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	06/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Civita Care Center at Milford	2028 Bridgeport Ave Milford, CT 06460

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, policy, and interviews for nineteen (18) of twentyˆnine (29) sampled residents (Residents #3, 4, 8, 9, 10, 11, 15, 16, 17, 18, 20, 22, 24, 26, 27, 28, 29, 30) reviewed for omitted medications, the facility failed to notify the provider immediately after omitted medications were identified. As a result, affected residents were not assessed timely and providers were not notified until the next day. The findings include: The Reportable Event (RE) dated 5/21/26 identified throughout the 3:00 PM to 11:00 PM shift, LPN #1 was off the unit multiple times due to feeling unwell. At approximately 11:00 PM, staff found LPN #1 lethargic in the employee restroom with suspected drug paraphernalia in her possession. Emergency Medical Services (EMS) arrived, LPN #1 was removed from the schedule pending investigation and twenty-two (22) residents were identified to have been omitted medications and/or treatments during the shift. The Medical Director was notified, and assessments were completed for the affected residents with no adverse effects identified. 1. Resident #3?s diagnoses included end-stage renal disease, dependence on renal dialysis, type II diabetes mellitus and chronic pain syndrome. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #3 had intact impaired cognition (Brief Interview for Mental Status (BIMS) score of 13) and was independent with bed mobility and transfers.The Resident Care Plan (RCP) dated 3/12/26 identified Resident #3 is on dialysis. Interventions included assuring medications are administered before and after dialysis as ordered by the physician to ensure maximum effectiveness and to avoid adverse effects of the medications.The May 2026 electronic Medication Administration Record (eMAR) identified Resident #3 was omitted the following medications on 5/21/26 at 8:00 AM: sevelamer carbonate (for treatment of high phosphate levels in the blood). Resident #3 was omitted the following medications on 5/21/26 at 9:00 AM: allopurinol (for treatment of gout and high uric acid levels in the blood) 100 milligrams (mg), take two (2) tablets once daily; amlodipine (for treatment of high blood pressure) 10 mg once daily on Sunday, Tuesday, Thursday and Saturday; bumetanide (diuretic) 2 mg, give two (2) tablets (4 mg) once daily on Sunday, Tuesday, Thursday, Saturday; losartan (for treatment of high blood pressure) 25 mg, give one (1) tablet daily on Sunday, Tuesday, Thursday, Saturday; Eliquis (blood thinner that reduces blood clotting) 5 mg, give 2 tablets (10 mg) twice daily; metoprolol tartrate (for treatment of high blood pressure and heart rate control) 50 mg twice daily; rosuvastatin (for treatment of high cholesterol) 5 mg once daily; Voltaren arthritis pain gel 1 percent (%), apply 4 grams (gm) to each knee topically twice daily;Review of nurse's notes dated 5/21/26 failed to identify that the provider was notified of the omissions.Interview with LPN #6 on 6/23/26 at 12:15 PM identified Resident #1 was scheduled for a fistulogram (a test that looks for abnormal areas in a dialysis graft or arteriovenous fistula) at 8:45 AM on 5/21/26 and was picked up for transport just after 7:00 AM. She reported the medications were not transcribed to be given early that day and she did not realize the medications were not administered until after Resident #3 left. LPN #6 identified she did not notify the nursing supervisor or the provider of the omissions.Interview with Resident #3 on 6/23/26 at 11:00 AM identified he/she did not receive morning medications on 5/21/26 prior to the fistulogram and reported he/she had not (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	MDS assessment dated [DATE] identified Resident #28 had severely impaired cognition (Brief Interview for Mental Status (BIMS) score of 3) and was dependent on staff for bed mobility and identified Resident #28 did not transfer or ambulate.The RCP dated 4/13/26 identified Resident #28 had Major Depressive Disorder and anorexia, had the potential for alteration in mood and/or behavior and has a history of chronic pain and osteoporosis, receives gabapentin twice daily for neuropathy, and was on tramadol and baclofen secondary to progressing contractures. Interventions included to administer medications per order, monitoring and recording effectiveness and reporting any adverse side effects.The Administration Compliance Report dated 5/21/26 identified Resident #28 was omitted the following medications and orders on 5/21/26: At 4:30 PM, gabapentin 100 mg, give 1 capsule twice daily. At 5:00 PM, house supplement, give 237 mL four times daily; liquid protein supplement, give 30 cc three times daily. At 7:30 PM, mirtazapine (for treatment of major depressive disorder) 30 mg, give 1 tablet daily at bedtime; tramadol 75 mg, give 1 tablet three times daily. At 8:30 PM, melatonin 3mg, give 2 tablets (6 mg) daily at bedtime. Review of the clinical record dated 5/21/26 failed to identify that the provider was notified of the omissions.A provider note dated 5/22/26 identified they were asked to see Resident #3 following medication omissions.Although attempted, Resident #28 was unable to be interviewed.17. Resident #29?s diagnoses included hypertension, GERD, schizoaffective disorder, paranoid schizophrenia, major depressive disorder and anxiety disorder.The quarterly MDS assessment dated [DATE] identified Resident #29 had moderately impaired cognition (Brief Interview for Mental Status (BIMS) score of 9) and required partial assistance for bed mobility and transfers.The RCP dated 2/28/26 identified Resident #29 had the potential for cardiac\pulmonary complications, secondary to diagnoses of Chronic Obstructive Pulmonary Disease (COPD), hypertension and hyperlipidemia and has behaviors related to schizophrenia, disorganized type, major depressive disorder, generalized anxiety disorder and alcohol-related dementia. Interventions included administering medications as ordered.The Administration Compliance Report dated 5/21/26 identified Resident #29 was omitted the following medications and orders on 5/21/26: At 5:00 PM, buspirone (used to treat anxiety disorder) 10 mg, give 2 tablets (20 mg) twice daily; valproic acid 250 mg, give 1 capsule twice daily; propranolol 10 mg, give 3 tablets (30 mg) twice daily. At 8:00 PM, famotidine (reduces the amount of acid in the stomach) 40 mg, give 1 tablet daily at bedtime.The May 2026 eMAR identified the following omitted medications on 5/21/26: At 9:00 PM, pregabalin (controlled anticonvulsant and nerve pain medication) 100 mg, give 1 capsule three times daily; sertraline (used to treat depression) 50 mg, give 3 tablets (150 mg) daily; The required pain assessment that was to be completed every shift was blank on the 3:00 PM to 11:00 PM shift on 5/21/26. Review of the clinical record dated 5/21/26 failed to identify that the provider was notified of the omissions.A provider note dated 5/22/26 identified they were asked to see Resident #29 following medication omissions.Interview with Resident #29 on 6/23/26 at 11:33 AM identified there was multiple occurrences when he/she did not receive medications on the 3:00 PM to 11:00 PM shift, but could not recall who the nurse was or the date the omissions occurred.18. Resident #30?s diagnoses included type II diabetes mellitus, long-term use of insulin and lymphedema (build-up of lymph fluid in the body's soft tissues causing swelling in the arms and legs).The admission Observation dated 5/18/26 identified Resident #30 was alert and oriented to person, place and time with intact memory and utilized a walker for mobility and ambulation.The RCP dated 5/21/26 identified Resident #30 had diabetes. Interventions included administering medications as ordered and obtaining finger sticks for blood glucose twice daily as ordered.The Administration Compliance Report dated 5/21/26 identified Resident #29 was omitted the following orders on 5/21/26 at 8:00 PM: obtaining and monitoring blood sugar twice daily. The required blood sugar was not documented. Review of the clinical record dated 5/21/26 failed to identify that the provider was notified of the omissions.Interview with Resident #30 on 6/23/26 at 10:30 AM identified he/she recalled 5/21/26, as it was a family member's birthday. Resident #30 reported he/she did not see LPN #1 that night and LPN #1 did not obtain his/her blood sugar or administer medications including alprazolam and pregabalin which resulted in Resident #30 having a panic attack and pain overn

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	06/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Civita Care Center at Milford	2028 Bridgeport Ave Milford, CT 06460

