

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 08/19/2025
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)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (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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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for four (4) of four (4) residents (Resident #3, Resident #4, Resident #5, and Resident #6) reviewed for medication administration, the facility failed to ensure the clinical records were accurate to reflect when medications were administered. The findings include: 1. Resident #3 had diagnoses that included adult failure to thrive, weakness, and dementia. The quarterly Minimum Data Set (MDS) dated [DATE] identified Resident #3 had a Brief Interview for Mental Status (BIMS) score of two (2) indicative of severely impaired cognition, was always incontinent of bowel and bladder, dependent on staff for all ADLs, including bed mobility, and transfers, was non ambulatory, and dependent on staff for mobility in the wheelchair. The physician's orders dated 7/17/2025 directed to administer liquid protein supplement 30 milliliters once per day at 9:00 A.M., magic cup twice per day at 9:00 A.M. and 5:00 P.M., and supplemental house milkshake 120 cubic centimeter (cc) twice per day at 9:00 A.M. and 5:00 P.M. Review of the facility's accident and incident report dated 7/28/2025 identified on 7/28/2025 an internal medication administration audit report was generated that flagged late medication administrations of one hour or more which revealed a consistent pattern where the scheduled medications times predominantly around 9:00 A.M. were documented later often between 10:00 A.M. and 2:00 P.M. affecting approximately 80 residents on various units. The facility's Medication Administration Audit report dated 7/28/2025 identified Licensed Practical Nurse (LPN) #3 documented at 11:30 A.M. she administered Resident #3's supplemental house milkshake 120 cc's (2 hours and 30 minutes late), at 11:57 A.M. LPN #3 documented she administered Resident #3's liquid protein supplement (2 hours and 57 minutes late), and at 2:17 P.M. LPN #3 documented she administered Resident #3's magic cup (4 hours and 17 minutes late). Review of the facility's accident and incident summary dated 8/2/2025 identified that no residents were negatively affected by the delay in documentation, medications were administered on time, but the documentation of the administration was delayed. Interview with Registered Nurse (RN) #1 (Regional Nurse) on 8/19/2025 at 11:00 A.M. identified on 7/28/2025 Resident #3's medications were administered per the physician's orders at 9:00 A.M. RN #1 indicated LPN #3 documented late in Resident #3's MAR not at the time she administered the medications. RN #1 identified her expectations are when the nurse administers any medication to a resident the nurse documents at the time of administration in the resident's MAR. RN #1 identified on 7/28/2025 LPN #3 should have documented in Resident #3's MAR at the time medications are administered. Interview with LPN #3 on 8/19/2025 at 1:12 P.M. identified on 7/28/2025 at 9:00 A.M. she administered 30 ml's of liquid protein supplement, magic cup, and supplemental house milkshake to Resident #3. LPN #3 identified she did not document Resident #3's MAR at time she administered Resident #3's medications. LPN #3 was unable to document because all the residents on her assignment had medications ordered to be administered at 9:00 A.M. LPN #3 signed off in the medication administration records for all the residents on her assignment after she finished administering the morning medications. Interview with the Director of Nursing (DNS) on 8/19/2025 at 2:00 P.M. identified that she would expect that any medication given to a resident would be signed off in the MAR at the time the medication was administered. The DNS identified the documentation needs to be completed in actual time not later. 2. Resident #4 had diagnoses that included dementia with behavioral disturbance, delusional disorder, anxiety, and depressive episodes. The quarterly MDS dated [DATE] identified Resident #4 had short-term and long-term memory impairment (not capable of completing a brief interview for mental status exam), severely impaired cognitive skills for daily decision making, was always incontinent of bowel and bladder, and dependent on staff for all ADLs, including bed mobility, and transfers, was non ambulatory, and dependent on staff for mobility in the wheelchair. The physician's orders dated 7/17/2025 directed to administer Ativan 0.5 mg twice per day at 8:00 A.M. and 8:00 P.M., acetaminophen 500 mg twice per day at 9:00 A.M. and 9:00 P.M., and Lexapro 10 mg one time per day at 9:00 A.M. Review of the facility's accident and incident report dated 7/28/2025 identified on 7/28/2025 an internal medication administration audit report was generated that flagged late medication administrations of one hour or more which revealed a consistent pattern where the scheduled medications times predominantly around 9:00 A.M. were documented later often between 10:00 A.M. and 2:00 P.M. affecting approximately 80 residents on various units. The facility's Medication Administration Audit report dated 7/28/2025 identified LPN #3 documented at 11:58 A.M. that she administered Resident #4's Ativan 0.5 mg (3 hours and 58 minutes late) acetaminophen 500 mg (2 hours</p>		