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	11/12/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observations, review of facility documentation, review of facility policy/procedures and interviews, the facility failed to ensure the residents had a safe, clean, comfortable environment. The findings included:1. Observation on 8/18/25, 8/19/25 and 8/20/25 identified the resident unit located on the first floor smelled of urine. The walls and baseboards in the hallways contained rust-colored stains, and peeling wallpaper. The floors were sticky in some areas making it hard to lift your feet off the floor. The water fountain in the hallway contained standing water in the drain that was brownish black in color. Several resident rooms (101, 104, 105, 108, 110, 118, 119 and 238) presented with peeling wallpaper that had a black substance on the back of the wallpaper and on the wall. The black substance was also noted on the wall underneath the air conditioning (AC) units. Some of the rooms had exposed inner wall and insulation around the AC units, and some were missing molding that exposed the insulation and wiring in the wall. In addition, some of the baseboard covers were detached from the wall, and holes in the wall noted with exposed insulation and a black substance. Interview on 8/20/2025 at 8:05 AM with LPN# 11 identified that the water fountain had not worked since prior to COVID and isn't cleaned regularly. LPN #11 identified that there was a housekeeper on the unit daily, but the unit had some residents with wandering and other behaviors that make it difficult to keep up with. Interview on 8/21/25 at 9:15 AM with RN#3 identified she would speak with the Administrator regarding the smell and cleanliness of the unit and indicated she noticed the floor was sticky in some areas and noted she had addressed this with the housekeeper. Interview on 8/21/25 at 9:34 AM with the Administrator and observation of the 1st floor nursing unit identified that the water fountain would be removed that day and indicated the dirty standing water could potentially be a safety concern for ambulatory residents with lower cognitive status or safety awareness. During a tour of the unit with the Administrator, the black growth and exposed insulation in the rooms as well as the residue on the walls and molding in the hallways was pointed out to him. The Administrator indicated he would assign an additional housekeeper to the unit. Interview on 8/21/2025 at 1:53 PM with the Director of Maintenance for another facility under the Civita umbrella, identified that any black substance should be treated with a bleach mixture that contained a cleaner for fungus growth. The Director of Maintenance could not identify if any of the black substance had been treated, nor could he identify when the air conditioning units were last cleaned or serviced but noted that the AC units should be cleaned. Interview on 8/21/2025 at 2:06 PM with Maintenance Worker #2 identified the AC units are cleaned one time in the spring but failed to provide documentation of when the cleaning was done. Maintenance Worker #2 identified that the water fountain would be removed from the unit, and the (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075286	A. Building B. Wing	11/12/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	facility had directed an additional housekeeper for cleaning. Subsequent to surveyor inquiry, the water fountain was removed from the hallway and the plumbing secured. 2. Observation on 8/15/25 at 9:45 AM identified the resident lounge on the Chateaux unit was warm and humid, the air conditioner located in the wall was not functioning and the television was out of order. Interview on 8/15/25 at 10:00 AM with Resident #76 identified the temperature in the lounge on the second floor (Chateux) was so hot that residents do not want to frequent the lounge to relax like they use to or to watch TV because it was too hot and the TV was broken. Resident #76 further noted that it had been like that for greater than two months and all they were told was that they were working on quotes. Resident #76 identified that he/she was frustrated about the length of time the AC was not working. Interview on 8/15/25 at 10:30 AM with the Maintenance Director from another Civita facility who noted that he visits the facility monthly to maintain maintenance because the facility did not have a maintenance director. He identified that he was aware of the broken AC unit and had informed Resident #76 that it was an electrical issue that required an electrician to fix. Interview on 8/19/25 at 9:30 AM with the Administrator identified that the AC unit had been broken for several weeks and note they had a new AC unit but had not installed it because he was told it was an electrical issue, and they were working on quotes to get the electrical issue repaired. Additionally, he identified that the facility was undergoing a change in ownership and expressed that it was his understanding he had until the change of ownership was completed to fix the issue. Interview on 8/21/25 at 1:30 PM with the Maintenance Assistant identified he had been on medical leave since May 2025 and returned 8/18/25 and noted that prior to his medical leave there was problems with the HVAC (Heating ventilation and Cooling) system in the building and currently there is a roof top unit that is not working properly. He also noted that he was aware that the AC in the lounge had been out for a couple of months and they tried to reset the breaker, and it tripped the breaker. He further noted that from what he has seen there has been a lot of quotes received but not much work completed, and the electrical company had been there that week to fix the breaker for the AC unit after the state survey team entered the facility. Interview on 8/21/25 at 2:00 PM with the Administrator identified that an electrical company had been there that week to repair the breaker for the resident lounge, and the new AC was installed. Interview on 8/21/25 at 2:10 PM with the Assistant Administrator identified that he started at the end of January and that the AC in the lounge had been an ongoing issue for about 4-5 weeks along with the rooftop AC unit which they had been working on. He noted that the plan had been to have an electrical crew come out before October 1st. Although a policy regarding temperature/environment was requested one was not received.

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	11/12/2025

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 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of clinical records, review of the facility assessment and interviews for four sampled residents residing on a secured nursing unit (Residents #32, #69, #161 and #173) and reviewed for involuntary seclusion, the facility failed to assess, care plan, demonstrate that the secured unit was the least restrictive setting, and obtain consents for residents who were selected to reside on the secured unit. The findings include: Observation on 8/15/25 at 10:30 AM identified there was one nursing unit located on the first floor of the facility. The double doors at the entry to the unit had a key pad entry that required a numeric code, there was also a doorbell that rang at the nursing station on the unit, and the staff could allow entry. The stairwells also required a numeric code entered into a key pad to allow for entry or egress. 1. Resident #32 was admitted to the facility in January 2025. Diagnoses included Parkinson's disease, psychosis not due to a substance or known physiological condition, post-traumatic stress disorder (PTSD), anxiety and dementia with other behavioral disturbances. The quarterly MDS assessment dated [DATE] identified Resident #32 had intact cognition, did not utilize alarms, did not exhibit wandering or rejection of care behaviors, was independent with toileting, personal hygiene, dressing, transfers and ambulation.The care plan dated 5/15/25 identified Resident #32 had a cognitive loss related to dementia with interventions that included, assist resident with bathing, washing and dressing as needed/tolerated with an assist of one, complete a dementia functional assessment on a quarterly basis, maintain consistent routines and use redirection and validation therapy as needed. Further review of the care plan identified that it did not contain information concerning the resident residing on the secured unit. The physician's orders in place for May 2025 identified Resident #32's care plan was reviewed and approved by the physician.The social worker's note dated 7/3/25 at 5:04 PM identified Resident #32 kept his/her room door closed all the time and conveyed that he/she felt anxious when other residents entered his/her room. The note further identified staff was assisting the resident with coping skills. The social worker's note dated 7/17/25 at 2:31 PM identified Resident #32 kept his/her room door closed all the time and conveyed that he/she felt anxious when other residents wandered into his/her room.The social worker's note dated 8/13/25 at 11:21 AM identified Resident #32's family member requested a discharge meeting that was scheduled for 8/20 at 1:00 PM. Interview on 8/15/25 at 10:58 AM with Resident #32 identified that he/she could not recall anyone discussing his/her placement on the secured unit with him/her. He/she further identified that most of the residents on the unit are not able to conversate and many wander in and out of other residents' rooms, take items from the rooms and are disruptive at times. Resident #32 further identified that he did not understand why he/she could not leave the unit. A review of the clinical for the time period of 1/1/25 through 8/17/25 failed to identify the criteria met for Resident #32 to be placed on the secured unit, it also failed to identify that the secured unit was the least restrictive environment. It further failed to identify the physician's involvement in the decision to place the resident on the secured unit or consent from the resident and/or responsible party. Observation on 8/18/25 at 8:59 AM identified Resident #32 redirected a resident who wandered into his/her room to leave his/her room. No staff were observed in the area. Resident #32 further identified that there were other residents on the unit that wandered into his/her room at times.A nursing note dated 8/19/25 (subsequent to surveyor inquiry) identified that the interdisciplinary team (IDT) reviewed the criteria met for placement on the secured unit and noted that the facility reached out to the resident's family member and was awaiting a call back. Interview on 8/20/25 at 12:28 PM with LPN#2 identified there were a lot of residents on the unit with behaviors that require more attention and redirection, and it is not always possible to be everywhere. He further noted that they did not always have enough staff to provide the level of supervision that is needed for the residents on the secured unit. Interview on 8/18/25 at 9:58 AM with Resident #32's Responsible (continued on next page)