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on a review of the clinical record, facility documentation, facility policies, and interviews, the facility failed to complete a thorough investigation following an incident in which a licensed nurse left the first^floor long^hall unit multiple times for long periods during the shift, resulting in omitted medications. Specifically, the facility did not interview all 29 residents on the unit to determine whether they received their medications as scheduled, experienced any signs or symptoms related to missed doses or observed any unusual behavior from the licensed nurse. The findings include: The Reportable Event (RE) dated 5/21/26 identified throughout the 3:00 PM to 11:00 PM shift, LPN #1 was off the unit multiple times due to feeling unwell. At approximately 11:00 PM, staff found LPN #1 lethargic in the employee restroom with suspected drug paraphernalia in her possession. Emergency Medical Services (EMS) arrived, LPN #1 was removed from the schedule pending investigation and twenty-two (22) residents were identified to have been omitted medications and/or treatments during the shift. The Medical Director was notified, and assessments were completed for the affected residents with no adverse effects identified. Additionally, the RE was reported as neglect.Review of the facility Accident and Incident (A&I) form dated 5/21/26 failed to identify statements were obtained from the residents residing on the first^floor long^hall unit on 5/21/26.A statement from LPN #3 (undated) identified on 5/22/26 she conducted interviews with Residents #7, 13, 14, 15, 24 and 28 regarding medication administration by LPN #1 on 5/21/26. All the residents reported they received their medications as scheduled and voiced no concerns regarding medication administration.Review of the facility census dated 5/21/26 identified the first^floor long^hall unit housed 29 residents. Only six (6) of the twenty-nine (29) residents were interviewed.Interview with LPN #3 on 6/18/26 at 1:01 PM identified no one directed her to interview the residents on the first^floor long^hall unit following the incident on 5/21/26 but she did so to help identify what happened. She reported selecting the residents she did because they were alert and oriented but did not conduct further interviews because she assumed someone else would conduct thorough interviews with all the residents.Interview with the Director of Nursing (DON) and the Regional Nurse on 6/24/26 at 3:10 PM identified all 29 residents residing on the first^floor long^hall unit should have been interviewed following the incident to include if they received their medications during the 3:00 PM to 11:00 PM shift on 5/21/26, if they had any signs and symptoms related to missed doses or observed any unusual behavior from LPN #1. They identified the statements should have been obtained and included in the A&I.Review of the Incidents and Accidents- Investigating and Reporting policy dated 11/29/24 directed, in part, all accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on facility premises shall be investigated and reported to the Administrator.Review of the Residents Right to Freedom from Abuse, Neglect and Exploitation policy (undated) directed, in part, staff must not use verbal, mental, sexual or physical abuse, corporal punishment or involuntary seclusion against any resident. When the facility has identified abuse, the facility will take all appropriate steps to remediate the noncompliance and protect residents from additional abuse immediately. The facility will increase enforcement action, including, but not limited to: Taking steps to prevent further abuse, reporting the alleged violation and investigation within required timeframes pursuant to federal and state statutes and regulations, conducting a thorough investigation of the alleged violation, taking appropriate corrective action and the facility will revise the resident's care plan if the resident's medical, nursing, physical, mental or psychosocial needs or preferences change as a result of an incident of abuse. In response to allegations of abuse, neglect, exploitation or mistreatment, the facility shall: Ensure all alleged violations involving abuse, neglect, exploitation or mistreatment are reported in the proper time frame pursuant to this policy, have evidence that all alleged violations are thoroughly investigated and prevent further abuse, neglect, exploitation or mistreatment while the investigation is in progress.

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	075213	A. Building B. Wing	06/24/2026

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F 0636 Level of Harm - Potential for minimal harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility policy and interviews for eighteen (18) of twenty-two (22) sampled residents (Residents #1, 3, 4, 8, 10, 11, 13, 14, 17, 18, 20, 22, 23, 24, 26, 27, 28 and 30) reviewed for comprehensive assessments, the facility failed to ensure the resident comprehensive assessments were completed within fourteen (14) days of the Assessment Reference Date (ARD) as required. The findings include:1. The admission Minimum Data Set (MDS) assessment for Resident #1 had an ARD of 5/4/26 and was due by 5/18/26.Review of the admission MDS dated [DATE] identified it was not completed as of 6/24/26 (37-days late). 2. The admission MDS assessment for Resident #3 had an ARD of 5/1/26 and was due by 5/15/26. Review of the admission MDS dated [DATE] identified it was completed on 5/26/26 (11-days late). 3. The quarterly MDS assessment for Resident #4 had an ARD of 5/12/26 and was due by 5/26/26. Review of the quarterly MDS dated [DATE] for Resident #4 identified it was not completed as of 6/24/26 (29-days late). 4. The annual MDS assessment for Resident #8 had an ARD of 4/4/26 and was due by 4/18/26. Review of the annual MDS dated [DATE] identified it was completed on 5/5/26 (17-days late). 5. The quarterly MDS assessment for Resident #10 had an ARD of 5/14/26 and was due by 5/28/26. Review of the quarterly MDS dated [DATE] identified it was not completed as of 6/24/26 (27-days late). 6. The annual MDS assessment for Resident #11 had an ARD of 3/28/26 and was due by 4/11/26. Review of the annual MDS dated [DATE] identified it was completed on 4/27/26 (16-days late).7. The annual MDS assessment for Resident #13 had an ARD of 4/9/26 and was due by 4/23/26. Review of the annual MDS dated [DATE] identified it was completed on 5/6/26 (13-days late).8. The quarterly MDS assessment for Resident #14 had an ARD of 4/5/26 and was due to be completed by 4/19/26.Review of the quarterly MDS dated [DATE] for identified it was completed on 4/29/26 (10-days late).9. The annual MDS assessment for Resident #17 had an ARD of 4/11/26 and was due to be completed by 4/25/26.Review of the annual MDS dated [DATE] identified it was completed on 4/29/26 (4-days late).10. The annual MDS assessment for Resident #18 had an ARD of 4/15/26 and was due by 4/29/26. Review of the annual MDS dated [DATE] identified it was completed on 5/28/26 (29-days late). 11. The quarterly MDS assessment for Resident #20 had an ARD of 4/27/26 and was due by 5/11/26. Review of the quarterly MDS dated [DATE] identified it was completed on 5/15/26 (4-days late). 12. The 5-day MDS assessment for Resident #22 had an ARD of 5/10/26 and was due to be completed by 5/24/26.Review of the quarterly MDS dated [DATE] identified it was completed on 6/9/26 (30-days late).13. The quarterly MDS assessment for Resident #23 had an ARD of 5/24/26 and was due to be completed by 6/7/26.Review of the quarterly MDS dated [DATE] identified it was not completed as of 6/24/26 (17-days late).14. The quarterly MDS assessment for Resident #24 had an ARD of 5/14/26 and was due by 5/28/26. Review of the quarterly MDS dated [DATE] identified it was not completed as of 6/24/26 (27-days late). 15. The quarterly MDS assessment for Resident #26 had an ARD of 4/27/26 and was due by 5/11/26.Review of the quarterly MDS dated [DATE] identified it was completed on 5/15/26 (4-days late).16. The quarterly MDS assessment for Resident #27 was noted to have an ARD of 5/4/26 and was due to be completed by 5/18/26.Review of the quarterly MDS dated [DATE] identified it was completed on 6/22/26 (35-days late). 17. The quarterly MDS assessment for Resident #28 had an ARD of 4/8/26 and was due by 4/22/26. Review of the quarterly MDS dated [DATE] identified it was completed on 4/29/26 (7-days late).18. The admission MDS assessment for Resident #30 had an ARD of 5/24/26 and was due by 6/7/26.Review of the admission MDS dated [DATE] identified it was completed on 6/16/26 (9-days late).Interview with the MDS Nurse on 6/23/26 at 2:22 PM identified each resident MDS assessment is to be completed within 14-days of the ARD date. She reported that she was behind due to her coworker being on extended leave and many of the MDS's were overdue.Interview with the DON and Regional Nurse on (continued on next page)

