STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075243	A. Building B. Wing	06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pierce Memorial Baptist Home, Inc.	44 Canterbury Road Brooklyn, CT 06234

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 clinical record review, facility documentation review, and interviews for one of three residents (Resident #1) reviewed for abuse, the facility failed to ensure the resident was free from neglect and failed to ensure the resident was not left on a commode without staff returning time, and care was provided timely. The findings include: Resident #1's diagnoses included Parkinson's Disease, sciatica, and dysarthria and anarthria (motor disorders impairing lips, tongue, vocal cords or diaphragm causing slurred, slow or difficult to understand speech). The Resident Care Plan (RCP) dated 3/15/2026 identified limited physical mobility and ADL assistance related to balance and coordination deficits. Interventions directed encourage to participate to fullest extent possible, transfer with [NAME] Hall [NAME] device with assistance of two (2), and resident was non-ambulatory. The quarterly Minimum Data Set (MDS) dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of fifteen out of fifteen, indicative of no cognitive impairment, required assistance with ADLs (activities of daily living), required substantial/maximal assistance with bed mobility, bathing, dressing, toilet hygiene, was non-ambulatory, and transferred with two (2) staff and standing rotary turning device. The facility reportable event (RE) dated 6/9/2026 at 11:15 PM identified Resident #1 had an unwitnessed fall in his/her room. Assessment identified a bump to right forehead with some decolorization and complained of pain to left arm. Resident had been assisted to commode around 8 PM by two (2) nurse aides (NAs). The NA on the 11 PM to 7 AM shift responded to resident's call bell and found Resident #1 on the floor. Resident #1 stated he/she fell reaching for his/her call bell and stated that he/she was left on the commode for hours. Review of the RE summary report dated 6/11/2026 indicated Resident #1 was assisted to commode between 8 and 8:30 PM by two (2) NAs. A NA on the 11 PM to 7 AM shift responded to Resident #1's call light around 11:15 (at the start of her shift, approximately 2 hours and 45 minutes after NA #1 left Resident #1 on the commode), and alerted the nurse that the resident was on the floor. Resident #1 stated he/she fell reaching for her call bell after staff left him/her on the commode for hours. The facility determined Resident #1 was left on the commode without access to the call bell (not in reach) and he/she sustained a fall. Resident #1 was transferred to the hospital, returned with no new orders, and imaging was negative. Interview and record review on 6/17/2026 at 10:40 AM with NA #1 identified on 6/9/2026, Resident #1 was on his assignment. Between 8 to 8:30 PM (approximately 2 hours and 45 minutes before Resident #1 was found on the floor), he and NA #2 assisted Resident #1 to the commode. NA #1 did rounds around 9:45 PM and stated he was distracted and forgot to go back to assist Resident #1 off the commode. In addition, NA #1 stated he forgot to go back and provide bedtime personal care and last care rounds for Resident #1. NA #1 further indicated that rounds should be done throughout the shift, and he forgot to give Resident #1 the call bell when he left him/her on the commode. Later during the shift, NA #2 had asked him if he needed help with anything, and he responded, no. NA #1 stated he should not have left Resident #1 on the commode without returning to assist Resident #1 off the commode and he should have left the call bell in reach. On 6/17/2026 at 11:25 AM interview and statement review with NA #2 identified on 6/9/2026 around 8 to 8:30 AM she assisted NA #1 to transfer Resident #1 onto the (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	commode. When they left the room the door was closed for privacy and AC was on. Resident #1 was dressed in clothes from the day (not in bedtime clothes), and Resident #1 indicated he/she wanted to change into a johnny after using the commode. NA #2 stated she left NA #1 with Resident #1 and later asked NA #1 if he needed help (indicating she meant if he needed help to transfer Resident #1 off the commode). NA #2 stated he was all set and she assumed another team member helped NA #1 assist Resident #1 off the commode. NA #2 stated NAs are supposed to check residents every two (2) hours or as needed, if she sees a resident's door is closed (with AC on), she stops and checks on the resident. Interview and observation with Resident #1 on 6/17/2026 at 9:06 AM identified Resident #1's voice was very quiet, and speech was slow. Resident #1 stated on 6/9/2026 staff assisted him/her onto the commode before bedtime, and left the call bell attached to the recliner chair out of reach, and attempts to reach the bell were unsuccessful. After waiting for a long time (hours), he/she attempted to reach the call bell again, and when tried to stand up, he/she fell to the floor. Resident #1 stated he/she got a bump on the head and was sent to the hospital and had scans done. Resident #1 stated he/she did not know why NA #1 or NA #2, who had helped him/her onto the commode. Resident #1 stated NA #1 was assigned to provide care for him/her and had no excuse to forget him/her. Resident #1 stated he/she was upset, and was observed to be weepy during the interview. Record review identified on 6/10/2026 DNS a follow up visit with Resident #1 and family member identified Resident #1 stated when he/she was left on the commode, I tried to call out but door was closed for privacy and the AC (air conditioner) was also on. Resident #1 stated, they forgot me, it was after 11 PM when NA #3 came in to help. Resident stated he/she was left on the commode for about three (3) hours. Interview and record review on 6/17/2026 at 1:33 PM with DNS indicated on 6/9/2026 Resident #1 was assisted by NA #1 and NA #2 onto the commode around 8 to 8:30 PM and the call bell was not placed within reach, the door was closed and the AC was on. Resident #1 attempted to reach for the call bell, fell and NA #3 (11-7 NA) found Resident #1 on floor still in his/her day clothes at 11:15 PM (approximately 2 hours and 45 minutes after NA #1 left him/her on the commode).The DNS further indicated NAs should perform resident care rounds at least every two (2) hours or more often as needed and NA #1 should have ensured the call bell was in reach, and revisited a resident who was left on a commode. Further, bedtime care should have provided and NA #1 should have completed last rounds on all residents on his assignment, including Resident #1. Review of facility Abuse, Neglect, Mistreatment, and Misappropriation of Resident Property directed in part; it is the policy of this facility that each resident will be free from Abuse. Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Review of facility Certified Nursing Assistant Job Description directed in part; the Certified Nursing Assistant is responsible for the direct care of resident needs for activities of daily living and maintains an environment which is safe, pleasant and therapeutic.

