STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075324	A. Building B. Wing	05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Civita Care Bayview	301 Rope Ferry Rd Waterford, CT 06385

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy review and staff interviews for two (2) of four (4) sampled residents (Residents #2 and #3) reviewed for neglect, the facility failed to ensure residents were free from neglect on the overnight shift when staff failed to respond timely to call bells, failed to provide incontinent and toileting care, failed to complete required rounds and failed to provide necessary supervision and assistance to residents on the short-term rehabilitation unit. The findings include:1. Resident #2?s diagnoses included Enterocolitis due to Clostridium Difficile (C. Diff) (inflammation in both intestines caused by a bacteria that causes an infection of the colon), acute kidney failure, adult failure to thrive, need for assistance with personal care and weakness.The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had intact cognition (Brief Interview for Mental Status (BIMS) score of 15), was dependent on staff for personal hygiene and transfers, required partial assistance for toileting hygiene and bed mobility and was always incontinent of bowel.The Resident Care Plan (RCP) dated 4/20/26 identified Resident #2 had an Activities of Daily Living (ADL) deficit due to generalized weakness and renal failure, had C. Diff and was incontinent of bowel and/or bladder. Interventions included keeping the call bell and needed items within reach, providing an assist of one (1) with all ADLs, offering to toilet or use the commode before leaving the room for activities, meals or ambulation and upon request and providing incontinent care approximately every two hours and as needed and upon request.Interview with Resident #2 on 5/13/26 at 8:50 AM identified he/she utilized the bedside commode independently on the overnight shift (11:00 PM to 7:00 AM), although he/she is not supposed to, because the call bell it is not answered and no one checks on him/her. Resident #2 identified the bedside commode is rarely emptied on the overnight shift, bed sheets are visibly dirty and staff do not change them unless requested and he/she feels afraid something will happen on the overnight shift and no one will know or respond.Review of the May 2026 Documentation Survey Report (NA documentation) failed to identify any documentation on the overnight shift on 5/1/26, 5/2/26 or 5/8/26 for bladder or bowel tasks.2. Resident #3 ?s diagnoses included Congestive Heart Failure (CHF), chronic kidney disease stage IV (severe kidney function loss), acute respiratory failure with hypoxia (low levels of oxygen in the body tissues), weakness and depression.The admission assessment dated [DATE] identified Resident #3 was alert and oriented to person, place and time and required partial assistance for self-care, toileting hygiene and transfers. Resident #2 utilized oxygen via a nasal cannula at 2.0 liters per minute.The RCP dated 5/12/26 identified Resident #3 had ADL deficits due to generalized weakness and recent hospitalization, utilized oxygen therapy due to CHF and had a foley catheter intact due to urinary retention. Interventions included performing catheter care every shift and as needed, keeping the call bell and needed items within reach and providing assistance with all ADLs.A Brief Interview for Mental Status (BIMS) assessment dated [DATE] identified Resident #3 was cognitively intact (score of 14).Interview with Resident #3 on 5/13/26 at 8:54 AM identified long wait times when using the call-bell on the overnight shift and staff do not perform safety checks every two (2) hours. Resident #3 reported bowel incontinence the previous night and staff did not assist timely. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #3 reported staff do not change the bed linens unless requested.Interview with RN #2 on 5/13/26 at 12:49 PM identified NA's are not doing every two (2) hour rounds, turn off the call bells, do not respond, hide out and play on their phones during the overnight shift. She reported when she would do her own rounds, she would question NA's about turning and repositioning the residents and they would reply they already did and ignore her. The Nas would tell her she cannot do anything about it because they would not be fired. RN #2 identified she reported the concerns to the DON many times but that the staff were never suspended, kept coming to work and she was afraid her car tires would be slashed in retaliation. RN #2 reported she did not feel comfortable naming the NA staff that were ignoring their duties on the overnight shift.Interview with Person #2 on 5/13/26 at 1:36 PM identified on 4/20/26 during the 11:00 PM to 7:00 AM shift, NA #3 reported that all the residents on the west unit were independent and frequent rounds did not need to be done, despite the west unit being a short-term rehabilitation unit. Person #2 reported that NA #3 was on her phone all night, turned off call bells from the nurse's station without responding and did not perform rounds until 5:30 AM. Person #2 identified that at that time, residents' sheets were visibly dirty with dried urine and feces, residents were left incontinent all night and dried blood was noted on the floor all night and not cleaned. Person #2 reported the concerns to the staffing scheduler on 4/21/26.Interview with the staffing scheduler on 5/13/26 at 1:36 PM accompanied by the DON identified on 4/21/26, Person #2 reported that during the previous 11:00 PM to 7:00 AM shift on the west unit, residents' beds were dirty, dried blood was on the floor, and it did not appear that care had been provided for the residents. The staffing scheduler identified that she immediately reported the concerns to the DON.Interview with the DON on 5/13/26 at 1:38 PM identified she could not recall the staffing scheduler reporting any lack of resident care on 4/21/26, and that the lack of care was an allegation of neglect which should have been reported to the State Agency within two (2) hours and investigated. She identified she was unaware there were complaints regarding care and call bell response time. She reported she could not recall licensed nurses reporting that NAs were not doing every 2-hour rounds, toileting residents or turning and repositioning residents. She was unaware that NA's were refusing to perform resident care tasks when directed by licensed nurses and that licensed nurses were afraid of retaliation by the NAs. The DON identified that NAs should complete every 2-hour rounds for all residents, turn and reposition residents per their plan of care and as needed, attend to call bells timely and never turn off call bells without first responding. Linens should be changed daily and when visibly soiled. NAs and other staff should be visible on the unit and not in the break room unless on break and other staff are aware they are on break. The DON reported if she were aware of the allegations of neglect, she would have suspended the employees that were accused of neglect and investigated the allegations immediately.Interview with LPN #3 on 5/13/26 at 2:08 PM identified she regularly worked with NA's #2 and #3 on the short-term unit overnight shift and they turn alarming call bells off at the nurse's station and do not respond to the residents rooms, do not perform rounds until after 5:00 AM, do not toilet residents, are rude to the residents, and hide in the break room with the door shut on their phones and sleep. LPN #3 reported when she requested NA #2 or #3 to do something they refused and told her to complain to administration because they cannot be fired. She identified she reported the behavior to the DON multiple times. LPN #3 identified she does her job and the NA's jobs when they refuse to respond. Although attempted, interviews with NAs #2 and #3 were not obtained.Review of the Residents Right to Freedom from Abuse, Neglect and Exploitation policy (undated) directed, in part, the facility is to ensure residents are free from abuse and neglect and staff must not use verbal, mental, sexual or physical abuse, corporal punishment or involuntary seclusion against any resident. When the facility has identified abuse, the facility will take all appropriate steps to remediate the noncompliance and protect residents from additional abuse immediately. The facility will increase enforcement action, including, but not limited to: Taking steps to prevent further abuse, reporting the alleged violation and investigation within required timeframes pursuant to federal and state statutes and regulations, conducting a thorough investigation of the alleged violation, taking appropriate (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	corrective action and the facility will revise the resident's care plan if the resident's medical, nursing, physical, mental or psychosocial needs or preferences change as a result of an incident of abuse. In response to allegations of abuse, neglect, exploitation or mistreatment, the facility shall: Ensure all alleged violations involving abuse, neglect, exploitation or mistreatment are reported in the proper time frame pursuant to this policy, have evidence that all alleged violations are thoroughly investigated and prevent further abuse, neglect, exploitation or mistreatment while the investigation is in progress.