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	06/03/2026

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a clinical record review, facility documentation, facility policies, and interviews, for one (1) of three (3) residents (Resident #1) reviewed for falls, the facility failed to ensure appropriate pain management and documentation. Specifically, licensed nursing staff did not document administered pain relief medication, did not complete a pain reassessment within one (1) hour of administration, and did not provide additional pain relief or interventions despite Resident #1 experiencing ongoing severe pain and having a confirmed fracture prior to transfer to the Emergency Department (ED). The findings include:Resident #1's diagnoses included low back pain, type I diabetes mellitus with diabetic neuropathy (nerve damage caused by persistently high blood sugars), longˆterm use of anticoagulants (medication that prevents blood clots), absence of the left leg above the knee, and anxiety disorder.A Physician's order dated 10/8/25 directed to administer acetaminophen 325 milligrams (mg), two (2) tablets by mouth every four (4) hours as needed for pain.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had intact cognition (Brief Interview for Mental Status (BIMS) score of 15), required substantial assistance with bed mobility, and was dependent on staff for toileting hygiene and transfers.The Resident Care Plan (RCP) dated 2/20/26 identified Resident #1 had chronic pain related to a cerebral infarction (an ischemic stroke caused by reduced blood flow to brain tissue) due to thrombosis of the right carotid artery (a blood clot in the primary artery supplying blood to the right side of the face and brain), and a left aboveˆknee amputation following hemiparesis (muscle weakness/partial paralysis affecting one side of the body) and hemiplegia (paralysis of one entire side of the body). Interventions included administering analgesia per order, anticipating Resident #1's need for pain relief and responding immediately to any pain complaint, evaluating the effectiveness of pain interventions and Resident #1's satisfaction with results, monitoring and recording pain characteristics, and notifying the physician if interventions were unsuccessful or represented a significant change from Resident #1's past pain experience.An Summary Background Assessment and Recommendation (SBAR) note by RN #1 dated 5/8/26 at 12:37 AM identified NA #1 reported on 5/7/26 at 10:45 PM that Resident #1 rolled out of bed onto the floor mat during repositioning. On arrival, Resident #1 was on his/her back on the window side of the bed with his/her head at the footboard and feet toward the headboard, reporting seven (7) out of ten (10) right knee pain. Acetaminophen was documented as administered for pain relief. No changes in mentation were noted. The onˆcall provider was notified, and new orders were obtained for a STAT right knee xˆray and for staff to monitor Resident #1's pain.The May 2026 Medication Administration Record (MAR) failed to identify acetaminophen administration following the 5/7/26 fall until 5/8/26 at 9:00 AM, approximately eleven (11) hours and fifteen (15) minutes later. A pain level of eight (8) out of ten (10), indicative of severe pain, was documented at that time.The clinical record failed to identify a pain reassessment following the 10:45 PM fall when Resident #1 reported severe pain rated seven (7) out of ten (10).A Medication Administration note by LPN #3 dated 5/8/26 at 9:00 AM identified acetaminophen 650 mg was administered to Resident #1.A pain level of eight (8) out of ten (10), indicating severe pain, was documented at 9:00 AM on 5/8/26.The clinical record failed to identify a pain reevaluation within one (1) hour of the 9:00 AM acetaminophen administration.An SBAR note by (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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RN #3 dated 5/8/26 at 12:18 PM identified intermittent right knee pain, edema, and decreased mobility. Ice and acetaminophen were administered. The STAT xˆray was completed, revealing an acute right patella fracture (a break in the kneecap). APRN #1 assessed Resident #1 and new orders were obtained to transfer Resident #1 to the ED for further evaluation.Review of the clinical record identified a pain level of eight (8) out of ten (10) at 12:47 PM (three (3) hours and fortyˆseven (47) minutes after the 9:00 AM administration) and a pain level of three (3) out of ten (10) at 1:36 PM, both documented by LPN #3. No additional pain relief medication was documented as administered.A Change in Condition note by LPN #3 dated 5/8/26 at 1:36 PM identified Resident #1 complained of right knee pain and had been given acetaminophen at 9:00 AM with fair effect. A mobile xˆray confirmed a right patella fracture, and Resident #1 was transferred to the ED.The Radiology Result Report dated 5/8/26 identified a right knee xˆray obtained at 11:00 AM and reported at 11:18 