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	02/21/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **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 #1), reviewed for accidents, the facility failed to ensure when the resident had a fall with injury failed to ensure an RN assessment was conducted prior to transferring the resident. The findings include: Resident #1 had diagnoses that included reduced mobility, depression, and anxiety. The care plan dated 12/11/24 identified Resident #1 requires a mechanical lift transfer related to reduced mobility as evidenced by impaired physical mobility with interventions that directed to provide the assistance of two (2) staff for transfers. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of ten (10) indicative of moderately impaired cognition, was frequently incontinent of bowel and bladder, required maximal assistance with ADLs, bed mobility, and toileting, and transfers were not attempted due to a medical condition or safety concern. The physician's order dated 1/15/25 identified Resident #1 was non-ambulatory and required a mechanical lift for transfers. Review of Resident #1's undated care card (directs the care the resident required) identified Resident #1 was non-ambulatory and required the assistance of 2 staff with a mechanical lift for transfers. Review of the Facility's Accident and Incident Form dated 1/22/24 at 2:45 P.M. identified while NA #1 was transferring Resident #1 to obtain h/her weight, Resident #1's legs buckled, and Resident #1 fell. Resident #1 was transferred to the hospital and reported to have a left ankle and right femur fracture. The nurse's note dated 1/22/25 at 3:52 P.M. written by LPN #1 identified at approximately 2:30 P.M. she was sitting at the nurse's station and heard a resident yelling I'm in pain. LPN #1 indicated she got up, went down the hallway and witnessed Resident #1 sitting in h/her wheelchair in the hallway. LPN #1 identified the DNS and ADNS were both present with Resident #1. LPN #1 identified that NA #1 reported she went into the shower room to obtain Resident #1's weight on the standing weighing scale, NA #1 had Resident #1 walk onto the scale, Resident #1 legs buckled, and Resident #1 fell. (continued on next page)

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Facility's Accident and Incident Summary dated 1/22/24 identified on 1/22/25 Resident #1 was non-ambulatory and required a mechanical lift for transfers when NA #1 was attempting to obtain Resident #1's readmission weight Resident #1 lost h/her balance and sustained a fall. Resident #1 complained of severe pain and was transferred to the emergency room for further evaluation. An investigation was initiated, and it was determined that NA #1 did not follow Resident #1's plan of care by attempting to transfer Resident #1 without the use of a mechanical lift. Interview with the Director of Nursing Services (DNS) on 2/19/25 at 10:45 A.M. identified on 1/22/25 she heard screaming coming from the shower room and went to find out who was screaming. The DNS identified when she entered the shower room, she observed Resident #1 sitting down on the stand-up weight scale with NA #1 standing next Resident #1. The DNS indicated although she did not direct NA #1 or NA #2 to pick-up Resident #1, nor did she stop them, NA #1 and NA #2 picked up Resident #1 and put Resident #1 into h/her wheelchair. The DNS identified that she was going to assess Resident #1, but things happened so quickly that she did not assess Resident #1 prior to NA #1 and NA #2 transferring the resident back into the wheelchair. Interview with NA #1 on 2/19/25 at 11:45 A.M. identified on 1/22/25 Resident #1 fell down on h/her buttocks on on the scale. NA #1 identified when NA #2 and the DNS came into the shower room, Resident #1 was still sitting on h/her buttocks on the scale with h/her back leaning against NA #1's legs for support. NA #1 indicated the DNS just stood there and did not direct them in anyway so she and NA #2 lifted Resident #1 from the scale and into the wheelchair. NA #1 identified after she and NA #2 lifted Resident #1 back into the wheelchair the ADNS came into the shower room stating, Resident #1 is a Hoyer lift. NA #1 identified after Resident #1 had fallen the DNS nor the ADNS assessed Resident #1 prior to transferring the resident into the wheelchair. Interview with NA #2 on 2/19/25 at 11:30 A.M. identified on 1/22/25 the housekeeper told her she was needed in the shower room. NA #2 identified when she entered the shower room, NA #1, the DNS, and ADNS were standing near Resident #1 who was sitting down on the stand-up scale in front of h/her wheelchair. NA #2 identified the DNS directed her and NA #1 to put Resident #1 in h/her chair so NA #2 and NA #1 lifted Resident #1 off the scale and put Resident #1 in h/her wheelchair. NA #2 identified when Resident #1 was seated in h/her wheelchair she noticed Resident #1's right foot was turning inward. NA #2 identified Resident #1 was not assessed by the DNS or the ADNS prior to transferring the resident into the wheelchair. Interview with the ADNS on 2/19/25 at 12:28 P.M. identified on 1/22/25 she was standing at the nurse's station and heard yelling coming from the shower room. The ADNS identified when she entered the shower room, she observed NA #1 standing next to Resident #1 who was sitting upright on h/her buttocks on a standing weight scale. The ADNS indicated she told NA #1 she needed to go get help and would be right back. The ADNS identified as she exited the shower room NA #2 was entering the shower room. The ADNS indicated she went to the nurse's station to notify the DNS, LPN #1, and the nurse practitioner that Resident #1 had fallen. The ADNS indicated she went back down to the shower room and Resident #1 was now seated in h/her wheelchair. The ADNS indicated she pulled down Resident #1's sock, noted a skin tear on h/her left ankle, Resident #1's left ankle appeared to be dislocated, and Resident #1 yelled out in pain. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and clinical record review with the Administrator and LPN #2 (Regional Nurse) on 2/19/25 at 1:00 P. M., was unable to provide documentation to reflect that on 1/22/25 when Resident #1 had a fall an RN assessment was conducted. The Administrator and LPN #2 identified the expectations are when a resident has a fall the resident is not moved, until an RN assessment is conducted. The Administrator and LPN #2 identified on 1/22/25 the DNS or ADNS should have ensured Resident #1 was assessed by an RN prior to the resident being transferred back into the wheelchair. Interview with MD #1 (Medical Director) on 2/19/25 at 1:07 P.M. identified his expectation is when a resident has a fall an RN assessment is conducted. MD #1 identified on 1/22/25 when Resident #1 had a fall an RN assessment should have been conducted, and Resident #1 should not have been moved off the floor. Review of facility fall protocol policy; in part, identified the nurse shall assess, document, and report the following: vital signs, recent injury, musculoskeletal function observing for any changes in normal range of motion, weight bearing, change in cognition or level of consciousness, neurological status, and pain.

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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 0689 Level of Harm - 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 #1), reviewed for accidents, the facility failed to ensure that staff provided the required assistance with a resident transfer which resulted in a fall with injuries. The findings include: Resident #1 had diagnoses that included reduced mobility, depression, and anxiety. Review of the Activity of Daily Living (ADL) administration history record dated 12/11/2024 identified that Resident #1 is non-ambulatory and requires the assistance of 2 staff members for all ADLs. Review of the care plan dated 12/11/2024 identified Resident #1 requires a Hoyer lift (a device that lifts patients mechanically) for transfers related to reduced mobility as evidenced by impaired physical mobility with interventions that directed to provide the assistance of two (2) staff for transfers. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of ten (10) indicative of moderately impaired cognition, was frequently incontinent of bowel and bladder, required maximal assistance with ADLs. Review of Resident #1's fall risk assessment dated [DATE] identified Resident #1 was at a high risk for falls. The physician's order dated 1/15/2025 identified Resident #1 was non-ambulatory and required a Hoyer lift for transfers. Review of Resident #1's undated care card (directs the care the resident required) identified Resident #1 was non-ambulatory and required the assistance of 2 staff with a Hoyer lift for transfers. Review of the Facility's Accident and Incident Form dated 1/22/2025 at 2:45 P.M. identified while Nurse Aide (NA) #1 was transferring Resident #1 to obtain h/her weight, Resident #1's legs buckled, and Resident #1 fell. Resident #1 was transferred to the hospital and reported to have a left ankle and right femur fracture. Review of the nurse's note dated 1/22/2025 at 2:46 P.M. written by the Director of Nursing Services (DNS) identified that Resident #1 had a witnessed fall in the shower room while NA #1 was attempting to obtain Resident #1's weight. The DNS indicated Resident #1 lost h/her balance and fell to the floor. The DNS identified she spoke with Advanced Practice Registered Nurse (APRN) #2 who ordered further evaluation and 911 was activated and the resident was transferred to the hospital. (continued on next page)

