

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075274	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/22/2023
NAME OF PROVIDER OR SUPPLIER Civita Care Center at Danbury		STREET ADDRESS, CITY, STATE, ZIP CODE 107 Osborne Street Danbury, CT 06810	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>43184</p> <p>Based on clinical record reviews, facility documentation, facility policy and interviews for 20 of 28 sampled residents (Residents #1, #2, #3, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, and #21) who were reviewed for the accuracy of their clinical records, the facility failed to ensure licensed staff documented at the time when the medications were administered in accordance with professional standards. The findings include:</p> <p>Review of the census for 10/28/23 identified a census of twenty-eight (28) residents on the 2 [NAME] Unit.</p> <p>Review of the facility Administration Compliance Report for the 2 [NAME] Unit dated 10/27/23 to 10/28/23 identified Residents #1, #2, #3, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, and #21 had multiple instances of missed signatures to denote that medications had been administered on the 7:00 AM to 3:00 PM shift at 7:30 AM, 8:00 AM, 9:00 AM and 10:00 AM scheduled dose times.</p> <p>Interview with the Corporate Nurse Consultant on 11/22/23 at 12:40 PM identified the facility policy directs to sign off all medications once they are administered to each resident. The Corporate Nurse Consultant identified on 10/28/23 the 7AM-3PM charge nurse, Registered Nurse (RN) #1, did not sign off that medications were administered to Residents #1, #2, #3, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, and #21. The Corporate Nurse Consultant identified on 10/28/23 the facility had an increase in COVID cases with many rooms shifted. The Corporate Nurse Consultant identified RN #1 should have signed off on all medications administered on the shift and by not signing off on the medications RN #1 did not follow facility policy.</p> <p>Interview with the Director of Nursing (DON) on 11/22/23 at 1:10 PM identified the facility policy was to sign off medications at the time when administered to a resident. The DON identified on 10/28/23 RN #1 was assigned to the 2 [NAME] Unit as well as acting as the RN Supervisor for the shift. The DON identified at the end of the shift, RN #1 reported she gave all meds and signed off the medications. The DON identified it was her speculation RN #1 signed off the medications for Residents #1, #2, #3, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, and #21 but failed to save her signature in the system that would have denoted the medications were administered. The DON identified RN #1 should have followed the facility policy and ensured that her signature was present for all medications administered.</p> <p>Although attempted, an interview with RN #1 was unable to be obtained.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the facility policy titled Administering Medications, last revised April 2019, directed, in part, the individual administering the medication initials the resident's medication administration record (MAR) on the appropriate line after giving each medication and before administering the next ones.</p>