AM, confirming a midˆtoˆinferior patella pole fracture with distracted fragments.A Provider note by APRN #1 dated 5/8/26 at 2:15 PM identified she evaluated Resident #1 following notification that the xˆray confirmed a right patella fracture. Resident #1's right knee was swollen, and Resident #1 reported ten (10) out of ten (10) pain with movement. Resident #1 was transferred to the ED for further evaluation.Review of the clinical record failed to identify pain medication administration following the confirmed fracture and prior to ED transfer, despite Resident #1 experiencing severe pain.Review of the Prehospital Care Report (ambulance run sheet) dated 5/8/26 identified they were notified of a fall with injury. Upon arrival at 1:47 PM, Resident #1 was lying in bed and staff reported Resident #1 rolled out of bed at approximately 10:30 PM on 5/7/26. Nursing staff identified Resident #1 had an x-ray of the right knee completed at the facility which resulted with a right patella fracture. Resident #1 complained of eight (8) out of ten (10) right knee pain on assessment. Resident #1's right knee was swollen with mild bruising. Nursing staff reported they last medicated Resident #1 with acetaminophen for pain at approximately 8:00 AM on 5/8/26.Hospital documentation dated 5/8/26 identified a pain assessment at 3:30 PM with a pain level of seven (7) out of ten (10).Interview with LPN #1 on 6/3/26 at 11:57 AM identified she thought she administered acetaminophen to Resident #1 around 11:00 PM (fifteen (15) minutes after the fall) on 5/7/26 after Resident #1 was transferred back to bed, but did not document the administration. LPN #1 identified she should have signed the MAR so the oncoming licensed nurse would reˆevaluate Resident #1's pain for effectiveness.Interview with RN #1 on 6/3/26 at 12:16 PM identified she documented in her 5/8/26 SBAR note that acetaminophen was administered following the fall; however, she did not administer or witness its administration. She instructed LPN #1 to administer the medication and identified Resident #1's pain should have been reassessed within one (1) hour.Interview with LPN #3 on 6/3/26 at 2:54 PM identified she administered acetaminophen at 9:00 AM and should have reevaluated Resident #1's pain within one (1) hour but was unable to do so for approximately three (3) hours and seventeen (17) minutes due to a heavy medication pass. When she reevaluated, Resident #1 continued to report right knee pain. She did not administer additional pain relief because Resident #1 was being transported to the ED and she assumed the ED would medicate Resident #1 upon arrival. She identified she should have administered pain relief prior to transport given the severe pain with movement.Interview with RN #2 on 6/3/26 at 3:09 PM identified she could not recall being notified by LPN #1 that acetaminophen was administered at approximately 11:00 PM. She did not complete a pain assessment within one (1) hour and only remembered Resident #1 experiencing pain with movement.Interview with the Director of Nursing (DON) on 6/3/26 at 3:41 PM identified Resident #1 should have been medicated for pain relief immediately following identified severe pain. The acetaminophen should have been signed in the MAR when administered. Once pain relief medication is administered, pain should be reassessed within one (1) hour, and if ineffective, additional pain interventions should be implemented or the provider should be notified. The DON identified that due to the confirmed fracture and severe pain with movement, Resident #1 should have been offered and/or administered pain medication prior to transfer to the ED.Interview with APRN #1 on 6/3/26 at 3:46 PM identified licensed nurses should evaluate pain and (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reassess pain following medication administration per facility policy. If pain interventions are ineffective, nurses should notify the provider. On 5/8/26 she assessed Resident #1 following notification of the fracture, identified severe pain with movement, and directed staff to transfer Resident #1 to the ED. She identified Resident #1 should have been offered and/or administered pain relief prior to ED transfer.Resident #1 was unavailable for interview.The Pain Clinical Protocol policy dated 3/2018 directed staff to assess pain upon admission, at quarterly review, with a significant change in condition, and with onset or worsening of pain. Staff were to identify pain characteristics, use a standardized pain assessment instrument, reassess pain at regular intervals (each shift for acute pain), and evaluate the effectiveness of standing and PRN analgesics. If pain was complex or unresponsive, the Attending Physician may consider additional consultation.The Charting and Documentation policy directed all services provided, progress toward goals, changes in condition, and medications administered be documented in the medical record.A policy on pain medication reevaluation was unavailable.

