STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075274	A. Building B. Wing	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Civita Care Center at Danbury	107 Osborne Street Danbury, CT 06810

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for 2 of 3 residents (Resident #79 and 87) reviewed for abuse, the facility failed to ensure the residents were free from verbal and physical abuse by another resident. The findings include: 1a. Resident #79 had diagnoses that included dementia and mild neurocognitive disorder with behavioral disturbance. The quarterly MDS dated [DATE] identified Resident #79 had severely impaired cognition and was independent with ambulation. The care plan dated 3/4/25 identified Resident #79 had behavioral symptoms related to dementia, inappropriate behaviors towards staff and other residents, agitation, and verbal behaviors. Interventions included psychiatry for increased aggression and approach resident in a calm manner. b. Resident #91 had diagnoses that included dementia and history of traumatic brain injury. The quarterly MDS dated [DATE] identified Resident #91 had memory problems with continuous inattentiveness and disorganized thinking and was independent with ambulation and toileting. The care plan dated 12/26/24 identified Resident #91 behavioral symptoms including wandering and intrusiveness. Interventions included encouraging diversional activities and encourage to walk with staff when possible. Physician's orders dated 3/1/25 directed independent ambulation on the unit without an assistive device. A reportable event form dated 3/4/25 identified at 5:00 PM, Resident #79 and Resident #91 were walking in the hallway, and Resident #79 said to Resident #91 that he/she was going to (kick his/her a**). Resident #91 said stop and put his/her right hand around Resident #79's neck slightly and pinned Resident #79 against the wall for two seconds. No injuries were sustained. Resident #91 was placed on 1:1 enhanced monitoring. The physician, police and resident representative were notified and Resident #91 was subsequently transferred to the emergency department. (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A late entry nurses note dated 3/5/25 at 5:15 PM completed by LPN #9 identified Resident #79 was observed walking in the hallway in front of Resident 91 and then stopped. Resident #91 asked Resident #79 to move. Resident #79 stated he/she was not going to move and to f*** off. Resident #91 grabbed Resident #79 around the neck, loosely. LPN #9 was immediately able to release and remove Resident #91's hand. No injury was noted. Both residents were separated without further issue. Psychiatric evaluation dated 3/6/25 identified Resident #79 was unable to remember the event. Medication adjustments were made to address behaviors with ongoing monitoring in place. Resident #79's care plan was further revised to attend recreational activities between 3:00 PM and 5:00 PM, to use distraction techniques and remove potential triggers. Resident #91's care plan was revised to include moving to a separate floor and to monitor hallway dynamics for known behaviors and intervene if needed. An interview with NA #1 on at 5/6/25 8:18 AM identified she was working during the 3:00 PM to 11:00 PM shift on 3/4/25 but was not assigned to Resident #79 or Resident #91. NA #1 indicated it was a busy night on the dementia unit. Residents were sundowning (a term used to describe increased agitation and restlessness in the late afternoon/early evening for those with dementia). NA #1 had just walked up to the nurse's station when she observed Resident #91 walk past her in the hall, pacing as he/she normally does. Resident #79 was also in the hall approximately 10 feet away from the nurse's station, standing with other residents, yelling out and using profanities. NA #1 further identified she was unclear of what was being said as the profanities were not directed at anyone particular and not unusual for Resident #79. NA #1 heard screaming, turned around and observed Resident #91 with his/her hands just below the base of Resident #79's neck. NA #1 and the nurse, LPN #9 quickly intervened. Resident #91 released after approximately 10 seconds. Other staff also intervened, and both residents were separated. NA #1 identified Resident #91 had never previously been involved in any other resident to resident altercations that she was aware of. An interview and facility documentation review with the Administrator on 5/6/25 at 2:19 PM identified prior to this incident, Resident#91 had not displayed any aggressive behaviors towards other residents and has not since. The Administrator further identified the interdisciplinary team initiated a plan of correction for licensed, nurse aides and all agency staff in response to the resident-to-resident altercation. However, the education provided was limited to staff on duty between 3/4/25 through 3/6/25 and was not inclusive of all staff working from 3/6/25 forward. The Administrator alleged correction of past noncompliance with continued biweekly audits in place monitoring combative behaviors. The Administrator indicated she would expect that all residents be free from abuse. A review of the facility policy for abuse directs the facility to provide protection for the health, welfare and rights of each resident to prevent abuse defined as the willful infliction of injury. Attempts to interview LPN #9 were unsuccessful. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A plan of correction with an alleged compliance date of 3/6/25 was initiated following the resident-to-resident altercation. Actions taken included immediate separation of residents with Resident #91 moving to a separate floor, medical and behavioral response with ongoing support services. Care plans were updated to include triggers and de-escalation strategies, increased monitoring and staff awareness, cues, enhanced documentation of mood and behavior. Resident #91 was placed on 1:1 monitoring during waking hours and every 15 minute checks while in his/her room post hospital discharge until stability was observed. Education was provided to licensed and nurse aide staff for recognizing early signs of agitation or conflict and managing interpersonal interactions, promote respectful communication, preventing conflict and support emotional wellbeing. A Quality Assurance and Performance Improvement (QAPI) was initiated to track behavior and monitor trends and trigger proactive interventions. Education was limited only to staff on schedule between 3/4/25 and 3/6/25. 2.a Resident #1 was admitted to the facility on [DATE] with diagnoses that included borderline personality disorder and dementia. The quarterly MDS dated [DATE] identified Resident #1 had intact cognition, reported feeling down, depressed, or hopeless 2 - 6 days over the last 2 weeks, and did not exhibit physical or verbal behavioral symptoms directed towards others. The care plan dated 3/4/25 identified Resident #1 had symptoms/needs related to depression. Interventions included maintaining a calm environment and setting limits and expectations for behavior. The nurse's note dated 3/10/25 identified at 2:55 AM the nurse reported that the Resident #1 was wailing and said he/she wanted to kill him/herself. The writer confirmed the statements were true with Resident #1, he/she answered yes but refused to answer additional questions. The APRN was notified and an order to transfer the resident to the emergency department for evaluation was obtained. Resident #1 was transferred to the emergency department at 3:30 AM via stretcher, accompanied by 3 EMS staff members. The nurse's note dated 3/10/25 at 4:48 AM identified that Resident #1 was transferred back from the emergency department. The facility staff sent Resident #1 back to the emergency department with the paramedic because the resident was not sent with clearance papers from the psychiatric provider. The nurse's note dated 3/10/25 at 5:49 AM identified that Resident #1 was sent back from the emergency department at 5:22 AM with clearance paperwork that he/she was not a danger to self or others. The resident was treated with Trazadone 50mg in the emergency department with recommendations to follow up with attending physician per emergency department recommendation. The emergency department paperwork dated 3/10/25 identified Resident #1 was evaluated on 3/10/25 and did not appear to be a threat to him/herself or others, and at this time it was recommended that the patient could return to his/her current living conditions and resume the maintenance of his/her current medications. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Resident #87 was admitted to the facility on [DATE] with diagnoses that included arthrodesis status and spondylolisthesis. The admission MDS dated [DATE] identified Resident #87 had intact cognition and required moderate assistance with walking 10 feet. The care plan dated 2/25/25 identified Resident #87 had complaints of acute back pain related to back surgery. Interventions included handling the resident gently and trying to eliminate any environmental stimuli. The nurse's note dated 3/10/25 at 8:22 AM identified Resident #87 notified the writer that Resident #1 threw a remote control at him/her while he/she was in bed. The remote control hit Resident #87 on the left side of the face and the resident sustained a 5cm x 2cm bruise. No open area was observed. The reportable event form dated 3/10/25 identified that Resident #1 and Resident #87 were roommates. Resident #1 was transferred to the emergency department for suicidal ideation on 3/10/25 at 3:30 AM. Shortly after returning to the facility, Resident #1 was in his/her room, the nurse aide passed by and heard Resident #1 talking to him/herself, and then Resident #1 left and went to the lounge. After a couple of minutes Resident #1 returned to the room, went into bed, and continued to talk to him/herself. Resident #87 reported that Resident #1 was unhappy most of the day on 3/9/25. Resident #87 also said that Resident #1 kept repeating that another resident was telling everyone he/she had money. Resident #87 said he/she tried to ignore Resident #1, and on the early morning of 3/10/25 another resident came into their room, and Resident #87 offered the other resident some chips, and when Resident #1 saw the other resident, he/she appeared to be upset, and started saying to Resident #87, that's why you became pregnant, and have 15 children, and they are *profanity used*. Resident #87 said he/she then reported what Resident #1 was saying to the nurse, Resident #87 left the room, and later returned to the room to have labs drawn, and as Resident #87 sat on the bed, Resident #1 threw the remote-control hitting Resident #87 on the side of the face. Resident #87 then yelled out for the nurse, and the staff came immediately, removed Resident #87 out of the room, and Resident #1 was transferred to the hospital. Interview with Resident #87 on 5/4/25 at 10:00 AM identified that on the evening of 3/9/25 Resident #1 was starting to have some behaviors, and then on 3/10/25 between midnight and 2:00 AM, Resident #1 started saying he/she was going to kill him/herself, and then Resident #1 was transferred to the hospital. Resident #87 indicated that Resident #1 returned from the hospital about an hour or 2 later, began pacing the hallways, and