STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075367	A. Building B. Wing	12/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Civita Care Meadowbrook	350 Salmon Brook Street Granby, CT 06035

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, review of facility documentation, and review of facility policy for one of three sampled residents (Resident #40) reviewed for medication reconciliation, the facility failed to ensure the medications from the hospital discharge instructions were accurately transcribed to the facility electronic physician's orders to prevent medication error and for one sampled resident (Resident #88) reviewed for bowel function, the facility failed to ensure the bowel regimen was followed as per physician order and facility policy. The findings include:1. Resident #40's was admitted to the facility on [DATE] with diagnoses that included multiple fractures of the ribs, wedge compression fracture of 4th lumbar vertebrae, delirium, glaucoma, Gastro-Esophageal Reflux Disease (GERD), depression and dementia. Review of Resident #40's hospital Discharge summary dated [DATE] identified the following medication instructions: continue taking cyanocobalamin 100 microgram (mcg) (vitamin) by mouth once a day, donepezil 10 milligram (mg) (dementia) by mouth once a day, memantine 10 mg (dementia) by mouth twice a day, pantoprazole 40 mg (GERD) by mouth once a day, sertraline 50 mg (anti-depressant) give 2 tablets by mouth once a day, Xalatan ophthalmic solution 0.005% (glaucoma) give 1 drop to both eyes at evening, oxycodone 5 mg (opioid analgesic) give one half tablet every 6 hours for mild to moderate pain, and oxycodone 5 mg give 1 tablet every 6 hours for severe pain. Review of the medications transcribed in the facility's electronic physician's orders dated 11/4/25 directed to administered cyanocobalamin 100 mcg by mouth once a day, donepezil 10 mg by mouth once a day, memantine 10 mg by mouth twice a day, pantoprazole 40 mg by mouth once a day, sertraline 50 mg give 2 tablets by mouth once a day, Xalatan ophthalmic solution 0.005% (glaucoma) give 1 drop to both eyes at bedtime, oxycodone 5 mg give one half tablet every 6 hours for mild to moderate pain, and oxycodone 5 mg give 1 tablet every 6 hours for severe pain. Further review of the physician's orders identified the following medications were also transcribed: administer gabapentin 300 mg (anti-convulsant) by mouth four times per day for neuropathy and senna-s (laxative) give 2 tablets by mouth at bedtime. The gabapentin 300 mg and senna-s medications were not part of Resident #40's medication instructions from the hospital. The Resident Care Plan (RCP) dated 11/4/25 identified Resident #40 had a fracture rib and wedge compression fracture. Care plan interventions directed to administer medication per physician's order to promote comfort, assist resident with position changes as needed for optimal comfort, physical and occupational therapy evaluation and treatment as physician orders. (continued on next page)

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

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Medication Administration Record (MAR) from 11/4/25 to 11/6/25 identified Resident #40 had received the gabapentin 300 mg by mouth on 11/5/25 at 5:00 PM and 9:00PM and senna-s 2 tablets by mouth (laxative) on 11/5/25 at 8:00 PM. The facility accident and incident report dated 11/6/25 at 12:40 AM identified Resident #40 had incorrect medications entered in the physician's orders. There were 2 doses of gabapentin 300 mg were given on 12/5/25 at 5:00 PM and 9:00 PM and 1 dose of senna-s 2 tablets was given on 11/5/25 at 8:00 PM. The nurse's note dated 11/6/25 at 2:15 PM identified that the ADNS was notified regarding a medication error that had occurred. Resident #40 received 2 doses of gabapentin 300 mg and one dose senna-s which were not prescribed to the resident. The physician was notified of the medication error who ordered the following laboratory tests; a Basic Metabolic Panel (BMP) and a Complete Blood Count (CBC). The orders also instructed to monitor Resident #40's neurological signs every 4 hours for 48 hours. Resident #40 denied pain or discomfort. The family was also notified with the medication error. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #40 had severe cognitive impairment and required extensive assistance with personal hygiene, dressing, toileting, and transfer. Interview with the ADNS on 11/26/25 at 10:25 AM identified she was notified that there was a medication error that had occurred with Resident #40's medication reconciliation. She identified that the gabapentin 300 mg and senna-s medication were incorrectly added to Resident #40's physician orders and he/she had received 2 doses of gabapentin 300 mg and 1 dose of senna-s medications. She identified that the process of medication reconciliation was the admitting nurse would enter all the medications in the physician order queue, and another nurse verifies that all physician orders are accurately transcribed from the hospital discharge record and activates the physician orders when it is verified that all medication in the physician order were accurately transcribed. She identified that the admitting nurse incorrectly transcribed the medication in the physician orders and second nurse activated the physician orders. She further identified that there were multiple admissions on 11/4/25 and the nurse accidentally added a medication in the physician's orders that did not belong to Resident #40 medication listing. Interview with LPN #2 on 11/26/25 at 2:10 PM identified that the facility asked her if she could help with the admission on [DATE] because there were five admissions expected. In