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	03/10/2026

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 0689 Level of Harm - Minimal harm or potential for 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, facility policy, and interviews for one (1) of three (3) residents (Resident #1) reviewed for activities of daily living (ADL) care, the facility failed to ensure a safe environment and protect a non-ambulatory, cognitively impaired resident who was totally dependent on staff for transfers from injury. This failure resulted in Resident #1 sustaining a femur fracture and displaced tibia and fibula fractures requiring surgical intervention. The findings include:Resident #1 was admitted to the facility with diagnoses that included dementia and osteoarthritis. Resident #1 had a power of attorney for health decisions. The Fall Risk assessment dated [DATE] identified Resident #1 was at risk for falls.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had severely impaired cognition (Brief Interview for Mental Status (BIMS) score of 0) and was always incontinent of bowel and bladder.The Resident Care Plan (RCP) dated 1/14/26 identified Resident #1 had an ADL deficit related to cognitive loss/dementia, impaired mobility and non-ambulatory total lift. Interventions included assist of two (2) dependent for bed mobility, assist of two (2) for transfers and customized wheelchair (WC) with head rest and bilateral leg rests.A progress note by APRN #1 dated 1/29/26 identified Resident #1 had baseline confusion due to dementia. APRN #1 identified Resident #1's musculoskeletal system identified no pain and was moving all extremities and had contractures to bilateral knees.The physician's orders dated February 2026 directed Hoyer lift with assist of two (2) for transfers and assist of one (1) ADL's and toileting at bed level.The physician's order dated February 2026 directed Acetaminophen 650 mg three (3) times a day for pain (at 8:00 AM, 2:00 pm and 8:00 PM).A skin check dated 2/7/26 identified Resident #1 had no new skin impairments.A nurse's note by RN #1 dated 2/10/26 at 4:00 PM, late entry, identified the Charge Nurse notified RN #1 that Resident #1 had increased body pain early that morning including lower bilateral pain. Per the Charge Nurse, Resident #1 was uncomfortable when personal care was provided and Tylenol was administered. Resident #1 was out of bed in the WC in the dining room. Resident #1's left leg was swollen, skin was intact but painful to touch. The pain regiment was discussed with the provider. APRN #1 was on site and notified of the change. Resident #1 was transferred to bed for further assessment by APRN #1 and new orders were placed for an ultrasound to rule out deep vein thrombosis (DVT) and an x-ray.The x-ray report dated 2/11/26 identified displaced angulated recent appearing proximal tibial and fibular fractures.A nurse's note by RN #1 dated 2/11/26 at 2:13 PM identified Resident #1 had a bedside x-ray and preliminary images appeared to show a fracture of the lower left leg. APRN #1 was notified and directed Resident #1 be transferred to the emergency department (ED).A physician note dated 2/11/26 identified he was updated on the results of the left leg x-ray that identified an acute left tibial fracture. He identified likely etiology as fracture due to severe osteoporosis which could have happened while transferring Resident #1 onto his/her lift. The physician ordered Resident #1 be sent to the ED for further evaluation.The hospital Discharge summary dated [DATE] to 2/16/26 identified the primary discharge diagnoses of tibia/fibula fracture and fracture of the right femur. Resident #1 underwent a left open reduction and internal fixation surgery and right lower extremity splint.The (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reportable Event (RE) form dated 2/11/26 identified on 2/10/26 Resident #1 had a complaint of left lower extremity pain. The APRN ordered an x-ray and Doppler to rule out DVT or trauma. The x-ray that resulted on 2/11/26 appeared to show a fracture on the lower left leg. Resident #1 was transferred to the ED for further evaluation where Resident #1 was diagnosed with a left tibia/fibula fracture and a right femur fracture. The RE identified on 2/9/26 during the afternoon, Resident #1's family member identified Resident #1 complained of left leg pain but did not report it due to chronic pain. Following review of the hospital documentation, the Medical Director stated there was no clear etiology for the fractures. It was possible the injuries represented osteoporosis-related fragility fractures, potentially associated with mechanical lift transfers.Interview with NA #1 on 3/10/26 at 1:00 PM identified on 2/9/26 she was assigned to provide care for Resident #1 on the 6:00 AM to 3:00 PM shift. She identified she performed morning care for Resident #1 around 6:30 AM and Resident #1 had no pain and was not crying out. She identified Resident #1 had lower extremity baseline edema but there was no discoloration or bruising. She identified Resident #1 was transferred to his/her WC with the Hoyer lift and assistance from NA #2. She Identified there were no issues with the transfer. She was then transferred back to bed around 12:15 PM with the Hoyer lift and assistance from NA #2 with no issues with the transfer. She further identified on 2/10/26 she was assigned to provide care for Resident #1 on the 6:00 AM to 3:00 PM shift and when she went to apply socks on Resident #1 around 6:30 AM, Resident #1 started screaming. She identified she stopped care and notified LPN #2 (11:00 PM - 7:00 AM charge nurse). She identified she also notified LPN #1 (7:00 AM - 3:00 PM charge nurse). She identified Resident #1 calmed down and was transferred to his/her WC with the Hoyer lift and NA #2 without issue. She identified Resident #1 appeared comfortable during the day and around lunch Resident #1 was transferred back to bed with the Hoyer lift and assistance from NA #3.Interview with LPN #1 on 3/12/26 at 3:50 PM identified on 2/10/26 