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	04/08/2025

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 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 review of the clinical record, facility documentation, facility policy, and interviews, the facility failed to ensure that care and services provided were in accordance with accepted professional standards for one (1) of three (3) residents (Resident #1) reviewed for falls with major injuries, who sustained multiple fractures from a fall out of bed and was repositioned by staff prior to a post fall assessment by a Registered Nurse. The findings include: Resident #1's diagnoses included muscle weakness, repeated falls, anxiety disorder and type 2 diabetes with neuropathy (nerve damage affecting the feet and legs that can cause numbness, tingling, pain and loss of sensation). The significant change in status Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Mental Interview for Mental Status (BIMS) assessment was conducted and identified both short-term and long-term memory problems indicative of moderately impaired cognition and was dependent on staff for bed mobility and transfers. Review of the Fall Risk Scale dated 2/14/25 identified Resident #1 had intermittent confusion, was prescribed three (3) or more medications that could contribute to a fall and had three (3) or more predisposing conditions. The Resident Care Plan (RCP) dated 2/27/25 identified Resident #1 was at risk for falls related to weakness and deconditioning and had actual falls on 3/14/23 and 9/16/24 with no injuries. Interventions included to ensure Resident #1 was positioned in the middle of the bed before turning. The RCP was updated on 4/4/25 to identify Resident #1 had a fall on 4/4/25 where he/she slid to the floor from the bed. Interventions included providing an assist of two (2) during care and positioning to prevent Resident #1 from sliding off the bed. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility Reportable Event (RE) report dated 4/4/25 by RN #1 identified that at 10:55 AM, during morning care in Resident #1 ' s room, Resident #1 was turned onto his/her left side and slid off the side of the bed onto the floor with his/her feet and legs hitting the floor first. The RE reported that upon RN assessment, Resident #1 was noted to be laying on the floor with both legs extended, and the right leg was externally rotated (away from the body where the inner portion now faced forwards) and the resident was complaining of pain. The RE identified that the Advanced Practice Registered Nurse (APRN) was notified, and Resident #1 was transferred to the Emergency Department (ED) for evaluation. The RE identified that the facility received a call from Resident #1's family member around 7:10 PM stating Resident #1 sustained bilateral (both) hip fractures and subsequently passed away at the hospital. A nurse's note dated 4/4/25 at 11:38 AM identified that during care, Resident #1 was turned and slid to the floor with his/her feet and legs first hitting the floor. The note identified Resident #1 was observed laying on the floor with legs extended, the right leg was externally rotated, and Resident #1 was guarding his/her right hip and complaining of pain. The note identified the APRN was notified, new orders were obtained to transfer Resident #1 to the ED for evaluation, and the family and Hospice were notified of the incident. Review of the hospital ED notes dated 4/4/25 identified that at 5:15 PM Resident #1 became lethargic, his/her heart rate dropped, he/she was no longer arousable (able to be awoken), and was pronounced dead at 5:15 PM. The notes identified there was a rapid onset of multiple conditions (including sepsis and multiple fractures) that were not survivable given Resident #1 ' s age. Further identified was that the CT (imaging technique that uses x-rays and computer technology to create detailed images of inside the body) of the chest, abdomen and pelvis identified multiple right-sided rib fractures, left-sided rib fracture, bilateral femur (long bone of the upper thigh) fractures including a left subtrochanteric fracture that is displaced (fragments of the bone are no longer aligned creating a gap between the broken ends) and a non-displaced right intertrochanteric fracture. Review of the facility Summary Report dated 4/7/25 identified that on 4/4/25 Resident #1 was receiving care when he/she was turned and his/her feet/legs dangled over the edge of the low air-loss mattress, causing a depression in the edge of the mattress, and the weight of his/her legs, caused Resident #1 to quickly slide off the mattress. NA #1 attempted to stop the fall by grabbing onto Resident #1 ' s shirt but failed, and Resident #1 subsequently landed in a sitting position, with legs stretched outwards and his/her back up against the bed. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with NA #1 on 4/8/25 at 9:13 AM identified that on 4/4/25 she was performing personal care for Resident #1 and used the drawsheet to pull Resident #1 towards her on the right side of the bed, crossed his/her right leg over the top of the left leg and turned Resident #1 on his/her left side. She identified that once Resident #1 was on their left side, the right leg went over the left side of the bed, subsequently causing Resident #1 to start sliding off the left side of the bed with legs down first. She identified Resident #1 had a low air-loss mattress which was unstable and started to sink on the left side but reported she was able to lean over the bed and pull the back of Resident #1 ' s shirt to try to prevent him/her from falling. NA #1 identified Resident #1 landed on the floor in a sitting position with his/her back up against the side of the bed with the left leg straight and the right leg crossed over the top of the left leg in a figure-four position. NA #1 reported she immediately ran to the doorway, called for help, and LPN #1 went to the room to assist. NA #1 indicated LPN #1 notified the Nursing Supervisor (RN #1) who then assessed Resident #1. NA #1 identified RN #1 directed staff to not move Resident #1 until the ambulance arrived. NA #1 reported she cared for Resident #1 many times and Resident #1 was an assist of one for bed mobility and Activities of Daily Living (ADL's). NA #1 further identified Resident #1 ' s capabilities varied and at times he/she was able to help and other times he/she was not able to help. Interview with RN #1 (Nursing Supervisor) on 4/8/25 at 10:00 AM identified that on 4/4/25, she was notified Resident #1 fell out of bed and was on the floor. She reported that when she arrived at the room, Resident #1 was lying on the floor between the left side of the bed and the window, his/her head was under a pillow towards the foot of the bed, and his/her feet and legs were extended straight towards the head of the bed but pointed towards the window. She identified Resident #1 ' s right leg was visibly externally rotated, but no deformities were noted to the left leg. She reported she directed staff not to move Resident #1 and notified the APRN who gave her an order to transfer Resident #1 to the ED for evaluation. RN #1 identified that the staff never reported Resident #1 was originally in a sitting position and that Resident #1 was moved prior to her assessment. Interview with LPN #1 on 4/8/25 at 11:08 AM identified that on 4/4/25, NA #1 reported Resident #1 was on the floor and when she entered the room, Resident #1 was sitting up with his/her back up against the left side of the bed, his/her right leg was crossed over the left leg and he/she was leaning to the right. LPN #1 identified Resident #1 appeared uncomfortable, so NA #1 and herself moved the bed to allow for more space to reposition Resident #1. LPN #1 identified that prior to RN #1 arriving to assess Resident #1, they slowly laid Resident #1 down to his/her right side while straightening his/her legs and placed Resident #1 on his/her backside. LPN #1 reported that when RN #1 arrived to the room she directed not to move Resident #1 and stated she (RN #1) was going to call the APRN. LPN #1 indicated she did not notify RN #1 that Resident #1 was moved. Interview with the DNS on 4/8/25 at 1:20 PM identified she was unaware that LPN #1 and NA #1 moved Resident #1 from a sitting position to a lying position and straightened his/her legs prior to an RN assessment and that the staff should not have moved Resident #1 until he/she was assessed by an RN. Re-interview with NA #1 on 4/8/25 at 2:46 PM identified that following the fall, she and LPN #1 moved Resident #1 prior to RN #1 arriving to the room to conduct as assessment. Additionally, she identified that prior to the ambulance arriving to transport Resident #1 to the hospital, LPN #2 told her Resident #1 needed a brief change and that they changed Resident #1 together, turning him/her back and forth on the floor. She identified that in both instances she did what she instructed to do by the LPN despite RN #1 directing Resident #1 not be moved. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with APRN #1 on 4/8/25 at 3:48 PM identified the facility staff notified her on 4/4/25 that Resident #1 appeared to be in pain after a fall out of bed and that the right leg was externally rotated so she directed Resident #1 be transferred to the ED for evaluation. She identified that Resident #1 would have had to sustain trauma, and not just slid out of bed, to have sustained numerous fractures. She identified that following a resident fall with a suspected fracture, staff should not move a resident until emergency services arrives. Review of the Fall policy (undated) directed, in part, that each resident will be assessed for fall risks to ensure adequate safeguards are in place to promote patient safety and prevent falls. Nursing staff will assess each resident on admission, quarterly and with any identified significant change using the Fall Risk Assessment form. After any resident fall, an Accident/Incident report and a Fall Investigation is completed by the charge nurse. The nurse manager will review the investigation and present issues to the interdisciplinary team for recommendations for prevention strategies. The nurse manager will facilitate or implement those recommendations and incorporate them into a fall risk care plan. A referral for a Physical Therapy Screen will be made via the 24-hour nursing report.

