

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075060	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2025
NAME OF PROVIDER OR SUPPLIER Civita Care Center at Salmon Brook		STREET ADDRESS, CITY, STATE, ZIP CODE 72 Salmon Brook Drive Glastonbury, CT 06033	
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, interview, and review of clinical documentation and policy for one resident (Resident #1) reviewed for resident rights, the facility failed to allow an alert and oriented resident access to an enclosed courtyard. The findings included: Resident #1 had diagnoses that included spina bifida with hydrocephalus, osteoarthritis, anxiety and major depressive disorder. Review of the RCP dated 7/7/2025 identified Resident #1 meets his/her emotional, intellectual, physical, and social needs by socializing with peers, and going outside when it's nice out, and dining in the Rosewood dining room for lunch. Interventions directed Resident #1 to go outdoors, and on short trips when able. Review of the annual Minimum Data Set assessment (MDS) dated [DATE] identified Resident #1 had a Brief Mental Interview for Mental Status (BIMS) of thirteen (13) indicative of intact cognition and was independent with wheelchair mobility. Review of a facility grievance dated 9/27/2025 identified Resident #1 had a concern that he/she was withheld from access to the outdoor Recreational Courtyard due to a lost facility key. Interview with the Recreation Director on 10/1/2025 at 12:18 PM identified she was aware residents could not use the Recreation Courtyard on Saturday, 9/27/2025 as the door leading to the courtyard was locked and the facility key was lost. The Recreation Director further indicated no other copies of that key existed in the facility on 9/27/2025 and that the key was located on 9/28/2025. Observation and interview with the Administrator and Recreation Director on 10/1/2025 at 12:32 PM identified the Recreation Director was unable to locate the key to unlock the courtyard door, and interview identified the key had been missing for an undetermined length of time prior to 9/27/2025. Further, interview identified that the nursing supervisor did not have a spare key to the door. Surveyor waited while the Recreation Director called another staff member to come to the Recreation Room and search for the key. Observation through the door window identified the courtyard was enclosed on all four (4) sides by the facility. The Administrator stated the door was kept locked to prevent a resident from eloping from the building, and interview identified the courtyard was secured by the facility building on all four (4) sides of the courtyard - there was no access to the grounds surrounding the facility. Another staff member arrived, the key was located, and the door unlocked to allow access to the courtyard. The Administrator stated the facility did not want residents sitting outside the building (due to the risk of elopements) and Resident #1 was prevented from using the courtyard on 8/27/2025. The Administrator was unable to explain why the key was missing previously and stated residents should be able to access the courtyard without the need to ask staff to unlock the door. Although requested, the Administrator indicated the facility did not have a policy regarding courtyard access. Review of the Resident's Rights Policy directed in part, residents have the right to exercise his/her rights as a resident of the facility and as a resident of the United States, and to be supported by the facility in exercising his/her rights.		

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
--	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075060	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2025
NAME OF PROVIDER OR SUPPLIER Civita Care Center at Salmon Brook		STREET ADDRESS, CITY, STATE, ZIP CODE 72 Salmon Brook Drive Glastonbury, CT 06033	
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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, interview, and review of clinical documentation and policy for one resident (Resident #1) reviewed for medication administration, the facility failed to ensure the nurse who prepared a medication was the nurse who administered the medication, in accordance with facility policy. The findings included: Resident #1 had diagnoses that included anxiety and major depressive disorder. Review of the RCP dated 7/7/2025 identified chronic back pain and pain medication therapy. Interventions directed to administer analgesic medications as ordered by the physician. Review of the annual Minimum Data Set assessment (MDS) dated [DATE] identified Resident #1 had a Brief Mental Interview for Mental Status (BIMS) of thirteen (13) indicative of intact cognition, and received pain medication. The MDS further identified Resident #1 as dependent with bathing, toileting, and personal hygiene. A physician's order directed Morphine Sulfate (Concentrate) Solution, 20 milligrams/milliliter, give 10 milligrams by mouth every four (4) hours as needed for pain. Review of Resident #1's Narcotics Log Sheet dated 9/30/2025 at 4:00 AM identified Morphine Sulfate (Concentrate) Solution 10 milligrams (mg) was administered. Interview with LPN #1 on 10/1/2025 at 1:32 PM identified she was working