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	02/10/2026

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, clinical record, and policy reviews for 1 of 3 sampled residents (Resident #23) reviewed for pressure ulcers, the facility failed to provide services to prevent worsening of 2 pressure wounds for a dependent resident. The findings include:Resident #23's diagnoses included open wound of the lower back and pelvis, quadriplegia (paralysis affecting all 4 limbs and the torso), and malnutrition.The comprehensive Minimum Data Set (MDS) assessment dated [DATE] identified Resident #23 had a Brief Interview of Mental Status of 00 indicating severe cognitive impairment and was totally dependent on staff for toileting, transfers, and changing positions in bed (rolling, lying and sitting). Additionally, Resident #23 was at risk for developing pressure ulcers and did not have any current unhealed pressure ulcers/injuries. The MDS identified skin ulcer/injury treatments included a pressure reducing device for the bed, a turning and repositioning program and application of non-surgical dressings.The Resident Care Plan dated 1/15/26 and in effect on 1/28/26 identified Resident #23 had a reopened stage 4 pressure ulcer wound to the sacrum and an unstageable pressure ulcer wound to the right upper back. Interventions included low air loss mattress to be checked for proper setting and function every shift, turn and position every 2 hours, and to monitor nutritional status.Review of the facility provided in-house acquired pressure ulcer list provided on entrance to the facility on 2/8/26 identified Resident #23 had a stage 4 pressure ulcer that had previously healed and reopened on 1/28/26 and a pressure ulcer to the right lower back.Review of quarterly skin evaluations dated 7/22/25 and 10/1/25 identified Resident #23 had a Braden Scale evaluation score of 8 indicating a very high risk for pressure ulcers. Although requested a Braden Scale evaluation was not located in the clinical record and not provided for January 2026.A physician's order dated 2/6/25 and in effect through 2/10/26 directed an air mattress to be set to (the resident's) weight and to check function and settings every shift.A physician's order dated 1/28/26 directed to turn and reposition Resident #23 every 2 hours when in bed, daily, every shift, for pressure ulcer/injury.Review of Resident #23's Nurse Aid (NA) Documentation Turning and Repositing Report which included all 3 shifts, dated 1/1/26 to 1/31/26 failed to identify a signature that would have indicated that Resident #23 was turned/repositioned for 28 of 93 turning and repositioning opportunities. (30.1% of January's shift documentation).Review of the wound care specialist progress note dated 1/28/26 identified Resident #23 was being seen for the first evaluation of an existing wound. Wound #1 was an unstageable pressure wound to the right lower back that measured 1 centimeter (cm) x 1.5 cm x 0 cm, and wound #2 was a stage 4 pressure wound to the sacrum that measured 1 cm x 0.2 cm x 0.3 cm. The assessment/plan included, in part, a redistribution mattress per facility protocol, and to reposition Resident #23 every 2 hours.Review of the wound care specialist progress note dated 2/4/26 identified Resident #23 was seen for evaluation and management of wounds. Wound #1 was an unstageable pressure wound to the right lower back that measured 1 cm x 2 cm x 0 cm (an increase from 1 cm x 1.5cm x 0 cm on 1/28/26) and wound #2 was a stage 4 pressure wound to the sacrum that measured 1 cm x 0.2 cm x 0.3 cm (no change from the evaluation on 1/28/26). The assessment/plan included, in part, a redistribution mattress per facility protocol, and to reposition Resident #23 every 2 hours.Review of Resident #23's Nurse Aid (NA) (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
	075061	A. Building B. Wing	02/10/2026

