STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075213	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Civita Care Center at Milford	2028 Bridgeport Ave Milford, CT 06460

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40172 Based on review of the clinical record, facility documentation, facility policy, and interviews for one (1) of three (3) residents (Resident #4) reviewed for ambulation, the facility failed to ensure treatment and services were provided to the resident to maintain ambulation status. The findings include: Resident #4 had diagnoses included diffuse traumatic brain injury, weakness, seizure disorder, and depression. Review of the Physical Therapy Discharge summary dated 6/28/24 identified the Resident #4 was discharged on the functional maintenance ambulation program with the recommendation that nursing ambulate Resident #4 in the hallway and in the facility with the use of a rolling walker and minimal assistance as tolerated. A physician's order dated 7/8/24 directed to provide the assistance of one with transfers and ADLs. The quarterly Minimum Data Set assessment dated [DATE] identified that the resident could ambulate 10 feet with moderate assistance. The annual MDS dated [DATE] identified Resident #4 had severely impaired cognition, was occasionally incontinent of bowel and bladder and required substantial assistance with ADLs and was non-ambulatory. A Physical Therapy discharge summary dated 6/28/24 identified that the resident had reached maximum potential and would be discharged from physical therapy and would be ambulated with nursing as part of the functional maintenance program. The resident was to ambulate with minimal assist in the hallway with a rolling walker. The care plan dated 7/16/24 identified Resident #4 required assistance with mobility and self-care needs related to decreased mobility, required assist of one to transfer, and to complete ADLs with interventions that directed to report any changes in ADL activities to the nurse, encourage increase participation in activities, and PT/OT/Speech evaluation and treatments as ordered. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075213	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2024
NAME OF PROVIDER OR SUPPLIER: Civita Care Center at Milford		STREET ADDRESS, CITY, STATE, ZIP CODE: 2028 Bridgeport Ave Milford, CT 06460	

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #4's ADL flow sheets from 7/26/24 to 8/26/24 under the task 'how did the resident walk in h/her room/corridor/unit' the nurse aide responses were all documented as activity did not occur. The care card dated 8/2/24 identified Resident #4 is to be ambulated as tolerated staff to encourage ambulation during transfers. Interview with Physical Therapist (PT) #1 on 9/9/24 at 1:30 P.M. identified on 6/28/24 Resident #4 was discharged from physical therapy and at the time of discharge Resident #4 was able to ambulate 100 feet with minimal assistance, the use of a rolling walker, and wheelchair to follow. PT #1 identified her discharge recommendations for Resident #4 were for nursing to continue the functional maintenance program, ambulate Resident #4 in the hallway and in the facility with the use of a rolling walker and minimal assistance as tolerated. PT #1 indicated she communicated to the DNS that Resident #4 was discharged and for Resident #4 to continue the functional maintenance (ambulation) program with nursing staff. PT #1 identified she was unable to locate the order dated 6/28/24 in Resident #4's clinical record that directed Resident #4 was on a functional maintenance program. PT #1 identified she is responsible for entering the order into the resident's clinical record indicating the resident is on a Functional Maintenance Program (FMP). PT #1 identified she would have expected to be notified when Resident #4 was not able to ambulate. Interview with the DNS on 9/9/24 at 1:50 P.M. identified on 8/15/24 that the resident was not on the FMP program as PT recommended upon discharge. Resident #4 tested positive for Covid-19 and Resident #4 was weak and not ambulating. The DNS indicated she was giving Resident #4 time to recover from Covid-19 and she had not made PT aware that Resident #4 was no longer able to ambulate. (The FMP program should have began on 6/28/24). Subsequent to surveyor inquiry the DNS completed a therapy referral form dated 9/9/24 that directed therapy to screen and reassess Resident #4's level of function. Review of the facility activities of daily living policy identified residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075213	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2024
NAME OF PROVIDER OR SUPPLIER Civita Care Center at Milford		STREET ADDRESS, CITY, STATE, ZIP CODE 2028 Bridgeport Ave Milford, CT 06460	

