STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075286	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Civita Care Center at Newington	240 Church St Newington, CT 06111

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 - Actual harm Residents Affected - Some	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** 47491 Based on record review and staff interviews the facility failed to ensure residents were free from abuse for three (3) of five (5) residents (Resident ID # 2, #3 and #7). The facility failed to ensure interventions were in place to address verbal altercations which occurred prior to a physical altercation between Resident #1 and Resident #2, and for Resident #3 and #7 the facility failed to ensure the residents were free from physical and psychosocial abuse. The findings included: 1. Resident #1 had diagnoses which included schizoaffective disorder, bipolar disorder, and schizophrenia. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1, had a Brief Interview for Mental Status (BIMS) of fifteen (15) indicative of intact cognition, was independent with Activities of Daily Living (ADL) including ambulation, did not present with hallucinations or delusions, and did not exhibit any physical, verbal or behavioral symptoms directed toward others. Review of Resident #1's care plan dated 2/11/24 identified Resident #1 had a potential for alteration in mood due to diagnoses of anxiety, bipolar, and schizoaffective disorders and received psychotropic medications with interventions that directed to provide support, medication administration as ordered, and to be alert to a decline in mood/behavior. Resident #2 had diagnoses which included cerebral infarction, hemiplegia affecting left, nondominant side, and adjustment disorder. Review of the quarterly Minimum Data Set assessment dated [DATE] identified Resident #2 had a Brief Interview for Mental Status (BIMS) of fourteen (14) indicative of intact cognition and required substantial assistance with ADL's and was non-ambulatory. Review of Resident #2's Care Plan dated 12/19/23 identified a risk for alterations in mood/behavior related to depressive episodes and anxiety disorder with interventions that directed to encourage resident to verbalize feelings and fears, to spend time talking to the resident, and to allow expression of feelings. Review of Social Worker (SW) #1's note dated 12/19/23 identified Resident #2 had concerns with his roommate (Resident #1), wanted to move to another room, and that SW #1 would assist. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075286	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Civita Care Center at Newington	240 Church St Newington, CT 06111

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 - Actual harm Residents Affected - Some	No further documentation about the room change was identified and the facility census on 2/15/24 identified Resident #2 remained in the room with Resident #1. Review of a nurse's note dated 2/15/24 at 8:58 AM identified that Resident #2 alleged that Resident #1 had stuck him/her in the face, the resident had a swollen bloody lip. Review of the Facility Licensing and Investigations Section Reportable Event form dated 2/15/24 identified that Resident #1 punched Resident #2 in the face because Resident #1 thought Resident #2 was the devil. The residents were immediately separated, and Resident #1 was transported to the hospital. Review of the police report dated 2/15/24 at 8:16 AM identified a physical altercation occurred between two roommates, Resident #1 and Resident #2. Interview with Resident #2 identified that Resident #1 came out of the bathroom, charged at Resident #2, and began punching him/her in the face. The police report further identified that Resident #1 then fell on top of Resident #2, causing a head-to-head collision, and a minor cut was observed on Resident #2's bottom lip. The police report noted in an interview with Resident #1 identified that he hit Resident #2 because he/she thought Resident #2 was the devil. Resident #1 was transferred to the hospital for evaluation. Review of a hospital discharge summary dated 2/15/24 identified that Resident #1 denied suicidal or homicidal ideation and did not meet the criteria for inpatient psychiatric hospitalization and was sent back to the skilled nursing facility. A nurse's note dated 2/15/24 at 10:53 PM identified that Resident #1 had returned from the hospital and moved to a different room, (with no roommate) and no behaviors were noted. Interview with Resident #2 on 10/2/24 at 8:52 AM identified he/she had requested a room change in December 2023 as he/she felt his roommate (Resident #1) was mentally unstable. Resident #2 identified feeling uncomfortable with the living situation and was concerned for his/her safety as he/she was unsure when a situation would become violent. Resident #2 further indicated he/she informed the Social Worker that he/she did not want to share a room with Resident #1 any longer and was told there were no rooms available. Resident #2 indicated he/she had to deal with the situation and tried to ignore Resident #1's verbal outbursts as the room change did not occur. Interview with Licensed Practical Nurse (LPN) #1 on 9/30/24 at 11:04 AM identified he/she did not witness the incident between Resident #1 and Resident #2 on 2/15/24, however had gone to the residents' room and saw Resident #2 sitting on the edge of his/her bed, bleeding from the mouth, crying, and visibly upset. LPN #1 further identified Resident #2 had reported he/she was attacked and did not retaliate due to weakness from his/her stroke and fear of getting into trouble. LPN #1 indicated Resident #1 was placed on one-to -one supervision until sent to the emergency room for further evaluation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075286	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/31/2024
NAME OF PROVIDER OR SUPPLIER Civita Care Center at Newington		STREET ADDRESS, CITY, STATE, ZIP CODE 240 Church St Newington, CT 06111	

