STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075413	A. Building B. Wing	03/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Civita Care Northbridge	2875 Main Street Bridgeport, CT 06606

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 - 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 observations, interviews, policy review, and clinical record review, for 2 of 3 sampled residents (Resident #16 and Resident #121), the facility failed to provide care and services consistent with professional standards of practice and the residents' care plans, as required at S483.25 (F684): (1) for Resident #16, the facility did not ensure ongoing, routine blood glucose monitoring after readmission, did not timely renew orders for blood sugar checks, and did not maintain/document provider orders for insulin administration, resulting in severe hyperglycemia (HI >600 mg/dL), lethargy, hypoxemia, transfer to the ED, and hospitalization with metabolic encephalopathy; and (2) for Resident #121, the facility failed to develop and implement an individualized, 24ˆhour positioning plan, evaluate and monitor a custom tiltˆinˆspace wheelchair, and educate staff on its use despite documented positioning needs and risk for impaired skin integrity. The findings include: 1.Resident #16's diagnoses included dysphagia (difficulty swallowing), gastrostomy tube (G-tube) and type 2 Diabetes Mellitus (DM) with hyperglycemia (high blood sugar levels). An admission physician order dated 11/26/25 directed to inject 5 units of Neutral Protamine [NAME] (NPH) insulin every 12 hours. A physician order dated 11/27/25 directed to perform blood sugar checks once daily. A physician order dated 11/30/25 directed to send Resident #16 to the Emergency Department. A nurse's note dated 12/9/25 identified that Resident #16 was discharged from the hospital with diagnoses of acute blood loss anemia from a rectal sheath hematoma (abdominal pain caused by bleeding into the rectus abdominis muscle sheath), aspiration pneumonia, elevated liver enzymes, low sodium levels, along with a resolved acute metabolic encephalopathy, and resolved acute kidney injury. The physician order dated 11/27/25 directing blood sugar checks was placed on hold from 12/1/25 to 12/4/25 during Resident #16's hospital stay. A readmission Nursing assessment dated [DATE] identified that Resident #16 had diabetes, was alert and oriented, and required partial/moderate assistance for upper body dressing, required substantial/maximal assistance for lower body dressing and bed mobility, and transfers were not attempted. The Resident Care Plan in effect from 12/10/25 through 12/22/25 identified Resident #16 was an insulin dependent diabetic. Interventions included performing blood sugar levels per the physician's order and administering insulin as ordered and check for signs of symptoms of hyperglycemia (high blood sugar). A readmission physician order dated 12/9/25 and in effect through 12/16/25, directed to inject 15 (continued on next page)

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

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F 0684 Level of Harm - Actual harm Residents Affected - Few	units of Glargine insulin at bedtime related to type 2 DM with hyperglycemia. The physician's orders failed to ensure reoccurring blood sugar monitoring for Resident #16. A nurse's note dated 12/15/25 at 10:18 PM identified Resident #16's blood sugar check was noted to show a reading of HI, the blood sugar was rechecked and verified to read HI. [A high blood sugar level indicated that Resident #16's blood sugar level was greater than 600 milligrams per deciliter (mg/dL.) (normal 80 to 130 for diabetics)]. The Advanced Practice Registered Nurse (APRN) was notified and directed to give 10 units of Lispro insulin immediately, and to recheck the resident's blood sugar levels in 1 hour related to type 2 DM with hyperglycemia. The nurse's note failed to identify the reason for checking Resident #16's blood sugar). A one-time physician's order dated 12/15/25 directed to re-check the resident's blood sugar in 1 hour, and if the results were higher than 400, call the clinician. A nurse's note dated 12/16/25 at 12:51 AM identified Resident #16's blood sugar re-check showed a reading of 586 mg/dL The nursing note further identified the resident remained asymptomatic and the nursing supervisor was made aware. A second one-time physician's order dated 12/16/25 identified the provider was updated of the resident's blood sugar reading of 586, and the provider directed to give an additional 5 units of Lispro insulin, to re-check the resident's blood sugar level in 2 hours, and to update the clinician if the blood sugar level re-check was greater than 400. A physician's order dated 12/16/25 directed to check Resident #16's blood sugar twice a day at 8:00 AM and 5:00 PM before meals. A nurse's note dated 12/16/25 at 5:27 AM identified the resident was observed in bed, lethargic but alert, and had an oxygen saturation (SpO2) level of 88% (normal SpO2 level 95% to 100%) on room air. The nurse's note further indicated that Resident #16 blood sugar re-check was 472, and the resident was placed on supplemental oxygen due to their low oxygen saturation level, the supervisor was called to assess the resident, and an Advanced Practice Registered Nurse (APRN) order was received to send the resident to the Emergency Department for further evaluation. The nurse's note also indicated that Resident #16 left the facility around 6:40 AM via ambulance A supervising Registered Nurse (RN) note dated 12/16/25 at 5:33 AM indicated that she was called to the resident's room by the floor nurse at 4:50 AM, the resident's blood sugar level was reported to be 449 mg/dL., the resident was observed to be lethargic, barely responding to verbal commands, and had SpO2 of 88% on room air. The note further identified that the APRN was notified at 5:08 AM, who immediately ordered to provide supplemental oxygen. At 5:30 AM Resident #16's SpO2 was identified to have increased to 95% while on 2 liters of oxygen. An order was received to transfer Resident #16 to the Emergency Department by the APRN, and the resident was given a one-time correctional dose of Lispro insulin of 8 units prior to his/her transfer to the Emergency Department, and 911 was called at 5:48 AM for transport. (The medical record failed to include an APRN order for the additional dose of Lispro). A nurse's note dated 12/22/25 identified that Resident #16 was discharged from the hospital on [DATE] with a diagnosis of metabolic encephalopathy (brain dysfunction caused by systemic illness, organ failure, or chemical imbalances rather than structural brain damage.) (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Interview with the Director of Nursing (DON) on 3/23/26 at 9:40 AM identified she was unable to locate an active order for Resident #16 to have any routine or reoccurring blood sugar levels taken since his/her readmission back to the facility on [DATE]. She stated she only saw one order to check the resident's blood sugar on 12/16/25, when the resident became symptomatic and prior to Resident #16's hospitalization. The DON also identified the resident should have had reoccurring orders to check blood sugar levels since Resident #16 had a past medical history of Type 2 DM with hyperglycemia. Additionally, the DON indicated no active orders in the clinical record directing a lab test for a Hemoglobin A1c check (measure of blood sugar level over 3 months) and the last Hemoglobin A1c ordered had occurred in 2023. Interview with APRN #3 on 3/23/26 at 12:30 PM identified that when the resident was readmitted on [DATE] she directed staff to perform Resident #16's blood sugar levels be checked daily at bedtime. APRN #3 indicated that there were no active orders to routinely check Resident #16's blood sugar levels prior to his/her