STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075350	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2026
NAME OF PROVIDER OR SUPPLIER Civita Sheriden Woods		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for one (1) of three (3) sampled residents (Resident #2) reviewed for falls, the facility failed to ensure Resident Care Conferences (RCCs) were completed at least quarterly. The findings include:Resident #2?s diagnoses included fracture of the scaphoid bone of the left wrist (one of the carpal bones on the thumb side of the wrist important for both motion and stability), weakness, Alzheimer's disease and aphasia following a cerebral infarction (language disorder affecting expression, comprehension, reading and writing following a stroke). The Resident Care Plan (RCP) dated 11/19/25 identified Resident #2 was at risk for falls secondary to being newly admitted to the facility, cognitive impairment and generalized weakness. Interventions included placing the call light within reach and orienting to surroundings, instructing to ask for assistance prior to attempting to transfer or ambulate and instructing the proper use of any appliance/device to aid with balance/transfers and encouraging use. The Interdisciplinary Care Plan Meeting Documentation dated 11/19/25 identified that an RCC was held for Resident #2 on 11/19/25. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had severely impaired cognition (Brief Interview for Mental Status (BIMS) score of 3) and required substantial assistance for bed mobility, transfers and ambulation. Review of the clinical record from 11/20/25 through 3/8/26 failed to identify an RCC had been scheduled or held for Resident #2 to correlate with the 2/3/26 MDS. The Interdisciplinary Care Plan Meeting Documentation dated 3/9/26 identified that an RCC was held for Resident #2 on 3/9/26 (1 month and 6 days after the MDS). Interview with the MDS Coordinator (RN #3) on 3/11/26 at 3:25 PM identified RCC's are to be completed for each resident at least quarterly and RCPs are to be reviewed. RN #3 identified Resident #2 should have had an RCC scheduled around 2/3/26 and an RCC was initially scheduled for 2/19/26 but there was no documentation in the clinical record to confirm the 2/19/26 RCC date. RN #3 was unable to provide documentation identifying an invitation was sent to Resident #2 or Resident #2's representative for the 2/19/26 meeting and identified she was on vacation prior to the 2/19/26 scheduled RCC date when the invitation should have been sent. Interview with the DON on 3/11/26 at 2:39 PM identified all residents are to have RCC's completed at least quarterly, which includes an RCP review, and should correlate with the MDS date and be documented in the clinical record. She identified that Resident #2 should have had an RCC scheduled on or around 2/3/26 before Resident #2's 2/10/26 fall which should have been documented in the clinical record, and if it was rescheduled, there should have been a note indicating why the RCC was rescheduled and to when. Review of the Comprehensive Care Planning policy dated 7/6/25 directed, in part, the resident is informed of his/her right to participate in his/her treatment and provided advanced notice of care planning conferences. If the participation of the resident and his/her resident representative in developing the resident's care plan is determined to not be practicable, an explanation is documented in the resident's medical record. The explanation should include what steps were taken to include the resident or representative in the process. The interdisciplinary team reviews and updates the care plan at least quarterly, in conjunction with the required quarterly MDS assessment.Although requested, a facility policy for Resident Care Conferences was not provided.

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for one (1) of three (3) sampled residents (Resident #2) reviewed for falls, the facility failed to ensure a Fall Risk Evaluation was completed at least quarterly. The findings include:Resident #2?s diagnoses included fracture of the scaphoid bone of the left wrist (one of the carpal bones on the thumb side of the wrist important for both motion and stability), weakness, Alzheimer's disease and aphasia following a cerebral infarction (language disorder affecting expression, comprehension, reading and writing following a stroke). Cross-reference F657 A Fall Risk Evaluation dated 10/30/25 identified Resident #2 was not at risk to a low fall risk. The Resident Care Plan (RCP) dated 11/19/25 identified Resident #2 was at risk for falls secondary to being newly admitted to the facility, cognitive impairment and generalized weakness. Interventions included placing the call light within reach and orienting to surroundings, instructing to ask for assistance prior to attempting to transfer or ambulate and instructing the proper use of any appliance/device to aid with balance/transfers and encouraging use. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had severely impaired cognition (Brief Interview for Mental Status (BIMS) score of 3) and required substantial assistance for bed mobility, transfers and ambulation. Review of the clinical record failed to identify a Fall Risk Evaluation had been completed from 10/31/25 through 2/9/26. A nurse's note written by RN #2 dated 2/10/26 at 1:31 AM identified she was called to the unit for reports that Resident #2 fell and was on the floor. When she entered the room, Resident #2 was noted to be on his/her right side on the floor, and the right hip was red from laying on it but Resident #2 denied pain. The note identified vital signs were obtained and the provider was notified. Review of the clinical record failed to identify orders were obtained for monitoring the reddened right hip. A nurse's note by the DON dated 2/10/26 at 12:16 PM identified Resident #2 sustained a fall at 12:20 AM and was found lying on the floor. The note reported that later in the day Resident #2 was noted with a bump to the right side of his/her head and was unable to move his/her neck but denied pain or discomfort. The note identified Resident #2 was evaluated by the APRN and subsequently transferred to the Emergency Department (ED) at 12:17 PM. The hospital documentation dated 2/16/26 identified Resident #2 was admitted from 2/10/26 through 2/16/26 following a fall with an acute displaced type II odontoid fracture (a break in the dens of the second cervical bone in the neck). Interview with the DON on 3/11/26 at 2:39 PM identified all residents should have a Fall Risk Evaluation completed by licensed nursing staff on admission, quarterly and with a change in condition and Resident #2 should have had a Fall Risk Evaluation completed on or around the 2/3/26 MDS date prior to the 2/10/26 fall. Review of the Falls Protocol policy dated 7/24/25 directed, in part, the staff and practitioner will review each resident's risk factors for falling and document in the clinical record. The staff and physician will document in the medical record a history of one or more recent falls (for example, within 90 days). The staff will evaluate and document falls that occur while the resident is in the facility. Although requested a policy on Fall Risk Evaluations was not available.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation/policy, and staff interviews for one (1) of three (3) residents (Resident #1) reviewed for accidents, the facility failed to ensure adequate supervision was provided to prevent an accident for a resident identified as cognitively impaired and at risk for falls. Specifically, the facility failed to ensure Resident #1 was supervised during bedside urinal use when left out of staff line of sight behind a privacy curtain, resulting in a fall with injury. The findings include:Resident #1?s diagnoses included Parkinson's disease (a movement disorder of the nervous system that worsens over time) with dyskinesia (involuntary, erratic and uncontrollable movements), dysarthria (speech disorder causing slurred, slow or quiet speech due to weakened muscles) and anarthria (severe form of dysarthria resulting in an inability to speak), generalized muscle weakness, lack of coordination, difficulty in walking and anxiety disorder.A Fall Risk Evaluation dated 1/20/26 identified Resident #1 was at risk for falls.A physician's order dated 1/20/26 directed Resident #1 required an assist of one (1) for Activities of Daily Living (ADLs) and toilet transfers.The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had moderately impaired cognition (Brief Interview for Mental Status (BIMS) score of 11) and required moderate assistance with personal hygiene and transfers. Additionally, the MDS identified Resident #1 had a history of falls and sustained one (1) fall with injury since admission.The Resident Care Plan (RCP) dated 1/29/26 identified Resident #1 had impaired cognition, was at risk for falls due to being newly admitted to the facility, a previous history of falls, impaired sense of balance and an unsteady gait, difficulty seeing and reported blurriness on his/her left side of vision and required assistance with bathing, dressing, eating, grooming and hygiene. Interventions included using simple language, direct communication, task segmentation and speaking slowly and clearly and explaining all procedures, ensuring the call bell is within reach, instructing Resident #1 to ask for assistance prior to attempting to transfer or ambulate, reorienting Resident #1 as needed, providing an assist of 1 for ADLs, and providing an assist of 1 for toileting at wheelchair level using the grab bar.A nurse's note by RN #1 dated 2/7/26 at 7:30 AM identified she was called to assess Resident #1 following a fall. Resident #1 was found on the floor in a seated position attempting to get up and a laceration with blood was noted to Resident #1's face. The note identified Emergency Medical Services (EMS) was notified and Resident #1 remained on the floor until EMS arrival and Resident #1 was subsequently transferred to the hospital at 6:30 AM. The on-call provider and Resident #1's representative were notified of the incident.A nurse's note by LPN #1 dated 2/7/26 at 7:51 AM identified at approximately 5:55 AM she was notified by NA #1 that Resident #1 sustained a fall and upon entering the room, Resident #1 was observed on the floor in front of his/her bed with visible bleeding to the head. The nursing supervisor (RN #1) was notified and assessed Resident #1 and Resident #1 remained sitting in an upright position on the floor due to active bleeding until EMS arrived. The note identified NA #1 reported Resident #1 had been assisted with the urinal, a few minutes prior to the incident, and was left sitting upright in bed. Hospital documentation dated 2/7/26 identified Resident #1 was evaluated in the Emergency Department (ED) following a fall and sustained multiple lacerations over the forehead that were repaired with absorbable sutures.A nurse's note by RN #4 dated 2/7/26 at 6:40 PM identified Resident #1 returned to the facility at 5:00 PM. Resident #1 had slight bleeding to the lacerations on both eyebrows with absorbable sutures intact, a scrape to the left wrist, new bruises to both posterior (backside) upper thighs and old bruises to both knees, hips and the right upper arm. The note identified Resident #1 as alert and responsive with slight agitation and that a family member was at Resident #1's bedside.Interview and review of a statement dated 2/7/26 with NA #1 on 3/12/26 at 4:10 PM identified that on 2/7/26, she