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	11/12/2025

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 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Party (Person #5) identified Resident #32 was placed on the secured unit after making an allegation of abuse against a staff member. Person #5 indicated the family had attempted to move Person #5 to another facility, but no other facility would accept the resident. She further identified that she felt the facilities would not accept the resident because the current facility has passed along the resident's behavior history. Person #5 identified that the facility had not notified her of the resident's placement on the secured unit and had not provided a rationale for the placement. Interview on 8/19/25 at 9:26 AM with RN #9 (nurse consultant hired as part of the change in ownership) identified the facility was working on care plans and assessments for the residents residing on the secured unit and noted that the facility had just hired an experienced unit manager for the unit. RN #9 further identified that the criteria for the secured unit was developed in November 2024. She further identified that assessments and reassessments or placement on the unit should be completed at admission and quarterly. Interview on 8/20/25 at 11:00 AM with the DNS identified that the regulatory criteria was not implemented for all of the residents residing on the secured unit. Interview on 8/20/25 at 11:21 AM with LPN #9 (Regional Director of Admissions) identified that the admission process for the secured unit involved reviewing the hospital discharge summary, speaking with the responsible party(ies) and with the resident if they are alert and oriented. LPN #9 identified that the hospital sometimes make a recommendation that a resident requires a secured unit. Further, LPN#9 identified the criteria for placement on the unit includes: a diagnosis of dementia, residents at risk for elopement, a resident who is not easily redirected, and a resident who is deemed unsafe to be on a non-secured unit. LPN #9 further conveyed that the decision to place Resident #32 on the secured unit was made prior to the resident's admission but could not locate documentation in the clinical record that identified why the resident required placement on a secured unit. Interview on 8/21/25 at 10:54 AM with the Social Worker and LPN #7 (MDS Coordinator) identified that they should discuss the resident's placement on the secured unit during the care plan meetings and the care plan should reflect that the resident resides on a secured unit but identified that review of Resident #32's clinical record failed to identify documentation that addressed the resident's placement on the secured unit.Interview on 8/21/25 at 11:35 AM with the DNS identified the follow-through for the secured unit was a work in progress and the facility is calling families and is still touching base regarding consent for the placement on the unit. She further identified that the implementation was started the day post surveyor inquiry. 2. Resident #69 was admitted to the facility in April 2024 with diagnoses that included dementia with behavioral disturbances, depression, and adjustment insomnia. The annual MDS assessment dated [DATE] identified Resident #69 had intact cognition, did not exhibit physical or verbal behaviors directed toward self or others, rejection of care or wandering behaviors, was independent with all mobility, transfers and did not use any physical restraints or alarms.The care plan dated 4/24/25 identified Resident #69 preferred to remain in the facility long term with interventions that include assess/discuss alternate discharge settings as needed to ensure resident's needs are met, discuss with resident/health care representative the experience and feelings about the stay in the facility at care plan meeting. The care plan identified Resident #69 had very mild cognitive decline and indicated he/she attempted to help other residents without permission. Interventions included: set boundaries with resident and redirect resident to call for assistance for other residents in need.Observation on 8/15/25 at 1:29 PM identified Resident #69 ambulating in the hallway on the secured unit. Interview on 8/15/25 at 1:29 PM identified Resident #69 conveyed that his/her rolling walker used for ambulation was missing from his/her room and noted that the only problem on the unit was the behaviors of some of the other residents on the unit. He/she identified that residents wander into his/her room. Resident #69 indicated that another resident had taken the rolling walker out of Resident #69's room and that it was required for Resident #69 to ambulate safely. Resident #69 identified that no one had ever discussed being locked in with him/her.A review of the clinical for the time period of 1/1/25 through 8/17/25 failed to identify the criteria met for Resident #69 to be placed on the secured unit, it also failed to identify that the secured unit was the least (continued on next page)

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	11/12/2025

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 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	restrictive environment. It further failed to identify the physician's involvement in the decision to place the resident on the secured unit or consent from the resident and/or responsible party. Interview on 8/19/25 at 10:23 AM with Resident #69's family member (Person #9) identified there was no need for Resident #69 to be on a secured unit and noted that the facility had not discussed the placement on the unit with her. Person #9 further identified Resident #69 is legally responsible for signing paperwork and making decisions.Interview on 8/20/25 at 11:21 AM with LPN #9 (Regional Director of Admissions) identified that the admission process for the secured unit involved reviewing the hospital discharge summary, speaking with the responsible party(ies) and with the resident if they are alert and oriented. LPN #9 identified that the hospital sometimes make a recommendation that a resident requires a secured unit. Further, LPN#9 identified the criteria for placement on the unit includes: a diagnosis of dementia, residents at risk for elopement, a resident who is not easily redirected, and a resident who is deemed unsafe to be on a non-secured unit. LPN #9 further conveyed that the decision to place Resident #32 on the secured unit was made prior to the resident's admission but could not locate documentation in the clinical record that identified why the resident required placement on a secured unit. Interview on 8/21/25 at 10:54 AM with the Social Worker and LPN #7 (MDS Coordinator) identified that they should discuss the resident's placement on the secured unit during the care plan meetings and the care plan should reflect that the resident resides on a secured unit but identified that review of Resident #69's clinical record failed to identify documentation that addressed the resident's placement on the secured unit.Interview on 8/21/25 at 11:35 AM with the DNS identified the follow-through for the secured unit was a work in progress and the facility is calling families and is still touching base regarding consent for the placement on the unit. She further identified that the implementation was started the day post surveyor inquiry. 3. Resident #161 was admitted to the facility on [DATE]. Diagnoses included Alzheimer's disease, anxiety and chronic pain syndrome.An elopement risk assessment dated [DATE] identified Resident #161 was not an elopement risk.The admission MDS assessment dated [DATE] identified Resident #161 had severely impaired cognition, did not exhibit physical or verbal behaviors directed toward others, rejection of care or wandering, utilized a manual wheelchair and required partial/moderate assistance with mobility.The care plan dated 5/1/25 identified Resident #161 was at risk for decline related to dementia diagnosis and becomes easily agitated and is combative at times. The care plan further identified the resident resided on the long-term dementia unit with interventions that included: supply community referrals as needed, discuss with resident/health care representative their experience and feelings about their stay in the facility at care plan meetings and as needed.Review of the clinical record from January 2025 through 8/19/25 identified Resident #161 failed to identify documentation regarding placement or discussion of placement on the secured unit, and documentation identifying placement on the secured unit was the least restrictive setting. Subsequent to surveyor inquiry an elopement risk assessment dated [DATE] at 11:49 PM identified Resident #161 was not an elopement risk due to being bed bound. Additionally, on 8/16/25, the facility completed a dementia functional assessment tool that identified Resident #161 had moderate cognitive decline. Interview on 8/20/25 at 11:00 AM with the DNS identified that she was under the impression the facility was following the rules of the regulation and set up criteria for the secured unit. Review of Resident #161's documentation, The DNS indicated that the criteria had not been implemented for all residents and that the regulation was reviewed and the facility was entering c Interview on 8/20/25 at 11:21 AM with LPN #9, Regional Director of Admissions, identified the admission process for the secured unit involved review of the hospital stay/discharge for residents discharging for a clinical review to make sure they are appropriate for the building. LPN #9 indicated she would have a conversation with the families or case manager, and with the resident if they are alert and oriented, in the hospital prior to admission and explain the unit and the services they offer. LPN #9 identified that the hospital makes the recommendation that the resident requires the secured unit. LPN#9 identified criteria to include a diagnosis of dementia, a wander risk, not easily (continued on next page)

