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	08/28/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the 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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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, and facility policy, and interviews for one of three residents (Resident #4) reviewed for change in condition, the facility failed to ensure the provider was notified timely of a delay in obtaining STAT (immediate) laboratory work in accordance with physician orders, and failed to ensure the physician/APRN was notified timely of critical lab results. The findings include:Based on review of the clinical record, facility documentation, and facility policy, and interviews for one of three residents (Resident #4) reviewed for change in condition, the facility failed to ensure the provider was notified timely of a delay in obtaining STAT (immediate) laboratory work in accordance with physician orders, and failed to ensure the physician/APRN was notified timely of critical lab results. The findings include: Resident #4's diagnoses included Alzheimer's, flaccid neuropathic bladder (weak bladder muscles unable to contract properly) and urinary retention. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified that Resident #4 had a Brief Interview for Mental Status (BIMS) score of three out of fifteen, indicative of severe cognitive impairment, was dependent for personal care and always incontinent of bowel and bladder. The Resident Care Plan (RCP) dated 5/22/2025 identified Resident #4 was incontinent of bowel and bladder at times, had a history of urinary retention, and to monitor for retention. Interventions directed to observe for signs and symptoms of infection such as changes in mental status, complaints of back pain/dysuria, hematuria and elevated temperature and observe urinary output color, odor, and presence of sediment or blood in urine. APRN noted dated 8/1/2025 identified a urinalysis was completed due to foul smelling urine, the culture and sensitivity was obtained and ordered to start Macrobid (antibiotic)100 milligrams (mg) twice a day for five (5) days, labs reviewed, good oral (po) intake, encourage extra fluids, and if any changes noted may repeat labs. APRN note dated 8/8/2025 (late entry 8/28/2025) identified Resident #4 was seen due to reported lethargy, poor po intake, sitting up in chair, alert when called name but appeared tired, confused with dementia, vitals signs were stable, afebrile (no temperature), lungs were clear, no cough or congestion was noted. Urinary tract infection/dementia progressing. New orders today: ordered STAT (urgent or rush, immediately) chest x-ray, CBC (complete blood count), CMP (comprehensive metabolic panel), UA (urinalysis), also D5 1/2 strength NS (normal saline) intravenous (IV) two (2) bags, and if workup shows any infection will start antibiotics, keep responsible party notified. A physician order dated 8/8/2025 at 12:51 PM directed STAT CBC, CMP, urinalysis (UA) and culture and sensitivity (C/S). The nursing note written by LPN #6 dated 8/8/2025 at 2:40 PM indicated Resident #4 was seen by the APRN with new orders obtained, and the responsible party was updated. Record review identified the IV was started on 8/8/2025, and the chest x-ray was unable to be completed due to resident movement, and the supervisor and provider were notified. Record review failed to identify that the STAT lab work and UA and C/S were obtained or that the physician/APRN was notified that the labs and urine sample were not obtained on 8/8 or 8/9/2025. Nurses note dated 8/10/2025 at 12:29 PM (written by RN #1) identified Resident #4 was alert but confused at baseline, lethargic for a few days, was receiving IV hydration, labs and urine were sent out and a chest x-ray was obtained with negative results. Vital signs were stable, temperature 98.3. Responsible party asked for resident to be sent to hospital for evaluation, and Resident #4 was transferred to the hospital via ambulance. Review of Emergency Medical Services (EMS) run sheet identified EMS left the facility to transport to the hospital on 8/10/2025 at 12:43 PM. Review of laboratory results for labs identified the sample was collected on 8/10/2025 at 7:42 AM with results received by the facility on 8/10/2025 at 1:09 PM. The results further identified the critical values were called to the facility and a read-back of the results were performed with facility RN #1 at 2:09 PM. Record review failed to identify the physician/APRN was notified the STAT orders were not obtained on 8/8/2025 when ordered, and were not obtained on 8/9/2025. Interview and record review on 8/28/2025 at 11:58 AM with LPN #6 identified he was the charge nurse on 8/8/2025 during the 7 AM to 3 PM shift, and Resident #4 was his patient. LPN #6 stated APRN #2 had ordered STAT blood work on 8/8/2025 after 12 noon for Resident #4 and APRN #2 had directed him to order the blood work STAT. LPN #6 stated he called the lab to book the lab draw for Saturday 8/9/2025. LPN #6 stated he believed APRN #2 was aware the lab would not draw blood work until the next day, but he did not have a conversation with the APRN #2 that STAT labs ordered at the facility after 12 noon are not drawn until the next day. Interview and record review on 8/28/2025 at 11:06 AM with RN #1 identified she worked 8/9/2025 and was aware the blood work was ordered for 8/8/2025. Although RN #1 stated she spoke with the on-call

