STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075274	A. Building B. Wing	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Civita Care Center at Danbury	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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **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 #5) reviewed for abuse, the facility failed to ensure the resident was free from abuse. The findings include: 1. Resident #4 had diagnoses that included psychosis, major depressive disorder, restlessness and agitation, anxiety, and mild neurocognitive disorder with behavioral disturbances. The quarterly MDS dated [DATE] identified Resident #4 had a Brief Interview for Mental Status (BIMS) score as eleven (11) indicative of moderately impaired cognition, independent with transfers and ambulation, and required supervision with personal hygiene and dressing. The care plan dated 11/4/24 identified Resident #4 has verbal behaviors and disruptive symptoms directed toward residents and nurses with interventions that directed to administer medication to resident in a timely fashion to avoid disruptive behaviors, nurse aides to redirect resident when intrusive and seeks out nurse aide while they are providing care to other residents (resident will go into another resident's room to seek out nurse aide), provide consistency in approaching resident, and talk with resident in a calm voice when behavior is disruptive and redirect resident. 2. Resident #5 had diagnoses that included dementia, psychotic disturbance without behavioral disturbance, adjustment disorder with mixed anxiety and depressed mood, and difficulty walking. The quarterly MDS dated [DATE] identified Resident #5's Brief Interview for Mental Status (BIMS) score as two (2) indicative of severely impaired cognition and required substantial assistance with ADLs, transfers, and ambulation. The care plan dated 9/17/24 identified Resident #5 had behavioral symptoms, resists care with interventions that directed to allow to choose options, all to have control of the situation, if possible, assess resistance to care, and actively involve in care. A nurse's note dated 11/16/24 at 6:15 P.M. written by RN #1 identified screaming was heard on the floor and upon investigation Resident #5 was seen holding a curtain around Resident #4's neck, Resident #5 was squeezing Resident #4's arm, and Resident #5 was using the walker to push into Resident #4. The residents were immediately separated. No injuries were identified to either resident. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's accident and incident report dated 11/16/24 identified a resident abuse without injury at approximately 5:45 P.M . The facility's summary dated 11/20/24 identified on 11/16/24 staff heard screaming coming from both Resident #4 and Resident #5 room, upon entering the room NA #3 observed Resident #5 standing next to Resident #4 in between the beds with the privacy curtain loosely wrapped around Resident #4's neck and back area. NA #3 immediately removed the curtain and separated both residents. Resident #4 was placed on 1:1 monitoring for safety until emergency services arrived and transported Resident #5 to the hospital. Review of the facility's correspondence letter to the crisis department at the hospital written by the Administrator dated 11/18/24 identified the letter was to serve as a notice that the facility has concerns about re-admitting Resident #5. The letter identified based on the following in less than a week Resident #5 has been placed on 1:1 due to the h/she stated h/she feels hopeless, has lived a long life and wants to die and in the same week Resident #5 proceeded to hold the curtain around Resident #4's neck, squeezed Resident #4's arm, and Resident #5 also used h/her walker to push into Resident #4, who did not provoke Resident #5 in any way. A review of the case has been conducted with the Medical Director as well as the facility's psychiatric consultants who agree that Resident #5 returning to the facility becomes a safety risk to all residents as well as Resident #5's own well-being. The facility is requesting a consultation with the hospital for the purpose of determining if the facility can meet Resident #5's needs and develop an appropriate care plan to safely meet Resident #5's needs. Interview with NA #3 on 12/3/24 at 11:48 A.M. identified on 11/16/24 she heard screaming coming out of Resident #4 and Resident #5's room, she entered the room, and observed Resident #4 sitting in the wheelchair with the privacy curtain wrapped loosely around his/her neck, upper back, chest, and shoulders with Resident #5 standing up right next to Resident #4. Interview with NA #4 on 12/3/24 at 12:00 P.M. identified on 11/16/24 she heard yelling coming from Resident #4 and