

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 02/26/2025
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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50059</p> <p>Based on clinical record reviews, facility documentation, facility policy and interviews for one (1) of three (3) sampled residents (Resident #1) who were reviewed for the misappropriation of personal property, the facility failed to ensure the resident's controlled medication was not removed from the facility. The findings include:</p> <p>Resident #1's diagnoses included chronic pain, dementia, and diabetes mellitus.</p> <p>A physician's order dated 1/1/25 directed to administer Pregabalin, a medication to treat nerve and muscle pain, 100 milligram (mg) capsule three (3) times a day at 9:00 AM, 2:00 PM, and 9:00 PM.</p> <p>The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 had no memory recall deficits and received scheduled and as needed pain medications for frequent pain that rated six (6) on the scale of one (1) to ten (10).</p> <p>The nurse's note dated 1/15/25 identified Resident #1 was notified of a misappropriation of property event in regard to Resident #1's medication, Pregabalin. The note indicated there would be no interruption of administering the Pregabalin as it will be dispensed from the emergency box. The note identified Resident #1 was in good spirits with no complaint of discomfort.</p> <p>The Facility Reported Incident form dated 1/15/25 at 11:15 AM identified three (3) capsules of Lyrica (Pregabalin) were noted to be missing from the medication cart during the shift to shift count of the controlled medications.</p> <p>The summary report dated 1/20/25 identified on 1/15/25 the 7AM-3PM charge nurse found during the shift to shift count of the controlled medications, the controlled drug proof of use disposition form for the Pregabalin was in the narcotic book but the blister pack was missing with the three (3) capsules that should have been left when last signed out on 1/14/25 at 8:00 PM. The summary identified a Drug Enforcement Agent (DEA) was on site 1/16/25 and was unable to determine the whereabouts of the missing Pregabalin blister pack.</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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 2/26/25 at 11:35 AM the Director of Nursing (DON) identified a blister pack that contained three (3) capsules of the controlled medication Pregabalin for Resident #1 was found to be missing on 1/15/25 at 8:00 AM by the 7AM-3PM charge nurse, Licensed Practical Nurse (LPN) #4. The DON stated although the medication disposition sheet was accounted for in the narcotic book, the blister pack was missing. The DON stated she conducted an extensive search of the medication carts and building and was unable to locate the missing blister pack. The DON identified Resident #1 did not miss any doses, the medication was taken out of the emergency medication box.</p> <p>Interview with the Infection Control nurse on 2/26/25 at 11:50 AM identified she worked the evening shift on 1/14/25, administered the evening dose of Pregabalin at about 8:00 PM, and there were three (3) capsules left in the blister pack for the 1/15/25 morning dose.</p> <p>Review of the Abuse, Neglect and Exploitation Policy identified Misappropriation means the deliberate misplacement, exploitation, or wrongful, temporary or permanent, use of a resident's belongings or money without the resident's consent.</p> <p>Review of facility documentation identified that a Plan of Correction was initiated immediately:</p> <p>Staff training in the Controlled Substance/Count and the Protocol when there are Discrepancies during narcotic count.</p> <p>Audit will be conducted twice a week until substantial compliance is met.</p> <p>Audits to be reviewed at the monthly QAPI meetings.</p> <p>The Director of Nursing is responsible for the plan.</p> <p>Compliance as of 1/21/25.</p> <p>The plan of correction was reviewed on 2/26/25 and the facility met all components for past non-compliance.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>50059</p> <p>Based on clinical record reviews, review of facility documentation and interviews for one (1) of three (3) sampled residents (Resident #1) who were reviewed for the misappropriation of personal property, the facility failed to ensure shift to shift count of the controlled medications was conducted by two (2) licensed nurses. The findings include:</p> <p>Resident #1's diagnoses included chronic pain, dementia, and diabetes mellitus.