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	06/24/2026

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F 0636 Level of Harm - Potential for minimal harm Residents Affected - Some	6/23/26 at 3:10 PM identified MDS assessments are to be completed for each resident at least quarterly and should be signed off as completed within 14-days of the ARD date. They identified they were unaware the MDS's were not being completed timely.Review of the MDS Assessment policy dated 2/6/26 directed, in part, the facility shall complete all MDS assessments using a comprehensive interdisciplinary approach. Information entered on the MDS must accurately reflect the resident's status during the Assessment Reference Date (ARD) look-back period and be supported by documentation contained within the medical record. The MDS Coordinator shall establish and maintain an MDS schedule, ensure assessments are completed according to federal and state requirements, monitor compliance with assessment due dates, communicate assessment schedules to interdisciplinary team members.Review of the Resident Participation in Care Planning policy dated 9/1/22 directed, in part, resident assessments are begun on the first day of admission and completed no later than the fourteenth day after admission.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for seven (7) of eighteen (18) sampled residents (Residents #6, 11, 13, 23, 26, 27 and 30) reviewed for neglect, the facility failed to ensure Resident Care Conferences (RCCs) were completed at least quarterly. The findings include:1. Resident #6?s diagnoses included dementia with behavioral disturbances, repeated falls, schizophrenia, anxiety disorder and adult failure to thrive.The quarterly MDS assessment dated [DATE] identified Resident #6 had severely impaired cognition (Brief Interview for Mental Status (BIMS) score of 3) and was dependent for personal hygiene and transfers.Review of the clinical record from 1/29/26 through 3/28/26 failed to identify an RCC was scheduled or held for Resident #6 following the 1/29/26 MDS.The annual MDS assessment dated [DATE] identified Resident #6 had severely impaired cognition (Brief Interview for Mental Status (BIMS) score of 3) and was dependent for personal hygiene and transfers.Review of the clinical record from 3/29/26 through 6/24/26 failed to identify an RCC was scheduled or held for Resident #6 following the 3/29/26 MDS.2. Resident #11?s diagnoses included type II diabetes mellitus, chronic kidney disease, dependence on renal dialysis, unspecified convulsions (involuntary muscle shaking or spasms but the exact cause or seizure type has not been identified) and acute embolism and thrombosis of the deep veins of the right proximal lower extremity (clotting of blood in the deep vein of the upper portion of the right leg).An RCC sign-in sheet identified an RCC was held for Resident #11 on 12/18/25.The quarterly MDS assessment dated [DATE] identified Resident #11 had intact cognition (Brief Interview for Mental Status (BIMS) score of 15) and was dependent for bed mobility and transfers.Review of the clinical record from 2/17/26 through 3/27/26 failed to identify an RCC was scheduled or held for Resident #11 following the 2/17/26 MDS.The annual MDS assessment dated [DATE] identified Resident #11 had intact cognition (Brief Interview for Mental Status (BIMS) score of 15) and required substantial assistance for bed mobility and was dependent for transfers.Review of the clinical record from 3/28/26 through 6/24/26 failed to identify an RCC was scheduled or held for Resident #11 following the 3/28/26 MDS.3. Resident #13?s diagnoses included spastic hemiplegia affecting left nondominant side (a neurological condition where muscle stiffness and weakness occur on the left side of the body due to right-brain damage), chronic pain, type II diabetes mellitus and gastro-esophageal reflux disease.An RCC sign-in sheet identified an RCC was held for Resident #13 on 2/5/26.The annual MDS assessment dated [DATE] identified Resident #13 had moderately impaired cognition (Brief Interview for Mental Status (BIMS) score of 11), was independent with bed mobility and was dependent on staff for transfers.Review of the clinical record from 4/9/26 through 6/24/26 failed to identify an RCC was scheduled or held for Resident #13 following the 4/9/26 MDS.4. Resident #23's diagnoses included Parkinson's disease, abnormal voluntary movements and restlessness and agitation.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #23 had intact cognition (Brief Interview for Mental Status (BIMS) score of 13) and required substantial assistance for transfers and was independent with bed mobility.Review of the clinical record from 2/23/26 through 5/23/26 failed to identify an RCC was scheduled or held for Resident #23 following the 2/23/26 MDS.A quarterly MDS dated [DATE] for Resident #23 had not yet been completed as of 6/24/26.Review of the clinical record from 5/24/26 through 6/24/26 failed to identify an RCC was scheduled or held for Resident #23.5. Resident #26?s diagnoses included hypertension, atrial fibrillation, gastrostomy status, seizures, pain, contractures of muscles, abnormal involuntary movements, depression and bipolar disorder.An RCC sign-in sheet identified an RCC was held for Resident #26 on 2/2/26.The quarterly MDS assessment dated [DATE] identified Resident #26 had moderately impaired cognition (Brief Interview for Mental Status (BIMS) score of 9) and was dependent on staff for bed mobility and transfers.Review of the clinical record from 4/27/26 through (continued on next page)

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	075213	A. Building B. Wing	06/24/2026

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6/24/26 failed to identify an RCC was scheduled or held for Resident #26 following the 4/27/26 MDS.6. Resident #29?s diagnoses included hypertension, GERD, schizoaffective disorder, paranoid schizophrenia, major depressive disorder and anxiety disorder.An RCC sign-in sheet identified an RCC was held for Resident #29 on 2/5/26.The quarterly MDS assessment dated [DATE] identified Resident #29 had moderately impaired cognition (Brief Interview for Mental Status (BIMS) score of 9) and required partial assistance for bed mobility and transfers.Review of the clinical record from 2/28/26 through 5/30/26 failed to identify an RCC was scheduled or held for Resident #29 following the 2/28/26 MDS.A quarterly MDS dated [DATE] for Resident #29 had not yet been completed as of 6/24/26.Review of the clinical record from 5/31/26 through 6/24/26 failed to identify an RCC was scheduled or held for Resident #29. 7. Resident #30 was admitted to the facility on [DATE] with diagnoses including type II diabetes mellitus, long-term use of insulin and lymphedema (build-up of lymph fluid in the body's soft tissues causing swelling in the arms and legs).Review of the clinical record from 5/18/26 through 5/23/26 failed to identify a 72-hr RCC was scheduled or held for Resident #30 following the 5/18/26 admission.The admission MDS assessment dated [DATE] identified Resident #30 had intact cognition (Brief Interview for Mental Status (BIMS) score of 15) and required substantial assistance for bed mobility and was dependent on staff for transfers.Review of the clinical record from 5/24/26 through 6/24/26 failed to identify an RCC was scheduled or held for Resident #30 following the 5/24/26 MDS.Interview with the MDS Nurse on 6/24/26 at 10:51 AM identified social services typically scheduled RCCs, but the facility lacked a social worker since 5/15/26. RCCs must be completed quarterly and within seven days of each resident's MDS ARD. The MDS Nurse reported being behind on MDS assessments and therefore unable to assist with scheduling the RCCs.Interview with the DON and Regional Nurse on 6/24/26 at 3:13 PM identified a new facility social worker started the week of 6/22/26. They reported RCCs should be completed at least quarterly and within seven days of each resident's MDS ARD, and they were unaware RCCs were not being held consistently for all residents.Review of the Resident Participation in Care Planning policy dated 9/1/22 directed, in part, the resident and his or her legal representative are encouraged to attend and participate in the resident's assessment and in the development of the resident's person-centered care plan. Facility staff supports and encourages resident/representative participation in the care planning process by: ensuring that residents, representatives and families understand the care planning process; holding care planning meetings at times of day when the resident, representative and family members can attend and are functioning at their best; providing sufficient notice in advance of meeting; planning for enough time for exchange of information and decision making. A comprehensive care plan is developed within 7-days of completing the resident assessment. A seven (7) day advance notice of the care planning conference is provided to the resident and his or her representative. Such notice is made by mail and/or telephone. The social service director or designee is responsible for notifying the resident/representative and for maintaining records of such notices. Notices include: the date, time and location of the conference; the name of each person contacted and the date he or she was contacted; the method of contact; input from the resident or representative if they are not able to attend; refusal of participation, if applicable; the date and signature of the individual making contact.

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	075213	A. Building B. Wing	06/24/2026

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, facility documentation, facility policy, and staff interviews for two (2) of four (4) sampled residents (Residents #1 and #30) reviewed for pain management, the facility failed to ensure pain was adequately assessed, pain medications were administered and documented as ordered, and required postˆadministration pain reˆevaluations were completed. Specifically, the facility failed to ensure as needed (PRN) opioid pain medication was documented as administered, monitored for effectiveness, and that pain reevaluations were completed for Resident #1 and failed to ensure scheduled pain medication was administered and accurately documented for Resident #30. These failures resulted in inadequate pain management, inaccurate medication documentation, missed reassessments, and increased risk for adverse outcomes. The findings include:1. Resident #1?s diagnoses included malignant neoplasm of the bone (bone cancer), malignant neoplasm of the hypopharynx (an aggressive cancer to the lower part of the throat) and depression.The admission Observation assessment dated [DATE] identified Resident #1 was alert and oriented to person, place and time, memory was intact and required assistance with Activities of Daily Living (ADLs). Further, it identified Resident #1 reported occasional back pain.A physician's order dated 4/28/26 directed to administer oxycodone 20 milligrams (mg) every three (3) hours for severe pain as needed.A physician's order dated 4/28/26 directed to administer Oxycontin extended release tablet 20 mg daily at bedtime.A physician's order dated 4/29/26 directed to administer Oxycontin extended release tablet 10 mg twice daily at 6:00 AM and 2:00 PM (to be administered with 15 mg tablet for a total of 25 mg).A physician's order dated 4/29/26 directed to administer Oxycontin extended release tablet 15 mg twice daily at 6:00 AM and 2:00 PM (to be administered with 10 mg tablet for a total of 25 mg).The Resident Care Plan (RCP) dated 4/29/26 identified Resident #1 had pain/discomfort and required palliative care related to cancer diagnoses. Interventions included assessing for pain and intervening as necessary, observing for nonverbal signs of pain and administering medications as ordered and assessing for effectiveness.A nurse's note by RN #4 on 5/21/26 at 3:24 PM identified Resident #1 was out of bed participating with therapy when LPN #7 called her to report Resident #1 required immediate assessment due to unresponsiveness and respiratory distress. On assessment Resident #1 was hypotensive (blood pressure of 87/70) and the blood oxygen level (Sp02) was 87 percent (%) on room air. The APRN was notified and new orders were obtained to administer oxygen at fifteen (15) liters via a non-rebreather mask and PRN Narcan (a medication that rapidly reverses the effects of opioid overdoses) was administered to both nostrils. Vital signs were reassessed and both the blood pressure and SP02 levels improved. Emergency Services was called and arrived at 1:56 PM and Resident #1 was transferred to the Emergency Department (ED) for further evaluation.Review of the May 2026 Medication Administration Record (MAR) identified Resident #1 had been administered both the 6:00 AM and 2:00 PM doses of Oxycontin prior to the incident on 5/21/26. The MAR failed to identify the PRN oxycodone had been administered to Resident #1 on 5/21/26 prior to the incident.The Controlled Proof-of-use/Disposition Form (used to track the administration, waste and reconciliation of controlled substances and proves that a specific dose was administered to a resident or properly disposed of) for Resident #1's oxycodone 20 mg, identified one (1) tablet of oxycodone 20 mg was signed out at 8:30 AM and 12:00 PM on 5/21/26 by LPN #7. The oxycodone 20 mg was removed from stock but had not been signed out as administered in the MAR, therefore Resident #1's pain was not reevaluated following the administrations.Review of nurse's notes dated 5/21/26 failed to identify documentation related to pain.Re-review of the May 2026 MAR identified eighteen (18) doses of PRN oxycodone 20 mg had been signed as administered to Resident #1 in May.Re-review of the Controlled Proof-of-use/Disposition Form identified forty (40) doses of PRN oxycodone 20 mg had been signed out of stock for Resident #1 in May 2026.Only 18 (45 % of the doses) of the PRN oxycodone 20 mg doses that were removed from stock for Resident #1 had been (continued on next page)

