident and what was happening, and directed NA #2 to put the back of Resident #1's wheelchair against the wall and to put a gait belt around the resident in the chair. NA #2 then placed the gait belt around the wheelchair and clipped the gait belt off to the right-hand side of the resident within the residents reach. NA #2 further indicated she was not supposed to use a gait belt to prevent the resident from standing up but stated she was following LPN #1's direction.</p> <p>Interview with LPN #1 on 1/2/2025 at 1:26 PM identified she worked on 12/5/2024 on the 11 PM to 7 AM shift and she saw Resident #1 was brought to the common area and she asked NA #1 to sit with the resident while she was getting shift report. LPN #1 stated she did not instruct any NA to put a gait belt on the resident as a seat belt and she did not see anyone put a gait belt on the resident.</p> <p>Interview with LPN #2 on 1/2/2025 at 1:49 PM identified she worked from 7 to 11 PM on 12/5/2024 and during walking rounds NA #1 and NA #2 placed Resident #1 in the common area. As LPN #2 was getting her belongings together to leave she, saw Resident #1 against the wall with the table close to him/her. LPN #2 stated she heard the word gait belt as she was walking out to leave the unit after her shift had ended, but she did not know who said the word and did not know what they were going to do with the gait belt. LPN #2 stated Resident #1 required use of a gait belt for ambulation and staff saying the word gait belt was not unusual. LPN #2 further stated she did not see anyone place a gait belt on Resident #1 as a seat belt and if she had she would have reported it immediately. LPN #2 also stated the resident would not be able to unclip the gait belt if it was applied on him/her.</p> <p>(continued on next page)</p>

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with the DNS and Administrator on 1/2/2025 at 2:07 PM identified NA#1 and NA #2 brought Resident #1 to the common area and the resident was trying to get up out of the wheelchair. NA #2 stated she was instructed by LPN #1 to put the gait belt around Resident #1 and the resident's wheelchair, and NA #2 applied the gait belt around both the resident and wheelchair and clipped it in place. NA #1 was present when NA #2 applied the gait belt around the resident and around the wheelchair and she should have reported the incident immediately. The resident had not been assessed for use of any seat belt in the wheelchair, and it was unknown if the resident would have been able to remove the clipped gait belt around him/her. The gait belt should not have been used as a seat belt to prevent Resident #1 from standing/getting out of the wheelchair. The Administrator stated LPN #2's shift had ended; LPN #2 did not hear anything about the use of the gait belt as she was either in another room to gather her belongings or leaving the unit. LPN #1 was alleged to have directed the use of the gait belt however denied the allegation. Interview identified NA #2's employment was terminated for applying a restraint, and LPN #1, LPN #2, NA #1's employment was also terminated.</p> <p>Review of facility Gait Belt Use policy dated April 2015 directed in part, to use gait belts to prevent injury and discomfort to the resident during transfer and ambulation tasks in which staff are called upon to provide physical assistance.</p> <p>Review of facility Restraint Management policy dated July 2015 directed in part, physical restraints are any manual, mechanical or physical device, material or equipment attached or adjacent to the resident's body the individual cannot remove easily, which restricts freedom of movement or normal access to ones body, and no restraint may applied unless there is a specific physician order.</p> <p>Review of facility Resident [NAME] of Rights policy dated July 2021 directed that residents have the right to be free from restraints administered for discipline or convenience and not required to treat medical symptoms.</p> <p>Facility documentation review identified the facility imitated all staff education regarding the facility abuse policy and restraint policy, and a QAPI meeting was held on 12/9/2024. Audits were initiated on 12/13/2024. Past non-compliance was identified.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation, and staff interviews for one of three residents (Resident #1) reviewed for abuse, the facility failed to ensure staff reported an alleged mistreatment timely and failed to ensure the State Agency was notified timely after the facility became aware of an allegation. The findings include:</p> <p>Resident #1 had a diagnosis of dementia and muscle weakness. An annual Minimum Data Set (MDS) dated [DATE] identified Resident #1 had a Brief Interview Mental Status (BIMS) score of two (2) indicating severely impaired cognition and used a walker and a manual wheelchair. The Resident Care Plan dated 11/15/2024 identified impaired cognition, required cueing for ambulation, and risk for falls. Interventions directed one (1) staff assist for transfers and ambulation, and speak slowly, clearly, and explain procedures.