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for three (3) of four (4) residents (Residents #1, #2 and #3) reviewed for neglect, the facility failed to ensure allegations of neglect were reported to the State Agency timely (within 2-hours). The findings include:1. Resident #1?s diagnoses included mild cognitive impairment, chronic respiratory failure with hypoxia (low levels of oxygen in the body's tissues), Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), depressive episodes and anxiety disorder.A physician's order dated 9/13/24 directed Resident #1 be placed on continuous oxygen at 2.0 to 4.0 liters per minute (lpm) via nasal cannula to keep oxygen saturation greater than 90 percent (%) and obtain oxygen saturation every shift.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had moderately impaired cognition (Brief Interview for Mental Status (BIMS) score of 12), required setup assistance with personal hygiene, was independent with bed mobility, transfers and ambulation and utilized oxygen therapy.The Resident Care Plan (RCP) dated 1/28/26 identified Resident #1 had a diagnosis of COPD, asthma, chronic respiratory failure with hypoxia and a history of COPD exacerbation requiring oxygen support. Interventions include administering oxygen and monitoring effectiveness by checking saturation as/if indicated.A nurse's note by LPN #1 dated 4/5/26 at 2:06 PM identified at around 11:00 AM Resident #1's representative (Person #1) arrived to pick up Resident #1 and asked for Resident #1's oxygen tank to be changed but it had been changed a few minutes prior so Resident #1 was fine to go out. They left and returned at around 1:45 PM and while LPN #1 was performing care for another resident, Person #1 waited outside the door, reported the oxygen tank was empty and asked LPN #1 to change the tank. LPN #1 communicated that any other licensed nurse or NA could change the tank because she was in the middle of a dressing change. The note identified Person #1 waited outside the room until LPN #1 was done and then stated the tank was supposed to last four (4) hours, but it was empty within two (2) hours and LPN #1 communicated that Person #1 assumed that LPN #1 did not change the oxygen tank and Person #1 started yelling and carrying on. The note identified LPN #1 then changed the oxygen tank and Person #1 asked for the nursing supervisor.Review of nurse's notes failed to identify a nurse's note from the nursing supervisor (RN #1) dated 4/5/26.A social service note by the Director of Social Services dated 4/6/26 at 12:00 PM identified a call was placed to Person #1 and Resident #1's family with herself, the DON and the ADON when Person #1 updated them on the events from the Leave of Absence (LOA) from the weekend. The note reported a follow-up family meeting was requested and scheduled for 4/9/26.A social service note by the Director of Social Services dated 4/6/26 at 7:29 PM identified, in part, Resident #1's family requested an in-person family meeting with the Interdisciplinary Team (IDT) to discuss care concerns and the recent LOA. She identified a family meeting was scheduled for 4/9/26 at 3:00 PM.A facility Grievance Sheet dated 4/6/26 identified Person #1 reported concerns over the oxygen tank administration and an interaction with staff and Resident #1's family. Education on oxygen with return demonstration was to be given to all nursing staff.A social service note by the Director of Social Services dated 4/9/26 at 12:06 PM identified a family meeting was held to review Resident #1's plan of care. The note reported Resident #1's plan of care was reviewed and they addressed concerns with the oxygen tank and education of staff.Review of the Connecticut Department of Public Health Facility Licensing and Investigations Section portal on 5/12/26 failed to identify the 4/5/26 incident was reported to the State Agency as an allegation of abuse or neglect.Interview with Person #1 on 5/12/26 at 12:14 PM identified on 4/5/26 he/she took Resident #1 on an LOA but had to return early due to the oxygen tank being almost empty. Person #1 identified when he/she returned to the facility with Resident #1 just before 2:00 PM, LPN #1 was in the hallway at a cart and Person #1 reported that the oxygen tank was empty. LPN #1 stated she was busy and (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	told Person #1 to find someone else to change it and then went into another resident's room. Person #1 identified everyone was busy and LPN #1 made Resident #1 wait over five (5) minutes. When LPN #1 arrived to assist, she yanked the oxygen tubing off the oxygen tank with the nasal cannula still attached to Resident #1's face, almost causing Resident #1 to fall. Person #1 identified he/she immediately reported the prolonged changing of the oxygen tank and the incident with LPN #1 to RN #1 (nursing supervisor) alleging neglect and roughness and then left a voicemail for the Director of Social Services with the timeline of events. Person #1 identified he/she spoke with the DON and Director of Social Services the next day, explaining the chain of events including LPN #1 making Resident #1 wait for more oxygen and the way she roughly pulled the oxygen tubing off the oxygen tank almost causing Resident #1 to fall and the DON reported RN #1 never reported the complaint to her. Person #1 reported during the 4/9/26 meeting, he/she again reported the chain of events and stated it was neglect and abuse. He/she told the DON he/she no longer wanted to visit the building without a witness and the DON identified she would ensure LPN #1 no longer cared for Resident #1 as an intervention.Interview with LPN #1 accompanied by the DON on 5/12/26 at 2:32 PM identified on 4/5/26 she changed Resident #1's oxygen tank to a full tank about fifteen (15) minutes prior to Person #1 arriving to take Resident #1 out on an LOA and ensured it was set to 3.0 lpm. She reported when Person #1 arrived to take Resident #1 out on the LOA, the regulator on the oxygen tank still read that the tank was full. At about 1:45 PM she was in the hallway at the treatment cart when Person #1 approached her and reported Resident #1's oxygen tank was empty. LPN #1 reported she was going to do a dressing change and told Person #1 she needed a few minutes. She further told Person #1 another licensed nurse or NA could change the oxygen tank. She reported she should have confirmed the oxygen tank was empty prior to entering another resident's room and should have checked Resident #1's oxygen level. She identified when she responded, the oxygen tank gauge was in the red area and on low but not completely empty.Interview with RN #1 accompanied by the DON on 5/12/26 at 2:47 PM identified on 4/5/26 Person #1 approached her upset because Resident #1 ran out of oxygen while on an LOA and LPN #1's response time in changing the oxygen tank but could not recall Person #1 reporting LPN #1 yanked the oxygen tubing almost causing Resident #1 to fall. RN #1 reported she immediately reported the complaint to the DON.Interview with the DON on 5/12/26 at 1:13 PM identified she could not recall RN #1 notifying her on 4/5/26 of Person #1's concerns. She recalled being notified on 4/6/26 by Person #1 regarding Resident #1 running out of oxygen on the LOA and LPN #1 not responding immediately