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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47826 Based on review of the clinical record, facility documentation, facility policy, and interviews for one (1) of three (3) residents (Resident #5) reviewed for accidents, the facility failed to ensure that a resident identified at risk for elopement did not leave the facility unescorted. The findings include: Resident #5 had diagnoses that included schizoaffective disorder and generalized muscle weakness. The admission MDS dated [DATE] identified Resident #5 had intact cognition, was occasionally incontinent of bowel and bladder and independent with ADLs. Review of the Elopement Risk Evaluation dated 6/28/24 at 2:24 P.M. identified Resident #5 was at risk for elopement. The care plan dated 6/30/24 identified Resident #5 was at risk for elopement as evidenced by wandering unit, goes freely inside the building to activities and to get exercise, and a history of elopement/exit seeking. Interventions directed to educate resident to let staff know when h/she wants to go outside, use distraction techniques, refuses wander guard: staff to monitor, supervise, or check frequently while wandering on unit. A physician's order dated 7/3/24 directed Resident #5 may go out on leave of absence with supervision with daughter only. Review of the Facility's Accident and Incident report dated 9/3/24 identified at 7:25 P.M. Resident #5 was witnessed by Receptionist#1 running out the front doors of facility when EMS was exiting with a resident via stretcher. Receptionist #1 reported that he immediately followed Resident #5 calling out the resident's name to stop, Resident #5 kept running, and Receptionist #1 was unsuccessful in stopping Resident #5. Receptionist #1 paged RN #1 and staff began the search for Resident #5 immediately. Resident #5 was located by the Police at around 8:39 P.M. at Stop & Shop which is half a mile away from the facility was safely back at facility. Resident #4 was transferred to the hospital for further evaluation. The nurse's note dated 9/3/24 at 9:43 P.M. written by RN #1 identified at around 7:10 P.M Resident #5 requested to go down to the lobby. RN #1 indicated she told Resident #5 h/she had to wait for one of the staff members to escort h/she down. RN #1 identified Resident #5 then went back to h/her room. RN #1 identified at approximately 7:25 P.M. Receptionist #1 alerted her to come to the lobby urgently because Resident #5 eloped from the building. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075213	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2024
NAME OF PROVIDER OR SUPPLIER Civita Care Center at Milford		STREET ADDRESS, CITY, STATE, ZIP CODE 2028 Bridgeport Ave Milford, CT 06460	

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 - Minimal harm or potential for actual harm Residents Affected - Few	The nurse's note dated 9/3/24 at 11:12 P.M. written by LPN #1 she identified at 3:00 P.M. Resident #5 was wandering on unit, restless, loud with constant request to 'go outside for fresh air, per Resident #5's usual behavior. LPN #1 identified staff brought Resident #5 outside twice for h/her breaks. LPN #1 indicated she last saw Resident #5 after dinner sitting in the room next to the supervisor's office looking out the window. LPN #1 identified at approximately 7:25 P.M. she was notified by RN #1 that Resident #5 was missing. LPN #1 indicated staff searched inside and outside the facility, but Resident #5 was still missing. LPN #1 identified the police, on call APRN, DNS, Administrator, and Resident #5's conservator was called. LPN #1 identified the police quickly located Resident #5 nearby and Resident #5 was brought back to the facility. Interview with the DNS on 9/6/24 at 11:00 A.M. identified Resident #5 was at risk for elopement, h/she refused to wear a wander guard. The DNS indicated prior to 9/3/24 when Resident #5 exhibited wandering and exit seeking behaviors h/she was able to be redirected with no prior elopements. The DNS identified although Resident #5 was at risk for elopement h/she was able freely move throughout the facility. The DNS identified she would not have expected Receptionist #1 to have done anything different on 9/3/24 when Resident #5 eloped from the facility. Review of facility wandering and elopement policy in part identified the facility will identify residents who are at risk of unsafe wandering and if identified at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety. Interview with Receptionist #1 on 9/6/24 at 11:55 A.M. identified on 9/3/24 at approximately 7:35 P.M. Resident #5 came down to the lobby with Resident #6. Receptionist #1 identified Resident #6 asked to sit outside so he entered the door code to unlock the lobby doors Resident #6 went outside and the doors then locked. Receptionist #identified Resident #5 remained in the lobby. Receptionist #1 indicated he was aware Resident #5 was at risk for elopement and Resident #5 remained in the lobby. Receptionist #1 identified a few minutes later EMS came to the locked front doors with a resident on a stretcher. Receptionist #1 indicated he directed Resident #5 to step back 10 feet from the doors so he could unlock the doors for EMS. Receptionist #1 indicated Resident #5 stepped back 10 feet, he entered the code to unlock the doors and as he opened the doors Resident #5 ran out of the facility. Receptionist #1 identified he ran after Resident #5 yelling h/her name telling Resident #5 to stop, but he could not catch up to Resident #5 and lost sight of Resident #5. Receptionist #1 identified he returned to the facility and notified RN #1 that Resident #5 eloped from the facility Dr. Wander code was called, staff searched in and outside of the facility and still unable to locate Resident #5. Receptionist #1 identified the police were called and located Resident #5 at a nearby store and Resident #5 returned to the facility at approximately 8:39 P.M. on 9/3/24. Review of facility wandering and elopement policy in part identified the facility will identify residents who are at risk of unsafe wandering and if identified at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety. ----------------- (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075213	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2024
NAME OF PROVIDER OR SUPPLIER Civita Care Center at Milford		STREET ADDRESS, CITY, STATE, ZIP CODE 2028 Bridgeport Ave Milford, CT 06460	

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 - Minimal harm or potential for actual harm Residents Affected - Few	Based on clinical record reviews, facility documentation, facility policies and interviews for one (1) of three (3) sampled residents (Resident #3) who was dependent on staff with getting in and out of the bed and chair and who had sustained a minor head injury, the facility failed to ensure the safety of Resident #3 during a Hoyer lift transfer from the bed to the chair. The findings include: Resident #3's diagnoses included anoxic brain disorder, seizures, and dysphagia. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #3 rarely or never made decisions regarding tasks of daily living, required extensive assistance of one (1) for dressing and hygiene and extensive two (2) person assistance, utilizing a Hoyer lift with getting in and out of the bed and chair, and was wheelchair bound. The Resident Care Plan dated 3/19/18 identified Resident #3 was at risk of falls. Interventions directed to keep the call bell in reach, call for assistance for transfers, physical and occupational therapy as ordered, and fall risk assessment per facility protocol. The nurse's note dated 4/28/18 at 5:19 PM identified the charge nurse reported at 1:50 PM Resident #3 fell off the Hoyer lift while being transferred from the chair to the bed. The note indicated Resident #3 was assessed, there was redness noted to the back, Resident #3 denied pain, there was no change in mental status, vital signs were stable, and Resident #3 was transferred to the hospital for further evaluation. The nurse's note dated 4/28/18 at 9:53 PM identified Resident #3 returned from the hospital. The hospital discharge paperwork dated 4/28/18 identified Resident #3 was evaluated at the hospital after the fall from the lift. The discharge diagnosis was a minor head injury without loss of consciousness. A CT scan was done and was negative for intracranial bleeding, there was no change in behavior from his/her baseline mental or neurological evaluation and was discharged back to the facility. Orders directed to follow up with the Primary Care Physician, conduct neuro checks as recommended, administer Tylenol as needed for pain, apply an ice pack as needed for pain and return to the nearest Emergency Department if symptomatic. The Nursing Assessment of Incident note dated 4/28/18 identified Resident #3 fell off the Hoyer lift while being transferred from the bed to the chair, staff reported one (1) of the strap pads slipped off causing Resident #3 to slide off the Hoyer lift feet first. The reportable event summary dated 4/28/18 identified the cause of the fall was operator error and the loops on the Hoyer hooks would not have come undone if they had been properly attached. In a written statement dated 4/28/18 the 7AM-3PM nurse aide, Nurse Aide (NA) #1, identified while assisting another nurse aide, Nurse aide (NA) #2, transfer Resident #3 from the bed to the chair one (1) of the straps came loose from the Hoyer lift and Resident #3 fell to the floor. In a written statement dated 4/28/18 NA #2, identified while assisting NA #1 transfer Resident #3 from the bed to the chair, after hooking up the Hoyer pad as they began to lift Resident #3 off the bed, she noticed one (1) of the straps came off of the Hoyer lift causing Resident #3 to fall. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075213	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2024
NAME OF PROVIDER OR SUPPLIER Civita Care Center at Milford		STREET ADDRESS, CITY, STATE, ZIP CODE 2028 Bridgeport Ave Milford, CT 06460	

