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	08/19/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation review, facility policy review, and interviews for one resident (Resident #2) reviewed for abuse, the facility failed to ensure the resident was free from verbal mistreatment. The findings include:Based on clinical record review, facility documentation review, facility policy review, and interviews for one resident (Resident #2) reviewed for abuse, the facility failed to ensure the resident was free from verbal mistreatment. The findings include: Resident #2's diagnoses included hemiplegia (muscle weakness) and hemiparesis muscle paralysis) affecting the left nondominant side, chronic pain, major depressive disorder, and anxiety. The Resident Care Plan (RCP) dated 5/16/2025 identified Resident #2 had the potential for alteration in elimination due to incontinence of bowel and bladder. Resident #2 uses his/her call bell to request assistance with incontinent care. Interventions directed incontinent checks every two (2) to three (3) hours and as needed, and repositioning as indicated for proper body positioning. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had a Brief Interview for Mental Status (BIMS) score of twelve out of fifteen (12/15), indicative of moderately impaired cognition, was substantial assistance with ADL's (activities of daily living), and was always incontinent of bowel and bladder. Facility reportable event form dated 7/15/2025 at 9:10 AM identified Resident #2's roommate (Resident #3) reported NA #1 emotionally abused Resident #2 on 7/14/2025 during the 3 PM to 11 PM shift. Record review identified Resident #3 was alert and oriented (BIMS 14). An interview statement by Resident #3 on 7/15/2025 dated 7/15/2025, without a time noted, identified Resident #3 reported that he/she heard and witnessed Resident #2 being taunted by a male voice over the intercom system when Resident #2 requested to be changed at 9:00 PM on 7/14/2025. Resident #3 indicated he/she reported the allegation the following morning at 7:00 AM to the charge nurse. A facility interview statement by Resident #2 dated 7/15/2025, without a time noted, identified Resident #2 reported that NA #1 was not his/her NA but answered his/her call light at the nurse's station. Resident #2 stated that it was at 9 or 10:00 PM when he/she rang the call bell for incontinent care. NA #1 answered the call bell from the nurse's station and stated Resident #2's aide would be in to change him/her in a few minutes. A few minutes went by, and Resident #2 called again and NA #1 answered by saying stop calling, but in a different voice. Resident #2 rang again, and NA #1 stated change yourself and shut the f*** up. Resident #2 said to stop playing games and to get someone to change him/her, and care was provided by Resident #2's assigned NA. A written statement by NA #1 dated 7/15/2025, without a time noted, identified at 10:00 PM on 7/14/2025, Resident #2 called and asked for help to be changed, and NA #1 told Resident #2 that his/her NA was with someone and afterwards, she will come to change you. After two (2) minutes, Resident #2 rang again and said stop playing games man and started cursing NA #1 off, saying f*** you, and mother f***** etc. NA #1 then told Resident #2 then go change yourself, if you don't stop calling, I will take the call bell from you. Facility reportable event summary dated 7/20/2025 indicated Resident #3 reported NA #1 spoke inappropriately to Resident #2 on 7/14/2025 and NA #1 was removed from the schedule on 7/15/2025 when the allegation was made. The summary further indicated when the facility interviewed NA #1, he stated he had notified the assigned NA when Resident #2 rang the call bell. NA #1 stated Resident #2 rang again and was agitated. NA #1 stated Resident #2 called him names, said he/she was not playing games and made a verbal threat to NA #1. The summary further indicated based on findings from interviews conducted during the investigation, the facility has concluded that abuse could not be substantiated, however, facility identified that there was a lack of judgement by NA #1 regarding expectations of customer service and the code of conduct when interacting with the resident. Interview with LPN #1 on 8/19/2025 at 2:15 PM identified on 7/14/2025 during the 3 PM to 11 PM shift, LPN #1 was at the nurse's station while NA #1 was also at the nurse's station talking to someone. LPN #1 was unaware who NA #1 was talking to, and thought he was on his cellphone and heard NA #1 say f*** you, I am not coming and felt that NA #1's demeanor was very harsh and intimidating. LPN #1 identified she realized NA #1 was speaking into the (call bell) intercom feature. LPN #1 stated she was unable to confirm who NA #1 was talking to, and she did not report the incident since she was aware who was on the other end of the intercom conversation. Interview with Resident #2 on 8/19/2025 at 9:30 AM identified on 7/14/2025 during the 3 PM to 11 PM shift when he/she rang the call bell, NA #1 spoke through the intercom and on the second time, they exchanged words. NA #1 stated I'll take your call bell away and to change myself, I'm the supervisor, NA Administrator and this is why your garbage, and you can't walk, and care was provided by

