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	01/21/2026

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

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility policy, facility documentation, and interviews for 3 of 5 residents (Resident #8, Resident #39, and Resident #48) reviewed for respiratory infections, the facility failed to implement droplet precautions prior to obtaining the results of nasal swabbing, and for 4 residents (Resident #17, Resident #29, and Resident #103, Resident #118) reviewed for transmission based precautions (TBP), the facility failed to ensure staff wore appropriate personal protective equipment (PPE) when entering a room with requiring droplet/contact precautions per posted signage. Additionally, for 2 of 3 residents (Resident #122 and Resident #143) reviewed for pressure ulcers, the facility failed to ensure signage was posted regarding Enhanced Barrier Precautions (Resident #122) and failed to properly store indwelling catheter supplies (Resident #143). The facility also failed to ensure the Infection Control program maintained accurate and consistent documentation/information pertaining to a facility wide respiratory outbreak. The findings include: 1a. Resident #8's diagnoses included end stage renal disease, vascular dementia, diabetes, and influenza.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #8 was cognitively intact, and was independent with eating, transfers, and walking.The Resident Care Plan (RCP) dated 10/22/25 identified Resident #8 had increased susceptibility to infection related to dialysis and the presence of a left upper extremity arteriovenous (AV) fistula (a connection between an artery and a vein surgically created for use in hemodialysis). Interventions included education of Resident #8 and family on the need for good hand hygiene, enhanced barrier precautions as ordered, and to notify the Medical Doctor (MD) on signs/symptoms of infection.A physician order dated 12/23/25 directed to administer Tamiflu 30 milligrams (mg) by mouth at bedtime every other day for 5 administrations related to flu exposure through 1/2/26.A physician order dated 1/5/26 directed to obtain a triple virus swab and COVID-19 swab.A nursing note dated 1/5/26 at 11:35 AM identified a swab was obtained for a respiratory panel and placed in the refrigerator for pickup by the lab.An Advanced Practice Registered Nurse (APRN) (late entry) progress note dated 1/5/26 at 12:24 PM identified Resident #8 was seen for a cough. The note identified Resident #8 complained of an infrequent non-productive cough and Resident #8 had been on Tamiflu prophylactively due to Influenza in the facility. The progress note identified related to influenza like symptoms: add cough medication (Tussin) as needed and await results of the respiratory viral swab due to no additional symptoms and renal impairment.A physician order dated 1/5/26 directed to administer 10 milliliters (ml) of Guaifenesin liquid 100 mg per 5 ml every 4 hours as needed (PRN) for cough for 7 days.Medication Administration Record (MAR) from 1/5/26 through 1/7/26 identified Resident #8 received Guaifenesin 10 ml by mouth for cough on 1/6/26 at 9:30 PM, 1/7/26 at 5:52 AM, and 1/7/26 at 11:49 AM.A nursing note dated 1/6/26 at 10:56 PM identified Resident #8 had no cough or shortness of breathA nursing note dated 1/7/26 at 4:04 PM identified Resident #8 was assessed for flu-like symptoms. The note identified Resident #8 had no complaints of body aches, chills, sore throat, or cough at that time and to continue to monitor the resident.A nursing note written by Registered Nurse (RN) #3 and dated 1/7/26 at 5:30 PM identified the APRN reviewed the results of the respiratory panel and Influenza A was detected. The note identified the responsible party and charge nurse were notified of the positive results.A physician (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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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	setup or clean-up assistance with eating, substantial/maximal assistance with bed mobility, and was dependent with bed/chair transfers.The Resident Care Plan (RCP) dated 12/29/25 identified Resident #118 was at risk for malnutrition related to significant weight changes, chronic diseases, difficulty self-feeding, and mechanically altered diet. Interventions included monitoring signs and symptoms of dehydration, obtain weights per physician order, and encourage the intake of food and fluids.Observation of posted signage located outside the doorframe of Resident #118's room indicated Resident #118 was on Transmission Based Precautions and directed staff to follow droplet/contact precautions which indicated PPE was required consisting of a gown, N95 mask, eye protection and gloves prior to entering the room. Observation on 1/14/26 at 9:12 AM identified Nurse Aide (NA) #2 entered Resident #17/Resident #118's room wearing only a surgical mask (without the benefit of wearing an N95 mask) she walked to Resident #118's side of the room (Resident ##17 and Resident #118 were in their bed) and exited the room with dishes which she carried 4 rooms down the hall and placed them into a black bin for transport to the kitchen. NA #2 was not observed changing her mask prior to or upon exiting Resident #17/Resident #118's room.Interview and review of the TBP sign posted outside Resident #17/Resident #118's room with NA #2 on 1/14/26 at 9:14 AM identified the sign was posted because at least 1 of the residents in that room had COVID-19 (Resident #17). NA #2 identified staff should wear a gown, gloves, and mask when entering that room and she should have been wearing all PPE items identified on the sign prior to entering the room, but she forgot.Subsequent to surveyor inquiry, observation of NA #2 on 1/14/26 at 9:18 AM noted she reentered Resident #17/Resident #118's room wearing a surgical mask (not an N95 mask) and had donned a gown and gloves. The observation identified NA #2 entered the room, conversed with the residents and upon exiting the room she removed the gown and gloves and performed hand hygiene. NA #2 was not observed changing her mask prior to or upon exiting the room.Interview and review of the TBP sign posted outside Resident #17/Resident #118's room with NA #2 on 1/14/26 at 9:20 AM identified that while the sign showed a picture of an N-95 mask with labeling underneath that read N-95 respirator, NA #2 identified still identified she should be wearing the surgical mask (despite the picture on the TBP sign directing an N95 mask) she currently had on when entering the room. NA #2 was unable to identify the difference between the N-95 mask and her surgical mask or why it was incorrect to wear only the surgical mask in that room.Interview with Licensed Practical Nurse (LPN) #3 (the Infection Preventionist) on 1/16/26 at 3:00 PM identified she used droplet/contact signage on resident rooms for residents that required TBP for COVID-19 to signify that the staff needed to wear an N-95 respirator mask in addition to the remaining posted PPE prior to entering that room.Review of the Infection Control Program policy included, in part, appropriate use of PPE (gloves, gowns, masks, and eye protection), implementation of contact, droplet, and airborne precautions as needed, implementation of enhanced barrier precautions where applicable.Review of current Centers for Disease Control (CDC) guidance last updated 1/23/26 directed that healthcare workers who enter the room of resident(s) with signs and symptoms of an unknown respiratory viral infection consistent with COVID-19 should use an N-95 respirator mask, gown, gloves, and eye protection. Further review of CDC guidance Appendix A (last updated 2/7/25): Type and duration of precautions recommended for selected infections and conditions recommends for COVID-19 that healthcare staff wear N-95 or higher protection, eye protection (goggles or face shield), and implement airborne plus droplet plus contact plus standard precautions (airborne preferred but if negative pressure room not available then droplet). 