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	075213	A. Building B. Wing	06/24/2026

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented as administered on the MAR, resulting in twenty-two (22) administrations (55 %) not receiving reevaluations of Resident #1's pain.Interview with LPN #7 on 6/24/26 at 12:53 PM identified although he administered PRN oxycodone 20 mg to Resident #1 on 5/21/26 at 8:30 AM and 12:00 PM for complaints of severe back pain, he did not document the administrations in the MAR or complete the required pain reˆevaluations one (1) hour afterwards. LPN #7 reported after the unresponsive episode, he failed to document the event in a nurse's note or notify RN #4 or a provider that Resident #1 had received two (2) doses of PRN oxycodone earlier in the shift.Interviews with APRN #2 on 6/24/26 at 1:34 PM and 3:04 PM identified on 5/21/26, she was in the hallway when Resident #1 was found unresponsive and responded immediately. Upon arrival, Resident #1 was seated in a bedside chair, slumped over, cyanotic, unresponsive, and breathing shallowly. She directed staff to administer oxygen, move Resident #1 to the floor, obtain vital signs, and apply the Automatic External Defibrillator; no shock was advised. Narcan was administered, and after the second spray, Resident #1 became alert. Although the PRN oxycodone was ordered every three (3) hours, she was not aware Resident #1 had been receiving it several times daily or that two (2) doses had been given during the shift before the incident. She identified this could have contributed to an overdose. APRN #2 reported that all PRN pain medication doses should be documented in the MAR and pain levels should be reassessed timely per facility policy, which could also identify adverse reactions, including preventing oversedation or unresponsiveness.Interview with the DON and Regional Nurse on 6/24/26 at 3:13 PM identified all PRN pain medications are expected to be documented in the MAR at the time they are administered. Staff are required to complete and document a pain reˆevaluation within one (1) hour after administering PRN pain medication. The DON and Regional Nurse reported they were unaware this process was not being followed consistently for Resident #1's PRN oxycodone and were unaware LPN #7 had administered two (2) doses of PRN oxycodone during the shift prior to Resident #1 becoming unresponsive. 2. Resident #30?s diagnoses included type II diabetes mellitus, long-term use of insulin and lymphedema.A physician's order dated 5/18/26 directed to administer pregabalin (used to treat nerve pain in those with diabetes) 100 mg three times daily.The admission Observation dated 5/18/26 identified Resident #30 was alert and oriented with intact memory and utilized a walker.The RCP dated 5/21/26 identified Resident #30 had diabetes. Interventions included administering medications as ordered and obtaining blood glucose twice daily.The Reportable Event (RE) dated 5/21/26 identified throughout the 3:00 PM to 11:00 PM shift, LPN #1 was noted to be off the unit multiple times due to feeling unwell. At approximately 11:00 PM, staff found LPN #1 lethargic in the employee restroom with suspected drug paraphernalia in possession. Emergency Medical Services (EMS) arrived, LPN #1 was removed from the schedule pending investigation and twenty-two (22) residents were identified to have been omitted medications and/or treatments during the shift.Interview with Resident #30 on 6/23/26 at 10:30 AM identified he/she did not see LPN #1 on 5/21/26 and did not receive pregabalin which resulted in pain overnight. Resident #30 identified he/she reported this the following day and a nurse reported the medication was signed off.The May 2026 electronic Medication Administration Record (eMAR) identified Resident #30 had scheduled pregabalin 100 mg three times daily at 9:00 AM, 1:00 PM and 5:00 PM, which was signed off as administered by LPN #1 on 5/21/26 at 5:00 PM.The Controlled Proof-of-use/Disposition Form for Resident #30's pregabalin 100 mg identified the 5:00 PM dose of pregabalin was not signed out of stock on 5/21/26.Review of nurse's notes dated 5/21/26 failed to identify documentation of omitted medications. Interview with LPN #1 on 6/24/26 at 10:04 AM identified on 5/21/26 she administered medications and treatments but did not document them at the time as required. She stated she passed some medications, may have missed others, and could not explain the discrepancies between what she signed off in the eMAR and the disposition sheets. Following her suspension on 5/21/26, she admitted accessing the eMAR from home and signing off medications and treatments when she was not certain she administered them.Interview with the DON and the Regional Nurse on 6/24/26 at 3:10 PM identified medications should be signed out on the eMAR at the time of administration and (continued on next page)

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	06/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Civita Care Center at Milford	2028 Bridgeport Ave Milford, CT 06460

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documentation should be accurate. The eMAR should have matched the Controlled Proof-of-use/Disposition Form for Resident #30's pregabalin 100 mg and since not signed out of stock, it was not administered to Resident #30, although it should have been.Review of the Clinical Protocol for Pain policy dated 9/1/22 directed, in part, residents are assessed regularly and whenever there is a change in condition or new/worsening pain. Staff evaluate pain characteristics (location, severity, pattern) and how pain affects daily function, mood, sleep, and safety. For treatment, the physician sets individualized goals and orders appropriate pain management, using the simplest and lowest-risk regimen when possible. Medications are to be administered as ordered by the physician, and non-medication interventions (such as repositioning, heat/ice, and other comfort measures) are used alongside medication therapy. PRN pain medications are specifically monitored and evaluated. Staff are responsible for tracking use of PRN analgesics, assessing their effectiveness, and reporting patterns such as frequent or escalating use. PRN effectiveness and pain status are reassessed regularly and during routine monitoring (at least each shift and more frequently if needed for acute pain or changes). If PRN medications are required frequently or are insufficient, the physician may adjust the regimen, including scheduling medications, changing agents, or adding additional therapies. Ongoing monitoring is required to evaluate response to treatment, side effects, and overall pain control. The physician may modify or discontinue medications based on effectiveness, safety, and patient response, and may also consider dose reductions when appropriate.

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	06/24/2026

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for nineteen (19) of twenty nine (29) sampled residents (Residents #3, 4, 8, 9, 10, 11, 13, 15, 16, 17, 18, 20, 22, 24, 26, 27, 28, 29, 30) reviewed for neglect, the facility failed to ensure that the residents were provided social services support timely after alleged neglect occurred within the facility. Specifically, LPN #1 repeatedly left the assigned unit for long periods without notifying staff, and failed to ensure resident medications and treatments were administered per physician's orders resulting in significant medication errors. The findings include:The Reportable Event (RE) dated 5/21/26 identified throughout the 3:00 PM to 11:00 PM shift, LPN #1 was off the unit multiple times due to feeling unwell. At approximately 11:00 PM, staff found LPN #1 lethargic in the employee bathroom with suspected drug paraphernalia in her possession. Emergency Medical Services (EMS) arrived, LPN #1 was removed from the schedule pending investigation and twenty-two (22) residents were identified to have been omitted medications and/or treatments during the shift. The Medical Director was notified, and assessments were completed on the affected residents with no adverse effects identified. The RE was classified as neglect.1.Resident #4?s diagnoses included chronic pancreatitis (progressive inflammation of the pancreas), central pain syndrome and type II diabetes mellitus.The quarterly MDS assessment dated [DATE] identified Resident #4 had severely impaired cognition (Brief Interview for Mental Status (BIMS) score of 6) and required substantial assistance with bed mobility.The RCP dated 5/11/26 identified Resident #4 had diabetes mellitus with diabetic neuropathy and was insulin dependent, required a therapeutic diet related to compromised endocrine function and had the potential for chronic pain secondary to chronic pancreatitis. Interventions included administering medications as ordered and monitoring and recording effectiveness.Review of social service notes from 5/21/26 through 5/27/26 failed to identify social worker interaction with Resident #4 regarding the neglect incident and omitted medications on 5/21/26.Although attempted, Resident #4 was unable to be interviewed.2. Resident #8?s diagnoses included hypertension, benign prostatic hyperplasia (enlargement of the prostate gland), adult failure to thrive, anxiety disorder and major depressive disorder.The annual MDS assessment dated [DATE] identified Resident #8 had moderately impaired cognition (Brief Interview for Mental Status (BIMS) score of 8), was independent with bed mobility and required supervision assistance for transfers.The RCP dated 4/6/26 identified Resident #8 had weight loss over the last month, was at risk for cardiac complications secondary to diagnoses of cerebral infarction, hyperlipidemia and orthostatic hypotension. Interventions included administering medications as ordered.Review of social service notes from 5/21/26 through 5/27/26 failed to identify social worker interaction with Resident #8 regarding the neglect incident and omitted medications on 5/21/26.Although attempted, Resident #8 was unable to be interviewed.3. Resident #9?s diagnoses included Congestive Heart Failure (CHF), chronic left lower quadrant abdominal spasms, diverticulitis (inflammation of irregular bulging pouches in the wall of the large intestine), retention of urine, anxiety disorder and major depressive disorder.The quarterly MDS assessment dated [DATE] identified Resident #9 had intact cognition (Brief Interview for Mental Status (BIMS) score of 13) and required setup assistance for bed mobility and was independent with transfers.The RCP dated 5/20/26 identified Resident #9 had heart failure, a history of urinary retention and a history of diverticulitis. Interventions included administering medications such as beta blockers, diuretics and antibiotics as ordered.Review of social service notes from 5/21/26 through 5/27/26 failed to identify social worker interaction with Resident #9 regarding the neglect incident and omitted medications on 5/21/26.Interview with Resident #9 on 6/23/26 at 11:22 AM identified he/she could not recall receiving medications on 5/21/26. Resident #9 reported LPN #1 was consistently rude to him/her and called him/her crazy on numerous occasions so Resident #9 tried to have as little (continued on next page)

