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	03/24/2026

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation review, facility policy review and interviews for three of four residents (Residents #2, #3 and #4) reviewed for abuse, the facility failed to ensure the residents were free from misappropriation. The findings include: Resident #2 was admitted with diagnoses that included fusion of the spine, Lumbar region, bipolar disorder and depression. The 5-day Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had a Brief Mental Interview for Mental Status (BIMS) of thirteen (13) indicative of no cognitive impairment and reported occasional pain in the last five (5) days. A physician order dated 8/31/2025 directed Oxycodone (a narcotic used for pain relief) five (5) milligrams (mg) by mouth, one (1) tablet every six (6) hours as needed for moderate pain and two (2) tablets for severe pain. The order directed an end date of 9/5/2025. The Resident Care Plan (RCP) dated 9/8/2025 identified pain due to lumbar spine surgery. Interventions included to administer pain medication as ordered. 2. Resident #3 was admitted with diagnoses that included dementia. Physician order dated 6/05/2025 directed Oxycodone five (5) milligrams (mg) by mouth, give 1 tablet by mouth every six (6) hours as needed for moderate pain and give two (2) tablets by mouth as needed for severe pain for fourteen days. The order was discontinued on 6/19/2025. A quarterly Minimum Data Set (MDS) dated [DATE] identified Resident #3 had a Brief Mental Interview for Mental Status (BIMS) of three (3), indicative of severe cognitive impairment, and reported no pain in the last five (5) days. The Resident Care Plan (RCP) dated 9/25/2025 identified Resident #3 was at risk for pain. Interventions directed to administer pain medication as ordered. A review of the June Medication Administration Record (MAR) identified that Resident #2 did not receive the Oxycodone. 3. Resident #4 was admitted with diagnoses that included dementia and anxiety. An admission Minimum Data Set (MDS) dated [DATE] identified Resident #4 had a Brief Mental Interview for Mental Status (BIMS) of three (3) indicative of severely impaired cognition. The Resident Care Plan (RCP) dated 10/1/2025 identified Resident #4 had anxiety. Interventions directed to administer anti-anxiety medication as ordered. A physician order dated 10/13/2025 directed to provide Lorazepam 0.5 mg, give one (1) tablet every six (6) hours as needed. The order was discontinued on 10/27/2025. A facility reportable event (RE) form dated 11/20/2025 identified discontinued medications that were scheduled to be destroyed appeared to be missing. Additional review of the form failed to identify the residents that were affected, and what the medications were. The form indicated the incident occurred on 11/10/2025 at 2 PM, and the Medical Director and Consumer Protection were notified on 11/10/2025, and the local law enforcement was not notified. Additional RE information provided on 12/2/2025 identified the local police were notified, and the disposition sheets (controlled medication administration documentation) were missing. The medications were last seen on 10/31/2025 during the 7 AM to 3 PM shift when an audit was conducted. Missing medications were identified as 37 tablets of Oxycodone (pain medication) 5 milligrams (mg) and 15 tablets of Lorazepam (used to treat anxiety) 0.5 mg. The facility RE summary dated 11/26/2025 identified on 11/9/2025 a drug audit identified missing narcotics scheduled for collection for discontinued medications. Missing medications were identified as discontinued, were all reported as last observed on 9/10/2025 by the nurse completing an audit and listed as: nine (9) (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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tablets of Oxycodone for Resident #2; 28 tablets of Oxycodone for Resident #3; and 15 tablets of Lorazepam for Resident #4. The facility initiated an investigation, and the report failed to identify the person responsible for the missing medications. Interview and facility documentation review with the RN #1/Corporate Nurse on 3/24/2026 at 10:13 AM identified she and the DON conducted the investigation into the missing medications for Resident #2, Resident #3 and Resident #4. RN #1 stated she was notified on 11/9/2026 that the white control substance disposition record (proof of use sheets used to sign narcotic medication removed from the locked box and administered to the resident) located in the unit narcotic book and the matching medication packs were missing. RN #1 stated two (2) nurses complete an end-of shift count using the