addition, she identified that the charge nurse was not feeling well so the nursing supervisor worked on the nursing unit. She identified that she transcribed the medications in the physician's order queue, but she accidentally transcribed the gabapentin 300 mg and senna-s that did not belong for Resident #40. She also identified that the second nurse is supposed to verify the medications transcribed in the physician's order queue before activating the physician's orders to ensure that they were correct. She identified that although she had accidentally transcribed the wrong medication the second nurse who activated the physician's orders should have verified all medications matched what was in the discharge summary medication list. An attempt to interview LPN #6 was made (who activated the physician's order) but she was not available for interview during the survey period. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Medication Reconciliation policy identified that the process of verifying the resident's current medication list matches the physician's orders for the purpose of providing the correct medications to the residents. The policy also identified to compare the physician's orders to the hospital record and obtain clarification as needed; the facility nurse would transcribe the physician's order in accordance with the procedures for admission orders and the second nurse would review the transcribed physician's orders for accuracy and co-sign the physician's order to indicate the review. 2. Resident #88 was admitted to the facility on [DATE] with diagnoses that included fusion of the cervical spine, cognitive communication deficit, and weakness. A nursing admission assessment dated [DATE] identified Resident #88's abdomen was soft, non-tender, and had normal bowel sounds. The assessment also indicated that Resident #88's last bowel movement was on 8/28/2025. A nursing note dated 8/29/2025 at 12:21 PM identified Resident #88 arrived at the facility alert and forgetful from the hospital. The physician's orders dated 8/29/25 directed to administer oxycodone extended release (a narcotic pain medication) 10 milligrams (mg) by mouth every morning and at bedtime for pain control and directed to implement bowel routine as per policy. A review of the medication administration record (MAR) identified Resident #88 received the scheduled oxycodone medication once on 8/29/2025, twice on 8/30/2025, and twice on 8/31/2025. A nursing note dated 8/31/2025 at 2:24 PM indicated Resident #88 had a syncopal episode while in the bathroom attempting to have a bowel movement and noted Resident#88's abdomen was firm, distended, and had decreased bowel sounds. The note further indicated that the on-call medical provider was notified, and a bowel regimen was started. A review of physician's orders identified that on 8/31/2025 at 2:28 PM the following orders were placed: 1) Give 30 milliliters (ml) of Milk of Magnesia Suspension 400 mg/ 5 ml for constipation, use first; 2) Insert one suppository of Bisacodyl Suppository 10 mg as needed for constipation if Milk of Magnesia was ineffective; 3) Administer Fleet Enema 7-19 grams (gm)/118 ml as needed for constipation if Bisacodyl ineffective. A review of the MAR for 8/31/2025 did not identify that bowel regimen medications were administered. On 9/1/2025 at 7:29 PM, Resident #88 was given 30 ml of Milk of Magnesia suspension 400mg/5ml; (17 hours after the bowel regimen was ordered). Additionally, the MAR identified that the medication was ineffective. On 9/2/2025 at 1:11 PM, an abdominal x-ray was taken. At 1:43 PM, Resident #88 was administered a bisacodyl suppository, 18 hours after the administration of Milk of Magnesia. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/2/2025 at 8:00 PM, Resident #88 was given two tablets of scheduled sennosides (a medication for constipation) 8.6 mg. At 11:00 PM, and 15 ml of lactulose solution (a medication for constipation) 10mg/15ml. A nursing note dated 9/3/2025 identified Resident #88 had a bowel movement; three days after Resident #88 was noted to have a firm and distended abdomen, and six days after the last documented bowel movement. On 12/1/2025 at 1:45 PM, an interview with LPN#4 identified that she did not recall whether she had administered bowel regimen medication to Resident #88 on 8/31/2025, but indicated that if she had administered anything, it would have been documented. Additionally, LPN#4 indicated that any shift can start the bowel regimen protocol and if the medication given is ineffective, then it would be reported to the next shift, so the resident can be administered the next step in the bowel regimen protocol. LPN#4 further indicated that the time between the different steps in the bowel regimen protocol is one shift or 8 hours. On 12/1/2025 at 3:11 PM, an interview with APRN#1 identified that on 9/2/2025, she evaluated Resident #88 and noted that the resident did not have a bowel movement after the bowel regimen was ordered. APRN#1 identified that she then ordered an abdominal x-ray, and when the x-ray results returned in the evening, she ordered a dose of lactulose. APRN#1 indicated that although she was not the provider on-call on 8/31/2025, she indicated that Resident#88's syncopal episode was most likely a vasovagal reaction while trying to have a bowel movement. APRN#1 indicated that if the bowel regimen was ordered on 8/31/2025 after the resident was noted to be constipated, then the bowel regimen medications should have been started that day. On 12/2/2025 at 9:59 AM, an interview with RN#5 identified that she did not recall whether she had administered a bowel regimen medication for Resident #88 on 8/31/2025. The Bowel Evacuation Protocol identified that the bowel protocol should start with Milk of Magnesia in the 3 PM to 11 PM shift. If the Milk of Magnesia were not effective, then the 11 PM to 7 AM shift would administer a bisacodyl suppository. If the bisacodyl suppository were ineffective, then the 7 AM to 3 PM shift would administer a Fleets enema. The protocol also indicated that if the bowel protocol was ineffective, notify the medical provider.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. (continued on next page)