</p> <p>A physician's order dated 1/1/25 directed to administer Pregabalin, a medication to treat nerve and muscle pain, 100 milligram (mg) capsule three (3) times a day at 9:00 AM, 2:00 PM, and 9:00 PM.</p> <p>The nurse's note dated 1/15/25 identified Resident #1 was notified of a misappropriation of property event in regard to Resident #1's medication, Pregabalin. The note indicated there would be no interruption of administering the Pregabalin as it will be dispensed from the emergency box. The note identified Resident #1 was in good spirits with no complaint of discomfort.</p> <p>The Facility Reported Incident form dated 1/15/25 at 11:15AM identified a blister pack containing 3 capsules of Lyrica (Pregabalin) missing from the med cart. The summary report dated 1/20/25 identified the 7:00AM-3:00PM charge nurse found the narcotic disposition sheet identifying 3 tablets left on the disposition sheet, but the blister pack containing the capsules was missing.</p> <p>The Facility Reported Incident form dated 1/15/25 at 11:15 AM identified three (3) capsules of Lyrica (Pregabalin) were noted to be missing from the medication cart during the shift to shift count of the controlled medications.</p> <p>The summary report dated 1/20/25 identified on 1/15/25 the 7AM-3PM charge nurse found during the shift to shift count of the controlled medications, the controlled drug proof of use disposition form for the Pregabalin was in the narcotic book but the blister pack was missing with the three (3) capsules that should have been left when last signed out on 1/14/25 at 8:00 PM. The summary identified a Drug Enforcement Agent (DEA) was on site 1/16/25 and was unable to determine the whereabouts of the missing Pregabalin blister pack. The summary identified although the controlled shift to shift narcotic sheet was signed, it was discovered during the interviews conducted with the licensed staff, that on the evening of 1/14/25, the 3-11PM and the 11PM-7AM shift charge nurses had not followed the facility policy on shift-to-shift count of controlled substances.</p> <p>In an interview on 2/26/25 at 11:35 AM the Director of Nursing (DON) identified a blister pack that contained three (3) capsules of the controlled medication Pregabalin for Resident #1 was found to be missing in the first floor Long Side medication cart on 1/15/25 at 8:00 AM by the 7AM-3PM charge nurse, Licensed Practical Nurse (LPN) #4. The DON stated although the shift-to-shift narcotic sheet was signed off, the facility policy had not been followed when one charge nurse left early and another was late.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with the 3-11PM charge nurse, LPN #2, on 2/26/25 at 11:50 AM identified on 1/14/25 she had to leave and at 11:00 PM she did count for the Long Side med cart with the 3-11PM charge nurse, LPN #3 before the 11PM-7AM, LPN #1, arrived. LPN #2 stated she must have forgotten to sign the change of shift narcotic sheet, and another nurse must have signed it.</p> <p>Interview on 2/26/25 at 12:08 PM with LPN #1 identified when she arrived to work on 1/14/25 at 11:15 PM she counted the meds for the Short Side med cart with LPN # 3, but did not count the meds on the Long Side med cart as LPN #3 said she counted the Long Side med cart with LPN #2 before LPN #2 left the unit. LPN #1 stated on 1/15/25 at 7:00 AM she counted the Short Side cart meds with LPN #4. LPN#1 stated because the oncoming 7AM-3PM nurse was late, she counted the Long Side med cart herself, signed the shift-to-shift count sheet, put the keys in the book behind the desk and left.</p> <p>Although attempted an interview with LPN #4 was unsuccessful.</p> <p>Review of the Controlled Substance/Count Policy dated August 2019 identified Licensed Nurses are to count controlled medications at the end of each shift. The nurse coming on duty and the nurse going off duty count together.</p> <p>Review of facility documentation identified that a Plan of Correction was initiated immediately:</p> <p>Staff training in the Controlled Substance/Count and the Protocol when there are Discrepancies during narcotic count.</p> <p>Audit will be conducted twice a week until substantial compliance is met.</p> <p>Audits to be reviewed at the monthly QAPI meetings.</p> <p>The Administrator and Director of Nursing are responsible for the plan.</p> <p>Compliance as of 1/21/25.</p> <p>The plan of correction was reviewed on 2/26/25 and the facility met all components for past non-compliance.</p>		