went into Resident #1's room and he/she requested to use the urinal. She reported she assisted Resident #1 in sitting on the bedside to use the urinal, but Resident (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	#1 was unable to urinate, so he/she requested privacy. NA #1 identified she was aware that Resident #1 was an assist of one (1) for ADL's and toileting, had a history of falls, was confused at times and had a history of not using the call bell. NA #1 identified she requested Resident #1 use the call bell when he/she was finished, pulled the privacy curtain around Resident #1's bed and went to perform care for the roommate. NA #1 identified that about two (2) minutes later, she heard a bang and when she opened the privacy curtain surrounding Resident #1's bed, she observed Resident #1 on the floor on the side of the bed with active bleeding from his/her head. She identified she asked Resident #1 if he/she was okay and then left Resident #1 unattended while she walked two (2) doors down the hallway to notify RN #1. NA #1 identified she did not call out for help or use the call bell for assistance. NA #1 identified she should not have left Resident #1 unattended, should have alerted LPN #1 of Resident #1's request for privacy and requested additional assistance while she performed care for the roommate.Interview with OTA #1 (Director of Rehab) and PT #1 on 3/11/26 at 1:53 PM identified Resident #1 was receiving therapy services at the time of the 2/7/26 fall and required an assist of one (1) for ADLs and toilet transfers.Interview with LPN #1 on 3/13/26 at 9:28 AM identified on 2/7/26 she was alerted Resident #1 sustained a fall and when she arrived to the room, Resident #1 was in a sitting position on the floor with a moderate amount of active bleeding from the forehead and RN #1 was applying pressure to the area. LPN #1 identified Resident #1 was admitted to the facility after sustaining a fall at home, had previously sustained a fall at the facility, and was identified as a fall risk due to tremors and poor safety awareness. LPN #1 identified Resident #1 should not have been left out of NA #1's line of sight, despite a request for privacy, without first notifying her or other staff for assistance, due to a known fall risk. LPN #1 reported that following the fall, NA #1 should have used the call bell or yelled for staff assistance rather than leave Resident #1 further unattended after it was identified he/she was actively bleeding from the head.Interview with the DON on 3/13/26 at 11:38 AM identified per Resident #1's plan of care, on 2/7/26, NA #1 should not have left Resident #1 out of sight while sitting on the bedside using the urinal, behind the privacy curtain and then moving on to perform care for the roommate. The DON reported that when Resident #1 requested privacy while using the urinal, NA #1 should have explained that she could not leave for safety reasons or notified a licensed nurse of the request and requested assistance before leaving Resident #1 out of sight while sitting on the bedside. Additionally, she identified that once NA #1 observed Resident #1 on the floor actively bleeding, she should have first yelled for assistance or used the call bell to request assistance rather than leave Resident #1 unattended in the room.Interview with RN #1 on 3/13/26 at 12:21 PM identified on 2/7/26, NA #1 approached her in the nursing supervisor's office to report Resident #1 fell and was bleeding. She reported she immediately went to Resident #1's room and observed Resident #1 sitting on the floor at the bedside, the urinal was on the floor and Resident #1 was bleeding significantly from the forehead requiring application of pressure to the area. RN #1 reported Resident #1 was a fall risk, was an assist of one (1) for ADLs and toileting and NA #1 should not have left Resident #1 unattended, behind a privacy curtain and out of her line of sight without first notifying the charge nurse (LPN #1) and requesting assistance from staff.Review of the Kardex Use policy (undated) directed, in part, the Kardex information should reflect the resident's current care plan, physician orders and clinical status and is used by Certified Nursing Assistant staff to guide daily care and communication including safety risks, activity level and transfer status. Updates must occur when there are changes in physician orders, care plans, mobility status and safety precautions. Staff must verify Kardex information against the current physician orders and care plan before using it for care decisions. Although requested, a facility policy for post-fall procedure was not provided.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for two (2) of three (3) residents (Residents #1 and #2) reviewed for falls, the facility failed to ensure a nursing assessment was completed and documented in the clinical record at the time of the fall when the assessment was completed.1. Resident #1?s diagnoses included Parkinson's disease (a movement disorder of the nervous system that worsens over time) with dyskinesia (involuntary, erratic and uncontrollable movements), dysarthria (speech disorder causing slurred, slow or quiet speech due to weakened muscles) and anarthria (severe form of dysarthria resulting in an inability to speak), generalized muscle weakness, lack of coordination, difficulty in walking and anxiety disorder. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had moderately impaired cognition (Brief Interview for Mental Status (BIMS) score of 11) and required moderate assistance with personal hygiene and transfers. Additionally, the MDS identified Resident #1 had a history of falls and sustained one (1) fall with injury since admission. The Resident Care Plan (RCP) dated 1/29/26 identified Resident #1 had impaired cognition, was at risk for falls due to being newly admitted to the facility, a previous history of falls, impaired sense of balance and an unsteady gait, difficulty seeing and reported blurriness on his/her left side of vision and required assistance with bathing, dressing, eating, grooming and hygiene. Interventions included using simple language, direct communication, task segmentation, speaking slowly and clearly and explaining all procedures, ensuring the call bell is within reach, instructing Resident #1 to ask for assistance prior to attempting to transfer or ambulate, reorienting Resident #1 as needed, providing an assist of 1 for ADLs, and providing an assist of 1 for toileting at wheelchair level using the grab bar. A nurse's note by RN #1 dated 2/7/26 at 7:30 AM identified she was called to assess Resident #1 following a fall. Resident #1 was found on the floor in a seated position attempting to get up and a laceration with blood was noted to Resident #1's face. The note identified Emergency Medical Services (EMS) was notified and Resident #1 remained on the floor until EMS arrival and Resident #1 was subsequently transferred to the hospital at 6:30 AM. The on-call provider and Resident #1's representative were notified of the incident. The note failed to identify that Range of Motion (ROM) was assessed for any further injuries or pain following the fall. Review of the clinical record failed to identify a Situation, Background, Assessment, Recommendation (SBAR) had been completed by RN #1 documenting a full assessment had been performed for Resident #1 on 2/7/26. Interview with RN #1 on 3/13/26 at 12:21 PM identified she performed a full assessment to include ROM and neurological signs for Resident #1 but did not document her findings. She identified that the assessment should have been documented as part of her note and completed prior to leaving her shift. 2. Resident #2?s diagnoses included fracture of the scaphoid bone of the left wrist (one of the carpal bones on the thumb side of the wrist important for both motion and stability), weakness, Alzheimer's disease and aphasia following a cerebral infarction (language disorder affecting expression, comprehension, reading and writing following a stroke). The Resident Care Plan (RCP) dated 11/19/25 identified Resident #2 was at risk for falls secondary to being newly admitted to the facility, cognitive impairment and generalized weakness. Interventions included placing the call light within reach and orienting to surroundings, instructing to ask for assistance prior to attempting to transfer or ambulate and instructing the proper use of any appliance/device to aid with balance/transfers and encouraging use. Cross-reference F657 The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had severely impaired cognition (Brief Interview for Mental Status (BIMS) score of 3) and required substantial assistance for bed mobility, transfers and ambulation. A nurse's note written by RN #2 dated 2/10/26 at 1:31 AM identified she was called to the unit for reports that Resident #2 fell and was on the floor. When she entered the room, Resident #2 was noted to be on his/her right side on the (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	floor, and the right hip was red from laying on it but Resident #2 denied pain. The note identified vital signs were obtained and the provider was notified. Review of the clinical record failed to identify new orders were obtained for monitoring the reddened right hip and failed to identify that Range of Motion (ROM) was assessed for any further injuries following the fall. Review of the clinical record failed to identify a Situation, Background, Assessment, Recommendation (SBAR) had been completed by RN #2 documenting a full assessment had been performed for Resident #2 on 2/10/26. A nurse's note by the DON dated 2/10/26 at 12:16 PM identified Resident #2 sustained a fall at 12:20 AM and was found lying on the floor. The note reported that later in the day Resident #2 was noted with a bump to the right side of his/her head and was unable to move his/her neck but denied pain or discomfort. The note identified Resident #2 was evaluated by the APRN and subsequently transferred to the Emergency Department (ED) at 12:17 PM. The hospital documentation dated 2/16/26 identified Resident #2 was admitted from 2/10/26 through 2/16/26 following a fall with an acute displaced type II odontoid fracture (a break in the dens of the second cervical bone in the neck). Interview with RN #2 on 3/13/26 at 1:37 PM identified she performed a full assessment to include movement and ROM for Resident #2 but she did not document her findings. She identified the assessment should have been documented as part of her note and completed prior to leaving her shift. Interview with the DON on 3/11/26 at 2:39 PM identified both RN #1 and RN #2 should have documented their full nursing assessment following Resident #1 and Resident #2's falls in their nurse's notes or an SBAR prior to leaving their shift. Review of the Falls Protocol policy dated 7/24/25 directed, in part, the nurse shall assess and document the following: vital signs, recent injury, musculoskeletal function, observing for change in normal range of motion or weight bearing, change in cognition or level of consciousness, neurological status, pain, frequency and number of falls since last physician visit and precipitating factors and details on how the fall occurred. Review of the Charting Documentation policy dated 8/4/25 directed, in part, all services provided to the resident, progress towards the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Documentation of procedures and treatments will include care-specific details including the assessment data and/or any unusual findings obtained.