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the Facility's Accident and Incident and Summary dated 1/22/2025 identified Resident #1 was non-ambulatory and required a Hoyer lift for transfers when NA #1 was attempting to obtain Resident #1's readmission weight Resident #1 lost h/her balance on the standing scale and sustained a fall. Resident #1 complained of severe pain and was transferred to the emergency room for further evaluation. An investigation was initiated, and it was determined that NA #1 did not follow Resident #1's plan of care by attempting to transfer Resident #1 without the use of a Hoyer lift. Review of the hospital orthopedic surgeon note dated 1/22/2025 at 6:46 P.M. identified Resident #1 sustained an acute traumatic fall at h/her facility earlier this evening upon arrival to the emergency department Resident #1 was noted to have an obvious open fracture of h/her lower left extremity with associated deformity. Resident #1 had severe pain and deformity of h/her right knee. MD #2 identified imaging demonstrated a severely displaced (bones are not in alignment) and comminuted (bones are broken into several pieces) left distal tibia (shin bone) and fibular (calf bone) fracture as well as a comminuted displaced and impacted (ends of bones are forced together) right femur (thigh) fracture. MD #2 identified Resident #1 was splinted and stabilized and received intravenous (IV) antibiotics for an open fracture in the emergency department. MD #2 identified Resident #1 required urgent operative intervention for the left lower extremity and semi-urgent operative intervention for the right femur. Review of the Hospital Discharge summary dated [DATE] identified Resident #1 was admitted on [DATE] for a fall with an open tibial fracture (broken bone breaks through the skin), open fibular fracture. Resident #1 is status post irrigation (cleaning) and debridement (removes damaged tissue) of the left tibia, intramedullary nailing (IM) (a metal rod used to stabilize the bone) of left tibia fracture with accompanying fibula fracture, as well as closed reduction (re-alignment of bones without the need for surgery) and splinting of the right distal femur fracture. The nurse's note dated 1/26/2025 at 3:17 P.M. identified Resident #1 was readmitted with diagnoses of a right distal femur fracture and left tibia and fibula fracture. Interview with NA #1 on 2/19/2025 at 11:45 A.M. identified on 1/22/2025 when LPN #1 directed her to obtain Resident #1's weight, NA #1 did not review Resident #1's plan of care nor ask LPN #1 what Resident #1's plan of care was for transfers. NA #1 identified on 1/22/2025 she assumed Resident #1 was able to transfer from the wheelchair to the standing scale because when she went to get Resident #1 out of bed into the wheelchair Resident #1 transferred independently into the wheelchair. NA #1 stated she wheeled Resident #1 into the shower room and pulled the wheelchair in front of the standing scale, Resident #1 stood up placed h/her hands on the metal grab bar around the scale, stepped on to the scale, and when Resident #1 took another step toward the middle of the scale NA #1 heard a popping sound and Resident #1 fell down on h/her buttocks on to the scale. NA #1 identified that she should not have assumed Resident #1 could transfer on to the standing scale without reviewing Resident #1's plan of care or asking LPN #1 how Resident #1 transferred. NA #1 further identified she knows better as it is her responsibility to review the resident's plan of care prior to providing care. Interview with the Director of Nursing Services (DNS) on 2/19/2025 at 10:45 A.M. identified on 1/22/2025 NA #1 did not follow Resident #1's plan of care for transfers, the resident fell and sustained fractures of the left tibia, left fibula, and right distal femur. The DNS identified NA #1 should have used the Hoyer lift scale instead of the standing scale, as the resident was not able to stand or transfer without the use of a Hoyer lift. The DNS further identified that she expects that all nurse aides review a resident's plan of care prior to providing care. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the facility falls protocol policy; in part, directed based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address the risks of clinically significant consequences of falling.