STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075222	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Civita Care Center at Cheshire	745 Highland Avenue Cheshire, CT 06410

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **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 #2) reviewed for activities of daily living and diabetes management, the facility failed to ensure a baseline care plan was implemented for a resident who required assistance with activities of daily living and had type 2 diabetes mellitus with hyperglycemia. The findings include: Resident #2 had diagnoses that included need for assistance with personal care, type 2 diabetes mellitus type with hyperglycemia The nursing admission evaluation dated 12/13/24 at 3:56 P.M. completed by LPN #2 identified Resident #2 has an amputation to h/her right lower leg and Resident #2 requires extensive assistance with transfers. Review of Occupational Therapist Assistant (OTA) #1's summary of daily skilled services dated 12/15/24 at 1:31 P.M. identified for Resident #2 use Hoyer at this time for h/her safety as well as the safety of staff due to frequent falls at home and the hospital. OTA #1 identified Resident #2's had poor sitting balance during ADLS, Resident #2 was unable to stand and Resident #2 was unable to participate in toileting. The Physical Therapy (PT) evaluation dated 12/16/24 at 2:22 P.M. completed by PT #1 identified Resident #2 requires moderate assistance with 2 for transfers and requires moderate assistance with bed mobility. Review of the Resident #2's 72-hour meet and greet admission meeting form dated 12/16/24 completed by SW #2 identified Resident #2 required rehabilitation services for bed mobility, gait, needed devices, need for assistance, strengthening, ADL/self-care, impaired vision/hearing, and cognitive abilities. The admission MDS dated [DATE] identified Resident #2 had a Brief Interview for Mental Status score of twelve (12) indicative of moderately impaired cognition, rejection of care behavior occurring one (1) to three (3) days, always incontinent of bowel, occasionally incontinent of bladder, required moderate assistance with personal hygiene, transfers, and non-ambulatory. The MDS dated [DATE] further identified Resident #2 received insulin injections 6 days during the last 7 days and Resident #2 is taking high-risk drug classes which included hypoglycemics. (continued on next page)

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

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

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The care plan dated 12/13/24 to 12/27/24 failed to reflect documentation that identified Resident #2 required assistance with ADLs. a) The physician's order dated 12/16/24 directed to provide the assistance of one with ADLs and transfers with Hoyer lift. Interview with OT #1 on 1/23/25 at identified Resident #2 required moderate assistance with ADLs, with transfers required the assistance of two with use of a Hoyer lift, and Resident #2 was non-ambulatory. b. Review of physician's orders dated 12/13/24 directed to administer Ozempic (medication for diabetes mellitus) 2 mg/3ml 0.5 mg once a day on Monday, Toujeo solostar U-300 (insulin glargine) 300 unit/ml (medication used for diabetes mellitus) 1.5 ml /80 unit at bedtime, Glimepiride (medication used for diabetes mellitus) 4 mg twice per day at 9:00 A.M. and 5:00 P.M., Actos (medication used for diabetes mellitus) 30 mg once per day, and administer Lispro insulin (medication used for diabetes mellitus) 100 unit/ml subcutaneously before meals and at bedtime per sliding scale: Blood Glucose (BG) is below 70, call MD. BG 150-200 administer 8 units. BG 201-250 administer 10 units. BG 251-300 administer 12 units. BG 301-350 administer 14 units. BG 351-400 administer 16 units. BG 401-450 administer 18 units. BG 451-500 administer 18 units. If BG is greater than 500, call MD. Review of the baseline care plan failed to address the for the assistance with ADLs and diabetes management. Interview and clinical record review with DNS on 1/23/25 at 12:10 P.M. identified the expectation is when a resident is admitted a baseline care plan is developed and implemented to meet the resident's needs within 72 hours. The DNS identified her expectations are the care plan would be implemented to identify ADL status and disease management. The DNS identified Resident #2 should have had a care plan developed and implemented for ADLs and for diabetes mellitus. