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	12/03/2025

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, review of facility documentation, facility policy and interviews, the facility failed to ensure kitchen dry goods were stored appropriately and the kitchen hood was cleaned and maintained. The findings include:Observation of the kitchen during initial tour on 9/15/25 at 9:40 AM with Dietary Director identified the following.Muffin Mix bag in the dry storage food area of the kitchen with a receipt date of 8/1 (no year) and no expiration date.Traditional stuffing mix 1 opened bag and 3 unopened bags. Best by date 8/7/25 on all 4 bags. One bag of croutons, opened, with no expiration date.Visible dust and debris present under the hood, matted to the underside, including fire suppression system. No date of last cleaning nor cleaning log was maintained or available to review. Interview on 9/15/25 at 10:15AM with Dietary Manager identified anyone who is in the dry storage is responsible for going through the food and seeing if things are labeled or expired. Usually, the Dietary Manager will go through the food to see if it is labeled and she talks to her staff regularly about doing the same, however it must have been missed. The food in the dry storage should be labeled with both a receipt date, an open date and expiration date if it is not already printed on the bag. The hood in the kitchen is usually cleaned weekly by the Dietary Manager however there is no log kept, and every six months by a professional company, however she would have to look for the paperwork from the company. Staff have not been cleaning it recently as they have been short staff. Interview on 9/22/25 at 11:30 AM with the Dietary Manager identified the hood was last cleaned on 11/19/24 by a professional company however she wasn't sure why there was not a sticker on the hood or why they hadn't come back in 6 months. Maintenance was responsible for doing the scheduling. Interview on 9/22/25 at 11:50 AM with Assistant Maintenance Director identified the professional company did the last cleaning and they may or may not have come back between then, however it should be completed every 6 months. Maintenance usually does schedule the cleanings, however if there is money owed from the facility the company usually will not come back until payment is received. Interview on 9/22/25 at 11:58AM with Person #5, owner of professional company identified the previous balance from 11/19/24 was never paid and therefore they would not come out to do another cleaning. If the balance was paid, they could come out as soon as October 2025 for a cleaning. Interview on 9/22/25 at 12:15 AM with the Administrator identified she was unaware as to why the bill had not been paid as it was in corporates hands and unsure why the hood had not been cleaned. However, the last time it was cleaned was during the time she was administrator at the facility. Currently she is filling in for the administrator who is out on leave. Review of the Dietary Department guidelines directed all food items should be labeled and dated to allow for rotation of supplies. All areas of the Dietary Department will be cleaned on a regular schedule. Logs/schedule will be kept of cleaning tasks as they are completed. The Dietary Departments will be maintained in a clean and sanitary manner to prevent food borne illness.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on review of facility documentation, facility policy, and interview for water management, the facility failed to provide documentation of water sampling (for legionella and other waterborne pathogens), ice machine cleaning, and the facility failed to ensure the annual water management plan meeting was conducted with records maintained according to the facility's water management plan. The findings include: Review of facility documentation regarding monthly ice machine cleaning failed to identify the ice machines in the facility were cleaned from August 2024 through December 2024, 4 months. In addition, the records failed to identify any water sampling testing results for testing done on 1/29/24 and 1/27/25. Review of the Facility Water Management Plan with the Director of Maintenance and the Assistant Director of Maintenance on 9/18/25 at 2:23 PM identified the facility water management plan included flushing monthly, of water supply areas not frequently used, water sampling testing twice yearly for legionella, hot water temperature checks, and monthly ice machine cleaning. In addition, they identified the facility also had a contract with a vendor for their water management program. Interview with the Director of Maintenance and the Assistant Director of Maintenance on 9/18/25 at 2:23 PM identified the facility does not have a copy of the water sampling test results due to lack of payment to the contracting water management company. They identified the contracting water management company would notify the facility or the State agency if they had a positive water sampling test. They identified the facility should maintain and have in their records a copy of the results but if the bills were not paid then they would not be able to obtain a copy. Interview with the Assistant Director of Maintenance in the presence of the Administrator on 9/22/25 at 10:43 AM identified the facility maintenance staff were responsible for cleaning the ice machines monthly in the facility. He identified that he was unable to locate any documentation that the ice machine cleaning had been done from August 2024 to December 2024. He indicated the facility had a different director at time, so he does not know where/how that documentation was done. Review of the Water Management Policy identified facility should maintain the environmental assessment, sampling, and management plan and any associated sampling results on the facility premises for at least three years, such records should be made available to the local and the state department upon request. Review of the Annual Water Management Plan Revision and Updates dated 1/29/24 that was provided to the facility by the contracted company identified all efforts should be made to utilize the mitigation set forth by the contracting company on risk assessment and the facility shall continue documentation to establish compliance in all areas of the plan.Review of the Facility Water Management Plan for 2024 to 2025 failed to identify that the facility had a water management meeting to review water sampling results, updating or revising the water management plan provided by the company that was contracted by the facility to manage the facility's water management plan. The last record of a water management meeting identified the meeting was held in July of 2024. Interview with the Director of Maintenance and the Assistant Director of Maintenance on 9/18/25 at 2:23 PM identified the facility did not have a water management meeting or a water management committee that they were aware of. The Director of Maintenance identified he had only started working as the director six months ago and has had no water management meetings. The Assistant Director identified the facility had no results of the water sampling testing due to lack of payment by the facility to the contracted company. In addition, the facility does not have an updated and revised plan as it is usually provided by the contracted company and due to the lack of payment to the company the facility had no documentation of the revised policy. Interview with the Infection Preventionist (RN #4) on 9/17/25 at 1:37 PM identified she could not recall being a part of a water management meeting as the facility had not received the water sampling testing result. Although a request was made on 9/22/25 for the safety meeting minutes or any water management meeting minutes conducted from January 2024 through September 2025, the facility failed to provide such documentation and had only provided the water management committee meeting dated 7/10/24. Interview with the Administrator (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	on 9/22/25 at 10:43 AM identified water management committee consisted of the infection control nurse, DNS, Director of Maintenance and Administrator, and they would conduct a meeting to review the water sampling results and to discuss the water management plan. She further identified the facility would receive the results of the water sampling testing when the bill was made to the contracted company, however they had not received the results or the updated plan due to lack of payment. She identified the water sampling testing would be done twice yearly according to the Assistant Director of Maintenance. Review of the Annual Water Management Plan Revision and Updates dated 1/29/24 that was provided to the facility by the contracted company identified the facility has identified team members to become a part of the water committee and meet annually. The water committee shall meet and review the water management plan, record topics discussed, and record meeting minutes with signatures of attendees, which meeting minutes are conducted by the facility.