3. Resident #122 had diagnoses that included cellulitis, pressure ulcer of the sacral region, and adult failure to thrive.The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #122 was moderately cognitively impaired, had 1 unhealed Stage 4 pressure ulcer, used a walker and wheelchair, was independent with eating, required supervision or touching assistance with bed mobility, and partial/moderate assistance with transfers.A physician order dated 12/30/25 directed to implement EBP related to wounds every shift (7AM-3PM, 3PM-11PM, and 11PM-7AM)The Resident Care Plan (RCP) dated 1/12/26 identified Resident #122 had an unstageable (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	rack. The observation also identified an unlabeled, uncovered/unbagged graduated cylinder sitting on top of the toilet with crumpled paper towels inside it. Observation on 1/13/26 at 11:00 AM in Resident #143's bathroom identified 2 unlabeled, uncovered/bagged urinary leg-bags were hanging off the towel rack, and an unlabeled, uncovered/bagged graduated cylinder sitting on top of the toilet.Interview with Licensed Practical Nurse (LPN) #3 (the Infection Preventionist) on 1/14/26 at 2:28 PM identified foley bags, leg bags, and graduated cylinders were to be labeled with the resident name, date and stored in a bag when not in use. LPN #3 identified the nurse aides were aware these items were supposed to be labeled and stored in a bag when not in use. LPN #3 identified there had not been recent education on care and storage of foley bags, but that she would initiate education.Interview with Nurse Aide (NA) #8 on 1/16/26 at 1:00 PM identified Resident #143 was on his assignment on 1/12/26 from 7:00 AM to 3:00 PM. NA #8 identified he knew that the foley bag(s) and graduated cylinder were supposed to be rinsed out and placed in a bag for storage prior to hanging them in the bathroom. NA #8 further identified he had not been aware of the 2 unlabeled, uncovered/unbagged urinary leg-bags hanging off the right side of the towel rack, the unlabeled, uncovered/unbagged night time closed urine bag was hanging off the left side of the towel rack, or the unlabeled, uncovered/bagged graduated cylinder sitting on top of the toilet, and indicated those items must have been there prior to his shift.Review of the Urinary Catheter policy directed, in part, to regularly empty the drainage bag while ensuring to avoid contamination of the drainage spigot. The policy directed to change the catheter and drainage bags only when clinically indicated. The policy directed all nursing staff must receive training on proper catheter care and prevention of catheter related urinary tract infections, and the education must be documented and performed regularly. The policy directed that periodic audits of catheter care practices should be conducted. Review of the Urinary Catheter procedures (Appendix A) policy directed, in part, to connect the urinary drainage bag to the catheter, and to empty the bag at least every 8 hours using a clean container and while avoiding contamination of the drainage spigot.Review of both policies and procedures related to urinary catheters failed to identify directives for storage of drainage bags when not in use or storage of the graduated cylinders used for measuring the urine output. 5a. Review of the Master Line List regarding a respiratory outbreak of COVID-10, Influenza and Respiratory Syncytial Virus (RSV) onset date of 11/28/25 identified the name of the facility and included tables with the following columns: room/unit, resident (name), symptoms, date of onset, treatment, test performed, date tested, test results, and end date. The tables were organized according to the respiratory organism(s): Influenza and COVID-19. The document included the Medical Director (Medical Doctor (MD) #1) was notified on 11/28/25 and the Infection Preventionist was LPN #3. Additionally, the rows within each table listed the residents in a general order by date, it was not consistent, so entries did not facilitate a timeline of events. The line list identified 26 resident names within the Influenza table although none of the entries included a date of 11/28/25. Additionally, the line list identified 7 resident names within the COVID-19 table although none of the entries included a date of 11/28/25. The document failed to identify a table for RSV and the staff line list was not included.Interview, observation, and facility documentation review with LPN #3 (the Infection Preventionist) and RN #2 on 1/14/26 at 2:15 PM identified LPN #3 had contacted MD #1 to notify him of the outbreak on 11/28/25 as it was shown on the Master Line List with onset date of 11/28/25 document. LPN #3 was unable to identify the reason the date on the line list document was 11/28/25 when none of the residents had an onset date for symptoms or of a positive test dated 11/28/25. LPN #3 identified she thought it might have been a resident who had been sent to the hospital and the facility found out afterwards that the resident tested positive for Influenza. LPN #3 identified the staff line list was kept separate from the resident line list. Review of the resident line list on LPN #3's computer identified additional columns which weren't reflected on the printed line list which included resident age, sex, and if hospitalized . LPN #3 identified the line list on her computer couldn't be printed out due to the number of columns without making it so small it couldn't be easily read. A request was made on 1/14/26 at 2:20 PM for LPN #3 to (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility policy, facility documentation, and interviews for 2 of 3 residents (Resident #78 and Resident #84) reviewed for dental, the facility failed to develop a dental care plan. The findings include: 1.Resident #78's diagnoses included chronic obstructive pulmonary disease (COPD), diabetes, and dementia. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #78 was cognitively intact, required a therapeutic diet, had no natural teeth or tooth fragments, and was independent with eating, oral hygiene, transfers, and ambulation. The Resident Care Plan (RCP) dated 12/21/22 identified Resident #78 required a therapeutic diet related to morbid obesity and poorly controlled diabetes. Interventions included to provide a consistent carbohydrate diet and monitor oral intake. The RCP failed to identify Resident #78's dental status and that Resident #78 had no natural teeth or tooth fragments, and no dentures. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #78 was cognitively intact, required a therapeutic diet, and was independent with eating, oral hygiene, transfers, and ambulation. The RCP dated 12/3/25 identified Resident #78 was at risk for malnutrition related to obesity, COPD, diabetes, dementia, bipolar disorder, depression, gastroesophageal reflux disease (GERD), hypothyroidism, disorder of bone density, peptic ulcer, psychosis, and a therapeutic diet. Interventions included providing a consistent carbohydrate diet, encourage diet compliance, and encourage the intake of food and fluids. The RCP failed to identify Resident #78's dental status and that Resident #78 had no natural teeth or tooth fragments, and no dentures. Interview with Resident #78 on 1/13/26 at 11:02 AM identified he/she had difficulty chewing meats because they are too hard to chew. Resident #78 identified he/she had no teeth and was waiting for dentures to be made. Resident #78 further identified he/she had not told staff about the difficulty with chewing meats. Interview with Person #1 on 1/16/26 at 9:19 AM identified Resident #78 had been without teeth and dentures for a long time. Person #1 identified Resident #78 had lost his/her dentures prior to admission to the facility and insurance wouldn't cover replacement of the dentures at first, but that Resident #78 was now in the process of getting new dentures made. Interview with Licensed Practical Nurse (LPN) #9, who was the Care Plan Coordinator on 1/16/26 at 12:07 PM identified Resident #78 should have a care plan related to oral health and condition of teeth/dentures. LPN #9 identified the RCP should reflect when a resident doesn't have teeth and/or dentures and that it would often be reflected in the RCP related to diet. LPN #9 identified she had just recently become responsible for Resident #78's care plan and that the previous nurse had not completed the care plan as expected. LPN #9 further indicated that she would be implementing a dental focus in Resident #78's RCP. Subsequent to surveyor inquiry the RCP dated 1/16/26 identified Resident #78 was edentulous (no natural teeth) on both upper and lower and was in the process of getting dentures. Interventions (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	included obtaining a dental consult as needed and monitor for complaints of difficulty chewing or swallowing. Subsequent to surveyor inquiry facility education titled Oral Health identified education on the policy for oral health was initiated by the DNS on 1/16/26. There are 42 staff member signatures identified. Review of this education and the Oral Health policy failed to identify directives within the policy to ensure the RCP was updated accordingly. Interview with the Director of Nursing Services (DNS) on 1/20/26 at 1:15 PM identified that Resident #78 should have a care plan that reflected his/her dental status. The DNS identified that there was an MDS nurse who was no longer employed at the facility that was not updating care plans appropriately and the current MDS nurse (LPN #9) was in the process of fixing those care plans. Interview and review of facility documentation for Quality Assurance and Performance Improvement (QAPI) with the Administrator on 1/21/26 at 3:31 PM failed to identify implementation of a QAPI plan prior to survey related to resident care plans and the need to review and update all care plans overseen by the former MDS nurse. 