being discharged to the hospital on [DATE], stating that I guess they were not renewed after the resident had been re-admitted from the hospital on [DATE]. She indicated that she saw a narrative note written by Supervising Registered Nurse (RN) #3 indicating an order for blood sugars, but apparently the order was incorrectly written. APRN #3 identified that there should have been orders for routine reoccurring blood sugar level checks for Resident #16, and if there were no reoccurring orders, there should be a note indicating why blood sugar levels were not being obtained. A review of the facility policy for Physician's Orders directs, in part that verbal orders must be recorded immediately in the resident's chart by the person receiving the order and must include the prescriber's last name, credentials, and the date and time of the order. It also directs that verbal orders must be signed by the prescriber on his/her next visit. The policy also directs that the orders for medications must include: name and strength of the drug; number of doses, start and stop date, and/or specific duration of therapy; dosage and frequency of administration; route of administration; clinical condition or symptoms for which the medication is prescribed; and any interim follow-up requirements (pending culture and sensitivity reports, repeat labs, therapeutic medication monitoring, etc.) 2. Resident #121's diagnoses included abnormal posture, unspecified arthritis and diabetes mellitus. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #121 had a Brief Interview of Mental Status score of 11 indicating moderate cognitive impairment, and was dependent on staff for toileting, transfers and dressing. Additionally, the MDS identified Resident #121 used a manual wheelchair, had upper extremity impairment on one side, and was at risk for developing pressure ulcers/injuries. The Resident Care Plan dated 10/29/25 identified Resident #121 was at risk for skin breakdown/pressure ulcers related to decreased mobility, bowel incontinence, diabetes mellitus, congestive heart failure and chronic obstructive pulmonary disease. Interventions directed to provide an air mattress, perform weekly skin inspections, and offer turning and repositioning every 2 hours and as needed. Review of the Occupational Therapy (OT) Evaluation and Plan of treatment dated 12/31/25 identified the referral was for positioning following a customized wheelchair (CWC) delivery. The assessment summary identified, in part, that Resident #121 presented with decreased trunk control, overall weakness, and was currently in a tilt in space CWC (custom wheelchair). Overall, Resident #121 was unable to reposition him/herself, and due to documented physical impairments and associated (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	functional deficits, was at risk for behavioral outbursts and decreased skin integrity. A physician's order dated 1/18/26 directed Resident #121 to be out of bed and up into the custom tilt-in-space wheelchair in the morning after morning care, then out of the custom tilt-in-space wheelchair and back to bed in evening prior to evening care. Resident #121 may request to be transferred in or out of the custom tilt-in-space wheelchair at any time and may be tilted in the custom tilt-in-space wheelchair to the resident's tolerance for pressure relief. The Resident Care Plan updated on 2/26/26 identified Resident #121 had a non-pressure skin tear to the left gluteal fold. Interventions directed to provide treatment to the gluteal cleft as ordered, a specialty air mattress was to be set at 200 and be checked for function and setting every shift. Resident #121 was to be out of bed and up into the custom tilt-in-space wheelchair in the morning after morning care, and out of custom tilt-in-space wheelchair and placed back to bed in the evening prior to evening care. Resident #121 may request to be transferred into or out of custom tilt-in-space wheelchair at any time, may be tilted in custom tilt-in-space wheelchair to resident tolerance for pressure relief. Observations on 3/16/26 at 11:37 AM and 3/17/26 at 10:00 AM identified Resident #121 in bed, awake watching television in the supine position. Observation, interview and facility documentation review on 3/19/26 at 10:19 AM with Nurse Aide (NA) #6 identified Resident #121 in bed, awake and watching television in the supine position. NA #6 identified he was the regular NA for Resident #121 and usually got her/him up right before lunch (around 11:45 AM) then back to bed before end of shift, around 2:30 PM, to provide incontinent care. Review of Resident #121's Resident Care Card (care guide) with NA #6 failed to identify any directions for an out-of-bed schedule, tilt in space schedule, or positioning plan. Interview and clinical documentation review with the Director of Rehabilitation, Physical Therapist (PT) #1 on 3/19/26 at 12:58 PM identified it was the facility policy to receive Custom Wheelchairs (CWC) from an outside vendor, with assessments, evaluations and physician's order per the original evaluation from Occupational Therapy (OT). Review of Resident #121's clinical record identified the resident received a CWC on 12/31/25 for abnormal posture, with the positioning plan consisting of a physician's order directing for Resident #121 to be out of bed and up into tilt-in-space CWC in the morning after morning care, then back to bed in evening prior to evening care without timeframes specified leaving it up to the NA's to discretion. PT #1 added that the OT Evaluation and Plan of Treatment dated 12/31/25 and the physician's order dated 1/18/26 was the only information she had for Resident #121's CWC seating plan. Interview with the Director of Nursing on 3/19/26 at 2:25 PM identified that it was facility policy for residents in need of CWC to be assessed by therapy with an outside vendor involved. Additionally, the DON identified that any staff education pertaining to the CWCs, a 24-hour positioning plan, and monthly as well as quarterly notes were all dictated by, and the responsibility of, the Therapy Department. The DON was unable to provide documentation reflecting staff had received education for Resident #121's CWC, quarterly or monthly CWC evaluation notes, or a positioning plan adding that she would expect the Resident Care Card to direct a positioning plan for a Resident #121's tilt-in-space CWC. Re-Interview with PT #1 on 3/23/26 at 9:45 AM identified she did not have documentation reflecting staff were educated for Resident #121's CWC use, any quarterly or monthly CWC evaluation notes, or (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	that a customized 24-hour positioning plan had been developed directing the use of CWC. The only documentation consisted of a physician's order that was reviewed on 3/19/26 directing Resident #121 be out of bed after morning care and back to bed after evening care but that resident with CWC's should have a 24-hour positioning plan and that CWC use required evaluation and monitoring. Going forward, she was going to audit all residents with CWC's for appropriate documentation. Interview with the CWC vendor on 3/23/26 at 12:12 PM identified when CWC are delivered to the facility, the vendor does not put a positioning schedule in place but it is strongly recommended to the facility to put a position schedule in place as well as education for NA's, and evaluation of the CWC quarterly and monthly to see if that plan is followed, if resident needs are met, and if the chair is in good working order. Review of Resident #121's position plan with the vendor identified it was too open ended and should have specific times or at least time frames for out of bed, back to bed and tilting. Additionally, the vendor identified a CWC was a prescribed piece of equipment to prevent contractures and skin breakdown that required monitoring and