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F 0684 Level of Harm - Minimal harm or potential for 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 clinical record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #1) reviewed for abuse, the facility failed to ensure the call bell was in reach, failed to ensure staff performed resident rounds and personal care timely. The findings include: Resident #1's diagnoses included Parkinson's Disease, sciatica, and dysarthria and anarthria (motor disorders impairing lips, tongue, vocal cords or diaphragm causing slurred, slow or difficult to understand speech). The Resident Care Plan (RCP) dated 3/15/2026 identified limited physical mobility and ADL assistance related to balance and coordination deficits. Interventions directed encourage to participate to fullest extent possible, transfer with [NAME] Hall [NAME] device with assistance of two (2), and resident was non-ambulatory. The quarterly Minimum Data Set (MDS) dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of fifteen out of fifteen, indicative of no cognitive impairment, required assistance with ADLs (activities of daily living), required substantial/maximal assistance with bed mobility, bathing, dressing, toilet hygiene, was non-ambulatory, and transferred with two (2) staff and standing rotary turning device. The facility reportable event (RE) dated 6/9/2026 at 11:15 PM identified Resident #1 had an unwitnessed fall in his/her room. Assessment identified a bump to right forehead with some decolorization and complained of pain to left arm. Resident had been assisted to commode around 8 PM by two (2) nurse aides (NAs). The NA on the 11 PM to 7 AM shift responded to resident's call bell and found Resident #1 on the floor. Resident #1 stated he/she fell reaching for his/her call bell and stated that he/she was left on the commode for hours. Review of the RE summary report dated 6/11/2026 indicated Resident #1 was assisted to commode between 8 and 8:30 PM by two (2) NAs. A NA on the 11 PM to 7 AM shift responded to Resident #1's call light around 11:15 (at the start of her shift, approximately 2 hours and 45 minutes after NA #1 left Resident #1 on the commode), and alerted the nurse that the resident was on the floor. Resident #1 stated he/she fell reaching for her call bell after staff left him/her on the commode for hours. The facility determined Resident #1 was left on the commode without access to the call bell (not in reach) and he/she sustained a fall. Resident #1 was transferred to the hospital, returned with no new orders, and imaging was negative. Interview and record review on 6/17/2026 at 10:40 AM with NA #1 identified on 6/9/2026, Resident #1 was on his assignment. Between 8 to 8:30 PM (approximately 2 hours and 45 minutes before Resident #1 was found on the floor), he and NA #2 assisted Resident #1 to the commode. NA #1 did rounds around 9:45 PM and stated he was distracted and forgot to go back to assist Resident #1 off the commode. In addition, NA #1 stated he forgot to go back and provide bedtime personal care and last care rounds for Resident #1. NA #1 further indicated that rounds should be done throughout the shift, and he forgot to give Resident #1 the call bell when he left him/her on the commode. Later during the shift, NA #2 had asked him if he needed help with anything, and he responded, no. NA #1 stated he should not have left Resident #1 on the commode without returning to assist Resident #1 off the commode and he should have left the call bell in reach. Interview and record review on 6/17/2026 at 1:33 PM with DNS indicated on 6/9/2026 Resident #1 was assisted by NA #1 and NA #2 onto the commode around 8 to 8:30 PM and the call bell was not placed within reach, the door was closed and the AC was on. The DNS indicated NA #1 should not have left Resident #1 on the commode without returning to check on him/her, should have left the call bell in reach, should have provided evening care, and should have completed rounds at least every two (2) hours. Review of facility Certified Nursing Assistant Job Description directed in part; the Certified Nursing Assistant is responsible for the direct care of resident needs for activities of daily living and maintains an environment which is safe, pleasant and therapeutic.