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	11/12/2025

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 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	redirectable, not able to keep safe on the regular units. LPN #9 indicated that the placement was made prior to admission, that she had only participated in 2 placements, and that the decision for admission was not documented in the clinical chart, but rather an email thread in the hospital system.Interview on 8/19/25 at 12:15 PM with Person #8 (family member) identified Resident #161 had been bedbound for a while and after returning from the hospital last week, was placed on hospice services. Person #8 indicated there were a lot of other residents who are confused and walking into the room and touching things, including personal items. Person #8 further identified that the facility did not have a discussion with him/her or Resident #161 regarding placement on the secured unit. Interview on 8/21/25 at 10:54 AM with LMSW and LPN#7 (MDS), identified they set up the 72 hour meeting after admission and indicated the secured unit placement conversation happens prior to admission and no conversation occurs at the 72 hour meeting. LPN#7 identified that they also set up a 14 day meeting and go over with the resident/representative about being on the secured unit. LPN #7 could not identify where this conversation was documented.Interview on 8/21/25 at 11:27 with RN #4 identified that she assisted with the input of the care plans and after a recent IDT meeting, RN #4 was directed by the DNS to input items related to the secured unit. Reviewed Residents #32, #69, #161 and #173 care plan items added and status and indicated that the interventions were not appropriate or resident specific and indicated she was provided a template for the input into the care plan. 4. Resident #173 was admitted to the facility June 2025. Diagnoses included dementia, anxiety disorder and depression.The admission MDS assessment dated [DATE] identified Resident #161 had intact cognition, did not exhibit physical or verbal behavioral symptoms directed toward others, did not exhibit wandering behavior, did not utilize alarms and was independent with transfers and position changes The care plan dated 6/24/25 identified Resident #161 had dementia and confusion and required assistance of 1 person for activities of daily living. Review of the clinical record dated 6/19/25 through 8/18/25 failed to identify documentation of Resident #173's placement on a secured unit, assessment for placement or MD documentation that the placement was the least restrictive environment for the resident. Elopement risk assessment dated [DATE] identified Resident #173 was not an elopement risk. Elopement assessment dated [DATE] identified Resident #173 had exhibited behavior that would cause concern related to wandering, exit seeking or safety and verbally expressed desire to leave center or go home. The assessment indicated Resident #173 was cognitively impaired with poor decision-making skills, had a diagnosis of dementia, had a recent medication change, had a recent housing changed and changed to long-term care. The score is a 3.0 which means Resident #173 was at risk for elopement.Psychiatric progress note dated 8/13/25 at 4:10 PM identified Resident #161 was anxious and depressed related to SNF placement and was requesting discharge.Interview on 8/15/2025 at 11:11 AM with Resident #173 identified confusion over placement at the facility and not being able to leave or access any money. Resident #173 indicated living at home with family and some damage to the home. Resident #173 identified the preference to keep the room door closed because of the elderly people that walk into the room and take things and indicated stress related to being on the secured unit and not feeling safe with others entering the room.Interview on 8/18/2025 at 9:24 AM with Person #10, Legal assistant to Resident #173's conservator, identified Resident #173 was placed in long term care on the secured unit because Resident #173 was identified by the conservator's office as possibly being a flight risk due to wanting to return home. Person #10 indicated the placement was to prevent Resident #173's family from having access to the resident and agreed that Resident #173 should be in a secured unit until everything calmed down with the family. Person #10 identified Resident #173 had some dementia but was going to be placed in assisted living at the point that the home sells.Interview on 8/20/25 at 11:21 AM with LPN #9, Regional Director of Admissions, identified the admission process for the secured unit involved review of the hospital stay/discharge for residents discharging for a clinical review to make sure they are appropriate for the building. LPN #9 indicated she would have a conversation with the families or case manager, and with the resident if they are alert and oriented, in (continued on next page)

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	11/12/2025

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 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the hospital prior to admission and explain the unit and the services they offer. LPN #9 identified that the hospital makes the recommendation that the resident requires the secured unit. LPN#9 identified criteria to include a diagnosis of dementia, a wander risk, not easily redirectable, not able to keep safe on the regular units. LPN #9 indicated that the placement was made prior to admission, that she had only participated in 2 placements, and that the decision for admission was not documented in the clinical chart, but rather an email thread in the hospital system.Interview on 8/21/25 at 10:54 AM with LMSW and LPN#7 (MDS), identified they set up the 72 hour meeting after admission and indicated the secured unit placement conversation happens prior to admission and no conversation occurs at the 72 hour meeting. LPN#7 identified that they also set up a 14 day meeting and go over with the resident/representative about being on the secured unit. LPN #7 could not identify where this conversation was documented.Interview on 8/21/25 at 11:27 with RN #4 identified that she assisted with the input of the care plans and after a recent IDT meeting, RN #4 was directed by the DNS to input items related to the secured unit. Reviewed Residents #32, #69, #161 and #173 care plan items added and status and indicated that the interventions were not appropriate or resident specific and indicated she was provided a template for the input into the care plan.Interview on 8/21/25 at 11:35 AM with the DNS identified the care plans were altered this week after a conversation with RN #9 that indicated each resident residing on the secured unit had to have a care plan identifying the placement. The DNS identified they had a template but realized that the care plan template was not patient specific and that the DNS then directed social work to go through and review the care plans to make sure they were patient specific. The DNS indicated the follow-through for the secured unit was a work in progress and that the facility are still calling families and are still touching base regarding permissions for the placement and remaining on the unit. The DNS identified the implementation was started the day after the surveyor started asking questions. A Secured Locked Unit admission policy, directed that decisions regarding an admission to the secured unit, will involve input from the resident's family, the IDT review and appropriate verbal consent from the resident's legal representative, family or power of attorney. It further indicated there was criterion for placement on the secured unit if any or more of the following were met; documented cognitive impairment, exit seeking risk, safety concerns, benefit from a structured monitored environment, interdisciplinary team review, which included nursing, physician/NP, social work and therapy and informed verbal consent, from the resident or legal guardian. Which should include an explanation of the secured unit, including purpose, risks and resident rights.

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	11/12/2025

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 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure that each resident?s assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews and interviews for 6 of 6 sampled residents (Residents #31, #45, #49, #56, #62, and #64) reviewed for resident assessment, the facility failed to ensure quarterly MDS assessments were completed timely. The findings include:Resident #31 had a quarterly MDS assessment dated [DATE], which means the next quarterly MDS assessment should have been dated 7/1/25 and completed by 7/15/25; however, the assessment was not completed until 8/20/25 making it 35 days late.Resident #45 had a quarterly MDS assessment dated [DATE], which means the next quarterly MDS assessment should have been dated 7/1/25 and completed by 7/15/25; however, the assessment was not completed until 8/22/25 making it 37 days late.Resident #49 had a quarterly MDS assessment dated [DATE], which means the next quarterly MDS assessment should have been dated 6/26/25 and completed by 7/10/25; however, the assessment had not been completed until 8/20/25 making it 40 days late.Resident #56 had a quarterly MDS assessment dated [DATE], which means the next quarterly assessment should have been dated 6/9/25 and completed by 6/23/25; however, the assessment had not been completed until 8/20/25 making it 57 days late.Resident #62 had a quarterly MDS assessment dated [DATE], which means the next quarterly assessment should have been dated 7/8/25 and completed by 7/22/25; however, the assessment had not been completed until 8/22/25 making it 21 days late.Resident #64 had a quarterly MDS assessment dated [DATE], which means the next quarterly assessment should have been dated 7/9/25, and completed by 7/23/25; however, the assessment had not been completed until 8/22/25 making it 29 days late.Interview with LPN #7 (MDS Coordinator) on 8/20/25 at 10:45 AM identified she is responsible for completing the MDS sections and RN #2 (Regional MDS Coordinator) is responsible for signing the RN MDS completion and submitting the completed MDS. She identified that the quarterly MDS assessment need to be signed off and completed within 14 days by an RN after setting the ARD (Assessment Reference Date). In addition, she acknowledged that the MDS assessments were late because the full-time RN MDS coordinator left 2 months ago and she only receives help remotely from another MDS Coordinator between 6 to 8 hours per week which is not enough help to complete the MDS assessment timely. She further identified that RN #2 was aware that she was getting behind with the completion of the MDS assessments.An attempt to interview RN #2 was unsuccessful. The Resident Assessment Instrument 3.0 user manual identified that the resident's assessment must be completed no later than the set assessment reference date (ARD) + 14 calendar days to be considered timely.

