STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075163	A. Building B. Wing	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Masonicare at Bishop Wicke Health & Rehabilitation	584 Long Hill Ave Shelton, CT 06484

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, interviews, and review of facility documents and policies for one (1) of three (3) residents (Resident #2) reviewed for falls, the facility failed to complete an evaluation and assessment following a resident's fall in accordance with facility policy. The findings included:Resident #2 was admitted to the facility in December of 2025 with diagnoses which included Alzheimer's, transient ischemic attack, and depression. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had moderate cognitive impairment (Brief Interview for Mental Status (BIMS) score of 7), required substantial assistance with personal hygiene, toileting, and bathing and was a partial to moderate assist of one (1) with transfers and ambulation with a walker. Review of the Resident Care Plan (RCP) dated 12/18/25 identified Resident #2 had impaired physical mobility due to Parkinson's Disease and was at risk for falls. Interventions directed to assist Resident #2 with ambulation and transfers, utilizing therapy recommendations. Review of a nursing note dated 12/26/25 at 7:03 AM identified Resident #2 was found on the floor in a prone position between his/her bed and closet and indicated he/she was trying to go to the bathroom and hit his/her head. The provider was informed and ordered Resident #2 be transferred to the emergency department for further evaluation. Review of the clinical record identified a Post Fall assessment was completed for the 12/26/25 fall event, however, failed to identify the Fall Risk assessment and the Post Fall evaluation were completed.Interview with the Assistant Director of Nurses (ADON) on 1/14/26 at 11:50 AM identified each fall incident event should be followed up with a Fall Risk assessment and Post Fall evaluation and that it was the responsibility of the nurse assigned to complete these documents.Review of the Fall Risk Evaluation policy directed a fall risk evaluation was to be performed on admission, change of condition, annually, quarterly or as needed.Review of the Documentation Procedure for Resident Falls directed it was the policy of the facility to assess all residents for a potential/actual injury sustained after a fall.

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