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 - Actual harm Residents Affected - Some	Interview with Social Worker (SW) #1 on 10/1/24 at 3:03 PM identified Resident #1 would frequently make negative and racist remarks to Resident #2 prior to the 2/15/24 incident. These remarks consisted of Resident #1 calling Resident #2 evil, the devil, racist remarks, and complaining about him/her leaving the bathroom unclean, however, there were no physical altercations were noted prior to 2/15/24. SW #1 indicated he/she had informed Administrator #2 (previous administrator) of their first argument, she could not recall the exact date, she identified it was sometime in December 2023. SW #1 further identified he/she did not move Resident #2 at that time of his/her request on 12/19/23 because he/she thought there were no empty beds available. SW #1 identified that the arguments between Resident #1 and Resident #2 had continued and after the second argument which SW #1 estimated had occurred sometime in January 2024, he/she again informed Administrator #2, and was instructed to move one of the residents to a new room, however both residents refused to move. SW#1 further identified that she did not document the ongoing arguments in the clinical record and was unsure why. Interview with Administrator #2 (Administrator in place at the time of the incident) on 10/1/24 at 4:02 PM identified he/she remembered the altercation between Resident #1 and Resident #2 on 2/15/24, however could not recall being informed that any verbal exchanges/concerns between the two residents occurred prior to the 2/15/24 incident. Administrator #2 identified anytime a physical or verbal incident had taken place, the resident's room would immediately be changed. Interview with the Administrator #1 (current administrator) 10/3/24 AT 9:30 AM identified rooms were available on the long-term care unit in December 2023. Interview with the Director of Nurses (DON) on 10/1/24 at 9:12 AM identified that Resident #1 was cleared psychiatrically on 2/15/24 and sent back to the facility and placed into a private room. The DON stated that she was not aware of any of the verbal exchanges that occurred between Resident #1 and Resident #2 prior to the 2/15/24 incident and was not informed by SW #1 that this was occurring. The DON further identified he/she would have immediately separated the residents had she known the verbal exchanges were taking place as it created an unsafe situation and would have also involved different disciplines to support/inquire about the issue and hopefully resolve it. 2. Resident #7 had diagnoses that included schizophrenia, generalized anxiety disorder, and congestive heart failure. Review of the quarterly Minimum Data Set assessment dated [DATE] identified Resident #7 had a Brief Interview for Mental Status (BIMS) of fourteen (14) indicative of intact cognition and was independent with ADLs and ambulation. Review of Resident #7's Care Plan dated 4/3/24 identified an alteration in mood state with interventions that directed to monitor for irritability, anxiety, depression, and any mood changes. A nurse's note dated 6/9/24 at 3:43 PM Resident #1 was noted to hit staff and a resident, 911 and a doctor strong (an emergency code for immediate assistance) was called. Resident #1 broke free from staff and hit another resident in the head. Review of the Facility Licensing and Investigations Section Reportable Event form dated 6/9/24 at 3:30 PM identified Resident #7 was standing at the nurse's station when he/she was punched on the side of the face by Resident #1. Resident #7 was assessed and no injuries were identified and Resident #1 was transferred to the hospital. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075286	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/31/2024
NAME OF PROVIDER OR SUPPLIER Civita Care Center at Newington		STREET ADDRESS, CITY, STATE, ZIP CODE 240 Church St Newington, CT 06111	

