STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075060	A. Building B. Wing	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Civita Care Center at Salmon Brook	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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation, facility policies, and interviews, for one (1) of three (3) sampled residents (Resident #1) reviewed for pressure ulcers, the facility failed to ensure appropriate assessment, monitoring, and treatment of existing pressure ulcers. This included failure to complete Braden Scale for Predicting Pressure Sore Risk assessments in accordance with facility policy; failure to complete weekly skin assessments using the Skin Observation Tool; failure to obtain and document weekly pressure ulcer measurements and wound assessments; and failure to ensure an as needed dressing change order was in place to address dressing dislodgement or soiling. The findings include:Resident #1's diagnoses included spinal stenosis of the lumbar region, spina bifida with hydrocephalus, muscle weakness, anxiety disorder, and major depressive disorder.The clinical record identified Resident #1 was transferred to the hospital on [DATE] with an unhealed stage 4 pressure ulcer.The Braden Scale for Predicting Pressure Sore Risk assessment dated [DATE] identified Resident #1 was at moderate risk for pressure ulcer development.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had intact cognition (Brief Interview for Mental Status (BIMS) score of 13), required supervision assistance for bed mobility, substantial assistance for personal hygiene and transfers, utilized a wheelchair for mobility, was always incontinent of bowel and bladder, was at risk for pressure ulcer development, and had one (1) current unhealed stage 4 pressure ulcer.The Resident Care Plan (RCP) dated 1/23/26 identified Resident #1 had potential for pressure ulcer development related to a history of pressure ulcers and immobility, had an actual stage 4 pressure ulcer to the sacrum and left buttocks, and a pressure area to the right buttocks. Interventions directed staff to follow facility policies and protocols for the prevention and treatment of skin breakdown, provide assistance to turn and reposition at least every two (2) hours or more often as needed or requested, administer treatments as ordered, and monitor for effectiveness.A. The clinical record failed to identify a Braden Scale for Predicting Pressure Sore Risk assessment had been completed between 10/10/25 and 4/3/26 (a period of five (5) months and twentyˆfour (24) days).A Braden Scale for Predicting Pressure Sore Risk assessment dated [DATE] identified Resident #1 as at risk for pressure ulcer development.B. A Physician's Order dated 3/30/22 directed licensed nursing staff to complete a weekly skin assessment (Skin Observation Tool assessment) every Wednesday during the 7:00 AM to 3:00 PM shift.A Skin Observation Tool assessment was completed on 2/24/26.The March 2026 Treatment Administration Record (TAR) identified weekly skin assessments were signed as completed on 3/4/26, 3/18/26, and 3/25/26, with 3/11/26 left blank and no refusals documented.The April 2026 TAR identified weekly skin assessments were signed as completed on 4/1/26, 4/8/26, 4/15/26, 4/22/26, and 4/29/26, with no refusals documented.Review of the Skin Observation Tool assessments failed to identify any completed weekly skin assessments between 2/25/26 and 4/12/26. A Skin Observation Tool assessment was opened on 4/13/26 but contained no documentation. A fully completed Skin Observation Tool assessment was not identified until 5/2/26, which was nine and oneˆhalf (9.5) weeks after the last completed assessment on 2/24/26.The May 2026 TAR identified blank administrations on 5/6/26 and 5/13/26, with no refusals documented. Skin Observation Tool (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessments were completed on 5/17/26 and 5/27/26. The clinical record failed to identify a completed weekly skin assessment between 5/1/26 and 5/19/26, and failed to identify a completed assessment on 5/20/26 despite a completed entry on the TAR.C. The clinical record identified Resident #1 had been followed weekly by an outside community wound clinic since 2024 and was not receiving wound care evaluations from the facility wound physician.Wound Care After Visit Summary notes dated 2/26/26, 3/5/26, and 3/12/26 identified Resident #1 had pressure ulcers to the coccyx, left buttocks, and right buttocks but failed to identify wound stage, wound measurements, condition of the skin or tissue, or presence of drainage.Wound Care After Visit Summary notes dated 3/19/26 and 3/26/26 identified wound