STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075324	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayview Health Care	301 Rope Ferry Rd Waterford, CT 06385

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075324	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayview Health Care	301 Rope Ferry Rd Waterford, CT 06385

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, facility documentation, facility policy, and interviews for one (1) of four (4) sampled residents (Resident #1) who required set up and reminders to complete daily hygiene care, the facility failed to implement the care plan and notify Resident #1's conservator when the resident refused to perform any portion of daily care. The findings include:Resident #1's diagnoses included mild cognitive impairment, chronic obstructive pulmonary disease, and congestive heart failure. The admission Record identified there was a family member that was appointed Resident #1's Conservator of Person (COP). The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 made reasonable decisions regarding tasks of daily life, was independent with most daily living skills, and required set up for hygiene and showers. The Resident Care Plan dated 7/30/25 identified Resident #1 had a self-care deficit, occasionally refused showers and had a history of dental problems with dental caries. Interventions directed to call Resident #1's conservator when refusing any care, assist with daily living skills as needed, administer medications as ordered, encourage tooth brushing two (2) times a day and apply prescribed oral treatments as ordered. Review of the July, August, September, and October 2025 nurse aide documentation sheets identified although the majority of time Resident #1 was compliant with care, there were occasions care did not occur and there was no documentation completed. Review of the September and October 2025 Medication Administration Records (MAR) identified entries to notify the conservator for refusal of care occurred two (2) times per week on shower days. The MAR failed to reflect documentation of notification of refusals for all care. Review of the nurse's notes from 10/13/25 to 11/10/25 failed to identify notification to the conservator of any refusals of care. Interview with Resident #1 on 11/12/25 at 9:40 AM identified Resident #1 was independent with personal care and per Resident 1's choice, did not wash, brush his/her teeth, or change clothes daily. Resident #1 identified he/she did take showers on shower days. Resident #1 indicated he/she felt there was no reason to perform hygiene tasks daily because he/she did not do anything to get dirty and when living at home he/she would not do these tasks daily. Interview with the 7AM-3PM nurse aide, Nurse Aide (NA) #1, on 11/12/25 at 1:10 PM identified she was Resident #1's primary nurse aide on the 7AM-3PM shift. NA #1 identified on shower days Resident #1 complied with showers however once NA #1 set the water temperature, toiletries and clean clothes and Resident #1 got in the shower, she left Resident #1 to perform the task independently because Resident #1 refused assistance. NA #1 indicated she would frequently check on Resident #1 and noticed Resident #1 with a washcloth, and Resident #1 would always change clothes on days she worked with Resident #1. NA #1 identified Resident #1 would refuse assistance with toothbrushing and would indicate he/she had done that independently. Interview with the Director of Nursing (DON) on 11/12/25 at 2:30 PM identified the facility had agreed to notify the Conservator of all refusals of care by Resident #1 and the DON was not aware refusals of care were not documented as identified in the RCP. The DON indicated she spoke to the Conservator multiple times regarding her concerns about Resident #1 not agreeing to daily care. Review of the Care Plan Policy identified the Resident Care Plan would be developed with the resident and/or caregiver and implemented.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075324	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayview Health Care	301 Rope Ferry Rd Waterford, CT 06385

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075324	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayview Health Care	301 Rope Ferry Rd Waterford, CT 06385

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, facility documentation, facility policies and interviews for four (4) of sixteen (16) sampled residents (Residents #1, #2, #3, and #4) who were reviewed for medication administration, the facility failed to properly secure medications when left unattended at the residents' bedside without an order for the residents to self-administer the medications or the resident was sleeping. The findings include: 1. Resident #1's diagnoses included mild cognitive impairment, chronic obstructive pulmonary disease, and congestive heart failure. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 made reasonable decisions regarding tasks of daily life. Review of the October and November 2025 physician orders identified there was no physician's order for self-administration of medication. Interview with Resident #1 and observations conducted with the 7AM-3PM charge nurse, Licensed Practical Nurse (LPN) #1 present, on 11/12/25 at 9:40 AM identified upon entering the room Resident #1 was noted to be sleeping and on the bedside table a white medication cup filled with several medications was observed. After interviewing and assessing Resident #1, LPN #1 picked up the medication to administer them to Resident #1. Resident #1 identified he/she was asleep when it was time for his/her medication which was why the medications were at the bedside. Interview with LPN #1 at 9:40 AM identified she left the medications in Resident #1's room because Resident #1 was asleep. LPN #1 explained she left the room to give another resident his/her medications with the intention of going back into Resident #1's room to administer the medications. LPN #1 stated she typically does not leave medications for the residents unless they had a physician's order to self-administer their medications. 2. Resident #2's diagnoses included diabetes mellitus, asthma, and anxiety. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #2 made reasonable decisions regarding tasks of daily life. The Resident Care Plan dated 10/14/25 identified Resident #2 had a physician's order to self-administer albuterol, simethicone, and Voltaren gel. Interventions directed to assess the resident's ability to self-administer medications, discuss the medications with the resident, and to monitor the self-administration of the medications. Physician orders dated through 11/13/25 identified several medications Resident #2 could keep at the bedside and self-administer, these included inhalers, vaginal cream and the simethicone. Observations of Resident #2's room on 11/12/25 at 9:50 AM identified Resident #2 was asleep, there was a white medication cup on Resident #2's bedside stand with a small white pill in it, this pill did not match the description of the simethicone Resident #2 was allowed to self-administer. Interview with LPN #1 at 10:10 AM identified she left Resident #2's medications at the bedside because Resident #2 had an order to self-administer his/her medications. 3. Resident #3's diagnoses included end stage renal disease and macular degeneration. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #3 made reasonable decisions regarding tasks of daily life. The self-administration of medication evaluation dated 9/11/25 identified Resident #3 had no desire to self-administer medications. Review of the physician's orders and care plan to the current date 11/12/25 failed to reflect documentation that Resident #3 could self-administer medications. Observations and interview with Resident #3 on 11/12/25 at 9:53 AM identified Resident #3 was awake and there was a white medication cup on Resident #3's bedside stand with an unidentified tablet in it. Resident #3 identified the pill was for his/her eye function. Interview with LPN #1 at 10:10 AM identified she left Resident #3's medications at the bedside because the resident had an order to self-administer his/her medications. 4. Resident #4's diagnoses included osteomyelitis of the left ankle, type two diabetes mellitus, anxiety, and opioid dependence. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #4 made reasonable decisions regarding tasks of daily life. Review of the physician's orders and care plan to the current date 11/12/25 failed to reflect documentation that Resident #3 could self-administer medications. Observations and interview with Resident #4 on 11/12/25 at 9:56 AM identified Resident #4 was awake and there was a white medication cup on Resident #4's bedside stand with an unidentified tablet in it. Resident #4 identified the pill was for the pancreas and the physician said he/she could take the medicine on his/her own. Interview with LPN #1 at 10:10 AM identified she left Resident #4's medications at the bedside because Resident #4 had an order to self-administer his/her medications. Interview with the 7AM-3PM floor nurse, Licensed Practical Nurse (LPN) #2 on 11/12/25 at 12:50 PM identified she would not leave medications at a resident's bedside unless they had an order for medication self-administration and if the resident was sleeping, she would never leave the medication at the bedside. Interview with the Director of Nursing (DON)