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	04/17/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation/policies, and interviews, for one (1) of three (3) sampled residents (Resident #1) reviewed for a change in condition, the facility failed to ensure timely notification of the physician, Registered Dietitian (RD) and resident's representative when the resident experienced a significant weight loss and decline in nutritional status, which delayed clinical assessment and intervention for a significant weight loss. The findings include:Resident #1's diagnoses included vascular dementia, history of falls, chronic obstructive pulmonary disease (COPD), gastroesophageal reflux disorder (GERD), and depression.The significant change in condition Minimum Data Set assessment dated [DATE] identified Resident #1 was severely cognitively impaired and unable to make reasonable and consistent decisions regarding tasks of daily living (Brief Interview for Mental Status (BIMS) score of 3) and required supervision when eating.The Resident Care Plan (RCP) dated 10/21/25 identified Resident #1 had a self-care deficit and nutritional risk. Interventions directed to supervise Resident #1 while eating, administer medications as ordered, diet as ordered, offer ice cream with lunch and supper, monitor and report signs of dysphagia, and report a significant weight loss of three (3) lbs. in one (1) week, greater than a five (5) % weight loss in one (1) month, over seven and a half (7.5 %) in 3 months or over ten (10) % in six (6) months, and Registered Dietician (RD) to evaluate and make diet changes as needed.Physician's orders dated 10/21/25 directed a regular diet, with a regular texture, and thin liquids.Review of the weight log from 5/29/25 to 12/3/25 identified the following weights: 5/29/25: 134 lbs., 6/11/25: 130.5 lbs., 7/13/25: 129 lbs., 8/28/25: 129 lbs., 9/19/25: 128.5 lbs., 10/15/25: 128 lbs., 11/6/25: 127.6 lbs., and 12/3/25: 105.6 lbs (documented by LPN #1).Review of the food intake log from 11/6/25 to 12/3/25 identified that out of 84 meals, Resident #1 consumed less than 50% or had no meal consumption documented for 45% of meals (26 meals: 26-50% consumed, 9 meals: 0-25% consumed, 9 meals: no documentation).Review of the nurses' notes from 11/6/25 to 12/3/25 failed to identify a cause for the significant weight loss or notification to the RD or physician. The Reportable Event (RE) form dated 12/6/25 at 2:05 AM identified Resident #1 yelled help, staff responded and observed Resident #1 on the floor in his/her room lying parallel to the bed frame on top of the floor mat. Resident #1 had a large hematoma on the left side of the head and was complaining of head and back pain. Resident #1 was confused at baseline and identified he/she was getting up to go to the bathroom and fell. The hospital record dated 12/6/25 identified Resident #1 sustained a left hip fracture from a fall and underwent an open reduction and internal fixation (ORIF) of the left hip on 12/7/25. The hospital record identified a weight of 96.6 lbs. was obtained using a bed scale prior to administering anesthesia for surgery. Hospital records identified Resident #1 weighed 133.54 lbs on 5/23/25. The hospital record further identified Resident #1 was at high nutritional risk due to significant weight loss and was diagnosed with severe malnutrition based on a body mass index (BMI) of 17.1 combined with age and interventions were required. A nutritional assessment was performed on 12/8/25 and identified a 28% weight loss over one month. A speech evaluation and twice daily nutritional supplements were ordered. Resident #1 remained in the hospital until discharged to hospice care on 12/12/25 and (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	expired on 12/18/25. Interview with Person #1 on 4/14/26 at 10:40 AM identified she reported concerns regarding Resident #1 losing weight to LPN #1 (the 7:00 AM to 3:00 PM charge nurse) in September and October 2025 and LPN #1 responded that Resident #1's weight was unchanged. Person #1 further identified she requested Resident #1 be given a dietary supplement and that was never started. Interview with the DON (Director of Nursing) on 4/14/26 at 12:46 PM identified the charge nurse was responsible for checking weights and if a significant weight change was noted, a re-weight should be obtained for accuracy and if the significant change still existed, the RD and physician should be notified. The DON identified that if a family member voiced a concern regarding a weight, a re-weight should be obtained to evaluate for a weight change and if a supplement was requested, the RD should be notified. The DON identified LPN #1 should have re-weighed Resident #1 on 12/3/25 and if the weight loss remained accurate, the LPN should have notified the RD and physician. The DON further identified the facility failed to follow its policy.Interview with RN #1 on 4/14/26 at 1:25 PM identified she did not recall anyone reporting a 22 lb. weight loss in one month and if LPN #1 had reported that to her she would have notified the physician. Interview with the dietician on 4/14/26 at 1:37 PM identified she did not recall staff informing her of the weight loss documented on 12/3/25 or concerns regarding weight loss, and if she were made aware, she would have requested a re-weight and reported to the physician regarding new interventions. Although attempted, an interview with LPN #1 was not obtained.Review of the facility policy for Weights identified, in part, that the nurse reviewed all weights for a weight loss or gain and signed off on the process. If the nurse were to identify a weight discrepancy of plus or minus five (5) lbs. they were to ask the nurse aide to re-weigh the resident and if the gain or loss was verified the nurse was to notify the RD, physician, and family member.