STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075063	A. Building B. Wing	01/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avery Nursing Home/Noble Building	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)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47491 Based on clinical record review, interviews, and review of facility documentation for three (3) of six (6) patients (Patient #5, #6, and #7) reviewed for abuse, the facility failed to update the residents care plans following their physical altercations. The findings included: 1. a. Resident #4 had diagnoses which included Alzheimer's Disease, Schizoaffective Disorder, bipolar type, and Type 2 diabetes mellitus. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #4 had a Brief Mental Interview for Mental Status (BIMS) of double zero (00) indicating severe impaired cognition. The MDS further identified Resident #4 required partial assistance with toileting hygiene and dressing, substantial assistance with showering and personal hygiene, and failed to identify any physical, verbal, or other behavioral symptoms. Review of Resident #4's Care Plan dated 7/23/24 identified difficulty communicating his/her needs due to a language barrier and psychotropic drug use, mental disorder, and mood state with interventions that directed to create a board with most common words in English and their native language that resident can point to communicate their needs, to encourage the resident to verbalize any feelings/concerns/needs as they arise and validate when expressed. b. Resident #5 had diagnoses which included vascular dementia with agitation, anxiety disorder and depression. Review of Resident #5's Care Plan dated 4/12/24 identified behavioral symptoms, mood/behavior - wandering. Interventions directed to redirect the resident from entering other resident's rooms and to redirect to the front of the nursing station for socialization with other residents. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #5 had a Brief Mental Interview for Mental Status (BIMS) of ninety-nine (99) indicating the resident was unable to complete the interview, however noted Resident #5 had severely impaired cognition. Further review of the MDS assessment identified Resident #5 required supervision with oral hygiene, bathing, and dressing, and identified wandering behavior. (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Reportable Events Report (RE) dated 8/28/24 identified Resident #5 entered Resident #4's room at approximately 3:00 AM, had gone through Resident #5's dresser and had taken out one of his/her undergarments. The RE further identified that Resident #4 had ordered Resident #5 to get out of his/her room. Resident #5 then became angry, hit Resident #4, and Resident #4 responded by hitting Resident #5 back and pushed him/her out of his/her room. Interview with the Assistant Director of Nurses (ADNS) on 1/6/25 9:50 AM identified Resident #5 had entered Resident #4's room and was rummaging through Resident #5's belonging in his/her dresser when Resident #4 told Resident #5 to leave his/her room, that Resident #5 hit Resident #4 when he/she refused to leave, and that Resident #4 pushed her back. The ADNS further indicated Resident #5 had not presented with any similar behaviors prior to this incident, that he/she was seen by psych the following day and was prescribed Risperidone for two (2) weeks following the incident. The ADNS identified Resident #4 had his/her room changed and that no other incidences involving either resident have occurred since. Interview with RN #1 on 1/2/25 at 2:20 PM identified Resident #4's Care Plan was updated following the 8/28/24 incident, however, Resident #5's Care Plan was not updated with an intervention following the 8/28/24 altercation to protect the resident and/or prevent another incident from reoccurring. 2. a. Resident #6 had diagnoses that included Alzheimer's Disease, anxiety disorder, and depression. Review of Resident #6's quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #6 had a Brief Mental Interview for Mental Status (BIMS) of seven (7) indicating severe cognitive impairment. The MDS further indicated Resident #6 required moderate assistance with dressing and personal hygiene, was independent walking 150 feet once standing, and failed to identify physical, verbal or other behavioral symptoms. Review of the Resident Care Plan dated 8/23/24 identified a potential for wandering (moves with no rationale purpose, seemingly oblivious to needs or safety) and potential for alteration in mood secondary to diagnoses of Alzheimer's dementia with behavioral disturbance and mild situational depression with interventions that directed to maintain a calm environment and approach to the resident, and encourage the resident to verbalize their needs, concerns, and feelings. b. Resident #7 had diagnoses that included dementia with psychotic disturbance, neurocognitive disorder with Lewy bodies, and other specified anxiety disorders. Review of Resident #7's quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #7 had a Brief Mental Interview for Mental Status (BIMS) of nine (9) indicating moderate cognitive impairment. The MDS further indicated Resident #7 required moderate assistance with personal hygiene and bathing and was independent walking 150 feet once standing. Review of Resident #7's Care Plan dated 6/17/24 identified resident experiences wandering and potential for alteration in mood secondary to diagnoses/history of dementia with psychotic behaviors, anxiety, hallucinations, insomnia, and depression with interventions that directed to maintain a calm environment and approach to the residents and encourage the residents to verbalize needs, concerns, and feelings. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Reportable Events Report (RE) dated 10/23/24 identified Resident #6 and Resident #7 were standing around the nurse's station when Resident #6 kicked Resident #7 in the foot. The RE further indicated Resident #7 had pushed Resident #6, causing Resident #6 to brush his/her right forearm against the doorway, causing a scrape measuring 5 centimeters by 0.3 centimeters. The residents were separated without further issue. Interview with the director of Nurses on 1/13/25 at 1:30 PM failed to identify both Resident #6 and Resident #7's care plans were not updated following the 10/22/24 altercation to protect the residents and/or prevent another incident from reoccurring. The DNS further indicated facility practice was to update the residents care plan immediately or to at least note the intervention on the incident report until staff could add it to the care plan(s). Review of the Development of the Resident Care Plan (DRCP) policy directed the interdisciplinary team at [NAME] Health Care Center collaborates to implement interventions in the plan of care that will help achieve optimal outcomes for each patient/resident based on their identified functional and psychosocial needs.