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility baseline care plan policy identified a baseline plan of care to meet the resident's immediate needs shall be developed for each resident on admission. The interdisciplinary team will review the healthcare practitioner's orders (e.g. dietary needs, medications, routine treatments, etc.) and implement a baseline care plan to meet the residents' immediate care needs including but not limited to initial goals based on admission orders, physician orders, dietary orders, therapy services, and social services.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **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 #2) reviewed for diabetes management, the facility failed to ensure the medical record was complete and accurate to reflect treatment of hypoglycemia. The findings include: Resident #2 had diagnoses that included need for assistance with personal care, type 2 diabetes mellitus type with hyperglycemia, abnormalities of gait and mobility, repeated falls, acquired absence of right below knee amputation, and generalized muscle weakness. The admission MDS dated [DATE] identified Resident #2 had a Brief Interview for Mental Status (BIMS) score of twelve (12) indicative of moderately impaired cognition, moderate assistance with ADLs The MDS and insulin injections 6 days during the last 7 days and Resident #2 was taking high-risk drug classes which included hypoglycemics. The physician's orders dated 12/20/24 directed to administer Ozempic (medication for diabetes mellitus) 4 mg/3 ml 1 mg every Monday at 9:00 A.M., Toujeo solostar U-300 (insulin glargine) 300 unit/ml (medication used for diabetes mellitus) 60 units once per day at bedtime, Glimepiride (medication used for diabetes mellitus) 4 mg twice per day at 9:00 A.M. and 5:00 P.M., Actos (medication used for diabetes mellitus) 30 mg once per day, administer Glucagon 1mg as needed if blood sugar is under 60 and the resident is unable to take anything by mouth, and administer Lispro insulin (medication used for diabetes mellitus) 100 unit/ml subcutaneously before meals and at bedtime per sliding scale Blood Glucose (BG) is below 70, call MD. BG 150-200 administer 8 units. BG 201-250 administer 10 units. BG 251-300 administer 12 units. BG 301-350 administer 14 units. BG 351-400 administer 16 units. BG 401-450 administer 18 units. BG 451-500 administer 18 units. If BG is greater than 500, call MD. a) Review of Resident #2's Vitals Report dated 12/20/24 at 8:52 A.M. identified LPN #2 recorded Resident #2's blood sugar as 36. Review of Resident #2's Medication Administration Record (MAR) dated 12/20/24 at 8:53 A.M. LPN #2 administered Glucagon solution 1 mg to Resident #2 and the result was effective. Review of Resident #2's Vitals Report dated 12/20/24 identified LPN #2 did not recheck Resident #2's blood sugar until 11:37 A.M. and recorded Resident #2's blood sugar as 149. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b) Review of Resident #2's Vitals Report dated 12/21/24 at 8:56 A.M. identified LPN #2 recorded Resident #2's blood sugar as 51. Review of Resident #2's Vitals Report dated 12/21/24 identified LPN #2 did not recheck Resident #2's blood sugar until 11:35 A.M. and recorded Resident #2's blood sugar as 70. c) Review of Resident #2's Vital Report dated 12/22/24 at 9:04 A.M. identified LPN #2 recorded Resident #2's blood sugar as 41. Review of Resident #2's Medication Administration Record (MAR) dated 12/22/24 at 9:05A.M. LPN #2 administered Glucagon solution 1 mg to Resident #2 and the result was effective. Review of Resident #2's Vitals Report dated 12/22/24 identified LPN #2 did not recheck Resident #2's blood sugar until 12:24 P.M. and recorded Resident #2's blood sugar as 60. The nurse's note dated 12/22/24 at 2:34 P. M. written by LPN #2 identified Resident #2's blood sugar this morning was 41, glucagon was administered, and blood sugar was 52. Resident #2 ate breakfast and she rechecked Resident #2's blood sugar at 11:30 A. M. with a result of 60. RN #1 was notified and will notify the APRN. The nurse's note dated 12/22/24 at 4:26 P.M. written by RN #1 identified Resident #2 ate breakfast and lunch and had 2 boosts (oral supplement) for dinner. RN #1 identified Resident #2's blood sugar before dinner was 68 and Resident #2 had no signs or symptoms of hypoglycemia. RN #1 indicated Resident #2's Toujeo and Glimepiride will be held. The physician's orders dated 12/22/24 directed to hold Toujeo and Glimepiride evening doses. The nurse's note dated 12/22/24 at 6:40 P.M. written by LPN #4 identified Resident #2's blood sugar was 60 and Resident #2 did not eat supper. LPN #4 identified Resident #2 has 2 boost beverages and has no signs or symptoms of hypoglycemia. Review of Resident #2's Vitals Report