

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075324	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/06/2026
NAME OF PROVIDER OR SUPPLIER Civita Care Bayview		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **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 of two residents (Resident #1) reviewed for care and services, the facility failed to ensure adequate supplies (drainage kit) to manage a PleurX catheter prior to Resident #1's admission, resulting in Resident #1 being transferred to the hospital. The findings include: Resident #1's diagnoses included malignant neoplasm (cancerous tumor) of the left breast, secondary malignant neoplasm of the pleura (lining of the lungs and chest wall), pneumothorax (collapsed lung), chronic pain, anxiety disorder and depression. The admission Evaluation dated 5/9/26 identified Resident #1 was alert to person, place and time, had weakness and impairment to both upper and lower extremities and was independent with bed mobility, required continuous oxygen at 3.0 liters (L) per minute via nasal cannula, and had a PleurX catheter (drain/a thin flexible tube that's placed in the chest to drain fluid from the pleural space and has a catheter extending outside of the body with a one-way valve that is capped until it is time to be drained) on the right and left sides. A physician order dated 5/9/26 directed to drain the right-side and the left-side pleural drain up to 1.0 Liter three (3) times per week on Monday, Wednesday and Friday on the day shift. A physician order dated 5/10/26 directed to drain the pleural drain as needed, maximum amount one (1) liter, for difficulty breathing and oxygen level less than 92 percent (%) - on 3 Liters per minute (l/m) oxygen as needed for Shortness of Breath (SOB) or difficulty breathing. The Resident Care Plan (RCP) dated 5/10/26 identified Resident #1 had altered respiratory status/difficulty breathing related to pleural effusions (abnormal buildup of excess fluids between the layers of the pleura surrounding the lungs), had pleural drains, utilized oxygen related to the pleural effusions and had malignant neoplasms and subsequent pain. Interventions directed to drain up to one (1) L from the pleural drains three (3) times weekly on Mondays, Wednesdays and Friday. The Brief Interview for Mental Status (BIMS) Evaluation dated 5/11/26 identified Resident #1 had a BIMS of 14, indicative of intact cognition. A nursing note by LPN #2 on 5/10/26 at 2:43 AM identified Resident #1 reported feeling SOB and requested to have his/her pleural drain emptied. Vital signs were obtained and blood pressure was 87/42 (hypotensive/low blood pressure), heart rate was 111 (tachycardic/fast heart rate) and oxygen level was 96% (normal 90% and above) on 3.0 L of supplemental oxygen. The note indicated equipment was unavailable for the pleural drain, the on-call provider was notified, and orders were obtained to transfer Resident #1 to the hospital to evaluate and manage the PleurX catheter. Ambulance run sheet dated 5/10/26 identified Resident #1 reported feeling SOB, and Resident #1 indicated that was how he/she feels when the PleurX catheter is not drained at night. Staff reported they did not have the equipment to drain the PleurX. Lung sounds were diminished in the lower fields, blood pressure was 108/74, heart rate was 108 (tachycardic), respirations were 20 and oxygen level was 99%. A nursing note dated 5/10/26 at 11:28 AM identified, Resident #1 returned from the hospital and after the hospital emptied the pleural drains. Hospital sent (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	two (2) additional drain bottles for use until more were able to be ordered by the facility. Interview with LPN #3 on 7/6/26 at 11:45 AM identified he completed Resident #1's admission on [DATE] (Saturday) and stated Resident #1 did not arrive at the facility with any PleurX drainage kits, which includes the catheter drainage line and vacuum bottles. LPN #3 stated the facility did not have supplies prior to Resident #1's admission and LPN # identified he did not order them or notify anyone the supplies were needed. LPN #3 was unable to explain why the supplies were not ordered. Interview with LPN #2 on 7/6/26 at 12:11 PM identified on 5/10/26 when Resident #1 complained of SOB, she looked for the drainage kits but was unable to locate any. She notified RN #4 and stated RN #4 did not locate any so Resident #1 was transferred to the hospital to have the PleurX drained. LPN #2 stated if she had the supplies available she would not have had to transfer Resident #1 to the hospital. Interview with the DON on 7/6/26 at 1:59 PM identified drainage kits should have been ordered for the PleurX prior to Resident #1's admission. The DON stated she thought the facility had supplies available and she was not notified there were no supplies until Resident #1 was transferred to the hospital. interview failed to identify why the facility did not verify supplies were available prior to Resident #1's admission. The DON stated if the supplies were available, Resident #1 would not have required transfer to the hospital. Review of the facility admission Criteria policy dated 2/1/26 directed, in part, residents are admitted to the facility as long as their needs can be met adequately by the facility. Although requested, a facility policy for ordering specialized equipment/treatments prior to admission was not provided for surveyor review.		