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	02/26/2026

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 Note: The nursing home is disputing this citation.	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #4) reviewed for resident rights, the facility failed to ensure resident rights were protected and free from interference from the facility in exercising their rights for Leave of Absence (LOA) from the facility, as per facility practice for physician orders for no LOA for all resident admissions. The findings include: Resident #4 was admitted to the facility during the beginning of 2/10/2026 with diagnoses that included a right femur fracture and diabetes. Nursing admission note dated 2/10/2026 at 11:56 AM identified Resident #4 was admitted from the hospital after a fall and surgical repair of a right hip fracture. Resident #4 was alert, oriented to person, place, time and situation, and required assistance with personal hygiene and mobility, and was able to make his/her needs known. Discharge was planned to return to the community. Nursing elopement risk assessment dated [DATE] identified Resident #4 was not a risk for elopement from the facility. Record review identified Resident #4 signed the Admissions Agreement for his/her admission to the facility. A physician order dated 2/10/2026 directed resident may not go out on leave of absence (LOA). The Resident Care Plan (RCP) dated 2/11/2026 identified discharge to the community (home) was anticipated in three (3) to four (4) weeks. Interventions directed to assist with community support resources and services. The admission Minimum Data Set (MDS) assessment dated [DATE], Section F - Preferences for Customary Routine and Activities, section F500, Activity Preferences, identified it was somewhat important to Resident #4 to go outside to get fresh air when the weather was good. Nursing note dated 2/17/2026 at 11:58 AM identified Resident #4 was alert and oriented to person, place, time and was noted to have short term memory impairment. APRN note dated 2/24/2026 at 9:30 AM identified Resident #4 was alert and oriented times three (3) and continued with physical and occupational therapy, with an improvement in mobility noted. Interview with Resident #4 on 2/26/2026 at 10:42 AM identified he/she would like to go on a LOA on a day to spend some time visiting with his/her grandchildren. And he/she was not aware the facility allowed any LOA for residents. Interview and record review with LPN #1 on 2/26/2026 at 12:59 PM identified she was a full-time nurse at the facility and had worked there for over 15 years. LPN #1 stated Resident #4 had a standard physician order that directed Resident #4 may not leave the facility on a LOA. LPN #1 stated orders are entered in the clinical record for all residents upon admission that direct no LOA. LPN #1 stated if a resident requests to go on a LOA, they need to ask permission and then the nurse calls the physician or APRN to get orders for a one-time (1) LOA from the facility. LPN #1 further stated LOA orders are only obtained if a resident or family member requests to go on an LOA, and only obtained for one-time LOAs, then if they want to go on another LOA, they again have to ask again. Interview and record review with RN #1 on 2/26/2026 at 1:05 PM identified she was the RN supervisor/unit manager that covered both short-term and long-term care units. RN #1 stated the electronic medical record system automatically (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	defaults to directed no LOA for all short-term and long-term care residents. RN #1 stated if a resident wants to leave the building on a LOA, the resident has to ask (staff), and then staff would call the physician/APRN to obtain an order. Once a physician order is obtained, the resident must be assessed by physical therapy before they are allowed to leave on a LOA. RN #1 stated the reason for automatic no LOA orders and not allowing residents to leave on LOA was due to insurance reimbursement, and any request would be addressed on a case-by-case basis. Interview with RN #2 on 2/26/2025 at 1:15 PM with RN #2 identified she was a facility RN supervisor/unit manager for one of the nursing units and stated all residents are admitted with physician orders that direct no LOA. RN #2 stated short- or long-term residents need to request an order for an LOA each time they want to leave the facility. When a resident requests and order, the physician/APRN may (or may not) give an order. If an order for LOA is obtained, the resident must be assessed by physical therapy before they are allowed to leave on a LOA. RN #2 stated it usually takes a day or a couple of days to obtain the order. Interview and record review on 2/26/2026 at 1:26 PM with the Director of Social Services/SW #1 identified all residents are admitted with physician orders for no LOA. If a resident would like to go on a LOA from the facility, nursing needs to obtain an order from the physician/APRN. Then, once an order was obtained, the resident must have a physical therapy evaluation before able to leave on a LOA. Interview and record review with PT #1 (Rehab Manager) on 2/26/2025 at 2:03 PM identified all residents are admitted with an automatic no LOA order. PT #1 stated residents must be cleared medically prior to any LOA order. PT #1 stated nursing has to obtain a doctors order first, then physical therapy evaluates if resident can safely transfer with/without a responsible party before cleared for LOA. Interview and review of facility documentation with the Administrator on 2/26/2026 at 2:55 PM identified the facility admission Welcome Book discusses LOAs from the facility and it refers residents and/or their responsible parties to pages 2-3 in the Admissions Agreement for any questions regarding LOAs. Review of the facility admission Welcome Book directed in part, for leave of absences please speak with the business office manager or refer to pages 2 and 3 in the Admissions Agreement for any questions regarding leave of absence(s). Requests for leave of absence require a physician approval. Please be sure to notify nursing supervisor at least 24 hours prior. Review of the Admissions Agreement failed to identify a page 2 and page 3 that referred to LOA from the facility; the pages were not numbered. Additional review of facility Resident Admissions Agreement packet identified item number 7 (seven) Leaves of Absence directed in part; the facility and its owners assume no responsibility for any personal injury, illness or deterioration in the resident's condition that may occur when the resident is temporarily absent from the facility, with or without physician or facility approval. The resident and responsible party release the facility, its owners, directors, officers and employees from all liability for any personal injury, illness, or deterioration in the resident's condition that may occur while resident is temporarily absent from the facility. However, the Admissions Agreement packet pages were not numbered, and no page 2 or 3 was provided, and failed to identify the Agreement directed there were no LOA privileges provided unless a request was made for an LOA at least 24 hours prior. Interview and record review with ADNS and DNS on 2/26/2026 at 3:03 PM identified the facility did not have a LOA policy but instead followed a LOA process. Upon admission, all residents receive orders marked no LOA, indicating the resident may not go on LOA. If a resident requests to go on a LOA, the physician/APRN would be notified to obtain an order, and the resident must be assessed by physical therapy before they are allowed to leave on a LOA. Although the DNS stated residents receive an admission Welcome Book and welcome speech covering LOAs, a copy was not provided for surveyor review. Review of facility Resident's [NAME] of Rights Policy dated 2/6/2026 directed in (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	part, you have the right to exercise your rights as a citizen. The facility must protect and promote your rights and encourage and assist you in exercising them. Although requested Leave of Absence policy or policy evaluation/assessment before LOAs were allowed were not provided for surveyor review.