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	01/13/2026

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 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 clinical record reviews, facility documentation, facility policy and interviews for two (2) of three (3) sampled residents (Resident #1 and #3) who were reviewed for falls, the facility failed to ensure a quarterly fall risk assessment was completed at the time the assessment was due. The findings include: 1. Resident #1's diagnoses included vascular dementia without behavioral disturbances, muscle weakness and anxiety disorder. The Resident Care Plan dated 11/13/25 identified Resident #1 was at risk for falls related to a history of several falls, generalized weakness, unsteadiness on their feet and forgetfulness. Interventions directed the resident required a mechanical lift and assistance from two (2) staff for transfers, to ensure the room was well lit and clutter free, ensure personal items were within reach, and provide frequent reminders to use the call light for assistance, and ensure the call light was within reach when in the room. Review of the quarterly Fall Risk Evaluation dated 12/2/25 identified although the assessment was opened by the Minimum Data Set Assistant, the assessment was noted to be blank and not filled out and the fall risk score was to be determined. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS)score of six (6) out of fifteen (15) indicating Resident #1 had poor short- and long-term memory recall and was dependent on staff for bed mobility and transfers. The nurse's note dated 12/12/25 at 11:02 AM identified Resident #1 had a witnessed fall at 8:30 AM when a nurse aide, Nurse Aide (NA) #1, transferred Resident #1 into a wheelchair, the locks failed and Resident #1 fell to the floor. The note indicated Resident #1 hit his/her face on the floor, remained alert, sustained a bloody nose and a skin tear to the bridge of the nose. The note identified Resident #1 was transferred to the hospital at 8:40 AM and the Director of Nursing (DON), nursing supervisor, Advanced Practice Registered Nurse (APRN) and family were notified of the incident. 2. Resident #3's diagnoses included polyneuropathy (the malfunction of many peripheral nerves throughout the body causing numbness, tingling weakness and burning pain), epilepsy (a brain disorder that causes seizures), weakness and anxiety. Review of the quarterly Fall Risk Evaluation dated 12/10/25 identified although the assessment was opened by the Minimum Data Set Assistant, the assessment was noted to be blank and not filled out and the fall risk score was to be determined. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #3 had a Brief Interview for Mental Status (BIMS) score of thirteen (13) out of fifteen (15) indicating Resident #3 was alert and oriented and was independent with bed mobility, transfers and ambulating. The Resident Care Plan dated 12/23/25 identified that Resident #3 was at risk for falls secondary to being newly admitted , generalized weakness, syncopal (fainting) episodes and seizures. Interventions directed to place the call light within reach and orient the resident to their surroundings. The nurse's note dated 1/1/26 at 6:58 AM identified Resident #3 had a fall. The note indicated Resident #3 reported he/she was trying to get to the bathroom, started to feel weak and slid to the floor onto his/ her knees. Interview with the Minimum Data Set (MDS) Assistant and the MDS (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nurse, Registered Nurse (RN) #3, on 1/13/26 at 2:26 PM identified the MDS Assistant was responsible for opening the assessments that were required for the upcoming MDS schedule so they would show up on the dashboard for the nurses to complete. They identified the nurses were then responsible for completing the assessments, including the Fall Risk Evaluations that were to be completed on admission, quarterly, annually and following a fall and were unsure why nursing did not complete the 12/2/25 quarterly Fall Risk Evaluation for Resident #1 or the 12/10/25 quarterly Fall Risk Evaluation for Resident #3. Interview with the Director of Nursing (DON) on 1/13/26 at 1:46 PM identified the quarterly Fall Risk Evaluations for both Resident #1 and Resident #2 should have been completed by nursing staff when the assessments were due. Review of the Falls Management policy dated August 2018 directed, in part, that a fall risk evaluation will be conducted on each resident upon admission, with the quarterly MDS cycle and when a significant change in status occurs including a fall.