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 0686 Level of Harm - Actual harm Residents Affected - Few	Documentation Turning and Repositing Report including all 3 shifts dated 2/1/26 to 2/10/26 failed to identify a signature which would have indicated that Resident #23 was turned/repositioned for 43 of 115 turning and repositioning opportunities. (37.3% of February's shift documentation).The undated Nurse Aid Care Card (directs NA care) directed Resident #23 had a low air loss mattress to be checked for proper function and setting every shift and that he/she was to be turned/repositioned every 2 hours.Review of the facility Turning & Repositioning Program identified residents should be repositioned to face the door from 6:00 AM to 8:00 AM, 12:00 PM to 2:00 PM, 6:00 PM- 8:00 PM and 12:00 AM to 2:00 AM, repositioned to face the window from 8:00 AM to 10:00 AM, 2:00 PM to 4:00 PM, 8:00 PM to 10:00 PM, and 2:00 AM to 4:00 AM, and repositioned on their back from 10:00 AM to 12:00 PM, 4:00 PM to 6:00 PM, 10:00 PM to 12:00 AM and 4:00 AM to 6:00 AM.Observations on 2/8/26 at 6:55 AM (should have been facing the door 6:00 AM -8:00 AM), 2/8/26 at 9:41 AM (should have been facing the window 8:00 AM to 10:00 AM) and 2/8/26 at 12:20 PM (should have been facing the door 12:00 PM to 2:00 PM) identified Resident #23 in bed on his/her back with the pressure relieving mattress set to 160 pounds at normal pressure.Observations on 2/9/26 at 8:25 AM (should have been facing the window 8:00 AM to 10:00 AM) and 2/9/26 at 10:12 AM (correctly positioned) identified Resident #23 in bed on his/her back with the pressure-relieving mattress set to 160 pounds at normal pressure.Interview with Licensed Practical Nurse (LPN) # 7 on 2/9/26 at 10:12 AM identified the facility policy for turning and repositioning residents directed that residents with repositioning orders be turned/repositioned every 2 hours by the NA's per the schedule and that the unit nurse would then verify compliance with repositioning and sign off as completed in the electronic health record. Interview, observation, and record review with Registered Infection Prevention Nurse (RN) #1 on 2/9/26 at 12:31 PM identified the facility policy directed residents at risk and with wounds be part of a universal turning and repositioning program where residents were turned every 2 hours alternating facing the door, on their back and facing the window. Additionally, RN #1 identified pressure alternating mattresses were provided to at risk residents and set per the resident's weight, with responsibility for the preventive measures being a collaborative effort between NA's and unit nurses. Observation of Resident #23 with RN #1 identified him/her positioned on his/her back (should have been facing the door 12:00 PM to 2:00 PM) and the pressure relieving mattress set to 160 pounds at normal pressure. RN #1 identified that Resident #23 should have been facing the door per the turning and rescheduling program, and upon record review, RN #1 identified that the pressure relieving mattress should not have been set to 160 pounds, but rather 91 pounds (to reflect the resident's current weight). She could not identify why Resident #23 was not positioned per the positioning schedule or why the mattress was set to an inaccurate weight, stating education was still ongoing.Subsequent to surveyor inquiry observation on 2/10/26 at 7:47 AM identified Resident #23 turned to his/her side and the pressure alternating mattress set between 80 and 120 pounds.Interview and record review with RN #1 on 2/10/26 at 9:28 AM identified Resident #23's wounds were first identified on 1/28/26 and the wound on the sacrum was a reopened wound that had healed approximately 1 year ago. RN #1 identified that the lower back area was an unstageable wound that measured 1 cm x 1.5 cm x 0 cm on 1/28/26, 1 cm x 2 cm x 0 cm on 2/4/26 and the measurement obtained on 2/10/26 was 2 cm x 2.2 cm x 0 cm, indicating the lower right back wound had worsened. Review of the reopened stage 4 wound to the sacrum with RN #1 identified a measurement of 1 cm x 0.2 cm x 0.3 cm on 1/28/26, 1 cm x 0.2 cm x 0.3 cm on 2/4/26, and 2 cm x 2.2 cm x 0.3 cm on 2/10/26, indicating the sacral wound had worsened. Additionally, RN #1 identified a lack of turning and repositioning and an inappropriately set pressure relieving mattress as well as poor nutrition status would cause the wounds to worsen.Interview with the Dietician #1 on 2/10/26 at 9:50 AM identified she was familiar with Resident #23 because he/she frequently triggered for weight loss due to fluctuations in meal intake. Additionally, although she was not aware of sacral wound worsening between 1/28/26 and 2/4/26, or the newly identified measurements obtained 2/10/26 Dietician #1 stated Resident #23 was already receiving interventions for being at high risk such as fortified cereal, (continued on next page)

