

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 12/18/2025
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 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</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 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**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 sustained a fall with major injury, the facility failed to administer pain medication at the time the injury was identified and after prior to transfer to the Emergency Department (ED) to ensure the resident was kept comfortable. The findings include: Resident #1's diagnoses included bilateral (both sides) osteoarthritis of the knees, muscle wasting and atrophy (thinning of muscle mass), and muscle weakness. A physician's order dated 11/12/25 directed to administer acetaminophen 325 milligrams (mg), two (2) tablets (650 mg), every six (6) hours as needed for generalized discomfort. The admission Minimum Data Set assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of five (5) out of fifteen (15) indicating Resident #1 had poor memory recall, required partial assistance for bed mobility and substantial assistance for transfers. The Resident Care Plan dated 11/26/25 identified that Resident #1 was at risk for pain due to diagnosis of arthritis. Interventions included offering pain medications as ordered. The nurse's note dated 11/28/25 at 4:48 AM identified that at approximately 1:40 AM Resident #1 was found on the floor, lying on his/her right side between two (2) beds. The note indicated Resident #1 was noted with a bump to the right temple area measuring 2.5 centimeters (cm) in diameter, was alert with baseline confusion, neurological signs were normal, passive range of motion was normal to all four (4) extremities and Resident #1 was showing no signs or symptoms of pain. The note identified Resident #1 was transferred back to bed with an assist of two (2) staff, an ice pack was applied to the head injury and the Advanced Practice Registered Nurse (APRN) was notified who advised to call Resident #1's Power of Attorney (POA) and ask if they wanted Resident #1 transferred to the hospital for evaluation. The POA was called twice, and voicemails were left requesting a call back to the facility. The Occupational Therapy (PT) encounter note dated 11/28/25 identified Resident #1 was seen in the morning and was noted with lethargy, eye closing and left lateral (to the side) lean while seated in the wheelchair. The note indicated the leg rests were removed in preparation of standing tasks, however Resident #1 was noted with edema to the right outer ankle and was observed grimacing with touch when removing the left leg rest. The note identified the standing tasks were not completed due to Resident #1 presenting with lower extremity pain and possible injury and nursing was notified and assessed Resident #1. The Physical Therapy (PT) encounter note dated 11/28/25 identified Resident #1 was noted leaning to the left with an inverted (turned inwards) right ankle while seated in the wheelchair. The note indicated Resident #1 had facial grimacing with gentle ankle palpation due to pain and nursing was aware. The nurse's note dated 11/28/25 at 1:35 PM identified the Assistant Director of Nursing reached out to the POA again with no response. The note indicated he assessed Resident #1 as part of a post fall assessment and Resident #1 showed facial grimacing when the right femur and ankle were touched and were noted to be painful and tender but without swelling. The note identified he contacted the APRN immediately to report his assessment and new orders were obtained for bilateral lower extremity x-rays and Resident #1 was not to be transferred to the hospital. Review of the November 2025 Medication Administration Record (MAR) failed to identify the acetaminophen was administered to Resident #1 for pain relief following the staff observations when Resident #1 had showed signs and symptoms of pain. The diagnostic imaging reports identified the x-rays of the right ankle, left ankle and bilateral hips and pelvis were obtained on 11/28/25. The right and left ankle x-rays results were negative for acute fractures. The bilateral hips and pelvis x-ray results on 11/29/25 at 4:44 AM showed an acute right femoral neck fracture (the upper thigh bone that connects the rounded ball of the hip joint to the main shaft of the bone). The nurse's note dated 11/29/25 at 8:13 AM identified the x-ray results of the bilateral hips and pelvis were made available on 11/29/25 at 4:44 AM and showed an acute right femoral neck fracture with complete displacement (when the broken pieces of the femur significantly shift out of alignment and can disrupt blood supply and lead to severe pain and the inability to bear weight). The note indicated the POA was notified of the results and the impending transfer to the Emergency Department (ED). The facility's hospital transfer form dated 11/29/25 identified Resident #1 was medicated with the acetaminophen 650 mg at 8:44 AM prior to the transfer to the hospital. Although the transfer note indicated Resident #1 had been medicated with the acetaminophen, review of the November 2025 Medication Administration Record failed to reflect documentation the acetaminophen was administered on 11/29/25 prior to the ED transfer. Interview with the 7AM-3PM charge nurse, Licensed Practical Nurse (LPN) #3, on 12/18/25 at 11:57 AM identified on</p>		

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<p>F 0777</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain x-rays/tests when ordered and promptly tell the ordering practitioner of the results.</p> <p>(continued on next page)</p>