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	075213	A. Building B. Wing	06/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	contact with LPN #1 as possible.4. Resident #10's diagnoses included chronic pain, atrial fibrillation (irregular, rapid heart rhythm) and depression.The quarterly MDS assessment dated [DATE] identified Resident #10 had intact cognition (Brief Interview for Mental Status (BIMS) score of 13) and required total assistance for transfers and was independent with bed mobility.The RCP dated 2/11/26 identified Resident #10 was at risk for impaired skin integrity due to Eliquis use and had a diagnosis of diabetes mellitus. Interventions included administering medications per orders and monitoring for any side effects.Review of social service notes from 5/21/26 through 5/27/26 failed to identify social worker interaction with Resident #10 regarding the neglect incident and omitted medications on 5/21/26.Interview with Resident #10 on 6/23/26 at 10:46 AM identified he/she remembered not receiving medications on 5/21/26. Resident #10 reported having increased pain and difficulty sleeping, which was abnormal for him/her, but denied reporting the incident to anyone.5. Resident #11?s diagnoses included type II diabetes mellitus, chronic kidney disease, dependence on renal dialysis, unspecified convulsions (involuntary muscle shaking or spasms but the exact cause or seizure type had not been identified) and acute embolism and thrombosis of the deep veins of the right proximal lower extremity (clotting of blood in the deep vein of the upper portion of the right leg).The annual MDS assessment dated [DATE] identified Resident #11 had intact cognition (Brief Interview for Mental Status (BIMS) score of 15), and required substantial assistance for bed mobility and was dependent on staff for transfers.The RCP dated 3/29/26 identified Resident #11 had the potential for injury due to seizure disorder, had the potential for pain/discomfort due to generalized discomfort and lymphedema wounds (slow- healing sores due to fluid buildup) and had a history of Deep Vein Thrombosis (DVT) and was on blood thinners. Interventions included administering medications as ordered.Review of social service notes from 5/21/26 through 5/27/26 failed to identify social worker interaction with Resident #11 regarding the neglect incident and omitted medications on 5/21/26.Interview with Resident #11 on 6/24/26 at 10:34 AM identified he/she could not recall if they were administered medications on 5/21/26.6. Resident #13?s diagnoses included spastic hemiplegia affecting left nondominant side (a neurological condition where muscle stiffness and weakness occurred on the left side of the body due to right-brain damage), chronic pain, type II diabetes mellitus and gastro-esophageal reflux disease.The annual MDS assessment dated [DATE] identified Resident #13 had moderately impaired cognition (Brief Interview for Mental Status (BIMS) score of 11), was independent with bed mobility and was dependent on staff for transfers.The RCP dated 5/6/26 identified Resident #13 had the potential for pain/discomfort related to polyneuropathy, had diabetes mellitus and was at risk for hyper/hypoglycemia. Interventions included administering medications as ordered.Review of social service notes from 5/21/26 through 5/27/26 failed to identify social worker interaction with Resident #13 regarding the neglect incident and omitted medications on 5/21/26.Interview with Resident #13 on 6/23/26 at 10:51 AM identified he/she could not recall receiving medications on the 3:00 PM to 11:00 PM shift on 5/21/26 but reported LPN #1 was consistently late administering medications and Resident #13 often called the nursing supervisor to complain. Resident #13 identified he/she was often in increased pain after LPN #1 worked due to getting his/her medications so late.7. Resident #15?s diagnoses included seizures, aphasia following cerebral infarction (language disorder caused by damage to the brain's language centers following a stroke), hypercholesterolemia (high cholesterol levels) and depressive disorder.The annual MDS assessment dated [DATE] identified Resident #15 had moderately impaired cognition (Brief Interview for Mental Status (BIMS) score of 8), and was independent with bed mobility and transfers.The RCP dated 3/16/26 identified Resident #15 had the potential for seizures. Interventions included monitoring lab values for a therapeutic level of anticonvulsant medications.Review of social service notes from 5/21/26 through 5/27/26 failed to identify social worker interaction with Resident #15 regarding the neglect incident and omitted medications on 5/21/26.Although attempted, Resident #15 was unable to be interviewed.10. Resident #17?s diagnoses included dementia without behavioral disturbances, restlessness and agitation, palliative care, major depressive disorder and (continued on next page)

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	06/24/2026

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	schizoaffective disorder, depressive type.The annual MDS assessment dated [DATE] identified Resident #17 had severely impaired cognition (Brief Interview for Mental Status (BIMS) score of 6) and was dependent on staff for bed mobility and transfers.The RCP dated 4/13/26 identified Resident #17 had the potential for pain/discomfort related to general discomfort, had the potential for alteration in mood and/or behavior, had a history of schizoaffective disorder and depressive disorder and was on hospice care. Interventions included evaluating for pain/discomfort as indicated and administering medications as ordered.Review of social service notes from 5/21/26 through 5/27/26 failed to identify social worker interaction with Resident #17 regarding the neglect incident and omitted medications on 5/21/26.Although attempted, Resident #17 was unable to be interviewed.11. Resident #18?s diagnoses included hypertension, hypothyroidism, type II diabetes mellitus with hyperglycemia and major depressive disorder.The annual MDS assessment dated [DATE] identified Resident #18 had intact cognition (Brief Interview for Mental Status (BIMS) score of 15), and was independent with bed mobility, transfers and ambulation.The RCP dated 4/16/26 identified Resident #18 had a history of both hypotension and hypertension and was at risk for pain. Interventions included monitoring vital signs as necessary and administering medications as ordered.Review of social service notes from 5/21/26 through 5/27/26 failed to identify social worker interaction with Resident #18 regarding the neglect incident and omitted medications on 5/21/26.Interview with Resident #18 on 6/23/26 at 11:14 AM identified he/she could not recall receiving medications on 5/21/26.12. Resident #20?s diagnoses included Atrial Fibrillation (AFIB), urinary retention, chronic interstitial cystitis with hematuria, visual hallucinations, restlessness and agitation and anxiety disorder.The quarterly MDS assessment dated [DATE] identified Resident #20 had moderately impaired cognition (Brief Interview for Mental Status (BIMS) score of 11), and required substantial assistance for bed mobility and was dependent on staff for transfers.The RCP dated 5/15/26 identified Resident #20 had AFIB and took medications that left the blood a little on the thinner side, had the potential for alteration in elimination due to incontinence, constipation, and urinary retention and had the potential for alteration in mood and/or behavior and displayed behaviors such as yelling out and talking to self and could present as agitated and accusatory. Interventions included administering medications as ordered.Review of social service notes from 5/21/26 through 5/27/26 failed to identify social worker interaction with Resident #20 regarding the neglect incident and omitted medications on 5/21/26.Interview with Resident #20 on 6/23/26 at 11:26 AM identified he/she could not recall receiving medications on 5/21/26.13. Resident #22?s diagnoses included Congestive Heart Failure (CHF), hypertension, hypotension, polyneuropathy, chronic pain, anxiety disorder and adjustment disorder with depressed mood.The 5-day MDS assessment dated [DATE] identified Resident #22 had moderately impaired cognition (Brief Interview for Mental Status (BIMS) score of 11) and was dependent on staff for bed mobility and transfers.The RCP dated 4/21/26 identified Resident #22 had a history of seizures, was at risk for cardiac/pulmonary complications secondary to diagnoses of ischemic heart disease, hypertension, CHF, anemia and chronic chest pain and had chronic generalized pain due to arthritis, polyneuropathy and chest pain. Interventions included administering medications as ordered. Review of social service notes from 5/21/26 through 5/27/26 failed to identify social worker interaction with Resident #22 regarding the neglect incident and omitted medications on 5/21/26.Interview with Resident #22 on 6/23/26 at 10:40 AM identified he/she could not recall receiving medications on 5/21/26.14. Resident #24?s diagnoses included dementia with behavioral disturbances, type II diabetes mellitus, unspecified abnormal involuntary movements, hypertension, Benign Prostatic Hyperplasia (BPH) with lower urinary tract symptoms, schizoaffective disorder, bipolar type, and anxiety disorder.The quarterly MDS assessment dated [DATE] identified Resident #24 had moderately impaired cognition (Brief Interview for Mental Status (BIMS) score of 10), and was independent with bed mobility and transfers.The RCP dated 5/11/26 identified Resident #24 had diabetes and was at risk for hypo and hyper glycemic episodes and was insulin dependent, had pain and chest pain and had the potential for alteration in mood and/or behavior due to multiple diagnoses and a history of impulsive behavior, (continued on next page)

