| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 075286 | A. Building<br>B. Wing | 11/12/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Civita Care Center at Newington | 240 Church St<br>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 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical records, review of facility documentation, review of facility policy and interviews for two sampled residents (Resident #151) observed with medications left unattended at the bedside, and (Resident #178) on controlled anti-anxiety medication, the facility failed to ensure that medications were administered and failed to ensure documentation entered on the medication administration record was in accordance with professional standards of practice. The findings include:1. Resident #151's diagnoses included heart attack, stroke, benign neoplasm of the spinal cord and paralysis of the lower body.The admission MDS assessment dated [DATE] identified Resident #151 was cognitively intact, required set-up assistance for meals and oral hygiene, and was dependent on staff for toileting, showering, upper/lower body dressing and personal hygiene.The care plan dated 6/3/25 identified Resident #151 required assistance with dressing, hygiene, eating, bathing and toileting and required a total mechanical lift with the assistance of two for transfers. Interventions included providing set-up supervision and/or assistance as needed. Observation on 8/19/25 at 9:46 AM identified Resident #151 in bed, and a medication cup containing medications located on an overbed table in front of the resident. The nurse was not in the room and Resident #151 proceeded to self-administer the medications. Interview with Resident #151 at the time of the observation identified that it takes him a while take his/her medications, so the nurse leaves the medications at the bedside. Resident #151 further identified that he/she does not have a problem taking the medications but does takes them one at a time which takes a long time. Interview with LPN #1 on 8/19/25 at 9:48 AM identified that she had poured the medications and brought them to the resident's room at which time, he/she asked her to heat up some hot cereal. She noted that she left the medications at the bedside and left the room to heat the cereal up. She further identified that she should not have the medications at the bedside and that Resident #151 was not assessed to self-administer his/her medications. In addition, LPN #1 verified that she had prepared the following medications for administration: 1. Gabapentin (anticonvulsant) 100 milligrams (mg) 1 capsule2. Cholecalciferol (Vitamin D3) 25 micrograms (mcg) 1 tablet3. Dexamethasone (corticosteroid) 2mg 1 tablet4. Acidophilus (probiotic) 1 capsule5. Vitamin C 500mg 1 tablet6. Multivitamin with minerals 1 tablet7. Prevagen (helps with mild memory loss) extra strength 1 tablet8. Aspirin 81mg delayed release 1 tablet9. Linezolid (antibiotic) 600mg 1 tablet Interview on 8/21/25 at 9:19 AM with the Nursing Supervisor (RN #4) identified LPN #1 was distracted and nervous, and when the resident asked for the cereal to be heated up, LPN #1 mistakenly left the medications at bedside. RN #4 further identified that LPN #1 had been re-educated and should have asked a NA to re-heat the cereal while she was in the process of medication administration. She further identified that medications should not be left at the bedside. The core principles of the five Rights of medication administration include the right patient, the right drug, the right dose, the right route and the right time. Also included is the observation of the patient while they take the medication that was poured by the nurse to ensure the medications are consumed as ordered. 2. Resident #178 was admitted to the facility from an acute care hospital on 6/25/25 with diagnoses that included depression, and anxiety disorder.The nursing admission assessment dated [DATE] identified Resident #178 was alert and oriented to person, place<br>(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 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | and time, had no impairments to upper or lower extremities and utilized a wheelchair for mobility.The care plan dated 6/26/25 identified Resident #178 required assistance with dressing, hygiene, eating, bathing and toileting with interventions directed to provide set-up, supervision and or assistance with activities of daily living (ADLs) as needed. The care plan further identified Resident #178 received psychotropic medication related to anxiety and depression. The physician order dated 6/26/25 directed to administer Alprazolam extended release (ER) (24hr) 1milligram (mg) tablet once daily at 9:00 AM for anxiety disorder.Review of the electronic medication administration record (eMAR) for the month of June 2025 identified Alprazolam ER 1mg tablet was administered to Resident #178 on 6/26/25 at 10:12 AM by LPN #5.Review of Resident #178's controlled disposition record for Alprazolam ER 1mg tablet identified that the medication was delivered to the facility on 6/27/25. Review of the facility's emergency medication supply inventory list failed to identify the facility stocked Alprazolam ER 1mg tablet as part of their emergency supply of medications. Review of the controlled medication transactions per patient for the period of 6/1/25 through 6/26/25 facility failed to identify any residents with an order for Alprazolam ER 1mg tablets.Interview with the Charge Nurse (LPN #5) on 8/19/25 at 11:20 AM after a review of the controlled disposition record for the Alprazolam ER 1 mg for Resident #178, she identified that the medication arrived to the facility on 6/27/25. She acknowledged that she signed the medication administration record on 6/26/25 indicating that the medication had been administered to Resident #178, but she could not identify where she obtained the medication or if the medication was actually administered. In addition, LPN #5 noted that when a medication is unavailable, she would normally notify the nursing supervisor and if the resident needed the medication emergently, she identified that she would borrow the medication from another resident. Interview with the Pharmacist (Pharmacist #3) from the pharmacy that supplies the medications to the facility on 8/19/25 at 12:05 PM identified the pharmacy received a prescription for Alprazolam ER 1mg tablet once daily on 6/26/25 and the medication was delivered to the facility on 6/27/25. Interview with the DNS on 8/19/25 at 2:44 PM identified that when a resident's medications are not available, the nurses should not borrow from another resident. She identified that if medication is unavailable, the charge nurse should notify the supervisor, the pharmacy should be contacted, the emergency supply of the medication should be checked, and the physician should be notified. Interview with the DNS on 8/20/25 at 8:30 AM identified she reviewed the controlled disposition reports for the facility for the time period of 6/1/25 through 6/26/25 and was unable to identify a resident in the facility on Alprazolam ER 1mg tablet at the time LPN #5 signed the eMAR indicating that the medication was administered to Resident #178 as ordered. She also identified that that medication was not a medication that the facility kept as part of their emergency supply of medications, thus LPN #5 could not have administered the medication and the eMAR documentation was incorrect. Review of the Medication Shortage/Unavailable Medications identified when medications are not received or are unavailable for the customers, the licensed nurse will urgently initiate action in cooperation with the attending physician and pharmacy provider. |