STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075324	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2026
NAME OF PROVIDER OR SUPPLIER Bayview Health Care		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, facility documentation, facility policies and interviews for one (1) of three (3) sampled residents (Resident #1) reviewed for medication administration, the facility failed to ensure the resident was free from a significant medication error when a schedule III opioid medication, which was prescribed for another resident, was inadvertently administered to Resident #1 causing the develop of an opioid-induced respiratory depression requiring hospitalization and treatment. The failure resulted in the finding of Immediate Jeopardy. The findings include: Resident #1's diagnoses included pulmonary embolism, depression, and difficulty walking.The five (5) day Minimum Data Set assessment dated [DATE] identified Resident #1 had short and long-term memory recall deficits (Brief Interview for Mental Status (BIMS) score of 7), was dependent on staff for toileting, dressing, bed mobility, and transfers, was non-ambulatory and utilized a wheelchair. The Resident Care Plan dated 2/5/26 identified Resident #1 had a self-care deficit. Interventions directed to keep the call bell in reach, administer medications as ordered, and monitor for side effects of medications.The nurse's note dated 2/5/26 at 9:30 PM by LPN #2 identified during the narcotic medication count, LPN #1 reported Resident #1 inadvertently received a dose of Suboxone eight (8) - two (2) milligrams (mg) prescribed to Resident #2. The Advanced Practice Registered Nurse (APRN), RN #1 (the 3:00 PM to 11:00 PM supervisor), and the Director of Nursing (DON) were immediately notified. Resident #1 was alert, verbal, with some confusion noted. Previous vital signs had been normal. The APRN directed to apply oxygen at 5 liters via nasal cannula for supportive therapy due to oxygen saturation levels between 83% to 86% (normal range 95% to 100%) on room air. Respiratory rate was thirteen (13) and non-labored and previously had been eighteen (18). Heart rate was ninety-two (92) and pupils were pinpoint. 911 was called and a nurse remained with Resident #1 until emergency medical services (EMS) arrival at 10:10 PM. Narcan was administered per APRN directions.The Emergency Department (ED) admission notes dated 2/5/26 identified Resident #1 arrived to the ED at 10:50 PM on 2/5/26 and was admitted with opioid-induced respiratory depression and altered mental status. Four (4) milligrams (mg) of intranasal Narcan was administered and Resident #1 was placed on five (5) liters of oxygen via nasal canula by EMS during transfer to the hospital. Resident #1 was not on oxygen at baseline. Resident #1 was given an additional two (2) doses of Intravenous (IV) Narcan and IV potassium due to a low potassium level (2.9). Resident #1 was admitted to the Intensive Care Unit (ICU) for hypertension, tachycardia (high heart rate), and continued somnolence. IV Diltiazem (for elevated blood pressure) was started. Resident #1 required constant telemetry and pulse oxygen monitoring. Resident #1 was hospitalized for a total of eleven (11) days.Interview with LPN #1 on 3/3/26 at 12:30 PM identified she administered medications to Resident #1 on 2/5/26 for the first time. LPN #1 was preparing medications for Resident #2 when a family member approached her and requested she meet Resident #1 since LPN #1 was Spanish speaking. After meeting the resident, LPN #1 continued preparing the medications for Resident #2 and reported there was an additional interruption by an NA. She then proceeded into Resident #1's room, who she thought was Resident #2, because both residents were Spanish speaking. LPN #1 did not verify Resident #1 by name or check the name bracelet and began to administer the medications. Resident #2 refused all medications (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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	except for the Suboxone. When reporting the medication refusal to LPN #2 during shift change, LPN #1 then realized she administered the medication to the wrong resident. She did not administer medications to Resident #2. The medication error was reported to RN #1.Interview with the APRN on 3/3/26 at 12:50 PM identified Suboxone was not prescribed for Resident #1 and Resident #1 had never been prescribed opioids. The APRN received a phone call from the facility reporting Resident #1 was administered Suboxone in error. The APRN directed monitoring and the administration of Narcan if Resident #1 had signs of respiratory depression and to transfer Resident #1 to the ED with any change in condition. The APRN identified complications of administering Suboxone in error were respiratory depression, change in level of consciousness, hypotension, and hypoxemia. The dose administered to Resident #1 was a super therapeutic dose for someone who had never previously taken Suboxone. The APRN further identified the administration of Suboxone to Resident #1 was dangerous, could cause significant respiratory depression and central nervous system depression, and was considered a significant medication error.Interview with the DON on 3/3/26 at 12:55 PM identified that the administration of Suboxone to Resident #1 was dangerous and was a significant medication error. The facility immediately initiated an internal investigation. The facility subsequently completed a plan of correction and initiated training and audits.The facility Medication Error Policy identified a medication error as the preparation or administration of drugs not in accordance with physician's orders and included a drug being administered without a physician's order. The policy further identified a significant medication error, in part, as an error that results in the resident requiring hospitalization, requiring the administration of a prescription medication to treat the error, and an error that is life threatening and/or could potentially lead to death.Review of facility documentation identified that a Plan of Correction was initiated immediately:Staff training was completed and included review of the five rights of medication administration and medication competencies were performed for all licensed nursing staff. LPN #1 received one-to-one education from the consulting pharmacy.Random audits of weekly narcotic reconciliation and medication pass observations with two (2) licensed staff, change-of-condition documentation, and RN assessment audits were completed weekly for four (4) weeksAudits were reviewed at the monthly QAPI meeting.The Director of Nursing was responsible for the implementation and monitoring with the Administrator maintaining overall regulatory oversight.Alleged compliance as of 2/9/26.The plan of correction was reviewed on 3/4/26 during an on-site visit by the state agency and the facility met all components for past non-compliance.