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on review of the clinical record, facility documentation, facility policy, and interviews for one of two residents (Resident #1) reviewed for care and services, the facility failed to ensure staff education was provided prior to a resident admission with a PleurX drainage catheter. The findings include: Resident #1's diagnoses included malignant neoplasm (cancerous tumor) of the left breast, secondary malignant neoplasm of the pleura (lining of the lungs and chest wall), pneumothorax (collapsed lung), chronic pain, anxiety disorder and depression. The admission Evaluation dated 5/9/26 identified Resident #1 was alert to person, place and time, had weakness and impairment to both upper and lower extremities and was independent with bed mobility, required continuous oxygen at 3.0 liters (L) per minute via nasal cannula, and had a PleurX catheter (drain/a thin flexible tube that's placed in the chest to drain fluid from the pleural space and has a catheter extending outside of the body with a one-way valve that is capped until it is time to be drained) on the right and left sides. A physician order dated 5/9/26 directed to drain the right-side and the left-side pleural drain up to 1.0 Liter three (3) times per week on Monday, Wednesday and Friday on the day shift. A physician order dated 5/10/26 directed to drain the pleural drain as needed, maximum amount one (1) liter, for difficulty breathing and oxygen level less than 92 percent (%) - on 3 Liters per minute (l/m) oxygen as needed for Shortness of Breath (SOB) or difficulty breathing. The Resident Care Plan (RCP) dated 5/10/26 identified Resident #1 had altered respiratory status/difficulty breathing related to pleural effusions (abnormal buildup of excess fluids between the layers of the pleura surrounding the lungs), had pleural drains, utilized oxygen related to the pleural effusions and had malignant neoplasms and subsequent pain. Interventions directed to drain up to one (1) L from the pleural drains three (3) times weekly on Mondays, Wednesdays and Friday. The Brief Interview for Mental Status (BIMS) Evaluation dated 5/11/26 identified Resident #1 had a BIMS of 14, indicative of intact cognition. A nursing note by LPN #2 on 5/10/26 at 2:43 AM identified Resident #1 reported feeling SOB and requested to have his/her pleural drain emptied. The note indicated equipment was unavailable for the pleural drain, the on-call provider was notified, and orders were obtained to transfer Resident #1 to the hospital to evaluate and manage the PleurX catheter. A nursing note dated 5/10/26 at 11:28 AM identified, Resident #1 returned from the hospital and after the hospital emptied the pleural drains. Hospital sent two (2) additional drain bottles for use until more were able to be ordered by the facility. a. Nursing note written by LPN #3 dated 5/11/26 at 9:15 AM identified Resident #1 complained of Shortness of Breath (SOB) and was scheduled to have the PleurX drained. LPN drained both PleurX catheters utilizing a sterile field and gloves; 450 milliliters (mL) was drained from the right side and 250 mL was drained from the left side. Resident #1 reported following the procedure, he/she was able to breathe normally again, was comfortable and SpO2 (blood oxygen levels) returned to baseline. The PleurX sites were then redressed. The note failed to identify the following: SpO2 levels prior to and after the procedure. Lung sounds prior to and after the procedure. A description and color of the fluid drained during the procedure or a description of the PleurX drain sites prior to the dressing being reapplied. Interview and record review with LPN #3 on 7/6/26 at 11:45 AM identified he received training on the PleurX system for another resident a few months prior to Resident #1's admission to the facility. Although he performed the PleurX drainage procedure to Resident #1 on 5/11/26, he was not aware an assessment was required prior to and after the procedure or that he should have documented on the color and consistency of the drainage from each PleurX catheter/drain, and the appearance of the catheter sites prior to redressing the areas. LPN #3 stated he could not recall that was included with (continued on next page)		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	training he received, and stated he only received education about the procedure. He was unable to recall what Resident #1's SpO2 levels were prior to and after the procedure, and