but she spoke with LPN #1 who denied Resident #1 ran out of oxygen. The DON indicated she was not aware LPN #1 was in the hallway when Person #1 approached LPN #1 regarding Resident #1's oxygen tank being empty and LPN #1 should have assisted Resident #1 immediately. The DON identified she did not initiate an investigation to include statements from other staff working at the time to include LPN #1 and RN #1 and did not believe the concerns voiced by Person #1 on 4/6/26 were allegations of abuse or neglect so she did not report to the State Agency. The DON identified all allegations of abuse and/or neglect are to be reported to the Stage Agency within two (2) hours and investigated.Interview with the Director of Social Services on 5/13/26 at 8:36 AM identified she could not recall listening to a voicemail on 4/6/26 from Person #1 regarding Resident #1 but she did speak with Person #1 on 4/6/26 who reported concerns about the oxygen becoming empty on the LOA on 4/5/26 and LPN #1's response time. She reported she could not recall what words Person #1 used to describe Resident #1 losing his/her balance when the oxygen tank was changed but identified there were concerns presented by Person #1 regarding the oxygen and LPN #1 that were concerning and should have been addressed immediately. The Director of Social Services reported the DON directed to write up the concerns as a grievance on 4/6/26.2. Interview with Person #2 on 5/13/26 at 1:36 PM identified on 4/20/26 during the 11:00 PM to 7:00 AM shift, NA #3 reported that all the residents on the west unit were independent and frequent rounds did not need to be done, despite the west unit being a short-term rehabilitation unit. Person #2 reported that NA #3 was on her phone all night, turned off call bells from the nurse's station without responding (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and did not perform rounds until 5:30 AM. Person #2 identified that at that time, residents' sheets were visibly dirty with dried urine and feces, residents were left incontinent all night and dried blood was noted on the floor all night and not cleaned. Person #2 reported the concerns to the staffing scheduler on 4/21/26.Interview with the staffing scheduler on 5/13/26 at 1:36 PM accompanied by the DON identified on 4/21/26, Person #2 reported that during the previous 11:00 PM to 7:00 AM shift on the west unit, residents' beds were dirty, dried blood was on the floor, and it did not appear that care had been provided for the residents. The staffing scheduler identified that she immediately reported the concerns to the DON. Review of the Connecticut Department of Public Health Facility Licensing and Investigations Section portal on 5/12/26 failed to identify the 4/20/26 incident was reported to the State Agency as an allegation of neglect.Interview with the DON on 5/13/26 at 1:38 PM identified she could not recall the staffing scheduler reporting any lack of resident care on 4/21/26, and that the lack of care was an allegation of neglect which should have been reported to the State Agency within two (2) hours and investigated. Although attempted an interview with NA #3 was not obtained.3. Resident #2?s diagnoses included Enterocolitis due to Clostridium Difficile (C. Diff) (inflammation in both intestines caused by a bacteria that causes an infection of the colon), acute kidney failure, adult failure to thrive, need for assistance with personal care and weakness.The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had intact cognition (Brief Interview for Mental Status (BIMS) score of 15), was dependent on staff for personal hygiene and transfers, required partial assistance for toileting hygiene and bed mobility and was always incontinent of bowel.The Resident Care Plan (RCP) dated 4/20/26 identified Resident #2 had an Activities of Daily Living (ADL) deficit due to generalized weakness and renal failure, had C. Diff and was incontinent of bowel and/or bladder. Interventions included keeping the call bell and needed items within reach, providing an assist of one (1) with all ADLs, offering to toilet or use the commode before leaving the room for activities, meals or ambulation and upon request and providing incontinent care approximately every two hours and as needed and upon request. Interview with Resident #2 on 5/13/26 at 8:50 AM identified he/she utilized the bedside commode independently on the overnight shift (11:00 PM to 7:00 AM), although he/she is not supposed to, because the call bell it is not answered and no one checks on him/her. Resident #2 identified the bedside commode is rarely emptied on the overnight shift, bed sheets are visibly dirty and staff do not change them unless requested and he/she feels afraid something will happen on the overnight shift and no one will know or respond.Review of the May 2026 Documentation Survey Report (NA documentation) failed to identify any documentation on the overnight shift on 5/1/26, 5/2/26 or 5/8/26 for bladder or bowel tasks.4. Resident #3 ?s diagnoses included Congestive Heart Failure (CHF), chronic kidney disease stage IV (severe kidney function loss), acute respiratory failure with hypoxia (low levels of oxygen in the body tissues), weakness and depression.The admission assessment dated [DATE] identified Resident #3 was alert and oriented to person, place and time and required partial assistance for self-care, toileting hygiene and transfers. Resident #2 utilized oxygen via a nasal cannula at 2.0 liters per minute.The RCP dated 5/12/26 identified Resident #3 had ADL deficits due to generalized weakness and recent hospitalization, utilized oxygen therapy due to CHF and had a foley catheter intact due to urinary retention. Interventions included performing catheter care every shift and as needed, keeping the call bell and needed items within reach and providing assistance with all ADLs.A Brief Interview for Mental Status (BIMS) assessment dated [DATE] identified Resident #3 was cognitively intact (score of 14). Interview with Resident #3 on 5/13/26 at 8:54 AM identified long wait times when using the call-bell on the overnight shift and staff do not perform safety checks every two (2) hours. Resident #3 reported bowel incontinence the previous night and staff did not assist timely. Resident #3 reported staff do not change the bed linens unless requested. Interview with RN #2 on 5/13/26 at 12:49 PM identified NA's are not doing every two (2) hour rounds, turn off the call bells, do not respond, hide out and play on their phones during the overnight shift. She reported when she would do her own rounds, she would question NA's about turning and repositioning the residents and (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	they would reply they already did and ignore her. The Nas would tell her she cannot do anything about it because they would not be fired. RN #2 identified she reported the concerns to the DON many times but that the staff were never suspended, kept coming to work and she was afraid her car tires would be slashed in retaliation. RN #2 reported she did not feel comfortable naming the NA staff that were ignoring their duties on the overnight shift.Interview with the DON on 5/13/26 at 1:33 PM identified she was unaware there were complaints regarding care and call bell response time. She reported she could not recall licensed nurses reporting that NAs were not doing every 2-hour rounds, toileting residents or turning and repositioning residents. She was unaware that NA's were refusing to perform resident care tasks when directed by licensed nurses and that licensed nurses were afraid of retaliation by the NAs. The DON identified that NAs should complete every 2-hour rounds for all residents, turn and reposition residents per their plan of care and as needed, attend to call bells timely and never turn off call bells without first responding. Linens should be changed daily and when visibly soiled. NAs and other staff should be visible on the unit and not in the break room unless on break and other staff are aware they are on break. The DON reported if she were aware of the allegations of neglect, she would have suspended the employees that were accused of neglect and investigated the allegations immediately Interview with LPN #3 on 5/13/26 at 2:08 PM identified she regularly worked with NA's #2 and #3 on the short-term unit overnight shift and they turn alarming call bells off at the nurse's station and do not respond to the residents rooms, do not perform rounds until after 5:00 AM, do not toilet residents, are rude to the residents, and hide in the break room with the door shut on their phones and sleep. LPN #3 reported when she requested NA #2 or #3 to do something they refused and told her to complain to administration because they cannot be fired. She identified she reported the behavior to the DON multiple times. LPN #3 identified she does her job and the NA's jobs when they refuse to respond. Subsequent to surveyor inquiry, review of the Connecticut Department of Public Health Facility Licensing and Investigations Section portal on 5/14/26 failed to identify the allegations of neglect reported by this surveyor to the DON on 5/13/26 were reported to the State Agency within two (2) hours as required.Review of the Residents Right to Freedom from Abuse, Neglect and Exploitation policy (undated) directed, in part, staff must not use verbal, mental, sexual or physical abuse, corporal punishment or involuntary seclusion against any resident. When the facility has identified abuse, the facility will take all appropriate steps to remediate the noncompliance and protect residents from additional abuse immediately. The facility will increase enforcement action, including, but not limited to: Taking steps to prevent further abuse, reporting the alleged violation and investigation within required timeframes pursuant to federal and state statutes and regulations, conducting a thorough investigation of the alleged violation, taking appropriate corrective action and the facility will revise the resident's care plan if the resident's medical, nursing, physical, mental or psychosocial needs or preferences change as a result of an incident of abuse. In response to allegations of abuse, neglect, exploitation or mistreatment, the facility shall: Ensure all alleged violations involving abuse, neglect, exploitation or mistreatment are reported in the proper time frame pursuant to this policy, have evidence that all alleged violations are thoroughly investigated and prevent further abuse, neglect, exploitation or mistreatment while the investigation is in progress.Review of the Reportable Events policy dated 9/1/22 directed, in part, that the facility shall identify, classify, document and report all events that meet criteria for reportable incidents under Connecticut DPH regulations. A Class B event includes a complaint or allegation of patient abuse, or any act involving abuse toward a patient by any person. Abuse includes verbal, mental, sexual or physical attack, injury, unreasonable confinement, intimidation or punishment.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for three (3) of four (4) residents (Residents #1, #2 and #3) reviewed for neglect, the facility failed to thoroughly investigate allegations of neglect. The findings include:1. Resident #1?s diagnoses included mild cognitive impairment, chronic respiratory failure with hypoxia (low levels of oxygen in the body's tissues), Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), depressive episodes and anxiety disorder.A physician's order dated 9/13/24 directed Resident #1 be placed on continuous oxygen at 2.0 to 4.0 liters per minute (lpm) via nasal cannula to keep oxygen saturation greater than 90 percent (%) and obtain oxygen saturation every shift.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had moderately impaired cognition (Brief Interview for Mental Status (BIMS) score of 12), required setup assistance with personal hygiene, was independent with bed mobility, transfers and ambulation and utilized oxygen therapy.The Resident Care Plan (RCP) dated 1/28/26 identified Resident #1 had a diagnosis of COPD, asthma, chronic respiratory failure with hypoxia and a history of COPD exacerbation requiring oxygen support. Interventions include administering oxygen and monitoring effectiveness by checking saturation as/if indicated.A nurse's note by LPN #1 dated 4/5/26 at 2:06 PM identified at around 11:00 AM Resident #1's representative (Person #1) arrived to pick up Resident #1 and asked for Resident #1's oxygen tank to be changed but it had been changed a few minutes prior so Resident #1 was fine to go out. They left and returned at around 1:45 PM and while LPN #1 was performing care for another resident, Person #1 waited outside the door, reported the oxygen tank was empty and asked LPN #1 to change the tank. LPN #1 communicated that any other licensed nurse or NA could change the tank because she was in the middle of a dressing change. The note identified Person #1 waited outside the room until LPN #1 was done and then stated the tank was supposed to last four (4) hours, but it was empty within two (2) hours and LPN #1 communicated that Person #1 assumed that LPN #1 did not change the oxygen tank and Person #1 started yelling and carrying on. The note identified LPN #1 then changed the oxygen tank and Person #1 asked for the nursing supervisor.Review of nurse's notes failed to identify a nurse's note from the nursing supervisor (RN #1) dated 4/5/26.A social service note by the Director of Social Services dated 4/6/26 at 12:00 PM identified a call was placed to Person #1 and Resident #1's family with herself, the DON and the ADON when Person #1 updated them on the events from the Leave of Absence (LOA) from the weekend. The note reported a follow-up family meeting was requested and scheduled for 4/9/26.A social service note by the Director of Social Services dated 4/6/26 at 7:29 PM identified, in part, Resident #1's family requested an in-person family meeting with the Interdisciplinary Team (IDT) to discuss care concerns and the recent LOA. She identified a family meeting was scheduled for 4/9/26 at 3:00 PM.A facility Grievance Sheet dated 4/6/26 identified Person #1 reported concerns over the oxygen tank administration and an interaction with staff and Resident #1's family. Education on oxygen with return demonstration was to be given to all nursing staff.A social service note by the Director of Social Services dated 4/9/26 at 12:06 PM identified a family meeting was held to review Resident #1's plan of care. The note reported Resident #1's plan of care was reviewed and they addressed concerns with the oxygen tank and education of staff.Review of the Connecticut Department of Public Health Facility Licensing and Investigations Section portal on 5/12/26 failed to identify the 4/5/26 incident was reported to the State Agency as an allegation of abuse or neglect.Interview with Person #1 on 5/12/26 at 12:14 PM identified on 4/5/26 he/she took Resident #1 on an LOA but had to return early due to the oxygen tank being almost empty. Person #1 identified when he/she returned to the facility with Resident #1 just before 2:00 PM, LPN #1 was in the hallway at a cart and Person #1 reported that the oxygen tank was empty. LPN #1 stated she was busy and told Person #1 to find someone else to change it and then went into another resident's room. Person #1 identified everyone was busy and LPN #1 made (continued on next page)

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	075324	A. Building B. Wing	05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Civita Care Bayview	301 Rope Ferry Rd Waterford, CT 06385