2. Resident #84 was admitted to the facility in March 2021 with diagnoses that included dementia, anxiety, and depressive disorder. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #84 had intact cognition, was independent with activities of daily living and had obvious or likely cavities or broken natural teeth. Advanced Practice Registered Nurse (APRN) # 1's progress note dated 4/11/25 identified that Resident #84 agreed to see an oral surgeon for teeth extractions and dentures but did not want to see the same oral surgeon that he/she saw on 10/16/24. Physician's orders dated 4/18/25 directed dental consults as needed, a no added salt diet with regular liquids and meats hand cut into small pieces A nursing note dated 4/19/25 at 2:47 PM identified Resident #84 was complaining of pain to his/her first molar on the left mandibular jaw and the resident was added to the dental list to be seen in the facility. The Resident Care Pan (RCP) dated 4/24/25 indicated that Resident #84 was on a mechanically altered diet, Resident #84 needed to eat well and maintain good nutrition. Interventions included to monitor and report weight changes, encourage foods and liquids, offer snacks 3 times a day, and give no added salt diet with thin liquids and meats hand cut into small pieces. APRN #1's progress note dated 5/9/25 identified Resident #84 was seen by APRN #1 due to his/her multiple refusals to see a dentist/oral surgeon for needed extractions and dentures. Resident #84 expressed that he/she felt fine and did not need to go to the dentist. A dental consultant at the facility on 8/20/25 identified that Resident #84 was missing 12 teeth in total and had 13 fractured teeth with severe demineralization and gingivitis. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An Oral Health Assessment conducted at the facility by licensed nursing staff on 12/2/25 identified Resident #84 had 4 or more decaying or broken teeth, pink gums, no pain, no swallowing difficulties and had food particles/tartar/plaque in areas of the mouth. A review of Resident #84's care plan and interview with LPN #9 (Resident Care Plan Coordinator) on 1/15/26 at 10:30 AM identified the RCP lacked a dental care plan and the care plan did not address Resident #84's missing and fractured teeth, the need for extractions and dentures, and Resident #84's refusal to follow up with the dentist/oral surgeon. LPN #9 indicated that nursing was responsible for initiating a dental care plan that was individualized related to Resident #84's dental needs. LPN #9 could not explain the reason Resident #84's dental care plan was not in place and that Resident #84 should have had a dental care plan. LPN #9 indicated that she had initiated an audit for all residents' care plans related to dental needs to ensure a dental care plan was in place and was in the process of updating everyone's care plan. A review of the Care Plan Policy directed, in part, the facility is committed to providing residents/patients with all necessary care and services. Recognizing each resident/patient as an individual, we clarify and meet these needs in a resident centered environment. Assessments and care plans are oriented toward preventing avoidable decline in functional levels and reflect resident/patient right to refuse certain services and treatments. The care plan is evaluated and revised quarterly and as needed.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on tour of the Dietary Department, staff interview and facility policy, the facility failed to ensure Dietary Aide (DA) #1's attire was clean and failed to ensure expiration dates were identified on various food items. The findings include: On 1/12/26 at 10:14 AM, tour of the Dietary Department with the Food Service Director (FSD) identified the following:a. Dietary Aide (DA) #1 was working in the dish room removing clean items from the dishwasher. She was wearing a black shirt with a heavy accumulation of fuzz/lint and animal hair on both sides of the shirt. Her shirt was not covered with any type of overshirt/apron which would contain the fuzz/lint/animal hair. Interview with DA #1 at that time identified that although she had a cat, she was unaware that her shirt had a heavy accumulation of fuzz/lint/animal hair.b. Observation of a cycle through the dish washing machine identified DA #1 removing 4 clean, mauve colored, plastic water pitchers from the dishwasher. The water pitchers were dripping wet with water and DA #1 stacked the water pitchers on the beverage station. Interview with DA #1 at that time identified that the water pitchers were clean and ready to be distributed to the units, however she did not have a dying rack to separate the water pitchers to air dry. Additionally, 17 clear dish covers/lids were observed to be located on the stainless-steel counter of the new tray line and stacked on top of one another, dripping wet with water. Interview with the FSD at that time identified the lids should be left to air dry, but there weren't enough drying racks to accommodate the items coming out of the dishwasher. c. Observation of the walk-in refrigerator identified a 128-ounce (oz) plastic container of Teriyaki sauce that was approximately 1/2 full, although the date opened (12/23/25) was noted, the expiration date located on the container was in a code, and the FSD was unable to decipher the actual expiration date. d. Observation of the walk-in freezer identified 20 pieces of French toast in a plastic bag, dated 1/6/26 (the date the French toast came in) but lacked an expiration date. Interview with the FSD at that time identified that the expiration date must have been located on the original box the French toast came in and when the item was removed from the box, the expiration date wasn't identified. The original box of French toast was not in the freezer for the expiration date to be referenced to. The FSD noted staff should have written the expiration date from the original box the items were taken from. Facility policy for the Dietary Department (undated) identified all Dietary employees will wear clean uniforms, rubber soled shoes, and restraints (long hair a hairnet is to be worn; for short hair, a cap). Facility policy for Dietary equipment (undated) identified all dishes, utensils and equipment will be air-dried after washing.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of the clinical record, facility documentation, and interviews for 1 of 3 residents (Resident #119) reviewed for edema, the facility failed to follow a physician's order for the application of compression stocking for a resident with edema. The findings include:Resident #119's diagnoses included Type 2 Diabetes Mellitus, chronic kidney disease and hypertension. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #119 was moderately cognitively impaired and required substantial/maximal assistance for bed mobility, toileting, and transfers. The Resident Care Plan (RCP) dated 1/7/26 identified a risk for skin breakdown. Interventions included compression stockings on in AM off at HS (hour of sleep) and may use Ace wraps to bilateral lower extremities if resident refuses compression stockings. A physician's order dated 1/12/26 directed to apply TED (compression stockings) stocking daily (on in AM and off at HS) to bilateral lower extremities and may use Ace wraps to bilateral lower extremities if resident refuses compression stockings. Observations on 1/13/26 at 10:30 AM and 1/14/26 at 11:44 AM identified Resident #119 was seated in a wheelchair without the benefit of compression stockings applied to his/her bilateral lower extremities. Observation, interview, and review of facility documents with Nurse Aide (NA) #5 on 1/13/26 at 12:11 PM identified Resident #119 was seated in a bedside chair without the benefit of compression stockings to his/her bilateral lower extremities. NA #5 indicated she could not locate the resident's compressions stockings and they must have been in the laundry department. NA #5 further identified she had not reviewed Resident #119's NA care card before providing the resident care and had not informed the charge nurse she was unable to locate the resident's compression stockings. Review of the NA care card with NA #5 indicated Resident #119 was to have compression stockings applied in the AM to his/her bilateral lower extremities. NA #5 identified she wound need to check with the charge nurse. Observation and interview with Licensed Practical Nurse (LPN) #5 and Resident #119 on 1/13/26 at 12:13 PM identified Resident #119 was seated in a bedside chair without the benefit of compression stockings to his/her bilateral lower extremities. LPN #5 indicated Resident #119 should have had the compression stockings on and proceeded to locate the compression stockings in the top drawer of the resident's dresser. LPN #5 identified it was the responsibility of the NA to apply the compressions stockings and if NA #5 was unable to locate the compression stockings she should have let her know. LPN #5 proceeded to apply the compression stockings to Resident #119's bilateral lower extremities. Resident #119 indicated he/she was not refusing to wear the compression stockings, had not had the stockings applied in a few days and was unsure of the reason. An Advanced Practice Registered Nurse (APRN) progress note dated 1/13/25 at 3:59 PM identified Resident #119 had weight gain and +2 (moderate pitting) edema to his/her bilateral lower extremities. An additional observation, interview, and review of facility documents with NA #6 on 1/15/26 at 12:06 PM identified Resident #119 was seated in a wheelchair without the benefit of compressions stockings applied to his/her bilateral lower extremities. NA #6 indicated she was unaware Resident #119 was supposed to have compression stockings applied and stated she had failed to review the NA care card prior to providing Resident #119 care. Review of the NA care card with NA #6 identified Resident #119 was to have compression stockings applied to his/her bilateral lower extremities in the AM. Another observation and interview with LPN #6 on 1/15/26 at 12:11 PM identified Resident #119 was seated in a wheelchair without the benefit of compression stockings applied to his/her bilateral lower extremities. LPN #6 indicated she had forgotten to tell NA #6 to apply the compression stockings, NA #6 should have reviewed the NA care card and applied the stockings for the resident. LPN #6 proceeded to locate the compression stockings in the top drawer of the resident's dresser, transferred Resident #119 to the bedside recliner and applied the compression stockings. LPN #6 indicated she should have checked earlier to ensure Resident #119 had the compression stockings applied with AM care. Resident #119 was agreeable with having the (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	compression stockings applied by LPN #6 and the resident indicated he/she also wanted to elevate his/her legs. Interview and review of the clinical record with the DNS on 1/16/26 at 12:39 PM identified she would have expected Resident #119's compression stockings to be applied to his/her bilateral lower extremities per the physician's order. The DNS indicated it would have been the responsibility of the NA or charge nurse to apply the compression stockings and identified the NA's should be checking the NA care cards prior to providing care. Additionally, the DNS noted the charge nurses should have checked the resident and directed the NA to apply the compression stockings. The DNS indicated she would need to provide further education to the NA's and charge nurses. Review of the facility policy, Anti-Embolic Stockings, dated 7/2025, directed stockings were provided to support and aid return circulation for lower extremities and to reduce edema. The policy further directed to apply and remove stockings per the physician's order.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, facility policy and interviews for 1 of 7 residents (Resident #31) reviewed for nutrition, the facility failed to provide supervision during a meal per the physician's order for a resident with dysphagia (swallowing difficulty). The findings include: Resident #31?s diagnoses include type 2 Diabetes, dysphagia (difficulty swallowing), transient ischemic attack (mini-stroke) and having a PEG tube (abdominal feeding tube). A Nutritional assessment dated [DATE] at 2:11 PM and written by the Dietician identified Resident #31 required mechanically altered food and nectar thick liquids. A physician's order dated 12/16/25 directed a mechanically altered texture, nectar thick consistency diet for risk of choking and directed staff to provide constant and individual (1 to 1) supervision with Resident #31's meals. The Resident Care Plan (RCP) dated 12/17/25 identified Resident #31 was at risk for aspiration related to dysphagia with interventions that included providing a regular, soft diet, with thickened liquids as well as encouraging Resident #31 to take small sips, bites, and allow for adequate swallow time and cue as needed. The RCP dated 12/17/25 also identified Resident #31 was at risk for malnutrition and directed staff to observe/ document/ report any signs or symptoms of dysphagia including pocketing, choking, coughing, drooling, holding food in mouth, several attempts to swallow, refusing to eat, and appearing concerned during meals. A dietary note dated 12/17/25 at 2:10 PM and written by the Dietitian identified Resident #31's diet recommendations included a mechanically altered and nectar thick liquids as part of aspiration precautions.The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #31 had intact cognition and was independent with most activities of daily living. Additionally, the MDS identified Resident #31 required set up/ clean up for eating and had symptoms of a possible swallowing disorder that included loss of liquid/solids from mouth when eating or drinking and coughing or choking during meals or when swallowing medication. On 12/30/25, a swallow evaluation completed by the Speech Therapist indicated that Resident #31 retained food in the mouth and cheeks after meals, exhibited coughing or choking during meals or when swallowing medications, and had food or liquid residue on or around the tongue, cheeks, and gums indicating the resident required a mechanically altered diet and nectar-thickened liquids. A dietary note dated 1/13/26 at 11:04 AM and written by the Dietician identified Resident #31 was able to feed him/herself however still required 1 to 1 supervision due a risk of choking. An observation 1/13/26 at 12:42 PM noted Resident #31 eating grilled cheese for lunch alone in his/her room without supervision. Observation on 1/14/26 at 12:06 PM noted Resident #31 to be eating alone in his/her room without supervision. Interview with Nurse Aide (NA) #4 on 1/14/26 at 12:22 PM indicated that she did not provide supervision to Resident #31 during the meal and was unaware that Resident #31 required supervision because it was not reflected on the care card. Interview with Speech Therapist # 1 (Speech Regional Director) on 1/16/26 at 9:45 AM identified that the active physician order of 1 to 1 meal supervision should have been followed during mealtime. An interview with the DNS on 1/16/26 at 12:57 PM also identified that the physician order for Resident #31 to be supervised during meals should have been followed although she was unaware there was an active order for 1 to 1 supervision. Review of the facility's Meal Service/Tray Service policy, dated July 2025, directed staff to verify any special meal-related instructions for each resident prior to meal delivery and to monitor residents during the meals, providing assistance as needed.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, review of facility documentation, review of facility policy and interviews for 4 of 4 residents (Resident #3, Resident #106, Resident #114 and Resident #119) reviewed for oxygen use, the facility failed to label and date oxygen tubing and failed to appropriately store nebulizer tubing for a resident with chronic obstructive pulmonary disease (COPD) (Resident #114) and pneumonia (Resident #119). The findings include:1. Resident #3's diagnosis included COPD, asthma, and obstructive sleep apnea. A physician's order dated 11/8/25 and currently in effect, directed oxygen via nasal cannula at 2 liters/minute and to change oxygen tubing every week on the Sunday 11:00 PM to 7:00 AM shift. The Resident Care Plan (RCP) dated 12/4/25 identified Resident #3 had an altered respiratory status and difficulty breathing with a diagnosis of COPD. Interventions included oxygen at 3 liters/minute via nasal cannula continuously and to administer oxygen and nebulizer treatments as ordered. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #3 was cognitively intact and required partial/moderate assistance with bed mobility and transfers and was dependent with toileting. The MDS indicated Resident #3 received continuous oxygen therapy. Observations on 1/13/26 at 11:36 AM and 1/14/26 at 12:01 PM identified Resident #3 was seated in a bedside chair and was receiving continuous oxygen via nasal cannula. The oxygen tubing was unlabeled and undated. Observation and interview with Licensed Practical Nurse (LPN) #6 on 1/15/26 at 12:00 PM identified Resident #3 was receiving oxygen via a nasal cannula and the oxygen tubing was undated. LPN #6 indicated Resident #3 was on continuous oxygen due to a diagnosis of COPD. LPN #6 identified it was the responsibility of the Sunday 11:00 PM to 7:00 AM nurse to change, label and date respiratory equipment weekly and she was unable to indicate why the appropriate tube change/labeling/dating was not done. 2. Resident #106's diagnosis included COPD, moderate persistent asthma, and dependence on supplemental oxygen. The quarterly Minimum Data Set (MDS) dated [DATE] identified Resident #106 was cognitively intact and was dependent with bed mobility, toileting, and transfers. The MDS indicated Resident #106 received continuous oxygen therapy. The Resident Care Plan (RCP) dated 10/15/25 identified Resident #106 had respiratory disease related to a diagnosis of COPD. Interventions included to administer oxygen via nasal cannula as ordered. A physician's order dated 11/8/25 and currently in effect, directed to administer oxygen via nasal cannula at 1 liter per minute continuous every shift and to change oxygen tubing every Sunday on the 11:00 PM to 7:00 AM shift. Observations on 1/13/26 at 11:35 AM and 1/14/26 at 12:00 PM identified Resident #106 was seated in a wheelchair and was receiving continuous oxygen via nasal cannula. The oxygen tubing was unlabeled and undated. Observation and interview with LPN #6 on 1/15/26 at 12:02 PM identified Resident #106's oxygen tubing was unlabeled and undated. LPN #6 indicated Resident #106 was on continuous oxygen due to a diagnosis of COPD. LPN #1 identified it was the responsibility of the Sunday 11:00 PM to 7:00 AM nurse to change, label and date respiratory equipment weekly and she was unable to indicate why appropriate tube change/labeling/dating was not done. 3. Resident #114's diagnoses included COPD, acquired absence of part of the lung and a personal history of tuberculosis. A physician's order dated 11/8/25 and currently in effect, directed oxygen via nasal cannula at 2 liters/minute and Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) mg/3ml inhale orally every 4 hours as needed for shortness of breath. The physician's orders further directed to change oxygen and nebulizer tubing every week on the Sunday 11:00 PM to 7:00 AM shift. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #114 was cognitively intact and required substantial/maximal assistance with bed mobility and was dependent with toileting and transfers. The MDS failed to indicate Resident #114 received oxygen therapy. The Resident Care Plan (RCP) dated 12/11/25 identified Resident #114 had a diagnosis of COPD and acute respiratory failure with a history of a partial lobectomy (removal of the left lower lobe of the lung). Interventions included oxygen via nasal cannula at 2 liters/minute and to (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administer oxygen and nebulizer treatments as ordered. Observations on 1/13/26 at 11:37 AM and 1/14/26 at 12:02 PM identified Resident #114 was seated in a wheelchair and was receiving continuous oxygen via nasal cannula. The oxygen tubing was not labeled and undated. There was a nebulizer mask that was stored uncovered, placed on top of the bedside table with undated tubing attached. Observation and interview with Licensed Practical Nurse (LPN) #6 on 1/15/26 at 12:03 PM identified Resident #114's oxygen and nebulizer tubing were not labeled and undated and the nebulizer mask was stored uncovered and placed on top of the bedside table. LPN #1 indicated Resident #114 was on continuous oxygen due to a diagnosis of COPD and was utilizing the nebulizer on a regular basis. LPN #1 identified it was the responsibility of the 11:00 PM to 7:00 AM nurse to change and date respiratory equipment weekly and she was unable to indicate why the nebulizer mask was uncovered. 4. Resident #119's diagnoses included pneumonia, dyspnea, and pulmonary hypertension. A physician's order dated 12/6/26 and currently in effect, directed oxygen via nasal cannula at 2 liters/minute and Ipratropium-Albuterol Inhalation Solution 0.5/2.5 (3) mg/3ml inhale orally every 6 hours as needed for wheezing and shortness of breath. The physician's orders further directed to change oxygen and nebulizer tubing every week on the Sunday 11:00 PM to 7:00 AM shift. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #119 was moderately cognitively impaired and required substantial/maximal assistance with bed mobility, toileting, and transfers. The MDS indicated Resident #119 required oxygen therapy. The Resident Care Plan (RCP) dated 1/7/26 identified Resident #119 had a risk of altered respiratory status related to dyspnea (shortness of breath) and cough. Interventions included to provide oxygen and medications/inhalers as ordered. Observations on 1/13/26 at 10:29 AM and 1/14/26 at 11:44 AM identified Resident #119 was seated in a wheelchair and was receiving continuous oxygen via nasal cannula. The oxygen tubing was unlabeled and undated. There was a nebulizer mask that was stored uncovered, placed on top of the bedside table with undated tubing attached. Observation and interview with Licensed Practical Nurse (LPN) #6 on 1/15/26 at 12:04 PM identified Resident #119's oxygen and nebulizer tubing was undated, and the nebulizer mask was stored uncovered and placed on top of the bedside table. LPN #6 indicated Resident #119 was on continuous oxygen due to a recent diagnosis of pneumonia and the resident was utilizing the nebulizer on a regular basis. LPN #6 identified it was the responsibility of the 11:00 PM to 7:00 AM nurse to change and date oxygen/nebulizer tubing and was unable to indicate the reason the nebulizer mask was not covered. Subsequent to surveyor inquiry an observation on 1/16/25 at 11:04 AM identified Resident #3, Resident #106, Resident #114 and Resident #119's oxygen tubing was labeled/dated 1/15/26 and Resident #114 and Resident #119's nebulizer tubing was labeled/dated 1/15/26, and the nebulizer masks were bagged and being stored on top of the bedside table. Interview with the DNS on 1/16/26 at 12:39 PM identified oxygen and nebulizer tubing should be changed weekly and as needed, should be dated, and stored appropriately. The DNS indicated it was the responsibility of the nurse on the Sunday 11:00 PM to 7:00 AM shift and the nurse should have made sure the oxygen and nebulizer tubing was changed and dated and nebulizer masks were bagged. Review of the facility policy, Oxygen Administration, undated, directed to replace and date masks, cannula and tubing weekly or sooner if visibly soiled or damaged. When not in use, masks and nasal cannulas must be stored in a plastic bag and kept off the floor. Review of the facility policy, Medication Administration Nebulizers, dated 7/2025, directed to change the nebulizer cup and tubing according to facility policy.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of the clinical record, facility policy and interviews for 1 of 7 residents (Resident #106) reviewed for nutrition, the facility failed to provide the appropriate consistency meal per the physician's order for a resident with dysphagia (difficulty swallowing). The findings include: Resident #106's diagnoses included dementia, swallow dysfunction, muscle weakness, and unspecified lack of coordination. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #106 was cognitively intact and was dependent with bed mobility, toileting, and transfers. The MDS indicated Resident #106 required setup or clean-up assistance with eating and was receiving a therapeutic diet. The Resident Care Plan (RCP) dated 10/15/25 identified Resident #106 had oropharyngeal dysphagia (difficulty swallowing) and was an aspiration risk with a risk for malnutrition. Interventions included to provide aspiration precautions and safe swallowing strategies. A physician's order dated 11/8/25 and currently in effect, directed a low-fat diet, puree texture with thin liquid consistency. Observation on 1/13/26 at 12:10 PM identified Resident #106 was alone, in bed and eating a peanut butter and jelly sandwich on white bread with crusts. The sandwich was served on white plate with plastic wrap still on and covering the plate with a small opening noted in the plastic wrap on one edge of the plate. The resident had 1/2 of the sandwich in his/her right hand and was taking small bites from one end of the sandwich. The resident's eyes were closed, and he/she was coughing at times. Subsequent to this observation, a record review indicated Resident #106 had dysphagia and a physician's order for a puree diet. Observation, interview, and review of Resident #106's meal ticket with Occupational Therapist (OT) #1 on 1/14/26 at 8:45 AM identified Resident #106 was served hash brown potatoes which were cubed for breakfast. Review of the resident's meal ticket with OT #1 indicated Resident #106 was on a pureed diet, OT #1 identified the resident should not have been served hash brown potatoes which were cubed for breakfast and proceeded to remove them from Resident #106's tray table. Interview and review of the clinical record with Speech Therapist (ST) #1 on 1/16/26 at 9:30 AM identified Resident #106 had dysphagia and was downgraded to a puree diet on 1/7/26. ST #1 indicated he would not have expected Resident #106 to be alone in his/her room eating a peanut butter and jelly sandwich and should not have been served hash brown potatoes which were cubed if he/she was on a puree diet. ST #1 identified a peanut butter and jelly sandwich and hash brown potatoes which were cubed were out of the scope of a puree diet and put the resident at risk for choking and aspiration (food going into the lungs). ST #1 indicated he would have expected Resident #106 to be served the correct diet and to be supervised if he/she was going to eat food other than what was supposed to be on a puree diet. Interview and review of facility documents with the DNS on 1/16/26 at 12:36 PM identified Resident #106's meals should have been plated by the dietary staff and served by the nursing staff according to the resident's meal ticket (which noted a puree diet). The DNS indicated Resident #106 should not have been served a peanut butter and jelly sandwich and hash brown potatoes which were cubed as those were not considered part of a puree diet. The DNS identified Resident #106 had dysphagia and would be at risk of choking and aspiration if not served a pureed diet. The DNS stated she would need to speak to the dietary director and provide further education to the nursing staff regarding Resident #106's pureed diet. Interview and review of facility documents with the Dietary Director on 1/16/26 at 2:21 PM identified dietary staff should have read Resident #106's meal ticket and accurately plated/served the resident's meal as puree per the physician's order. The Dietary Director indicated a peanut butter and jelly sandwich and hash brown potatoes which were cubed were not part of a puree diet and should not have been served to Resident #106. The Dietary Director identified it was the Dietary Aide's (DA) responsibility to serve the resident's meal according to the meal ticket and there were pureed options for starch servings (pureed danish, cream of rice or mashed potato) available on (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the steam table that the DA should have served instead. The Dietary Director indicated he would need to provide further education to the Dietary staff regarding Resident #106's puree diet. Review of facility policy, Food and Dining Service, dated 07/2025, directed the objective of food service is to supply the resident with a diet that is comparable to the individual's needs and therapeutic diets are to be to be prepared and served as prescribed by the attending physician. Review of the facility policy, Meal Service Tray Service, dated 07/2025, directed the policy of the facility was to provide the correct meal for the right resident and the diet card should be checked for the resident's diet order and any special instructions. Before serving the meal, staff should verify the residents name and ensure that the right diet is being served to the right resident and if differences are found between what the diet card says and what is served, the charge nurse should be notified, or the kitchen should be called.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of the clinical record, facility documentation, facility policy and interviews for 1 of 7 residents (Resident #106) reviewed for nutrition, the facility failed to provide adaptive equipment at mealtime per the physician's order. The findings include:Resident #106's diagnoses included dementia, swallow dysfunction, muscle weakness, and unspecified lack of coordination. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #106 was cognitively intact and was dependent with bed mobility, toileting, and transfers. The MDS indicated Resident #106 required setup or clean-up assistance with eating and was receiving a therapeutic diet. The Resident Care Plan (RCP) dated 10/15/25 identified Resident #106 had oropharyngeal dysphagia (difficulty swallowing) and was an aspiration risk with a risk for malnutrition. Interventions included aspiration precautions and safe swallowing strategies and to provide an inner lip plate at meals. A physician's order dated 11/8/25 and currently in effect, directed adaptive equipment of an inner lip plate at meals. Observation on 1/13/26 at 12:10 PM noted Resident #106 in bed and eating his/her lunch meal without the benefit of an inner lip plate on his/her tray table. Observation, interview, and review of Resident #106's meal ticket with Nurse Aide (NA) #7 on 1/15/26 at 12:19 PM identified she served and set up Resident #106 for lunch without the benefit of an inner lip plate on the meal tray. NA #7 indicated she made a mistake and served Resident #106 lunch without ensuring the kitchen had plated the resident's lunch on an inner lip plate. NA #7 did not notify the kitchen and Resident #106 continued to eat from a regular plate. Review of the resident's meal ticket with NA #7 identified Resident #106 required adaptive equipment of a Kennedy cup and inner lip plate at meals. Observation, interview, and review of the meal ticket with LPN #6 on 1/15/26 at 12:26 PM identified Resident #106 was in bed eating lunch without the benefit of an inner lip plate. LPN #6 indicated the resident's adaptive equipment should have come up from the kitchen and been served on an inner lip plate from the steam table in the dining room. LPN #6 stated NA #7 should have ensured Resident #106's meal was on an inner lip plate before she provided the tray and set up the resident's lunch. LPN #6 indicated she was going to call the kitchen and get it corrected. Interview and review of the clinical record with Occupational Therapist (OT) #1 on 1/16/26 at 10:51 AM identified Resident #106 had weakness and hand tremors which can affect the resident's nutrition and dignity. OT #1 indicated an inner lip plate provided Resident #106 with better nutrition because Resident #106 was able to get more food on the spoon and into his/her mouth. OT #1 further stated due to Resident #106's tremoring, decreased strength and fine motor function he/she required the inner lip plate (which provided an edge) to prevent spillage. OT #1 identified it was the responsibility of the kitchen to provide adaptive equipment and the dietary staff should have served the resident's meal on an inner lip plate. Additionally, the nursing staff was responsible to ensure the meal was plated on an inner lip plate before serving the meal to the resident. Interview and review of facility documents with the DNS on 1/16/26 at 12:36 PM identified Resident #106's meals should be plated on an inner lip plate by the dietary staff and served by the nursing staff according to the resident's meal ticket. The DNS indicated adaptive equipment should be sent up from the kitchen on the dietary cart and provided to the resident per the physician's order. The DNS stated she would need to speak to the Dietary Director and provide further education to the nursing staff regarding Resident #106's adaptive equipment. Interview and review of the clinical record with the Dietary Director on 1/16/26 at 2:21 PM identified dietary staff should have read Resident #106's meal ticket and accurately served the resident's meal on an inner lip plate. The Dietary Director indicated adaptive equipment came up to the unit with the steam table and Dietary staff should have cross checked the meal ticket and plated the resident's meal accordingly. The Dietary Director identified Dietary staff should have provided Resident #106 with adaptive equipment per the physician's order and the NA should have ensured the (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	inner lip plate was present before serving the resident's meal. The Dietary Director indicated he would need to provide further education to the Dietary staff regarding Resident #106's adaptive equipment. Review of facility policy, Nutrition, dated 07/2025, directed it is the policy of the facility to provide appropriate interventions according to the physical and mental abilities of the resident. Meals will be placed in front of the resident with all equipment/assistive devices and assistance required.