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	11/24/2025

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and resident and staff interviews for Resident #1, reviewed for a change in condition, the facility failed to ensure that licensed staff informed the provider that an alternative method of oxygen delivery was implemented to maintain adequate oxygenation. The findings include:Resident #1 was admitted with diagnoses that included moderate persistent asthma. An annual MDS assessment dated [DATE] identified Resident #1 was cognitively intact and utilized oxygen therapy.A care plan dated 6/26/2025 identified Resident #1 had impaired respiratory function related to recurrent shortness of breath and obstructive sleep apnea. Interventions included administering medications as ordered, and reporting changes/concerns to the medical provider as needed.The physician orders dated 9/2/2025 directed to administer 2L of oxygen via nasal cannula for obstructive sleep apnea as needed.A nursing note dated 9/25/2025 identified Resident #1's oxygen saturation was 90 to 92% on 3 liters of oxygen via nasal cannula and decreasing to 88% while talking despite having received an albuterol nebulizer (a medication used for treating shortness of breath). The nursing note indicated that the nursing supervisor was made aware, and Resident #1 was placed on a non-rebreather mask as requested by the nursing supervisor. The note further indicated that Resident #1's oxygen saturation increased to 97-98% on 5L oxygen delivered via a non-rebreather mask.A nursing supervisor's note dated 9/25/2025 indicated that Resident #1 complained of not feeling well with chills and shortness of breath. The note further identified that Resident #1's oxygen saturation was 88% on room air and that afterwards oxygen was administered via a non-rebreather mask. The note indicated that APRN #1 was made aware, and new orders were obtained.On 10/2/2025 at 11:00 AM, an interview with Resident #1 identified he/she had told LPN#1 about their continued shortness of breath and that the LPN took an oxygen saturation reading, and it was high 80s, low 90s. Resident #1 indicated that afterwards, LPN#1 placed a non-rebreather mask on them, and their oxygen saturation increased to 100% but they still felt short of breath. Resident #1 indicated that the mask had a bag that inflated like a balloon (the reservoir bag of a non-rebreather mask).On 10/2/2025 at 12:10 PM, an interview with LPN#1 indicated that on 9/25/2025 at 8:00 PM, Resident #1 indicated that they were short of breath and did not feel like themselves. LPN#1 indicated she notified the nursing supervisor (RN#1), who then contacted the APRN (APRN#1). LPN#1 indicated that new orders were obtained by RN#1 and that she updated the resident. LPN #1 indicated she noticed Resident #1's oxygen saturation would decrease to 88% from 94 % when talking. LPN#1 indicated she had notified the nursing supervisor, who directed LPN#1 to place a non-rebreather mask. LPN #1 indicated that she placed the non-rebreather mask and that the oxygen flow rate was set at 5 liters/minute.On 10/2/2025 at 1:18 PM, an interview with RN#1 indicated that when she had initially assessed Resident #1, the resident had been on a nasal canula at 3 liters/minute, but that the oxygen tubing prongs were not well placed in the resident's nostrils. When she adjusted it, the resident's oxygen improved. RN#1 indicated she had later told LPN#1 to place a non-rebreather mask on Resident #1 when she was informed that the resident's oxygen was decreasing to 88%. RN#1 indicated she did not recall if she had informed APRN#1 that Resident #1 was requiring oxygen through a non-rebreather mask, but thought that the mask was placed after an ambulance was called. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/2/2025 at 1:53 PM, an interview and review of messages from the facility with APRN#1 indicated that RN#1 communicated with her through messaging regarding Resident #1's condition. APRN #1 indicated that although RN#1 informed APRN#1 about Resident #1's shortness of breath, APRN #1 was not informed that Resident #1 was placed on a non-rebreather mask. APRN#1 indicated that when a resident needs a non-rebreather mask, it should be communicated to her; however, APRN #1 indicated that her medical management would not have changed since she would have attempted to wean the mask off with the medications she had already ordered had the resident not been transferred to the hospital.The facility policy for Change in a Resident's Condition or Status indicated that the nurse should notify a physician on call when there is a significant change in a resident's condition or if a resident's medical treatment needs to be altered significantly. Additionally, the policy indicated that the nurse should make detailed observations and gather relevant and pertinent information for the provider.