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	075213	A. Building B. Wing	06/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	violent behavior and accusatory behavior. Interventions included administering prescribed medication and evaluating for the effectiveness.Review of social service notes from 5/21/26 through 5/27/26 failed to identify social worker interaction with Resident #24 regarding the neglect incident and omitted medications on 5/21/26.Although attempted, Resident #24 was unable to be interviewed.15. Resident #26?s diagnoses included hypertension, atrial fibrillation, gastrostomy status, seizures, pain, contractures of muscles, abnormal involuntary movements, depression and bipolar disorder.The quarterly MDS assessment dated [DATE] identified Resident #26 had moderately impaired cognition (Brief Interview for Mental Status (BIMS) score of 9), and was dependent on staff for bed mobility and transfers.The RCP dated 5/15/26 identified Resident #26 utilized a gastrostomy tube for feeding and medications as needed, was at risk for cardiovascular events and was on blood thinners and had the potential for alteration in mood and/or behavior due to diagnoses of borderline personality disorder, bipolar disorder, depression, social phobia, and restlessness and agitation. Interventions included administering medications as ordered and monitoring for side effects.Review of social service notes from 5/21/26 through 5/27/26 failed to identify social worker interaction with Resident #26 regarding the neglect incident and omitted medications on 5/21/26.Although attempted, Resident #26 was unable to be interviewed.16. Resident #27?s diagnoses included dementia with behavioral disturbances, type II diabetes mellitus with hyperglycemia, hypertension, epilepsy and polyneuropathy.The annual MDS assessment dated [DATE] identified Resident #27 had moderately impaired cognition (Brief Interview for Mental Status (BIMS) score of 8) and required supervision assistance for transfers and was independent with bed mobility.The RCP dated 5/4/26 identified Resident #27 had the potential for pain/discomfort related to general discomfort, low back pain, foot pain and diabetes mellitus, was at risk for cardiac complications due to diagnoses of hypertension and diabetes, had a mood disorder and was at risk for anxiety and/or depression. Interventions included administering medications as ordered.Review of social service notes from 5/21/26 through 5/27/26 failed to identify social worker interaction with Resident #27 regarding the neglect incident and omitted medications on 5/21/26.Although attempted, Resident #27 was unable to be interviewed.17. Resident #28?s diagnoses included muscle spasms, functional quadriplegia, chronic pain, insomnia, adult failure to thrive, moderate protein-calorie malnutrition and major depressive disorder.The quarterly MDS assessment dated [DATE] identified Resident #28 had severely impaired cognition (Brief Interview for Mental Status (BIMS) score of 3), and was dependent on staff for bed mobility and did not transfer or ambulate.The RCP dated 4/13/26 identified Resident #28 had Major Depressive Disorder and anorexia, had the potential for alteration in mood and/or behavior and had a history of chronic pain and osteoporosis, received gabapentin twice daily for neuropathy, and was on tramadol and baclofen secondary to progressing contractures. Interventions included administering medications per order, monitoring and recording effectiveness and reporting any adverse side effects.Review of social service notes from 5/21/26 through 5/27/26 failed to identify social worker interaction with Resident #28 regarding the neglect incident and omitted medications on 5/21/26.Although attempted, Resident #28 was unable to be interviewed.18. Resident #29?s diagnoses included hypertension, GERD, schizoaffective disorder, paranoid schizophrenia, major depressive disorder and anxiety disorder.The quarterly MDS assessment dated [DATE] identified Resident #29 had moderately impaired cognition (Brief Interview for Mental Status (BIMS) score of 9), and required partial assistance for bed mobility and transfers.The RCP dated 2/28/26 identified Resident #29 had the potential for cardiac/pulmonary complications secondary to diagnoses of COPD, hypertension and hyperlipidemia and had behaviors related to schizophrenia, disorganized type, major depressive disorder, generalized anxiety disorder and alcohol-related dementia. Interventions included administering medications as ordered.Review of social service notes from 5/21/26 through 5/27/26 failed to identify social worker interaction with Resident #29 regarding the neglect incident and omitted medications on 5/21/26.Interview with Resident #29 on 6/23/26 at 11:33 AM identified there had been multiple occurrences when he/she had not received medications on the 3:00 PM to 11:00 PM (continued on next page)

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	06/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Civita Care Center at Milford	2028 Bridgeport Ave Milford, CT 06460

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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	06/24/2026

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy and interviews, the facility failed to ensure medications were administered as ordered and failed to prevent significant medication errors for nineteen (19) of twenty-nine (29) sampled residents (Residents #3, 4, 8, 9, 10, 11, 13, 15, 16, 17, 18, 20, 22, 24, 26, 27, 28, 29, and 30). This resulted in missed doses of highˆrisk medications, unsafe controlledˆsubstance handling, and a lack of timely assessment or provider notification. Specifically, LPN #1 repeatedly left the unit without notifying supervisory staff, was unavailable to administer scheduled and PRN medications, and was later found unresponsive in an employee restroom with drug paraphernalia present. Despite these concerns, nursing leadership did not remove LPN #1 from duty, did not assess residents for potential omissions, did not review the electronic Medication Administration Record (eMAR), and did not notify the provider until the following day. Following suspension, LPN #1 retained remote access to the eMAR and subsequently signed off medications she could not verify as administered. Record review identified widespread omitted medications on 5/21/26-including anticoagulants, insulin, anticonvulsants, cardiac medications, psychotropics, controlled substances, and timeˆsensitive treatments. Required vital signs, pain assessments, diabetic monitoring, gastrostomy tube (G-tube) (a medical device inserted through the abdomen directly into the stomach) care, and treatment documentation were also missing. Controlledˆsubstance counts were inaccurate, and RN #2 permitted LPN #1 to retroactively sign out narcotics without verifying administration. Additionally, for Resident #3, the facility failed to administer multiple timeˆsensitive medications prior to the resident's scheduled fistulogram, and nursing staff failed to identify the missed doses or notify the nursing supervisor or provider of the omissions. These failures resulted in a finding of Immediate Jeopardy. The findings included:Please cross-reference F580, F636 and F657.The Reportable Event (RE) dated 5/21/26 identified throughout the 3:00 PM to 11:00 PM shift, LPN #1 was off the nursing unit multiple times due to reportedly feeling unwell. At approximately 11:00 PM, staff located LPN #1 lethargic in an employee restroom with suspected drug paraphernalia in possession. Emergency services were called and police and Emergency Medical Services (EMS) arrived; LPN #1 was removed from the schedule pending investigation and twenty-two (22) residents were identified to have been omitted medications and/or treatments during the shift. The Medical Director was notified, and assessments were completed for affected residents with no adverse effects identified.1a. Resident #4?s diagnoses included chronic pancreatitis (progressive inflammation of the pancreas), central pain syndrome and type II diabetes mellitus.The quarterly MDS assessment dated [DATE] identified Resident #4 had severely impaired cognition (Brief Interview for Mental Status (BIMS) score of 6) and required substantial assistance with bed mobility.The RCP dated 5/11/26 identified Resident #4 had diabetes mellitus with diabetic neuropathy and was insulin dependent, required a therapeutic diet related to compromised endocrine function and had the potential for chronic pain secondary to chronic pancreatitis. Interventions included administering medications as ordered and monitoring and recording effectiveness.Review of the Administration Compliance Report dated 5/21/26 identified the following medications were omitted on 5/21/26:5:30 PM: baclofen (muscle relaxant and antispasmodic) 5 mg, give 1 tablet twice daily;6:30 PM: Creon (for the treatment of exocrine pancreatic insufficiency) 36,000-114,000-180,000 units delayed release, administer 1 capsule with meals.The May 2026 eMAR identified the 5:30 PM dose of baclofen and the 6:30 PM dose of Creon were documented as administered on 5/21/26 by LPN #1, however, review of the Audit Log (a report that identifies when charting was completed or documentation was edited) identified LPN #1 accessed the eMAR and signed off the omitted medications on 5/22/26 (while suspended from employment at the facility).Although attempted, Resident #4 was unable to be interviewed.1b. Resident #8?s diagnoses included hypertension, benign prostatic hyperplasia (enlargement of the prostate gland), adult failure to thrive, anxiety disorder and major depressive disorder.The annual (continued on next page)

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	06/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Civita Care Center at Milford	2028 Bridgeport Ave Milford, CT 06460