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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 0684 Level of Harm - 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 review of the clinical record, facility documentation, facility policy, and interviews for one (1) of three (3) residents (Resident #1) reviewed for falls with major injuries, the facility failed to ensure a timely assessment pertaining to bed mobility during provisions of care. As a result, Resident #1 sustained a fall out of bed resulting in multiple subsequent fractures. The findings include: Resident #1's diagnoses included muscle weakness, repeated falls, anxiety disorder and type 2 diabetes with neuropathy (nerve damage affecting the feet and legs that can cause numbness, tingling, pain and loss of sensation). The significant change in status Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Mental Interview for Mental Status (BIMS) assessment was conducted and identified both short-term and long-term memory problems indicative of moderately impaired cognition and was dependent on staff for bed mobility and transfers. Review of the Fall Risk Scale dated 2/14/25 identified Resident #1 had intermittent confusion, was prescribed three (3) or more medications that could contribute to a fall and had three (3) or more predisposing conditions. The Resident Care Plan (RCP) dated 2/27/25 identified Resident #1 was at risk for falls related to weakness and deconditioning and had actual falls on 3/14/23 and 9/16/24 with no injuries. Interventions included to ensure Resident #1 was positioned in the middle of the bed before turning. The RCP was updated on 4/4/25 to identify Resident #1 had a fall on 4/4/25 where he/she slid to the floor from the bed. Interventions included providing an assist of two (2) during care and positioning to prevent Resident #1 from sliding off the bed. Review of the facility Reportable Event (RE) report dated 4/4/25 by RN #1 identified that at 10:55 AM, during morning care in Resident #1 ' s room, Resident #1 was turned onto his/her left side and slid off the side of the bed onto the floor with his/her feet and legs hitting the floor first. The RE reported that upon RN assessment, Resident #1 was noted to be laying on the floor with both legs extended, and the right leg was externally rotated (away from the body where the inner portion now faced forwards) and the resident was complaining of pain. The RE identified that the Advanced Practice Registered Nurse (APRN) was notified, and Resident #1 was transferred to the Emergency Department (ED) for evaluation. The RE identified that the facility received a call from Resident #1's family member around 7:10 PM stating Resident #1 sustained bilateral (both) hip fractures and subsequently passed away at the hospital. A nurse's note dated 4/4/25 at 11:38 AM identified that during care, Resident #1 was turned and slid to the floor with his/her feet and legs first hitting the floor. The note identified the APRN was notified, new orders were obtained to transfer Resident #1 to the ED for evaluation, and the family and Hospice were notified of the incident. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the hospital ED notes dated 4/4/25 identified that at 5:15 PM Resident #1 became lethargic, his/her heart rate dropped, he/she was no longer arousable (able to be awoken), and was pronounced dead at 5:15 PM. The notes identified there was a rapid onset of multiple conditions (including sepsis and multiple fractures) that were not survivable given Resident #1 ' s age. Further identified was that the CT (imaging technique that uses x-rays and computer technology to create detailed images of inside the body) of the chest, abdomen and pelvis identified multiple right-sided rib fractures, left-sided rib fracture, bilateral femur (long bone of the upper thigh) fractures including a left subtrochanteric fracture that is displaced (fragments of the bone are no longer aligned creating a gap between the broken ends) and a non-displaced right intertrochanteric fracture. Review of the facility Summary Report dated 4/7/25 identified that on 4/4/25 Resident #1 was receiving care when he/she was turned and his/her feet/legs dangled over the edge of the low air-loss mattress, causing a depression in the edge of the mattress, and the weight of his/her legs, caused Resident #1 to quickly slide off the mattress. NA #1 attempted to stop the fall by grabbing onto Resident #1 ' s shirt but failed, and Resident #1 subsequently landed in a sitting position, with legs stretched outwards and his/her back up against the bed. Interview with NA #1 on 4/8/25 at 9:13 AM identified that on 4/4/25 she was performing personal care for Resident #1 and used the drawsheet to pull Resident #1 towards her on the right side of the bed, crossed his/her right leg over the top of the left leg and turned Resident #1 on his/her left side. She identified that once Resident #1 was on their left side, the right leg went over the left side of the bed, subsequently causing Resident #1 to start sliding off the left side of the bed with legs down first. She identified Resident #1 had a low air-loss mattress which was unstable and started to sink