had awoken other residents, one of which was a male resident that wandered into their room asking for a snack. Resident #87 indicated that Resident #1 returned to their room as the male resident was exiting the room with a snack, Resident #1 returned to his/her bed, and started yelling at Resident #87 that he/she was a *profanity used*, had *profanity used* children, and that he/she hoped Resident #87 would die. Resident #87 indicated that he/she was trying to ignore Resident #1, and then Resident #1 threw a remote control, from a 3 - 4-foot distance, striking Resident #87 on the side of the head, behind the left ear. Resident #87 indicated that he/she left the room immediately and Resident #103 (who lived directly across the hall) witnessed the event and started calling for help. Resident #87 identified that he/she was assessed by a nurse, declined going to the hospital for further evaluation, and requested an immediate room change; Resident #1 was transferred back to the hospital. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Resident #1 on 5/4/25 at 10:50 AM identified that he/she had gotten along with his/her old roommate; it just didn't work out. Resident #1 indicated that while he/she tries not to get into arguments with other residents, he/she was not sure that he/she has friends at the facility. Interview with the Administrator on 5/5/25 at 1:08 PM identified that the incident between Resident #1 and Resident #87 was an isolated incident and after completing their investigation, the facility was not able to substantiate abuse, as Resident #1 did not intentionally try to hurt Resident #87. Resident #1 was feeling slighted that Resident #87 had shared chips with another resident. The Administrator indicated that just prior to the alleged incident, Resident #1 was evaluated at the hospital, after making suicidal remarks, and had received psychiatric clearance that he/she was safe to return to the facility and did not pose a threat to him/herself or others. Interview with the Nursing Supervisor (RN #7) on 5/06/25 at 9:59 AM indicated that she did not have her notes in front of her but from what she could remember on 3/10/25, Resident #1 was having behavior issues, and he/she stated that he/she wanted to kill him/herself. RN #7 indicated that she sent Resident #1 to the emergency department around midnight for talk of suicidal ideation, and the hospital sent Resident #1 back to the facility about 30 minutes later, with no papers indicating that he/she had been cleared by a psychiatric provider. RN #7 further indicated that she sent Resident #1 back to the hospital for psychiatric clearance; Resident #1 was then sent back to the facility, after approximately 30 minutes, with the paperwork that he/she was cleared and did not pose a risk to her/himself or others. RN #7 identified that she re-assessed Resident #1 upon admission and he/she was not agitated at that time. Approximately an hour later the floor nurse notified her that Resident #1 threw a remote control at Resident #87. RN #7 indicated that she identified a small bruise during her assessment of Resident #87's head. RN #7 further indicated that she tried to make Resident #87 comfortable, but he/she indicated that he/she was fine, and Resident #1appeared calm and was returned to the hospital. Interview with the Charge Nurse (LPN #6) on 5/06/25 at 11:11 AM identified that he did not have his notes in front of him, but from what he could recall on 3/10/25, he checked Resident #1's vital signs when he/she returned from the hospital, and Resident #1 was calm and did not appear agitated. LPN #6 indicated that, sometime later, while he was providing care to another resident, he heard yelling and loud talking from many residents. LPN #6 indicated that he went to see why residents were yelling, he saw Resident #87 being assisted out of his/her room (could not recall by whom), and when he asked what had happened Resident #87 reported to him that Resident #1 threw a remote control at his/her head. LPN #6 could not recall if he looked at Resident #87's head, but he notified the Nursing Supervisor. LPN #6 identified he recalled that something triggered Resident #1 to become agitated, but he could not recall what the trigger was. Interview with Resident #103 (intact cognition) on 5/7/25 at 8:25 AM identified that a few months ago (could not recall the exact day or time of day), Resident #1 was sent out to the hospital for emotional reasons and then came back to the facility. Resident #103 further indicated that, at that time, Resident #1 and #87's room was directly across the hall, and he/she had been sitting in his/her wheelchair and could see their room. Resident #103 identified that approximately half hour to one hour after Resident #1 returned to the facility, he/she heard Resident #1 expressing her/himself loudly and started to say nasty things to Resident #87. Resident #103 identified that he/she saw Resident #1 pick up an object and throw it, hitting Resident #87 right at the back of his/her head, Resident #1 had good aim. Resident #103 indicated that he/she began yelling for help, and Resident #87 was assisted out of the room. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Abuse, Neglect, and Exploitation policy defines abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations, and defines willful as the individual must have acted deliberately, not that the individual must have intended to inflict harm or injury. The policy further directs that the facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, and misappropriation of resident property, and exploitation that achieves, in part, identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect.