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	05/26/2026

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **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 quality of care, the facility failed to ensure an adequate supply of oxygen was sent with a resident for a Leave of Absence (LOA) from the facility for a medical appointment, and failed to ensure a staff member accompanied a resident with a known cognitive impairment when on LOA to a medical appointment to ensure the oxygen remained at the prescribed liter flow. The findings include: Resident #1 had a diagnosis of acute respiratory failure, pulmonary embolism, plural effusion, heart failure, autism, intellectual disability, and displaced [NAME] fracture of the right tibia (break at the bottom of the shinbone/tibia) and a displaced fracture of the lateral malleolus right fibula (break in the prominent bony bump on the outside of ankle/leg bone). The admission Minimum Data Set, dated [DATE] identified Resident #1 had a Brief Interview Mental Status (BIMS) score of four (4) indicating severely impaired cognition, had no behaviors, and received no oxygen. Physician order dated 4/6/26 directed orthopedic follow up. Record review identified Resident #1 was transferred to the hospital on 4/16/26 for lethargy, hypotension, hypoxia with oxygen saturations in the 80's (normal 90% and above) on room air, and a temperature 100.6 degrees Fahrenheit. The readmission nursing assessment dated [DATE] identified Resident #1 returned from the hospital on oxygen. The Resident Care Plan (RCP) dated 3/18/26 identified autism, and alteration in respiratory status. Interventions directed to monitor for signs of respiratory distress, and administer oxygen per physician order. Physician order dated 4/24/26 directed oxygen at one (1) liter per minute via nasal canula, may titrate to four (4) liters to maintain PO greater than 90%. Physician order dated 4/27/26 directed oxygen via nasal cannula at one (1) to two (2) liters, may titrate as tolerated, may titrate as tolerated for ARFH (acute respiratory failure hypoxia). Nursing note dated 4/30/26 at 2:21 PM identified Resident #1 was sent from his/her appointment to the hospital due to a low oxygen saturation and the nursing supervisor was notified. Record review failed to identify the time Resident #1 left the facility for the medical appointment. Interview with the orthopedic office Administrator on 5/26/26 at 12:23 PM identified the office was not informed prior to Resident #1's arrival that he/she required use of oxygen. The office Administrator stated that a person that was with Resident #1 in the office, notified the office staff that Resident #1 had trouble breathing. Office staff then checked Resident #1's oxygen tank and identified it was empty, and the staff obtained one (1) of their office oxygen tanks. By the time the office staff obtained the tank, Emergency Medical Services (EMS) was already with Resident #1, and EMS transported the resident to the hospital. Emergency Medical Services (EMS) run sheet dated 4/30/26 identified dispatch was called at 10:26 AM and they arrived at the resident at 10:35 AM. The report indicated Resident #1 had a D oxygen tank cylinder that was empty and Resident #1's oxygen saturation level was at 80 % (normal 90 and above). EMS applied a new oxygen tank at four (4) liters per minute (LPM) which increased the oxygen saturation level to 91%. Bilateral lung wheezing was noted, and oxygen was increased to six (6) LPM and a nebulizer (breathing treatment) was administered. Resident #1 was then placed on 10 LPM of oxygen via a non-rebreather mask and his/her oxygen saturation level increased to 96%, and Resident #1 was transported to the hospital. Hospital record review identified chest CT Scan results dated 4/30/26 identified a near (continued on next page)

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	complete collapse (atelectasis)of the right lung with minimal aerated lung within the right upper and middle lobes. May represent a combination of atelectasis and infection/inflammation, and a large local right pleural effusion (excess fluid in the space between the lungs and the chest wall). Observation of the facility oxygen storage room on 5/26/26 at 11:30AM identified the facility had E-cylinder oxygen tanks (bigger tank) and D-cylinder oxygen tanks (smaller) tank in the oxygen storage tank room. Interview with LPN #1 on 5/26/26 at 10:51 AM identified she was the charge nurse when Resident #1 left about 9:30 AM for an orthopedic appointment and his/her pulse ox (oxygen saturation) was 96% at 7:30 AM. LPN #1 stated she sent Resident #1 with one (1) oxygen tank cylinder and indicated it was the bigger, E-tank). LPN #1 stated she switched Resident #1 from his/her oxygen concentrator to the E-cylinder oxygen tank right before he/she left the facility, and the cylinder was full. LPN #1 stated she placed the gauge on the tank it read a little past full and air was coming out of the tank, but she did not inform the orthopedic office that Resident #1 was on oxygen. LPN #1 further stated that Resident #1 was met at the medical office by a representative from Resident #1's prior living setting (Person #1). Interview with Person #1 on 5/26/26 at 11:57 AM identified he/she did not adjust the oxygen tank liter flow. Further, Person #1 stated Resident #1 was discharged from the hospital to another facility. Interview with APRN #1 on 5/26/26 at identified the atelectasis and pleural effusion would not be caused by the lack of oxygen in the oxygen cylinder. Interview with the facility oxygen vendor Director of Operations (DOO) on 5/26/26 at 11:47 AM identified the company supplies the facility with cylinder oxygen tanks. The oxygen DOO stated if an E-cylinder (larger tank) was set at three (3) liters, it would last approximately three (3) hours. The DOO did not provide information regarding how long the D-cylinder (smaller tank sent with Resident #1) would last. Interview with the Director of Nursing (DNS) on 5/26/26 at 2 PM identified Resident #1 left the facility with an oxygen tank, and she did not know if the oxygen tank level was checked prior to leaving, and she thought Resident #1 left with a large oxygen tank that would last about four (4) hours if full. The DNS stated the orthopedic office called and notified the facility the oxygen tank was empty, and he/she was transferred to the hospital. The DNS identified it was the nurse's responsibility to ensure the resident had enough oxygen prior to going out on appointments. The DNS stated the facility did not usually send a nurse with residents to appointments, and for Resident #1, a representative from Resident #1's prior living setting met Resident #1 at the appointment. Although Resident #1 had severe cognitive impairment, interview failed to identify why the facility did not provide a staff member to accompany Resident #1 in the transport vehicle to ensure the oxygen level remained at the ordered liter flow. Interview with the Director of Rehabilitation on 5/26/26 at 2:18 PM identified she did not think Resident #1 would have been able to change the oxygen liter flow. Review of Oxygen Administration Policy (no date) directed in part, when preparing to place the resident on oxygen to verify oxygen was flowing. No facility policy was provided for surveyor review regarding ensuring sufficient supply of oxygen on LOAs.