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, review of facility documentation, review of facility policy/procedures and interviews for 3 of 3 sampled residents (Residents #1, 58 and 110) reviewed for advance directives, the facility failed to ensure the resident's choice for code status was honored. The findings include: 1. Resident #1 was admitted to the facility [DATE]. Diagnosis included dementia with agitation, Type II diabetes mellitus with hyperglycemia and difficulty in walking.The admission MDS dated [DATE] identified Resident #1 had severely impaired cognitive skills for daily decision making.Review of the Facility Advance Directives Declaration Code Status form dated [DATE] identified Resident #1 was a Do Not Resuscitate (DNR) and Do Not Intubate (DNI) as received by Resident #1's daughter by phone. The bottom of the form notes the physician must write an order and a progress note in the resident's chart.Physician's order dated [DATE] directed full code status (perform CPR if Resident #1's heart stopped).Physician's progress note dated [DATE] at 4:45 PM identified Resident #1's code status was DNR: RN may pronounce.The care plan dated [DATE] identified Resident #1 had an established advance directive of Full code/CPR.APRN progress note dated [DATE] at 1:15 PM identified Resident #1's code status as full code/CPR.Interview on [DATE] at 11:40 AM with RN #6 identified she works at the facility per diem and indicated the code status is listed on the bed board printout the nurses utilize during the shift and indicated Resident #1 was identified as a full code in both the EHR and on the bed board. RN #6 indicated the paper chart should also be checked to verify the code status.Interview [DATE] at 11:45 AM with RN #7, nursing supervisor, identified that the elected advance directive in Resident #1's paper chart was a DNR/DNI but indicated the code status listed in the EHR and on the bed board was full code and identified it needed to be corrected. RN#7 identified the responsibility for adding the order or updating the care plan was that of the DNS or ADNS. Interview on [DATE] at 12:48 PM with the DNS identified the advance directives are obtained by the admission nurse initially at the time the residents come into the facility or when the forms are signed by family representatives. The DNS indicated that the nurse who received the information regarding code status should the information in the computer as orders and add them to the care plan. The DNS identified this is normally done by the nurse, admits the resident and is usually the nursing supervisor.Interview on [DATE] at 1:14 PM with the DNS identified the admission nurse is responsible for getting the signatures on admission and the RN supervisors are responsible to follow up with obtaining the signatures within 2 days but indicated sometimes it takes longer. The DNS reviewed Resident #1's clinical chart and identified Resident #1 should be a DNR but that it was ordered in the computer as CPR and indicated that it had to be changed. Subsequent to surveyor inquiry physician's order dated [DATE] directed Resident #1's code status as DNR and RN may pronounce.Subsequent to surveyor inquiry the care plan was revised on [DATE] to reflect Resident #1's code status choice of Do not resuscitate, RN may pronounce.The facility policy for Advance Directives identified the admissions coordinator will discuss with the resident and/or responsible party whether or not they have executed any form of advanced directive and will obtain a copy to be placed in the resident's medical record and will document the existence of the advance directive on the MDS sheet and on the advance directive checklist. The policy indicated that the advance directive status of each resident will be reviewed at their resident care conference 2. Resident #58 was admitted to the facility in [DATE]. Diagnosis included adjustment disorder with anxiety, chronic embolism and depression. Review of the Facility Advance Directives Declaration Code Status form signed [DATE] by the power of attorney elected do not resuscitate (DNR) and do not intubate (DNI).The interdisciplinary care plan meeting form dated [DATE] did not address advance directive status. APRN progress note dated [DATE] at 1:45 PM identified Resident #58's code status was full code/CPR.The quarterly MDS dated [DATE] identified Resident #58 had intact (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cognition.The care plan dated [DATE], first initiated [DATE] identified Resident #58 had an established advance directive of CPR with interventions to administer CPR and review advance directives with resident and/or healthcare decision maker quarterly.The interdisciplinary care plan meeting form dated [DATE] identified Resident #58's code status was discussed as being a full code/CPR.Physician's order dated [DATE] directed a code status of full code/CPR. APRN progress note dated [DATE] at 3:45 PM identified Resident #58's code status was full code CPR. Interview on [DATE] at 11:40 AM with RN #6 identified the code status is listed on the bed board printout the nurses utilize during the shift and indicated Resident #58 was identified as a full code in both the EHR and on the bed board. RN #6 indicated the paper chart should also be checked to verify the code statusInterview [DATE] at 11:45 AM with RN #7, nursing supervisor, identified that the elected advance directive in Resident #58's paper chart was a DNR/DNI but indicated the code status listed in the EHR and on the bed board was full code and identified it needed to be corrected. RN #7 identified the responsibility for adding the order or updating the care plan was that of the DNS or ADNS. Interview on [DATE] at 12:48 PM with the DNS identified the advance directives are obtained by the admission nurse initially at the time the residents come into the facility or when the forms are signed by family representatives. The DNS indicated that the nurse who received the information should put it in the computer as orders and add them to the care plan. The DNS identified this is normally done by who admits the resident and is usually the nursing supervisor.Interview on [DATE] at 1:14 PM with the DNS identified the admission nurse is supposed to get the signatures on admission and the RN supervisors are supposed to follow up with obtaining the signatures within 2 days but indicated sometimes it takes longer. The DNS reviewed Resident #58's clinical chart and identified Resident #58 should be a DNR but that it was ordered in the computer as CPR and indicated that it had to be changed. Interview on [DATE] at 9:34 AM with Person #3 identified that she had selected DNR for Resident #58 and indicated that she had signed paperwork for the facility quite a while ago, at the time Resident #58 was admitted to the facility.The facility policy for Advance Directives identified the admissions coordinator will discuss with the resident and/or responsible party whether or not they have executed any form of advanced directive and will obtain a copy to be placed in the resident's medical record and will document the existence of the advance directive on the MDS sheet and on the advance directive checklist. The policy indicated that the advance directive status of each resident will be reviewed at their resident care conferenceSubsequent to surveyor inquiry a physician's order dated [DATE] directed a code status of DNR and RN may pronounce.Subsequent to surveyor inquiry the care plan was revised on [DATE] to identify Resident #58 had an established advance directive with interventions to not administer CPR and that RN may pronounce. 3. Resident #110 was admitted to the facility [DATE] with diagnosis that included unspecified dementia, alcohol dependence with alcohol-induced persisting dementia, unspecified mood disorder and urinary tract infection. Review of the Facility Advance Directives Declaration Code Status form dated [DATE] identified Resident #110 did not want resuscitation efforts performed and elected code status was DNR. This form was signed by Resident #110 and witnessed by a nursing supervisor.Resident #110 had a hospital stay and was re-admitted to the facility [DATE].Physician's orders dated [DATE] directed a code status of full code/CPR.The admission MDS dated [DATE] identified Resident #110 had intact cognition.The care plan dated [DATE] identified Resident #110 had an established advance directive with interventions to perform CPR. Interview on [DATE] at 11:40 AM with RN #6 identified the code status is listed on the bed board printout the nurses utilize during the shift and indicated Resident #110 was identified as a full code in both the EHR and on the bed board. RN #6 indicated the paper chart should also be checked to verify the code status.Interview [DATE] at 11:45 AM with RN #7, nursing supervisor, identified that the elected advance directive in Resident #110's paper chart was a DNR/DNI but indicated the code status listed in the EHR and on the bed board was full code and identified it needed to be corrected. RN #7 identified the responsibility for adding the order or updating the care plan was that of the DNS or ADNS. Interview on [DATE] at 12:48 PM with the DNS identified the advance (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	directives are obtained by the admission nurse initially at the time the residents come into the facility or when the forms are signed by family representatives. The DNS indicated that the nurse who received the information should put it in the computer as orders and add them to the care plan. The DNS identified this is normally done by who admits the resident and is usually the nursing supervisor.Interview on [DATE] at 1:14 PM with the DNS identified the admission nurse is supposed to get the signatures on admission and the RN supervisors are supposed to follow up with obtaining the signatures within 2 days but indicated sometimes it takes longer. The DNS reviewed Resident #110's clinical chart and identified Resident #110 should be a DNR based on the previously signed advance directive, but that this should have been reviewed at the subsequent admission to the facility. The DNS identified the code status was ordered in the computer as CPR and indicated that it should have been followed up with Resident #110 and had to be changed. The facility policy for Advance Directives identified the admissions coordinator will discuss with the resident and/or responsible party whether or not they have executed any form of advanced directive and will obtain a copy to be placed in the resident's medical record and will document the existence of the advance directive on the MDS sheet and on the advance directive checklist. The policy indicated the advance directive status of each resident will be reviewed at their resident care conference.Subsequent to surveyor inquiry an advance directives declaration code status form dated [DATE] was signed by Resident #110 and signed by the physician Subsequent to surveyor inquiry physician's orders dated [DATE] directed a code status of DNR/DNI and RN may pronounce. Subsequent to surveyor inquiry on [DATE], the care plan was revised to identify Resident #110 had an established advance directive that identified do not resuscitate and RN may pronounce and indicated the advance directives would be reviewed with resident and/or healthcare decision maker quarterly.

