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	03/27/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, review of facility documentation, review of facility policy, and staff interviews, for two of six sampled residents (Resident #17 and Resident #24) reviewed for accidents, the facility failed to ensure that staff utilized a gait belt during assisted ambulation in accordance with the facility's policy, which resulted in a fall with injury, and failed to ensure that a resident who required staff assistance for transfers did not sustain a skin tear during a staff-assisted transfer. The findings include: Resident #24 had diagnoses that included anemia, osteoarthritis, weakness, and difficulty walking.The fall risk assessment dated [DATE] identified Resident #24 received a total score of 3, a score of 3 indicates a low fall risk.The Resident Care Plan (RCP) dated 2/12/26 identified Resident #24 had limited physical mobility related to weakness. The care plan interventions directed staff to transfer the resident with assistance of one and to ambulate the resident with assistance of one using a gait belt and walker.The admission MDS assessment dated [DATE] identified Resident #24 had intact cognition, required extensive assistance for toileting, personal hygiene, dressing, transfers, and ambulation. It further identified the resident utilized both a rolling walker and a wheelchair for mobility and had no documented history of falls.The nurses' aide care card, updated on 3/11/26 identified Resident #24 was alert and oriented but could be forgetful, and required assistance of one with a rolling walker for transfers and ambulation.The facility reportable event report dated 3/12/26 at 3:20 PM identified Resident #24 experienced a fall while ambulating in the hallway. The facility's investigation identified NA #1 had not utilized a gait belt while assisting the resident during ambulation. An intervention put in place following the fall consisted of re-educating NA #1 regarding the purpose of using the gait belt and competency in proper gait belt application.LPN #1's nurse's note dated 3/12/26 at 8:12 PM identified Resident #24 was walking in the hallway with NA #1 using a rolling walker when the resident lost balance and fell to the floor. The RN completed an assessment and noted a skin tear to the resident's left forearm. Resident #24 denied hitting his/her head. Range of motion was intact to all extremities, and the resident reported left elbow pain rated 7 out of 10 on a 0-to-10 pain scale.The physician's orders dated 3/12/26 directed staff to transfer Resident #24 to the hospital for evaluation following the fall.The twoˆview left elbow Xˆray (an imaging diagnostic test) dated 3/12/26 at 5:23 PM completed at the hospital identified Resident #24 presented after a fall with left elbow pain and limited range of motion. The radiology findings identified posterior elbow softˆtissue swelling and a nondisplaced fracture of the left olecranon.The nurse's notes dated 3/12/26 at 11:19 PM identified Resident #24 returned from the hospital with a sling to the left arm. The nurse assessed the resident's hand and fingers, performed rangeˆofˆmotion checks and documented that the left hand and fingers were warm to the touch. Resident #24's neurological checks were within normal limits.The physician's orders dated 3/13/26 directed staff to ensure proper positioning of the left arm sling every shift, to ensure the hard splint was properly positioned to the left arm and/or elbow, to monitor circulation, motion, and sensation of the left upper extremity, and to maintain nonˆweightˆbearing status to the left upper extremity.The revised Resident Care Plan (RCP) dated 3/16/26 identified Resident #24 had limited physical mobility related to weakness. 