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<p>F 0777</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, facility documentation, and interviews for one (1) of three (3) sampled residents (Resident #1) reviewed for falls with major injury, the facility failed to follow through with obtaining the x-ray reports when the diagnostic provider failed to notify the facility immediately of a positive finding which resulted in a delay of care. The findings include: Resident #1's diagnoses included bilateral (both sides) osteoarthritis of the knees, muscle wasting and atrophy (thinning of muscle mass) and muscle weakness. The admission Minimum Data Set assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of five (5) out of fifteen (15) indicating Resident #1 had poor memory recall, required partial assistance for bed mobility and substantial assistance for transfers. The nurse's note dated 11/28/25 at 4:48 AM identified that at approximately 1:40 AM Resident #1 was found on the floor, lying on his/her right side between two (2) beds. The note indicated Resident #1 was noted with a bump to the right temple area measuring 2.5 centimeters (cm) in diameter, was alert with baseline confusion, neurological signs were normal, passive range of motion was normal to all four (4) extremities and Resident #1 was showing no signs or symptoms of pain. The note identified Resident #1 was transferred back to bed with an assist of two (2) staff, an ice pack was applied to the head injury and the Advanced Practice Registered Nurse (APRN) was notified who advised to call Resident #1's Power of Attorney (POA) and ask if they wanted Resident #1 transferred to the hospital for evaluation. The POA was called twice, and voicemails were left requesting a call back to the facility. The Physical Therapy (PT) encounter note dated 11/28/25 identified Resident #1 was noted leaning to the left with an inverted (turned inwards) right ankle while seated in the wheelchair. The note indicated Resident #1 had facial grimacing with gentle ankle palpation due to pain and nursing was aware. The nurse's note dated 11/28/25 at 1:35 PM identified the Assistant Director of Nursing reached out to the POA again with no response. The note indicated he assessed Resident #1 as part of a post fall assessment and Resident #1 showed facial grimacing when the right femur and ankle were touched and were noted to be painful and tender but without swelling. The note identified he contacted the APRN immediately to report his assessment and new orders were obtained for bilateral lower extremity x-rays and Resident #1 was not to be transferred to the hospital. A physician's order dated 11/28/25 directed to obtain x-rays of the bilateral hips, legs, and ankles on 11/28/25. The diagnostic imaging reports identified the x-rays of the right ankle, left ankle and bilateral hips and pelvis were obtained on 11/28/25. The right and left ankle x-rays results were negative for acute fractures. The bilateral hips and pelvis x-ray results on 11/29/25 at 4:44 AM showed an acute right femoral neck fracture (the upper thigh bone that connects the rounded ball of the hip joint to the main shaft of the bone) approximately fifteen (15) hours after the resident began showing signs and symptoms of pain and was assessed for a possible injury. The nurse's note dated 11/29/25 at 8:13 AM identified the x-ray results of the bilateral hips and pelvis were made available on 11/29/25 at 4:44 AM and showed an acute right femoral neck fracture with complete displacement (when the broken pieces of the femur significantly shift out of alignment and can disrupt blood supply and lead to severe pain and the inability to bear weight). The note indicated the POA was notified of the results and the impending transfer to the Emergency Department (ED). Review of the clinical record from 11/28/25 when the x-rays were obtained through 11/29/25 failed to reflect documentation the radiology provider notified the facility on 11/29/25 at 4:44 AM when the results of the bilateral hip and pelvis reports were available and that the facility failed to follow up obtaining the results of the bilateral hip and pelvis reports after the right ankle, left ankle x-ray results were reported to the facility as evidenced in the 11/28/25 at 10:30 PM nurse's note. Interview with the Director of Nursing (DON) on 12/19/25 at 1:18 PM identified although the diagnostic provider should have called the facility, they did not call to notify the facility of Resident #1's positive x-ray report on 11/29/25 at 4:44 AM. The DON explained she checked their website on 11/29/25 at 7:00 AM and pulled up the final results that identified Resident #1 had a right femoral neck fracture, the APRN was notified immediately, and Resident #1 was transferred to the ED. Interview with the APRN on 12/18/25 at 2:00 PM identified although Resident #1's hip and pelvis x-ray results were available at 4:44 AM on 11/29/25, she was not notified until 7:00 AM by text from the facility (over two (2) hours later). The APRN stated the diagnostic company should have notified the facility immediately of the abnormal results so she could be notified timely. Interview with the diagnostic provider, Person #2, on 12/18/25 at 3:04 PM identified the x-ray exam was completed on 11/28/25 at 5:30 PM and the hip and pelvis x-ray results were not available until 11/29/25 at</p>		