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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 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, review of facility policy and, interviews for three sampled residents residing on the first floor secure unit (Residents #58, #96 and #10) and for four sampled residents residing on the second floor (Residents #5, #7, #64, and #89) reviewed for involuntary seclusion, the facility failed to ensure the secured unit had established criteria for placement on the secured unit, failed to ensure the resident representative and/or resident was involved in the decision for placement on the secured/locked area, failed to ensure the resident's clinical record contained documentation of the clinical criteria met for placement, failed to indicate that the secured unit was the least restrictive setting, failed to include ongoing assessments of the continued appropriateness of the placement and failed to ensure that residents and visitors had access to the code for independent egress from the unit. The findings include: Observations on all days of the survey (9/15/25, 9/16/25, 9/17/25, 9/18/25, and 9/22/25) identified the nursing unit located on the first floor, which could be accessed from two doors off the main corridor. Once on the unit, a numeric code was required to be entered into a keypad located on the wall by the doors. The doors to the stairwells on the unit also require a code to access the doors. The unit consisted of an East Wing hallway and a South Wing hallway. The unit resident capacity is 39 and the census was 37. The facility assessment dated [DATE] identified the facility had 127 licensed beds consisting of 3 nursing units: a 37-bed dementia unit, a 30-bed subacute short-term care unit and a 60-bed long-term care unit. The assessment did not identify the existence of a locked unit. 1. A review of the resident roster for the secured dementia unit identified Resident #58 resided on the unit. Resident #58 was admitted to the facility in May 2025. Diagnosis included adjustment disorder with anxiety, chronic embolism and depression. The admission assessment dated [DATE] identified Resident #58 was well adjusted, cheerful, cooperative, and alert and oriented to person, place and time, able to ambulate independently, did not express a desire to leave the facility, did not have a history of wandering within the past six months and was not at risk for wandering or elopement. Social Work progress note dated 6/19/25 at 6:18 PM identified the social worker met with the family of Resident #58 who voice concerns regarding Resident #58 not coming out of the resident room to socialize. Social work note indicated that this was an adjustment to placement period which can take months before feeling comfortable in this environment and offered supportive listening. The note failed to identify the placement was on a secured unit. The quarterly MDS assessment dated [DATE] identified Resident #58 had intact cognition, required supervision with walking and ambulated with the use of a walker, and did not exhibit rejection of care or wandering. The care plan dated 8/27/25 (initiated 5/6/25) identified Resident #58 was a new admission to the memory care unit with interventions that included social work to offer opportunities for supportive listening, rapport building of friendship and trust. The care plan did not identify that the resident resided on a secure unit. (continued on next page)

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with Resident #58 on 9/15/25 at 1:53 PM identified he/she felt that his/her family and the facility had taken everything and left him/her with nothing to do and nowhere to go. Resident #58 further noted that he/she felt stuck in his/her room. Interview with the DNS on 9/16/25 at 10:44 AM identified that placement on the dementia unit required a diagnosis of dementia. The DNS identified there was not a policy or criteria for the secured unit. She noted that she had reached out to corporate yesterday (9/15/25) and they sent the policy for the dementia unit coordinator. Interview with the Director of Recreation (the previous dementia unit coordinator), and the current Dementia Unit Coordinator on 9/16/25 at 2:08 PM identified the coordinator is consulted regarding placement on the secured unit and that the IDT talks about resident placement in morning report. The Dementia Unit Coordinator indicated that she had received the dementia care unit disclosure yesterday from corporate and the Director of Recreation had not been aware of the disclosure prior to yesterday. Both staff members identified that all residents placed on that unit had to have a diagnosis of dementia. Observation on 9/17/25 at 8:04 AM identified Resident #58 sitting in a recliner and eating breakfast intermittently looking out of the window. Interview on 9/18/25 at 9:34 AM with Person #3 (Resident #58's conservator) identified the facility recommended Resident #58 be placed on the secured unit because the upstairs nursing units were [NAME]. Person #3 identified that when Resident #58 was admitted to the facility the open bed was on the locked unit and that's where Resident #58 was placed. Person #3 further indicated that although the family requested to have Resident #58 moved to another unit because of the lack of residents that he/she would be able to interact with, Person#3 indicated he/she was told by the facility that it was the safest place because the other parts of the building were wild. He/she noted that he had not signed a consent#3 identified Resident #58 stays in his/her room and noted he/she has brought this to the attention of the facility but was told it was normal. Additionally, Person #3 identified that prior to being in the nursing home, Resident #58 lived independently and participated in silver singles. Interview with the Social Work Director on 9/22/25 at 11:11 AM identified Resident #58's placement on the unit is okay because of the diagnosis of dementia. The Social Work Director identified that she was unaware of set criteria used for placement on the secured unit other than the diagnosis of dementia or a neurocognitive disorder. The Social Work Director identified that the placement is discussed with the interdisciplinary team at risk and morning meetings and indicated she did not know where the discussion of placement was documented. She further noted that she had never developed a care plan for residents residing on the secured unit. Interview with the Medical Director on 9/22/25 at 12:42 PM identified that the secured unit was necessary for the health and safety of the residents but indicated he does not document anything regarding the placement on the secured units. The Medical Director indicated that it is clear who needs to be on the secured unit and although it may be discussed, it is not documented in the clinical record. He further noted with the multiple nursing homes he attends residents; he would not be able to identify why a particular resident was on a secured unit. Additionally, he noted that he would continue to place residents on the secured unit because he did not want to be on the news because a resident wandered across the street and drowned or was killed by a car. (continued on next page)