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 - Actual harm Residents Affected - Some	Review of the police report dated 6/9/24 at 4:01 PM identified a physical altercation between a resident and staff member, where Resident #1 had a mental episode and jumped on LPN #2's back and then punched another resident in the face. The report further indicated Resident #1 was calm, in the presence of staff, sitting in a wheelchair upon police arrival to the facility. The report identified Resident #1 was transported to the hospital following the incident. Review of a care plan dated 7/1/24 identified that the resident had been hospitalized after hitting a resident and a staff member and had returned to the facility on [DATE] and was placed on one-to-one supervision until 7/11/24, when every fifteen-minute checks were initiated. Although the hospital discharge summary for the hospital stay from 6/9/24-7/1/24 was requested it was not provided. Interview with Resident #7 on 10/3/24 at 1:50 PM identified he/she was hit in the head, back and arms by Resident #1 on 6/9/24, that Resident #1 had punched him/her hard, called him/her a demon, and threatened to kill me. Resident #7 further identified that he/she still has flashbacks of the incident and was frightened after the incident. Interview with LPN #2 on 10/2/24 at 3:40 PM identified he/she had walked into the unit at 3:00 PM on 6/9/24, and walked into the nurse's station to receive report, and that Resident #1 had followed him and started hitting him with his/her fist in the back and then on the chest. LPN #2 further identified the floor staff assisted in separating the resident from LPN #2 and had placed Resident #1 in a wheelchair in front of the nurse's station under the supervision of staff. LPN #2 indicated he/she stepped away from the incident and was at the elevator when he/she heard commotion at the nurse's desk and heard Resident #1 had hit Resident #7. Interview with Nurse Aide (NA) #1 on 10/2/24 at 10:12 AM identified witnessing Resident #1 hitting LPN #2 on 6/9/24 and that, five (5) staff members separated Resident #1 from LPN #2, Resident #1 was placed in a wheelchair near the nurse's station under staff supervision. NA #1 identified staff had attempted to calm Resident #1 down, but Resident #1 had gotten up from the wheelchair, and ran into a resident ' s room, grabbed an overbed table, and brought it into the hallway as Resident #7 was approaching the nurse's station. Resident #1 then broke away from staff and ran over to Resident #7 started hitting Resident #7 in the head and calling him/her a demon. NA #1 further indicated Resident #7 was crying following the incident and was taken to his/her room where he/she remained until Resident #1 was transferred out of the facility. Interview with the Regional Clinical Consultant on 10/3/24 at 3:00 PM identified that Resident #1 had an extended hospital stay and upon return was placed on one-to-one supervision until 7/11/24, the resident had not exhibited behaviors so the interdisciplinary team decided every 15 minute checks was appropriate, the resident then was on every 30 minute checks and then every hour checks until they were discontinued due to a hospital stay for another physical altercation with a resident on 9/13/24. 3. Resident #3 had diagnoses which included disorganized schizophrenia, anxiety disorder, and encephalopathy. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075286	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/31/2024
NAME OF PROVIDER OR SUPPLIER: Civita Care Center at Newington		STREET ADDRESS, CITY, STATE, ZIP CODE: 240 Church St Newington, CT 06111	

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 - Actual harm Residents Affected - Some	Review of the admission Minimum Data Set assessment dated [DATE] identified Resident #3 had a Brief Mental Interview for Mental Status (BIMS) of twelve (12) indicative of moderately impaired cognition, did not exhibit physical or verbal behaviors towards others, and was independent with ADLs. Review of the Care Plan dated 7/25/24 identified Resident #3 had memory loss, impaired cognition, and was at risk for communication impairment with interventions that directed to face resident when speaking, and if resident was restless/agitated, to reapproach later in a calm, soothing manner. Review of the Facility Licensing and Investigations Section Reportable Event form dated 9/13/24 identified that Resident #1 attacked Resident #3 and was punching him/her in the face. Both residents were assessed, and no injuries were noted. Review of the police report dated 9/13/24 at 9:51 AM identified an altercation between Resident #1 and Resident #3 where Resident #1 had punched Resident #3 in the head and a scuffle had ensued. The report further indicated Resident #3 had identified Resident #1 had struck him/her in the head for no reason while he/she was walking by and threatened that he/she was going to get a gun and come back and shoot Resident #1. When the police officer asked Resident #1 what had occurred, Resident #1 responded, I saw the devil in that person. Both residents were sent to the emergency room for further evaluation. Interview with Occupational Therapist (OT) #1 on 9/30/24 at 2:46 PM identified that on 9/13/24, he was following Resident #1 with a wheelchair as he/she was walking in the hallway and had passed by Resident #3 who was ambulating in the hallway in the opposite direction when Resident #1 punched Resident #3. OT #1 further indicated Resident #3 retaliated and punched back at Resident #1. OT #1 identified the staff were able to successfully separate the two residents and that Resident #1 had stated Resident #3 was the devil. Both residents were sent to the emergency room for further evaluation. Interview with the Administrator on 10/3/24 at 5:10 PM identified that she was the administrator when the incident on 9/13/24 occurred. Resident #1 was sent to the hospital and subsequently transferred to another facility better suited for the resident's needs. The administrator further identified that the facility has zero tolerance any form of abuse. Review of the abuse policy identified that the residents in the facility will be free from abuse.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075286	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Civita Care Center at Newington	240 Church St Newington, CT 06111

