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	09/09/2025

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 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

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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 observations, review of clinical records, facility documentation, facility policy, and interviews for one of three residents (Resident #1) reviewed for accidents, staff failed to move the food service cart in a safe manner to ensure no residents were in the path. The failure resulted in a resident fall with injury. The findings include: Resident #1's diagnoses included dementia, glaucoma, and schizoaffective disorder. The Resident Care Plan (RCP) dated 6/11/2025 identified Resident #1 ambulated independently with a cane. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of six out of fifteen, indicative of severe cognitive impairment, and required supervision with ambulation. Physician order dated 8/14/2025 directed independent ambulation in room and hall with or without single point cane (SPC). Facility Reportable Event dated 8/27/2025 at 9:30 AM identified Resident #1 was alert and forgetful and ambulated independently with a cane. Resident #1 exited his/her room at the same time the food service cart was passing by the room. Resident #1 made contact with the food service cart and fell on his/her left side. Resident #1 was transferred to the hospital and identified to have a left femoral fracture (broken upper leg bone). Review of the hospital x-ray results dated 8/27/2025 identified diffuse osteopenia (decreased bone density), and a left intertrochanteric (upper thigh bone) femoral fracture. Hospital Discharge summary dated [DATE] identified Resident #1 underwent a surgical Open Reduction Internal Fixation (ORIF) and directed weight bearing as tolerated (WBAT) and use of a Sara lift with two (2) staff for transfers. Resident #1 was readmitted to the facility on [DATE] and Resident #1 used a wheelchair (was non-ambulatory). Facility Reportable Event Summary dated 9/3/2025 identified Resident #1's cane came into contact with the bumper of the food service cart when he/she exited his/her room. Resident #1 stumbled and fell onto his/her left side with the upper torso (body) landing in the room. The food service cart was 6 foot, 2 inches tall and 23.5 inches wide with a bumper that extends outward four (4) inches. NA #1 looked to his left and right to be sure no one was in his pathway as he proceeded to push the food cart forward. A re-enactment identified Resident #1's cane would have come into contact with the food service cart bumper which caused Resident #1 to lose his/her balance and fall. Interview and record review with NA #1 on 9/9/2025 at 1:02 PM identified he started to push the food service cart back to the kitchen and checked both sides of the cart to be sure no one was in his path. As he was pushing, he felt something on the left side of the cart and saw that the cart made contact with a resident who had just come out of his/her room. NA #1 stated Resident #1 was stumbling and fell. NA #1 stated he could not see over the food service cart when he was pushing it. Although attempted, an interview with LPN #1 was not obtained during the survey. Interview, and record review with the DNS on 9/9/2025 at 1:37 PM identified Resident #1 ambulated independently and had no prior history of falls. As NA #1 was pushing the food cart Resident #1 came into contact with the bumper of the cart, lost his/her balance and fell. The DNS stated staff should ensure they are looking when moving carts to ensure the pathway remains clear of residents. Review of the facility Accident/Incident Prevention Policy directed in part, to make the environment as free from accident hazards as possible. Review of facility documentation identified staff education was initiated on 9/3/2025 that directed transportation of meal carts must prioritize safety, dietary staff will bring food service carts to the units and then NAs are responsible for maneuvering the cart into the appropriate serving area, an audible alert and/or light mechanism will be attached to each cart to alert staff/residents the cart is moving, all staff must be trained in safe cart handling, and when returning meal carts to the kitchen, the meal carts must be accompanied by two (2) staff members. Audits were initiated on 9/3/2025 and a QAPI meeting was held on 9/3/2025. Based on documentation review a finding of past-non-compliance was identified.