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for 2 of 6 residents (Resident #126, and Resident #143) reviewed for pneumococcal immunization, the facility failed to ensure that pneumococcal vaccines were administered when Resident #126 consented to receive and failed to offer or obtain a history of receiving the pneumococcal vaccine on admission (Resident #143). The findings include:1. Resident #126 was admitted to the facility on [DATE] on the short-term rehabilitation unit with diagnoses that included hypertension, dementia, and depression.A Resident admission Vaccination Education form dated 1/2/26 and signed by Resident #126 identified consent to receive the Pneumococcal conjugate vaccine (PCV20).Additionally, Resident #126's electronic medical record did not reflect any historical pneumococcal vaccinations nor indicate a pending pneumococcal vaccine order. 2. Resident #143 was admitted to the facility on [DATE] on the short-term rehabilitation unit.A Resident admission Vaccination Education form was located in the paper chart and blank (not filled out), indicating that the resident's vaccination status had not been reviewed with him/her and the pneumococcal vaccine was not offered.Interview with Licensed Practical Nurse (LPN) #3 (the Infection Preventionist) on 1/20/26 at 3:10 PM identified that she had not reviewed or administered any pneumococcal vaccines for residents since assuming the role of Infection Preventionist in October 2025. She explained that, as a new employee she was focused on managing the current facility outbreak, was unable to complete this responsibility despite being aware of the facility's policy requiring pneumococcal vaccine review and offering upon admission. LPN #3 stated that each resident should receive a vaccination consent form in their admission packet, which was placed in the paper chart by the admission nurse and later collected by her for review, tracking, ordering, administration, and documentation. However, due to time constraints related to a facility respiratory outbreak, these tasks were not completed. She acknowledged the expectation that residents who consent to pneumococcal vaccination should receive the vaccine within one to two weeks of consent, typically obtained during admission. LPN #3 described methods for obtaining vaccine history, including verbal reports from residents or families, previous health records, and the State of Connecticut resource CT Wiz. She confirmed that any history of pneumococcal vaccination or refusal should be documented under the immunization tab in the electronic medical record. When documentation is absent, it indicates the resident's vaccination status was not formally reviewed and the vaccine was not administered. An interview with the Director of Nursing Services (DNS) on 1/21/26 at 12:48 PM indicated her expectation was that residents' pneumococcal vaccination status would be reviewed, documented in the electronic medical record, and administered when consent had been obtained, in accordance with facility policy. She further indicated that all residents, including short-term residents who may stay for only one to two weeks, should have the opportunity to receive the pneumococcal vaccine. The DNS confirmed that LPN #3's expectation of administering the vaccine within one to two weeks of obtaining consent is reasonable. A review of the facility's undated policy, Procedure for Pneumococcal Vaccination of Residents, undated, directs that upon admission, each resident should be asked whether they have previously received any pneumococcal vaccines and at what age. The policy further states that if a resident's vaccination status is unknown, the pneumococcal vaccine should be offered and administered to those who consent. Additionally, the policy specifies that adults aged 65 or older who have not previously received a pneumococcal vaccine, or whose vaccination history is unknown, should receive a pneumococcal conjugate vaccine (PCV20 or PCV15). If PCV15 is administered, a dose of PPSV23 should be given within one year of the PCV15 administration.

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F 0865 Level of Harm - Potential for minimal harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on review of facility policy, facility documentation, and interview for the Quality Assurance and Performance Improvement (QAPI) and Quality Assessment and Assurance (QAA) programs, the facility failed to implement a QAPI plan related to management of the infection prevention and control program . The findings include: Interview and review of facility documentation with the Administrator on 1/21/26 at 3:31 PM identified the QAA committee met monthly to review current QAPI plans and needs for additional quality improvement. The Administrator identified 12 current QAPI plans located within the QAPI binder, but the 12 QAPI plans did not include the additional QAPI plans initiated prior to the start of the survey in response to infection prevention concerns identified by surveyors during interviews with facility staff. (Refer to F 880 and F 883)Interview with the Administrator on 1/21/26 at 3:43 PM identified she was unaware of a QAPI related to the facility outbreak which Registered Nurse (RN) # 2 had indicated was implemented in December 2025. Although the re-certification survey had identified several areas of deficient practice (refer to F 880 and F 883), the Administrator identified she was not specifically aware of concerns related to the infection prevention and control program. The Administrator identified that she was not the only staff member who could initiate a QAPI plan, and that depending on the department affected, the DNS could initiate a plan. The Administrator was unable to identify why the facility had not implemented a QAPI plan for the management of the infection prevention and control program (IPCP) due to her not being aware that there were concerns related to the IPCP.Review of facility documentation received 2/4/26 identified a Performance Improvement Project (PIP) worksheet dated 12/29/25 which indicated the problem was rapid transmission of respiratory viruses (COVID-19 and Influenza A) among residents on 2 units. Inservice education provided by Licensed Practical Nurse (LPN) #3 titled Outbreak Management and QAPI identified 15 of 16 staff signatures were obtained on 12/29/25, and 1 of 16 staff signatures was obtained on 1/14/26 (the facility had 180 staff members).Review of the Quality Assurance and Performance Improvement (QAPI) Plan policy directed, in part, all staff are engaged in the QAPI process. The policy directed the QAPI program was ongoing and addressed all systems of care including infection control under clinical care. The policy directed that the administration is responsible for the QAPI program. The policy directed the Administrator monitors the effectiveness of the QAPI program through regular reports from the QAPI committee. The policy directed the QAPI coordinator (DNS) supports the development and implementation of performance and improvement projects (PIPs). The policy directed that information/data is collected from a variety of sources including, in part, staff feedback from department meetings, infection control surveillance data, and incident reports. The policy directed that PIPs will focus on high risk, high problem areas. The policy directed the facility will use the Plan-Do-Study-Act cycle for all PIPs. The policy directed the facility will use a structured approach to analyze the root causes of identified concerns. The policy directed root cause analysis will be conducted for all adverse events (facility outbreaks). The policy further directed that all QAPI activities, including meeting minutes, data collection tools, reports, PIPs, RCA reports, and action plans will be documented and maintained in a secure accessible location.