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1 wait over five (5) minutes. When LPN #1 arrived to assist, she yanked the oxygen tubing off the oxygen tank with the nasal cannula still attached to Resident #1's face, almost causing Resident #1 to fall. Person #1 identified he/she immediately reported the prolonged changing of the oxygen tank and the incident with LPN #1 to RN #1 (nursing supervisor) alleging neglect and roughness and then left a voicemail for the Director of Social Services with the timeline of events. Person #1 identified he/she spoke with the DON and Director of Social Services the next day, explaining the chain of events including LPN #1 making Resident #1 wait for more oxygen and the way she roughly pulled the oxygen tubing off the oxygen tank almost causing Resident #1 to fall and the DON reported RN #1 never reported the complaint to her. Person #1 reported during the 4/9/26 meeting, he/she again reported the chain of events and stated it was neglect and abuse. He/she told the DON he/she no longer wanted to visit the building without a witness and the DON identified she would ensure LPN #1 no longer cared for Resident #1 as an intervention.Interview with LPN #1 accompanied by the DON on 5/12/26 at 2:32 PM identified on 4/5/26 she changed Resident #1's oxygen tank to a full tank about fifteen (15) minutes prior to Person #1 arriving to take Resident #1 out on an LOA and ensured it was set to 3.0 lpm. She reported when Person #1 arrived to take Resident #1 out on the LOA, the regulator on the oxygen tank still read that the tank was full. At about 1:45 PM she was in the hallway at the treatment cart when Person #1 approached her and reported Resident #1's oxygen tank was empty. LPN #1 reported she was going to do a dressing change and told Person #1 she needed a few minutes. She further told Person #1 another licensed nurse or NA could change the oxygen tank. She reported she should have confirmed the oxygen tank was empty prior to entering another resident's room and should have checked Resident #1's oxygen level. She identified when she responded, the oxygen tank gauge was in the red area and on low but not completely empty.Interview with RN #1 accompanied by the DON on 5/12/26 at 2:47 PM identified on 4/5/26 Person #1 approached her upset because Resident #1 ran out of oxygen while on an LOA and LPN #1's response time in changing the oxygen tank but could not recall Person #1 reporting LPN #1 yanked the oxygen tubing almost causing Resident #1 to fall. RN #1 reported she immediately reported the complaint to the DON.Interview with the DON on 5/12/26 at 1:13 PM identified she could not recall RN #1 notifying her on 4/5/26 of Person #1's concerns. She recalled being notified on 4/6/26 by Person #1 regarding Resident #1 running out of oxygen on the LOA and LPN #1 not responding immediately but she spoke with LPN #1 who denied Resident #1 ran out of oxygen. The DON indicated she was not aware LPN #1 was in the hallway when Person #1 approached LPN #1 regarding Resident #1's oxygen tank being empty and LPN #1 should have assisted Resident #1 immediately. The DON identified she did not initiate an investigation to include statements from other staff working at the time to include LPN #1 and RN #1 and did not believe the concerns voiced by Person #1 on 4/6/26 were allegations of abuse or neglect so she did not report to the State Agency. The DON identified all allegations of abuse and/or neglect are to be reported to the Stage Agency within two (2) hours and investigated.Interview with the Director of Social Services on 5/13/26 at 8:36 AM identified she could not recall listening to a voicemail on 4/6/26 from Person #1 regarding Resident #1 but she did speak with Person #1 on 4/6/26 who reported concerns about the oxygen becoming empty on the LOA on 4/5/26 and LPN #1's response time. She reported she could not recall what words Person #1 used to describe Resident #1 losing his/her balance when the oxygen tank was changed but identified there were concerns presented by Person #1 regarding the oxygen and LPN #1 that were concerning and should have been addressed immediately. The Director of Social Services reported the DON directed to write up the concerns as a grievance on 4/6/26.2. Interview with Person #2 on 5/13/26 at 1:36 PM identified on 4/20/26 during the 11:00 PM to 7:00 AM shift, NA #3 reported that all the residents on the west unit were independent and frequent rounds did not need to be done, despite the west unit being a short-term rehabilitation unit. Person #2 reported that NA #3 was on her phone all night, turned off call bells from the nurse's station without responding and did not perform rounds until 5:30 AM. Person #2 identified that at that time, residents' sheets were visibly dirty with (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dried urine and feces, residents were left incontinent all night and dried blood was noted on the floor all night and not cleaned. Person #2 reported the concerns to the staffing scheduler on 4/21/26.Interview with the staffing scheduler on 5/13/26 at 1:36 PM accompanied by the DON identified on 4/21/26, Person #2 reported that during the previous 11:00 PM to 7:00 AM shift on the west unit, residents' beds were dirty, dried blood was on the floor, and it did not appear that care had been provided for the residents. The staffing scheduler identified that she immediately reported the concerns to the DON. Review of the Connecticut Department of Public Health Facility Licensing and Investigations Section portal on 5/12/26 failed to identify the 4/20/26 incident was reported to the State Agency as an allegation of neglect.Interview with the DON on 5/13/26 at 1:38 PM identified she could not recall the staffing scheduler reporting any lack of resident care on 4/21/26, and that the lack of care was an allegation of neglect which should have been reported to the State Agency within two (2) hours and investigated. Although attempted an interview with NA #3 was not obtained.3. Resident #2?s diagnoses included Enterocolitis due to Clostridium Difficile (C. Diff) (inflammation in both intestines caused by a bacteria that causes an infection of the colon), acute kidney failure, adult failure to thrive, need for assistance with personal care and weakness.The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had intact cognition (Brief Interview for Mental Status (BIMS) score of 15), was dependent on staff for personal hygiene and transfers, required partial assistance for toileting hygiene and bed mobility and was always incontinent of bowel.The Resident Care Plan (RCP) dated 4/20/26 identified Resident #2 had an Activities of Daily Living (ADL) deficit due to generalized weakness and renal failure, had C. Diff and was incontinent of bowel and/or bladder. Interventions included keeping the call bell and needed items within reach, providing an assist of one (1) with all ADLs, offering to toilet or use the commode before leaving the room for activities, meals or ambulation and upon request and providing incontinent care approximately every two hours and as needed and upon request. Interview with Resident #2 on 5/13/26 at 8:50 AM identified he/she utilized the bedside commode independently on the overnight shift (11:00 PM to 7:00 AM), although he/she is not supposed to, because the call bell it is not answered and no one checks on him/her. Resident #2 identified the bedside commode is rarely emptied on the overnight shift, bed sheets are visibly dirty and staff do not change them unless requested and he/she feels afraid something will happen on the overnight shift and no one will know or respond.Review of the May 2026 Documentation Survey Report (NA documentation) failed to identify any documentation on the overnight shift on 5/1/26, 5/2/26 or 5/8/26 for bladder or bowel tasks.4. Resident #3 ?s diagnoses included Congestive Heart Failure (CHF), chronic kidney disease stage IV (severe kidney function loss), acute respiratory failure with hypoxia (low levels of oxygen in the body tissues), weakness and depression.The admission assessment dated [DATE] identified Resident #3 was alert and oriented to person, place and time and required partial assistance for self-care, toileting hygiene and transfers. Resident #2 utilized oxygen via a nasal cannula at 2.0 liters per minute.The RCP dated 5/12/26 identified Resident #3 had ADL deficits due to generalized weakness and recent hospitalization, utilized oxygen therapy due to CHF and had a foley catheter intact due to urinary retention. Interventions included performing catheter care every shift and as needed, keeping the call bell and needed items within reach and providing assistance with all ADLs.A Brief Interview for Mental Status (BIMS) assessment dated [DATE] identified Resident #3 was cognitively intact (score of 14). Interview with Resident #3 on 5/13/26 at 8:54 AM identified long wait times when using the call-bell on the overnight shift and staff do not perform safety checks every two (2) hours. Resident #3 reported bowel incontinence the previous night and staff did not assist timely. Resident #3 reported staff do not change the bed linens unless requested. Interview with RN #2 on 5/13/26 at 12:49 PM identified NA's are not doing every two (2) hour rounds, turn off the call bells, do not respond, hide out and play on their phones