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation review, facility policy review, and interviews for one (Resident #1) reviewed for quality of care, the facility failed to ensure the resident was free from a medication error. The findings include: Based on clinical record review, facility documentation review, facility policy review, and interviews for one (Resident #1) reviewed for quality of care, the facility failed to ensure the resident was free from a medication error. The findings include: Resident #1's diagnoses included urinary tract infection with Escherichia coli, ESBL resistance - urine, anxiety, severe major depressive disorder with psychotic symptoms, and neuralgia (pain caused by damaged nerves). The Resident Care Plan (RCP) dated 6/11/2025 identified Resident #1 had the potential for pain. Interventions directed to administer medications as ordered, report changes in urine color or odor. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 was alert and oriented (Brief Interview for Mental Status score of thirteen out of fifteen indicative of being cognitively intact), used a manual wheelchair, and received an opioid medication during the prior seven (7) days. Physician order dated 7/9/2025 directed Gabapentin (used to treat neuropathic pain and seizures). 300 mg, three times a day for neuralgia, and Oxycodone (opioid pain medication) 5 mg every twelve (12) hours for chronic leg pain. Physician orders dated 7/9/2025 for Resident #1 directed to administer Narcan (naloxone, reversal medication for opioid overdose) spray, non-aerosol; 4 milligrams (mg) as needed for opioid overdose, call MD and call 911. May repeat three (3) times, three (3) minutes apart. Nursing note dated 8/3/2025 at 2:42 PM identified Resident was status post day two (2) for antibiotic treatment for a UTI/ESBL (urinary tract infection). Nursing note dated 8/4/2025 at 11:30 AM identified at 10:40 AM RN #1 was notified Resident #1 was not responding while in his/her wheelchair. Observed Resident #1 in his/her wheelchair with eyes closed, leaning to the left side. APRN #1 (psychiatric APRN) was on the unit and assisted to place Resident #1 in bed, with no resident response. Temperature 97. 6, pulse 109, respiration 20, blood pressure 152/72 and blood sugar was 126. APRN #2 (medical APRN) was notified, started on 15 liters of oxygen (02) with a non-rebreather mask; oxygen saturation on 02 was 99%. Recheck blood pressure 88/64, placed in Trendelenburg position (head lower than body), and 911 was called. Resident #1 was transferred to the hospital for evaluation. APRN #2 gave report to EMS and hospital nurse that Resident #1 received Nayzilam nasal spray, and family updated. APRN #2 (medical APRN) note dated 8/4/2025 at 8:05 PM identified Resident #1 had a history of chronic neuropathic pain, vascular dementia, a history of recurrent UTIs (ESBL) and was unresponsive with pinpoint pupils. Was seen by staff minutes before noted unresponsive. Assessment identified ill-appearing, pale, diaphoretic, tachycardia irregular pulse, shallow respirations, 911 was called, and ordered Narcan one (1) dose as Resident #1 received Oxycodone for chronic pain, with no effect. Transferred to the hospital. EMS report dated 8/4/2025 identified EMS was notified at 10:48 AM and was at the resident at 10:54 AM. Facility incident report dated 8/4/2025 at 11 AM identified Resident #1 received Nayzilam (benzodiazepine, used to treat seizures) intranasal spray during a change in condition. Record review failed to identify an order for Nayzilam for Resident #1. A Hospital Emergency Department Note dated 8/4/2025 at 12:45 PM identified RN #2 received a phone call from APRN #2 at skilled nursing facility who reported Resident #1 was mistakenly given Nyzilam 5 mg intranasal instead of the intended Narcan. The Hospital admission summary dated [DATE] at 3:46 PM identified Resident #1 had multiple medical problems with no seizure history, no chronic benzodiazepine or alcohol use, and was admitted with a diagnosis of encephalopathy (altered brain function including confusion and altered consciousness). The summary indicated the degree to which his/her mental status was depressed prior to inadvertent Nayzilam administration out of his/her facility is not entirely clear, and at least some component of the encephalopathy is likely explained by the Nayzilam administration. Resident #1 received Flumazenil (reversal medication for Nayzilam), and seemed significantly improved although remained somewhat encephalopathic. The Hospital Discharge summary dated [DATE] at 12:41 PM identified Resident #1 presented to the emergency department on 8/4/2025 with altered mental status after he/she was found poorly responsive at the rehabilitation facility. Resident #1 was intended to receive 4 mg of Narcan at the facility and inadvertently received intranasal Nayzilam. Resident #1 was unresponsive to Naloxone, remained poorly responsive in the emergency department with three (3) liters nasal cannula oxygen and was admitted to the ICU (intensive care unit). Resident #1 has been wakeful in last 24-hours without recurrent episodes of poor responsiveness and had an episode of low blood pressure on 9/5/2025 with transfer back