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 0689 Level of Harm - Actual harm Residents Affected - Few	care plan interventions directed staff to transfer the resident with assistance of one from the bed to the wheelchair, and wheelchair to toilet, remove resident from the ambulation list at this time, and resident is non-ambulatory with nursing staff at this time. Interview with LPN #1 on 3/25/26 at 10:00 AM identified NA #1 was assisting Resident #24 with ambulation in the hallway when the resident lost his/her balance and fell to the floor. LPN #1 also identified that the nursing supervisor was called to assess the resident following the fall and Resident #24 was directed to be sent to the hospital for further evaluation. She identified that NA #1 acknowledged she had not applied a gait belt to Resident #24 and reported that she had forgotten to apply the gait belt. She further identified that the facility's policy required the use of a gait belt during transfers and/or ambulation whenever a resident required assistance.Interview with OTA #1 on 3/25/26 at 10:10 AM identified that all staff should use a gait belt for all transfers and/or ambulation unless a resident is independent with transfers and ambulation. He identified that the purpose of a gait belt is to allow staff to maintain a secure grasp on the resident in case the resident loses balance. He identified that Resident #24 required assistance of one for transfers and ambulation, and that staff should have been using a gait belt whenever assisting the resident. He further identified that NA #1 may have been able to maintain control of Resident #24 if a gait belt had been used at the time of the fall, and could have assisted the resident to the floor, thereby preventing a major injury. In addition, he identified that Resident #24 was removed from the ambulation list following the fall and could only ambulate with physical therapy.Interview with the DNS on 3/25/26 at 10:33 AM identified that all staff are required to use a gait belt during transfers and/or ambulation for any resident who requires assistance. She identified that the gait belt is used to maintain the staff's grasp in the event the resident loses balance and to help prevent a major injury if a fall occurs. She further identified that NA #1 was recently hired but had been trained and deemed competent in the use of the gait belt during orientation. She further identified that NA #1 had not used a gait belt while assisting Resident #24 with ambulation, which resulted in a fall and left elbow fracture. Additionally, the DNS noted that NA #1 received reeducation and competency validation regarding proper gait belt use following the incident.Attempts to interview NA #1 were unsuccessful during the survey period.The facility's policy for Gait Belt Use and Ambulation identified that staff are required to use a gait belt with residents who cannot independently ambulate and/or transfers, and a gait belt is used to support, guide the resident and to avoid using the resident's clothing or limbs to support their weight. Resident #17 had diagnoses that included type 2 diabetes mellitus, dementia, venous insufficiency, anxiety, and peripheral vascular disease.The annual MDS assessment dated [DATE] identified Resident #17 had severe cognitive impairment, required extensive assistance for toileting, personal hygiene, dressing, and transfers, was non-ambulatory and utilized a rolling walker and wheelchair for mobility.The nursing aide care card identified that Resident #17 required the assistance of one staff member with a rolling walker for transfers. The Accident and Incident (A&I) report dated 11/20/25 at 7:45 PM identified that Resident #17 was transferred by NA #2 and NA #8 and was noted to have a skin tear to his/her left lower leg that measured 2.5 cm in length by 1.5 cm in width following the transfer. The facility's investigation identified Resident #17 did not have a skin tear prior to the transfer. Statements obtained from NA #2 and NA #8 identified that Resident #17 was giving them a hard time during the transfer. NA #2 identified that she attempted to talk to the resident, but nothing helped, and NA #8 identified that they could have waited for Resident #17 to calm down.LPN #2's nurse's note dated 11/20/25 at 9:54 PM identified that NA#2 and NA #8 transferred Resident #17, after which the resident was noted to have a skin tear on the left lateral lower leg. The skin tear measured 2.5 cm in length by 1.5 cm in width. The nursing supervisor, physician, and family were notified of the incident.The Resident Care Plan (RCP) dated 11/20/25 identified Resident #17 had a skin tear to the left lateral lower leg. Care plan interventions directed staff to use protective sleeves to the leg, identify the potential causative factor and resolve when possible, and encourage good nutrition and hydration to promote healthier skin.The Occupational Therapy (OT) screening dated 11/24/25 identified Resident #17 was seen for an OT screen related to sustaining a skin tear while (continued on next page)

