

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  11/18/2025
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)
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>Based on clinical record review, facility policy and interviews for one (1) of three (3) sampled residents (Resident #1) who had a history of falls, the facility failed to complete a fall risk assessment following the fall in accordance with facility policy. The findings include: Resident #1's diagnoses included dementia with behavioral disturbances and Parkinson's disease (a movement disorder of the central nervous system that worsens over time). The Resident Care Plan dated 3/21/24 identified Resident #1 was at risk for falls due to weakness. Interventions directed to ensure the call light was within reach and encourage the resident to call for assistance as needed, provide assistance with bed mobility, transfers, and ambulating as ordered and needed and ensure two (2) half side rails are up on the bed to aid with turning and repositioning as needed. The late entry nurse's note dated 4/25/25 at 11:26 AM for 4/20/25 at 11:25 PM identified Resident #1 was heard crying in his/her room and observed sitting on the floor crying. The note indicated Resident #1 was assessed and noted to have no injuries, skin was intact and displayed no signs of pain or discomfort, Resident #1 was then assisted up to bed, provided a snack and no further distress was noted for the remainder of the night. Review of the clinical record failed to identify that a Morse Fall Scale (fall risk assessment) had been completed following the 4/20/25 fall, the next assessment was conducted on 8/23/25, four (4) months later. Interview with the Director of Nursing (DON) and the Regional Nurse on 10/8/25 at 2:54 PM identified that the Morse fall scale was to be completed for each resident on admission, following a fall (change in condition), quarterly and as needed. They reported the Morse fall scale should have been completed for Resident #1 following the 4/20/25 fall. The DON identified she was responsible to ensure an assessment was completed when she was reviewing the completed Accident and Investigation (A &amp; I). Review of the Assessing Falls and Their Causes policy (undated) directed, in part, that residents must be assessed upon admission and regularly afterward for potential risk of falls. Relevant risk factors must be addressed immediately. When a resident falls, the following information should be recorded in the resident's medical record: Completion of a fall risk assessment.</p>

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:  075286	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/18/2025
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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on clinical record review, observations, facility policy and interviews for one (1) of three (3) sampled residents (Resident #1) who were dependent on staff assistance with personal hygiene, the facility failed to ensure infection control practices were implemented and dirty linen and a soiled incontinent brief were not left on top of the resident's table in the room. The findings include: Resident #1's diagnoses included dementia with behavioral disturbances and Parkinson's disease (a movement disorder of the central nervous system that worsens over time). The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) conducted by the staff identifying Resident #1 had short and long-term memory problems, did not make decisions regarding tasks of daily life, had difficulty focusing attention, disorganized thinking and an altered level of consciousness, required substantial assistance for bed mobility and was dependent on staff for transfers and was incontinent of bowel and bladder. The Resident Care Plan dated 9/9/25 identified that Resident #1 has cognitive loss/dementia. Interventions directed to assist the resident with bathing, washing and dressing as needed and tolerated and the resident required the assistance of one (1) with activities of daily living. Observations of Resident #1's room on 10/8/25 at 10:46 AM identified dirty linen and a dirty incontinent brief on the dresser in front of Resident #1's bed and a dirty johnny coat on the overbed table. Observations on 10/8/25 at 10:56 AM identified the dirty linen and incontinent brief had not been removed from Resident #1's room. Interview with a 7AM-3PM nurse aide, Nurse Aide (NA) #1, on 10/8/25 at 10:56 AM identified she was Resident #1's assigned nurse aide that day. NA #1 explained she left the soiled linen and incontinent brief on both the dresser and overbed table because the soiled linen cart was unavailable in the hallway outside of Resident #1's room and she should have bagged the linen and then came back for it and not left it on table surfaces. Interview with the Regional Nurse, Licensed Practical Nurse (LPN) #1, on 10/8/25 at 11:06 AM identified staff should never place dirty linens or incontinent briefs on furniture surfaces, they should have been bagged separately and then discarded as NA #1 left Resident #1's room. Although requested, a policy on infection control practices related to disposing of soiled linens and incontinence supplies was not provided.</p>		