stated he should have documented the levels in his note and was unsure why he had not done so. b. Nursing note written by LPN #1 dated 5/13/26 at 12:21 identified Resident #1 appeared lethargic, unable to hold head up and refused medications. Supervisor was notified and Resident #1 was transferred to the hospital. Nursing note written by RN #1 dated 5/13/26 at 11:58 AM identified at 11:30 AM Resident #1 was non-responsive with eyes closed and unable to hold his/her head up. Oxygen saturation was 94% (normal 90% and above) on oxygen, heart rate was 105, respirator rate was 28 with use of accessory muscles, and 911 was implemented. Interview and record review with LPN #1 on 7/6/26 at 12:31 PM identified she was the 7:00 AM to 3:00 PM charge nurse on 5/13/26 and around 11:30 AM Resident #1 was lethargic, appeared to be in respiratory distress and she notified the RN #1. LPN stated she had not been trained on the PleurX system and she had not attempted to drain the PleurX because she was not provided education. Interview with RN #1 on 7/6/26 at 12:57 PM identified she was notified by LPN #1 on 5/13/26 that Resident #1 was in respiratory distress and she assessed the resident. RN #1 stated that she had not been trained recently on the PleurX system or the assessment and documentation requirements. Review of facility in-service documentation identified PleurX education was provided by the Staff Development nurse on 2/27/26 to LPN #3 and verbal education was offered to LPN #4. The education attached for LPN #3 was a printout on the PleurX procedure, but there was no documentation identifying assessment and documentation requirements for residents with a PleurX. Additional facility documentation review failed to identify LPN #1 or RN #1 had received education or training on the PleurX system. An interview with the Staff Development Nurse on 7/6/26 at 1:20 PM identified facility policy required all licensed nurses to be educated and signed off as competent on any specialized equipment and treatments prior to a resident's admission or prior to the start of any shift during which they would be responsible for that resident's care. The Staff Development Nurse (SDN) stated Resident #1 was admitted on a Saturday, and she was off duty and unaware of the admission. The SDN stated in her absence, any supervisor was responsible for providing the required education and training to licensed staff, and if she was notified of the admission, she would have ensured staff were educated and trained prior to Resident #1's arrival at the facility. The SDN stated she attempted to PleurX provide education for LPN #4, however, LPN #4 declined the education offered and had stated she was comfortable with how to perform the procedure. The SDN was unable to provide documentation that education was provided previously for LPN #4 regarding use of the PleurX. Although the SDN stated she provided education regarding assessing and documenting lung sounds and SpO2 levels before and after draining the PleurX system, and assessing, documenting the color and consistency of the drainage and the condition of the catheter site for any changes, she stated she did not have documentation of the education provided. She stated although she educated staff to perform the assessments and documentation, she did not know why staff had not completed them as per her description. Review of facility in-service documentation dated 2/27 and 3/30/26 identified the only RN that received education on the PleurX was the ADON. Interview with APRN #1 on 7/6/26 at 1:35 PM identified staff should be listen to lung sounds before and after draining the catheter, obtain SpO2 levels before and after draining, and document the observed drainage and monitor for changes for all residents with PleurX catheters. Interview with the DON on 7/6/26 at 1:59 PM identified all licensed nurses are required to be educated and signed off as competent on any specialized equipment and treatments prior to a resident's admission or prior to the start of any shift during which they will provide care. The DON stated she was not aware all staff assigned to care for Resident #1 and all nursing supervisors had (continued on next page)		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not received training on the PleurX system and its associated assessment and documentation requirements. The DON stated if she was aware, she would have ensured the required education and training was completed. Review of the facility Specialized Equipment Training and Competency Policy dated 10/3/25 directed, in part, the facility shall ensure that only employees who have successfully completed required education and demonstrated competency are authorized to operate specialized equipment. Training shall be provided before independent use of equipment, whenever new equipment is introduced, when equipment or manufacturer instructions change, following identified competency concerns, and at intervals determined by facility policy or manufacturer recommendations. Employees shall not use equipment for which they have not received training and documented competency validation. Education shall include, as applicable: purpose of equipment, resident selection criteria, indications and contraindications, documentation requirements and return demonstration. Competency shall include: review of written educational materials, demonstration by qualified instructor, return demonstration, verbal questioning when appropriate, observation during resident care, successful skills completion and documentation of training. Employees who do not demonstrate competency shall receive additional education before independent use.