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	MDS assessment dated [DATE] identified Resident #8 had moderately impaired cognition (Brief Interview for Mental Status (BIMS) score of 8), was independent with bed mobility and required supervision assistance for transfers.The RCP dated 4/6/26 identified Resident #8 had weight loss over the last month, was at risk for cardiac complications secondary to diagnoses of cerebral infarction, hyperlipidemia and orthostatic hypotension. Interventions included administering medications as ordered.The Administration Compliance Report dated 5/21/26 identified the following medications were omitted on 5/21/26:4:00 PM: midodrine (for the treatment of symptomatic orthostatic hypotension) 10 mg, give 1 tablet three times daily; Ensure supplement, give 237 milliliters (mL) 4 times daily.5:00 PM: tamsulosin (for the treatment of symptoms of an enlarged prostate such as difficulty urinating) 0.4 mg, give 1 capsule daily.The May 2026 eMAR identified the 4:00 PM dose of midodrine, the Ensure supplement and the 5:00 PM dose of tamsulosin were documented as administered on 5/21/26 by LPN #1, however, review of the Audit Log identified LPN #1 accessed the eMAR and signed off the omitted medications on 5/22/26 (while suspended from employment at the facility). The MAR further identified missing entries for a blood pressure and heart rate which were required prior to the administration of the midodrine.Although attempted, Resident #8 was unable to be interviewed.1c. Resident #9?s diagnoses included Congestive Heart Failure (CHF), chronic left lower quadrant abdominal spasms, diverticulitis (inflammation of irregular bulging pouches in the wall of the large intestine), retention of urine, anxiety disorder and major depressive disorder.The quarterly MDS assessment dated [DATE] identified Resident #9 had intact cognition (Brief Interview for Mental Status (BIMS) score of 13), required setup assistance for bed mobility and was independent with transfers.The RCP dated 5/20/26 identified Resident #9 had heart failure, a history of urinary retention and a history of diverticulitis. Interventions included administering medications such as beta blockers, diuretics and antibiotics as ordered.The Administration Compliance Report dated 5/21/26 identified the following medications were omitted on 5/21/26:5:00 PM: metoprolol succinate (for the treatment of CHF and high blood pressure) extended release 25 mg, give 3 tablets (75 mg) twice daily; Voltaren gel 1 %, administer 4 g topically three times daily.6:00 PM: check bladder ultrasound and straight catheterize as needed for more than 450 cubic centimeters (cc) in the bladder every 6 hours.The May 2026 eMAR identified 5:00 PM doses of metoprolol succinate, calcium carbonate and Voltaren gel were omitted on 5/21/26. 9:00 PM doses of rosuvastatin 20 mg, give 1 tablet daily; Eliquis 5 mg, give 1 tablet every 12 hours; gabapentin 100 mg and 400 mg tablet (500 mg dose) three times daily for chronic leg pain; metronidazole 500 mg, give 1 tablet every 12 hours for bacterial vaginosis; mirtazapine (for the treatment of major depressive disorder) 30 mg, give 1 tablet daily at bedtime; oxycodone 5 mg, give 1 tablet three times daily for chronic leg pain; tamsulosin 0.4 mg, give 2 capsules daily at bedtime for urinary retention were omitted on 5/21/26. The pain assessment scheduled to be completed each shift was blank for the 3:00 PM to 11:00 PM shift on 5/21/26. The May 2026 Treatment Administration Record (TAR) identified blank entries for the 6:00 PM bladder ultrasound. Review of nurse's notes dated 5/21/26 failed to identify LPN #1 documented regarding the omitted medications.The Controlled Proof-of-use/Disposition Form for oxycodone 5 mg identified one (1) tablet of oxycodone 5 mg was signed out at 9:00 PM on 5/21/26.Interview with Resident #9 on 6/23/26 at 11:22 AM identified he/she could not recall receiving medications on 5/21/26.1d. Resident #10's diagnoses included chronic pain, atrial fibrillation (irregular, rapid heart rhythm) and depression.The quarterly MDS assessment dated [DATE] identified Resident #10 had intact cognition (Brief Interview for Mental Status (BIMS) score of 13) required total assistance for transfers and was independent with bed mobility.The RCP dated 2/11/26 identified Resident #10 was at risk for impaired skin integrity due to Eliquis use and had a diagnosis of diabetes mellitus. Interventions included administering medications per order and monitoring for side effects.The Administration Compliance Report dated 5/21/26 identified the following medications were omitted on 5/21/26:8:00 PM: acetaminophen (for treatment of mild to moderate discomfort/pain) 500 mg, give 2 tablets (1000 mg) every 12 hours; Eliquis 5 mg, give 1 tablet every 12 hours.The May 2026 eMAR identified (continued on next page)

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	075213	A. Building B. Wing	06/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	075213	A. Building B. Wing	06/24/2026

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	receiving medications during the 3:00 PM to 11:00 PM shift on 5/21/26 but reported LPN #1 was consistently late administering medications and Resident #13 often called the nursing supervisor to complain. Resident #13 identified he/she was often in increased pain after LPN #1 worked due to receiving medications late.1g. Resident #14?s diagnoses included pain disorder with psychological factors, personal history of a traumatic brain injury, migraines, anxiety disorder and depression.The quarterly MDS assessment dated [DATE] identified Resident #14 had intact cognition (Brief Interview for Mental Status (BIMS) score of 14), was independent with bed mobility and transfers.The RCP dated 4/6/26 identified Resident #14 had pain. Interventions included administering pain medications as ordered.The May 2026 eMAR identified all scheduled medications were signed off as administered on the 3:00 PM to 11:00 PM shift on 5/21/26 by LPN #1.Further review identified Resident #14 received as needed (PRN) acetaminophen 500 mg on 5/21/26 at 7:27 PM by LPN #4, who was not Resident #13's assigned nurse that shift. Resident #14's pain level was not reˆevaluated until the next shift by LPN #6, but a re-evaluation time was not identified (the next shift was over 3.5 hours later).Interview with LPN #4 on 6/23/26 at 12:43 PM identified on 5/21/26, just before 7:30 PM, Resident #14 rang the call bell complaining of a headache. Staff alerted her they could not locate LPN #1 so she administered acetaminophen to Resident #14 and then notified the nursing supervisor (RN #1) that she had not seen LPN #1 since approximately 6:00 PM. LPN #1 was paged overhead three (3) times before returning to the unit at 8:00 PM. LPN #4 notified LPN #1 that acetaminophen was administered. LPN #4 reported LPN #1 did not notify her that she was leaving the unit.Although attempted, an interview with Resident #14 was not obtained.1h. Resident #15?s diagnoses included seizures, aphasia following cerebral infarction (language disorder caused by damage to the brain's language centers following a stroke), hypercholesterolemia (high cholesterol levels) and depressive disorder.The annual MDS assessment dated [DATE] identified Resident #15 had moderately impaired cognition (Brief Interview for Mental Status (BIMS) score of 8) and was independent with bed mobility and transfers.The RCP dated 3/16/26 identified Resident #15 had the potential for seizures. Interventions included monitoring lab values for a therapeutic level of anticonvulsant medications.The Administration Compliance Report dated 5/21/26 identified the following medications were omitted on 5/21/26:8:00 PM: levetiracetam 250 mg, administer 6 tablets (1,500 mg) twice daily; rosuvastatin 40 mg, give 1 tablet daily at bedtime.The May 2026 eMAR identified the levetiracetam and rosuvastatin were signed off as administered on 5/21/26 by LPN #1, however, review of the Audit Log identified LPN #1 accessed the eMAR and signed off the omitted medications on 5/22/26 (while suspended from employment at the facility).Although attempted, Resident #15 was unable to be interviewed.1i. Resident #17?s diagnoses included dementia without behavioral disturbances, restlessness and agitation, palliative care, major depressive disorder and schizoaffective disorder, depressive type.The annual MDS assessment dated [DATE] identified Resident #17 had severely impaired cognition (Brief Interview for Mental Status (BIMS) score of 6) and was dependent on staff for bed mobility and transfers.The RCP dated 4/13/26 identified Resident #17 had the potential for pain/discomfort related to general discomfort, had the potential for alteration in mood and/or behavior, had a history of schizoaffective disorder and depressive disorder and was on hospice care. Interventions included evaluating for pain/discomfort as indicated and administering medications as ordered.The Administration Compliance Report dated 5/21/26 identified the following medications were omitted on 5/21/26:4:30 PM: acetaminophen 500 mg, give 2 tablets (1,000 mg) three times daily.5:30 PM: lorazepam (for treatment of anxiety, comfort) 0.5 mg, give 1 tablet once daily.The May 2026 eMAR identified the lorazepam was signed off as administered on 5/21/26 by LPN #1, however, review of the Audit Log identified LPN #1 accessed the eMAR and signed off the omitted medication on 5/22/26 (while suspended from employment at the facility). The acetaminophen administrations at both 4:30 PM and 9:00 PM on 5/21/26 were blank.Review of nurse's notes dated 5/21/26 failed to identify documentation regarding the omitted medications.The Controlled Proof-of-use/Disposition Form for lorazepam 0.5 mg failed to identify the 5:30 PM dose of lorazepam was signed out by LPN #1 on (continued on next page)

