

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075063	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/17/2024
NAME OF PROVIDER OR SUPPLIER Avery Nursing Home/Noble Building		STREET ADDRESS, CITY, STATE, ZIP CODE 705 New Britain Ave Hartford, CT 06106	

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)
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41223</p> <p>Based on clinical record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #1) reviewed for abuse, the facility failed to ensure the clinical record was complete and accurate to include and assessment after an allegation of abuse. The findings include:</p> <p>Resident #1 was admitted with diagnoses that included Alzheimer's disease. An admission MDS assessment dated [DATE] identified Resident #1 had severe cognitive impairment and was dependent for transfers. A resident care plan (RCP) dated 6/12/2024 identified Resident #1 was combative with staff. Interventions directed that Resident #1 had a private NA in room due to impulsiveness and if observed walking without assistance, assist for safety.</p> <p>A physician's order dated 6/4/2024 directed Resident #1 was an assist of for transfers.</p> <p>A facility accident incident report dated 6/27/2024 identified an allegation of staff to resident abuse without injury. NA # 2 reported that NA #1 was rude and rough on 6/24/2024 during a transfer into bed on the 3:00 to 11:00 PM shift.</p> <p>A facility summary dated 6/28/2024 identified NA #1 let go of Resident #1's legs quickly and NA#1's heavy accent when she responded to Resident #1, directing Resident #1 to stop kicking were interpreted as being rude.</p> <p>Interview with RN #2 on 7/17/2024 at 1:51 PM identified that she was the nursing supervisor on 6/26/2024 on the 3:00 PM to 11:00 PM shift when she was called to the unit regarding an allegation of rough care provided by NA #1 to Resident #1. RN #2 stated she performed an assessment, noted Resident #1 was not upset, had no injuries upon skin assessment and no reported pain when assessed. RN #1 stated she could not recall if she had documented her assessment in the medical record and indicated she may have forgotten to document; the assessment should have been documented.</p> <p>Interview with the acting DON, ADNS on 7/17/2024 at 2:15PM identified that when there is an allegation of abuse, an assessment of the alleged victim should be complete and documented in the medical record. She did not know why RN #2 did not document her assessment.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility policy Abuse, Neglect, Mistreatment and Exploitation directed in part that upon receiving reports of physical abuse, the nursing supervisor shall direct the charge nurse to immediately examine the resident. The findings of the examination must be recorded in the resident's record.</p>