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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. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, facility documentation, facility policy, and interviews for one of three residents (Resident #4) reviewed for change in condition, the facility failed to ensure laboratory work was obtained timely in accordance with physician orders, and failed to act on critical lab results timely. The findings include: Based on a review of clinical records, facility documentation, facility policy, and interviews for one of three residents (Resident #4) reviewed for change in condition, the facility failed to ensure laboratory work was obtained timely in accordance with physician orders, and failed to act on critical lab results timely. The findings include: Resident #4's diagnoses included Alzheimer's, flaccid neuropathic bladder (weak bladder muscles unable to contract properly) and urinary retention. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified that Resident #4 had a Brief Interview for Mental Status (BIMS) score of three out of fifteen, indicative of severe cognitive impairment, was dependent for personal care and always incontinent of bowel and bladder. The Resident Care Plan (RCP) dated 5/22/2025 identified Resident #4 was incontinent of bowel and bladder at times, had a history of urinary retention, and to monitor for retention. Interventions directed to observe for signs and symptoms of infection such as changes in mental status, complaints of back pain/dysuria, hematuria and elevated temperature and observe urinary output color, odor, and presence of sediment or blood in urine. APRN noted dated 8/1/2025 identified a urinalysis was completed due to foul smelling urine, the culture and sensitivity was obtained and ordered to start Macrobid (antibiotic)100 milligrams (mg) twice a day for five (5) days, labs reviewed, good oral (po) intake, encourage extra fluids, and if any changes noted may repeat labs. Record review identified the last dose of Macrobid was administered on 8/6/2025. APRN note dated 8/8/2025 (late entry 8/28/2025) identified Resident #4 was seen due to reported lethargy, poor po intake, alert when called name but appeared tired, confused with dementia, vital signs were stable, afebrile (no temperature), lungs were clear, no cough or congestion was noted. The note indicated urinary tract infection/dementia progressing. Further, the note directed new orders today: ordered STAT (urgent or rush, immediately) chest x-ray, CBC (complete blood count), CMP (comprehensive metabolic panel), UA (urinalysis), also D5 1/2 strength NS (normal saline) intravenous (IV) two (2) bags, and if workup shows any infection will start antibiotics, keep responsible party notified. The nursing note written by LPN #6 dated 8/8/2025 at 2:40 PM indicated Resident #4 was seen by the APRN with new orders obtained, and the responsible party was updated. Record review identified the IV was started on 8/8/2025, and the chest x-ray was unable to be completed due to resident movement, and the supervisor and provider were notified. Additional record review failed to identify that the STAT lab work and UA and C/S were obtained on 8/8 or 8/9/2025. Interview on 8/28/2025 at 11:37 AM with Lab Representative #1 identified the laboratory picked up the urine sample on 8/9/2025 and had no record of any blood work drawn for Resident #4 on 8/9/2025. Interview and record review on 8/28/2025 at 11:58 AM with LPN #6 identified he was the charge nurse on 8/8/2025 during the 7 AM to 3 PM shift, and Resident #4 was his patient. LPN #6 stated APRN #2 had ordered STAT blood work on 8/8/2025 after 12 noon for Resident #4 and APRN #2 had directed him to order the blood work STAT and he called the lab to book the lab draw for Saturday 8/9/2025. LPN #6 stated STAT labs ordered at the facility after 12 noon are not drawn until the next day and he believed APRN #2 was aware, but he did not have a conversation with the APRN #2 that the blood work would not be obtained on 8/8/2025. Although LPN #6 stated he ordered the lab work to be drawn STAT, he was unable to identify when the lab said they would do the lab draw. Interview, clinical record review and facility documentation review on 8/28/2025 at 10:31 AM with RN #3 identified she was the evening shift supervisor on 8/8/2025 and did not recall if STAT bloodwork was ordered for Resident #4 on 8/8/2025. RN #3 further stated if the lab does not obtain STAT bloodwork by noon (12:00 PM), the physician/APRNs are aware and if needed residents can be sent to the hospital to obtain bloodwork. Interview failed to identify why the APRN was not notified the STAT lab work was not drawn on 8/8/2025 as ordered. Interview, clinical record review, and facility documentation review on 8/28/2025 at 11:06 AM with RN #1 identified she worked 8/9/2025 and was aware the blood work was ordered for 8/8/2025. The laboratory indicated they would not be in on 8/9/2025 and would be in on 8/10/2025 to obtain the blood work. Although RN #1 stated she spoke with the on-call provider on 8/9/2025 regarding continuing the IV hydration pending the blood work, but she was unaware the blood work was ordered STAT and was not aware they were delayed until late in the day. Interview on 8/28/2025 at 10:59 AM with Lab Representative Supervisor