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	075243	A. Building B. Wing	03/27/2026

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F 0689 Level of Harm - Actual harm Residents Affected - Few	being transferred. The OT screen identified that Resident #17 had not had a change in his/her functional mobility. The plan was to request the maintenance department to place a cushion liner on the right side of the bed frame, where Resident #17 had been pressing his/her left leg against the metal frame.The physician's initial wound consultation dated 11/25/25 at 10:56 AM identified the skin tear to the left lower extremity was evaluated. The skin tear measured 2 cm in length by 0.7 cm in width by 0.1 cm in depth, with a small amount of serosanguineous drainage. The treatment plan directed to cleanse the wound with normal saline, apply silver hydrogel to the base of the wound, and cover it with a dry, clean dressing daily and as needed when soiled or dislodged.The weekly wound physician's progress notes from 12/2/25 through 12/23/25 identified Resident #17 had a skin tear to the left lower leg. Documentation reflected that the wound physician continued to monitor the condition and provided an ongoing treatment plan for the skin tear throughout this period.The nurse's notes dated 12/30/25 at 10:35 AM identified that Resident #17's skin tear to the left lower leg was documented as healed.Interview with LPN #2 on 3/26/26 at 11:00 AM identified that NA #2 had reported a skin tear that had occurred during Resident #17's transfer. She identified that NA #2 had reported Resident #17 did not have a skin tear prior to the transfer and that the skin tear to the left lower leg had been obtained after the resident was transferred from the wheelchair to the bed. She identified that Resident #17 required assistance of one staff member for transfers. She further identified that she could not recall whether Resident #17 had been agitated at the time of the transfer. She also identified that Resident #17 had not been using a leg rest on his/her wheelchair because he/she could self^propel while in the wheelchair.Interview with the DNS on 3/26/26 at 1:30 PM identified that Resident #17's skin tear had been noted after the resident was transferred from the wheelchair to the bed. She reviewed the witness statements obtained from NA #2 and NA #8, which identified that the resident had been agitated and that staff should have waited prior to transferring the resident; however, she identified that Resident #17 had been agitated during the transfer. She further identified that Resident #17 should have been free from any type of accident while care was being provided by her staff.Attempts to interview NA #2 and NA #8 were unsuccessful during the survey period.The facility's policy for Accidents and Supervision identified that the facility would maintain the resident environment free of accident hazards to the greatest extent possible and ensure that each resident received adequate supervision and appropriate assistive devices to prevent accidents.

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	075243	A. Building B. Wing	03/27/2026

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of the clinical record, review of facility policy and interviews for one sampled resident (Resident #45) reviewed for respiratory care, the facility failed to ensure a physician's order was in place directing the use of oxygen therapy and failed to ensure a comprehensive care plan was developed to address how to provide care for the resident utilizing continuous oxygen therapy. The findings include:Resident #45's diagnoses included mild intermittent asthma, type 2 diabetes, dementia, and anxiety. The annual MDS assessment dated [DATE] identified Resident #45 had moderately impaired cognition, required moderate assistance with personal hygiene, and required supervision with ambulation utilizing a walker. The assessment further identified that the resident was not receiving oxygen therapy. Observation on 3/23/26 at 1:19 PM identified a posted sign on the outside of the doorframe with the written warning. caution, oxygen in use no smoking or open flame. Upon entering the room, Resident #45 was sitting on the side of the bed wearing a nasal cannula connected to the oxygen concentrator at 3 liters/minute (LPM). Resident #45 identified he/she uses oxygen at all times except when he/she goes to the bathroom. Review of the physician's orders for the time period of December 16, 2025, through March 23, 2026, failed to identify an order for continuous or as needed use of oxygen therapy. Review of Resident #45's care plan dated 2/12/26 failed to identify the use of oxygen therapy or interventions that might include: monitor resident for respiratory distress and report to the provider as needed, oxygen settings as directed by the physician's order, to promote lung expansion and improve air exchange by positioning with proper body alignment. Interview with LPN #3 on 3/24/26 at 11:50 AM Resident #45 should have an order for oxygen use, and it is the responsibility of the nurse who obtains the order from the provider to ensure the order is transcribed into the computer. Review of the clinical record with LPN #3 failed to identify an order for oxygen therapy. Interview and review of the clinical record with the Charge Nurse (LPN #3) on 3/24/26 at 11:49 AM identified that all residents receiving oxygen therapy should have a physician's order directing the use of oxygen indicating how many liters of oxygen needed specific to the resident. LPN #3 identified Resident #45 utilizes oxygen therapy and should have an order for oxygen usage as the resident started on oxygen over a month ago when he/she had pneumonia. LPN #3 failed to identify a physician's order or a care plan regarding the use of oxygen therapy for Resident #45. Review of the nurse aide care card also failed to identify that the resident utilized oxygen and/or how to provide care for the resident in regard to the continuous oxygen therapy.Interview with the Administrator and the Infection Preventionist Nurse (RN #4) on 3/24/25 at 1:30 PM identified that the ADNS, who is also the MDS Coordinator, was on vacation but is responsible for revising and updating the care plan. RN #4 identified Resident #45 utilizes oxygen therapy and should have had a care plan for the use of oxygen with interventions. They identified that the facility has a library of care plans which include oxygen usage and they would have to review the care plans to see what interventions needed to be included in the care plan for this resident. Following surveyor's inquiry on 3/24/26, oxygen therapy related to ineffective gas exchange was added to the resident care plan. Interview with the DNS on 3/25/26 at 2:04 PM identified Resident #45 utilized continuous oxygen and should have had an order directing the use of oxygen in the clinical records and an individualized care plan in place regarding the use of oxygen. The DNS further identified the care plan should include specific interventions related to the resident. Review of the Oxygen Administration policy identified oxygen is administered under orders of a physician, except in the case of an emergency. The policy further identifies the residents' care plan shall identify the interventions for oxygen therapy, based upon the resident's assessment and orders, such as, but not limited to: the type of oxygen delivery system; when to administer, such as continuous or intermittent and/or when to discontinue; equipment setting for the prescribed flow rates, monitoring oxygen saturation levels and monitoring for complications associated with the use of oxygen.Review of the (continued on next page)