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	075213	A. Building B. Wing	06/24/2026

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	075213	A. Building B. Wing	06/24/2026

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	9:00 PM levetiracetam 500 mg and melatonin 6 mg were not signed off on 5/21/26Review of nurse's notes dated 5/21/26 failed to identify documentation of omitted medications.Interview with Resident #22 on 6/23/26 at 10:40 AM identified he/she could not recall receiving medications on 5/21/26.1m. Resident #24?s diagnoses included dementia with behavioral disturbances, type II diabetes mellitus, unspecified abnormal involuntary movements, hypertension, Benign Prostatic Hyperplasia (BPH) with lower urinary tract symptoms, schizoaffective disorder, bipolar type, and anxiety disorder.The quarterly MDS assessment dated [DATE] identified Resident #24 had moderately impaired cognition (Brief Interview for Mental Status (BIMS) score of 10) and was independent with bed mobility and transfers.The RCP dated 5/11/26 identified Resident #24 had diabetes and was at risk for hypo and hyper glycemic episodes and was insulin dependent, had pain and chest pain and had the potential for alteration in mood and/or behavior due to multiple diagnoses and a history of impulsive behavior, violent behavior and accusatory behavior. Interventions included administering prescribed medication and evaluating for the effectiveness.The Administration Compliance Report dated 5/21/26 identified the following medications were omitted on 5/21/26:5:00 PM: benztropine (used to treat Parkinson's disease and manage symptoms caused by antipsychotic medications) 0.5 mg, give 1 tablet twice daily; Humalog (fast acting) insulin 100 units per mL, give 5 units with meals; metformin 1000 mg twice daily.8:00 PM: divalproex delayed release sprinkles 125 mg, give 8 capsules (1000 mg) three times daily; escitalopram oxalate (used to treat depression) 20 mg, give 1 tablet daily; tamsulosin 0.4 mg, give 1 capsule daily; trazodone 150 mg, give 1 tablet daily at bedtime8:30 PM: propranolol 10 mg, give 3 tablets (30 mg) twice dailyThe May 2026 eMAR identified the benztropine, Humalog, metformin, divalproex, escitalopram oxalate, tamsulosin, trazodone and propranolol were signed off as administered on 5/21/26 by LPN #1, however, review of the Audit Log identified LPN #1 accessed the eMAR and signed off the omitted medications on 5/25/26 (while suspended from employment at the facility). The eMAR identified the required blood sugar and injection site were not documented for the Humalog administration.Although attempted, Resident #24 was unable to be interviewed.1n. Resident #26?s diagnoses included hypertension, atrial fibrillation, gastrostomy status, seizures, pain, contractures of muscles, abnormal involuntary movements, depression and bipolar disorder.The quarterly MDS assessment dated [DATE] identified Resident #26 had moderately impaired cognition (Brief Interview for Mental Status (BIMS) score of 9) and was dependent for bed mobility and transfers.The RCP dated 5/15/26 identified Resident #26 utilized a gastrostomy tube, was at risk for cardiovascular events, was on blood thinners and had the potential for alteration in mood and/or behavior. Interventions included administering medications as ordered and monitoring for side effects.The Administration Compliance Report dated 5/21/26 identified the following medications were omitted on 5/21/26:5:00 PM: Eliquis 5 mg, give 1 tablet via Gastric tube (G-tube) twice daily; gabapentin 100 mg, give 2 capsules (200 mg) via G-tube three times daily; metoprolol tartrate 25 mg, give 0.5 tablet (25 mg) via G-tube twice daily.5:30 PM: levetiracetam 500 mg, give 1 tablet via G-tube twice daily.8:00 PM: clonazepam 0.5 mg, give 1 tablet via G-tube daily; valproic acid solution 250 mg per 5 mL, give 5 mL via G-tube every six (6) hours.The May 2026 eMAR identified the Eliquis, gabapentin, metoprolol, levetiracetam and clonazepam were signed off as administered on 5/21/26 by LPN #1, however, review of the Audit Log identified LPN #1 accessed the eMAR and signed off the omitted medications on 5/22/26 (while suspended from employment at the facility). The pre administration heart rate and blood pressure required prior to metoprolol administration were not documented. The valproic acid administration at 8:00 PM was blank.Further review of the eMAR identified:The required pain assessment for the 3:00 PM to 11:00 PM shift was blank.The orders G-tube feeding, Peptamen AF liquid 0.0756 gram- 1.2 kilocalorie (kcal) per mL to be run at 65 mL per hour via G-tube continuously was not signed off as administered on the 3:00 PM to 11:00 PM shift on 5/21/26 and the tube feeding intake was not documented on as required;The order to flush the G-tube with 30 mL of water before and after each medication administration was not signed off as administered on the 3:00 PM to 11:00 PM shift on 5/21/26;The order to verify G-tube placement prior (continued on next page)

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	075213	A. Building B. Wing	06/24/2026

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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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	to administration of food, fluids, or medications was not signed off as administered on the 3:00 PM to 11:00 PM shift on 5/21/26.The Controlled Proofˆofˆuse/Disposition Form identified one (1) tablet of clonazepam 0.5 mg was signed out at 9:00 PM on 5/21/26.Although attempted, Resident #26 was unable to be interviewed.1o. Resident #27?s diagnoses included dementia with behavioral disturbances, type II diabetes mellitus with hyperglycemia, hypertension, epilepsy and polyneuropathy.The annual MDS assessment dated [DATE] identified Resident #27 had moderately impaired cognition (Brief Interview for Mental Status (BIMS) score of 8) and required supervision for transfers and was independent with bed mobility.The RCP dated 5/4/26 identified Resident #27 had potential for pain/discomfort, risk for cardiac complications, a mood disorder, and risk for anxiety/depression. Interventions included administering medications as ordered.The Administration Compliance Report dated 5/21/26 identified the following medications were omitted on 5/21/26:4:00 PM: Novolog insulin 100 units per mL, follow sliding scale and administer subcutaneously before meals.5:00 PM: carvedilol 3.125 mg, give 1 tablet twice daily; divalproex delayed release 500 mg tablet, give 1 tablet every eight (8) hours; metformin 500 mg, give 1 tablet twice daily; trazodone 50 mg, give 0.5 tablet (25 mg) twice daily.6:00 PM: Novolog insulin 100 units per mL, give 26 units subcutaneously with meals.8:00 PM, gabapentin 800 mg, give 1 tablet three times daily.The May 2026 eMAR identified the sliding scale Novolog, carvedilol, divalproex, metformin, Novolog 26 units, and gabapentin were signed off as administered on 5/21/26 by LPN #1, however, review of the Audit Log identified LPN #1 accessed the eMAR and signed off the omitted medications on 5/22/26 (while suspended from employment at the facility). The blood sugar and injection site for the Novolog were not documented. The trazodone administration was blank at 5:00 PM. The required pain assessment for the 3:00 PM to 11:00 PM shift was blank.Review of nurse's notes dated 5/21/26 failed to identify documentation of omitted medications.Although attempted, Resident #27 was unable to be interviewed.1p. Resident #28?s diagnoses included muscle spasms, functional quadriplegia, chronic pain, insomnia, adult failure to thrive, moderate proteinˆcalorie malnutrition and major depressive disorder.The quarterly MDS assessment dated [DATE] identified Resident #28 had severely impaired cognition (Brief Interview for Mental Status (BIMS) score of 3), was dependent on staff for bed mobility and did not transfer or ambulate.The RCP dated 4/13/26 identified Resident #28 had Major Depressive Disorder and anorexia, had potential for mood alteration, had chronic pain and osteoporosis, received gabapentin twice daily, and was on tramadol and baclofen for contractures. Interventions included administering medications per order and monitoring effectiveness.The Administration Compliance Report dated 5/21/26 identified the following medications were omitted on 5/21/26:4:30 PM: gabapentin 100 mg, give 1 capsule twice daily.5:00 PM: house supplement, give 237 mL four times daily; liquid protein supplement, give 30 cc three times daily.7:30 PM: mirtazapine (for treatment of major depressive disorder) 30 mg, give 1 tablet daily at bedtime; tramadol 75 mg, give 1 tablet three times daily.8:30 PM: melatonin 3mg, give 2 tablets (6 mg) daily at bedtime.The May 2026 eMAR identified the gabapentin, liquid protein, mirtazapine, tramadol, and melatonin were signed off as administered on 5/21/26 by LPN #1, however, review of the Audit Log identified LPN #1 accessed the eMAR and signed off the omitted medications on 5/22/26 (while suspended from employment at the facility). The house supplement was not signed off at 5:00 PM or 9:00 PM as ordered. The required pain assessment for the 3:00 PM to 11:00 PM shift was blank.The Controlled Proofˆofˆuse/Disposition Form for tramadol 75 mg identified one (1) tablet was signed out at 9:38 PM on 5/21/26 (over 2 hours late).Review of nurse's notes dated 5/21/26 failed to identify documentation of omitted medication