white proof of use sheets. RN #1 stated on 11/9/2025 the following were identified to be missing:Resident #2's proof of use sheet #173495 identified 30 tablets of Oxycodone 5 mg was delivered on 8/26/2025 and nine (9) tablets were missing and was discontinued on 9/10/2025 (62 days prior to identified missing). Resident #3's proof of use sheet #172617 identified 30 tablets of Oxycodone 5 mg was delivered on 6/7/2025 and 28 tablets were missing and was discontinued on 6/19/2025 (144 days prior to identified missing). Resident #4's proof of use sheet #186063 identified 30 tablets of Loazepam 0.5 mg was delivered on 10/22/2025 and 15 tablets were missing and was discontinued on 10/20/2025 (30 days prior to identified missing). RN #1 stated the facility investigation identified the missing medications were from two (2) different units and 30 nurses had access to the locked narcotic storage boxes from the 10/31/2025 audit until the 11/9/2025 audit. RN #1 stated the medications had been moved to the back of the narcotic lock boxes in the two (2) unit medication carts for future removed for disposal/destruction. RN #1 stated the facility was unable to identify the nurse who removed the medications from the lock boxes. Interview and record review with LPN #3 on 3/24/2026 at 1:00 PM identified she completed a narcotic medication audits on 11/9/2025 and when she identified the discrepancy, she notified the DON. Interview and documentation review with the Administrator on 3/24/2026 at 1:30 PM identified a Consumer Protection drug control division memo dated 12/4/2025 indicated on 11/9/2025 there was a significant loss of controlled substances. The investigation confirmed there was a procedural lapse as discontinued medications were not segregated immediately upon discontinuation, and the facility was unable to locate the white proof of use sheets required for tracking movement and custody of the medications. The investigation confirmed that the narcotic loss occurred while the medications were under the security of the narcotic lock box enabled by procedural nonadherence concerning handling of discontinued stock and subsequent inability to reconcile inventory due to missing logs. Interview failed to identify who, or when, staff were able to remove the medications. The DON was not available for interview during the survey. The facility Abuse, Neglect and Exploitation Policy directed in part, to prohibit and prevent abuse. Misappropriation of Resident property was defined as the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's property without the resident's consent. Facility documentation review identified staff education was initiated on 11/13/2025 for licensed nurses regarding controlled substances handling including securing and reporting of discrepancies, loss of controlled substance, resident abuse and neglect policy and resident rights policy. A QAPI was developed and meeting held on 11/9/2025 and audits were initiated on 11/14/2025. Based on review of facility documentation, past non-compliance was identified.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation review, facility policy review and interviews for three of four residents (Residents #2, #3 and #4) reviewed for abuse, the facility failed to ensure an incident report listed the residents affected, failed to ensure a reportable event was classified correctly, and failed to ensure the State Agency was notified timely after an allegation of misappropriation. The findings include: Resident #2 was admitted with diagnoses that included fusion of the spine, Lumbar region, bipolar disorder and depression. The 5-day Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had a Brief Mental Interview for Mental Status (BIMS) of thirteen (13) indicative of no cognitive impairment and reported occasional pain in the last five (5) days. A physician order dated 8/31/2025 directed Oxycodone (a narcotic used for pain relief) five (5) milligrams (mg) by mouth, one (1) tablet every six (6) hours as needed for moderate pain and two (2) tablets for severe pain. The order directed an end date of 9/5/2025. The Resident Care Plan (RCP) dated 9/8/2025 identified pain due to lumbar spine surgery. Interventions included to administer pain medication as ordered. 2. Resident #3 was admitted with diagnoses that included dementia. Physician order dated 6/05/2025 directed Oxycodone five (5) milligrams (mg) by mouth, give 1 tablet by mouth every six (6) hours as needed for moderate pain and give two (2) tablets by mouth as needed for severe pain for fourteen days. The order was discontinued on 6/19/2025. A quarterly Minimum Data Set (MDS) dated [DATE] identified Resident #3 had a Brief Mental Interview for Mental Status (BIMS) of three (3), indicative of severe cognitive impairment, and reported no pain in the last five (5) days. The Resident Care Plan (RCP) dated 9/25/2025 identified Resident #3 was at risk for pain. Interventions directed to administer pain medication as ordered. A review of the June Medication Administration Record (MAR) identified that Resident #2 did not receive the Oxycodone. 