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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 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 record reviews, facility documentation, policy, and staff interviews for one (1) of three (3) sampled residents (Resident #1), who required two-person assistance and a mechanical lift for safe transfers, the facility failed to follow established transfer procedures during a transfer on 12/12/25. A Nurse Aide (NA #1) relied on an outdated assignment sheet indicating single-staff assistance, did not verify current transfer requirements on the resident care card, and attempted a manual pivot transfer without obtaining a second staff or mechanical lift. The wheelchair brakes were not reliably engaged, resulting in Resident #1 falling face-first, sustaining a bloody nose and nasal laceration requiring sutures and hospital transport. The findings include:Resident #1's diagnoses included vascular dementia without behavioral disturbances, muscle weakness and anxiety disorder. A physician's order dated 10/28/25 directed to transfer Resident #1 in and out of the bed and chair via a mechanical lift and the assistance of two (2) staff. The Resident Care Plan dated 11/13/25 identified Resident #1 had Activities of Daily Living (ADL) deficits related to generalized weakness, vascular dementia, and forgetfulness. Interventions included the resident required a mechanical lift and assistance of two (2) staff for transfers. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of six (6) out of fifteen (15) indicating Resident #1 had poor short-and-long term memory recall and was dependent on staff for bed mobility and transfers. The nurse's note dated 12/12/25 at 11:02 AM identified Resident #1 had a witnessed fall at 8:30 AM when a nurse aide, Nurse Aide (NA) #1, transferred Resident #1 into a wheelchair, the locks failed and Resident #1 fell to the floor. The note indicated Resident #1 hit his/her face on the floor, remained alert, sustained a bloody nose and a skin tear to the bridge of the nose. The note identified Resident #1 was transferred to the hospital at 8:40 AM and the Director of Nursing (DON), nursing supervisor, Advanced Practice Registered Nurse (APRN) and family were notified of the incident. The hospital documentation dated 12/12/25 identified Resident #1 presented in the Emergency Department (ED) following a fall and was noted with a bleeding laceration (a cut, tear or rip in the skin and soft tissue) to the bridge on the nose and was on Eliquis (a blood thinner). The note indicated head and cervical spine imaging were obtained and resulted negative for any acute injuries or fractures and five (5) sutures were required to repair the nasal laceration. The note indicated Resident #1 was transferred back to the facility on [DATE]. Interview with NA #1 on 1/13/26 at 11:48 AM identified he did not consistently care for Resident #1 so prior to transferring Resident #1 to the wheelchair on 12/12/25 he checked his assignment sheet which identified Resident #1 was an assist of one (1) for transfers. NA #1 explained he placed the wheelchair on the right side of Resident #1's bed and sat Resident #1 up on the side of the bed, placed the gait belt around Resident #1's waist and then stood Resident #1 up. NA #1 identified Resident #1 was much weaker and heavier than he had expected, and instead of sitting Resident #1 back down on the side of the bed and requesting help, he bear hugged Resident #1 and pivoted Resident #1 with difficulty into the wheelchair. NA #1 indicated he was only able to get Resident #1 partially into the wheelchair so Resident #1 was seated at the edge of the wheelchair seat, the wheelchair then began to roll backwards, and Resident #1 fell forwards out of the wheelchair and hit his/her face on the floor. NA #1 identified although he put the brakes on the wheelchair prior to transferring Resident #1, he did not move or jiggle the wheelchair to ensure the locks were engaged and the chair would not move. NA #1 stated when he stood Resident #1 prior to the transfer and identified Resident #1 was weak and heavy, he should have sat Resident #1 back down on the bed and requested assistance. NA #1 identified he was not sure of what a (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	resident care card was or where it was located and was not aware he should have been following the transfer status on the resident care card and not the assignment sheet. Interview with the charge nurse, Licensed Practical Nurse (LPN) #1, on 1/13/26 at 11:31 AM identified although she was unsure if the assignment sheet was updated with the Resident #1's transfer status prior to the 12/12/25 fall, the assignment sheet was only used to briefly summarize Resident #1 and was not Resident #1's accurate plan of care, and NA #1 should have reviewed the resident care card for the transfer status and not the assignment sheet. Interview with the Occupational Therapist, (OT) #1, on 1/13/26 at 1:10 PM identified as of 10/28/25, Resident #1 required assistance of two (2) staff and a Hoyer (mechanical) lift for all transfers due to safety and Resident #1 had been a Hoyer lift for more than a month prior to the fall on 12/12/25. Interview with the Director of Nursing (DON) on 1/13/26 at 1:46 PM identified the nurse aides are directed to check a residents' activity of daily living status, including transfer status on the resident care card each shift prior to contact with the resident. The DON indicated the assignment sheets are only to be used for a quick summary and should always be compared to the care card and if there are discrepancies then the nurse aide should be clarifying the discrepancies with the charge nurse. The DON identified NA #1 should have checked Resident #1's care card prior to the transfer and if he had, he would have known to secure a second staff member and utilize a Hoyer lift to transfer Resident #1 from the bed to the wheelchair, which would have prevented the fall and also one (1) of the staff members would have been standing behind the wheelchair which would have prevented the wheelchair from rolling if the brakes truly were in disrepair. The DON explained NA #1 should have sat Resident #1 down on the bed immediately and requested assistance when he realized Resident #1 was too weak to stand and should never have bear hugged Resident #1 and continued transferring Resident #1 by himself. Review of the Wheelchair policy dated April 2015 directed, in part, that when transferring a resident to a wheelchair, position the wheelchair in the appropriate position for transfer, apply brakes to lock the wheels and secure the chair and assist the resident into the chair using proper transfer techniques and the use of a gait belt.