identified Resident #2's blood sugar was not obtained again until 12/23/24 at 8:02 A.M. by LPN #2 and Resident #2's blood sugar was 49. d) Review of Resident #2's Vitals Report identified on 12/23/24 at 11:51 A.M. LPN #2 recorded Resident #2's blood sugar as 37. The nurse's note dated 12/23/24 at 1:49 P.M. written by RN #2 identified she was updated by LPN #2 that Resident #2's blood glucose levels over the weekend ranged between 26-189 and Resident #2 had no signs or symptoms of hypoglycemia. RN #2 identified she notified APRN #2, verbal orders obtained to hold Glimepiride and decrease Toujoe to 50 units once a day at bedtime. The physician's orders dated 12/23/24 directed to administer Toujeo solostar U-300 (insulin glargine) 300 unit/ml (medication used for diabetes mellitus) 50 units once per day at bedtime and discontinue Glimepiride 4 mg. Review of Resident #2's Vitals Report dated 12/23/24 at 7:07 P.M. identified LPN #4 recorded Resident #2's blood sugar as 67 and at 8:58 P.M. LPN #4 recorded Resident #2's blood sugar as 72. e) Review of Resident #2's Vitals Report dated 12/24/24 at 4:36 P.M. identified LPN #3 recorded Resident #2's blood sugar as 64. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LPN #2 on 1/23/25 at 8:15 A.M. identified when Resident #2's blood sugars were below 60 on 12/20/24, 12/21/24, 12/22/24, 12/23/24, and on 12/24/24 she indicated Resident #2 alert and did not exhibit any signs or symptoms of hypoglycemia. LPN #2 indicated when Resident #2's blood sugars were 60 or below she gave Resident #2 two (2) boost nutritional shakes and Resident #2 drank both shakes. LPN #2 indicated after Resident #2 drank the shakes she would wait 15 minutes and always recheck Resident #2's blood sugar and notify the RN supervisor. LPN #2 identified she is responsible for recording resident's blood sugar readings in the resident's Vitals report. LPN #2 identified although she rechecked Resident #2's blood sugar levels anytime h/her blood sugar was below 60 she forgot to enter the blood sugar results in Resident #2's clinical record. Interview with RN #2 on 1/23/25 at 9:25 A.M. identified she was notified by LPN #2 on 12/20/24, 12/22/24, and 12/23/24 that Resident #2's blood sugars were below 60. RN #2 identified LPN #2 would notify her within 30 minutes that she rechecked Resident #2's blood sugar and Resident #2 was stable. RN #2 identified the charge nurses are responsible for entering blood sugars readings in the resident's Vitals report or by writing a nurse's note. RN #2 indicated on 12/20/24, 12/22/24, and 12/23/24 she did notify APRN #2 when Resident #2's blood sugars were under 60. RN #2 identified she did not write nurse's notes in Resident #2'clinical record every time she updated APRN #2, because she wrote notes on the supervisor's reports. Interview with APRN #2 on 1/23/25 at 11:10 A.M. identified she was aware of Resident #2's low blood sugar readings. APRN #2 indicated when Resident #2's blood sugars were below 60, RN #2 notified her. APRN #2 identified multiple medication changes were made to address Resident #2's low blood sugars. Interview and clinical record review with the DNS on 1/23/25 at 12:10 P.M. unable to reflect on 12/20/24, 12/21/24, 12/22/24, 12/23/24, and 12/24/24 LPN #2, LPN #3, and LPN #4 what interventions were implemented when Resident #2's blood sugars were under 60, that the provider was notified, and Resident #2's blood sugars were rechecked within 15 minutes and what the results were. The DNS identified the expectation is when a resident's blood sugar is under 70 the nurse administers juice, health shakes, or a snack to the resident, notifies the supervisor or APRN, rechecks the resident's blood sugar in 15 minutes and documents in the clinical record the blood sugar result. The DNS identified when Resident #2's blood sugars were below 70 the nurses LPN #2, LPN #3, and LPN #4 should have written a nurse's note to identify what Resident #2's blood sugar reading was, how they treated the hypoglycemia, Resident #2's response, and obtained another blood sugar in 15 minutes documented the follow-up blood sugar reading in Resident #2's clinical record. Review of the facility management of hypoglycemia policy dated 9/1/2022 identified management for level 1 hypoglycemia is to give the resident an oral form of rapidly absorbed glucose, notify the provider immediately, remain with the resident, recheck the blood glucose in 15 minutes and document the resident's blood glucose before the intervention, note blood sugar after each administration of rapid-acting glucose and the follow up blood sugar, and document any provider instructions.