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident #96 was admitted in April 2025 with diagnoses that included vascular dementia with other behavioral disturbances, depression, insomnia and anxiety disorder. The admission MDS assessment dated [DATE] identified Resident #96 had intact cognition, did not exhibit rejection of care or wandering, and was dependent for chair to bed transfers. The care plan dated 5/16/25 identified Resident #96 required assistance with ADLs with interventions that included assistance of 1 staff as resident will allow. The care plan further identified Resident #96 was taking anti-anxiety and antipsychotic medications with interventions to administer medications as ordered and monitor Resident #96 for safety and adverse effects of medications. The care plan failed to identify placement on a secured unit and failed to identify any behaviors. The social work progress note dated 6/9/25 at 4:26 PM identified Resident #96's family was notified that the competency evaluation indicated Resident #96 lacked the capacity to weigh risks and benefits of decision making. The note further identified that the social worker spoke with the resident's family regarding moving resident #96 to the secured unit and the family was agreeable but requested not to tell Resident #96 that the move was for dementia. Observation on 9/18/25 at 1:00 PM identified Resident #96 exiting his/her room and shutting the door. Resident #96 walked down the hallway toward the nurses' station but suddenly turned around and moved quickly toward another resident sitting in a chair at the end of the hallway. Resident #96 aggressively approached the other resident and grabbed the rolling walker throwing it across the hallway and threatened to kill the other resident. Resident #96 had to be removed from the area and was placed on one-to-one observation. Interview with the DNS on 9/16/25 at 10:44 AM identified that placement on the dementia unit required a diagnosis of dementia. The DNS identified there was not a policy or criteria for the secured unit. She noted that she had reached out to corporate yesterday (9/15/25) and they sent the policy for the dementia unit coordinator. A request for the criteria for placement on the secured unit was made on (9/15/25 at 1:00 PM), and none was provided as of (9/22/25 at 3:00 PM). Interview with the Director of Recreation (the previous dementia unit coordinator), and the current Dementia Unit Coordinator on 9/16/25 at 2:08 PM identified the coordinator is consulted regarding placement on the secured unit and that the IDT talks about resident placement in morning report. The Dementia Unit Coordinator indicated that she had received the dementia care unit disclosure yesterday from corporate and the Director of Recreation had not been aware of the disclosure prior to yesterday. Both staff members identified that all residents placed on that unit had to have a diagnosis of dementia. Interview on 9/18/25 at 1:45 PM with the ADNS and DNS identified Resident #96 was placed on 1:1 observation but when Resident #96 observed the second resident again, Resident #96 aggressively went after the resident again and was being sent out to the ER for behaviors. The DNS indicated that Resident #96 had been heard verbalizing that Resident #96 hated old people and talked about hurting them. Additionally, The ADNS and DNS identified Resident #96 did not want to be on the secured unit and was not an appropriate fit for the safety of other residents. (continued on next page)

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 9/22/25 at 10:55 AM with the Social Work Director identified a conservator was assigned to Resident #96 on 9/9/25 and that Resident #96 was placed on the secured unit because of the dementia diagnosis and the results of the cognitive competency assessment that identified Resident #96 lacked capacity to weigh risks and benefits. The Social Work Director acknowledged that Resident #96's family member agreed to the secured unit placement but at the time Interview with the Medical Director on 9/22/25 at 12:42 PM identified that the secured unit was necessary for the health and safety of the residents but indicated he does not document anything regarding the placement on the secured units. The Medical Director indicated that it is clear who needs to be on the secured unit and although it may be discussed, it is not documented in the clinical record. He further noted with the multiple nursing homes he attends residents; he would not be able to identify why a particular resident was on a secured unit. Additionally, he noted that he would continue to place residents on the secured unit because he did not want to be on the news because a resident wandered across the street and drowned or was killed by a car. 3. Resident #110 was admitted to the facility August 2025 with diagnoses that included alcohol dependence with alcohol-induced persisting dementia, and mood disorder. The physician's orders dated 8/28/25 directed to admit to skilled level of care and to approve the current plan of care. Physician's orders directed monitoring of exit seeking/wandering on every shift and to administer Trazodone HCL oral tablet 25 mg by mouth every 8 hours as needed for anxiety and persistent wandering/exit seeking but this order was discontinued on 9/17/25. The APRN progress note dated 8/29/25 at 1:30 PM identified Resident #110 had ended up at the police department after wandering and wanted to confess to some crimes that Resident #100 had committed. Resident #110 was taken to the ER both times with negative findings for infection and positive for some confusion and was admitted at the facility. Nursing progress note dated 8/31/25 at 12:58 PM identified Resident #110 was showing some signs of confusion and deemed an elopement risk The treatment administration record (TAR) dated September 2025 identified Resident #110 was being monitored for auditory or visual hallucinations, delusions and paranoia and indicated that Resident #110 had not exhibited these behaviors for 9/1, 9/2, 9/3, 9/4 (days and eves), 9/5 (eves) 9/6, 9/7 and 9/8/25. These are the only days these behaviors were monitored although the order went through 9/16/25 when it was discontinued. The TAR dated September 2025 identified behavior monitoring for exit seeking and wandering and documentation indicated this behavior was monitored 9/17 (days and evenings) 9/18, 9/19, 9/20 and 9/21 with no behaviors observed. The monitoring was ordered to continue through 9/30/25 but there was no documentation after 9/21/25. The admission MDS dated [DATE] identified Resident #110 had intact cognition, did not exhibit hallucinations or delusions, did not exhibit physical or verbal behavioral symptoms directed towards others or not directed towards others, did not exhibit rejection of care but did exhibit wandering 1 to 3 of 7 days prior to admission, utilized a walker. Nursing progress note dated 9/8/25 at 11:41 PM identified Resident #110 continued to elope off the unit during shift changes and needed to be redirected back to unit. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, review of facility policy and interviews, the facility failed to secure the keys that opened the medication cart and medication room on the dementia unit. The findings include:Observation on 9/18/25 at 2:30 PM identified the DNS handed a set of keys to RN #3. RN #3 accompanied this Nurse Consultant (NC) to the med cart and opened it. After the observation of the medication cart, and narcotic count, RN #3 opened the medication room door with the same set of keys. Once the review/observations were completed, RN #3 was noted to place the keys into a plastic 3 draw bin which was located on top of the nurse's station desk. Interview on 9/18/25 at 2:31 PM with RN #3 indicated that he/she has always placed the keys in that bin since he/she has worked at the facility. Interview on 9/18/25 at 2:57 PM with the DNS indicated the keys for the medication cart/medication room should be kept on the nurse's person for the whole 8-hour shift and then given to the oncoming nurse after report, no exceptions. The DNS identified RN #3 should not have left the keys to the medication cart and medication room in the bin on the nurse's station desk. Review of the Medication Storage Room/Medication Cart policy dated 2/2018, directed the facility provided pharmaceutical services that were conducted in accordance with acceptable ethical and professional standards of practice. Medications are stored primarily in a locked mobile medication cart which is accessible only to licensed nursing personnel. Storage of other medications will be limited to a locked medication room.