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on review of the clinical record, facility documentation, facility policy and interviews for one of three residents (Resident #1) reviewed for medication administration, the facility failed to ensure a PRN treatment and an as needed medication effectiveness were documented timely. The findings include: Resident #1's diagnoses included malignant neoplasm (cancerous tumor) of the left breast, secondary malignant neoplasm of the pleura (lining of the lungs and chest wall), pneumothorax (collapsed lung), chronic pain, anxiety disorder and depression. The admission Evaluation dated 5/9/26 identified Resident #1 was alert to person, place and time, had weakness and impairment to both upper and lower extremities and was independent with bed mobility, required continuous oxygen at 3.0 liters (L) per minute via nasal cannula, and had a PleurX catheter (drain/a thin flexible tube that's placed in the chest to drain fluid from the pleural space and has a catheter extending outside of the body with a one-way valve that is capped until it is time to be drained) on the right and left sides. The Resident Care Plan (RCP) dated 5/10/26 identified Resident #1 had altered respiratory status/difficulty breathing related to pleural effusions (abnormal buildup of excess fluids between the layers of the pleura surrounding the lungs), had pleural drains, utilized oxygen related to the pleural effusions and had malignant neoplasms and subsequent pain. Interventions directed to drain up to one (1) L from the pleural drains three (3) times weekly on Mondays, Wednesdays and Friday. The Brief Interview for Mental Status (BIMS) Evaluation dated 5/11/26 identified Resident #1 had a BIMS of 14, indicative of intact cognition. A physician order dated 5/10/26 directed to drain the pleural drain as needed (PRN), maximum amount one (1) liter, for difficulty breathing and oxygen level less than 92 percent (%) - on three (3) Liters per minute (l/m) oxygen as needed for Shortness of Breath (SOB) or difficulty breathing. Late entry nursing note by LPN #4 dated 5/12/26 at 10:10 PM identified she drained 400 mL from the right and 250 mL from the left PleurX catheters. The SpO2 was 94%, lung sounds were diminished and Resident #1 was anxious at times. Review of the nursing note identified the note dated 5/12/26 failed to identify why the PleurX catheters were drained, failed to note the SpO2 and lung sounds levels prior to and after the procedure, and a description of the fluid drained during the procedure or a description of the PleurX drain sites prior to the dressing being reapplied. Review of the May 2026 Medication Administration Record (MAR) failed to identify LPN #4 signed the MAR on 5/12/26 to indicate the PleurX catheters were drained in accordance with the physician PRN order PRN. Although attempted an interview with LPN #4 was unable to be obtained during the survey. a. A physician order dated 5/12/26 directed to administer Lorazepam intensol oral concentrate (used to treat anxiety) two (2) milligrams per milliliter (mg/mL), give 0.25 mL sublingually every eight (8) hours as needed for panic/fear/anxiety for 14 days. MAR review identified Lorazepam intensol was administered by LPN #5 on 5/13/26 at 6:30 AM. Nursing note by RN #1 dated 5/13/26 at 11:28 AM identified Resident #1 was observed to be non-responsive with eyes closed and was unable to hold up his/her head at 11:30 AM. Emergency Services was activated, and Resident #1 was transferred to the hospital. Review of Emergency Medical Services run sheet dated 5/13/26 identified EMS was called at 11:38 AM, and they were at the resident at 11:45 AM. Record review failed to identify the effectiveness of the Lorazepam was documented prior to Resident #1's transfer at 11:45 AM (5 hours and 15 minutes after administration). Further, the MAR effectiveness was documented at 2:20 PM as unknown. Interview with LPN #5 on 7/6/26 at 12:04 PM identified she worked on 5/13/26 until 8 AM, and she administered the Lorazepam intensol to Resident #1 on 5/13/26 at 6:30 AM for fidgeting, crying out, and complaints of difficulty breathing. LPN #5 stated she checked on Resident #1 before (continued on next page)		

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