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	02/10/2026

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 0686 Level of Harm - Actual harm Residents Affected - Few	high calorie supplements, and high protein nutritional shakes so there was not much that could be added from a nutritional standpoint.Interview and record review with wound APRN #1 on 2/10/26 at 10:15 AM identified she was following Resident #23 weekly for the lower right back and sacral wound identified on 1/28/26. Review of the wound measurements with APRN #1 obtained on 2/10/26 identified both the wounds were larger in size since she last evaluated them on 2/4/26. Additionally, APRN #1 identified that Resident #23 was a very compromised individual with an overall decline in health, and the worsening of the wounds could be attributed to a compilation of factors which included the lack of turning and repositioning and an incorrectly set air mattress.Review of the Pressure Injury/Pressure Assessment Prevention and Management Policy directed in part that the facility will provide care and services consistent with professional standards of practice to prevent pressure injury/ulcer development and promote the healing of existing pressure injuries/ulcers. Additionally, develop a positioning schedule, avoid positioning residents on the pressure injury, and use a low air loss mattress for residents with a preexisting Stage 3 or 4 pressure injury.Review of the Specialty Mattress Policy directed, in part, that settings will be checked every shift by a licensed nurse and documented.Review of the Turning and Repositioning Policy dated 7/2020 directed, in part, that it was the facility's policy to identify residents who require turning and repositioning and place them on a repositioning schedule.

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	02/10/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, facility documentation, and facility policy, the facility failed to provide safe and comfortable air temperature levels in resident rooms and common areas. The findings include: During an initial tour of the facility, observation and interview with Licensed Practical Nurse (LPN) #5 on 2/8/26 at 7:02 AM, identified the 1st Floor East hallway air temperature was noted to be cold. LPN #5 was dressed in a winter hat, 2 sweaters, and a scarf. LPN #5 stated that it's freezing on the 1st floor and is always like this at night. Observation and interview on 2/8/26 at 7:11 AM with Resident #52 identified him/her in bed, covered with 3 blankets, and the facility heating system in the room was running at the highest possible setting. Using a probe thermometer, the room temperature read 69.8 degrees Fahrenheit (F). Resident #52 stated, I'm freezing. Interview with the Administrator on 2/8/26 at 7:42 AM identified that the facility was aware of the heating issue and that their intervention had been to close resident doors to preserve heat within the rooms. Observation and re-interview with LPN #5 on 2/8/28 at 7:52 AM at the 1st Floor East Unit nurses' station identified she remained dressed in her winter clothing and was noted to be visibly shaking. A probe thermometer was used to monitor the air temperature at the nursing station (an area also utilized by residents) and identified a reading of 57.6 F. LPN #5 stated, I'm so cold. Observation of Housekeeper #1 on 2/8/26 at 9:56 AM noted that he remained in his winter coat while performing housekeeping duties on the 1st Floor East Unit while cleaning the hallway with 1 resident present in the area. The temperature reading in this area at 9:56 AM using a probe thermometer was 61.3 .Observation, interview, and facility tour with the Maintenance Director on 2/8/26 at 9:57 AM using an ambient air temperature thermometer directed away from the heat source identified the following: 1st Floor Lobby 53 F- 1 resident was present by door receiving medications.68 F in resident room [ROOM NUMBER]- 1 resident was present in the room.69 F in resident room [ROOM NUMBER]- 1 resident was present in the room.70 F in resident room [ROOM NUMBER]- 1 resident was present in the room.64 F at the entrance to the 1st Floor East Resident Dining Room.61 F in the 2nd Floor East Resident Dining Room.59 F in the 2nd Floor East Resident Hallway, - 1 resident was present in hallway.67 F in the 2nd Floor Resident Community Room- 3 residents were present in the Community Room.65 F in the 4th Floor Resident Hallway- 4 residents were present in the hallway.63 in the elevator used for resident transport.The Maintenance Director stated that the facility was aware of heating issues, however, temperature logs (not currently available) had not reflected temperatures observed as low as the measured probe thermometer or ambient air temperatures that had currently registered. Observation on 2/8/26 at 10:19 AM identified Resident #84, eating breakfast, seated on the side of the bed and wearing a winter coat. Re-interview with Administrator on 2/8/26 at 10:37 AM identified that this was the first time temperature issues had been identified in the facility. The Administrator stated that the changes in the outside air temperature contributed to the facility heating issue and the plan was to close resident doors, check resident temperatures, and start a Quality Assurance and Improvement Project (QAPI) to monitor temperatures in the facility to ensure residents' comfort. Interview and review of the facility Temperature Logs dated 1/26/26 to 2/1/26 with the Maintenance Director on 2/8/26 at 10:45 AM identified the facility was in compliance with the requirement and that temperatures had ranged between 72 F and 78 F. Further, the Maintenance Director stated the facility was aware of the heating issue and had contacted a heating company to inspect and maintain the heating system. Subsequent to Surveyor Inquiry on 2/8/26 the facility obtained and installed warm air heating units for the 1st Floor East and 2 units for the 2nd Floor to help provide comfortable ambient temperature levels in resident rooms and care areas identified with inadequate temperature readings.A Resident Council Meeting, held on 2/9/26 at 10:17 AM (following supplement heat installation) with Residents #48, # 51, #89, #118, #140, #144, #147, and #156 identified residents had (continued on next page)