3. Resident #4 had diagnoses that included anxiety. An admission Minimum Data Set (MDS) dated [DATE] identified Resident #4 had a Brief Mental Interview for Mental Status (BIMS) of three (3) indicative of severely impaired cognition. The Resident Care Plan (RCP) dated 10/1/2025 identified Resident #4 had anxiety. Interventions directed to administer anti-anxiety medication as ordered. A physician order dated 10/13/2025 directed to provide Lorazepam 0.5 mg, give one (1) tablet every six (6) hours as needed. The order was discontinued on 10/27/2025. A facility reportable event (RE) form dated 11/20/2025 identified discontinued medications that were scheduled to be destroyed appeared to be missing. Additional review of the form failed to identify the residents that were affected, and what the medications were. The form indicated the incident occurred on 11/10/2025 at 2 PM (10 days prior to the report submitted to the State Agency). Additional RE information provided on 12/2/2025 identified the disposition sheets (controlled medication administration documentation) were missing and the medications were last seen on 10/31/2025 during the 7 AM to 3 PM shift when an audit was conducted. Missing medications were identified as 37 tablets of Oxycodone (pain medication) 5 milligrams (mg) and 15 tablets of Lorazepam (used to treat anxiety) 0.5 mg. The facility RE summary dated 11/26/2025 identified on 11/9/2025 a drug audit identified missing narcotics scheduled for collection for discontinued medications. Missing medications were identified as discontinued, were all reported as last observed on 9/10/2025 by the nurse completing an audit and listed as: nine (9) tablets of Oxycodone for Resident #2; 28 tablets of Oxycodone for Resident #3; and 15 tablets of Lorazepam for Resident #4. The facility initiated an investigation, and the report failed to identify the person responsible for the missing medications. A review of the facility incident report dated 11/9/2026 at 1:00 PM identified discontinued medication that were scheduled to be destroyed appear to missing, and did not list any of the affected residents. Review of the State Agency Reportable Events on-line portal identified the RE was submitted to the State Agency on 11/20/2025 at 1:51 PM for the incident identified on 11/10/2025 at 2 PM (10 days prior). The report was initially classified as (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a Class C (loss of heat/water/emergency systems or evacuation) and was changed to a Class B (abuse). Interview with the DON on 3/23/2026 at 9:30 AM identified although she submitted the RE to the State Agency as a Class B she did not classify the incident as a misappropriation; she classified it as other and it was submitted ten (10) days after the incident was identified. The DON stated she did not classify the RE as misappropriation because the medication orders were discontinued and the medications should have been destroyed. Interview failed to identify why the RE was not submitted to the State Agency timely and why the residents affected were not identified. Interview and documentation review with the Corporate RN #1 on 3/24/2026 at 10:13 AM identified the medications and related documentation were identified missing on 11/9/2025. RN #1 stated she did not notify the State Agency of the resident names, and she did not think it was a potential misappropriation because the physician orders had directed the medications were discontinued. The facility Abuse, Neglect and Exploitation Policy directed in part, misappropriation meant the deliberate misplace or use of a resident's belongings without the resident's consent. The facility will report all alleged violation to the State Agency immediately, but not later than 2 hours after the allegation is made if the allegation involves abuse. The facility Accident and Incident Policy directed in part, the accident and incident must include name of individuals involved, a detailed description of the event and condition of the residents involved.