

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  03/17/2025
NAME OF PROVIDER OR SUPPLIER  Havencare at Valerie Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  1360 Toringford 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 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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41682</b></p> <p>Based on clinical record review, facility documentation review, facility policy review, and interviews for two of three residents (Resident #1 and #2) reviewed for abuse, the facility failed to ensure staff reported an allegation of abuse timely. The findings include:</p> <p>A. Resident #1's diagnoses included Wernicke's encephalopathy, mild cognitive impairment, and adjustment disorder. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of seven out of fifteen (7/15), indicative of severe cognitive impairment and ambulated independently. The Resident Care Plan (RCP) dated 1/2/2025 identified Resident #1 had behaviors/swearing at staff. Interventions directed to decrease visual or auditory stressors when over stimulated, and ask for resident cooperation with task.</p> <p>B. Resident #2's diagnoses included Parkinson's disease, vascular dementia, neurocognitive disorder, and anxiety disorder. The quarterly MDS assessment dated [DATE] identified Resident #2 had a BIMS score of seven out of fifteen (7/15), indicative of severe cognitive impairment and ambulated independently. The RCP dated 2/14/2025 identified Resident #2 exhibited sexually inappropriate behavior. Interventions directed to redirect, change environment and activity as indicated.</p> <p>A nursing note dated 2/26/2025 at 10:32 PM by LPN #1 identified Resident #1 was noted sitting closely to Resident #2 during dinner with his/her hand on Resident #2's thigh. LPN #1 asked Resident #1 to remove his/her hand, which was complied with. After dinner, both residents sat on the couch in the TV room, with Resident #1's arm around Resident #2. LPN #1 went to check on the residents and noted that Resident #1's hand was resting against Resident #2 upper chest area and LPN #1 separated the residents.</p> <p>A reportable event form dated 2/26/2025 identified on 2/26/2025 at 5:30 PM, Residents #1 and #2 were sitting on a couch together and Resident #1 had his/her arm around Resident #2 with his/her hand was resting against Resident #2's breast.</p> <p>Facility summary dated 3/3/2025 identified Resident #1 was observed by staff on 2/26/2025 with his/her hand on Resident #2's breast over clothing. Resident #1 removed his/her hand when directed by staff.</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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NAME OF PROVIDER OR SUPPLIER  Havencare at Valerie Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  1360 Tarringford 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)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of State Agency FLIS Events Report Tracking System identified the incident occurred on 2/26/2025 at 5:30 PM. Additional review identified the State Agency was notified on 2/27/2025 at 10:14 AM (16 hours and 44 minutes after the incident occurred).</p> <p>Interview with DON on 3/17/2025 at 3:00 PM identified LPN #1 did not initially report that staff observed Resident #1 had his/her hand over Resident #2's breast. The DON stated that LPN #1 had reported Resident #1 had his/her hand on Resident #2's thigh. On 2/27/2025 she identified Resident #1 was observed with his/her hand on Resident #2's breast area, and she notified the State Agency at that time. The DON stated the allegation of abuse should have been reported immediately.</p> <p>Review of the facility Abuse, Neglect, and Exploitation Policy dated 2/2023 under Reporting/Response, directed in part, to report all alleged violations to the Administrator, State Agency, Adult Protective Services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: a. Immediately, but not later than two (2) hours after the allegation is made if the events that cause the allegation involve abuse.</p>		