Resident #5's room. When she entered the room, she observed the privacy curtain draped loosely around Resident #4's shoulders, back, and neck, Resident #5 stated He/she deserved it. Interview with LPN #2 on 12/3/24 at 11:55 A.M. identified on 11/16/24 she was notified by NA #4 she was needed immediately to Resident #4 and Resident #5's room. Upon entry into the room, she observed Resident #5's hand holding on to Resident #4's upper arm and Resident #4 stated Resident #5 hurt h/her and the resident's were immediately separated. Interview with the Administrator on 12/3/24 at 12:40 P.M. identified the investigation identified the resident-to-resident incident on 11/16/24 between Resident #4 and Resident #5 was unsubstantiated because it was not known how Resident #4 ended up with the privacy curtain wrapped loosely around h/her neck and shoulders. The Administrator identified she sent a letter to the hospital on [DATE] requesting a discussion take place to discuss concerns regarding safety concerns with Resident #5 being re-admitted to the facility. Interview with the DNS on 12/3/24 at 11:20 A.M. identified on 11/16/24 there were no witnesses to the alleged incident between Resident #4 and Resident #5. Further, there was no evidence to identify who or how the privacy curtain became draped around Resident #4's neck and upper body, however, the DNS identified that Resident #4 lacks the dexterity to wrap the curtain around his/herself. The DNS identified based on the investigation she was unable to substantiate resident to resident abuse. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility was granted past non-compliance as of 12/2/24 as education, audits, and QAPI were completed prior to the survey. Review of the facility Abuse Neglect and Exploitation policy, in part, identified it is the policy of the facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property.

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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 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 upon clinical record review, facility documentation review, and staff interviews for one of three residents (Resident #3) reviewed for quality of care, the facility failed to ensure the residents medical record was complete and accurate to include documentation of foley output. The findings include: Resident #3 had a diagnosis of paraplegia. The admission Minimum Data Set (MDS) dated [DATE] identified Resident #3 had a Brief Interview for Mental Status (BIMS) score of 15 (alert and oriented) and had an indwelling catheter. The Resident Care Plan (RCP) dated 9/6/2024 identified (foley) catheter use. Interventions directed to monitor intake and output. Nursing note dated 10/2/2024 at 4:30 PM identified the residents foley was patent but no output has been noted thus far and will continue to monitor. Nursing note dated 10/2/2024 at 7:30 PM identified the provider was updated regarding an abdominal mass on Resident #3's right upper quadrant and no urine output. An order was obtained to send the resident out for further evaluation. Record review identified no urine output was recorded from 9/26 until 9/30/2024 (four days). Further, the last urine output recorded was on 10/1/2024 at 2:51 PM and the amount recorded was 500 milliliters (ml). No output was recorded on 10/2/2024 to indicate any amount or zero amount of urinary output. Interview and record review with LPN #1 on 12/4/2024 at 11:06 AM identified she never has known Resident #3 not have any urine output. LPN #1 further stated she did not record the output on 10/2/2024 during the 7 AM to 3 PM shift because the NA's are supposed to record the output, but she could not remember if the NA told her what the output was that day. Interview and record review with NA #9 on 12/4/2024 at 11:33 AM identified she provided care for Resident #3 on 10/2/2024 and stated he/she had a small amount of urine in the foley catheter. NA #9 stated she is supposed to document the resident's urine output after emptying it and she did not remember if she documented or told the nurse about the urine output amount. Interview and record review with the Regional Clinical Nurse, Administrator and DNS on 12/4/2024 at 2:17 PM identified intake and output are documented in the computer and not on paper. When staff empty a resident's foley catheter they are supposed to document the resident's output. The DNS and Regional Clinical Nurse further stated they do not know why Resident #3's output was not documented from 9/26 to 9/30/2024 but their expectation would be when a staff member empties a foley catheter to document the output, even if the amount is zero. Review of the facility Urinary Catheter Care policy dated 2024 directed to maintain an accurate record of the residents daily output.