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	02/11/2026

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 - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #10) reviewed for accidents, the facility failed to ensure staff opened an access door to a resident unit in a safe manner to ensure a resident was not hit by the door. The failure resulted in a resident fall with injury. The findings include: Resident #10's diagnoses included Alzheimer's disease, dementia with behaviors and osteoarthritis. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #10 had severe cognitive impairment, required set up assistance to ambulate independently, and had no falls since the prior assessment (90 days).The Resident Care Plan (RCP) dated 11/25/2025 identified Resident # 10 as a fall risk. Interventions directed to wear gripper socks and directed frequent checks when ambulating in the hallway.The nursing note dated 1/14/2026 at 10:58 PM identified Resident #10 had an unwitness (ed) fall standing behind the double doors on unit. Resident #10 denied discomfort, had a nosebleed with discoloration, range of motion was at baseline. APRN was notified and ordered Resident #10 to be transferred to the hospital for x-ray of the face to rule out fracture. The nursing note dated 1/15/2026 at 3:07 PM identified Resident #10 returned from the hospital with a diagnosis of a closed nasal bone fracture. Facility reportable event form dated 1/15/2026 at 10 AM identified Resident #10 had an unwitnessed fall at the secured unit entrance. A staff member opened the double doors and did not recognize the resident positioned behind the door. Resident #10 subsequently fell and sustained a closed nasal bone fracture.Facility reportable event summary dated 1/19/2026 identified the fall occurred when a staff member opened the double doors to the unit and did not recognize the resident was positioned behind the door. Resident #10 subsequently fell to the floor. Resident #10 was alert with no loss of consciousness, had a nosebleed and was transferred to the hospital. The plan of care was updated to redirect Resident #10 away from unit doors and heightened staff awareness during door access.Observation of the nursing unit on 2/5/2026 at 10:30 AM identified access to Resident #10's unit had double metal doors. The door on the right side of the hallway had a push bar located approximately three (3) feet above the floor, to allow opening of the door; the opposite door had a push bar from the inside of the unit to allow exit from the unit. Above both push bars was a clear glass rectangular window near where the two (2) doors met. Each window was approximately 10 or 12 inches wide and approximately 24 inches tall. Continued observation identified Resident #10 paced walking near the walls. Observation and interview with the DNS and RN #1 on 2/5/2026 at 10:40 AM identified on 1/14/2026 when NA #2 entered the unit, Resident #10 was near the corner of the wall and the door that NA #2 opened. RN #1 stated NA #2 did not see Resident #10 when she opened the door, and the door hit Resident #10 causing him/her to fall. Observation identified a person positioned in the corner near the wall was visible through the door window. Interview identified NA #2 should have looked through the window to ensure there were no residents near the door and should have entered the unit (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 0689 Level of Harm - Actual harm Residents Affected - Few	slowly. Interview and record review with NA #2 on 2/5/2026 at 12:25 PM identified she did not see Resident #10 when she opened the unit door on 1/14/2026. The door hit Resident #10 causing the resident to fall. NA #2 stated she looked through the window but Resident #10 was in the corner (near the wall) and she did not see Resident #10. NA #2 stated when she pushed open the door, it knocked Resident #10 and he/she lost his/her balance and fell. NA #2 stated she needed to be more careful.Interview and record review with the DNS and LPN #2 on 2/5/2026 at 2:30 PM identified Resident #10 ambulated independently with a walker and paced on the unit, often walking close to the walls. Further, the unit had multiple residents that wandered or paced who could be near the doors. The DNS stated she expected staff to open the door slowly and to be attentive to residents when opening the door.Review of facility documentation identified education was initiated on 1/15/2026 and included to open doors slowly and to look at both sides of the doors to ensure no residents are standing nearby. Further, observation identified signs were posted on the doors that directed staff to stop, before you open the door, look through both glass windows to ensure there is no resident behind the doors. A second sign directed to open door slowly, as resident could be behind door! audits were initiated on 1/15/2026 and a QAPI meeting was held on 1/16/2026. A finding of past non-compliance was identified.

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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 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** Based on clinical record review, facility documentation review, facility policy review, and interviews for one of four residents (Resident #6) reviewed for therapy, the facility failed to ensure the clinical record was complete and accurate to include orthopedic consults, post wrist surgery documentation and related therapy notes as part of the medical record. The findings include:| Resident #6 was admitted to the facility with diagnoses that included neurogenic bladder, stage 4 pressure wound of the sacral region (base of the spine), chronic pain and contractures (permanent tightening and shortening of muscle, tendons, skin or nearby tissue turning them into stiff tissue). An annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #6 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated he/she was alert and oriented, was dependent for all care, had an indwelling catheter, an ostomy for bowels, a feeding tube, and had a stage 4 pressure ulcer that was present on admission or readmission. A Resident Care Plan (RCP) dated 5/1/2021identified Resident #6 was dependent for activities of daily living requiring bilateral elbow extension splints and a personal tilt in space custom wheelchair due to poor postural control. Interventions directed gentle range of motion prior to donning splint and therapy screen as needed. APRN progress note dated 5/19/2021 at 2:40 PM identified Resident #6 was seen by a bone/joint specialist for contractures of the hands and right wrist carpectomy (removal of wrist bones) without complications and was scheduled for left wrist hand surgery on 5/25/2021. A nursing note dated 5/25/2021 at 3:40 PM identified Resident #6 returned from a surgical appointment with a left wrist dressing in place, dressing clean, dry and intact (CDI) and no acute distress noted. A grievance form dated 6/2/2021 identified Resident #6 had reported to the hospital bone and joint institute that he/she was not receiving physical therapy. The grievance response identified that after Resident #6's wrist surgery, the therapy required was specialized and the facility was unable to complete the therapy at the facility. Attempts were made to set up therapy outside the facility were complicated by Resident #6's special needs (tracheostomy, special transport and monitoring during therapy). Resident #6 was thoroughly evaluated by therapy and was not appropriate for any therapy pending removal of a wrist splint by the orthopedist. Record review failed to identify any therapy notes/records related to the wrist surgery, documentation of the 5/25/2021 orthopedic procedure, and outside consultations. Although requested, the facility was unable to provide any therapy documentation for 2021 or outside consultations prior to 6/1/2021. Interview and record review with APRN #1on 2/11/2026 at 12:40 PM identified she recalled that Resident #6 had orthopedic surgery and was followed by an outside orthopedist. APRN #1 stated that any documentation of the procedure and any therapy evaluations should be included as part of Resident #6's medical record. Interview with the DON on 2/11/2026 at 2:00PM identified she would expect Resident #6's medical record to include documentation of any therapy provided or why it was not provided, and orthopedic consultations/surgeries or results of any outside appointment or surgeries. The DON stated she did not know why the medical record did not include these documents. The facility Charting Documentation Policy directed in part, all services provided to the resident, progress toward goals, any changes in medical, physical, functional or psychosocial condition shall be documented in the resident's medical record in order to facilitate communication between the interdisciplinary team members.