STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075063	A. Building B. Wing	10/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avery Nursing Home/Noble Building	705 New Britain Ave Hartford, CT 06106

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 review of the clinical record review, facility documentation, and facility policy, and interviews for one of three residents (Resident #1) reviewed for wandering, the facility failed to ensure adequate supervision for a resident with known wandering behaviors to ensure Resident #1 could not leave the unit without staff knowledge resulting in a fall outside the building (last seen 2 hours prior to observed outside). These failures resulted in a finding of immediate jeopardy. The findings include: Based on review of the clinical record review, facility documentation, and facility policy, and interviews for one of three residents (Resident #1) reviewed for wandering, the facility failed to ensure adequate supervision for a resident with known wandering behaviors to ensure Resident #1 could not leave the unit without staff knowledge resulting in a fall outside the building (last seen 2 hours prior to observed outside). These failures resulted in a finding of immediate jeopardy. The findings include: Resident #1 had a history of dementia, muscle weakness, legally blind, and disorder of bone density. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident # 1 had a Brief Interview for Mental Status (BIMS) score of 0 (was severely cognitively impaired), and was independent with transfers and ambulation. The Resident Care Plan (RCP) dated 9/2/2025 identified Resident #1 was at risk for wandering and/or elopement due to a history of wandering. Interventions directed independent walking, increased staff supervision with intensity, elopement assessment quarterly, place photo of Resident at the reception desk and if exit alarm was activated, staff should take care to be sure that only one (1) resident triggered the exit alarm and return the resident to unit. A facility incident report dated 9/25/2025 at 4:00 AM identified Resident #1 had a fall outside the building, at the end of his/her unit exit door with injury to both elbows, knees and a hematoma (bruise/clotted blood within the tissue) to the right eye. Online search for local news weather report identified a slight chance of rain on 9/25/2025 with temperatures between 63- and 67-degrees Fahrenheit between 3 AM and 7 AM. Nursing note dated 9/25/2025 at 9:15 AM identified that LPN #1/charge nurse notified RN#1/supervisor at 4:00 AM that Resident #1 had fallen outside. Assessment identified Resident #1 was sitting in a chair by the exit door, after a Nurse's Aide (NA) had put him/her in the chair. Resident #1 was alert, confused per baseline and could not say why he/she had gone outside. Abrasions were noted on the bilateral elbows, forearms and knees, and a hematoma was noted on the right upper eyelid. Denied pain and was able to ambulate back to his/her room, was assisted back to bed and the APRN was notified. Plan to have APRN in-house see the resident in the morning. Nursing note dated 9/25/2025 at 11:33 identified Resident #1 complained of pain in the right hip and had a reddened area on the right hip. The APRN was notified, and new orders were obtained for hip x-ray. Nursing note dated 1:24 PM identified Resident #1 was seen by the APRN with new orders to transfer to the hospital. APRN note dated 9/26/2025 at 4:19 PM (late entry for 9/25/2025) identified Resident #1 was evaluated on 9/25/2025 after a fall outside near the building. Resident #1 continued with wandering behaviors related to dementia, had abnormalities of gait and mobility, and was unsteady on his/her feet. Resident #1 denied pain, was jittery, reported feeling tired and cold, and was in bed holding a blanket tight to his/her chest with knees moved towards the abdomen in an apparent fetal position. Multiple red abrasions and bruises were noted on the bilateral elbows, forearms and knees, with no bleeding. A hematoma was noted above the right upper lid including the eyebrow, measured six (6) centimeters (cm) by five (5) cm. Resident #1 complained of right hip pain and was transferred to the hospital for evaluation and head CT scan. Nursing note dated 9/25/2025 at 11:01 PM identified Resident #1 returned to the facility at 9:17 PM with a diagnosis of a urinary tract infection and new orders for antibiotics. Hospital CT scan and x-ray results identified no injuries. Observations during the survey identified Resident #1 resided on a secured unit that required staff to enter a code in a keypad to be able to open any of the doors on the unit. Further, documentation review identified the unit had a census of 46 and had two (2) other residents identified at risk for elopement (included in the facility elopement book). Interview and observations with the ADNS/unit manager on 9/30/2025 at 11:20 AM identified Resident #1 had a history of ambulating independently throughout the unit, into other resident rooms and the snack room. The ADNS further stated Resident #1 would walk back and forth all the time looking for his/her mother/father or to cook dinner. Interview with NA #1 on 9/30/2025 at 9:48 AM identified Resident #1 walked independently with no assistive device, rarely wandered at times during the night shift, and stated when he/she was in bed, he/she was in bed. NA #1 stated if Resident #1 wandered, she would offer toileting or redirect Resident #1 back to bed. NA