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	075243	A. Building B. Wing	03/27/2026

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Comprehensive Care Plan policy identified that the facility is to develop a comprehensive person-centered care plan for each resident consistent with resident rights, that includes measurable objectives and timeframes to meet the resident's medical, nursing, and mental psychological needs that are identified in the resident's comprehensive assessment. The policy further identifies that the comprehensive care plan will describe at a minimum the following the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, psychological well-being and will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment.

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	075243	A. Building B. Wing	03/27/2026

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation, facility policy and interviews for 1 of 2 sampled medication rooms, the facility failed to store medications appropriately. The findings include:Observation on 3/26/26 at 2:30PM with LPN#4 of Level 1 Medication room identified 2 boxes of Mucus Relief ER with an expiration date of 12/20/25. Interview on 3/26/26 at 2:35PM with LPN#4 identified that the nurses and the person that stocks the medications check the medication room for expired medication. Interview on 3/27/26 at 2:02PM with the DNS identified that expired medication should not be stored in the medication room. The nurses or the person who stocks it are responsible for going through the medications regularly as well as the pharmacy consultant going through everything once a month. Review of Consultant Pharmacy Summary for February 1st- February 28th, 2026, identified there were isolated issues observed of expired medications that were removed from the carts on Unit 2 and given to the nurse. Review of the medication storage policy directed the medication carts and all medication rooms routinely inspected by the consultant pharmacist for discontinued, outdated, defective, or deteriorated medications with worn, illegible, or missing labels.

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	075243	A. Building B. Wing	03/27/2026

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, review of facility documentation and interviews for one of two sampled residents (Resident #36) with an allegation of mistreatment, the facility failed to ensure social service visits were documented and readily accessible in the medical record. The findings include: Resident #36's diagnoses included chronic systolic congestive heart failure, depression, anxiety and adult failure to thrive.The quarterly MDS assessment dated [DATE] identified Resident #36 had intact cognition, no identified behaviors, required maximal assistance with toileting hygiene, lower body dressing, was dependent on staff for transfers, and always incontinent of bladder and frequently incontinent of bowel functioning. The care plan dated 1/29/26 identified Resident #36 had limited physical mobility related to a history of stroke and left hip fracture with an intervention dated 2/3/26 to ensure special care when turning resident due to chronic right knee pain. The accident and incident report dated 2/2/26 at 8:15 PM identified Resident #36 reported NA #5 was rude and rough with him/her and that the she doesn't like her job. The resident further noted he/she had chronic right knee pain, and NA #5 had just rolled him/her over like it was a job. Review of the Service Recovery/Grievance/Concern form with a date of occurrence of 2/2/26 identified Resident #36 reported a nurse aide was rough with care and the DNS and social service spoke with the resident who is alert and oriented to time, person and place. The outcome/resolution identified that the nurse aide was relieved of his/her duties. In addition, an attached note to the grievance dated 2/3/26 written by the DNS identified she saw the resident after breakfast with SW #1, to speak with Resident #36 regarding what happened last evening. The note further identified resident had no pain today, and no alterations in skin integrity, and the resident indicated he/she thought they would be fine now knowing that nurse aide would not be taking care of him/her. Review of social services progress notes for the period of February 1, 2026, through February 28, 2026, failed to identify written documentation regarding the alleged allegation of rough care occurring on 2/2/26. Interview with SW #1 on 3/24/26 at 2:45 PM identified that she was aware of the incident between Resident #36 and a staff member which occurred on 2/2/26 and saw the resident. SW #1 identified that she would have written a note after her visit with the resident and it is usually included in the investigation. SW #1 thoroughly reviewed the folder provided by the facility to the surveyor and identified that her documentation was not included and would have to check her records.Interview with SW #1 on 3/25/26 at 8:50 AM identified she was unable to locate her note written after her visit with the resident. Interview with the DNS on 3/25/26 at 8:40 PM identified she reviewed the records and was unable to identify a note from social services as there should have been a note documented from the social worker regarding the allegation in the resident's record. The DNS identified Resident #36 was offered a psychiatric consult which the resident declined at the time as the nurse aide would no longer care for the resident. Review of the Documentation in Medical Record policy identified each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation. Review of the Abuse/Indignity/Mistreatment/Neglect policy and procedure identified under the follow-up care section that the Social Services Department will be notified to provide counseling and support to the residents (and family as indicated). Follow-up care, including counseling and support, will be documented in medical records.

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	075243	A. Building B. Wing	03/27/2026

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, review of facility documentation, review of facility policy/procedure and interviews for one of five sampled residents (Resident #17), reviewed for immunizations, the facility failed to ensure that the pneumococcal vaccine was offered to the resident. The findings include: Resident #17 was admitted to the facility in November/2024 with diagnoses that included type 2 diabetes, dementia and cognitive communication deficit. The quarterly MDS assessment dated [DATE] identified Resident #17 had severely impaired cognition. The assessment further identified Resident #17 had not received the pneumococcal vaccine with the reason indicated that the vaccine was offered and decline. Resident #17's Pneumococcal Vaccination history under the immunization tab identified the resident had received the PPSV 23 (pneumococcal vaccine) on 10/4/2012 and had received the Prevnar 13 vaccine (PCV 13) on 4/6/2026 prior to his/her admission to the facility. The record also identified Resident #17 was not eligible for the pneumococcal vaccine (PCV 20) with a reason of no consent obtained dated 11/2024. The immunization records for Resident #17 on 3/25/26 at 11:15 AM with the Infection Preventionist (RN #4) failed to identify any documentation that the pneumococcal vaccine (PCV 20) was offered to the resident on admission or thereafter. Interview with RN #4 on 3/25/26 at 11:15 AM identified it is the responsibility of the IP nurse to ensure the resident vaccination status is assessed and the appropriate vaccine offered to the resident on admission and thereafter. RN #4 identified Resident #17 was eligible to receive the PCV 20 pneumococcal vaccine on admission but checked off ineligible because she was unable to get a hold of the resident's responsible party to offer the PCV20 vaccine to obtain the consent. RN #4 further identified she had not tried to obtain the consent for the pneumococcal vaccine since admission, even though she had contacted Resident #17's responsible party a few times to obtain the influenza and covid-19 vaccine and could have obtained consent for the pneumococcal at that time. RN #4 identified she should have tried again to obtain a consent. Subsequent to surveyor's inquiry consent from the responsible party was obtained on 3/26/26 and the resident was given the PCV 20 pneumococcal vaccine. Review of the Immunizations Pneumococcal vaccine PVC 20 (Prevnar 20) policy identified each resident's pneumococcal immunization status will be determined upon admission and will be documented in the resident's medical record. The policy further identifies that all resident with undocumented, unknown, or not up to date pneumococcal vaccination status will be offered the vaccine. Informed consent in the form of a discussion regarding the risks and benefits of vaccination will occur prior to vaccination (this may be with the resident's authorized representative when appropriate and signed consent or declination of the vaccine will be obtained at this time.