on X-Wing of the facility on the morning of 9/30/2025 and was asked to administer a medication to Resident #1, who resided on a different wing in the facility. LPN #1 stated RN #1 was the nurse assigned to care for Resident #1. RN #1 had prepared the medication (had the medication poured in the medication cup ready to administer), so LPN #1 needed to do was to administer the medication poured/prepared by RN #1 to Resident #1. RN #1 signed the medical record on the Treatment Administration Record (TAR) that the medication was administered. LPN #1 stated it was okay for her to administer medication that was prepared by another nurse. Interview failed to identify why LPN #1 administered the medication that she did not prepare. Interview with RN #1 on 10/3/2025 at 11:37 AM identified although he had poured/prepared the requested dose of Morphine on 9/30/2025 at 4:00 AM for Resident #1, it was LPN #1 that administered the dose of Morphine to the resident. Interview failed to identify why RN #1 did not administer the medication. Interview with the DNS on 10/1/2025 at 3:45 PM identified resident medications were to be prepared and administered by the same nurse. Interview failed to identify why LPN #1 administered the medication that she did not prepare. Review of the Administration of Medications Policies and Procedures dated September 2025 directed medications should always be prepared and administered by the same licensed person.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075060	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2025
NAME OF PROVIDER OR SUPPLIER Civita Care Center at Salmon Brook		STREET ADDRESS, CITY, STATE, ZIP CODE 72 Salmon Brook Drive Glastonbury, CT 06033	
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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. Based on facility documentation review and interviews, the facility failed to provide sufficient laundry services to ensure resident laundry was completed timely due to broken washing machines. The findings included: Review of a grievance dated 8/4/2025 identified Resident #2 was displeased with the amount of time it was taking his/her personal items to be laundered. The grievance identified Resident #2 had sent personal items to be laundered about one (1) week prior, and was still waiting for them to be washed and returned. The grievance further identified a response from the facility administration indicating the facility was were working on buying a new washing machine. Review of Vendor #1 invoice dated 8/14/2025 identified a sixty (60) pound washing machine was purchased and due to the facility on 8/29/2025. Review of Resident Council minutes dated 8/29/2025 and 9/25/2025 identified residents were displeased with the delay in having personal items laundered. Interview with the Environmental Services Director on 10/1/2025 at 9:29 AM identified two (2) of the three (3) washing machines that broke down were irreparable due to replacement parts were not available to fix the washing machines. The Environmental Services Director stated the facility replaced one (1) of broken machines about six (6) weeks ago. The Environmental Services Director further indicated he was unsure as to the reason for the delay in replacing the washing machines as the corporate office, the regional manager, and Administrator were all aware of the issue. Interview with Laundry Technician #1 on 10/1/2025 at 10:38 AM identified the facility utilized three (3) washing machines to launder resident's laundry and linens, however, one (1) of the three (3) washing machines (the large washing machine) broke down over two (2) years ago and the second washing machine broke down about one (1) year ago, leaving staff with only one machine to launder the resident's items, causing a delay in completion of the laundry. Interview with Laundry Technician #2 on 10/1/2025 at 10:45 AM identified the facility had only one (1) functioning washing machine to launder resident's items for approximately six (6) months before adding a second washer. Laundry Technician #2 stated outsourcing the resident's soiled clothing started two months ago at a rate of one time per week. Housekeeping #3 further indicated that the facility did add an additional shift of employees (third shift) to better manage the facility's laundry needs and the facility is still down/short one (1) washing machine and one (1) dryer, causing a continued delay in completing resident laundry. Interview with the Central Supply Manager on 10/1/2025 at 10:50 AM identified Nurse Aides (NAs) would at times have to retrieve clothes from lost and found bins to provide clean clothes for the residents who did not have any clean closed due to the delay in completing the personal laundry. Review of Vendor #1 invoice dated 9/12/2025 identified a quote for an additional sixty (60) pound washing machine to replace the third washing machine. Interview with the Administrator on 10/1/2025 at 9:41 AM identified that he was aware the facility was having laundry issues as two (2) of the three (3) washing machines were not working at one time, and that the facility had only replaced one (1) washing machine as of 10/1/2025 (58 days after the grievance was filed, and 48 days after the invoice dated 8/14/2025).		