definition of positioning. Review of the Custom Wheelchair Policy dated 9/1/22 directed in part that all residents requiring a custom wheelchair receive appropriate assessment, fitting, maintenance, and monitoring to promote safety, prevent injury, maintain functional mobility, and enhance quality of life. Review of the Positioning and Repositioning Program Policy revised 8/3/25 directed in part to implement and maintain an individualized 24-hour positioning and repositioning program for residents at risk for skin breakdown, impaired mobility or pressure injuries. Additionally, a 24-hour positioning plan was defined as a comprehensive, individualized schedule outlining positioning, repositioning, support surfaces, and assistive devices across a full day that is specific (ex. every 2 hours in bed). Furthermore, monitoring and evaluation will be completed, and staff will receive education on use of devices and support surfaces. Review of the Repositioning Policy revised on 10/3/25 directed in part that repositioning is a common, effective intervention for preventing skin breakdown, promoting circulation and providing pressure relief. Additionally, evaluation of a resident's skin integrity after pressure has been reduced or redistributed should guide the development and implementation of repositioning plans. Review of the Therapy Services Policy revised 10/2/25 directed in part that OT would provide adaptive equipment training. Additionally, therapy documentation requirements included weekly progress notes (or per regulation). Review of the Wheelchair Assessment Policy revised 7/6/25 directed in part that nursing responsibilities included daily monitoring, safe use and documentation and OT responsibilities included seating assessments, recommendations and training. Additionally, that staff will be educated on hire and annually on safe wheelchair operation and transfers, proper positioning techniques and identifying equipment issues.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observations, interviews, review of facility documentation, and policy, the facility failed to ensure fans in resident rooms were maintained in a clean manner. The findings include:Observations on 3/16/26 at 11:01 AM) identified a gray, fuzzy material on the edges of fan blades, bottom of the fan enclosure, and in the grills of fans located in the resident rooms: 411, 412, 415, 416, 417, 418, 419, 420, 422. Fans were used and running in rooms 411, 412, 416, 418 and 419.Observations on 3/17/26 at 9:31 AM identified a gray, fuzzy material on the edges of fan blades, bottom of the fan enclosure, and in the grills of fans located in the resident rooms: 411, 412, 415, 416, 417, 418, 419, 420, 422. Fans were used and running in rooms 411, 412, 415, 417, 418 and 422.3/18/26 at 10:35 AM (3 consecutive days) identified a gray, fuzzy material on the edges of fan blades, bottom of the fan enclosure, and in the grills of fans located in the resident rooms: 411, 412, 415, 416, 417, 418, 419, 420, 422. Fans were used and running in rooms 412, 416, 417, 419, 420, and 422.Interview on 3/18/26 at 10:40 AM with Housekeeper (HK) #1 identified facility policy directed resident rooms to be cleaned daily, and the housekeeper assigned to the room ensured proper cleaning. HK #1 indicated that her schedule had her assigned to different rooms on different days. She indicated a checklist directed that she clean the bathroom, wipe down all surfaces in the bathroom and room, and swept and mopped the floors. HK #1 indicated that she had never been instructed to clean resident fans and that it was the Maintenance Department's responsibility.Interview with the Assistant Maintenance Director on 3/18/26 at 10:59 AM identified that it was the responsibility of the Housekeeping Department to clean fans in resident rooms and that it has been that way since he began employment at the facility 8 years ago.Interview with the Housekeeping Director on 3/18/26 at 11:06 AM identified that it was the responsibility of the Maintenance Department to clean resident fans. She indicated that it had been that way as long as she could remember. Additionally, she indicated had she been asked, her housekeepers would have cleaned the fans.Interview and observation with the Administrator on 3/18/26 at 11:26 AM identified the fans located in resident rooms 411, 412, 415, 416, 417, 418, 419, 420, and 422 had a gray, fuzzy material located on the fan blades, bottom of the fan enclosure, and in the grills. The Administrator indicated that it was the responsibility of the Housekeeping Department to ensure resident fans were clean. The Administrator could not identify why the fans were not cleaned as they should have been.Review of the Daily Resident Room Routine Audit form failed to direct resident fans to be cleaned.Subsequent to surveyor inquiry, the fans located in resident rooms 411, 412, 415, 416, 417, 418, 419, 420, and 422 were cleaned.Review of the facilities Cleaning and Disinfecting Resident Rooms policy dated 4/13/2025 identified the purpose of the procedure was to provide guidelines for cleaning and disinfecting resident rooms. Additionally, the policy failed to identify cleaning of fans in resident rooms.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, review of the clinical record and policy for 1 of 5 sampled residents (Resident #121) reviewed for unnecessary medications, the facility failed to transcribe physician's orders for psychotropic (psychiatric) medications resulting in the medications not being administered for a resident experiencing mood and behavioral issues. The findings include:Resident #121's diagnoses included unspecified dementia with behavioral disturbances, anxiety disorder and adjustment disorder.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #121 had a Brief Interview of Mental Status score of 11 indicating moderate cognitive impairment, and was dependent on staff for transfers and dressing, had a Resident Mood Interview score of 6 indicating a high likelihood of depression, and had physical behavioral symptoms directed toward others (defined as hitting, kicking, pushing, scratching, grabbing or abusing others sexually) occurring 1-3 days of the week.Review of the Resident Care Plan dated 10/29/25 identified Resident #121 had episodes of anxiety, a history of anxiety and depressive disorder. Interventions included administering anti-anxiety medications per the physician's orders and monitoring for effectiveness, observing behaviors and providing psychiatry evaluations and follow up as needed for medication management and counseling.Review of a psychiatry prescriber note and physician's order sheet in the paper record dated 12/2/25 identified worsening of inappropriate sexual behaviors and orders directed to adjust medications, discontinue the current dose of Zoloft 125 milligrams (mg), start Zoloft 75 mg once a day for anxiety, start Prozac 10 mg once a day for anxiety, and start Trazodone 25 mg once a day prior to (assistance with) care for dementia with agitation.Review of the nurses note dated 12/7/25 at 6:07 AM identified Resident #121 slapped a nurse aide twice while receiving incontinent care.Review of the nurses note dated 12/10/25 at 3:07 PM identified Resident #121 was disruptive during activities by yelling out and using profanities.Review of the psychiatry prescriber note dated 12/11/25 identified increased agitation in the dining room the day prior, and to continue with current medications.Review of the nurses note dated 12/23/25 at 5:03 AM identified Resident #121 was difficult with care, yelling profanities in Spanish, as well as grabbing and scratching at the staff's arms.Review of the nurses note dated 1/5/26 at 5:25 AM identified Resident #121 was slapping, grabbing, and scratching staff during care.Review of the nurses note dated 2/19/26 at 3:00 PM identified Resident #121 was disruptive during activities