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation, review of facility documentation, facility policy and interviews, the facility failed to ensure the call bell system was functioning properly. The findings include:Observation on 9/15/25 at 9:45 AM identified the resident call bell system was not functioning on the second floor. There was no audible ring when activating the call bell. The light functioned outside of the resident rooms, however observation at this time identified no staff in the hall to see the light. Bells were located at the bedside of the residents, however not present in the residents' bathrooms. Interview on 9/15/25 at 10:00 AM with several residents identified the call system had not been functioning for a while and they were provided with bells as an alternative, however they did not always have the bells in reach and did not have the bells in the restroom. Review of the resident council meeting minutes from July 2025 identified the call bell system does not have sound. The lights go on, but the bell system is not working. Hand bells had been handed out and in service had been given to staff. Interview on 9/15/25 at 10:35 AM with Assistant Maintenance Director identified the call bell system had been down for several months and they have tried to reset the system however they really need a new call bell system. Call to the repair company on 9/18/24 at 11:02 AM left message requesting phone call back. Interview on 9/18/25 at 12:15PM with the Interim Administrator identified the call bell system has been functioning off and on and a quote for a new system was received 8/22/24, however no one has proceeded to go forward with the new system at the corporate level. She also believes that the company that was coming out to repair it can't make further repairs at this time because they do not make the parts anymore for the system to repair it. The quote for a new call bell system was dated 8/22/24. Interview on 9/18/25 at 1:45 PM with Assistant Maintenance Director and Maintenance Director identified there were no work orders for any work that had been done on the system, however indicated they could contact the company that comes out to do the repairs to see if they can locate any paperwork. The last repair was a reset via phone several months ago. Interview on 9/22/25 at 1:15 PM with Assistant Maintenance director identified he cannot locate any paperwork nor get a phone call back from the repair company. Interview on 9/22/25 at 1:30 PM with Interim Administrator identified she had reached out to the repair company as well and is not receiving a return phone call to get any work orders. Review of the Call light use policy/procedure identified report any defective call lights in the maintenance log. If call light is unable to be repaired immediately provide an alternative communication method.

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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 clinical record review, facility policy review, and interviews for two of three sampled residents (Resident #13 and 126) reviewed for constipation, the facility failed to monitor bowel movements (BM) and administer the facility bowel regimen policy. The findings include: 1. Resident #13 's diagnoses included chronic kidney disease stage 3, hypertension, and venous thrombosis.The physician's order dated 8/29/25 directed to administer Senna 8.6 mg give 2 tablets by mouth at bedtime for constipation, administer Milk of Magnesia (MOM) (laxative) 400mg/5ml give 30ml as needed for constipation if no bowel movement for 3 days (a total of 9 shifts) on the 3-11 shift, give Bisacodyl suppository 10 mg insert 1 suppository rectally during the 11-7 shift as needed for constipation used for second step if MOM not effective, and give fleet enema insert 1 application rectally as needed for constipation during the 7-3 shift if Bisacodyl not effective, and call physician for further order if fleet enema was not effective. The care plan dated 8/29/25 identified Resident #13 required extensive assistance with dressing, grooming, and hygiene. Care plan interventions included: assist resident with bed mobility, hygiene, toilet use and transfers.The admission MDS assessment dated [DATE] identified Resident #13 had moderate cognitive impairment, required extensive assistance for bed mobility, toilet hygiene and transfers. The assessment further identified the resident was continent of bowel and had a foley catheter for urinary drainage.Review of the bowel continence flow sheet from 9/4/25 to 9/15/25 identified Resident #13's bowel movement documentation identified that he/she had a large bowel movement on 9/3/25 during the 7:00 AM - 3:00 PM shift and did not move his/her bowel movement from 9/4/25 to 9/11/25, 24 shifts. Resident #13 had a small bowel movement on 9/12/25 during the 11:00 PM - 7:00 AM shift. Resident #13 did not have a bowel movement from 9/13/25 to 9/15/25 (a total of 11 shifts). The nurse's notes dated 9/15/25 at 6:41 PM identified Resident #13 had nausea and vomited. Resident #13 had hypoactive bowel sounds present, and no abdomen distention was noted. The supervisor and physician were notified and obtain an orders to administer lactulose 20 gm/ml give 30 ml and may administered up to 3 doses with one hour apart, obtain KUB (Kidney, Ureter and Bladder) a diagnostic imaging to view an organ was also ordered.Review of the medication administration record (MAR) identified Resident #13 did not receive any part of the facility bowel regimen from 9/4/25 to 9/15/25. Further review of the record/documentation identified a new order for lactulose 20 gm/ml, 30ml was administered on 9/15/25 after the resident had an episode of nausea and vomiting.Review of KUB x-ray result dated 9/15/25 identified Resident #13 had no bowel obstruction and moderate amount of stool in the colon that compatible with constipation. 2. Resident #126 's diagnoses included low back pain, Parkinson's disease, osteoarthritis, and lack of coordination.The admission MDS assessment dated [DATE] identified Resident #126 had a severe cognitive impairment, required extensive assistance for bed mobility, toilet hygiene and transfers. The assessment further identified the resident was frequently incontinent of bowel and had a foley catheter for urinary drainage.The physician's order dated 8/5/25 directed to administer Senna 8.6 mg give 2 tablets by mouth at bedtime for constipation, Milk of Magnesia (MOM) suspension 400mg/5ml (laxative) give 30ml by mouth as needed for constipation daily used first if no bowel movement, Bisacodyl suppository 10 mg insert 1 suppository rectally as needed for constipation used for second step if MOM was not effective, and fleet enema insert 1 application rectally as needed for constipation administered if Bisacodyl was not effective and call physician for further order if fleet enema was not effective.The care plan dated 8/18/25 identified Resident #126 required extensive assistance with dressing, grooming, and hygiene. Care plan interventions included: assist resident with bed mobility, hygiene, toilet use and transfers.The nurse's progress note dated 8/20/25 at 11:53 AM identified Resident #126 had complaints of constipation and had not moved his/her bowels for 7 days. The note also identified that Resident #126's last bowel movement was on 8/14/25. The APRN was notified of Resident #126's constipation and a new (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physician's order was obtained to administer lactulose 20mg/ml give 30 ml, may administered up to 3 doses with one hour apart.Review of the bowel continence flow sheet from 8/13/25 to 8/20/25 identified Resident #126 did not have a bowel movement for a total of 22 shifts. The last time Resident #126 had a documented bowel movement was on 8/13/25.Review of the medication administration record (MAR) identified Resident #126 did not received any part of the facility bowel regimen from 8/13/25 to 8/20/25. Further review of the record/documentation identified Resident #126 received lactulose 20 gm/ml 30ml on 8/20/25 after the resident complained of constipation.Interview on 9/16/25 at 11:30 AM with LPN #6 (7AM-3PM shift unit manager for cobblestone nursing unit) identified residents who have not have a bowel movement for 3 days would have an alert in the electronic medical record identifying such. She identified that she checked the alert daily and resident's who did not have BM for 3 days would be offered the bowel protocol. She identified that she was aware of Resident #13 and Resident #126 did not have a BM for 3 days and indicated both residents had refused the bowel protocol; however, she could not provide documentation of the refusals. She further identified that she updated the APRN after Resident #13 had nausea and vomiting and Resident #26 had complaint of constipation to obtain new orders from the APRN. Interview on 9/16/25 at 12:55 PM with the DNS identified that the 3PM -11PM shift charge nurse is responsible to check if a resident did not have a bowel movement for 9 shifts. She identified that she would expect the charge nurse to follow the facility bowel protocol policy if any resident's did not have a bowel movement. She also identified the physician's would be notified if the resident refused to accept the bowel protocol to obtain a new order and/or review the resident's bowel regimen and it will be documented in the nursing progress notes. Review of Resident #13 and Resident #126 bowel movement records with the DNS identified that both residents should have received the bowel protocol after 9 shifts without a bowel movement. She identified Resident #13 and Resident #126 required assistance with toileting so nursing staff would be aware if both residents had a bowel movement. She could not identify why nursing staff did not follow the facility bowel protocol because all nursing staffs were trained with the facility bowel protocol.Interview on 9/17/25 at 1:55 PM with LPN #5 (3PM- 11PM shift charge nurse) identified that any resident's who did not have a bowel movement for total 9 shifts will be offered a MOM on her shift. She identified that she would check in the resident record of any residents who did not have a bowel movement for 3 days. Review of Resident #13 and Resident #126 bowel movement with LPN #5, she identified that both residents were residing on the cobblestone unit which is not her typical nursing unit. She identified that she would not have enough time to check every resident's clinical record who did not have a bowel movement. She further identified that she would rely on the previous shift to give her a report of which would require a bowel protocol. She could not remember whether she was aware whether Resident #13 and Resident #126 did not have a bowel movement for 3 days.The Bowel Evacuation Protocol policy identified the facility had the responsibility to ensure that each resident develops regular bowel habits with or without cathartic assistance. The purpose of this policy was to prevent impaction and/or incontinence and promote psychological and social well-being. The policy also identified that resident's who had no bowel movement for 9 consecutive shifts would begin with the bowel protocol on the 3 PM - 11PM shift. The bowel protocol is to give MOM on 3PM - 11PM shift. If MOM not effective, the resident will receive a bisacodyl suppository on 11PM - 7AM shift. If the bisacodyl suppository was not effective, the resident will receive a fleet enema on the 7AM - 3PM shift. The record of the result of bowel protocol will be documented in the MAR and/or nurse's notes and physician will be notified if the bowel protocol was not effective.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, facility documentation, facility policy and interviews for 2 of 2 residents (Resident #23 and 114) reviewed for respiratory care, the facility failed to order BiPAP equipment timely for Resident #23 and failed to follow a physician's order to change the oxygen tubing weekly for Resident #114. The findings include:1. Resident #23's diagnoses included sleep apnea, heart failure and anxiety. A physician's order dated 3/30/22 directed BiPAP on at bedtime with oxygen at 2 - 3 liters per minute. The annual Minimum Data Set assessment dated [DATE] identified Resident #23 was cognitively intact, had sleep apnea and utilized oxygen. The care plan dated 7/9/25 identified Resident #23 used BiPAP with oxygen and the resident would maintain an effective breathing pattern during sleep and have restful sleep. Interventions included to keep BiPAP in the resident's room, monitoring for sleep and any complaints of insomnia or refusal's to wear BiPAP. Interview on 9/15/25 at 11:45 AM with Resident #23 identified, he/she has not had a BIPAP mask for 2 weeks. Several nurses and staff were told masks were needed and none had been ordered. A new nurse, LPN #3 ordered them last week and hopefully they will be in today. Interview on 9/17/25 at 1:52 PM with Resident #23 and LPN #1 indicated LPN #3 ordered the BiPAP masks a week ago and they have not come in. LPN #1 indicated she was not aware that the resident had run out of masks. Usually, the unit secretary or the DNS orders the masks for the BiPAP machines. ^ Observation on 9/18/25 at 11:58 AM with the DNS indicated there were no BiPAP masks in the resident's room. Interview with the DNS at that time identified she was made aware that the resident ran out of masks a couple of days ago. The durable medical equipment (DME) company comes once weekly and they are responsible for ordering BiPAP equipment, including masks. They also do fit testing of the masks. The DNS indicated they were notified that Resident #23 ran out of masks. The resident had refused the current mask because it didn't fit and was leaking. Interview on 9/22/25 at 10:43 AM with LPN #3 indicated she ordered the masks on 9/8/25 and notified the DNS. LPN #3 indicated on 9/15/25 the resident still had not received the masks. LPN #3 indicated the resident had been without a mask at least 2 weeks. The masks came in on 9/19/25. Interview on 9/22/25 at 10:54 AM with the Customer Service Representative #1 for the DME supplier indicated the last delivery of BiPAP equipment was back in June of 2025 and included masks, humidified chamber, tubing and an oxygen adaptor. The Customer Service Representative #1 was unable to see what was ordered in September. Interview on 9/22/25 at 11:18 AM with the Director of Clinical Services of the DME company indicated a message was received on 9/19/25 at 12:01 PM that the resident needed equipment, so the RT went out and a Respiratory Therapist (RT) brought a medium full-face mask and head gear. Interview on 9/22/25 at 12:06 PM with Resident #23 identified he/she was using a mask that was too large and the air escaped from the sides. 2. Resident #114's diagnoses included breast cancer, liver disease and depression. A medical director's note dated 7/1/25 identified Resident #114 had a history of sleep apnea. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #114 was moderately cognitively impaired and utilized oxygen. The care plan dated 8/11/25 identified the resident had an altered respiratory status and or difficulty breathing and used C-PAP and oxygen. Interventions included administering C-PAP, medication and inhalers as ordered and monitoring effectiveness. A physician's order dated 8/13/25 directed to change the oxygen tubing every Sunday on the 11 - 7 shift. Observation on 9/15/25 at 10:30 AM identified Resident #114's oxygen tubing was dated 6/22, over 2.5 months prior. Interview on 9/18/25 at 10:25 AM with LPN #4, the 11-7 nurse, indicated the oxygen tubing is to be changed weekly during the 11-7 shift. LPN #4 was not sure who was responsible to change the oxygen tubing weekly. Review of the CPAP/BiPAP management policy dated 5/2025 instructed to provide and treat sleep apnea or sleep disorders as ordered by the physician. To wash the masks & nasal pillows daily, with mild detergent rinse thoroughly with warm water to remove any residue; air dry. Wash tubing bimonthly with mild detergent or white vinegar (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	solution and allow to air-dry in between uses. When the equipment is not is use the mask will be stored in a bag at the resident bedside. Review of the policy of Care Instructions for BIPAP/CPAP Units, directed when using disposable tubing, (BIPAP circuit-equipment that connects the BIPAP machine to the resident's mask.) change the tubing monthly, also replace the oxygen bleeder-in adaptor (a mechanism that releases a small continuous amount of oxygen) 7-foot oxygen extension tubing also if used.