STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075061	A. Building B. Wing	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stamford Care Center	53 Courtland Avenue Stamford, CT 06902

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 reviews, facility documentation, and staff interviews for one (1) of three (3) sampled residents (Resident #1) who required staff assistance with personal hygiene, the facility failed to ensure the resident was positioned safely in the bed and the correct number of staff assistance were present in accordance with the care plan prior to adjusting the height of the bed to prevent the resident from sliding out of the bed. The findings include: Resident #1's diagnoses included hemiplegia, hemiparesis, vascular dementia, aphasia, cerebrovascular disease, disorder of bone density and structure. The significant change Minimum Data Set assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS of 0 out of 15 indicating Resident #1 never or rarely made decisions regarding tasks of daily life, did not exhibit behavioral symptoms, and was dependent on staff with bed mobility, personal hygiene, toileting, dressing, and transfers. The Resident Care Plan dated 4/21/25 identified Resident #1 had a lack of functional physical mobility and self-care deficit related to cerebrovascular disease with functional quadriplegia. Interventions directed total assist of two (2) staff with bed mobility and transfers The Situation Background Assessment Recommendation (SBAR) note dated 5/11/25 at 7:51 AM identified Resident #1 sustained a witnessed fall during care. Resident #1 was observed in the supine position and moaning while lying on floor and unable to verbally express his/her pain. The note indicated the physician was notified and recommended to send Resident #1 to the hospital. The hospital record dated 5/11/25 at 8:35 AM identified Resident #1 presented after a witnessed fall, a Computerized Tomography (CT) scan of the chest, abdomen, and pelvis was conducted and identified Resident #1 had sustained an acute comminuted and mildly displaced fracture of the proximal right femur. Resident #1 was admitted for further management. The facility's summary report dated 5/16/25 identified on 5/11/25 at 7:45 AM the 7AM-3PM nurse aide, Nurse Aide (NA) #1, reported a witnessed fall, Resident #1 had slid out of the bed to the floor while she was adjusting the bed. NA #1 explained Resident #1 was positioned on his/her right side, in a sitting position with a pillow between his/her legs. NA#1 identified she started adjusting the bed when Resident #1 slid off the right side of the bed landing in a sitting position on the floor. NA #1 stated she was unable to reach Resident #1 from where she was standing. (continued on next page)

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

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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	Interview with NA #1 on 6/2/25 at 11:48 AM identified she was assigned to Resident #1 on the 7AM-3PM shift on 5/11/25. NA #1explained she gathered the supplies and then adjusted the height of the bed, but she did not first check to ensure Resident #1 was in a safe position. NA #1 identified as she was raising the bed she noticed Resident #1 started to slide out of the bed and she could not grab Resident #1 in time to prevent the fall to the floor. NA #1 stated although she saw Resident #1 was on their side, she did not know Resident #1 was on the edge of the bed before adjusting the height of the bed and indicated she should have checked to ensure Resident #1 was in a safe position before adjusting the height of the bed. Interview with the Director of Rehabilitation on 6/2/25 at 12:50 PM identified Resident #1 was dependent on staff and required two (2) staff members for transfers and bed mobility. Interview and record review with the Director of Nursing (DON) on 6/2/25 at 1:14 PM identified when NA #1 went to provide care to Resident #1, Resident #1 was on her/his side and while NA #1 was adjusting the height of the bed Resident #1 slid out of the bed onto the floor. The DON indicated NA #1 did not see Resident #1 was on the edge of the bed because Resident #1 had a sheet on him/her. The DON stated it would be her expectation that staff ensured a resident was in a safe position prior to adjusting the bed. The DON identified considering Resident #1 was on an air mattress, when the bed was adjusted the air in the mattress could have shifted causing the resident to slide out of bed.