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	11/12/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on review of facility documentation, review of facility policy, and interviews during a review of the Infection Control Program, the facility failed to ensure environmental rounds were conducted/completed monthly, the facility failed to ensure infection surveillance data collection reports and analysis of infection trends within the facility were completed monthly, and failed to follow the policy and procedural measures developed by the facility to prevent the growth of Legionella and other water borne pathogens in the building water system. The findings include:1. Review of the infection control environmental round documentation for the past two years with the Infection Preventionist (RN #7) and the DNS on 8/19/25 at 1:00 PM failed to identify documentation of monthly environmental rounds that were completed for October 2024 and January of 2025. Interview with the Infection Preventionist (RN #7) and the DNS on 8/21/25 at 12:23 PM identified they were unable to locate any documentation for environmental rounds completed for October 2024 and January of 2025. RN #7 and the DNS identified that environmental rounds are completed monthly and it was the responsibility of the previous infection preventionist nurse to ensure they were completed as the DNS only started working at the facility in February of 2025 and only RN #7 started working at the facility in March of 2025.Review of the Environmental Rounds policy identified the infection control professional or his/her designee, charge nurses, supervisors, and department heads on their own units/departments complete environmental rounds on a regular basis. The policy further identified the environmental survey worksheets would be retained for possible review by survey teams to illustrate the improvement of quality of life within the facility.Review of the Compliance Rounds policy identified the Infection Preventionist is responsible for conducting periodic compliance rounds throughout the facility. 2. Review of the infection control program for the period of January 2024 to August 2025 with the Infection Preventionist (RN #7) and the DNS on 8/21/25 at 12:23 PM failed to provide documentation of monthly surveillance infection reports and analysis of infection trends were completed for the period of January 2024 to May 2024 and for the period of July 2024 to September 2024.Interview with the Infection Preventionist (RN #7) and the DNS on 8/21/25 at 12:23 PM identified they were unable to locate any of the monthly surveillance infection reports and analysis of infection for the period of January 2024 to May 2024 and for the period of July 2024 to September 2024 after searching thoroughly throughout the facility. RN #7 identified the monthly report and analysis data included the rate of healthcare/facility acquired infections and community acquired infections within the facility, and at the end of each month the total infection rate is calculated using a formula. They identified it was the responsibility of the infection preventionist nurse to track, identify and analyze infection rates within the facility monthly.Review of the Surveillance for Infections policy is to identify both individual cases and trends of epidemiologically significant organisms and healthcare-associate infections, to guide appropriate interventions, and to prevent future infections. The policy further identified monthly collection of information from individual resident infection reports and enter line listing of infections by resident for the entire month; and summarize monthly data for each nursing unit by site and by pathogen and monthly/quarterly identify predominant pathogens or sites of infection among residents in the facility or in particular units by recording them month to month and observing trends. 3. Review of the facility Water Management Plan/Program for the period of January 2024 to August 2025 with the Administrator, Maintenance #2 and Maintenance #3 (Director of Maintenance at another facility) on 8/20/25 at 1:29 PM identified the facility water management plan included flushing of not regularly used water pipes and locations include the soiled utility room, medication room sinks, shower tubs twice monthly, annual water sampling and daily water temperature checks. Review of the flushing log for the period of January 2024 to August 2025 failed to identify flushes were completed in the identified locations and documented twice for January 2025, February 2025 and July 2025.Interview with the Maintenance #3 staff on 8/20/25 at 1:29 PM identified the facility flushing plan had changed in January of 2025 from (continued on next page)

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	11/12/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	monthly to twice a month. He identified that he was the one flushing the locations that were identified as not commonly used but went on family medical leave in May 2025 and had just returned to work on 8/18/25.Interview with the Administrator on 8/21/25 at 11:13 AM identified the facility flushing plan for the water management plan was to flush the identified locations twice monthly. He further identified he was not working at the facility during those timeframes and was unable to state why the flushes were not completed.Although a request was made on 8/20/25 at 1:29 PM for their contracted company water management binder in which the Annual Water Management Plan Revision and Update dated 10/12/24 made reference to, the facility failed to provide the water management plan binder provided by their contracted company. Review of the Annual Water Management Plan Revision and Updates dated 10/12/24 in which the Administrator, Maintenance #2 and Maintenance #3 (Director of Maintenance at another facility) identified this as the current revision of the water management plan which identifies the facility is conducting and documenting flushing records and shall continue documentation to establish compliance in all areas of the plan. The plan further identifies where a dead leg cannot be avoided, the plumbing design should consider a means for flushing the dead leg or locating it in line with a downstream fixture.Review of the Legionella Water Management Program policy identifies situations that can lead to Legionella growth such as construction, water breaks, water temperature fluctuations, water pressure changes and water stagnation and identifies specific measures used to control the introduction and /spread of legionella for example temperature, disinfectants and for documentation of the program.

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	11/12/2025

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. Based on review of facility documentation, review of facility policy and interviews, during a review of the facility antibiotic stewardship program, the facility failed to ensure the antibiotic surveillance tracking report of antibiotic usage and outcome was collected and documented for analysis. The findings include: Review of the antibiotic stewardship program for the past two years with the Infection Preventionist (RN #7) and the DNS on 8/21/25 at 12:23 PM failed to provide any documentation related to antibiotic surveillance data for the period of January 2024 to May 2024 and for July 2024 to September 2024. The facility also failed to provide documentation that a quarterly review of antibiotic usage for the first, second, and third quarters of 2024 and the first and second quarter of 2025 was presented at the quarterly medical staff meeting.Interview with the RN #7 and the DNS on 8/21/25 at 12:23 PM identified they were not working at the facility during the time frame and were only able to locate the monthly Antibiotic surveillance tracking report for June 2024, and for October to December of 2024. In addition, the DNS identified she was unable to locate any infection control reports which included the antibiotic stewardship program that was presented at the quarterly medical staff meeting that was held in the first, second, and third 2024 and for the first and second quarters in 2025. RN #7 identified the antibiotic surveillance report is tracked monthly which is included in the infection surveillance report and is presented at the quarterly medical staff meeting by the infection preventionist. RN #7 identified it would have been the responsibility of the previous IP to track and complete the antibiotic surveillance usage report monthly as it was a part of the monthly infection surveillance report, which is then presented at the quarterly medical staff meeting.Review of the Antibiotic Stewardship Review and Surveillance of Antibiotic Use and Outcomes policy identified antibiotic usage and outcome data will be collected and documented using a facility-approved antibiotic surveillance tracking form. The data will be used to guide decisions for the improvement of individual resident antibiotic prescribing practices and facility-wide antibiotic stewardship.Review of the Infection Control and Control Program policy identified culture reports, sensitivity data, and antibiotic usage reviews are included in surveillance activities and data gathered during surveillance is used to oversee infections and spot trends. The policy further identified monthly rates can then be plotted graphically or otherwise compared side-by-side to allow for trends and comparison.

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	11/12/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **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 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 (continued on next page)

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	11/12/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.

