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	10/28/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 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 review of the clinical record, facility documentation and facility policy, and interviews for one of three residents (Resident #2) reviewed for abuse, the facility failed to provide adequate supervision to prevent a resident-to-resident incident. The findings include: 1. Resident #1 had diagnoses that included dementia with agitation and adjustment disorder with mixed anxiety and depressed mood. Record review identified Resident #1 had a court appointed Conservator of Person (COP). The quarterly Minimum Data Set (MDS) dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of six (6), indicative of severely impaired cognition, and was independent with ambulation. The Resident Care Plan (RCP) dated 7/24/2025 identified Resident #1 had a history of inappropriate sexual behaviors and seeking out residents of the opposite sex, and observed on 2/26/2025 rubbing a Resident #2's thighs with his/her hand near or on Resident #1's breasts. Further the RCP identified the COP consented Resident #1 can spend time with Resident #2 in the common area holding his/her hands, but the resident cannot kiss other residents. Interventions directed to report inappropriate sexual behaviors, administer medications as ordered, offer diversional activities, encourage the resident to verbalize feelings and concerns, and attempt to identify sources of mood and behavior. 2. Resident #2 had diagnoses that included vascular dementia, depression, anxiety. Record review identified Resident #2 had a court appointed Conservator of Person (COP). The quarterly MDS dated [DATE] identified Resident #2 had a BIMS score of three (3), indicative of severely impaired cognition, and was independent with ambulation.The RCP dated 10/2/2025 identified Resident #2 exhibited sexually inappropriate behavior, had a potential for anxiety related to Resident #1 rubbing his/her thigh and was observed with his/her hand near Resident #1's breast on 2/26/2025. Further review identified the COP gave consent for Resident #2 to spend time with Resident #1 in a common area holding hands and did not consent to the residents being alone in a room or kissing. Interventions directed to encourage to attend communal activities, social services support, and encourage to verbalize thoughts and feelings. Record review and observation identified Resident #1 and Resident #2 resided on the same unit in the facility. Facility reportable event dated 10/5/2025 at 7:19 PM identified NA #1 observed Resident #2 with his/her chest exposed, and Resident #1 was in contact with it. The residents were separated and Resident #1 was placed on one-to-one (1:1) supervision pending psychiatry evaluation with plan for Resident #1 to be transferred to the hospital as a Physician Emergency Certificate (PEC). A facility written statement by NA #1 dated 10/5/2025 at 6:45 P.M. identified he witnessed Resident #1 and Resident #2 sitting at a table in the common area, Resident #2's chest and left breast were exposed, and Resident #1 was touching Resident #2's left chest and breasts. NA #1 indicated he intervened, and Resident #1 immediately became aggressive and threatened NA #1 with violence, and the nurse escorted the residents to their respective rooms. MD #2 (psychiatry) note dated 10/6/2025 identified Resident #1 was evaluated after the resident-to-resident incident occurred on 10/5/2025. The note indicated when staff redirected Resident #1, he/she became very agitated, threatening, and combative and Resident #1 was on 1:1 observation. A PEC was completed for transfer to the hospital due to exacerbation of symptoms. Facility reportable event summary dated 10/10/2025 identified when staff separated Resident #1 and Resident #2 on 10/5/2025, Resident #1 became agitated, combative, and used threatening language directed toward staff. Due to Resident #1's behavior, new orders were obtained to transfer Resident #1 to the hospital with a PEC for evaluation, and was subsequently admitted to the hospital. Record review identified Resident #1 was not re-admitted to the facility at the time of the survey. Interviews with NA#3, NA #4, NA #5, and NA #6 on 10/28/2025 at various times identified that they cared for Resident #1 and Resident #2, and they were aware that Resident #1 and Resident #2 had a friendly relationship. NA #3, NA #4, NA #5, and NA #6 stated Resident #1 and Resident #2 would spend time together holding hands, conversing, or just hanging out in the common area. Further, NA #4 stated Resident #1 and Resident #2 were both care planned to hold hands. Interview with Licensed Practical Nurse (LPN) #1 on 10/28/2025 at 11:15 A.M. identified she was aware Resident #1 and Resident #2 had a friendly relationship and often sat together in the common area. LPN #1 stated she observed Resident #1 at the nursing station and Resident #2 in his/her room at 6:40 PM. When the incident was reported by NA #1, she assisted to separate the residents and placed Resident #1 on 1:1 observation. Interview with APRN #2 (psychiatry) on 10/28/2025 at 11:52 A.M. identified Resident #1 and Resident #2 were allowed to spend time together in the common area and hold hands per their COP. APRN #2 stated she was aware Resident #1