STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075244	A. Building B. Wing	07/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avon Health Center	652 West Avon Rd Avon, CT 06001

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, facility documentation, and interviews for one of three residents (Resident #1) reviewed for accidents, the facility failed to ensure the resident was provided care in accordance with physician orders and the plan of care to prevent a fall resulting in a femur fracture that required a closed non-surgical reduction of fractured bone. Resident #1 was admitted to the facility with diagnoses that included Alzheimer's disease, anxiety, and osteoarthritis. An annual Minimum Data Set (MDS) dated [DATE] identified Resident #1 had severe cognitive impairment, required extensive assistance with two (2) staff for bed mobility, and was incontinent. A Resident Care Plan (RCP) dated 6/5/2025 identified Resident #1 was at risk for falls due to impaired mobility, incontinence and cognitive impairment. Interventions directed assist of two (2) staff for Activities of Daily Living (ADLs). A physician order dated 6/5/2025 directed comfort care (CMO) and do not hospitalize (DNH).A physician order dated 6/5/2025 directed assist of two (2) staff for ADLs, Hoyer lift for transfers and Resident #1 was non-ambulatory. A facility reportable event (RE) form dated 6/28/2025 at 5:00 PM identified while Nurse Aide (NA) #1 was providing incontinent care and turning Resident #1 to his/her side, Resident #1 rolled away from NA #1 with his/her arms up and fell from the bed onto the floor. The NA was unable to reach Resident #1, and rushed to the other side of the bed, but was not able to reach Resident #1 before his/her legs went on the floor followed by his/her upper body. An RN assessment was completed, and Resident #1 was assisted back to bed. Resident #1's right knee was noted to be slightly swollen, ice was applied, Tylenol was administered, and new orders were obtained for an x-ray. X-ray results identified an acute distal (away from the torso) femur fracture. The report identified due to Resident #1's CMO and DNH status, the responsible party requested Resident #1 remain at the facility. During a follow-up APRN assessment on 6/30/2025 the responsible party agreed to a hospital transfer. Resident #1 was transferred to the hospital and underwent a closed reduction (non-surgical procedure) with placement of a knee immobilizer. The RE summary dated 6/30/2025 identified Resident #1 required two (2) staff to provide personal care (ADL care) and on 6/28/2025 at approximately 4:45 PM, NA #1 was providing incontinence care alone when Resident #1 became resistive. Resident #1 attempted to move away from NA #1 while on her/his side and facing away from NA #1. Resident #1 rolled off the bed and onto the floor and NA #1 was unable to stop the fall. Resident #1 had a physician order for assist of two (2) staff for ADLs. NA #1 reported that she did not feel she needed a second person and felt she was able to handle turning Resident #1 alone as Resident #1 did not have combative behaviors. Resident #1 remained in the facility after the fracture was identified due to DNH orders and the family decision. An APRN assessment was completed on 6/30/2025 due to increased pain, the responsible party agreed with a hospital transfer, and Resident #1 underwent a closed fracture reduction under sedation 6/30/2025. Record review identified Resident #1 returned to the facility on 7/1/2025 with a knee immobilizer in place, and no additional orthopedic follow up. Interview with the Director of Therapy on 7/22/2025 at 10:30 AM identified Resident #1 required two (2) staff for all care, including turning and positioning. Interview with LPN #1 on 7/22/2025 at 10:26 AM identified she was the charge nurse on 6/28/2025 and indicated all resident care cards contain resident specific information about the resident needs. LPN #1 stated the electronic care card is accessible for all staff electronically on the unit, and she did not remember if she gave any specific directions to NA #1 regarding care for Resident #1 on 6/28/2025. Interview with NA #2 on 7/22/2025 at 11:32AM identified she worked on the same unit with NA #1 on 6/28/2025, and at the start of the shift she told NA #1 that Resident #1 required the assistance of two (2) staff for care. NA #2 stated she told NA #1 that both residents in that room required two (2) staff for care. Interview with NA #1 on 7/22/2025 at 12:32 PM identified she provided incontinent care by herself to Resident #1 on 6/28/2025 at 5:30 PM. NA #1 stated she turned Resident #1 onto his/her left side, facing away from NA #1 and centered in the bed. NA #1 stated the bed was raised to her waist height with the 1/2 side rail raised on the side the resident was turning towards. NA #1 indicated Resident #1 was grabbing her hand as she turned him/her and began to wiggle his/her body, and stated Resident #1 was not fighting to turn but acting more afraid. NA #1 stated she thought it was better to get the care done quickly instead of going to get help when Resident #1 was acting afraid. As Resident #1 turned away from NA #1, he/she rolled towards the edge of the bed and his/her upper body rolled forward. NA #1 indicated she tried to grab Resident #1's legs but was unable to reach them and she ran around the bed but it was too late. Resident #1's legs fell off the bed followed by his/her upper body; Resident #1's knees landed