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 - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy Mechanical Lift Use identified at least two (2) nurses' aides and/or nurses are needed to safely move a resident with a mechanical lift. The policy further identified to make sure all necessary equipment (slings, hooks, chains, straps, and supports) are on hand and in good condition. Transfer steps directed to attach sling straps to the sling bar; make sure sling is securely attached to the clips and that it is properly balanced; before the resident is lifted, double check the security of the sling attachment; examine all hooks, clips or fasteners; check the stability of the straps; and ensure the sling bar is securely attached and sound.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075213	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Civita Care Center at Milford	2028 Bridgeport Ave Milford, CT 06460

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47826 Based on clinical record reviews, facility documentation, facility policies and interviews for one (1) of three (3) sampled residents (Resident #3) who had a stage four (4) pressure ulcer to the coccyx, the facility failed to maintain a complete and accurate clinical record that demonstrated the wound was assessed weekly and wound care was done per the physician's orders. The findings include: Resident #3's diagnoses included Stage 4 pressure ulcer to the coccyx, anoxic brain disorder, and seizures. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #3 rarely or never made decisions regarding tasks of daily living, required extensive assistance with activities of daily living, had a Stage 4 pressure ulcer measuring 3.8 centimeter (cm) by 2.3 cm by 0 cm depth and the ulcer was covered with eschar. The physician's progress note dated 11/30/18 identified Resident #3 was seen due to a low-grade temperature and orders directed to start the urinary tract infection protocol, lab work, and a chest x-ray for diminished lung sounds. The nurse's note dated 12/2/18 at 11:36 PM identified Resident #3 was sent to the hospital for evaluation due to a temperature of 101.3 degrees and although the Advanced Practice Registered Nurse (APRN) was notified and directed blood work for the following day, Resident #3's family member requested Resident #3 be sent to the hospital. The nurse's note dated 12/13/18 at 2:46 PM identified Resident #3 returned from the hospital, Resident #3 continued with a Stage 4 pressure ulcer to the coccyx which measured 3 cm x 2 cm by 2.5 cm, a wet to dry dressing was in place and Resident #3 received Amoxicillin (an antibiotic) for right thigh cellulitis. The following documents were requested from the facility, however the facility was unable to locate the records: The Resident Care Plan which was in effect prior to 12/2/18, the Resident Care Conference Note from the Care Plan meeting prior to 12/2/18, the physician orders effective as of 12/2/18, Social Work documentation for 12/18, wound risk assessment prior to 12/2/18, weekly skin and wound documentation for November and December 2018, physician skin and wound documentation for November and December 2018, and hospital records from the 12/2/18 hospital admission. Email correspondence dated 9/11/24 with the Director of Nursing identified the facility was unable to locate the above listed records and the facility provided the only records they could locate. Review of the facility policy for Retention of Medical Records identified the facility shall retain medical records in accordance with current applicable laws.