

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 11/04/2024
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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50094</p> <p>Based on clinical record review, facility documentation review, and staff interviews for two of four residents reviewed for abuse (Resident #1, and #3), the facility failed to ensure the residents were free from abuse. The findings include:</p> <p>1. Resident #1 had a diagnoses that included metabolic encephalopathy and history of alcohol use. The nursing admission assessment dated [DATE] identified Resident #1 was alert and oriented to person and had limited mobility. The RCP dated 9/23/2024 identified to acclimate to the unit. Interventions directed to report any changes to the provider and encourage the resident to become involved with activities.</p> <p>Resident #2 had a diagnosis of dementia without behavioral disturbance and metabolic encephalopathy. The quarterly Minimum Data Set (MDS) dated [DATE] identified Resident #2 had a Brief Interview for Mental Status (BIMS) score of three (3) indicative of severely impaired cognition and independent with bed mobility. The Resident Care Plan (RCP) dated 7/4/2024 identified Resident #2 had dementia with use of psychotropic drug use. Interventions directed to monitor behaviors and update physician as indicated.</p> <p>Record review identified Residents #1 and #2 were roommates.</p> <p>Review of the facility incident report dated 10/4/2024 at 9 AM identified after Resident #1 blew his/her nose, Resident #2 approached from behind and placed his/her hands around Resident #1's neck with pressure applied. Resident #1 stated he/she could not understand what Resident #2 was saying when the incident occurred. The residents were separated, and Resident #2 was placed on one to one (1:1) observation. Both residents were assessed, Resident #1 had slight redness on the right side of his/her neck, and no other injury noted and both residents were transferred to the hospital for evaluation.</p> <p>Nursing note dated 10/4/24 at 1:05 PM identified Resident #1 returned from the hospital with no new orders. Hospital transfer note dated 10/4/2024 identified Resident #1 was discharged from the hospital with no sign of damage to the underlying neurovascular structures and no imaging was indicated.</p> <p>Nursing note 10/4/2024 at 5 PM the hospital indicated Resident #2 was admitted to the psychiatric unit for monitoring. Nursing note dated 10/11/2024 at 5:53 PM identified Resident #2 was readmitted to the facility with no new orders.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Facility summary dated 10/8/2024 identified on 10/4/2024 Resident #2 unexpectedly approached Resident #1 from behind and placed his/her hands around Resident #1's neck and applied pressure. Resident #1 was assessed to have a slight redness on the right side of the neck and discomfort as a level five (5) on a scale of one (1) to ten (10). Resident #1 was placed on 1:1 monitoring until he/she was transferred to the hospital and was unable to state what his/her intention was when he/she placed hands on Resident #1's neck. APRN ordered a neck x-ray for Resident #1, and the resident refused stating he/she wanted to be transferred to the hospital. Both residents were transferred to the hospital; Resident #1 returned on 10/4/2024 with no injury and was seen by psychiatry at 12:30 PM with no issues identified. Resident #2 was readmitted to a different unit on 10/11/2024.</p> <p>Interview with LPN #1 on 10/25/2024 at 12:20 PM identified Residents #1 and #2 were roommates when Resident #1 reported Resident #2 attempted to strangle him/her. When she walked in the room Resident #2 was by the sink using foul language about Resident #1. The Supervisor was notified, and Resident #2 was placed on a 1:1 until he/she was transferred to the hospital.</p> <p>Interview and record review with the RN #1 on 10/25/2024 at 12:35 PM identified Resident #1 had come out of his/her room and stated that Resident #2 had put his/her hands on Resident #1's neck. RN #1 assessed both residents. No injury was identified for Resident #2, and Resident #1 was noted to have redness on the right side of his/her neck, and both residents were transferred to the hospital for evaluation. RN #1 placed Resident #2 on 1:1 observation until transferred to the hospital.</p> <p>Interview with the DNS on 10/25/2024 at 1 PM identified after the incident on 10/4/2024 between Residents #1 and 2, Resident #2 was placed on 1:1 observation until transferred to the hospital. further Resident #1 was noted to have a slight pinkness on his/her neck. The DNS stated although staff did not witness the incident, the facility substantiated the allegation of abuse based on Resident #1's statement (alert and oriented) and the red marks on the neck.</p> <p>Interview with the DNS on 10/25/2024 at 2:35 PM identified although staff did not witness the incident, the facility substantiated the allegation of abuse based on Resident #1's story of the incident, resident was alert and oriented (BIMS 13), and the resident had red marks on his/her neck.</p> <p>During an interview with the DNS on 10/25/2024 at 2:45 PM the DNS stated she did not substantiate the allegation of abuse because staff did not witness the incident.