STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075350	A. Building B. Wing	03/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Civita Sheriden Woods	321 Stonecrest Drive Bristol, CT 06010

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, review of facility documentation, review of facility policy/procedures and interviews for one sampled resident (Resident #114) reviewed for mistreatment, the facility failed to ensure the resident was free from mistreatment. The findings include: Resident #114's diagnoses included neurocognitive disorder with Lewy bodies dementia, major depressive disorder, and mood disorder.The quarterly MDS assessment dated [DATE] identified Resident #114 was moderately cognitively impaired, had no behaviors, required limited assistance for bed mobility, transfers, dressing, and personal hygiene. The assessment further identified the resident utilized a wheelchair for mobility. The care plan dated 10/3/25 identified Resident #114 was at risk for refusing care and not waiting for assistance with transfers related to behavior problems with interventions that included assistance of two staff for care and transfers, introduce self to resident, explain what you are going to do, use calm, gentle, approach, and work slowly. A late entry nurse's note from the DNS dated 11/3/25 at 8:30AM identified Resident #114 was alleged to have been slapped on his/her left arm by a NA while providing care. The NA was removed from the schedule upon receiving report of the allegation and a body audit was performed and no injuries were noted. The Accident and Investigation report dated 11/3/25 identified statements from NA #1, #2, and #3 pertaining to the allegation of physical abuse. NA#3's statement identified that on Friday 10/31/25 at about 8:30PM, NA#3, NA#2, and NA#1 went into Resident #114's room to provide care. Resident #114 did not want to get changed and was combative swinging his/her arms and feet. NA#3 held Resident #114's arms so NA#2 could change his/her brief. NA#1 assisted in holding the resident's arms and slapped Resident #114 hard on the arm and used an expletive (F word). NA#3 identified she should have reported it on Friday when it happened. NA#2's statement identified she was providing incontinent care while NA#3 held Resident #114's left hand because he/she was agitated and cursing. NA#1 slapped Resident #114 with her hand she and NA#3 told NA#1 to calm down since they were more familiar with Resident #114. Resident #114 was on NA#3's assignment. The statement further identified that she did not report the incident because she thought NA #3 would report it because Resident #114 was on her assignment. NA#1's statement identified she was helping with Resident #114's care. She noted that the resident started fighting and she grabbed his/her hand twice to stop the resident from hitting NA #3. She further noted that she kept grabbing Resident #114's hands until the brief was changed. The statement noted that the resident continued to resist by kicking and slapping NA #3. Once the change occurred, she noted they all left the room. The Nursing Supervisor's (RN #7) note dated 11/3/25 identified that on 11/2/25 toward the end of the 3pm to 11pm shift, NA #3 reported that NA #1 slapped Resident #114 during the provision of care. The note further noted that NA #2 confirmed what NA #3 had reported. She further noted that the incident had occurred on 10/31/25 and there were no noted signs or symptoms of injury. The Social Worker's progress note dated 11/3/25 identified Resident #114 was in bed and reported he/she had a good weekend. The Social worker asked Resident #114 if he/she had any concerns or complaints related to care he/she had received over the last few days and Resident #114 reported no concerns. The social worker asked the resident if there were any staff members that had (continued on next page)

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

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	been treating him/her differently than usual or if care had not been done well, Resident #114 did not recall the reported event. The skin audit dated 11/3/25 by completed by RN#1 identified no new skin impairments.RN #1's nursing note dated 11/7/25 identified that the allegation of abuse was substantiated because it was witnessed by two staff members. Interview with NA #2 on 2/23/26 at 12:36 PM identified that during the provision of incontinent care to Resident #114, the resident was combative and refusing care. She acknowledged that she was aware that Resident #114 had the right to refuse care, but his/her brief and sheet were soaked with urine and felt it was to the resident's benefit to be cleaned up. She further identified that she witnessed NA #2 slap the resident's arm several times. Additionally, she noted that she had not reported the incident because she thought NA #3 was going to report it, although they had not discussed the reporting of the incident. She further noted that she was put on leave following the reporting of the incident and subsequently fired. Interview with the DNS on 2/27/26 at 9:14AM identified she was notified of the allegation of abuse on 11/3/25 via text message from RN #7. The DNS identified she immediately started the investigation. NA#1, NA#2 and NA#3 worked on 11/1/25, and 11/2/25 in the facility due to the fact the allegation had not been reported. Statements were obtained from NA#1, NA#2, and NA#3, who were subsequently terminated. RN#7 was given a final written counseling regarding the incident and remains employed at the facility. The facility reported the incident to the police and to the state survey agency. Review of the facility policy directed to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, and exploitation and misappropriation of resident property. An immediate investigation is warranted when suspicion of abuse, neglect, or exploitation or reports of abuse, neglect or exploitation occur.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, review of facility documentation, review of facility policy/procedures and interviews for one sampled resident (Resident #114) reviewed for abuse, the facility failed to ensure the allegation of abuse was reported to the state survey agency in a timely manner. The findings include: Resident #114's diagnoses included neurocognitive disorder with Lewy bodies dementia, major depressive disorder, and mood disorder.The quarterly MDS assessment dated [DATE] identified Resident #114 was moderately cognitively impaired, had no behaviors, required limited assistance for bed mobility, transfers, dressing, and personal hygiene. The assessment further identified the resident utilized a wheelchair for mobility. The care plan dated 10/3/25 identified Resident #114 was at risk for refusing care and not waiting for assistance with transfers related to behavior problems with interventions that included assistance of two staff for care and transfers, introduce self to resident, explain what you are going to do, use calm, gentle, approach, and work slowly. A late entry nurse's note from the DNS dated 11/3/25 at 8:30AM identified Resident #114 was alleged to have been slapped on his/her left arm by a NA while providing care. The NA was removed from the schedule upon receiving report of the allegation and a body audit was performed and no injuries were noted. The Accident and Investigation report dated 11/3/25 identified statements from NA #1, #2, and #3 pertaining to the allegation of physical abuse. NA#3's statement identified that on Friday 10/31/25 at about 8:30PM, NA#3, NA#2, and NA#1 went into Resident #114's room to provide care. Resident #114 did not want to get changed and was combative swinging his/her arms and feet. NA#3 held Resident #114's arms so NA#2 could change his/her brief. NA#1 assisted in holding the resident's arms and slapped Resident #114 hard on the arm and used an expletive (F word). NA#3 identified she should have reported it on Friday when it happened. NA#2's statement identified she was providing incontinent care while NA#3 held Resident #114's left hand because he/she was agitated and cursing. NA#1 slapped Resident #114 with her hand she and NA#3 told NA#1 to calm down since they were more familiar with Resident #114. Resident #114 was on NA#3's assignment. The statement further identified that she did not report the incident because she thought NA #3 would report it because Resident #114 was on her assignment. NA#1's statement identified she was helping with Resident #114's care. She noted that the resident started fighting and she grabbed his/her hand twice to stop the resident from hitting NA #3. She further noted that she kept grabbing Resident #114's hands until the brief was changed. The statement noted that the resident continued to resist by kicking and slapping NA #3. Once the change occurred, she noted they all left the room. The Nursing Supervisor's (RN #7) note dated 11/3/25 identified that on 11/2/25 toward the end of the 3pm to 11pm shift, NA #3 reported that NA #1 slapped Resident #114 during the provision of care. The note further noted that NA #2 confirmed what NA #3 had reported. She further noted that the incident had occurred on 10/31/25 and there were no noted signs or symptoms of injury. The Social Worker's progress note dated 11/3/25 identified Resident #114 was in bed and reported he/she had a good weekend. The Social worker asked Resident #114 if he/she had any concerns or complaints related to care he/she had received over the last few days and Resident #114 reported no concerns. The social worker asked the resident if there were any staff members that had been treating him/her differently than usual or if care had not been done well, Resident #114 did not recall the reported event. The skin audit dated 11/3/25 by completed by RN#1 identified no new skin impairments.RN #1's nursing note dated 11/7/25 identified that the allegation of abuse was substantiated because it was witnessed by two staff members. Interview with NA #2 on 2/23/26 at 12:36 PM identified that during the provision of incontinent care to Resident #114, the resident was combative and refusing care. She acknowledged that she was aware that Resident #114 had the right to refuse care, but his/her brief and sheet were soaked with urine and felt it was to the resident's benefit to be cleaned up. She (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	further identified that she witnessed NA #2 slap the resident's arm several times. Additionally, she noted that she had not reported the incident because she thought NA #3 was going to report it, although they had not discussed the reporting of the incident. She noted that she should have reported the incident at the time she witnessed the incident. She further noted that she was put on leave following the reporting of the incident and subsequently fired. Interview with the DNS on 2/27/26 at 9:14AM identified she was notified of the allegation of abuse on 11/3/25 via text message from RN #7. The DNS identified she immediately started the investigation. NA#1, NA#2 and NA#3 worked on 11/1/25, and 11/2/25 in the facility due to the fact the allegation had not been reported. Statements were obtained from NA#1, NA#2, and NA#3, who were subsequently terminated. RN#7 was given a final written counseling regarding the incident and remains employed at the facility. The facility reported the incident to the police and to the state survey agency. Review of the facility policy directed to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, and exploitation and misappropriation of resident property. An immediate investigation is warranted when suspicion of abuse, neglect, or exploitation or reports of abuse, neglect or exploitation occur.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on observation, review of facility documentation, review of facility policy and interviews, the facility failed to ensure residents were provided a substantial evening snack daily. The findings include:Observation of the dietary department's dry storage room on 2/19/26 at 11:15 AM identified one box of crackers and seven 1-liter bottles of cola on a shelf identified as the snack shelf. Observation on 2/27/26 at 12:30 PM identified there were no more snacks available to residents. Observation of the snack cart identified there was a coffee carafe present, a basket with one package of crackers, but nothing else on the cart. Interview with FSD on 3/02/2026 at 2:07 PM identified that snacks were received on Thursdays and ran out by Mondays with the new budget. Observation of the snack cart on 3/02/2026 at 1:45 PM identified a coffee carafe, a ginger ale bottle and a half pack of crackers on the bottom of the cart. Interview with FSD at this time identified the kitchen aides refill the cart from the storage room but on observation of the storage room there are 6 bottles of cola and 4 bottles (liters) of ginger ale without any chips, cookies, crackers or any other snacks in the room. Observation of the refrigerator in the cafe on 3/2/26 at 2:30 PM identified there were less than 20 containers of Jello, pudding or fruit cups in the refrigerator. Interview with the Food Service Director (FSD) on 3/02/2026 at 2:50 PM identified there had been a cut in the budget for the snacks and the budget is $315 weekly for snacks for a facility resident capacity of 125. Interview with the Administrator on 3/2/26 at 3:00 PM identified they were working with alternative options for snacks with the new budget and that she was aware of the lack of snacks as the FSD had verbalized her concerns.Interview with the dietician on 3/02/2026 at 3:31 PM identified snacks have significantly declined since the ownership transition. The dietician indicated that she has spoken with the FSD regarding the lack of snacks and indicated the purchase of more snacks was not approved. The dietician identified that if there is a diabetic or if a resident didn't eat meals the alternate ways of getting the calories in the resident is essential but indicated she could add in the snacks for supplementation, but they aren't always available.