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical record, facility policy, facility documentation, and interviews for one of five sampled residents (Resident #11) reviewed for immunizations, the facility failed to ensure that the pneumococcal vaccine was offered to the resident upon admission. The findings include: Resident #11 was admitted to the facility in May 2024 and had diagnoses of anxiety, dementia, and hypertension. The quarterly MDS assessment dated [DATE] identified Resident #11 had moderately impaired cognition. Review of Resident #11 immunization consents and records identified the resident had received the Prevnar 13 on 06/06/2017 at age [AGE] years of age, and Pneumococcal vaccine (PPV23) on 6/2/2016 at age [AGE] years of age prior to been admitted to the facility. However, the clinical records and consent records failed to identify Resident #11 was offered the pneumococcal vaccine as to complete pneumococcal vaccine series on admission. Review of Resident #11 immunization consents and records with the Infection Preventionist (RN #4) on 9/17/25 at 1:37 PM failed to identify that the pneumococcal vaccine was offered to the resident on admission. Interview with RN #4 on 9/17/25 at 1:37 PM identified she was responsible for ensuring residents are offered the pneumococcal vaccine on admission. RN #4 identified she had not offered Resident #11 the vaccine because she thought the resident had completed the pneumococcal vaccine series. She identified after reviewing the facility policy and the resident pneumococcal immunization records Resident #11 was eligible to receive the pneumococcal vaccine (PCV 20 or PCV 21). She identified based on that information she should have offered the resident the pneumococcal vaccine when admitted to the facility and review the consent with the physician to select the appropriate vaccine for the resident. RN #4 identified she had not discussed the appropriateness of the pneumococcal vaccination for Resident #11 with the provider as she did not think the resident had needed an additional pneumococcal vaccine. Review of the Procedure for Pneumococcal Vaccination of Residents identified each resident, or their responsible party will be asked on admission if they have previously had any pneumococcal vaccinations and their age at the time of vaccination. The policy further identified for a resident over age [AGE] who had received the PCV13 (Prevnar13) and one dose of PPSV23 after age [AGE] (shared clinical decision making) may give one dose of PCV20 or PCV21 at least 5 years after the last pneumococcal vaccine dose after discussion with the provider (MD).

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F 0838 Level of Harm - Potential for minimal harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of facility documentation and interviews, the facility failed to ensure the facility assessment identified that they had secure nursing units and failed to indicate the criteria or policies and procedures related to the secure units. The findings include: Observations on all days of the survey (9/15/25, 9/16/25, 9/17/25, 9/18/25, and 9/22/25) identified the facility had a secured (locked) unit on the first and second floors. Both units require you to enter a code for egress off the unit. Review of the facility assessment dated [DATE] on 9/16/25 at 9:46 AM provided by the DNS identified that the assessment was signed by the Administrator, Medical Director, Director of Nursing, Plant Manager, a direct care staff representative and the resident council president.The facility assessment dated [DATE] identified the facility had 127 licensed beds with three nursing units consisting of a 37-bed dementia unit, a 30-bed subacute short-term care unit and a 60-bed long-term care unit. The facility assessment did not identify that there was a secured/locked on the first floor and failed to note that the second floor was also secured. Interview on 9/22/2025 at 12:30 PM with the former Administrator (Administrator #2 who was the interim administrator from September of 2024 through March of 2025) identified she had completed the facility assessment. She did not provide a reason why the assessment did not address the secured units. Further, she identified that the assessment should be updated with any changes in the facility that occur and noted that keeping the assessment updated is the responsibility of the Administrator.

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for 3 sampled residents (Resident #5, 9 and 128) reviewed for hospitalization and had multiple hospitalizations, the facility failed to ensure the resident and/or resident representative were provided with written information regarding the bed hold policy at the time the resident was sent to the hospital. The findings include:1. Resident #5's diagnoses included congestive heart failure, atrial fibrillation, and chronic obstructive pulmonary disease. The quarterly MDS assessment dated [DATE] identified Resident #5 was cognitively intact. Review of the clinical record failed to reflect that written notice, which specifies the duration of the bed-hold policy, had been provided to the resident and/or the resident representative when the resident was transferred to the hospital on 7/6/25, 8/31/25 and 9/2/25. Interview with the DNS on 9/16/25 at 2:43 PM identified a copy of the bed hold policy should be provided to a resident at time of transfer to the hospital and copy should remain in the chart which is to be mailed to the resident/resident representative. She identified a copy of the bed hold policy and transfer should be attached to the paperwork being sent to the hospital with the resident. She identified it was the responsibility of the Director of Social Services to provide the bed hold policy at the time of transfer and not the supervisor's responsibility. When asked for a copy of the bed hold notice provided to Resident #5 at the time of transfer to the hospital on 9/2/25, the DNS identified the DNS identified they were not completed. Interview with the current Director of Social Services on 9/16/25 at 12:50 PM identified the social worker is responsible for providing a copy of the bed hold policy and notification to the residents/resident representative. She identified the transfer notice and bed hold policy would be sent to the hospital with the resident and a copy would be mailed to the resident responsible party the next day. She indicated that she had only started working back at the facility approximately three weeks ago, but previous practice was for the Director of Social Services to provide a copy of the bed hold policy to residents and/the resident representative. Interview on 9/17/24 at 12:14PM with RN #5 identified as a supervisor she does not provide the bed hold policy to the resident when they are getting sent to the hospital, nor was she informed that she needed to do so. Interview on 9/17/24 at 1:45 PM with previous SW Director identified she worked for the facility July 2024 to August 2025. At this time the nursing supervisor was responsible for providing the resident with the bed hold policy when transferred to an acute care hospital. She was not sending the notice/policy and was not aware that it was her role. Review of the Emergency Transfers to Acute Care Hospitals and Psychiatric Hospitals policy identified acute care hospitalization the notice of immediate emergency transfer to a hospital must be completed and sent with the resident, a copy must also be sent to the resident's responsible party , the facility's policy for the reservation of bed: notification to residents must also accompany the notice sent to the resident and their responsible party and both notices that are sent with the resident upon transfer and should be stapled to the W/10/Interagency transfer form. (continued on next page)

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of the Notice Regarding Reservation of the Residents Bed if the Resident is hospitalized identified the facility will for a Medicaid - assisted resident, the facility will reserve the bed for up to 7 days if the facility has not received information that the resident is not expected to return to the facility. The facility reserves the bed for up to an additional 8 days if the facility has not received information that the resident is not expected back to the facility. If a Medicaid -assisted resident wishes to reserve the bed during a period of hospitalization for any other or longer period, the bed will be reserved if payment is made by the resident or resident representative at the facilities usual Medicaid per diem rate. The facility will reserve the bed of a private-pay resident who has been transferred to a hospital as long as payment at the usual self-pay per diem rate is available to reserve the bed. 2. Resident #9 was admitted to the facility in February 2024 and had diagnoses that included transient cerebral ischemic attack, dementia, and heart failure. The significant change MDS assessment dated [DATE] identified Resident #9 had severely impaired cognition. a. The nurse's note dated 7/6/25 at 10:56 AM identified Resident #9 fell out of the wheelchair and observed with a laceration and bleeding to the head. The APRN was notified, and Resident #9 was sent to the hospital evaluation. b. The nurse's note dated 8/31/25 at 11:05 AM identified Resident #9 had facial droop, drooling and was unresponsive. Subsequent to APRN notification, Resident #9 was sent to the hospital. Review of the clinical record failed to reflect that written notice, which specifies the duration of the bed-hold policy, had been provided to the resident and/or the resident representative when the resident was transferred to the hospital on 7/6/25 or 8/31/25. Interview with the DNS on 9/16/25 at 2:43 PM identified a copy of the bed hold policy should be provided to a resident at time of transfer to the hospital and copy should remain in the chart which is to be mailed to the resident/resident representative. The DNS identified a copy of the bed hold policy and transfer should be attached to the paperwork being sent to the hospital with the resident. The DNS identified it was the responsibility of the Director of Social Services to provide the bed hold policy at the time of transfer and not the supervisor's responsibility. When asked for a copy of the bed hold notice provided to Resident #9 at the time of transfer to the hospital on 7/6/25 and 8/31/25, the DNS identified they were not completed. 