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based clinical record review, facility documentation review, facility policy review and interviews for three of four residents (Residents #2, #3 and #4) reviewed for misappropriation, the facility failed to assure adequate controls of narcotic medications leading to controlled substance medications misplacement and loss of medications. The findings include: Resident #2 was admitted with diagnoses that included fusion of the spine, Lumbar region, bipolar disorder and depression. The 5-day Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had a Brief Mental Interview for Mental Status (BIMS) of thirteen (13) indicative of no cognitive impairment and reported occasional pain in the last five (5) days. A physician order dated 8/31/2025 directed Oxycodone (a narcotic used for pain relief) five (5) milligrams (mg) by mouth, one (1) tablet every six (6) hours as needed for moderate pain and two (2) tablets for severe pain. The order directed an end date of 9/5/2025. The Resident Care Plan (RCP) dated 9/8/2025 identified pain due to lumbar spine surgery. Interventions included to administer pain medication as ordered. 2. Resident #3 was admitted with diagnoses that included dementia. Physician order dated 6/05/2025 directed Oxycodone five (5) milligrams (mg) by mouth, give 1 tablet by mouth every six (6) hours as needed for moderate pain and give two (2) tablets by mouth as needed for severe pain for fourteen days. The order was discontinued on 6/19/2025. A quarterly Minimum Data Set (MDS) dated [DATE] identified Resident #3 had a Brief Mental Interview for Mental Status (BIMS) of three (3), indicative of severe cognitive impairment, and reported no pain in the last five (5) days. The Resident Care Plan (RCP) dated 9/25/2025 identified Resident #3 was at risk for pain. Interventions directed to administer pain medication as ordered. A review of the June Medication Administration Record (MAR) identified that Resident #2 did not receive the Oxycodone. 3. Resident #4 was admitted with diagnoses that included dementia and anxiety. An admission Minimum Data Set (MDS) dated [DATE] identified Resident #4 had a Brief Mental Interview for Mental Status (BIMS) of three (3) indicative of severely impaired cognition. The Resident Care Plan (RCP) dated 10/1/2025 identified Resident #4 had anxiety. Interventions directed to administer anti-anxiety medication as ordered. A physician order dated 10/13/2025 directed to provide Lorazepam 0.5 mg, give one (1) tablet every six (6) hours as needed. The order was discontinued on 10/27/2025. A facility reportable event (RE) form dated 11/20/2025 identified discontinued medications that were scheduled to be destroyed appeared to be missing. Additional review of the form failed to identify the residents that were affected, and what the medications were. The form indicated the incident occurred on 11/10/2025 at 2 PM, and the Medical Director and Consumer Protection were notified on 11/10/2025, and the local law enforcement was not notified. Additional RE information provided on 12/2/2025 identified the local police were notified, and the disposition sheets (controlled medication administration documentation) were missing. The medications were last seen on 10/31/2025 during the 7 AM to 3 PM shift when an audit was conducted. Missing medications were identified as 37 tablets of Oxycodone (pain medication) 5 milligrams (mg) and 15 tablets of Lorazepam (used to treat anxiety) 0.5 mg. The facility RE summary dated 11/26/2025 identified on 11/9/2025 a drug audit identified missing narcotics scheduled for collection for discontinued medications. Missing medications were identified as discontinued, were all reported as last observed on 9/10/2025 by the nurse completing an audit and listed as: nine (9) tablets of Oxycodone for Resident #2; 28 tablets of Oxycodone for Resident #3; and 15 tablets of Lorazepam for Resident #4. The facility initiated an investigation, and the report failed to identify the person responsible for the missing medications. Review of the facility record of disposal for medications identified the last date of recorded medication disposal prior to 11/9/2025 was 10/8/2025. Interview and record review with LPN #3 on 3/24/2026 at 1:00 PM identified she completed a narcotic medication audit on 11/9/2025 and when she identified the discrepancy, she (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	notified the DON. Interview and facility documentation review with the RN #1/Corporate Nurse on 3/24/2026 at 10:13 AM identified she and the DON conducted the investigation into the missing medications for Resident #2, Resident #3 and Resident #4. RN #1 stated she was notified on 11/9/2026 that the white control substance disposition record (proof of use sheets used to sign narcotic medication removed from the locked box and administered to the resident) located in the unit narcotic book and the matching medication