

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 07/28/2026
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)		
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for one (1) of three (3) residents (Resident #91) reviewed for elopement, the facility failed to ensure when the receptionist unlocked the front doors a resident identified at risk for elopement was not able to elope from the facility. The findings include: Resident #91 was admitted to the facility on [DATE] with diagnoses including schizophrenia, anxiety, schizoaffective disorder, depression, and post-traumatic stress disorder (PTSD). Resident #91 was conserved of person and estate. Review of the Elopement Risk Evaluation dated 3/21/26 at 2:01 AM identified Resident #91 was at risk for elopement. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #91 had moderately impaired cognition, was an elopement risk, and independent with ambulation. A physician's order dated 6/21/26 directed to apply an elopement prevention bracelet to Resident #91's left ankle, verify the device's placement every shift (7 AM-3 PM, 3 PM-11 PM, and 11 PM-7 AM), and check the functioning of the device once daily on the overnight shift. The Resident Care Plan (RCP) dated 6/22/26 identified Resident #91 was at risk for elopement related to exit seeking behaviors, independent ambulation, and history of removing the elopement prevention bracelet. Interventions directed staff to educate the resident on the purpose and importance of the device, provide frequent checks, and offer 1:1 supervision as needed. A psychiatric evaluation dated 6/23/26 at 5:36 PM identified Resident #91 removed the elopement prevention bracelet. Resident #91 understood the behavior was unacceptable, expressed remorse, and stated he/she would not remove it again. The nurse's note dated 6/24/26 at 4:00 PM identified Resident #91 initially refused the elopement prevention device but later agreed, and the device was applied to the resident's left ankle. The nurse's note dated 6/28/26 at 10:57 PM written by Registered Nurse (RN) #4 (supervisor) identified at 5:45 PM she received a call from Receptionist #1 reporting Resident #91 had exited the building after the main door was opened for a visitor. RN #4 indicated an elopement code was initiated, the police, the administrator, the Director of Nursing Services (DNS), and Resident #91's conservator were notified. RN #4 indicated she instructed staff to search the grounds, but the search was unsuccessful. RN #4 identified the administrator located Resident #91 at 7:55 PM near the medical offices adjacent to the facility. RN #4 indicated she and the DNS assessed Resident 91 upon return and no injuries were noted. RN #4 identified Resident #91 was evaluated by a provider, who ordered 1:1 supervision until he/she has a psychiatric assessment. The physician's order dated 6/28/26 directed 1:1 supervision and neurological checks every shift for three days. A facility reportable event (RE) dated 6/28/26 identified at 5:45 PM Resident #91 was witnessed by Receptionist #1 briskly walking out the front doors of the facility as a visitor exited. Receptionist #1 reported she attempted verbal redirection to stop Resident #91, but Resident #91 became resistive, used profanities, and continued speed walking. Receptionist #1 was (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 075213 If continuation sheet Page 1 of 3

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	unsuccessful in stopping Resident #91 and notified RN #4, prompting an immediate search for Resident #91. Resident #91 was located at 7:30 PM by the Administrator, walking on the sidewalk in front of the medical offices located next door to the facility and was escorted safely back to the facility. Resident #91 reported visiting a gas station and then a church around the corner. A facility written statement by Receptionist #1 dated 6/29/26 identified she witnessed Resident #91 exit the main elevator with a visitor. Resident #91 asked if the dining room was open, then Resident #91 motioned toward the dining area before running out the front doors, which she had opened for a visitor. Receptionist #1 instructed Resident #91 to return to the building, but Resident #91 did not comply and responded with profanities while increasing his/her pace. Receptionist #1 then notified RN #4 and activated the elopement code. A facility RE summary dated 7/2/26 identified on 6/28/26 at 5:45 PM, Resident #91 exited the facility through the front doors witnessed by the receptionist on duty. At 7:30 PM, the Administrator located Resident #91 walking on the sidewalk in front of the medical offices next door and safely escorted the resident back to the facility. Resident #91 reported going to a gas station and then to a church around the corner. Resident #91 was calm, allowed an RN assessment, and had no injuries or complaints. Resident #91 was immediately placed on 1:1 monitoring. The investigation determined that Resident #91 had already been identified as an elopement risk and was wearing a wander guard, last confirmed in place at 5:00 PM on 6/28/26 by the assigned charge nurse. The receptionist last saw Resident #91 at 5:45 PM exiting the main elevator with a visitor. Resident #91 asked if the dining room was open, gestured in its direction, then suddenly turned and quickly followed the visitor out of the facility. The receptionist stated she attempted to stop the resident, but the resident walked away quickly while using profanities. The receptionist immediately notified the nursing supervisor and activated Dr. [NAME] (elopement) to initiate the staff search. Interventions after the event included continued 1:1 monitoring of Resident #91, follow-up with the psychiatric APRN, and social services involvement to support psychosocial well-being. Interview with Receptionist #2 on 7/27/26 at 9:15 AM indicated that when a resident identified as high risk for elopement attempts to leave the building or exit the building the expectation is the receptionist follows the resident or ensures another staff member does and maintains proximity until additional staff arrive. Interview with RN #4 on 7/27/26 at 9:30 AM identified she was notified by Receptionist #1 that Resident #91 had exited the facility through the main front doors on 6/28/26. RN #4 stated that she immediately went to the main entrance, where Receptionist #1 was seated at the front desk, and an elopement code was initiated. RN #4 indicated she exited the building to search for Resident #91 but was unable to locate the resident. RN #4 further indicated she directed staff to continue searching for Resident #91, but the search was unsuccessful. RN #4 indicated she notified the police, Administrator, DNS, and Resident #91's conservator. Interview with RN #3 (Corporate Nurse) on 7/27/26 at 11:00 AM identified Resident #91 was an elopement risk and wore an elopement prevention bracelet on the left ankle. RN #3 indicated on 6/28/26 it was unclear whether the alarm was activated when Resident #91 exited the facility through the front doors. RN #3 indicated her investigation showed LPN #5 checked Resident #91's elopement-prevention bracelet at 5:00 PM on 6/28/26 and found it in place and functioning. RN #3 identified when Resident #91 returned to the facility, the bracelet was no longer on the resident's ankle. RN #3 identified that Receptionist #1 should have followed Resident #91 outside to maintain visual contact. Although attempted, interviews with Receptionist #1 and LPN #5 were not obtained. Review of facility Wandering and Elopement policy dated 2/4/26, in part, identified when a resident is at risk for wandering, the resident's care plan will include strategies and interventions to maintain the resident's safety. The policy directs that if an employee observes a resident leaving the premises, the employee (continued on next page)		

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