during the overnight shift. She reported when she would do her own rounds, she would question NA's about turning and repositioning the residents and they would reply they already did and ignore her. The Nas would tell her she cannot do anything about (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	it because they would not be fired. RN #2 identified she reported the concerns to the DON many times but that the staff were never suspended, kept coming to work and she was afraid her car tires would be slashed in retaliation. RN #2 reported she did not feel comfortable naming the NA staff that were ignoring their duties on the overnight shift.Interview with LPN #3 on 5/13/26 at 2:08 PM identified she regularly worked with NA's #2 and #3 on the short-term unit overnight shift and they turn alarming call bells off at the nurse's station and do not respond to the residents rooms, do not perform rounds until after 5:00 AM, do not toilet residents, are rude to the residents, and hide in the break room with the door shut on their phones and sleep. LPN #3 reported when she requested NA #2 or #3 to do something they refused and told her to complain to administration because they cannot be fired. She identified she reported the behavior to the DON multiple times. LPN #3 identified she does her job and the NA's jobs when they refuse to respond. Interview with the DON on 5/13/26 at 1:33 PM identified she was unaware there were complaints regarding care and call bell response time. She reported she could not recall licensed nurses reporting that NAs were not doing every 2-hour rounds, toileting residents or turning and repositioning residents. She was unaware that NA's were refusing to perform resident care tasks when directed by licensed nurses and that licensed nurses were afraid of retaliation by the NAs. The DON identified that NAs should complete every 2-hour rounds for all residents, turn and reposition residents per their plan of care and as needed, attend to call bells timely and never turn off call bells without first responding. Linens should be changed daily and when visibly soiled. NAs and other staff should be visible on the unit and not in the break room unless on break and other staff are aware they are on break. The DON reported if she were aware of the allegations of neglect, she would have suspended the employees that were accused of neglect and investigated the allegations immediately Subsequent to surveyor inquiry, review of the Connecticut Department of Public Health Facility Licensing and Investigations Section portal on 5/14/26 failed to identify the allegations of neglect reported by this surveyor to the DON on 5/13/26 were reported to the State Agency within two (2) hours as required.Review of the Residents Right to Freedom from Abuse, Neglect and Exploitation policy (undated) directed, in part, staff must not use verbal, mental, sexual or physical abuse, corporal punishment or involuntary seclusion against any resident. When the facility has identified abuse, the facility will take all appropriate steps to remediate the noncompliance and protect residents from additional abuse immediately. The facility will increase enforcement action, including, but not limited to: Taking steps to prevent further abuse, reporting the alleged violation and investigation within required timeframes pursuant to federal and state statutes and regulations, conducting a thorough investigation of the alleged violation, taking appropriate corrective action and the facility will revise the resident's care plan if the resident's medical, nursing, physical, mental or psychosocial needs or preferences change as a result of an incident of abuse. In response to allegations of abuse, neglect, exploitation or mistreatment, the facility shall: Ensure all alleged violations involving abuse, neglect, exploitation or mistreatment are reported in the proper time frame pursuant to this policy, have evidence that all alleged violations are thoroughly investigated and prevent further abuse, neglect, exploitation or mistreatment while the investigation is in progress.Review of the Reportable Events policy dated 9/1/22 directed, in part, that the facility shall identify, classify, document and report all events that meet criteria for reportable incidents under Connecticut DPH regulations. A Class B event includes a complaint or allegation of patient abuse, or any act involving abuse toward a patient by any person. Abuse includes verbal, mental, sexual or physical attack, injury, unreasonable confinement, intimidation or punishment.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for one (1) of three (3) sampled residents (Resident #1) reviewed for activities of daily living (ADL) care and allegations of neglect, the facility failed to ensure Resident #1 received showers and related hygiene care in accordance with physician's orders and the resident's comprehensive care plan, failed to ensure refusals or missed showers were accurately documented in the clinical record, and failed to ensure the resident's responsible party was notified when showers were refused or not provided as directed. The findings include:Resident #1?s diagnoses included mild cognitive impairment, Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), depressive episodes and anxiety disorder. A physician's order dated 5/7/25 directed Resident #1 was to have supervision with showering and Activities of Daily Living (ADL) tasks and directed to provide increased verbal cues to complete personal hygiene as well as peri care on a daily basis and provide assistance when needed. Encourage Resident #1 to use shampoo and fully rinse.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had moderately impaired cognition (Brief Interview for Mental Status (BIMS) score of 12), required setup assistance with personal hygiene and showering/bathing self and was independent with bed mobility, transfers and ambulation.The Resident Care Plan (RCP) dated 1/28/26 identified Resident #1 had ADL deficits related to generalized weakness and recent hospitalization. It identified Resident #1 refused showers at times or refused assistance when in shower and to notify the responsible party (Person #1) when Resident #1 refused. Interventions included the NA is to notify the nurse if the resident refused any care, showers, etc., staff to assist or cue concerning tasks including showers, changing clothes, brushing teeth, personal hygiene as well as peri care daily and licensed nurse to call Person #1 with refusals of care, showers, dental hygiene and the NA was to notify the licensed nurse.A. A physician's order dated 2/8/25 directed to notify Person #1 of any and all refusals of showers, care and medications and document in the clinical record every day shift on Wednesdays and Saturdays.A physician's order dated 8/27/25 directed to perform weekly skin checks on bath/shower day, Wednesday 7:00 AM to 3:00 PM shift and Saturdays 7:00 AM to 3:00 PM shift and notify Person #1 if Resident #1 refused and document in the clinical record why Resident #1 refused every day shift every Wednesday and Saturday.Review of the April 2026 Treatment Administration Record (TAR) failed to identify documentation on 4/29/26 that a shower had been given or that Person #1 was notified of a refusal.Review of nurse's notes dated 4/29/26 failed to identify documentation that Resident #1 received a shower or that Resident #1 refused a shower.A On the Job Training document for LPN #2 dated 4/29/26 identified, in part, that for Resident #1, LPN #1 needed to ensure Person #1 was notified of Resident #1 refusing showers and care, to document in the clinical record and to use the shift to shift report tool and give good report to the oncoming licensed nurse.Interview with LPN #1 accompanied by the DON on 5/13/26 at 11:51 AM identified on 4/29/26 Resident #1 refused his/her shower and she should have documented the refusal and notified Person #1 per the plan of care.Interview with the DON on 5/13/26 at 2:30 PM identified LPN #1 should have notified Person #1 of Resident #1's refusal to shower on 4/29/26 per the plan of care and documented that Resident #1 refused.B. A physician's order dated 4/29/26 directed to notify Person #1 of any and all refusals of showers, care and medications and document in the clinical record every day shift on Wednesdays and Saturdays.A