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	11/12/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, review of facility documentation, review of facility policy/procedures and interviews for three sampled residents (Residents #1, #66 and #123) reviewed for pressure ulcer, the facility failed to ensure skin checks were being completed prior to the identification of a pressure ulcer and an assessment of a skin issue following identification as well as a provider order implemented and failed to ensure the low air loss mattress was set according to the physician's orders The findings include: 1. Resident #1's diagnoses included muscle weakness, hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage affecting left dominant side, and difficulty in walking. The quarterly MDS assessment dated [DATE] identified Resident #1 was cognitively intact, had no behaviors, required substantial maximal assist with bed mobility, partial moderate assistance with transfers, substantial/moderate to partial/moderate assistance for dressing and substantial maximal assistance with personal hygiene. The assessment further identified that the resident did not ambulate and utilized a wheelchair for mobility. The care plan dated 9/25/24 identified Resident #1 was at risk for skin breakdown due to decreased mobility. Interventions directed to encourage to get out of bed as needed, nutritional supplements as ordered skin checks and skin treatment as ordered. Review of the skin assessments failed to identify weekly skin assessment being completed prior to 11/19/24. The 11/19/24 skin assessment identified 0 for no skin issues. Physician's order dated 11/1/24 directed Skin check weekly on Tuesday 7-3 shift. The nurse's note dated 11/10/24 identified area on right inner buttocks opened wound measures 1cmx1cm no drainage. Information written in APRN book. Supervisor updated. Interview on 8/20/25 at 11:49 AM with RN#6 identified she was the supervisor on duty the night on 11/10/24 when the area was noted to be identified. She did not recall being notified of the open area, and if she was notified, she would not put the information into the APRN book, she would contact the on-call provider who would place an order, and the care plan would have been updated. If she completed an assessment of the resident she would document that via a progress note. Interview on 8/20/25 at 10:48AM with APRN #2 identified she would frequently be updated if there was something that needed to be seen or a treatment started prior to the wound physician coming to the facility. Review of the clinical record identified the first time she noted the wound in a note was not until 12/20/24 and if she had been made aware, ordered a treatment, or assessed the wound prior to then she would have documented it. Interview on 8/20/25 at 2:20PM with MD#2 identified that in the wound management detail provided by the facility the right buttock area was identified as a stage III on 11/10/24 and healed by him on 11/22/24 at 1:28PM. MD#2 identified he would not have healed an area in which he had not yet consulted on. Following a review of his notes and text messages to the Wound Nurse RN#8 at the facility at this time identified he never ordered the area to be healed as he had not yet consulted on it nor had text any orders for treatment or healing. If he had assessed the area it would have been found (continued on next page)

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	11/12/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	in his wound notes. The area was not mentioned in his wound notes until 12/8/24 when it was identified as a new pressure wound to the right buttock. When MD#2 first saw the wound it was on 12/8/24 and it was identified to be Stage 3 pressure ulcer measuring 1.5cmx1.5cmx0.2cm with a moderate amount of serous exudate. If MD#2 would have been notified of the open area on 11/10/25 he would have ordered a treatment typically of Triad Paste if it was MASD or Calcium Alginate Dry with a dry clean dressing if the area was noted to be an open area. Interview on 8/21/25 at 9:44AM with wound nurse RN#8 identified she did not observe the wound noted on 11/10/24. She was not the nurse who discovered the area, and she did not work on Sunday's therefore she was not there that day to assess it. She also would not complete the assessments in the absence of the wound physician, and she followed him for wound rounds on Fridays. The new orders that were placed into the computer were only orders that she received from him. Everything they saw were documented in the weekly wound progress notes. If there was a wound that was not documented in the weekly progress notes then it was not seen due to the fact the wound physician would document each wound that he observed/assessed. When asked as to why the observation detail was noted as healed by the wound physician under an assessment with her name on it she stated that those details can be edited in the system and when she left she left her login information with the DNS and unless the wound physician had seen it and documented it she would not document it as healed. Review of physicians ordered identified no treatment was ordered following the identification of the open area on the buttocks on 11/10/24 Review of the Skin Assessment policy directed change in the resident's skin should be documented as part of the resident's record, any change in condition if identified, documentation in the record of MD notification if new skin alteration noted with change of plan of care. 2. Resident #66's diagnoses included Alzheimer's disease, dementia with agitation and depression. The annual MDS assessment dated [DATE] identified Resident #66 was severely cognitively impaired, nonverbal, had no behaviors, was non-ambulatory, dependent on staff for transfers, was at risk for skin breakdown and had pressure relieving devices for the bed and chair. A Braden scale assessment (used for predicting the risk of developing pressure ulcers) dated 3/1/25 identified Resident #66 was determined to be at a high risk for the development of pressure ulcers with a score of 11 (a score of 19 or higher indicates not at risk, 15-18 mild risk, 13-14 moderate risk, 10-12 high risk, 9 or less very high risk). A physician's order dated 5/27/25 directed Resident #66's air mattress be set at 160 lbs. and check function and settings every shift. The care plan dated 5/29/25 identified Resident #66 had a re-opened stage 3 wound to the coccyx, with interventions that included setting the air mattress to 160 and checking function every shift, turning and positioning every 2-3 hours, and observing the affected area for signs and symptoms of infection or deterioration. Observation on 8/15/25 at 12:12 PM identified Resident #66 was in bed, and the low air loss (LAL) mattress was set at 360 lbs. (continued on next page)

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	11/12/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 8/19/25 at 9:53 AM identified the resident's LAL was set at 360. Observation on 8/20/25 at 12:10 PM identified the resident's LAL was set to 125. Interview and observation on 8/20/25 at 2:48 PM with the Nursing Supervisor (RN #3) identified the low air loss mattress was set to 125 lbs. RN #3 identified they had residents who wanderer and suggested they could have changed the setting on the bed. She further identified that the mattress should be set according to the resident's weight. RN #3 checked the physician's orders and identified that the mattress should be set at 160 pounds (lbs.). Interview on 8/20/25 at 2:53 PM with LPN #2 identified that when she checks the mattress, she checks that it is inflated, she does not look at the settings. She further identified that she had checked the mattress that day and had signed it off in the treatment administration record. Review of the Pressure Ulcers/Skin Breakdown policy directed, that the physician will order pertinent treatments for treating a wound, for example, pressure reduction surfaces, wound cleansing and debridement approaches, dressings and application of topical ointments. 3. Resident #123's diagnoses included left upper arm wound, protein -calorie malnutrition, pressure ulcer stage 3 to buttocks and anemia. The admission MDS assessment dated [DATE] identified Resident #123 was cognitively intact, required moderate assistance with dressing, bathing, personal hygiene, bed mobility, transfers, ambulation, and utilized a manual wheelchair requiring moderate assistance for mobility. The assessment further identified Resident #123 was at risk for the development of pressure ulcers and had one stage 3 pressure ulcer and an open lesion present on admission; and utilized a pressure reducing device for the bed. The care plan dated 7/25/25 identified Resident #123 had a stage 3 pressure ulcer to the right buttock, and a cancerous lesion to the left upper arm with interventions that included the utilization of a pressure reducing mattress, and to encourage and assist with frequent turning and repositioning. The physician's order dated 7/25/25 directed the air mattress setting to be at 150 pounds (lbs.) and to check the function and placement every shift. Resident #123's weight record identified his/her weight was 119 lbs. on 8/8/25. The Wound Nurse's note (RN #7) dated 8/15/25 at 2:31PM identified that the stage three to the buttocks was resolved. The Wound Physician's (MD#2) note dated 8/17/25 at 12:48 PM identified Resident #123 had a carcinoma to the left upper arm that was a full thickness wound that measured 12 centimeters (cm) in length by 10 cm in width by 0.5 cm in depth with a moderate amount of serous drainage and 75-99 percent (%) slough. The note further identified that the resident had a pressure redistribution mattress per facility protocol. Observations on 8/18/25 at 9:52 AM and on 8/19/25 at 9:40 AM and 11:32 AM identified Resident #123 in the bed positioned on his/her back with the pressure mattress set to a weight of 320 pounds. (continued on next page)

