| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 075332 | A. Building<br>B. Wing | 05/06/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Havencare at Valerie Manor | 1360 Torringford St<br>Torrington, CT 06790 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation review, facility policy review, and interviews for one resident (Resident #1) reviewed for abuse, the facility failed to ensure the resident was free from abuse by a staff member. The findings include:<br><br>Resident #1's diagnoses included dementia, depression, adjustment disorder and anxiety. A quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated severe cognitive impairment, required moderate assistance for personal hygiene. Resident Care Plan (RCP) dated 3/26/2025 identified Resident #1 had episodes of anxiety. The RCP directed to encourage resident to verbalize feelings, use a calm, gentle approach to quiet Resident and monitor for triggers and avoid them.<br><br>A Facility Reportable Event (RE) report dated 4/12/2025 at 9:05 AM identified nursing and dietary staff in the dining room observed Nurse Aide (NA) #1 be verbally rude to Resident #1 and Resident #1 had emotional distress. NA #2 was removed from the dining room, an investigation was initiated, and NA #2 was sent home pending investigation. Facility statements provided by NA #1, #3 and #4 identified they witnessed NA #2 using inappropriate language and tone, and state loudly near Resident #1's face, I am going to tell my supervisor for you to leave me the hell alone.<br><br>A facility interview completed by NA #2 as part of the 4/12/2025 investigation identified she had had it with Resident #1 as Resident #1 targeted her since Resident #1 came to the floor. NA #2 continued she ignored Resident #1 all the time when Resident #1 picked on her, called her names and sometimes followed NA #2 around. The facility interview identified on 4/12/2025, NA #2 had to say something for Resident #1 to stop. NA #2 identified she told Resident #1 she was going to speak to her supervisor for Resident #1 to leave her the hell alone noting that Resident #1 targeted her all the time.<br><br>The facility summary dated 4/17/2025 identified three (3) NAs in the dining room on 4/12/2025 observed Resident #1 tell NA #2 to get back to work. NA #2 responded to Resident #1's comment by saying I am going to tell my supervisor to tell you to leave me the hell alone. Facility investigation substantiated NA #2 made the comments, and NA #2's employment was terminated. Resident #1 was initially upset, but then had no recollection of the event later in the day.<br><br>(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 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview and facility documentation review with NA #3 on 5/6/2025 at 9:55 AM identified she was in the dining room on 4/12/2025 and witnessed Resident #1 said something to NA #2 who was standing outside the dining room. NA #2 then aggressively marched over to Resident #1 yelling with her finger pointed at Resident #1 standing in front of Resident #1 and telling Resident #1 that she was tired of the way Resident #1 talked to her, she had enough, and she was going to tell the supervisor to tell Resident #1 to leave her the hell alone. Then NA #2 left the dining room, and NA #1, #3 and #4 notified the supervisor.<br><br>Interview and facility documentation review with NA #1 on 5/6/2025 at 10:06 AM identified on 4/12/2025 at around 9:00 AM while she was in the dining room she observed NA #2 suddenly walk fast from the hallway to Resident #1 who was sitting at a table. NA #2 was standing, leaning in close, and pointed her finger at Resident #1 and yelling loud enough for the whole dining room to hear said that she was going to tell the supervisor to tell Resident #1 to leave her the hell alone.<br><br>Interview with NA #4 on 5/6/2025 at 1:45 PM identified on 4/12/2025 at breakfast time she observed NA #2 march from the doorway to Resident #1 and while pointing her finger at the resident and loudly telling him/her she was going to tell the supervisor to tell Resident #1 to leave her the hell alone.<br><br>Attempts to interview NA #2 were unsuccessful during survey.<br><br>Interview with RN #2, nursing supervisor on 4/12/2025 on the 7:00 AM to 3:00 PM shift, staff notified her of the allegation of verbal abuse directed at Resident #1 in the dining room by NA #2. RN #2 indicated she thought it was abuse and NA #2 should not have acted in that manner toward any resident. After the incident was reported, she took Resident #1 back to his/her room to speak with the resident, and Resident #1 was not upset about the incident at that time.<br><br>Interview and facility documentation review with RN #1/acting DON on 5/6/2025 at 12:00 PM identified NA #2 should not have behaved that way. The DON indicated the allegation of abuse was substantiated and NA #2's employment was terminated due to resident abuse.<br><br>The facility Abuse, Neglect and Exploitation policy, dated 2/2023, directed in part<br><br>The facility prohibits (resident) abuse. The policy defined abuse as the will infliction of injury, intimidation with resulting physical harm, pain or mental anguish. Verbal abuse was the use of oral, written or gestured communication that willfully includes disparaging or derogatory terms to a resident or within hearing distance. Mental Abuse includes but is not limited to harassment or threats of punishment.<br><br>The facility Resident Rights policy, dated July 2021, directed in part that residents have the right to be free from abuse.<br><br>Facility documentation review identified staff education was initiated on 4/14/2025 for all staff, and included review of facility abuse policy. Audits were initiated on 4/16, and a QAPI meeting was held on 4/12/2025. Past non-compliance was identified as of 4/16/2025. |