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a clinical record review, facility documentation, facility policy, and interviews, for one (1) of three (3) residents (Resident #1) reviewed for falls with major injury, the facility failed to ensure a STAT xˆray was obtained in a timely manner by not contacting the diagnostic provider when they failed to arrive within the required four (4) to six (6) hour timeframe. As a result, the xˆray was not performed for approximately eleven (11) hours, and the provider was not notified of the delay, resulting in delayed diagnosis and treatment. The findings include:Resident #1's diagnoses included low back pain, type I diabetes mellitus with diabetic neuropathy, longˆterm use of anticoagulants, absence of the left leg above the knee, and anxiety disorder.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had intact cognition (Brief Interview for Mental Status (BIMS) score of 15), required substantial assistance with bed mobility, and was dependent on staff for toileting hygiene and transfers.The Resident Care Plan (RCP) dated 2/20/26 identified Resident #1 had actual falls and was at risk for falls related to confusion, deconditioning, psychoactive medication use, and a left aboveˆknee amputation. Interventions included anticipating and meeting Resident #1's needs and following the facility fall protocol.A Summary Background Assessment and Recommendation (SBAR) note by RN #1 dated 5/8/26 at 12:37 AM identified NA #1 reported on 5/7/26 at 10:45 PM that Resident #1 rolled out of bed onto the floor mat during repositioning. RN #1 notified the onˆcall provider and received new orders for a STAT right knee xˆray.A Physician's order dated 5/8/26 directed to obtain a STAT right knee xˆray.The clinical record dated 5/8/26 failed to identify documentation that the diagnostic provider was contacted to inquire about the delayed arrival of the technician for the STAT xˆray.A Nurse's note by RN #2 dated 5/8/26 at 5:23 AM identified the right knee xˆray was scheduled for the morning.The Radiology Result Report dated 5/8/26 identified the right knee xˆray was obtained at 11:00 AM (approximately twelve (12) hours and fifteen (15) minutes after the fall) and resulted at 11:17 AM confirming a midˆtoˆinferior patella pole fracture with distracted fragments.An SBAR note by RN #3 dated 5/8/26 at 12:18 PM identified the STAT xˆray had been completed and confirmed an acute right patella fracture. APRN #1 assessed Resident #1 and ordered transfer to the Emergency Department (ED) for further evaluation.Interview with RN #1 on 6/3/26 at 12:16 PM identified she was the nursing supervisor from 7:00 PM on 5/7/26 to 7:00 AM on 5/8/26. She reported calling the STAT xˆray order to the diagnostic provider at approximately 11:00 PM on 5/7/26. Although STAT orders should be completed within four (4) to six (6) hours, she reported overnight delays of eight (8) hours or more were not uncommon. She did not follow up with the diagnostic provider when the technician failed to arrive, and she did not notify the onˆcall provider of the delayed STAT order.Interview with Person #1 (diagnostic provider account representative) on 6/3/26 at 1:45 PM identified the xˆray order was received on 5/7/26 at 11:47 PM. STAT exams should be obtained within four (4) to six (6) hours. The technician arrived on 5/8/26 at 10:29 AM and the exam was resulted at 11:17 AM. Person #1 could not identify whether the facility called to inquire about a delayed arrival.Interview with RN #3 on 6/3/26 at 2:41 PM identified she was the nursing supervisor from 7:00 AM to 3:00 PM on 5/8/26. She was aware the STAT xˆray had not been completed at the start of her shift. When she attempted to call the diagnostic provider at approximately 11:00 AM, the technician had just arrived. RN #3 identified the overnight shift should have contacted the diagnostic provider once the STAT order exceeded six (6) hours.Interview with RN #2 on 6/3/26 at 3:09 PM identified she was the charge nurse on the overnight shift from 5/7/26 into 5/8/26. Despite the diagnostic provider not arriving by 6:00 AM, she did not call to inquire about their arrival, stating it was not uncommon for the technician to arrive after the start of the 7:00 AM to 3:00 PM shift.Interview with the Director of Nursing (DON) on 6/3/26 at 3:41 PM identified the facility had ongoing concerns with the diagnostic provider's response times. Nursing supervisors were (continued on next page)

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	responsible for contacting the diagnostic provider when a STAT order exceeded four (4) to six (6) hours and were expected to notify the provider and request further direction. The DON identified there was no documentation to show the physician was notified of the delay.The diagnostic provider's Standard Service Terms and Conditions policy dated 2026 directed STAT xˆrays were available upon request and that customers could call the provider at any time for an update on any order, including STAT orders.Although requested, a facility policy on STAT diagnostic test timeframes was not available.