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	11/12/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the electronic Medication Administration Record/Treatment Administration Record (eMAR/eTAR) for August 2025 identified LPN #5 who worked the day shift on signed that the air mattress setting was set to 150 lbs. on 8/18/25 and 8/19/25 on the day shift. Interview and observation on 8/19/25 at 2:55 PM with the Charge Nurse LPN #5 identified Resident #123 in bed positioned on his/her back with the pressure mattress on and set to a weight of 320 pounds. LPN #5 identified she had checked the mattress setting earlier and it was at 320 pounds, and she thought it was correct. Interview with the Nursing Supervisor (RN #4) on 3/19/25 at 3:15 PM identified the mattress should be set based on the resident's weight. She indicated if the resident's weight was 126 pounds, then the 150 setting would be good as the mattress cannot be set at the resident's exact weight. Interview with the Wound Nurse (RN #7) on 8/20/25 at 10:58 AM identified Resident #123 is on an alternating air loss mattress which is set based on the resident's current weight. She identified that even though Resident #123 stage 3 pressure ulcer to the buttocks recently healed on 8/8/25, he/she still had a cancerous wound to his/her left upper extremity and would remain using the alternate air mattress to prevent new and further skin breakdown. RN #7 identified a setting of 320 was hard and could cause pain that could contribute to the development of a pressure ulcer. Interview with the DNS on 8/20/25 at 11:09 AM identified she expects the mattress to be set according to the physician's order, and the nurses should check the setting of the mattress prior to signing off in the eMAR/eTAR. The DNS added that the nurse aides are supposed to check the setting of the mattress likewise the nurses. Interview with the Wound Physician (MD #2) on 8/20/25 at 2:50 PM identified Resident #123 was on an alternate air mattress for protection and prevention of skin breakdown on elbows, hips, heels, back and buttocks, given the resident had a thinner weight. MD #2 identified a setting of 320 pounds was inappropriate for Resident #123 as a setting of 320 lbs. would make the mattress hard making the intervention not effective. MD #2 identified the setting on the mattress is set based on the resident's weight. Review of the Pressure Ulcers/Skin Breakdown policy identifies in the treatment/management section that a physician will order pertinent treatments for treating a wound for example, pressure reduction surfaces, wound cleansing and debridement approaches, dressings and application of topical agents.

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	11/12/2025

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 - 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, review of facility documentation, and interviews for two of four sampled residents (Resident #111 & 133) reviewed for accidents, the facility failed to ensure the wheelchair leg rests were in place during resident transport to prevent an accident and failed to ensure adequate supervision was provided to prevent resident from smoking in the facility ground after repeated non-compliance with non-smoking policy. The findings include:1. Resident #111's diagnoses included Alzheimer's disease, congestive heart failure, and Parkinson's disease. The annual MDS assessment dated [DATE] identified Resident #111 had moderate cognitive impairment, required extensive assistance with bed mobility, dressing, toileting, hygiene, and transfers, and required staff assistance with wheelchair mobility. The facility's accident and incident report dated 4/22/25 at 10:45 AM identified a nurse aide was assisting Resident #111 with wheelchair mobility when he/she slid from the wheelchair to the floor.The nurse's note dated 4/22/25 at 11:27 AM written by RN #1 (unit manager) identified Resident #111 slid from the wheelchair while being transferred to the bathroom, did not sustain injuries and denied pain related to the fall. The care plan dated 4/23/25 identified Resident #111was at risk for falls related to weakness, history of falls and required assistance with wheelchair mobility. Care plan interventions directed to ensure resident is properly position in the wheelchair prior to transport, Should not sit on a blanket while in a wheelchair to prevent sliding, ensure call light within reach, provide assistance with bed mobility, transfers, ambulation, and wheelchair mobility as needed, and physical therapy and/or occupational therapy evaluation as needed.The therapy referral form dated 4/23/25 identified Resident #111 slid from the wheelchair while being wheeled by a nurse aide. The therapy screen also identified Resident #111 was receiving physical therapy and recommended to ensure the wheelchair leg rests are in place to ensure proper positioning while sitting in the wheelchair.The current monthly physician's order dated 8/8/25 identified Resident #111 needed assistance from staff with wheelchair mobility.Interview with RN #1 on 8/19/25 at 11:45 AM identified NA #3 was transporting Resident #111 to the bathroom, when the resident slid from the wheelchair to the floor in his/her room. She identified that she made a referral for physical therapy to address proper wheelchair positioning. Further, RN #1 identified Resident #111 typically needed assistance from the staff for wheelchair mobility and noted that she could not recall whether the leg rests were in place at the time of his/her fall. She also noted that it would be unlikely for Resident #111 to slide from the wheelchair when the leg rests are utilized during transport. Interview with the Occupational Therapist/Rehabilitation Director (OT #1) on 8/19/25 at 12:10 PM identified that she received a therapy screen for Resident #111 related to a fall from the wheelchair. She identified that Resident #111 was receiving physical therapy services at the time of his/her fall. She also identified that she recommended that the leg rests be used to ensure the resident positioned properly while sitting in the wheelchair. She further identified that the use of the wheelchair leg rests ensure and promote the resident's ideal position while seated in a wheelchair and to prevent sliding from the wheelchair.Attempts to interview NA #3 were unsuccessful.A request was made for a policy that addressed wheelchair transportation, but the facility did not provide the surveyor with the policy. 2. Resident #133's diagnoses included malignant neoplasm of the stomach, malnutrition, bipolar disorder, and nicotine dependence.The quarterly MDS assessment dated [DATE] identified Resident #133 had intact cognition and was independent with dressing, hygiene, transfer, and ambulation without assistive devices.The resident care plan dated 5/6/24 identified Resident #133 had a strong smell of smoke; 2 lighters found in his/her room, refused smoking cessation and was observed smoking outside on the facility grounds. The care plan interventions directed to search room as needed with resident permission, initiate 1:1 supervision when room search refused, educated resident on safety protocol regarding smoking, non-smoking policy reviewed with the resident, and (continued on next page)