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47491 Based on review of clinical records, interview, and review of facility documentation for two (2) of six (6) residents reviewed for the plan of care for Resident #4, the facility failed ensure a velcro stop sign was in place in accordance with the plan of care, and for Resident #6 reviewed for falls, the facility failed to follow a care plan intervention. The findings included: 1. Resident #4 had diagnoses which included paranoid schizophrenia, schizoaffective disorder, and chronic obstructive pulmonary disease. Review of the admission Minimum Data Set assessment dated [DATE] identified Resident #4 as cognitively intact and was independent with Activities od Daily Living. Review of the Facility Licensing and Investigations Section Reportable Event form dated 6/24/24 identified a physical altercation between Resident #4 and Resident #5 and identified a stop sign banner would be placed across Resident #4's doorway. A Nurses note dated 6/24/24 identified that another resident had entered h/her room and would not leave, so Resident #4 punched Resident #5 in the head. Review of Resident #4's Care Plan dated 6/24/24 identified psychotropic medication related to schizoaffective disorder and potential for altered mood behavior with interventions that directed to administer medications as ordered, observe for changes in mood, psych consultation and treatment as ordered, and stop sign banner placed at the front of room door. Observation and interview on 9/30/24 with LPN #4 identified a stop sign banner was missing from Resident #4's and all staff was responsible to ensure the stop sign remains on Resident #4's door. Interview with the Regional Clinical Consultant on 9/30/24 at 4:40 PM identified a stop sign banner should have been in place on Resident #4's door per incident/care plan directive. The care plan policy directed that the comprehensive care plan would: describe services that would be furnished to attain the resident's highest practicable physical, mental, and psychosocial well-being; incorporate identified problem areas; incorporate risk factors associated with identified problem areas; and aid in preventing or reducing decline in the resident's functional status.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075286	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Civita Care Center at Newington	240 Church St Newington, CT 06111

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** 47491 Based on review of clinical records, interview, and review of facility policy for one (2) of three (3) residents (Resident #1 and Resident #6) reviewed for medication and treatment administration, the facility failed to administer a psychiatric medication to a resident with a schizophrenia and failed to provide wound care to a patient with a Stage III pressure ulcer. The findings included: 1. Resident #1 had diagnoses which included schizoaffective disorder, bipolar disorder, and schizophrenia. Review of the quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 as cognitively intact, did not present with hallucinations or delusions, and did not exhibit any physical, verbal or behavioral symptoms directed toward others. Review of Resident #1's care plan dated 2/15/24 identified Resident #1 had a potential for alteration in mood due to diagnoses of anxiety, bipolar, and schizoaffective disorders and received psychotropic medications with interventions that directed to provide support, medication administration as ordered, and to be alert to a decline in mood/behavior. Review of a physician's order dated 6/1/24 directed for the resident to have an Absolute Neutrophil Count (ANC) (bloodwork used to monitor the neutrophil level in residents on clozapine) every month. Results should be sent to the pharmacy on the first of the month so clozapine can be dispensed, Clozapine will not be dispensed if the bloodwork is not received. Review of the medication administration record identified the order to fax labwork to the pharmacy for 6/1/24 had initials with parentheses around them indicating that the task was not done, however no explanation as to why it wasn't done was documented. Review of physician's orders dated 6/4/24 directed to administer clozapine 375 mg (a medication used to treat schizophrenia) by mouth at bedtime. Review of the Medication Administration Record dated June 2024 identified Resident #1 was administered 75 mg of clozapine (of the 375 mg order) on 6/4/24 at bedtime. A nurse's noted dated 6/4/24 at 9:00 AM identified clozapine 300 mg was not in stock due to Resident #1's lab draw for an Absolute Neutrophil Count (ANC-for residents on clozapine) was not completed as ordered. The note further indicated the Advanced Practice Registered Nurse (APRN) was made aware and directed to administer 75 mg (of the 375 mg order) to the Resident #1 on 6/4/24. A nurse's noted dated 6/5/24 identified an ANC was obtained on 6/5/24 and a request to the pharmacy to send an emergency supply for clozapine 100 mg. Review of the Medication Administration Record dated June 2024 identified Resident #1 was administered 375 mg of clozapine on 6/5/24 at bedtime and nightly thereafter per physician's order. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075286	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/31/2024
NAME OF PROVIDER OR SUPPLIER: Civita Care Center at Newington		STREET ADDRESS, CITY, STATE, ZIP CODE: 240 Church St, Newington, CT 06111	

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	Interview with the Regional Clinical Consultant on 10/3/24 at 4:00 PM identified the standard of practice is that a physician's order, whether it be medication or lab, was to be followed. The Regional Clinical Consultant further indicated there was a laboratory order monthly for Resident #1 and was unsure of why it was missed. Review of the medication administration policy identified that medications will be administered in accordance to physician orders. 2. Resident #6 had diagnoses of neurocognitive disorder with Lewy bodies, anxiety, and major depressive disorder. Review of the admission Minimum Data Set assessment dated [DATE] identified Resident #6 as moderately cognitively impaired and could ambulate with assistance. Review of Resident #6's updated Care Plan dated 3/27/24 identified the resident was at risk for pressure ulcers and had a pressure ulcer to the coccyx with interventions that directed to administer the treatment to the coccyx as ordered and encourage/assist with turning and repositioning as needed. Review of the Wound Management Detail Report dated 5/31/24 identified a deteriorating Stage III pressure ulcer in the coccyx region measuring 2.5 centimeters (cm) in length, and 4 cm in width. Review of a physician order dated 6/14/24 directed to wash coccyx with normal saline, followed by moisten Dakin's solution (an antiseptic), followed by foam dressing daily. Review of the June 2024 Administration Report identified Resident #6's treatment on 6/27/24 was not signed off as administered. Interview with the Regional Clinical Coordinator on 10/3/24 at 4:00 PM failed to identify why wound care was not provided to Resident #6 on 6/27/24 and that the standard of practice was to follow the physician's order. Review of the pressure ulcer policy identified that pressure ulcer treatments will be administered in accordance with the physician orders.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075286	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Civita Care Center at Newington	240 Church St Newington, CT 06111

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 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47491 Based on clinical record reviews, facility policy and interviews for seven (7) of fifteen (15) residents (Residents #1, #2, #3, #4, #5, #6, and #7) reviewed for physician visits, the facility failed to ensure physician visits were conducted in accordance with state agency requirements. The findings included: 1. Resident #1 had diagnoses which included Alzheimer's Disease, seizure disorder, and schizoaffective disorder, bipolar type. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified that the resident had short term and long term memory deficits and was dependent with bathing, toileting, oral, and personal hygiene. Review of the physician's evaluation/visit notes dated 1/31/24 through 8/26/24 failed to identify Resident #1 was evaluated by the physician every sixty (60) days in accordance with the public health code. 2. Resident #2 had diagnoses which included Alzheimer's Disease, Diabetes Mellitus, anxiety, and depression. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified that the resident had short term and long term memory deficits and required partial to moderate assistance with toileting and bathing. Review of the physician's evaluation/visit notes dated 3/25/24 through 10/7/24 failed to identify physician's evaluation/visits were conducted for Resident #2 from 3/25/24 through 10/7/24. 3. Resident #3 had diagnoses which included Alzheimer's disease, anxiety, and adjustment disorder. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Mental Interview for Mental Status (BIMS) of thirteen (13) indicative of intact cognition and was independent with toileting, dressing, and personal hygiene. Review of the physician's evaluation/visit notes dated 4/1/24 through 10/14/24 failed to identify Resident #3 was evaluated by a physician or advanced nurse practitioner during the month of June 2024. Review of the physician's evaluation/visits further identified the physician had evaluated Resident #3 in August 2024 an April 2024, however failed to evaluate the resident in June 2024. 4. Resident #4 had diagnoses which included schizophrenia, anxiety, and coronary artery disease. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #4 had a Brief Mental Interview for Mental Status (BIMS) of fourteen (14) indicative of intact cognition and was independent with toileting, dressing, and personal hygiene. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075286	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Civita Care Center at Newington	240 Church St Newington, CT 06111