physician's order dated 4/29/26 directed to perform weekly skin checks on bath/shower day, Wednesday 7:00 AM to 3:00 PM shift and Saturdays 7:00 AM to 3:00 PM shift and notify Person #1 if Resident #1 refused and document in the clinical record why Resident #1 refused every day shift every Wednesday and Saturday.A nurse's note by the ADON dated 5/7/26 at 3:16 PM identified a NA brought Resident #1 to another unit to use the shower because the shower room was (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	being worked on and out of use. Resident #1's shower day should have been Wednesday (5/6/26), however the shower was being worked on so the NA was instructed to bring Resident #1 to another unit for a shower.Review of the May 2026 TAR identified on 5/6/26 Resident #1's shower was documented as administered and notification of Person #1 for any refusals is signed off as ?NA'.Interview with LPN #1 accompanied by the DON on 5/13/26 at 11:51 AM identified on 5/6/26 NA #4 notified her that she did not give Resident #1 a shower because the shower was broken and it was being worked on. She reported she was unsure why she documented that Resident #1 received the shower but should have questioned NA #4 whether there was another shower Resident #1 could have used and documented accurately that the shower was not given. Additionally, she reported she was unsure if she reported to the next shift that Resident #1 didn't receive his/her shower but should have.Interview with NA #4 accompanied by the DON on 5/13/26 at 2:25 PM identified she did not give Resident #1 a shower on 5/6/26 because the shower stall was being worked on. She identified she should of offered Resident #1 a different shower room. Interview with the DON on 5/13/26 at 2:30 PM identified NA #4 should have offered Resident #1 another shower stall or shower room on a different unit and if Resident #1 refused, she should have reapproached Resident #1 later. The DON reported if Resident #1 continued to refuse the shower, then LPN #1 should have been notified of the refusal so that she could document appropriately and notify Person #1.Review of the Comprehensive Care Planning policy dated 9/1/22 directed, in part, a comprehensive, person-centered care plan includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The comprehensive, person-centered care plan: includes measurable objectives and timeframes; describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment. Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. When possible, interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. The resident has the right to refuse to participate in the development of his/her care plan and medical and nursing treatments. Such refusals are documented in the resident's clinical record in accordance with established policies.Review of the Charting Documentation policy dated 9/1/22 directed, in part, documentation in the medical record will be objective, complete and accurate, whether the resident refused the procedure/treatment and notification of family, physician or other staff, if indicated. Although requested, facility policies for following physician's orders and showers were not provided.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, and staff interviews for one (1) of three (3) sampled residents (Resident #1) reviewed for allegations of neglect, the facility failed to ensure Resident #1's hearing aids were timely sent for repair, monitored for return, and followed up on after staff identified the hearing aids were broken and unavailable beginning on 3/11/26. As a result, Resident #1 remained without hearing aids for approximately two (2) months. The findings include:Resident #1?s diagnoses included mild cognitive impairment, depressive episodes and anxiety disorder. A physician's order dated 2/7/25 directed to apply hearing aids in the morning and remove at bedtime. The order directed to keep the hearing aids in the treatment cart and open the battery compartment. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had moderately impaired cognition (Brief Interview for Mental Status (BIMS) score of 12), required setup assistance with personal hygiene and was independent with bed mobility, transfers and ambulation. Additionally, it identified Resident #1 utilized hearing aids. The Resident Care Plan (RCP) dated 1/28/26 identified Resident #1 had Activities of Daily Living deficits related to generalized weakness and recent hospitalization. Interventions included Resident #1 utilized hearing aids. A nurse's note by RN #4 dated 3/11/26 at 5:31 PM identified Resident #1's hearing aids needed to be repaired by the vendor. The hearing aids were sent on 3/11/26 and Resident #1 was aware. Nurse's notes dated 3/12/26 through 5/12/26 failed to identify a follow up note regarding the whereabouts of the hearing aids or if they were returned. Review of the March, April and May 2026 Treatment Administration Record (TAR) for Resident #1 identified from 3/11/26 through 5/12/26 Resident #1's hearing aids were ?Not Available'. Interview with Person #1 on 5/12/26 at 12:14 PM identified on 5/8/26, after awaiting the return of Resident #1's hearing aids for over a month he/she was notified by the facility that Resident #1's hearing aids were found in the appointment schedulers desk and were never sent out. Person #1 reported the facility communicated they would send them out as soon as possible. Interview with the DON on 5/12/26 at 1:13 PM identified she was unaware Resident #1's hearing aids were not sent out per the 3/11/26 nurse's note until questioned by Person #1. She reported Resident #1's hearing aids were subsequently found in the former appointment scheduler's desk about two (2) weeks prior and when returned to her, she cleaned them and changed the batteries, and they still did not work. The audiology group was contacted to inquire about the next steps but identified they should have been initially sent out immediately upon discovering they were broken. The DON reported they were sent for repair on 5/12/26 but was unable to identify why it took an additional 2 weeks to do so. Additionally, the DON identified that nursing staff, who had been signing off on both the day and evening shifts that the hearing aids were unavailable should have notified her or the appointment scheduler that the hearing aids had still not been returned and inquired about their whereabouts prior to the family having to inquire 2 months later. Interview with the former appointment scheduler on 5/13/26 at 12:10 PM identified her last day of employment was on 4/21/26. She reported broken medical devices would go to the nursing supervisor, ADON or DON and they would clean them to try to get them functioning. She identified if they were unable to do so, they would notify her that they needed to be sent out for repair but she could not recall ever being given Resident #1's hearing aids to send out and no staff had come to her inquiring about the whereabouts of Resident #1's hearing aids prior to her last day. Although requested, a policy on repair of medical devices was not available.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075324	A. Building B. Wing	05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Civita Care Bayview	301 Rope Ferry Rd Waterford, CT 06385

