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	05/28/2025

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 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** Based on clinical record reviews, facility documentation, facility policy and interviews for one (1) of three (3) sampled residents (Resident #1) who had a history of elopement, refused to wear a wander guard bracelet, and wandered throughout the facility, the facility failed to ensure the resident did not leave the facility unsupervised. The findings include: Resident #1's diagnoses included vascular dementia, chronic paranoid delusions, bipolar disorder, psychosis, and a history of smoking. The Elopement Risk report dated 11/4/24 identified Resident #1 had wandering and exit-seeking behaviors, was independent with ambulating, and was assessed to be an elopement risk. The report indicated Resident #1 refused to wear a wander guard and an intervention included adding a photo identification of Resident #1 to the elopement book at the reception desk. The quarterly Minimum Data Set, dated [DATE] identified that Resident #1 was oriented to person, time and place, required assistance with decision making, and was independent with activities of daily living. A physicians' order dated 5/1/25 identified Resident #1 was allowed to go on a leave of absence with a specific family member only per permission of the Conservator. The Resident Care Plan dated 5/6/25 identified Resident #1 had a history of elopement, refused to wear a wander guard bracelet, and wandered throughout the unit. Interventions directed to provide diversional activities, quarterly elopement assessments, and staff supervision of the resident frequently. The nurse's progress note dated 5/19/25 at 8:07 AM identified Resident #1 had an unsupervised leave of absence from the facility, upon return to the facility was placed on one to one (1:1) observation, and all proper notifications were made. The Facility Reported Incident form dated 5/19/25 identified at approximately 7:03 AM a staff member found Resident #1 across the street at the gas station sitting on a bench smoking a cigar. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The summary report dated 5/23/25 identified on 5/19/25 Resident #1 exited the facility through the front door entrance of the facility around 6:51 AM when a staff member was entering the building to start their work shift. The summary identified Resident #1 was last seen at approximately 6:45 AM having a cup of tea in the small second floor lounge. The summary indicated Resident #1 had no injuries, distress, pain or discomfort. Interview with a 7AM-3PM charge nurse, Licensed Practical Nurse (LPN) #1, on 5/27/25 at 11:25 AM identified on 5/19/25, on her way to work, she saw Resident #1 sitting on a bench smoking a cigar. LPN #1 stated she stopped and attempted to give Resident #1 a ride back to the facility, but Resident #1 refused. LPN #1 identified she did not have a cell phone with her, so she left Resident #1 sitting on the bench, went to the facility, reported Resident #1 had eloped, and two (2) staff members used the company van to transport Resident #1 back to the facility. Interview with the Director of Nursing (DON) on 5/27/25 at 12:20 PM identified that the housekeeper did not report to anyone she had observed Resident #1 exit the building when she entered the main entrance. The DON indicated she pulled the housekeeper's timecard and noted the housekeeper punched in at 6:51 AM. Interview with Resident #1 on 5/28/25 at 10:20 AM identified his/her feet hurt from neuropathy, and walking helps relieve the discomfort. Resident #1 stated he/she exited the building, walked to the gas station, bought a cigar, walked to a facility known as the Bridges, sat on a bench, and smoked the cigar. Resident #1 stated he/she intended to return to the facility and did not understand why he/she could not go for a walk alone. Interview with the Administrator on 5/28/25 at 12:45 PM identified the expectation is that anytime a resident exits the facility unsupervised, it was to be reported immediately, and staff should follow the resident until the resident is escorted back into the facility. The Administrator explained that elopement education is completed as part of orientation and annual education and he could not identify why the housekeeper did not immediately report Resident #1 leaving the facility. Interview with the housekeeper on 5/28/25 at 1:00 PM identified when she entered the building at 6:51 AM Resident #1 walked by her and exited the building. The housekeeper stated she received an emergency phone call that lasted 15-20 minutes and did not report to anyone that Resident #1 had left the building. The housekeeper explained when she arrived on her unit, which is the same unit Resident #1 resides on, Resident #1 was there. The housekeeper indicated the Administrator asked if anyone had seen Resident #1 exit the building, she told the Administrator she had when she entered the building, but did not know Resident #1 had left the premises. The housekeeper stated she should have immediately reported Resident #1 exiting the building and followed Resident #1 until redirected back into the facility. Review of the Elopement Policy dated 5/12/23 identified that Elopement occurs when a patient wanders, walks, runs away, escapes, or otherwise leaves the facility unnoticed and unsupervised and/or prior to a scheduled discharge. The facility identified the deficient practice and developed an immediate plan of correction for past noncompliance as of May 21, 2025. Resident #1 is on a constant 1:1 observation. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility has completed in-service and education on all residents identified as elopement risks, whether or not a wander guard is in place. House-wide audits are conducted of the residents at risk for elopement. QAPI meetings to be held monthly to review findings.