measurements but failed to identify wound stage, condition of the skin or tissue, or presence of drainage. The 3/26/26 note identified the right buttocks wound had resolved.Wound Care After Visit Summary notes dated 4/2/26, 4/9/26, 4/16/26, 4/23/26, 4/30/26, 5/7/26, 5/14/26, and 5/21/26 failed to identify wound stage, wound measurements, condition of the skin or tissue, or presence of drainage.The clinical record from 2/26/26 through 5/21/26 failed to identify any facilityˆcompleted pressure ulcer assessments, including wound measurements, surrounding skin condition, or documentation required by facility wound protocols.D. A Physician's Order dated 2/5/26 directed to cleanse the open area to the coccyx with warm soap and water, pat dry, apply a thick layer of zinc oxide paste to the area around the wound, apply Iodosorb paste to the wound bed, apply calcium alginate, cover with gauze, secure with a bordered foam dressing, and change the dressing every shift.A Physician's Order dated 3/20/26 directed to cleanse the coccyx wound with warm soap and water, pat dry, apply zinc oxide paste to the surrounding area, apply Iodosorb to the wound bed, apply calcium alginate, secure with a super absorbent dressing, and change every shift.The February, March, and April 2026 TARs failed to identify an as needed dressing change order for Resident #1's coccyx pressure ulcer until 4/16/26.Interview with RN #1 (the wound care nurse) on 5/28/26 at 11:28 AM identified Resident #1 had been evaluated weekly by a community wound clinic due to a history of refusals to be seen by the facility wound provider. RN #1 identified licensed nurses should have assessed and measured the wounds weekly and documented the wound condition and measurements with the weekly skin assessment, but this had not occurred since Resident #1 began visiting the outside wound clinic. RN #1 identified she had been instructed by the previous wound nurse to obtain wound status and measurements from the wound clinic rather than assess the wounds herself. RN #1 identified the wounds should have been assessed and measured weekly and documented in the clinical record. She identified Resident #1 should have received Braden Scale assessments at least quarterly due to existing pressure ulcers. She identified an as needed dressing change order should have been in place since February 2026 and had been overlooked.Interview with Resident #1 on 5/28/26 at 1:30 PM identified Resident #1 was incontinent of bowel and bladder and required frequent dressing changes due to soiling. Resident #1 identified he/she had not refused dressing changes or wound measurements at the facility.Interview with the Director of Nursing (DON) and the Regional Nurse on 5/28/26 at 2:28 PM identified Resident #1 should have received Braden Scale assessments at least quarterly and with any change in condition. They identified that although Resident #1 was seen by a community wound clinic, licensed nursing staff should have continued to assess, measure, and document the wounds weekly. They identified the facility should have obtained its own wound measurements and added wound clinic measurements to the facility wound tracker. They identified Resident #1 should have had an as needed dressing change order to address dressing soiling or dislodgement and were unsure why the order was not in place until 4/16/26.The Braden Scale Assessment policy dated 12/1/25 directed staff to complete Braden Scale assessments upon admission, readmission, quarterly, with significant change in condition, and as clinically indicated. Residents with scores of 18 or below were identified as at risk and required implementation of preventative interventions.The Skin Assessment policy dated 1/23/25 directed residents at risk for skin impairment, wounds, or pressure injuries to receive a comprehensive weekly skin assessment by licensed nursing staff, with findings documented and communicated to the (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interdisciplinary team. Required elements included full^body assessment and wound measurements.The Weekly Wound Measurement and Documentation policy dated 12/14/25 directed that residents with wounds receive weekly wound assessments and measurements, documented with wound stage, exact measurements, wound appearance, treatment regimen, changes from previous assessment, and provider notifications as indicated.The Dry Clean Dressing Changes policy dated 9/1/22 directed licensed nursing staff to verify orders, assess the wound and surrounding skin, complete dressing changes, and document wound appearance and measurements.Although requested, a policy on as needed dressing changes was not obtained.