she was Resident #1's LPN for the 7:00 AM - 3:00 PM shift. She identified NA #1 notified her that Resident #1 was screaming in the morning. She identified she notified the Supervisor (RN #1) and APRN #1 around 8:00 AM. She identified Resident #1 received scheduled Tylenol at 8:00 AM with good effect. Resident #1 had no signs or symptoms of pain throughout the shift.Interview with RN #1on 3/10/26 at 2:40 PM identified on 2/10/26 she was Resident #1's RN for the 7:00 AM - 3:00 PM shift. She identified Resident #1 did not have pain after NA #1 performed morning care. She identified around 11:30 AM, with APRN #1, Resident #1 was observed sitting at the dining room table. Resident #1 was not crying out or complaining but appeared uncomfortable. APRN #1 had Resident #1 transferred back to bed for further assessment and ordered a Doppler and x-rays of the lower left extremity.Interview with APRN #1 on 3/10/26 at 3:02 PM identified on 2/10/26 when she was rounding, she was notified that Resident #1 complained of left leg pain and there was no known trauma. APRN #1 assessed Resident #1 around 12:00 PM and ordered a Doppler to rule out DVT and x-ray.Interview with APRN #2 on 3/10/26 at 3:11 PM identified if Resident #1 had fallen alone, he/she would not have been able to get up independently. Resident #1 had no recent falls reported and was an assist of two staff for transfers with a Hoyer lift. She identified if Resident #1 did fall out of bed, she would expect different injuries would have presented. She identified that she does not think the injuries occurred during care with rolling Resident #1 because that would not cause bilateral injuries and Resident #1 was not frail. She identified the probable cause of injury was from the Hoyer lift.Interview with the DNS on 3/10/26 at 10:00 AM identified the incident was discussed with the Medical Director to try to identify the cause of Resident #1's injuries. A probable cause could have been a Hoyer lift accident therefore, in-services, education and competencies were conducted for Hoyer lift transfers.Review of the Activities of Daily Living policy directed that residents will be provided with care, treatment and services to ensure that their activities of daily living do not diminish unless the circumstances of their clinical condition(s) demonstrate that diminished ADL's are unavoidable.The facility presented a corrective action plan dated 2/13/26 which included:Facility-wide audit of residents requiring mechanical lift transfers and extensive ADL assistance.Maintenance evaluation of all mechanical (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	lifts.Staff education dated 2/11/26 to include: Safe resident handling and mechanical lift use Proper ADL assistance and positioning Monitoring for changes in resident condition Timely physician and family notification Accurate documentation of resident careClinical competency evaluations for Transferring a Resident Using a Mechanical Lift were conducted.Weekly Audits of 3 residents requiring mechanical lift transfers.Compliance date 2:13/26The corrective action plan for past non compliance was accepted by the state agency during an on site visit on 3/10/26.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, and interviews for one (1) of two (2) residents (Resident #1) reviewed for medically-related social services, the facility failed to ensure medically-related social services were provided and documented.The findings include: Resident #1 was admitted to the facility with diagnoses that included dementia and schizoaffective disorder. Resident #1 had a power of attorney (POA) for health decisions. The Social Work (SW) Annual assessment dated [DATE] identified Resident #1 was alert to self primarily with observed cognition deficits related to place and times as well as confusion. The note identified the SW was available for emotional support as well as concerns or complaints.The Social Service Quarterly assessment dated [DATE] identified Resident #1 continued to present with severe cognitive impairment due to advanced dementia. Resident #1's mood remained stable and continued to appear calm and friendly with poor insight and judgement. The note identified the SW would remain available for ongoing support, care coordination and advocacy for Resident #1's needs and comfort.The quarterly Minimum Data Set (MDS) dated [DATE] identified Resident #1 had severely impaired cognition (Brief Interview for Mental Status (BIMS) score of 0) and Resident #1 was rarely/never understood.The Resident Care Plan (RCP) dated 1/14/26 identified Resident #1 was in a facility for long term care due to care needs. Interventions included to encourage Resident #1 to make needs known, only ask about Money Follows the Person (MFP) during comprehensive assessments and orient Resident #1 to the environment and staff. The RCP further identified Resident #1 had diagnoses of schizoaffective disorder and bipolar disorder with interventions that included to encourage Resident #1 to express his/her thoughts and feelings, provide support and validation as needed and psychiatric services within the facility.Review of the clinical record failed to identify SW quarterly progress notes since 7/2/25 (total of 8 months).Review of the clinical record failed to identify SW annual assessments since 11/13/24 (total of one year and four months).Interview with the DNS on 1/14/26 identified there were no further SW notes in Resident #1's clinical record.Subsequent to surveyor inquiry, SW #1 documented a care plan progress note dated 1/14/26, late entry, regarding a care plan meeting with Resident #1's POA.Interview with SW #1 on 3/10/26 at 4:00 PM identified she is the only SW for the building. She identified Resident #1's annual and quarterly progress notes were missed due to an oversight. She identified the computerized medical record does not prompt her to document. She identified progress notes should be completed at a minimum of quarterly and annually.Although requested, a SW documentation and assessment policy was not provided.