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	11/12/2025

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 - Minimal harm or potential for actual harm Residents Affected - Few	nicotine patch as ordered.The physician's orders directed leave of absence with responsible party and/or family member and independent with ambulation without assistive devices.A review of the nursing progress notes from 5/5/24 to 8/20/25 identified the following occurrences of non-compliance with smoking:A nursing note dated 5/5/24 at 8:59 PM identified Resident #133's room had a strong smell of cigarette smoke, and the nursing supervisor was made aware. The note further identified Resident #133 became agitated during a conversation about safety in the facility related to smoking.A nursing note dated 9/11/24 at 3:57 PM identified Resident #133 was observed smoking outside on facility grounds and was educated regarding the non-smoking policy. A room search was completed, and no smoking material was found.A nursing note dated 9/16/24 at 8:57 PM identified Resident #133 was observed smoking outside on facility grounds and refused to identify where the cigarette and lighter came from. A room search was completed, and a lighter was found but no cigarettes.A nursing note dated 10/10/24 at 3:35 PM identified Resident #133 handed over a cigarette to the Administrator and requested to transfer to a smoking facility. A room search was completed with no contraband found. Resident #133 was educated regarding the smoking policy and offered smoking cessation but refused.A nursing note dated 11/4/24 at 3:40 PM identified Resident #133 was observed smoking outside on facility grounds. A room search was done with the resident's permission, and no contraband was found.A nursing note dated 7/11/25 at 10:27 PM identified Resident #133 returned from a leave of absence and immediately went outside. He/she was then observed smoking in the facility's parking lot. The DNS directed to send the resident to the hospital to be evaluated but Resident #111 refused and was then placed on 1:1 supervision. After Resident #133 non-compliance with facility nonsmoking rules, the facility provided Resident #133 the review of no smoking policy acknowledge form dated 5/6/24 identified Resident #133 had received an acknowledgement that the facility has a strict non-smoking policy and understand that if you are currently a smoker and would like an assistance to stop smoking. A smoking cessation program would be available to the resident and will be supervise and managed by the physician. Resident #133 also received and acknowledge that smoking in the facility ground was not allowed, keeping any type of smoking material/cigarette in the room was not allowed, receiving smoking material is not allowed, non-compliance to the non-smoking policy may subject to periodic search, and repeated non-compliance to the non-smoking policy may be necessity to be discharged to ensure other resident safety. Resident #133 were again educated and presented the no smoking policy acknowledgement form dated 9/11/24, 10/11/24, 11/4/24, and 7/11/25 of each non-compliance with facility smoking rulesThe physician's order dated 8/14/25 directed to apply a nicotine patch 7mg/24 hour once a day until 8/28/25.Interview with SW#1 (Social Worker) on 8/18/25 at 2:45 PM identified Resident #133 was alert, oriented, independent with ambulation, and could leave the facility any time he/she wishes. She identified that Resident #133 was being referred to be discharged to the community and/or discharged to another skilled facility that allowed smoking. She further identified that Resident #133 had an episode of non-compliance with the smoking policy and was observed smoking on facility grounds on 7/11/25. SW#1 further identified that Resident #111 refused to disclose where the smoking materials came from but noted Resident #133 frequently goes out of the facility. A room search was conducted when he/she comes back from leave of absence with the resident permission. Interview on 8/19/25 at 9:35 AM with the DNS in the presence of the Administrator identified the facility is non-smoking and smoking is not allowed on the grounds. She also identified that the facility would not offer a bed to a potential resident who wished to smoke, and residents with a history of smoking are offered smoking cessation and education. She further identified that Resident #133 had an episode of non-compliance on 7/11/25 when he/she was observed smoking outside on facility grounds. Further, she noted that she instructed the nursing supervisor to send the resident to the hospital, but Resident #133 refused. She further noted that the facility was actively looking for a safe alternative living arrangement for Resident #133. In addition, the DNS identified Resident #133 refused the offer of a nicotine patch but agreed to smoking cessation. The DNS identified that she had no prior (continued on next page)

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	11/12/2025

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 - Minimal harm or potential for actual harm Residents Affected - Few	knowledge of Resident #133's previous non-compliance related to smoking on facility grounds because it was prior to her employment with the facility. The smoking policy identified smoking is not allowed within the facility or on the property.

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	11/12/2025

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 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on review of facility documentation, review of facility policy, and staff interviews for two of three nurse aides (NA #4 and NA #5), the facility failed to complete an annual performance evaluation. The findings include:Review of NA #4's personnel file identified a hire date of 1/31/22. Further review identified that the last performance evaluation was completed on 5/26/23. The facility failed to identify that a yearly performance evaluation was completed for 2024 and 2025.Review of NA #5's personnel file identified a hire date of 8/14/2002. Further review identified that the last performance evaluation on file was dated 8/20/2018. The facility failed to identify that a yearly performance evaluation was completed for 2023, 2024 and 2025.Interview with the DNS on 8/20/25 at 1:25 PM identified that each employee should have a performance evaluation completed yearly based on their date of hire yearly anniversary. She identified that human resources makes the notification of when the performance evaluation is due and the yearly evaluation is then distributed to the nursing supervisor to complete. Human Resources is responsible for ensuring the yearly performance evaluations are completed and in the employee record. She further identified that the facility did not currently have a human resource person. The How to Complete the Performance Evaluation policy identified that the facility reviews and summarizes the employee counseling session to identify a trend and pattern. The facility also reviews the job description performance rating with the employee to ensure the employee understands the performance rating for the function of their position and the performance evaluation is filed in accordance with facility policy.

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	11/12/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observations, review of facility documentation, review of facility policy/procedures and interviews, the facility failed to ensure a system of records of receipt and disposition of all controlled drugs was in place to sufficiently enable an accurate reconciliation of all controlled medications. The findings include:Interview with the DNS on 8/20/25 at 1:10 PM identified that she conducts a biweekly audit of the narcotic signature sheets. Review of the audit sheets identified the DNS conducted all the audits from April through August.Observation and review of the narcotic reconciliation binders on 8/21/2025 at 3:33 PM with the DNS identified the facility has a binder that they keep duplicate copies of the controlled drug receipt/proof of use/disposition forms to compare to narcotics in use in the facility. The dates noted on the duplicate copies ranged from 2023 through 8/20/25 and all duplicate forms in the book had not been reconciled and appeared to still be outstanding Interview on 8/21/25 at 3:36 PM with the DNS identified the narcotic audit is completed twice a month and indicated the process for the reconciliation is to take the duplicate binder to each of the medication carts, count the carts and verify that the medication sheets in the carts were also present in the duplicate binder. The DNS identified that the duplicate binder had been in use prior to her taking her position and many of the narcotics were not accounted for when she took over the position in February 2025. The DNS indicated that when she does complete the narcotic reconciliations, she does not utilize the duplicate binder as a guide and therefore there are outstanding duplicate sheets that she does not know the reconciliation status of.The DNS identified that of the 30 medication forms (randomly picked by the surveyor to review whether they were in use in the facility, destroyed, returned or unaccounted for) there were some dated prior to her taking over the position and might be difficult to locate. Interview on 8/21/2025 at 5:12 PM with the Administrator identified he was not aware the reconciliations were not being completed appropriately but indicated the reconciliations were being completed bimonthly. A message was left on 8/21/2025 at 5:13 PM with the pharmacy consultant but no return call was received. Interview on 8/21/25 at 5:30 PM with the DNS identified that 25 of the 30 flagged outstanding controlled substance forms were located in the narcotic destruction logs sent home with the resident or destroyed. The medications not able to be located/reconciled were as listed below:1. Amphet/dextrin cap 50 mg ER quantity of 15 received on 8/22/2024 at the facility.2. Hydromorphone HCL 2 mg tab quantity of 120 received on 7/30/25 by the facility.3. Pregabalin cap 150 mg Quantity of 60 received on 11/14/24 by the facility.4. Oxycodone IR 5mg tab Quantity of 30 received on 12/19/24 by the facility.5. Oxycodone IR 5 mg tab Quantity of 30 received on 10/31/24 by the facility.6. Clonazepam 0.5mg tab Quantity of 45 received on 11/12/24 by the facility. #15 were reconciled but there are #30 outstanding. The facility policy for Inventory of control of dugs identified the director of nursing or his/her nursing supervisor designee shall conduct unannounced documented audits of all controlled substance stock on all units at least twice a month. The policy identified that the controlled substances be counted per facility policy and in accordance with state regulations and in the event of significant loss/theft the appropriate agencies will be notified and indicated the consultant pharmacist and facility administration will routinely audit controlled medications. The facility policy for best practice for medication dispensing regarding scheduled II Narcotics identified any ordered narcotic/controlled substance that is delivered to a facility, signed for and accepted by an authorized person may not be returned to the pharmacy for any reason and indicated that if a patient is discharge home or transferred to a hospital, any ordered, dispensed, and delivered narcotic/controlled substance must not be accepted at time of delivery. Additional policy provided by the facility was from the state department of consumer protection drug control division and identified audits of all controlled substance stock on all units at least twice a month and indicated that required receipt records for patients' controlled substance stock must be separately maintained and required disposition records for patients' controlled substance stock must (continued on next page)

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	11/12/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	be separately maintained, and required destruction records shall be maintained whenever partial or individual doses of controlled substance stock are discarded by nursing personnel.