on the left side but reported she was able to lean over the bed and pull the back of Resident #1 ' s shirt to try to prevent him/her from falling. NA #1 identified Resident #1 landed on the floor in a sitting position with his/her back up against the side of the bed with the left leg straight and the right leg crossed over the top of the left leg in a figure-four position. NA #1 reported she cared for Resident #1 many times and Resident #1 was an assist of one for bed mobility and Activities of Daily Living (ADL's). NA #1 further identified Resident #1 ' s capabilities varied and at times he/she was able to help and other times he/she was not able to help. Interview with RN #1 (Nursing Supervisor) on 4/8/25 at 10:00 AM identified that on 4/4/25, she was notified Resident #1 fell out of bed and was on the floor. She reported that when she arrived at the room, Resident #1 was lying on the floor between the left side of the bed and the window, his/her head was under a pillow towards the foot of the bed, and his/her feet and legs were extended straight towards the head of the bed but pointed towards the window. She identified Resident #1 ' s right leg was visibly externally rotated, and Resident #1 was grabbing his/her right hip, but no deformities were noted to the left leg. She reported she directed staff not to move Resident #1 and notified the APRN who gave her an order to transfer Resident #1 to the ED for evaluation. RN #1 identified she questioned if the fall was caused from Resident #1 being turned too fast or if there should have been a second staff member to assist with care. RN #1 identified she performed care for Resident #1 numerous times and that Resident #1 was on hospice and inconsistent with required levels of assistance needed. RN #1 identified she always asked another staff member for assistance with Resident #1 because a two-person assist was safer. RN #1 identified she discussed the level of assistance Resident #1 required with the DNS, but the DNS decided if staff need additional assistance when performing care, they would request additional assistance. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Interview with the DNS on 4/8/25 at 1:20 PM identified she was unable to find past imaging for Resident #1 that identified he/she had osteoporosis. She identified that she was unable to determine the cause of Resident #1 ' s fractures and her investigation identified no facility failure. The DNS identified Resident #1 was transitioned to hospice services in January of 2025, and no staff reported functional changes, therefore, there was no indication for Resident #1 to be screened by therapy or to have a change in level of assistance. Interview with OTA #1 and the Rehab Director on 4/8/25 at 1:39 PM identified Resident #1 was last evaluated for Activities of Daily Living (ADL's) on 8/15/24 and Resident #1 was found to be an assist of one (1) for toileting, upper body/lower body dressing and upper body/lower washing and an assist of two (2) for transfers with a Hoyer (mechanical) lift. Additionally indicated, was when a resident is transitioned to hospice or has a significant change in status, the resident is not screened by therapy unless nursing reports a functional status change, which had not been reported for Resident #1 from January 2025 to present. Interview with NA #2 on 4/8/25 at 2:02 PM identified Resident #1 was inconsistent with his/her ability to help with bed mobility and ADL's and that, at times, Resident #1 required two-person assistance. Interview with APRN #1 on 4/8/25 at 3:48 PM identified the facility staff notified her on 4/4/25 that Resident #1 appeared to be in pain after a fall out of bed and that the right leg was externally rotated so she directed Resident #1 be transferred to the ED for evaluation. She identified that Resident #1 would have had to sustain trauma, and not just slid out of bed, to have sustained numerous fractures. She identified that following a resident fall with a suspected fracture, staff should not move a resident until emergency services arrives. Interview with MD #2 on 4/8/25 at 3:48 PM identified that he had no records to indicate that Resident #1 had a diagnosis of osteoporosis. He identified that the number of fractures that Resident #1 sustained was dramatic and in the absence of underlying cancer or osteoporosis, it was very unusual to sustain fractures that Resident #1 did, without trauma. Review of the Fall policy (undated) directed, in part, that each resident will be assessed for fall risks to ensure adequate safeguards are in place to promote patient safety and prevent falls. Nursing staff will assess each resident on admission, quarterly and with any identified significant change using the Fall Risk Assessment form. After any resident fall, an Accident/Incident report and a Fall Investigation is completed by the charge nurse. The nurse manager will review the investigation and present issues to the interdisciplinary team for recommendations for prevention strategies. The nurse manager will facilitate or implement those recommendations and incorporate them into a fall risk care plan. A referral for a Physical Therapy Screen will be made via the 24-hour nursing report.