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review and staff interviews, the facility failed to ensure that staff used an oxygen mask appropriately and failed to ensure staff followed a physician's order for the flow of oxygen. The findings include:Resident #1 was admitted with diagnoses that included moderate persistent asthma. An annual MDS assessment dated [DATE] identified Resident #1 was cognitively intact and had oxygen therapy.A care plan dated 6/26/2025 identified Resident #1 had impaired respiratory function related to recurrent shortness of breath and obstructive sleep apnea. Interventions included administering medications as ordered, and reporting changes/concerns to the medical provider as needed.The physician orders dated 9/2/2025 directed to administer 2L of oxygen via nasal cannula for obstructive sleep apnea as needed.A. A nursing note dated 9/25/2025 identified that Resident #1's oxygen saturation was 90 to 92% on 3 liters of oxygen via nasal cannula and decreasing to 88% while talking despite having received an albuterol nebulizer (a medication used for treating shortness of breath). The nursing note indicated that the nursing supervisor was made aware, and Resident #1 was placed on a non-rebreather mask as requested by the nursing supervisor. The note further indicated that Resident #1's oxygen saturation increased to 97-98% on 5L oxygen delivered via a non-rebreather mask.A nursing supervisor's note dated 9/25/2025 indicated that Resident #1 complained of not feeling well with chills and shortness of breath. The note further identified that Resident #1's oxygen saturation was 88% on room air and that afterwards oxygen was administered via a non-rebreather mask. The note indicated that APRN #1 was made aware, and new orders were obtained.On 10/2/2025 at 11:00 AM, an interview with Resident #1 identified that Resident #1 had told LPN#1 about their continued shortness of breath and that the LPN took an oxygen saturation reading, and it was high 80s, low 90s. Resident #1 indicated that afterwards, LPN#1 placed a non-rebreather mask on them, and their oxygen saturation increased to 100% but they still felt short of breath. Resident #1 indicated that the mask had a bag that inflated like a balloon (the reservoir bag of a non-rebreather mask).On 10/2/2025 at 12:10 PM, an interview with LPN#1 indicated she noticed Resident #1's oxygen saturation would decrease to 88% from 94 % when talking on 3 liters/minute of oxygen. LPN#1 indicated she had notified the nursing supervisor, who directed LPN#1 to place a non-rebreather mask. LPN #1 indicated that she placed the non-rebreather mask and that the oxygen flow rate was set at 5 liters/minute (the flow rate required for a non-rebreather mask is 10 to 15 liters/minute to ensure a patient does not rebreathe exhaled air). LPN #1 identified that the correct oxygen flow rate for a non-rebreather mask was 10 liters/minute, but that the air compressor only went as high as 5 liters/minute. LPN#1 indicated that in an emergency, there was an emergency cart available on the floor that had an oxygen tank that could be set to a liter flow as high as 15 liters/minute. LPN#1 indicated she did not know why she did not ensure the liter flow was set to the appropriate level for the non-rebreather and indicated that the reservoir bag of the non-rebreather mask was inflated.On 10/2/2025 at 1:53 PM, an interview and review of messages with APRN#1 indicated that RN#1 communicated with her through messaging regarding Resident #1's condition. APRN #1 indicated that although RN#1 informed APRN#1 about Resident #1's shortness of breath, APRN #1 was not informed that Resident #1 was placed on a non-rebreather mask. APRN#1 indicated that an oxygen liter flow of 5 liters/minute through a non-rebreather mask was not an appropriate use of a non-rebreather mask. APRN#1 indicated that she did not think a flow of 5 liters/minute through a non-rebreather mask would have made Resident #1 retain carbon dioxide. Additionally, even though an inappropriate liter flow could make it harder to improve hypoxia, Resident #1's oxygen saturations did improve with the non-rebreather.The facility policy for Oxygen Administration indicated that an oxygen mask is a device that fits over the resident's nose and mouth and is different than a nasal cannula. The policy failed to identify appropriate liter flows for a nasal cannula and different types of masks. A review of a facility in-service dated 7/22/2025 identified (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	appropriate handling of oxygen tanks, but did not address the liter flow of various types of oxygen masks. B. On 10/2/2025 at 11:00 AM, an observation of Resident #1 identified that Resident #1's oxygen concentrator was set to 2.5 liters/minute. A second observation at 2:45 PM identified that Resident #1's oxygen was set to 4 liters/minute.On 10/2/2025 at 2:40 PM, an interview and record review with LPN#3 identified an order dated 10/1/2025 that directed continuous oxygen at 2 liters/minute via nasal cannula. LPN#3 indicated that he had received a report that Resident #1 should be on 4 liters/minute, but had requested to have it lowered overnight due to the flow irritating their nostrils. LPN#3 indicated that when he evaluated Resident #1 at 12:00 PM on 10/2/2025, he increased the oxygen to 4 liters/minute to increase the flow back to what he thought was the ordered rate, although the resident's oxygen saturations were stable. A follow-up interview with LPN #3 at 3:00 PM identified that he had spoken to APRN#1 and that the resident should be ordered for 2 to 3 liters continuous oxygen via nasal cannula for a target oxygen saturation of greater than 90%.A review of the facility policy for Physician orders indicated that orders for medications and treatments should be consistent with principles of safe and effective order writing. Additionally, the facility policy for oxygen administration indicated that when administering oxygen, the physician's order should be verified and reviewed.