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	12/19/2025

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 0689 Level of Harm - Immediate jeopardy to resident health or safety 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)

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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(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 - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, facility documentation, facility policies and interviews for one (1) of three (3) sampled residents (Resident #1), reviewed for accidents, the facility failed to adequately supervise a resident with a known history of wandering who ambulated independently, during a period with a higher than usual volume of visitors, to ensure the resident remained on the secured memory care unit when visitors were entering and exiting. Subsequently, the resident exited the secured memory care unit, ambulated through two facility hallways, exited the main facility entrance without staff knowledge, and was located by police 0.4 miles away from the facility. This failure resulted in the finding of Immediate Jeopardy. The findings include: Resident #1's diagnoses included dementia, anxiety, and depression. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 was severely cognitively impaired (Brief Interview for Mental Status (BIMS) score of 3) had short and long-term memory recall deficits and was independent with transfers and ambulation. The Resident Care Plan (RCP) dated 8/27/25 identified Resident #1 had a self-care deficit and a history of wandering throughout the unit in and out of other resident's rooms while self-ambulating. Interventions directed to provide a structured routine and redirect when wandering or exit seeking.The Psychiatric note dated 11/13/25 identified the Advanced Practice Registered Nurse (APRN) saw Resident #1 due to an increase in agitation and increase in wandering in other residents' rooms. The APRN prescribed additional Trazadone 25 mg two times per day as needed for increased agitation/restlessness. The Facility Reported Incident form dated 11/19/25 at 1:10 PM identified Resident #1 left the unit unsupervised and was last seen by staff at 1:10 PM. The Nurse's note dated 11/19/25 at 4:27 PM identified Resident #1 left the unit without staff knowledge and upon return, stated he/she went for a walk. The APRN was notified and ordered labs and visual monitoring.Review of the undated facility's summary report indicated that at approximately 1:40 PM on 11/19/25, the police department notified the facility that Resident #1 was found 0.4 miles away from the facility and Resident #1 was returned to the facility by a police officer and two facility staff members. The facility was unaware Resident #1 left the facility unsupervised. Resident #1 was last seen by NA #1 at 1:10 PM in the lounge and was seen ambulating in the hall. Based on staff interviews, there were many visitors on the unit during the time Resident #1 exited the unit. The summary report indicated Resident #1 may have inadvertently walked out alongside visitors as they left the unit and that during the post-event interview, Resident #1 was able to demonstrate to staff that he/she exited the building by the main facility door. The summary report identified that an Elopement Risk assessment conducted on 8/27/25 identified Resident #1 had a history of wandering and the RCP was updated to reflect wandering behaviors with interventions to redirect when wandering or exit seeking and encourage recreation activities.A written statement dated 11/19/25 by the receptionist identified she did not see Resident #1 exit the building on 11/19/25. Interview with RN #1 on 12/18/25 at 11 AM identified on 11/19/25 the facility received a phone call from the police inquiring if a resident was missing from the facility. RN #1 identified Resident #1 was not on the secured memory care unit and then went with a police officer to assist the resident back to the facility. RN #1 identified Resident #1 had a history of wandering throughout the secured memory care unit and walked up and down the halls. RN #1 identified that on 11/19/25 from 7 AM to 3 PM, there were several out-of-state visitors, unfamiliar with the facility, who were entering and exiting the secured memory care unit in groups of six (6) to eight (8) at a time. RN #1 further identified Resident #1 likely walked off the unit with exiting visitors. In addition to the visitors, a Social Worker was visiting the unit and construction was occurring in the building. RN #1 identified secure door codes should not be given to visitors. Interview with NA #2 on 12/18/25 at 11:10 AM identified he/she worked the 7 AM to 3 PM shift on 11/19/25. NA #2 identified she did not give the secure door code to visitors and that staff were responsible for escorting visitors in and out of the secured memory care unit and ensuring the door shuts and locks once visitors pass through the door. NA #2 further identified the secured memory care unit was busier than usual on 11/19/25 due to several visitors entering and exiting. NA #2 saw Resident #1 ambulating in the hallway around 1 PM and did not recall assisting any visitors out of the secured memory care unit. Observation of the secured memory care unit and interview with the DON on 12/18/25 at 2 PM identified that when visitors enter and exit the secured memory care unit, staff should enter the secured door code to assist visitors in and out. The DON identified staff should stay at the door as visitors pass through the doorway, then close the door and ensure the door is secured, which is indicated by a light illuminating red above the door. Staff should not give