STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075332	A. Building B. Wing	07/16/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, facility documentation review, and staff interviews for one of three residents (Resident #1) reviewed for accidents, the facility failed to ensure the care plan intervention was implemented timely after a fall with an injury. The findings include: Resident #1 had a diagnosis of anxiety, dementia, history of falls, weakness, and insomnia. The quarterly Minimum Data Set (MDS) dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 10 indicating moderately impaired cognition, Resident #1 had no behaviors, and was required one (1) staff assistance for mobility. The Resident Care Plan (RCP) dated 4/23/2025 identified an alteration in mobility and a risk for falls. Interventions directed to place call bell within reach and assist of one (1) with bed mobility. The nursing note written by RN #2, dated 6/23/2025 at 2:03 AM identified the charge nurse reported Resident #1 was noted screaming and was found on floor at 1 AM. Resident #1 was lying in the prone position, partially on his/her left side next to the bed and had his/her left arm behind his/her torso, and screaming my legs. Resident #1's right leg was observed over the left leg and yelled when his/her legs were touched. 911 was called and Resident #1 was transferred to the hospital. The hospital x-ray report dated 6/23/2025 identified an oblique (slanting) distal (lower part of the femur) left femoral shaft fracture with moderate displacement, and an oblique moderately displaced fractured deformity distal femoral metadiaphysis of the right femur. Further, the x-ray results identified osteopenia (bone loss). The physician note dated 6/23/2025 at 2:47 PM identified Resident #1 had severe dementia, and a family decision to treat Resident #1 conservatively, without surgery. Resident #1 was discharged back to the skilled nursing facility. Nursing note dated 6/23/2025 at 9:10 PM identified Resident #1 was readmitted to the facility from the hospital on 6/23/2025 at 8:15 PM with orders for a hospice consult. The nursing note dated 6/25/2025 at 2:39 PM identified Resident #1 was admitted to hospice services. Additional record review identified the care plan dated 6/25/2025 directed use of a bolster mattress. Facility incident summary dated 6/27/2025 identified a new intervention was for a bolster mattress to be applied to the bed. The summary indicated the bolster mattress was to be delivered by hospice. Although record review identified the care plan was updated to include pain management after the fall, the review failed to identify the care plan was updated to include an intervention to prevent another fall, prior to 6/25/2025. Further the care plan intervention for the bolster mattress was not implemented until 6/27/2025 (four days after the fall with injury). Interview and record review with the Director of Nursing (DNS), Administrator and RN #1/corporate representative on 7/16/2025 at 1:40 PM identified Resident #1 had an unwitnessed fall on 6/23/2025 at 1 AM, was transferred to the hospital and diagnosed with femur fractures to both legs. Resident #1 returned from the hospital on 6/23/2025. Interview identified although the care plan was updated on 6/25/2025 to direct use of a bolster mattress, the mattress was not applied to the bed until 6/27/2025 (four days after the fall). The DNS stated the care plan should have been updated with interventions prior to 6/25/2025 and the interventions (bolster mattress) should have been implemented prior to 6/27/2025. Interview failed to identify why interventions were not implemented until 6/27/2025.