by yelling out and using profanities.Interview and record review with Licensed Practical Nurse (LPN) #2 on 3/18/26 at 8:31 AM identified the facility protocol directed providers to write orders on a paper physician's order form in the chart, then nurses were responsible to transcribe the orders into the electronic health record so nursing staff would know to administer the medications. Review of Resident #121's electronic health record failed to identify the orders directing medication changes from the 12/2/25 psychiatric provider note and subsequent physician orders had been transcribed, stating they should have been, but was unable to identify why no changes had been made.Interview and clinical record review with the Director of Nurses (DNS) on 3/18/26 at 11:35 AM identified the previous psychiatry provider wrote orders on a physician's order sheet in the paper chart and nurses were responsible for transcribing the orders into the electronic health record. Review of Resident #121's clinical record with the DNS identified that the physician's orders dated 12/2/25 had not been transcribed changing Resident #121's orders despite continued behavioral issues with care. Additionally, the DNS identified she felt the orders were never transcribed due to the psychiatry Advanced Practice Registered Nurse (APRN) being unable to reach the Power of Attorney (POA).Interview and record review with psychiatry APRN #1 on 3/23/26 at 9:49 AM identified that although she had access to the electronic health record, the facility practice was to write orders on paper on a physician's order form, get orders approved, then transcribe the orders into the electronic health record. Review of Resident #121's clinical record with APRN #1 identified that she wrote the recommendations and physician's order on 12/2/26 after being notified of Resident (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	#121's increased agitation. She had been unable to reach the POA for medication change notification. Since it was a collaborative effort with the facility, the facility nurses would have been responsible to continue to contact the POA and then subsequently transcribe the orders into the electronic health record. APRN #1 indicated she expected nursing to have notified the POA and transcribe the orders by Resident #121's next psychiatry visit at the latest which occurred on 12/11/25. Although APRN #1 could not identify why she did not follow up on the orders that were not transcribed, she stated at this point, 3 months later, she would have to re-evaluate Resident #121 to determine if the previously ordered medication were still appropriate. APRN #1 was unable to indicate if Resident #121 had any ill effects due to the lack of medication recommendation implementation.Reinterview with the DNS on 3/23/26 at 12:07 PM identified that the 12/2/25 psychiatry recommendations most likely were not flagged which would have indicated nurses needed to pursue the new medication orders for transcription. Additionally, the DNS stated there were no nurses' notes indicating that POA notification was attempted or occurred. Subsequent to surveyor inquiry a nurses note dated 3/19/26 at 5:17 PM identified the in-house APRN was notified of the psychiatry recommendations from 12/2/26, with directives for the psychiatry APRN to evaluate Resident #121 to see if recommendations were still appropriate.Review of the Physician's Orders Policy revised 10/3/25 directed in part that medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in this state.Review of the Physician's Orders Transcription Policy dated 4/2015 directed, in part, that all physician's orders must be duly noted and accurately transcribed.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, review of the clinical record, and facility policy for 1 resident (Resident #64) during the initial resident screening process, the facility failed to ensure medications were not left unattended at the resident's bedside, for a resident without a self-administration physician orders and for 1 of 3 medication carts reviewed for medication storage, the facility failed to ensure medications and biologicals were stored according to professional standards and failed to ensure controlled medications were under double locked. The findings include: The findings include: 1.Resident #64's diagnoses included type 2 diabetes mellitus with diabetic neuropathy (nerve pain) and peripheral vascular disease. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #64's short-and long-term memory were okay and further identified the resident as being independent to make decisions regarding tasks of daily life. Resident #64's most recent MDS dated [DATE] was not completed regarding his/her BIMS score but did identify that the resident was independent with eating, toileting hygiene, personal/oral hygiene. The Resident Care Plan (RCP) in effect from 12/6/25 through 3/23/25 identified Resident #64 exhibited behavior problems at times including but not limited to yelling out and becoming verbally agitated towards staff, refusing to participate in mental status testing, and Social Determinates of Health assessments. Interventions included educating the resident on the importance of taking medications and obtaining vital signs taken. Observation and interview with Resident #64 in his/her room on 3/17/26 at 11:15 AM identified 4 medications (meds) in a medication cup stored on his/her bedside tray table next to personal belongings and his/her breakfast. Resident #64 indicated he/she was unaware that meds were there and indicated he/she must have been asleep when the nurse passed meds and leaving them at the bedside to take when he/she woke up. Interview with LPN #3 at 11:30 AM indicated he passed meds to Resident #64 around 8:00 AM but was called out of the resident's room by one of the unit's Nurse's Aids (NA) leaving Resident #64's medications on his/her bedside tray table and walked away. LPN #3 indicated he did not physically see the resident take his meds, he should not have left the medications on the resident's tray table, and that he should have taken the meds with him if he was going to leave the room without seeing the resident take their meds. Interview with the DNS at 11:35 AM indicated that should have never happened, that the medications should have never been left with the resident unattended, and that LPN #3 should have taken the meds with him when he exited the room if he did not observe the resident take their medications. Review of the facility administration of medication policy directed, in part, residents not in their rooms, or otherwise unavailable to receive medication on the pass, the medication administration record may be flagged by the nurse, and after completing the medication pass, the nurse will return to the missed resident to administer the medication. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2.Observation on 3/18/26 at 6:14 AM identified the medication cart on Beardsley Park was unlocked in a resident hallway parked between resident room [ROOM NUMBER] and the game room with no nurse in sight of the medication cart. Observation and interview with Licensed Practical Nurse (LPN) #1 on 3/18/2026 6:20 AM identified her approach the cart from the other end of the hallway. LPN #1 identified it was facility policy for the charge nurse to always keep the medication cart locked when not in use. Although LPN #1 could not identify why the medication cart was left unlocked and unattended, she stated it should have been locked. Review of the Controlled Substances Policy revised 11/1/25 directed in part that the facility complies with all laws, regulations, and other requirements relating to handling, storage, disposal and documentation of controlled medications. Review of the Medication Storage Policy reviewed 10/5/25 directed in part that the facility stores all drugs and biologicals in a safe, secure and orderly manner. Additionally, compartments containing drugs and biologicals are locked when not in use and unlocked medication carts are not left unattended.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, policy, and interviews, for 1 of 3 sampled residents (Resident #38) reviewed for choices, the facility failed to honor a dependent resident's preference for oral hygiene. The findings include:Resident #38's diagnoses included quadriplegia, contractures of multiple sites and injury of unspecified nerves of the neck.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #121 had a Brief Interview of Mental Status score of 15 indicating intact cognition and was totally dependent on staff to provide oral hygiene, personal hygiene, and all activities of daily living. The Resident Care Plan dated 1/9/26 and in effect through 3/19/26 Identified Resident #38 had oral /dental health problems due to poor oral hygiene. Interventions directed to brush teeth 3 times daily after meals per the Resident #38's request.A review of the Resident Care Card (Nurse Aid care guide) dated 12/4/25 and in effect through 3/19/26 directed staff to provide Resident #38 with mouth care 3 times a day.The physician's order in effect for March 2026, directed assistance with Resident #38's activities of daily living at the bedside due to being totally dependent.Interview with Resident #38 on 3/17/26 at 10:00 AM identified although he/she had requested to have his/her teeth brushed 3 times per day, staff were not following his/her request. Interview and review of facility documentation and policy with Nurse Aide (NA) #7 on 3/19/26 at 10:09 AM identified it was the policy to provide oral hygiene daily, and any resident who required/requested more frequent mouth care would have the information documented on the Resident Care Card. NA #7 reported that Resident #38 was dependent on staff for oral care and she was the primary NA caregiver. During a review of the Resident Care Card, NA #7 indicated Resident #38 was supposed to have oral hygiene provided 3 times daily, including twice during the day shift. NA #7 was unable to explain why she had not been providing mouth care as directed stating the resident was often out and about (but returned to the unit for meals). Additionally, a review of the resident's flowsheet (documentation of care) with NA #7 failed to identify that Resident #38 was consistently receiving oral care 3 times daily but should have been per the Resident Care Card.Interview and clinical record review with the Director of Nurses (DNS) on 3/19/26 at 10:26 AM identified facility practice required NA's to perform oral hygiene/mouth care during morning and evening care and more frequently as indicated in each resident's care plan. Review of Resident #38's clinical record identified his/her plan of care directed oral hygiene to occur 3 times daily. The DNS indicated that the information was documented on the NA Resident Care Card located in the resident's room. A review of Resident #38's electronic health record dated 2/28/26 to 3/19/26 identified Resident #38 had been receiving oral hygiene, on the average, once per day but should have been provided oral care 3 times per day as directed in the plan of care.Review of the Mouth Care Policy 10/3/25 directed, in part, to record the date and time mouth care was provided, complaints of pain or discomfort or refusal.Review of the Resident Rights policy revised on 10/3/25 directed in part that residents had the right to self-determination and participation in his/her treatment.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of the clinical record, facility documentation, facility policy and interviews for 1 of 3 sampled residents reviewed for food and nutrition (Resident #15) and for the only sampled resident (Resident # 122) reviewed for hydration the facility failed to follow physician's orders for obtaining weights after a significant weight loss and failed to maintain intake and output fluid amounts for residents receiving Intravenous (IV) fluids. The findings include:1. Resident #15 ?s diagnoses included acute cholecystitis, diabetes, and encephalopathy.The admission Minimum Data Set assessment dated [DATE] identified Resident #15 had a Brief Interview for Mental Status score of 15 indicating no cognitive impairment and required substantial/maximum assistance with bed mobility, total staff assistance with transfers, and was independent with eating. Resident #15's weight was noted to be 177 pounds without a weight loss or gain.The Resident Care Plan dated 2/3/26 identified a potential for impaired nutrition status due to diabetes, anemia, and gastroesophageal reflux disease (GERD). Interventions included, assist with meals as needed, monitor and document percent consumed solids/fluids and snacks, monitor labs and monitor weight as needed, obtain and update preferences as needed, provide diet as ordered, provide selective menu as able. Review of the Resident Care Plan failed to identify a significant weight loss or that Resident #15 was receiving Intravenous (IV) fluids.a. A physician's order dated 3/4/26 directed to reweigh Resident #15 on the day shift daily for 3 days.Review of the weights and vital sign report and Medication Administration Record (MAR) identified that the resident was weighed on 3/5/25, and on 3/6/26, however, the facility failed to obtain a weight for Resident #15 on 3/4/26 or 3/7/26 (missed 1 weight).An Advanced Practice Registered Nurse (APRN) note dated 3/5/26 at 1:27 PM identified complaints of vomiting and weight loss. Weight review showed an 11-pound loss since admission and albumin (protein level) remained low. Etiology of vomiting remained unclear.A dietitian note dated 3/12/26 at 11:42AM identified a significant weight loss. Resident #15 reported poor appetite, history of bariatric surgery. Weight loss was discussed and Resident #15 was agreeable to Boost VHC 120 (ml) twice a day and was currently on liquid protein and weekly weights.An APRN note dated 3/19/26 at 8:11 PM identified poor oral intake and ongoing clinical decline characterized by greater than a 30-pound weight loss since admission despite dietitian involvement and supplementation attempts. Resident #15 was now refusing most protein shakes. Continue Monday, Wednesday, Friday weights. Resident #15 appears volume depleted intravascularly despite third spacing, encourage oral intake as tolerated, consider a trial of IV fluids and or albumin support.Review of the physician's orders failed to identify a physician order for Monday, Wednesday, and Friday weights.A dietitian note dated 3/20/26 at 12:37PM identified a significant weight loss, Resident #15 had a history of gastric bypass. Discussed weight loss and reviewed menu options and identified likes and dislikes. An updated menu to fill out would be provided and the resident was encouraged to increase protein intake. Encouraged to fill out menu or call down to kitchen if he/she wanted something different to eat.An APRN note dated 3/20/26 at 7:22 PM identified Resident #15 continued with poor oral intake but was now agreeable to a trial of a liquid protein supplement and continue Boost supplements. Severe protein calorie malnutrition: abnormal and significant weight loss 178 pounds upon admission on [DATE] and now 141 pounds today, a loss of 37 pounds in less than 2 months.The physician's orders dated 3/20/26 and 3/21/26 directed staff to obtain daily weights due to abnormal weight loss.Review of the weights and vital sign report and Medication Administration Record (MAR) identified that the resident was weighed on 3/23/26, however, the facility failed to weigh Resident #15 on 3/21/26 or 3/22/26. (missing 2 weights).b. An APRN note dated 3/19/26 at 8:11 PM identified poor oral intake and ongoing clinical decline. Resident #15 continued with severe protein calorie malnutrition and poor oral