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 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for one (1) of three (3) sampled residents (Resident #1) reviewed for allegations of neglect, the facility failed to review and act upon in-house dental consult recommendations, coordinate recommended community dental appointments, document follow-up actions, and timely notify the resident's representative of dental findings and refusals of recommended care. As a result, recommended dental restorations were not completed and dental decline progressed from restorations being recommended to multiple teeth becoming non-restorable and requiring extractions. The findings include: Resident #1?s diagnoses included dental caries (cavities/tooth decay), mild cognitive impairment, Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), depressive episodes and anxiety disorder. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had intact cognition (Brief Interview for Mental Status (BIMS) score of 13), and was independent with oral and personal hygiene, transfers and ambulation. The Resident Care Plan (RCP) dated 2/6/25 identified Resident #1 has a history of oral/dentalhealth problems, has been diagnosed with dental caries and has Activities of Daily Living deficits related to generalized weakness and recent hospitalization. Interventions included monitoring, documenting and reporting as needed any signs and symptoms of oral/dental problems needing attention, coordinating arrangements for dental care and transportation as needed/as ordered and nursing to call resident representative with refusals of in part, care and dental hygiene- the NA is to notify the nurse of refusals. A physician's order dated 2/6/25 directed to notify Resident #1's responsible party (Person #1) of any and all refusals of showers, care and medications every day shift every Wednesday and Saturday. A dental consult note dated 3/4/25 identified, in part, Resident #1 had decay to upper tooth number (#) 9 (left front tooth) and the mesial portion (facing forwards, towards the midline) of the tooth was fractured (broken). Root caries and plaque on the teeth and on and under the partial and oral hygiene needed to be greatly improved or Resident #1's teeth would break off at the gumline from root caries. The note identified Resident #1 would be referred to a community health center or a dental practice for four handed dentistry (a practice with a dental assistant) for large restorations (procedure to repair or replace damaged or decayed teeth) to teeth #9, #20, #21, and #29. Review of nurse's notes dated 3/4/25 through 6/19/25 failed to identify documentation of Resident #1's 3/4/25 dental visit, notification of Person #1 or documentation that the facility attempted to set up an appointment with an outside dental clinic for the dental restorations to be completed per recommendations. A dental consult note dated 6/20/25 identified, in part, Resident #1 had not had the restorations completed that were recommended last visit and a dental cleaning and dental x-rays were recommended. The note directed to refer Resident #1 to a community health center or a dental practice for four handed dentistry for restorations to teeth #9, #20, #21, and #29. Review of nurse's notes dated 6/20/25 through 7/6/25 failed to identify documentation of Resident #1's 6/20/25 dental visit, notification of Person #1 or documentation that the facility attempted to set up an appointment with an outside dental clinic for the dental restorations to be completed per recommendations. A dental consult note dated 7/7/25 identified Resident #1 was seen by the Registered Dental Hygienist (RDH), dental x-rays were obtained and Resident #1 tolerated the procedure well. A dental consult note dated 8/19/25 identified dental x-rays were reviewed and Resident #1 had moderate decay to tooth #8 (right upper front tooth) and non-restorable decay to tooth #9 and #29 (right bottom premolar). Resident #1 had deep decay with sensitivity to tooth #20 and #21 (left bottom premolars) and recommendations were made for extractions to teeth #9, #20, #21 and #29. The note identified Resident #1 was refusing the extractions at that time and the next visit they would restore (fill) tooth #8. Review of nurse's notes dated 8/19/25 through 9/14/25 failed to identify documentation of Resident #1's 8/19/25 dental visit or notification of Person #1 of the visit or the refusal of the extractions. A late entry nurse's note by (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the DON dated 9/15/25 at 6:15 PM (created on 9/16/25 at 7:49 AM) identified she spoke with Person #1 and updated him/her in part, dental consults and any refusals (27 days after the last dental visit). A dental consult note dated 9/16/25 identified restoration of tooth #8 was attempted but Resident #1 refused anesthesia and pulled away when the lingual surface (the inner facing side of the tooth that directly faces the tongue) was touched so the restoration was unable to be completed. Extractions were discussed with Resident #1 but Resident #1 stated he/she was too nervous and did not like shots. The note reported Resident #1 was to be referred for extraction of teeth #9, #20, #21 and #29 when Resident #1 was accepting. Review of nurse's notes dated 9/16/25 through 10/29/25 failed to identify documentation of Resident #1's 9/16/25 dental visit or notification of Person #1 of the visit or the refusal of the dental restoration. Interview with Person #1 on 5/12/26 at 12:14 PM identified although abnormalities were noted to Resident #1's dentition, he/she was not notified of Resident #1's dental visits on 3/4/25, 6/20/25 or 8/19/25 or the recommendations made until September of 2025. Person #1 identified had he/she known of the recommendations, he/she could have been present for future dental visits, encouraged Resident #1 to have the dental work done and assisted with setting up the appointments for the restorations and extractions. Person #1 reported that due to the lack of communication, Resident #1's dental care has been delayed. Interview with the former appointment scheduler on 5/13/26 at 12:10 PM identified following in-house appointments, the consult notes are emailed to herself, the DON and the ADON and the DON and/or ADON were responsible for reviewing them for any abnormalities and new recommendations. She reported if a resident required an appointment in the community, the ADON or ADON would have first had to review the recommendations, ensure the resident and/or responsible party agreed with the appointment and then she would be directed to make the appointment if applicable. She identified she was unsure if and when she was notified to set up a dental appointment in the community for Resident #1. Interview with the DON on 5/13/26 at 1:33 PM identified that following in-house dental visits, nursing staff should have written notes in the clinical record identifying Resident #1 was seen by the dentist and again when the consult notes were available if recommendations were noted. Person #1 should have been notified immediately. The DON reported the consult notes were emailed to the ADON and herself and the recommendations should have been identified and acted upon. Additionally, she was unsure why she did not contact Person #1 following Resident #1's dental visit on 8/19/25 until 9/15/25. She identified Person #1 should have been notified immediately of all refusals of care, including dental care. Review of the Coordination of Care from External Providers policy dated 9/01/22 directed, in part, the facility shall coordinate care and services provided by external healthcare providers to ensure that all resident care is integrated, communicated appropriately, documented accurately and consistent with the resident's plan of care, physician orders, goals, preferences and applicable regulations. The facility shall ensure services are integrated into the resident's comprehensive care plan and maintain documentation of all consultations, recommendations, treatments and follow-up care. The medical record shall include: consultation reports, provider recommendations, orders received, treatment documentation, progress notes, follow-up actions, appointment summaries and diagnostic reports. The facility shall review external provider documentation and ensure recommendations are addressed appropriately. The Director of Nursing is responsible for: oversight of clinical coordination processes, ensuring timely communication and documentation and monitoring compliance with policy.Review of the Refusing or Requesting Discontinuation of Care policy dated 9/01/22 directed, in part, Residents/representatives are informed in advance of: the care that will be furnished or made available to the resident based on his or her assessment and plan of care, the risks and benefits of the proposed care, treatment, treatment alternatives or treatment options, the type of caregiver or professional that will provide the care and any changes to the resident's care plan. If a resident/representative requests, discontinues or refuses care or treatment, an appropriate member of the interdisciplinary team will meet with the resident/representative to: determine why he/she is requesting, refusing or discontinuing care or treatment, try to address his/her concern and discuss alternative options and discuss the potential outcomes or consequences of the decision.