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - 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 clinical record review, facility documentation, facility policies, and interviews, for one (1) of three (3) sampled residents (Resident #1) reviewed for nutrition, the facility failed to ensure adequate nutritional status and timely identification and response to significant weight loss. This included failure to accurately monitor and evaluate weight changes, obtain a timely re-weight to confirm a significant weight loss, recognize and act upon poor oral intake, notify the physician and Registered Dietitian (RD), implement nutritional interventions, and respond to family concerns. These failures resulted in a significant, unaddressed weight loss and severe malnutrition requiring hospitalization and clinical intervention. The findings include:Resident #1's diagnoses included vascular dementia, history of falls, chronic obstructive pulmonary disease (COPD), gastroesophageal reflux disorder (GERD), and depression.The significant change in condition Minimum Data Set assessment dated [DATE] identified Resident #1 was severely cognitively impaired and unable to make reasonable and consistent decisions regarding tasks of daily living (Brief Interview for Mental Status (BIMS) score of 3) and required supervision when eating.The Resident Care Plan (RCP) dated 10/21/25 identified Resident #1 had a self-care deficit and nutritional risk. Interventions directed to supervise Resident #1 while eating, administer medications as ordered, diet as ordered, offer ice cream with lunch and supper, monitor and report signs of dysphagia, and report a significant weight loss of three (3) lbs. in one (1) week, greater than a five (5) % weight loss in one (1) month, over seven and a half (7.5 %) in 3 months or over ten (10) % in six (6) months, and Registered Dietician (RD) to evaluate and make diet changes as needed.Physician's orders dated 10/21/25 directed a regular diet, with a regular texture, and thin liquids.Review of the weight log from 5/29/25 to 12/3/25 identified the following weights: 5/29/25: 134 lbs., 6/11/25: 130.5 lbs., 7/13/25: 129 lbs., 8/28/25: 129 lbs., 9/19/25: 128.5 lbs., 10/15/25: 128 lbs., 11/6/25: 127.6 lbs., and 12/3/25: 105.6 lbs. (documented by LPN #1).Review of the food intake log from 11/6/25 to 12/3/25 identified that out of 84 meals, Resident #1 consumed less than 50% or had no meal consumption documented for 45% of meals (26 meals: 26-50% consumed, 9 meals: 0-25% consumed, 9 meals: no documentation).Review of the nurses' notes from 11/6/25 to 12/3/25 failed to identify a cause for the significant weight loss or notification to the RD or physician. The Reportable Event (RE) form dated 12/6/25 at 2:05 AM identified Resident #1 yelled help, staff responded and observed Resident #1 on the floor in his/her room lying parallel to the bed frame on top of the floor mat. Resident #1 had a large hematoma on the left side of the head and was complaining of head and back pain. Resident #1 was confused at baseline and identified he/she was getting up to go to the bathroom and fell. The hospital record dated 12/6/25 identified Resident #1 sustained a left hip fracture from a fall and underwent an open reduction and internal fixation (ORIF) of the left hip on 12/7/25. The hospital record identified a weight of 96.6 lbs. was obtained using a bed scale prior to administering anesthesia for surgery. Hospital records identified Resident #1 weighed 133.54 lbs on 5/23/25. The hospital record further identified Resident #1 was at high nutritional risk due to significant weight loss and was diagnosed with severe malnutrition based on a body mass index (BMI) of 17.1 combined with age and interventions were required. A nutritional assessment was performed on 12/8/25 and identified a 28% weight loss over one month. A speech evaluation and twice daily nutritional supplements were ordered. Resident #1 remained in the hospital until discharged to hospice care on 12/12/25 and expired on 12/18/25. Interview with Person #1 on 4/14/26 at 10:40 AM identified she reported concerns regarding Resident #1 losing weight to LPN #1 (the 7:00 AM to 3:00 PM charge nurse) in September and October 2025 and LPN #1 responded that Resident #1's weight was unchanged. Person #1 further identified she requested Resident #1 be given a dietary supplement and that was never started. Interview with the DON (Director of Nursing) on 4/14/26 at 12:46 PM identified the charge nurse was responsible for checking weights and if a significant weight change was noted, a re-weight should be obtained for accuracy and if the significant change still existed, the (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	RD and physician should be notified. The DON identified that if a family member voiced a concern regarding a weight, a re-weight should be obtained to evaluate for a weight change and if a supplement was requested, the RD should be notified. The DON identified LPN #1 should have re-weighed Resident #1 on 12/3/25 and if the weight loss remained accurate, the LPN should have notified the RD and physician. The DON further identified the facility failed to follow its policy.Interview with RN #1 on 4/14/26 at 1:25 PM identified she did not recall anyone reporting a 22 lb. weight loss in one month and if LPN #1 had reported that to her she would have notified the physician. Interview with the dietician on 4/14/26 at 1:37 PM identified she did not recall staff informing her of the weight loss documented on 12/3/25 or concerns regarding weight loss, and if she were made aware, she would have requested a re-weight and reported to the physician regarding new interventions. Although attempted, an interview with LPN #1 was not obtained. Review of the facility policy for Weights identified, in part, that the nurse reviewed all weights for a weight loss or gain and signed off on the process. If the nurse were to identify a weight discrepancy of plus or minus five (5) lbs. they were to ask the nurse aide to re-weigh the resident and if the gain or loss was verified the nurse was to notify the RD, physician, and family member.