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, review of facility policy and interviews for one sampled resident reviewed for hydration (Resident #88), the facility failed to ensure a resident's hydration needs were assessed and did not ensure that intake and output were consistently documented as per facility policy. The findings include: A hospital discharge summary report dated 8/28/2025 identified Resident #88 may have been dry with a creatinine that had increased from 1.2 to 1.5 on 8/24/2025 and that there were no concerns that would necessitate hospitalization. Resident #88 was then admitted to the facility on [DATE] with diagnoses that included fusion of the cervical spine, cognitive communication deficit, and weakness. A nursing admission assessment dated [DATE] at 9:30 AM identified Resident #88 was alert and oriented to person, place, and time. The resident's abdomen was soft, non-tender, and had normal bowel sounds, and the last bowel movement was on 8/28/2025. The admission assessment also indicated Resident #88 was independent with eating and oral hygiene, and dependent for bed mobility. A medical provider's note dated 8/29/2025 identified Resident #88 had moist mucus membranes. The note identified that Resident #88's most recent laboratory data was from 8/20/2025. The note did not identify any fluid intake goals. A physician's order dated 8/29/2025 directed to monitor I & O (intake and output) every shift for 72 hours upon admission/readmission and to document on the I&O paper flowsheet. A review of the I&O flowsheet identified that no I&O documentation for 8/29/2025, although Resident #88 had been readmitted to the facility on [DATE] at 9:30 AM. The I&O flowsheet for 8/30/2025 failed to identify if Resident #88 drank or had fluids offered from 12:00 AM to 3:00 PM. Additionally, two instances of intake of 240mL each were recorded for a total of 480mL of total fluid for the 3:00 PM to 11:00 PM shift. No 24-hour estimated fluid needs were recorded in the designated area of the I&O flowsheet. A nursing note dated 8/31/2025 at 2:24 PM indicated Resident #88 had a syncopal episode while in the bathroom attempting to have a bowel movement. The note identified that Resident#88's abdomen was firm and distended, with bowel sounds present but decreased. The note also indicated that the on-call medical provider was notified, and the facility's bowel regimen was started. The I&O flowsheet for 8/31/2025 identified a total intake of 1,320 ml the flowsheet for 9/1/2025 identified a total intake of 1,620 ml, and the flowsheet for 9/2/2025 identified a total intake of 1,500 ml. No 24-hour estimated fluid needs were recorded in the designated area of the I&O flowsheet. The I&O flowsheet for 9/3/2025 identified a total intake of 1,440 ml. A 24-hour estimated fluid needs of 3,431 mL was recorded in the designated area of the I&O flowsheet. A further review of the medical record failed to identify a nursing hydration assessment or a nutritional assessment after the resident was admitted on [DATE] or after the resident was found to be constipated on 8/31/2025. On 12/01/2025 at 3:11 PM, an interview with APRN #1 identified that all residents are placed on I&O monitoring for three days and that if residents are not meeting their fluid intake needs, then staff would notify the medical provider. APRN#1 indicated that the Dietitian calculates the fluid needs and puts it in their assessment, and that nursing staff could also calculate the fluid needs from a chart. APRN#1 also indicated that she would try to look at lab values from the hospital when a resident gets admitted to the facility but could not recall if she looked at Resident#88's lab values recorded in the hospital discharge summary; APRN #1 indicated that the lab values in her note were from 8/20/2025 and that those must have been the lab values she looked at when admitting Resident #88 to the facility. A record review with APRN#1 identified that the Resident's BUN and creatinine (lab tests used to evaluate kidney function) had increased from 8/20/2025 to 8/24/2025. The BUN had gone from 29 milligrams (mg)/deciliter (dL) to 39 mg/dL (normal range is 9 to 20 mg/dL), and the creatinine had gone from 1.0 mg/dL to 1.5 mg/dL (normal range is 0.7 mg/dL to 1.3 mg/dL). APRN#1 indicated that it could indicate a hydration need, but that other information would need to be gathered, such as medications the resident may have been on; APRN#1 further indicated that a hydration evaluation would have been helpful in managing care. On 12/2/2025 at 12:01 PM, an interview with ADNS indicated that a hydration assessment should be done on each admission and readmission if a resident had been on medical leave for over 24 hours. On 12/02/2025 at 12:33 PM, an interview with the Dietitian identified that she sees all admissions and readmissions to the facility and calculates hydration needs. The Dietitian indicated that she looks at general intake, laboratory values, and a clinical assessment when determining if someone is dehydrated or to evaluate their hydration needs. The Dietitian indicated that she may not have seen Resident #88 because she works two days a week at the facility, and the resident may have been at the hospital. The Dietitian indicated that had she seen the