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	11/12/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, review of facility policy/procedures and interviews, the facility failed to ensure expired or discontinued medications were removed from the medication cart according to facility policy. The findings include:Observation on 8/20/25 at 6:49 AM with LPN #6 identified the medication cart contained the following expired medications: 1. Lisinopril tab 10 mg (18 tablets) with an expiration date of 8/1/252. Gabapentin 300mg (1 capsule) with an expiration date of 7/1/253. Gabapentin 100mg 2 (30 capsules) with an expiration date of 7/31/254. Gabapentin 100mg (28 capsules) with an expiration date of 7/31/255. Gabapentin 100mg (25 capsules plus an additional three bubble packs of capsules totaling 90 capsules) with an expiration date of 8/1/25 Interview on 8/20/2025 at 6:52 AM with LPN #6 identified that someone in the facility is responsible for removing expired medications from the medication carts. LPN#6 indicated she was not responsible for removing expired medications. Interview on 8/20/2025 at 7:06 AM with LPN #4 identified the pharmacy consultant goes through the carts every month and removes all of the medications that are expired or discontinued. Interview on 8/20/2025 at 7:36 AM with the RN Supervisor (RN #3) identified she was unsure of the protocol for the storage/removal of expired medications from the active medication supply but would review the protocol.Interview on 8/21/25 at 3:36 PM with the DNS identified that the pharmacist is at the facility once monthly and removes expired medications in the cart if she sees it but noted that the nurses are responsible for ensuring their carts are in order and to remove expired or discontinued medications.Interview on 8/21/2025 at 5:03 PM with Pharmacist #2 identified that when medication is discontinued or expired, or if the resident leaves the facility the medication should be removed from the medication cart. She indicated that if a medication is on hold or discontinued it might remain in the cart in case it is needed again. She further identified she was at the facility approximately a week ago but did not conduct any cart audits that day and indicated the last cart audits she completed were in June 2025. The facility policy for storage of medications identified that discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed.Additional policy provided by the facility was from the state department of consumer protection drug control division and identified patient medications which are discontinued, unauthorized or no longer needed for other reasons should be immediately removed from nursing unit locations and properly documented and stored while awaiting appropriate disposition.

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	11/12/2025

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of facility documentation, review of facility policy and interviews for two sampled residents (Resident#32, and Resident #173) reviewed for food, the facility failed to ensure the food tray ticket were accurate and fruit was available to the resident. The findings include:Resident #32's diagnoses included Parkinson disease, dementia, dysphagia, and diabetes mellitus.The quarterly MDS assessment dated [DATE] identified Resident #32 was cognitively intact, required set-up help for eating, was on therapeutic diet and received regular consistency foods. The care plan dated 5/16/25 identified Resident #32 had a potential for alteration in nutritional status related to therapeutic diet, dysphagia and diabetes mellitus. The care plan interventions directed to ensure accurate diet as ordered, report any changes/concern to the physician, offer snack as indicated, and weigh as ordered.The current monthly physician's order directed to give regular consistency and carbohydrate-controlled diet.During the resident council meeting conducted on 8/18/25 at 1:00 PM, the resident brought up a concern regarding the availability of bananas and oranges. Although the residents had been told that bananas and oranges were always available, they are frequently not available when requested.Observation on 8/20/25 at 8:06 AM identified Resident #32's meal ticket identified he/she should have 1 serving of oatmeal, 1/2 cup of hashbrowns, 1 slice of toast, 1 serving of diet jelly, 1 piece of margarine, 1 serving of coffee with creamer, 1 serving of yogurt, 1 banana, 1 packet of salt and pepper and 4 ounces of juice; however, there was no banana noted on the resident's tray of food. Resident #172's diagnosis included dementia, hypertension, and diabetes mellitus.The admission MDS assessment dated [DATE] identified Resident #172 had moderate cognitive impaired, required set-up help with eating and was on a regular consistency therapeutic diet.The care plan dated 7/17/25 identified Resident #172 had a potential for alteration in nutritional status related to therapeutic diet and weight loss. The care plan interventions directed to ensure accurate diet as ordered, report any changes/concern to the physician, offer snack as indicated, and weight as ordered.The current monthly physician's order directed to give regular consistency and carbohydrate-controlled diet.Observation on 8/20/25 at 8:12 AM identified Resident #172's meal ticket identified that he/she should have 3 ounces of scrambled egg, 1 1/4 cup of rice Krispies cereal, 1/2 cup of hashbrowns, 1 slice of toast, 1 serving of diet jelly, 1 piece of margarine, 2 serving of coffee with sugar substitute, 1 packet of salt and pepper, 1 banana, 4 ounces of juice, and 8 ounces of skim milk; however, there was no banana noted on the resident's tray of food.Interview with the Food Service Director (FSD) on 8/20/25 at 11:30 AM identified that bananas and oranges are always available to all residents. He identified that the resident tray ticket indicates whether a banana and/or orange were requested. He identified that the resident should receive the food items identified on the meal ticket. The FSD further noted they had run out of bananas. He further identified that he had decreased the order of bananas from 80 pounds to 60 pounds in June 2025 because they frequently go bad.Review of facility Planning and Food Service policy identified that the facility would provide a varied and balance diet for all residents in accordance with federal, state and local regulations, professional dietary standards, and resident preferences. Menus would be planned, reviewed, and updated to meet the nutritional and therapeutic need of the residents.

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	11/12/2025

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, review of facility policy, review of facility documentation, and interviews for one of five sampled residents (Resident #59) reviewed for immunizations, the facility failed to offer and/or assess for pneumococcal immunizations to the resident. The findings include:Resident #59's diagnoses included Alzheimer's disease, acute kidney failure and anxiety disorder.The annual MDS assessment dated [DATE] identified Resident #59 had severely impaired cognition. The assessment further identified that Resident #59 had not received the pneumococcal vaccine as it was not offered. Review of Resident #59's clinical records with the Infection Preventionist (RN #7) on 8/19/25 at 1:00 PM failed to identify that he/she had been offered/received any of the pneumococcal vaccines while at the facility. The records also did not contain any documentation that the resident had past pneumococcal vaccination history. Interview with RN #7 and the DNS on 8/19/25 at 1:00 PM identified residents are assessed and offered the pneumococcal vaccine on admission and whenever there is a new series. RN #7 identified that the admitting nurse would obtain the consent from the resident and the Infection Preventionist (IP) nurse would review the consent and obtain the appropriate physician order for the vaccine needed to be administered. RN #7 identified she was not working at the facility at the time, and it would be the responsibility of the previous IP nurse to assess and offer the pneumococcal vaccine to the resident.Review of the Pneumococcal Vaccine identified prior to or upon admission, residents will be assessed for eligibility to receive the pneumococcal vaccine series and when indicated, will offer the vaccine series on admission to the facility unless medically contraindicated or the resident had already been vaccinated.

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	11/12/2025

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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical records, review of facility documentation, facility policy/procedures, and interviews for 1 of 5 residents (Resident #59) reviewed for immunizations, the facility failed to ensure that the COVID-19 booster vaccination were offered and/or assessed to resident. The findings include:Resident #59's diagnoses included Alzheimer's disease, acute kidney failure and anxiety disorder.The annual MDS assessment dated [DATE] identified Resident #59 had severely impaired cognition. The assessment further identified that Resident #59 was not up to date with the COVID-19 vaccination.Review of Resident #59's immunization consent records and preventative health care report in the electronic medical records, with the Infection Preventionist (RN #7) on 8/19/25 at 1:00 PM failed to identify that the COVID-19 booster vaccine was offered to the resident. Interview with RN #7 and the DNS on 8/19/25 at 1:00 PM identified residents are assessed and offered the COVID-19 vaccine on admission and whenever there is a new series. She identified a new Covid vaccine consent form is provided to resident/responsible party annually with the influenza vaccine for the current/new COVID-19 vaccine (booster vaccine). RN #7 further identified she had started as the Infection Preventionist in March of 2025, and it was the responsibility of the previous infection preventionist nurse to offer the current Covid-19 vaccine to the resident. Review of the COVID-19 Vaccination Policy identified the COVID-19 vaccine will be offered to all residents unless the vaccine has been medically contraindicated, or the resident has been previously immunized.