3. Resident #128 was admitted to the facility in January 2022 and had diagnoses that included type 2 diabetes mellitus, anemia, and hypothyroidism. The quarterly MDS assessment dated [DATE] identified Resident #128 had severely impaired cognition. The nurse's note dated 8/23/25 at 5:41 PM identified Resident #128 was unresponsive to voice, responded to minimal pressure with sternal rub, and was unable to voice how he/she was feeling. Subsequently, Resident #128 was transferred to the hospital. The nurse's note dated 8/24/25 at 12:58 PM identified Resident #128 returned from the hospital approximately at 12:30 PM. The note further identified Emergency Medical Technician was concerned (continued on next page)

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	and advised the nurse they did not feel comfortable bringing the resident back to facility as the resident continued to be unresponsive/lethargic arousable to sternal rub. The note indicated that the resident representative would like the resident to be sent back to the emergency room for an entire work-up and resident was sent with paperwork. Review of the clinical record failed to reflect that written notice, which specifies the duration of the bed-hold policy, had been provided to the resident and/or the resident representative when the resident was transferred to the hospital on 8/23/25 or 8/24/25. Interview with the Director of Social Services on 9/16/25 at 12:50 PM identified the social worker responsible for providing a copy of the bed hold policy and notification to the residents/resident representative. The Director of Social Services identified the transfer notice and bed hold policy would be sent to the hospital with the resident and a copy would be mailed to the resident responsible party on the next day of the transfer. The Director of Social Services indicated that she had only started working back at the facility approximately three weeks now, but previous practice was for the Director of Social Services to provide a copy of the bed hold policy and transfer to residents and/the resident representative. Interview with the DNS on 9/16/25 at 2:43 PM identified a copy of the bed hold policy should be provided to a resident at time of transfer to the hospital and copy should remain in the chart which is to be mailed to the resident/resident representative. The DNS identified a copy of the bed hold policy and transfer should be attached to the paperwork being sent to the hospital with the resident. The DNS identified it was the responsibility of the Director of Social Services to provide the bed hold policy at the time of transfer and not the supervisor's responsibility. When asked for a copy of the bed hold notice provided to Resident #128 at the time of transfer to the hospital on 8/23/25 and 8/24/25, the DNS identified they were not completed. Review of the Emergency Transfers to Acute Care Hospitals and Psychiatric Hospitals policy identified acute care hospitalization the notice of immediate emergency transfer to a hospital must be completed and sent with the resident, a copy must also be sent to the resident's responsible party , the facility's policy for the reservation of bed: notification to residents must also accompany the notice sent to the resident and their responsible party and both notices that are sent with the resident upon transfer and should be stapled to the W/10/Interagency transfer form. Review of the Notice Regarding Reservation of the Residents Bed if the Resident is hospitalized identified the facility will for a Medicaid - assisted resident, the facility will reserve the bed for up to 7 days if the facility has not received information that the resident is not expected to return to the facility. The facility reserves the bed for up to an additional 8 days if the facility has not received information that the resident is not expected back to the facility. If a Medicaid -assisted resident wishes to reserve the bed during a period of hospitalization for any other or longer period, the bed will be reserved if payment is made by the resident or resident representative at the facilities usual Medicaid per diem rate. The facility will reserve the bed of a private-pay resident who has been transferred to a hospital as long as payment at the usual self-pay per diem rate is available to reserve the bed.

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	12/03/2025

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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, review of facility policy/procedures and interviews for 3 of 5 sampled residents (Residents #5,6,99) reviewed for Preadmission Screening and Resident Review (PASRR), the facility failed to ensure the MDS accurately reflected the residents' status. The findings include: 1. Resident #5's diagnoses included schizoaffective disorder, vascular dementia, bipolar disorder.The PASRR assessment dated [DATE] identified Resident #5 was determined to have diagnoses that qualified him/her to have a positive level II PASRR. The annual MDS assessment dated [DATE] identified Resident #5 was cognitively intact and did not display behaviors. The assessment further reflected that the resident did not have a positive level 2 PASRR. The assessment failed to reflect the resident's accurate status. 2. Resident #6's diagnoses included bipolar disorder, anxiety disorder, and depression. The PASRR level II screening dated 9/17/19 identified Resident #6 was determined to have diagnoses that qualified him/her to have a positive level II PASRR. The annual MDS assessment dated [DATE] identified Resident #6 was cognitively intact and had no behaviors. The assessment further reflected that the resident did not have a positive level 2 PASRR. The assessment failed to reflect the resident's accurate status. 3. Resident #99's diagnoses included schizoaffective disorder depressive type, generalized anxiety disorder, and major depressive disorder. The PASRR level II screening dated 1/17/20 identified Resident #99 was determined to have diagnoses that qualified him/her to have a positive level II PASRR. The annual MDS assessment dated [DATE] identified Resident #99 had intact cognition, and no behaviors The assessment further reflected that the resident did not have a positive level 2 PASRR. The assessment failed to reflect the resident's accurate status. Interview with the Social Worker (SW#2) on 9/18/25 at 12:20 PM identified that he was responsible for completing the section of the MDS that addressed PASRR level 2 status. He noted that when making the determination of status, he checks the medical record and looks for the level 2 PASRR assessment. SW #2 further identified that he had not completed the MDS assessments for the residents in question, it was the former social worker. He noted that the MDS assessments should reflect that Residents #5, #6 and #99 have positive level 2 PASRR assessments. The Resident Assessment Instrument (RAI) manual provides guidance on how to complete the MDS assessment. And it notes that a positive PASRR screen indicates the resident has a mental illness, intellectual disability, or a related condition and should be coded in section A1500 as yes.