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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 review of clinical records, review of facility policy/procedures and interviews for two of three sampled residents (Residents #2 and #4) reviewed for Preadmission Screening and Resident Review (PASRR) and hospitalization, the facility failed to ensure the comprehensive MDS assessments accurately reflected a positive Level II PASRR screening and the resident's correct admission date. The findings include:Resident #2's diagnoses included alcoholic cirrhosis of the liver, type 1 diabetes mellitus, dementia, and neoplasm of digestive organ. The quarterly MDS assessment dated [DATE] identified Resident #2 had severe cognitive impairment, and required extensive assistance for toileting, dressing, personal hygiene, and transfers. The nurse's notes dated 10/11/25 identified Resident #2 was observed expressing suicidal ideation and expressed an intent to harm himself/herself by stabbing himself/herself. The room was checked for sharp objects, while staff remained with the resident. When informed of the plan to be sent to the hospital for evaluation, the resident became nonˆverbal and unresponsive, with a flat affect and minimal eye contact. The resident was transferred to the hospital for further evaluation. The electronic clinical record identified Resident #2 was out of the facility from 10/12/25 to 10/27/25. The nurse's note dated 10/28/25 identified Resident #2 returned to the facility from the hospital via ambulance at 3:30 PM. Resident #2 was readmitted to the facility with diagnoses of urosepsis and atrial fibrillation. The entry MDS assessment identified the resident returned to the facility on [DATE], when Resident #2 actually returned to the facility on [DATE]. The date of 10/29/25 was incorrect. Interview with the DNS on 3/26/26 at 10:35 AM identified the MDS nurse was unavailable for interview. She identified that she was not very knowledgeable about MDS coding; however, she would expect the coding to be accurate. She identified that Resident #2 was readmitted to the facility on [DATE] from the hospital. Subsequent to the surveyor's inquiry, the MDS entry date was corrected and submitted. The facility's MDS 3.0 Policy and Procedures identified that an entry tracking record would be created on the date of admission or readmission. Resident #4's diagnoses included anxiety, depression, and psychotic disorder with delusions. The PASRR level II outcome determination dated 2/20/2023 identified Resident #4 had a positive level II PASRR. The annual MDS assessments dated 2/19/25 and 2/16/26 identified Resident #4 had intact cognition and under the Preadmission Screening and Resident Review (PASRR) section, a response of no to the question that asks if the resident was currently considered by the level II PASRR process to have a serious mental illness and or intellectual disability or a related condition. The response of no was incorrect because the resident had a positive level II assessment. (continued on next page)

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	03/27/2026

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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Interview with the Social Worker (SW #1) on 3/25/26 at 1:25 PM identified that the comprehensive MDS assessments should be coded to reflect Resident #4 had a positive level II PASRR assessment. She noted that the MDS Coordinator is responsible for completing that section of the MDS. She further identified that the MDS Coordinator at times asks her about residents' PASRR status, she noted that the PASRR assessments are located in the physical clinical record or uploaded to the electronic clinical record and if necessary, the assessment can be pulled off the PASRR portal. The MDS Coordinator was not available to be interviewed due to a planned leave of absence. Interview with the DNS on 3/25/26 at 2:04 PM identified the ADNS is responsible for completing the MDS assessment but is currently away on vacation. The DNS identified that if the resident has a positive level II PASRR it should be reflected on the MDS. The MDS 3.0 policy and procedure identified that according to federal regulations, the facility conducts an initial and periodical, comprehensive, accurate and standardized assessment of each resident's functional capacity, using the RAI specified by the state. The policy and procedures further identified persons completing part of the assessment must attest to the accuracy of the section they completed by signature and indication of the relevant sections.