</p> <p>2. Resident #3 had a diagnosis of vascular dementia, cognitive communication deficit, and anxiety. The annual MDS dated [DATE] identified Resident #3 had a Brief Interview for Mental Status (BIMS) score of one (1) indicating severe cognitive impairment and was independent for mobility. The RCP dated 8/15/2024 identified Resident #3 had a potential for alteration in mood or behaviors. Interventions directed to give step by step directions and to redirect as appropriate.</p> <p>Resident #4 had a diagnosis of dementia, without behavioral disturbance, mood disturbance, psychotic disturbance, and anxiety. The nursing admission assessment dated [DATE] identified Resident #4 was alert and disoriented to time, place, and situation indicating impaired memory. The Resident Care Plan (RCP) dated 10/1/2024 identified Resident #4 had dementia, agitation and was restless. Interventions directed to avoid over stimulation/environment stimulation, psychiatry consult to review impulsive behaviors and medications, and redirect if becomes combative.</p> <p>Record reviews identified Resident #3 and #4 were roommates.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility incident report dated 10/5/2024 at 3 AM identified the nursing supervisor responded to noise in the resident's room and observed Resident #3 and Resident #4 holding hands, and the residents were separated. Resident #3 reported Resident #4 came over to his/her bed and tried to remove his/her pillow. When Resident #3 tried to stop him/her, Resident #4 punched Resident #3 in the face three (3) times. Resident #4 was placed on one to one (1:1) monitoring until transferred to the hospital for evaluation. RN assessments were completed for both residents with no injuries noted. Resident #4 was unable to recall the events due to impaired cognition.</p> <p>Hospital provider note dated 10/5/2024 at 4:08 PM identified Resident #4 was admitted on Physicians Emergency Certificate (PEC) for psychiatric stabilization and medication management.</p> <p>Interview with LPN #2 on 10/28/2024 at 11:44 AM identified prior to the incident on 10/5/2024, Resident #4 was sleeping and had no aggressive or combative behaviors prior to the 3 AM incident.</p> <p>Interview with RN #2 on 10/28/2024 at 12:15 PM identified she was the supervisor on 10/5/2024 at about 3 AM she responded to Resident #3 and #4's room when she heard noise. RN #2 observed Resident #4 at the head of Resident #3's bed, and they were holding each other's hands; Resident #3 was trying to defend him/herself and push Resident #4 away. Resident #3 stated Resident #4 tried to take his/her pillow and then hit him/her in the face three (3) times. RN #2 separated the residents and placed Resident #4 on 1:1 monitoring. Both residents were assessed with no injuries noted and Resident #4 was transferred to the hospital.</p> <p>Interview with the DNS on 10/28/2024 at 1:10 PM identified Residents #3 and #4 were roommates with no issues prior to the incident on 10/5/2024. The DNS stated neither resident had any injury, and the investigation was unable to identify the cause of the incident.</p> <p>Record review identified Resident #4 was not readmitted to the facility at the time of the survey.</p> <p>Review of the undated facility Resident Rights Policy directed in part, residents have the right to be free from abuse, neglect, misappropriation of property, and exploitation.</p>		

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<p>F 0805</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.</p> <p>41223</p> <p>Based on clinical record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #5) reviewed for dining, the facility failed to ensure staff provided the correct diet texture and failed to ensure staff knew or verified what the diet orders were, resulting in a choking episode. The failures resulted in a finding of Immediate Jeopardy.</p> <p>Resident #5 was admitted with diagnoses that included dysphagia (difficulty swallowing), dementia and end stage renal disease. The nursing admission note dated 10/4/2024 at 9:26 PM identified Resident #5 was oriented to person. The Resident Care Plan (RCP) dated 10/4/2024 identified a potential for alteration in kidney function due to dialysis and nutritional status. The RCP directed treatments as ordered and diet as ordered.</p> <p>A physician order dated 10/4/2024 directed carbohydrate-controlled diet (CCD), renal, dysphagia advanced diet.</p> <p>An APRN admission note dated 10/5/2024 at 10:30 PM identified Resident #5 was alert, confused and disoriented.</p> <p>A speech therapy note dated 10/5/2024 identified Resident #5 had severe cognitive impairment. Speech evaluation dated 10/5/2024 identified Resident #5 held food in his/her mouth and cheeks after meals and had clinical signs of dysphagia - oral phase (excessive chewing time and leaving residue on the tongue base). Resident #5 left residue on his/her palate and tongue with clearance attempts when trialing the ordered diet. Recommendations were for dysphagia, soft diet with thin liquids, alternate liquids with solids, and medications to be crushed in puree.</p> <p>A speech therapy note dated 10/8/2024 identified Resident #5 fed him/herself without cueing.