STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075423	A. Building B. Wing	06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Davis Place	111 Westcott Rd Danielson, CT 06239

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**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, the facility failed to ensure a resident was treated in a respectful and dignified manner which caused an escalation of behaviors resulting in a fall with fractures. The findings include: Resident #1 's diagnoses included dementia with behavioral disturbances, mood disorder and muscle weakness. Review of the Morse Fall Scale assessment dated [DATE] identified that Resident #1 had a history of falls, exhibited an impaired gait (abnormal walking pattern) and overestimates or forgets his/her own limits, categorizing the resident as a high risk for falling. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Mental Interview for Mental Status (BIMS) of three (3) indicative of severely impaired cognition and was dependent on staff for bed mobility and transfers. Additionally, the MDS identified Resident #1 had not exhibited any behaviors. The Resident Care Plan (RCP) dated 5/26/25 identified Resident #1 was at risk for falls due to confusion, deconditioning and gait/balance problems. Interventions included anticipate and meet needs, appropriate footwear, and attempt to determine root cause of falls. The RCP identified Resident #1 had impaired cognition, a self-care deficit and was an assist of 1 with transfers. The facility Reportable Event (RE) dated 5/30/25 identified at 9:00 PM NA #1 was transporting Resident #1 in his/her wheelchair in the hallway when Resident #1 put his/her feet down to the ground, stopping the wheelchair abruptly, and caused Resident #1 to fall forward out of the wheelchair sustaining a lump to the forehead. The RE identified the family and provider were notified and an order was obtained to transfer Resident #1 to the Emergency Department (ED) for further evaluation. Resident #1 further sustained a mildly displaced odontoid neck fracture (fracture of the bony projection from the second cervical vertebrae) and a fracture of the first cervical vertebrae. The RE identified that following the incident, footrests were to be applied to the wheelchair for all staff transports outside of the room. Review of staff statements failed to identify statements from LPN #1 (assigned nurse) and LPN #2 (additional unit nurse). Review of the hospital documents dated 5/30/25 identified Resident #1 was transported to the ED from the facility and the facility reported Resident #1 was agitated, did not want to be moved, staff moved him/her anyways and Resident #1 did what he/she always does, stuck his/her right foot out straight, leading to a fall forward. The note indicated Resident #1 had a small laceration to the upper forehead, denied pain and a cervical collar was intact to the neck. It identified head and cervical spine imaging was obtained and resulted in a prominent anterior (front) scalp hematoma (a closed wound where blood collects and fills a space because it cannot flow out or drain), a mildly displaced fracture of the odontoid neck (a fracture through the bony projection from the second cervical vertebrae where the fragment shifted out of alignment) and non-displaced fractures (when the bone fragment remains aligned and in normal position) of both sides of the posterior (backside) arch of the first cervical vertebrae (C1). The RCP revised 5/30/25 identified Resident #1 was at risk for falls due to confusion, deconditioning and gait/balance problems and had an actual fall out of the wheelchair resulting in cervical fractures (vertebrae in the neck). Interventions included anticipating and meeting the resident's needs, observing/documenting/reporting to the provider any changes in mental status and ensuring footrests are in place to the wheelchair during transport and removing them after transport so that the resident may self-propel. Interview with NA #1 on 6/16/25 at 11:14 AM identified that on 5/30/25, Resident #1 was given a trash bag necklace consisting of a ribbon attached to a small plastic bag that Resident #1 was proudly wearing around his/her neck. NA #1 identified that between 8:00 PM and 9:00 PM, Resident #1 self-propelled in his/her wheelchair down to the West-Unit and was showing LPN #2 (agency nurse) the necklace. Resident #1 was heard yelling and NA #2 was pushing Resident #1 back to his/her room. She reported Resident #1 immediately went back into the hallway and self-propelled back to the West-Unit and yelled at LPN #2. NA #1 identified LPN #2 stated she did not have time for Resident #1 and directed her (NA #1) to bring Resident #1 back to his/her room again. NA #1 identified Resident #1's behavior continued to escalate but LPN #2 was insistent Resident #1 be brought back to his/her room. NA #1 then instructed Resident #1 to lift his/her feet and then she started to push Resident #1 in the wheelchair until Resident #1 abruptly placed his/her feet down on the ground, causing the wheelchair to stop and Resident #1 fell forward out of the wheelchair to the floor. NA #1 identified that LPN #2 taking the necklace off Resident #1, throwing it in the garbage in front of him/her without calmly explaining why, then continuing to dismiss Resident #1 when he/she reapproached LPN #2 angrily, caused an escalation in Resident #1's

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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)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	**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, the facility failed to ensure wheelchair footrests were in place to support a safe transfer. Resident #1, who was severely cognitively impaired, was directed by staff to lift his/her feet during the transfer; subsequently, the resident fell from the wheelchair and sustained multiple fractures. The findings include: Resident #1 's diagnoses included dementia with behavioral disturbances, mood disorder and muscle weakness. Review of the Morse Fall Scale assessment dated [DATE] identified that Resident #1 had a history of falls, exhibited an impaired gait (abnormal walking pattern) and overestimates or forgets his/her own limits, categorizing the resident as a high risk for falling. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Mental Interview for Mental Status (BIMS) of three (3) indicative of severely impaired cognition and was dependent on staff for bed mobility and transfers. Additionally, the MDS identified Resident #1 had not exhibited any behaviors. The Resident Care Plan (RCP) dated 5/26/25 identified Resident #1 was at risk for falls due to confusion, deconditioning and gait/balance problems. Interventions included anticipate and meet needs, appropriate footwear, and attempt to determine root cause of falls. The RCP identified Resident #1 had impaired cognition, a self-care deficit and was an assist of 1 with transfers. 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