intake. Resident #15 appears volume depleted intravascularly despite third spacing, encourage oral intake as tolerated, consider trial of IV fluids.An APRN note dated 3/20/26 at 7:22 PM identified severe (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	malnutrition with acute kidney injury. Gentle IV fluid trial initiated with normal saline 0.9% at 50 ml per hour for a total of 1 liter then stop and reassess Basic Metabolic Panel (BMP) (labs) on 3/22/26 to evaluate renal response. Initiate normal saline 0.9% at 50 milliliters (ml) per hour for a total of 1 liter via midline then stop.A physician's order dated 3/21/26 directed a gentle trial of normal saline 0.9% Intravenous Fluids (IV) at 50 ml per hour for a total of 1 liter via a midline (type of IV access site) catheter.A nurse's note dated 3/21/26 at 6:20 PM identified a physician's order received to increase the normal saline IV rate to 75 ml per hour due to decreased oral intake.A physician's order dated 3/22/26 directed to administer IV normal saline 0.9% at 75 ml per hour 1 time only for dehydration for 1 day.A nurse's note dated 3/22/26 at 3:44 AM IV fluid completed this shift, no signs of complications noted. Right upper arm midline intact, no infiltration, flushed without concerns.A nurse's note dated 3/22/26 at 7:03 PM identified Resident #15 was started on an additional 1 liter of normal saline intravenous fluid at 75 ml per hour because of poor oral intake.A nurse's note dated 3/23/26 at 7:20 AM identified IV normal saline at 75 ml per hour, no signs of infiltration noted, right upper arm midline in place, intact, flushed without concerns.Review of the MAR from 3/1/26 through 3/23/26 identified although IV fluids were given on 3/20/26, 3/21/26, 3/22/26, and 3/23/26 the MAR failed to indicate that Resident #15 required monitoring of fluid intakes due to his/her IV administration.Review of flowsheets in an intake and output binder at the nurse's station for March 2026 failed to identify that Resident #15 had a monitoring form to record fluid intake during the time he/she was receiving IV fluids.Interview and clinical record review with LPN #3 on 3/23/26 at 10:52 AM identified the intake and output binder failed to include flowsheets for Resident #15. LPN #3 was unable to explain why a flow sheet for Resident #15 was not present in the intake and output binder. LPN #3 reviewed the MAR for IV fluid intakes and daily weights and was unable to explain why the clinical record failed to reflect documentation for IV fluid intake or daily weights.An interview and clinical record review with Director of Nursing Services (DNS) on 3/23/26 at 10:54 AM, identified the IV fluid quantity would be documented on an IV sheet, Medication Administration Record (MAR), and was possibly on a worksheet that was never entered into the MAR. Subsequent to surveyor interview with the DNS on 3/23/26, the DNS initiated an intake and output form dating it for 3/22/26.A re-interview with the DNS on 3/23/26 at 11:49 AM identified the clinical record failed to reflect documentation of Resident #15's oral intake or IV fluid amounts received. The DNS indicated that it was the responsibility of the nursing staff to complete intake and output sheets for oral intakes for a resident receiving IV fluids as well as the amount of the IV fluids administered. Additionally, she was unable to locate Resident #15's missing weights directed to be taken by the physician, but the nursing staff should have followed the physician's orders and obtained the weights. The DNS was unable to explain why Resident #15's intake and output was not recorded or why the residents weights were never obtained. 2. Resident #122 ?s diagnoses included Alzheimer's dementia, pneumonia, and severe protein calorie malnutrition.The admission Minimum Data Set assessment dated [DATE] identified Resident #122 had a Brief Score for Mental Status score of 8 indicating moderate cognitive impairment and required supervision for eating, substantial maximum assistance with bed mobility and total dependence for transfers with a functional limitation in range of motion for bilateral lower extremities.a. The Resident Care Plan dated 3/3/26 identified Resident #122 was at the end of life and decline in overall status/death was anticipated. Interventions included assisting with meals, encouragement to eat and drink, food for comfort, weight per physician order.A physician's order dated 3/2/26 directed to weigh on admission and then for 4 consecutive weeks post admission then reassess.A physician's order dated 3/20/26 directed weekly weights due to poor oral intake on during the day shift on Mondays for severe protein calorie malnutrition. A review of Medication Administration Record (MAR) dated 3/1/26 through 3/23/26 identified weekly weights failed to be obtained on 3/16/26 and 3/23/26 as directed by the physician's orders.b. The Resident Care Plan dated 3/6/26 identified Resident #122 was receiving IV therapy for hydration. Interventions included changing IV insertion site as ordered, IV as ordered, monitor intake and output every shift, receiving IV via peripheral catheter.The physician's (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	orders in effect from 3/3/26 through 3/19/26 directed staff to document urinary catheter output every shift.A physician's order dated 3/6/26 directed to attempt to place a peripheral IV and maintain with 10 milliliters (ml) normal saline flushes per shift for dehydration for 3 days, administer IV fluids normal saline 0.9% at 50 ml per hour via peripheral IV catheter for a total of 1 liter every shift for dehydration and hypovolemia (blood/fluid volume depletion) for 3 days.An APRN note dated 3/6/26 at 2:54 PM identified the Medical Director was consulted and recommended gentle IV hydration given severe dehydration and inability to tolerate oral fluids. Start normal saline at 50 ml per hour for 1 liter if peripheral IV can be successfully placed.A physician's order dated 3/8/26 directed administer sodium chloride intravenous solution 0.45% use 2 liter intravenously every shift for hydration, poor oral intake for 4 days at a rate of 100 ml per hour for 2 liters.A nurse's note dated 3/8/26 at 7:06 PM identified a family member was updated that 2 liters of IV fluid was ordered for poor oral intake and low blood pressure. The family member identified that Resident #122 consumed approximately 900 ml of fluids, and he/she was concerned regarding additional IV fluids because of pedal edema. The physician was notified and the order was placed on hold.A physician's order dated 3/14/26 directed to insert peripheral IV for IV hydration for 1 day, sodium chloride intravenous solution 0.45% use 75 ml per hour for IV hydration for 4 days for 2 litersAn APRN note dated 3/16/26 at 12:31 PM identified dehydration follow up with generalized weakness and dehydration. She/he completed the second liter of normal saline. Urine remained dark orange in the catheter bag. A review of the [DATE]/1/26 through 3/23/26 identified IV fluids were administered on 3/6/26, 3/7/26. 