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F 0584 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and facility documentation for 1 of 4 residents (Resident #66) reviewed for environment, the facility failed to ensure Resident #66's room was free from insects, and in good repair. The findings include: Resident #66 was admitted to the facility in December 2023 with diagnoses that included paranoid schizophrenia, dementia, and intellectual disabilities. An annual Minimum Data Assessment (MDS) assessment dated [DATE] identified Resident #66 was severely cognitively impaired and required moderate assistance of 1 staff member for activities of daily living (ADLs).The Resident Care Plan (RCP) dated 12/18/25 identified an ADL deficient due to cognitive loss, dementia, paranoid schizophrenia, and intellectual disabilities. Interventions included to assist with gathering and setting up clothing, toiletries, and equipment. Additionally, the RCP noted to encourage self-performance and praise all attempts and allow sufficient time for task completion, occupational evaluation and treatment as needed and provide assist of 1 and cueing to maximize current level of functioning.Physician orders dated 1/12/26 directed independent with bed mobility, transfers and supervision with ambulation off unit and assist with self-care. Observations on 1/12/26 at 11:00 AM, 1/15/26 at 3:20 PM and 1/16/26 at 9:00 AM and 11:10 AM noted Resident #66 to have a private room and be seated in his/her recliner chair that was located in proximity to the windowsill. The windowsill on the inside to the room, was observed to have a white towel rolled up and laying on the right side of the windowsill up against the bottom of the window and ledge. The rolled towel was noted to have a heavy accumulation of small black insects with wings that were dead. Additionally, on 1/12/26 at 11:00 AM and 1/16/26 at 9:00 AM identified the radiator cover below the window was falling off, and an approximate 6 foot section of wallpaper below the window ledge was marred and in disrepair. The toilet seat in Resident #66's bathroom was visibly discolored with an orange/rust color stain.Interview with Resident #66 on 1/16/26 at 11:10 AM identified that he/she was unaware of the towel with the insects and did not know who put the towel on the windowsill (despite 3 observations made by the surveyor).Interview with the Administrator on 1/16/26 at 11:14 AM noted she was unaware of the towel containing the dead bugs in Resident #66's room and she had not received any concerns from staff or residents regarding any insects.Interview with the Director of Housekeeping Services on 1/16/26 at 11:30 AM indicated he was unaware of who put the towel on the windowsill and that there were dead insects on the towel. He indicated that basic cleaning was completed daily by the assigned housekeeper and consisted of emptying the garbage, wiping down over the bed tables and any visible dirty areas in the room, and light sweeping of the floor. He indicated that the housekeeper was not aware of the towel having dead insects on it.Interview with the Director of Environmental Services indicated that he was unaware of the insects on the towel in Resident #66's room. He indicated that pest control did not visit the facility in December, however; were in the facility on 1/13/26 with no indication of insects/bugs in the facility. Furthermore, he indicated that there were no reports from staff that there was an issue with bug/insects in Resident #66's room. The Director of Environmental Services indicated that staff should have reported the bugs/insects on the towel. Subsequent to survey inquiry, the Director of Environmental Services and his assistant installed an insulation weather strip in windowsill of Resident #66's room on 1/16/25. The housekeeper cleaned the windowsill prior to the installation of the weatherstripping. In addition, pest control was notified on 1/16/26 and a visit was conducted on 1/18/26. Resident #66's room was checked along with 2 adjacent resident rooms with no pest activity identified.A second interview with the Director of Housekeeping on 1/20/26 at 1:00 PM identified that a complete cleaning of Resident #66's room had taken place on 1/8/26 and no insects were noted in the room at that time. A review of the housekeeping cleaning checklist form for Resident #66's room completed on 1/8/26 failed to identify that windowsills were part of the cleaning of a room. The Director of Housekeeping indicated (continued on next page)

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	01/21/2026

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 0584 Level of Harm - Potential for minimal harm Residents Affected - Some	that it was an error in the form, and a new form would be developed containing windowsills. A review of the Environmental Services Room Cleaning Policy and Disinfection dated July 2025 directed, in part that standard procedures for environmental sanitation to provide a safe, sanitary and comfortable environment for residents and staff while preventing the transmission of infectious agents.Routine daily cleaning focuses on removing soil and minimizing the microbial load in the resident's environment. Daily cleaning involves the cleaning of high touch surfaces, horizontal surfaces and floors.

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	01/21/2026

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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 0761 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and facility policy for 1 of 2 (Skyview Medication Room) medication rooms observed for medication storage, the facility failed to ensure that items were not stored under the sink in the medication room. The findings included: Observation of the Skyview Medication Room on 1/16/26 at 10:30 AM identified that items were stored under the sink cabinet. The items included: Bottle of Harvey's Bristol Cream 750ml that was 3/4 full33 Empty various assorted size containers(7) 3M masks1 full box of black KN95 masks3 VHS tapes2 plastic wash basins1 phone charger labeled BB [NAME] R4 boards 1 stack of sports cards1 empty notebook binderInterview and observation of the cabinet under the sink in the medication room with the DNS on 1/16/26 at 10:40 AM identified that the cabinet under the sink should be locked and no items should be stored under the sink. The DNS stated she was unsure why items were stored under the sink and that nursing staff must have put them there. She indicated that it was facility policy that no items should be stored under the sink in the medication room. She indicated that it was nursing's and maintenance's responsibility to ensure items were not stored under the sink. Interview with Director of Environmental Services on 1/16/26 at 12:00 PM identified that he was unaware that items were being stored under the sink. Subsequent to surveyor inquiry, the Director of Environmental Services removed the items from under the sink and locked the cabinet. A review of Environmental Rounds that were conducted by LPN #9 on 12/26/25 identified all medication rooms on 12/26/25 and noted that no items were stored under the sinks in the medication rooms. The Medication Storage Policy (undated), directed, in part, medications must be stored in accordance with manufacturer's specifications and secured in locked storage area in compliance with state and federal requirements and acceptable standards of practice.