</p> <p>Physician order dated 9/24/2024 directed assist of one (1) for ambulation with rolling walker.</p> <p>Facility reportable event incident report dated 12/9/2024 at 12:21 PM identified Resident #1 was alert, confused, required assist of one (1) staff for transfers and one (1) staff for ambulation with rolling walker. The report further indicated the facility became aware on 12/9/2024 at 9 AM (3 hours and 21 minutes before the report was submitted) that it was reported that a staff member used a gait belt to restrict a resident's movement in a wheelchair on 12/5/2024 at 11:05 PM; the resident was confined to a wheelchair using the gait belt. No physical or emotional injuries were noted. After a comprehensive investigation that included interviews, and collection of statements from employees both directly and indirectly connected to the incident, it was determined that the employees' actions or lack of action did in fact demonstrate a failure to follow the facility policy or protocol on restraint use. The facility separated employment with those employees directly involved in the incident.</p> <p>The facility incident summary dated 12/13/2024 identified on 12/9/2024 it was reported that on 12/5/2024 at 11:05 PM during the change of shift NA #2 restricted Resident #1 from getting up from a wheelchair using a gait belt. The facility summary identified the employee's actions or lack of action demonstrated a failure to follow the facility policy on restraint use, and the facility separated employment with the employees directly involved with the incident.</p> <p>Interview with NA #1 on 1/2/2025 at 11:34 AM identified on 12/5/2024 she started her shift at 11 PM (worked 11 PM to 7 AM shift) and during her initial walking rounds with NA #2 they observed Resident #1 in his/her closet. NA #2 put Resident #1 in a wheelchair and brought him/her to the common area and placed Resident #1 at a table. NA #1 stated she witnessed NA #2 place a gait belt around the wheelchair and clip the resident in, with the clip part being within the residents reach. NA #1 stated she did not know if Resident #1 could unclip the gait belt him/herself, and she was unsure if a gait belt was supposed to be used to prevent the resident from standing.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with NA #2 on 1/2/2025 at 11:59 AM identified on 12/5/2024 she worked on from 3 to 11 PM and had Resident #1 on her assignment. NA #2 was doing walking rounds with NA #1 and found Resident #1 in his/her closet. Resident #1 was then placed in a wheelchair and brought to the common area and placed him/her at a table. NA #2 stated Resident #1 was agitated, the 11 PM to 7 AM nurse saw the resident and what was happening and directed NA #2 to put the back of the resident's wheelchair against the wall and to put a gait belt around the resident in the chair. NA #2 then placed the gait belt around the wheelchair and clipped the gait belt off to the right-hand side of the resident within the residents reach. NA #2 further indicated she was not supposed to use a gait belt to prevent the resident from standing up but stated she was following the nurse's direction.</p> <p>Interview with the DNS and Administrator on 1/2/2025 at 2:07 PM identified NA #1 and NA #2 brought Resident #1 to the common area and the resident was trying to get up. NA #2 stated she was instructed by LPN #1 to put the gait belt around the resident's wheelchair. Then later in the shift, NA #1 took the resident back to his/her room and unclipped the gait belt from around the resident and wheelchair.</p> <p>The DNS and Administrator stated since NA #1 was present when NA #2 applied the gait belt around the resident's wheelchair, NA #1 should have reported the incident immediately but failed to do so. Further, the gait belt should not have been used as a seat belt and staff should have reported the incident prior to 12/13/2024 (8 days after the incident occurred), and they learned of the incident when a non-nursing staff reported a rumor that they had heard that a NA had used a gait belt to restrain Resident #1. Further, interview identified although the facility was aware of the allegation on 12/9/2024 at 9 AM, the facility did not notify the State Agency until 12/9/2024 at 12:21 (three hours and 21 minutes after the facility first knew of the event).</p> <p>Review of facility Abuse Prohibition Policy dated September 2020 directed staff to report violations of mistreatment immediately, but not later than 2 hours after the violation.</p> <p>Facility documentation review identified the facility imitated all staff education regarding the facility abuse policy and restraint policy, and a QAPI meeting was held on 12/9/2024. Audits were initiated on 12/13/2024. Past non-compliance was identified.</p>		