3/8/26, 3/14/26, 3/15/26, 3/16/26 but failed to identify the quantity administered. A review of the intake and output flowsheets in the binder at the nurse's station identified that output amounts on 3/4, 3/5, 3/12, 1/13, 3/15, 3/16, 3/17, 3/18, 3/19, 3/20, and 3/21/26 were blank for the 24-hour period.A review of the documentation survey report dated March 2026, failed to identify any fluid intake.Interview on 3/19/26 at 11:05 AM with LPN #3 identified that the Nurse Aids (NAs) were responsible for documenting the intake and output on the flow sheets and did not know why Resident #122's outputs were not documented.Interview and record review on 3/19/26 at 2:55 PM with the DNS indicated that a hydration evaluation was completed on 3/17/26 and that intake should be documented on both the MAR and the intake and output flowsheet. The DNS further stated she was not aware that the output flowsheets contained no documentation of urine output. Re-Interview with the DNS on 3/23/26 at 11:49 AM identified she was unable to locate Resident #122's missing weights directed to be taken by the physician, but the nursing staff should have followed the physician's orders and obtained the weights. The DNS was unable to explain why Resident #122's IV fluid administration amounts were not recorded or why output records were left blank. Review of the Weight Assessment and Interventions policy dated 9/1/22 directed, in part, weights are monitored for undesirable or unintended weight loss or gain. Weights are recorded in the individual's medical record.Review of the Intake and Output Monitoring policy dated April 2015 directed in part; residents identified for a potential at risk for dehydration will be placed on intake and output monitoring until adequate hydration status is achieved or until Intake and output monitoring is no longer clinically indicated.Review of the Intake Measurement policy dated 9/1/22 directed in part, fluids taken intravenously are recorded by the licensed nurse. Record all fluid intake on the intake and output record in milliliters.Review of the Intravenous therapy policy dated 9/1/22 directed, in part, track intake and output as indicated. Document in the medical record fluids administered, rate and volume. Nursing will monitor and document fluid intake.Review of the Catheter Care policy dated 6/26/25 directed, in part, to follow the facility procedure for monitoring and documenting intake and output.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation and policy and interviews for the only sampled resident (Resident #61) reviewed for hemolytic treatments, the facility failed to consistently maintain a fluid restriction according to the physician's orders. The findings include:Resident #61?s diagnoses included End Stage Renal Disease (ESRD), cirrhosis of the liver, low sodium, and dependence on hemolytic treatments. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #61 was cognitively intact and required substantial/maximum assistance for toileting, bathing, dressing and personal hygiene and set-up assistance for eating and oral care.The Resident Care Plan in effect from 1/11/26 through 3/24/26 identified Resident #61 had a potential for impaired nutritional status due to ESRD on hemolytic treatment. Interventions included to document the percentage of food and fluids consumed, renal diet with thin liquids, and a fluid restriction of 1000 milliliters (ml) daily with the following shift parameters: 120 ml on 11:00 PM to 7:00 AM, 240 ml on 7:00 AM to 3:00 PM and 240ml on 3:00 PM to 11:00 PM with 400 ml from dietary.A physician's order on readmission dated 2/26/26 directed to keep Resident #61 on a strict 1000 ml fluid restriction with parameters: 120 ml on 11:00 PM to 7:00 AM, 240 ml on 7:00 AM to 3:00 PM and 240 ml on 3:00 PM to 11:00 PM with 400 ml from dietary.Interview and facility record review with Licensed Practical Nurse (LPN #6) on 3/24/26 at 9:39 AM identified that the Nurse Aid (NA) was responsible for reporting to nursing and nursing was responsible for recording any fluid intake into an Intake and output binder at the end of their shift. LPN #6 showed the binder and Resident #61's records indicated that 54 out of 198 opportunities had been missed to record fluid intake since 1/11/26. The binder contained flowsheets to record oral intake and add up the total amount at the end of each day.Interview, review of the clinical record and facility documentation with the Nursing Supervisor Registered Nurse (RN) #3 on 3/24/26 at 11:12 AM identified that both nursing and dietary were responsible for monitoring fluid intakes for Resident #61's fluid restriction orders. RN #3 stated that at the end of each shift licensed nursing staff was responsible for obtaining the intake information from the NAs, adding in the medication pass fluid amounts, and documenting the information under the resident's flowsheet located in the intake and output binder. Interview with the Dietician on 3/24/26 at 11:28 AM indicated that dietary plays a part in helping monitor Resident #61 on fluid restriction. The Dietician stated that on each meal ticket there is a specific amount of fluid to go up on the meal tray and that nursing was responsible for administering and monitoring any other consumed fluids.Interview with the Director of Nursing Services (DNS) on 3/24/26 at 11:58 AM indicated nursing was responsible for monitoring fluid intakes, restriction, and documentation. The DNS was unable to explain why Resident #61's fluid intake was not being consistently monitored.Review of the Fluid Restriction policy dated 8/4/25 directed, in part, if a resident is prescribed a limit on total daily fluid intake, the facility would have a current provider order, care plan the restriction and would accurately measure and document all fluid intake each shift.Review of the Hemodialysis policy dated 4/2015 stated that if a resident is placed on fluid restriction, monitor intake. Allocate fluids to be given by nursing and dietary with amounts documented per shift.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observation, interview, and review of facility policy during a tour of the kitchen, the facility failed to maintain the garbage and refuse storage area in a clean manner. The findings include:During a tour of the garbage and refuse storage area with the Food Service Director (FSD) 3/18/26 at 10:45 AM the following was observed:At the corner of the ramp down to the garbage dumpster area was a pair of used clear gloves inside out and two blue surgical masks on the stone to the left of the rampIn the dumpster area a pair of used clear gloves, a blue surgical mask, and multiple cigarette butts were observed.There were 3 dumpsters in a row, trash dumpster 1, trash dumpster 2, and recycling dumpster 3. The following was observed:The lid and side panel to dumpster #3 was open. A trash bag was visibly coming out of the side of the closed lid on dumpsterMultiple wrappers and pieces of paper were noted scattered around the 2 trash dumpsters to the front, side, and behind. Two wet pieces of cardboard were wedged under dumpster #1. Cigarette butts were scattered around the entire garbage disposal area. Ten cardboard boxes were strewn around dumpster #3 from the curb and throughout the entire disposal field. A black copy machine with the cord placed on top was slightly to the front of dumpster #3. The debris field of trash and cardboard extended 15 feet from the lid opening of the dumpsters. Interview on 3/18/26 at 11:00 AM with FSD identified that this was not normal practice for the facility and the garbage disposal area could use cleaning. The FSD indicated that it was the responsibility of maintenance and housekeeping to keep the area clean.Interview with the Administrator on 3/18/26 at 11:07 AM identified that maintenance and housekeeping were responsible for the cleanliness of the garbage and refuse area. The Administrator stated it was her expectation that any staff disposing of refuse from any department was responsible to maintain a clean area and if anything was dropped it should be picked up and disposed of at that time. Interview and observation with the Assistant Maintenance Director on 3/18/26 at 11:18 AM identified that the condition of the garbage and refuse were, not acceptable, there is a lot of cardboard everywhere.Although requested, the facility policy for garbage and refuse removal was not provided.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **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 1 of 3 sampled residents (Resident #11) reviewed for a facility acquired Pressure Ulcer (PU), the facility failed to maintain appropriate infection control practices for a dressing change according to the facility policy. The findings include:Resident # 11?s diagnoses included a stage 3 Pressure Ulcer (PU) of the coccyx region (lower back, top of buttocks), fracture of the right lower leg, and generalized muscle weakness. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #11 was moderately cognitively impaired, required supervision for eating and a substantial amount of assistance for bathing, toileting, and personal care.The Resident Care Plan dated 2/14/26 identified Resident #11 had a PU on the coccyx, required a mechanical lift for transfer, assist of 1 for care, was a fall risk, was staying as a long-term care resident, and was able to consent for themself.An Advance Practice Registered Nurse (APRN) order dated 2/27/26 directed staff to wound treatment cleanse wound with betadine, apply a sterile, antibacterial foam dressing and to cover with a dry clean dressing. Change daily and as needed.Observation and interview of Resident #11's pressure ulcer dressing change with Licensed Practical Nurse (LPN #6) on 3/19/26 at 12:34 PM identified with her gloved hands she removed the old, contaminated dressing. LPN #6 then, without the benefit of removing her gloves, sanitizing or washing her hands, placed a new clean dressing over the residents PU. LPN #6 indicated that prior to placing the new clean dressing, she should have removed her dirty gloves, washed or sanitized her hands and applied on a new pair of clean gloves. LPN #6 stated that she had not followed the facility wound policy for glove use and hand sanitizing when changing Resident #11's pressure ulcer dressing.Interview on 3/19/26 at 12:44 PM with the Infection Prevention Nurse (LPN # 9) identified when providing wound care, extra gloves if needed should be at bedside, the old dressing removed, gloves removed, then hand hygiene performed prior to the application of the new dressing. The nurse providing the dressing change was responsible to ensure the proper dressing change procedure was followed. Interview with Director of Nursing Services (DNS) at 12:52 PM on 3/19/26 identified that the nurse should have changed gloves and wash hands between the dirty dressing removal and application of a clean dressing.Review of the Wound Care policy dated 7/22/2025 directed, in part, to wash and dry hands, place exam gloves, loosen tape and remove dressing, pull glove over dressing and discard into an appropriate receptacle, wash and dry hands thoroughly and place on clean gloves.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075413	A. Building B. Wing	03/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Civita Care Northbridge	2875 Main Street Bridgeport, CT 06606

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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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on review of facility annual training for nursing staff, facility documentation and interviews, the facility failed to ensure the required 12 hours Nurse Aid training was completed. The findings include:Review of the facility's mandatory yearly in-service for 1 out of 5 nurse's aides, the facility failed to ensure that the required 12 hours of in-service training including abuse prevention, dementia care, effective communication, infection control, resident's rights, and behavioral health were provided to staff in 2025.Interview with the Staff Development Nurse (RN #2) on 3/24/26 at 12:12 PM, identified she was unable to locate the required educational in-service documentation and required competencies for NA #3 in the areas of Abuse/Neglect, Resident Rights, Dementia Care, Infection Control, Effective Communication, and Behavioral Health. RN #2 indicated she referred to the requested educational documentation as yearly competencies, and indicated she stored all the nursing staff's competencies into monthly binders located in the Staff Development office. RN #2 indicated she wasn't sure why the documents were missing, and that she and several other staff members were attempting to locate them. Interview and review of facility documentation with the facility Administrator on 3/24/26 at 2:00 PM identified an inconsistent signature for NA #3's yearly in-service annual abuse education and prevention for the 2025 training. The Administrator indicated that she had been provided with the requested documentation by staff, she had not reviewed the document, and that the signature and date did not match other documentation signed by NA #3. She apologized for unknowingly providing the altered documentation of NA #3's training.Review of the Facility Assessment in effect from 8/18/17 identified that staff competencies are provided upon hire, annually, and as needed when areas of concern arise, or identified. The topics included, but are not limited to: dementia care, abuse prevention, infection control/hand hygiene, resident rights, compliance and ethics, behavioral health, abuse, neglect and exploitation.

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 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 observations, review of the clinical record, facility policy and interviews for 2 of 2 sampled residents (Resident #3 and Resident #101) reviewed for Resident Assessment, the facility failed to code a pressure ulcer for Resident #3 on the quarterly Minimum Data Set assessment and failed to submit a death record for Resident #101 to the Internet Quality Improvement Evaluation System (IQIES). The findings include:1. Resident #3 ?s diagnoses included diabetes, moderate protein calorie malnutrition and anemia.The admission quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #3 had a Brief Interview for Mental Status score of 15 indicating no cognitive impairment and was independent with eating, hygiene, bed mobility and transfer, was at risk for pressure ulcers and currently did not have a pressure ulcer.The Skin assessment dated [DATE] identified a stage 2 pressure ulcer (top and bottom skin layers affected) blister on right lower leg with an onset of 1/18/26. A wound progress note dated 1/23/26 identified a blister on the right lower leg measuring 1 centimeter (cm) in length by 0.5 cm wide by 0.1 cm deep. 2. Resident #101's diagnosis included adult failure to thrive, dementia, and palliative care.The discharge Minimum Data Set (MDS) tracking form dated 12/13/25 identified although a death in facility MDS had been completed, the form was never submitted through the IQIES system.Interview and clinical record review with RN #1 on 3/19/26 at 2:20 PM identified Resident #3's stage 2 pressure ulcer had not been correctly coded on the quarterly MDS assessment dated [DATE]. Subsequent to surveyor inquiry, RN #1 discussed the coding with LPN #8, indicated the incorrect coding was an oversight, and that a modification to the 1/23/26 MDS would be submitted. RN #1 further indicated that she had been on vacation when Resident #101 passed and a corporate staff was completing the MDS assessments for her. RN #1 indicated that although the covering MDS staff had completed the death record, it was never submitted to CMS through IQIES and subsequent to surveyor inquiry, she would submit the entry. Review of Resident #3's quarterly MDS dated [DATE] identified a modification MDS form had been completed on 3/19/26 to include the stage 2 pressure ulcer.A review of the validation report from IQIES identified Resident #101's MDS tracking form: death in the facility was completed and submitted late.Review of the Resident Assessment Instrument (RAI) manual dated October 2025, page M-2 directed, in part, to enter the number of pressure ulcers that are currently present and whose deepest anatomical stage is a Stage 2.Review of RAI manual page dated October 2025, page 2-38 directed in part, death in facility tracking record must be completed within 7 days after the resident's death and must be submitted within 14 days after the resident's death.