</p> <p>A facility incident report dated 10/9/2024 at 4:50 PM identified a choking episode resulting in a resuscitation event. Resident #5 requested a sandwich after return from dialysis, and NA #1 provided a ham and cheese sandwich. NA #1 was present when Resident #5 had difficulty swallowing and could not expel the food. NA #1 called LPN #3 and LPN #3 immediately performed an abdominal thrust. A small piece of ham was expelled after one thrust and Resident #5 reported feeling better.</p> <p>Observations during survey identified postings in the unit nourishment rooms that included diet types and foods that were/were not allowed on the specific diet types.</p> <p>Interview with dietician on 11/4/2024 at 11:20 AM identified diets are posted on all the units in the nourishment room. The postings include what is allowed on diet types, including Dysphagia Advanced diet.</p> <p>(continued on next page)</p>		

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<p>F 0805</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Interview and record review with the Director of Rehabilitation and Speech therapist (SL#1) on 11/04/2024 at 12:00 PM identified that a dysphagia advanced diet allows ground meats with additional sauce, and allows soft breads softened with syrup or sauce (the sauce increases moisture and enhanced cohesiveness of the food for swallowing). SL #1 stated the ham and the bread on the sandwich were not an allowable food on Resident #5's ordered diet, and there was no moisture added to the sandwich; no mayonnaise or mustard was on the bread. Interview further identified that the foods allowed on the dysphagia diet were posted on the refrigerators in the unit nourishment rooms.</p> <p>Interview with NA # 1 on 11/4/2024 at 12:10 PM identified she was not Resident #5's aide, but after the resident returned from dialysis about 4:30 PM on 10/9/2024, Resident #5 told her that he/she was hungry and wanted a sandwich. NA #1 took a ham sandwich from the unit refrigerator, showed it to LPN #3 and asked if she could give it to Resident #5. LPN #3 told her it was ok to provide the sandwich to Resident #5. NA #1 stated she always checked with the nurse prior to giving food to any resident to ensure it was the correct diet, and for Resident #5 she did not know what the diet order was because she was not the NA assigned to the resident. NA #1 gave the sandwich to Resident #5 in his/her room. Resident #5 quickly took the sandwich from her and took a big bite while she was in the room, and he/she began to cough. NA #1 asked the resident if he/she was ok, but Resident #5 could not talk. NA #1 called to LPN #3 who immediately came to the room, went behind Resident #5 who was sitting on the edge of the bed and provided an abdominal thrust. After one thrust, a piece of ham was expelled, and Resident #5 began to cough again.</p> <p>Interview with LPN #3 on 11/4/2024 at 12:56 PM identified that on 10/9/2024 she was the charge nurse assigned Resident #5 on the 3 to 11 PM shift. LPN #3 stated about 4:30 PM NA #1 asked if she could give Resident #5 a sandwich. LPN #3 stated the sandwich was wrapped in cellophane and she did not ask what kind of sandwich it was. LPN #3 stated she did not check Resident #5's diet orders to verify the sandwich was allowed on the diet prior to responding to NA#1 that she could provide the sandwich to Resident #5. A few minutes later NA #1 called her to Resident #5's room because he/she was choking. When she entered the room, Resident #5 was not coughing and looked distressed. She asked Resident #5 if he/she was ok and when he/she could not respond, she provided an abdominal thrust. Resident #5 expelled a small piece of ham and began to cough reporting he/she felt better. LPN #3 stated she should have checked the diet order before approving the sandwich, and she did not know why she did not.</p> <p>Interview with the DON on 11/4/2025 at 2:19 PM identified the nursing staff should always verify a resident's ordered diet, if any staff member asked if they could provide a resident any food. The DON stated NA #1 did the right thing to check with LPN #3 to verify the sandwich was allowed on the diet, and LPN #3 did not check Resident #5's diet orders prior to telling NA #1 it was ok to give the resident the sandwich, and she did not know why. The DON stated she spoke with LPN #3 on 10/9/2024 after the incident occurred, and LPN #3 knew she should have verified the diet orders prior to approving the sandwich.</p> <p>The facility guidelines for Dysphagia Advanced Diet directed in part, that this diet offers more advanced texture and consists of ground meats, soft fruits and vegetables and soft bread products. The Dysphagia Advanced Diet further directed that breads and cured meats are not allowed, and the diet allowed bread softened with syrup or sauce, and ground meats.</p> <p>(continued on next page)</p>		

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<p>F 0805</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Facility documentation review identified staff education was initiated on 10/9/2024 regarding verifying resident diets prior to providing food. Audits were initiated on 10/10/2024, and a QAPI meeting was held on 10/10/2024. Based on review of facility documentation, past non-compliance was identified on 10/10/2024.</p>		