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 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the physician's evaluation/visit notes dated 1/8/24 through 10/16/24 failed to identify Resident #3 was evaluated by a physician every sixty (60) days in accordance with the public health code. 5. Resident #5 had diagnoses which included Alzheimer's Disease, diabetes mellitus, and heart failure. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #5 had a Brief Mental Interview for Mental Status (BIMS) of eleven (11) indicative of moderately impaired cognition and required substantial assistance with toileting, bathing, and personal hygiene. Review of the physician's evaluation/visit notes dated February 2024 through October 2024 identified physician visits were conducted in February 2024 and April 2024, however failed to evaluate the resident every sixty (60) days thereafter. 6. Resident #6 had diagnoses which included depression, anxiety, and atrial fibrillation. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #6 had a Brief Mental Interview for Mental Status (BIMS) of thirteen (13) indicative of intact cognition and required substantial assistance bathing, applying footwear, and with performing personal hygiene. Review of physician's evaluation/visit notes dated July 2024 through September 2024 identified a physician saw Resident #6 on 7/19/24, however failed to maintain monthly evaluations for the first ninety (90) days of the resident's admission to the facility in accordance with the public health code. 7. Resident #7 had diagnoses which included heart failure, anxiety, and bipolar disorder. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #7 had a Brief Mental Interview for Mental Status (BIMS) of fifteen (15) indicative of intact cognition and was dependent with bathing. Review of the physician's evaluation/visit notes dated 3/22/24 through 9/19/24 identified Resident #7 was evaluated by a physician every sixty days as identified by documented visits on 3/22/24 and 5/10/24, however failed to maintain visits every 60 days thereafter as his/her next evaluation was dated 8/20/24. Interview with the Regional Nurse Consultant on 10/31/24 at 3:30 PM identified the facility's standard of practice was for physician's to assess/evaluate each resident every thirty (30) days for the first ninety (90) day of residency, then every sixty (60) days thereafter, alternating with an advanced nurse practitioner, and/or whenever the need presented. Review of the Physician's Services policy directed to conduct routine, required visits, physician orders and progress notes were maintained in accordance with current OBRA regulations and facility policy, and physician visits, frequency of visits, emergency care of residents, etc., were provided in accordance with current OBRA regulations and facility policy. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075286	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Civita Care Center at Newington	240 Church St Newington, CT 06111

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 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the Connecticut Public Health Code identified each resident in a chronic and convalescent nursing home shall be examined by his/her personal physician at least once every thirty (30) days for the first ninety (90) days following admission. After ninety (90) days, alternative schedules for visits may be set if the physician determines and so justifies in the patient's medical record that the patient's condition does not necessitate visits at thirty (30) day intervals. At no time may the alternative schedule exceed sixty (60) days between visits.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075286	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Civita Care Center at Newington	240 Church St Newington, CT 06111

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 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** 47491 Based on review of clinical records, interviews and review of facility documentation for one (1) of three (3) residents, (Resident #6) reviewed for activities of daily living, the facility failed to document activities of daily living each shift. The findings included: Resident #6 had diagnoses of neurocognitive disorder with Lewy bodies, anxiety, and major depressive disorder. Review of the admission Minimum Data Set assessment dated [DATE] severely cognitively impaired and required substantial assistance with toileting. Review of Resident #6's Care Plan dated 4/29/23 identified a risk for skin breakdown due to decreased mobility and assistance with dressing, hygiene, bathing, and toileting with interventions that directed to assist with turning and repositioning, skin care after each incontinent episode, and provide assistance with activities of daily living as needed. Review of Resident #6's Point of Care History for May and June of 2024 identified staff failed to document the resident's activities of daily living (which included support provided for eating, percentage of meal consumed, how the resident used the toilet and support provided for toileting) each shift. Interview with the Regional Clinical Consultant on 10/1/24 at 1:35 PM identified it was facility practice to document activities of daily living each shift and the responsibility of the nursing supervisors and Director of Nurses (DON) to review the reports. Interview with the DON on 10/1/24 at 1:38 PM identified the activity of daily living reports may have not been completed per shift as the facility hires several nurse's aides from the agency who do not have passwords to the charting system and therefore were unable to chart. The DON further indicated that facility staff was aware of their charting expectations and responsibilities.