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, facility documentation, facility policy, and interviews for two of three residents (Resident # 2 and Resident #3) reviewed for abuse, the facility failed to ensure adequate supervision for residents with known wandering behaviors to prevent a resident-to-resident interaction. The findings include: Based on a review of clinical records, facility documentation, facility policy, and interviews for two of three residents (Resident # 2 and Resident #3) reviewed for abuse, the facility failed to ensure adequate supervision for residents with known wandering behaviors to prevent a resident-to-resident interaction. The findings include: 1. Resident #2's diagnoses included dementia, bipolar disorder and schizoaffective disorder. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had severely impaired cognition and ambulated independently. The Resident Care Plan (RCP) dated 5/15/2025 identified Resident #2 had a potential for alteration in safety related to wandering behavior. Interventions directed approach in a calm manner, encourage recreation activities as a diversion, and redirect as needed if wandering into others rooms. 2. Resident #3's diagnoses included dementia. The annual MDS assessment dated [DATE] identified Resident #3 had severe cognitive impairment, had no behaviors, and was independent with wheelchair mobility. The RCP dated 6/12/2025 identified a risk for alteration in safety related to wandering behavior. Interventions directed encourage recreation activities as a diversion, and redirect as needed. Facility reportable event dated 8/17/2025 at 3:15 PM identified Resident #2 was observed in another resident's room sitting on Resident #3's lap with Resident #2's undergarment around Resident #2's ankles. Resident #3 appeared to be attempting to remove Resident #2 from his/her lap by pushing him/her away from his/her lap. Resident #3's pants were intact and zipped. Staff immediately intervened, separated and relocated both residents, the APRN was notified, and evaluated Resident #2 and had no injuries. Staff evaluated Resident #3, no injuries were identified, and both residents were transferred to the hospital for evaluation. Facility summary dated 8/22/2025 identified the incident occurred at 3:15 PM, and staff last observed Resident #3 at 2:53 PM in his/her room, and Resident #2 was last observed walking in the hallway at 3 PM. The room the residents were observed in was located closed to Resident #2's room, and the room had a video camera. Facility review of the video identified Resident #3's clothing remained intact. Both residents were identified to have no injuries and subsequent to the incident, Resident #3 was moved to another unit. Interview with Nurse Aide (NA) #3 on 8/27/2025 at 11:52 AM and review of her written statement identified on 8/17/2025 shortly after 3 PM she observed Resident #2 and #3 in another resident's room. Resident #3 was sitting in his/her wheelchair, and Resident #2 was sitting on Resident #3's lap and Resident #2's undergarment was at his/her ankles. Resident #3's clothing was intact (wearing pants that were zipped). Resident #2 had his/her back to Resident #3 (was facing forward on Resident #3's lap), Resident #2 was bouncing while Resident #3 was trying to push Resident #2 away. Interview, clinical record review, and facility documentation review on 8/27/2025 at 2:28 PM with DNS identified Resident #2 and Resident #3 had a history of wandering behaviors, and NA #3 observed the residents in another resident's room. Resident #2 was sitting on Resident #3's lap with Resident #2's undergarments down around his/her ankle. Resident #3's clothing was intact. The residents were separated, evaluated with no injuries identified, and transferred to the hospital for evaluation. Subsequent to the incident, both residents were seen by psychiatry services, and Resident #3's room was moved to another unit. Further, Resident #2 was placed on every 15-minute checks, and remained on every 15-minute checks as of 8/27/2025. Although interview identified the facility thought Resident #2 pushed Resident #3's wheelchair into the room, interview failed to identify how the residents were able to access another resident's room without staff knowing where Resident #2 and Resident #3 were. Review of facility Resident Right To Freedom From Abuse, Neglect, and Exploitation Policy and Procedure directed in part, staff shall monitor for any behaviors that may provoke a reaction by resident or others, which include, but are not limited to: Sexually aggressive behavior such as saying sexual things, inappropriate touching/grabbing. The Policy further directed the facility will take steps to ensure that the resident is protected from abuse.