packs were missing. RN #1 stated two (2) nurses complete an end-of shift count using the white proof of use sheets. RN #1 stated on 11/9/2025 the following were identified to be missing:Resident #2's proof of use sheet #173495 identified 30 tablets of Oxycodone 5 mg was delivered on 8/26/2025 and nine (9) tablets were missing and was discontinued on 9/10/2025 (62 days prior to identified missing). Resident #3's proof of use sheet #172617 identified 30 tablets of Oxycodone 5 mg was delivered on 6/7/2025 and 28 tablets were missing and was discontinued on 6/19/2025 (144 days prior to identified missing). Resident #4's proof of use sheet #186063 identified 30 tablets of Loazepam 0.5 mg was delivered on 10/22/2025 and 15 tablets were missing and was discontinued on 10/20/2025 (30 days prior to identified missing). RN #1 stated the medications had been moved to the back of the narcotic lock boxes in the two (2) unit medication carts for future removed for disposal/destruction. RN #1 stated that medications that required destruction should have been removed immediately from the narcotic lock boxes on the carts and placed in a secured lock box located in the nursing office, and it was the responsibility of the DON and/or ADNS to remove the drugs timely. RN #1 stated she did not know why the narcotics were not removed from the unit lock boxes when the medications were discontinued. Interview and documentation review with the Administrator on 3/24/2026 at 1:30 PM identified a Consumer Protection drug control division memo dated 12/4/2025 indicated there was a procedural lapse as discontinued medications were not segregated immediately upon discontinuation, and the facility was unable to locate the white proof of use sheets required for tracking movement and custody of the medications. The investigation confirmed that the narcotic loss occurred while the medications were under the security of the narcotic lock box enabled by procedural nonadherence concerning handling of discontinued stock and subsequent inability to reconcile inventory due to missing logs. Interview and review of the bimonthly audit results with LPN #3 on 3/24/2026 at 1:00 PM identified when she completed narcotic audits, and if she identified any discrepancy in the actual physical medication count compared to the proof of use sheet, she notified the ADNS and made a note on the yellow copy of the proof of use sheet identifying the reason for the discrepancy. LPN #3 stated her audits did not include review of the Medication Administration Record (MAR). Review of the 6/30 and 10/8/2025 audits completed by LPN identified a discrepancy for Resident #3's Oxycodone 5 mg; one extra tablet was listed on the white proof of use sheet than on the yellow master proof of use sheet, and she adjusted the audit count to match the white sheet. Review of the signatures for completion of the end-of-shift narcotic counts for August and September 2025 identified that the required two (2) nurse signatures were missing signatures on the following dates: 8/1, 8/30, 9/1, 9/3, 9/7 and 9/14/2025 for the on-coming and off-going nurses for the 7:00 AM to 3:00 PM shifts. Additional review identified signatures were missing for 8/18 and 8/22/2025 for the on-coming and off-going nurses for the 11:00PM to 7:00 AM shift. The facility failed to implement adequate narcotic control procedures to ensure adequate process controls were in place, to ensure discontinued medications were removed timely from the unit lock boxes, and to prevent the misappropriation narcotics. The DON was not available for interview during the survey. The facility Controlled Substance Handing Policy directed in part, when administering a controlled substance (Oxycodone and Lorazepam was considered a controlled substance), the nurse must document immediately in the controlled drug accountability. A physical inventory is completed at the change of shift by two (2) licensed nurses and was documented. Discontinued controlled drugs were returned to the nursing office after the count was verified. The drugs are stored in a double locked cabinet in the nursing office until permission to destroy has been obtained. Facility documentation review identified staff (continued on next page)

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	education was initiated on 11/13/2025 for licensed nurses regarding controlled substances handling including securing and reporting of discrepancies, loss of controlled substance, resident abuse and neglect policy and resident rights policy. A QAPI was developed and reviewed on 11/9/2025 and a house wide audit was completed. Based on review of facility documentation, past non-compliance was identified.