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	02/10/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	concerns with cold facility temperatures prior to commencement of the state recertification survey that had begun on 2/8/26. Residents stated they had brought concerns to nursing about being uncomfortable and needing heat for at least two weeks. Although requested, documentation of temperature logs dated 2/2/26-2/7/26 and confirmation of documentation that a heating company had been contacted prior to surveyor inquiry, were not provi

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	02/10/2026

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on interviews, a sample test tray, facility documentation, and policy, the facility failed to provide appetizing and palatable food. The findings include:Review of the Resident Council Minutes dated 9/26/25 identified Resident concerns that meat was not tender and hard to chew (there was no response noted from the Dietary Department).Review of the Resident Council Minutes dated 11/21/25 identified Resident concerns that food was delivered cold, and the meat was not tender (there was no response noted from the Dietary Department).Review of the Resident Council Minutes dated 12/24/25 identified Resident concerns about the pork being overcooked, the facility response from the Dietary Food Director was to speak to the cooks regarding overcooking protein.Review of Resident Council minutes dated 1/27/26 identified Resident concerns with the repetitive chicken meals given frequently with the same seasoning, the facility response from Dietary Food Director was to speak with cooks regarding improved seasoning options.Interview with Resident #7 on 2/8/26 at 9:38 AM described the food as terrible, always late and cold, stating he/she usually asked for the food to be warmed up.Interview with Resident #28 on 2/8/26 at 9:45 AM identified the food tasted disgusting and was always cold.Interview with Resident #140 on 2/08/26 at 9:39 AM identified the food was of low quality, did not taste good, and was always cold.A Resident Council meeting was held on 2/9/26 at 11:12 AM with 13 residents who identified that the quality of food was lacking and often cold.A lunch test tray was requested with the Dietary Director on 2/8/26 at 11:11 AM, a second request for a test tray was made 2/8/26 at 1:00 PM and delivered 2/8/26 at 1:20 PM. Multiple surveyors sampled lunch and found the food to be unappetizing and not palatable. Surveyors found that the mashed potatoes lacked flavor, although the roast beef was not tough, it was accompanied by watery gravy that was lumpy and separating, and the vegetables consisted of watery, overcooked cauliflower, broccoli, and green beans. No dessert was provided. Interview with the Regional Dietary Director on 2/8/26 at 1:57 PM identified that upon hearing the multiple food complaints, he tried the lunch served that day and noted that the vegetables tasted like cauliflower but were overcooked, and the instant mashed potatoes tasted as such (indicating instant and from a box flavor). Additionally, the Regional Dietary Director identified it was challenging to make meals that included different consistencies, but he spoke to the kitchen staff regarding adding flavor into the food by using seasoning such as garlic and parsley to make the food more appetizing.Review of the Meal Service Assistance of Residents policy directed, in part, that facility protocol was to provide each resident with a nourishing, palatable diet at the proper temperatures.Review of the Standardized Recipes Policy dated 11/16 directed in part that food preparation methods conserve the nutritive value, flavor, and appearance of food.Review of the Timely Meal Service Policy directed in part that food be served at preferable temperatures.

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	02/10/2026

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 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on interviews, observations, and facility documentation, the facility failed to provide meals at regularly scheduled intervals. The findings include:Review of the Resident Council Minutes dated 10/27/25 identified Resident concerns that food trucks were late to some of the units. (there was no response noted from the Dietary Department).Review of the Resident Council Minutes dated 11/21/25 identified Resident concerns that food took too long to be delivered and was cold (there was no response noted from the Dietary Department).Review of the Resident Council Minutes dated 12/24/25 identified Resident concerns with the food trucks, and food not being passed out when it reached the unit destination (there was no response from the facility).Review of Resident Council minutes dated 1/27/26 identified Resident concerns with the meals arriving cold and late, response from the Dietary Food Director was to adjust tray delivery timing.Observation and review of facility documentation identified the breakfast meal truck was delivered to the 4th floor on 2/8/26 at 9:03 AM but according to the 4th floor breakfast delivery schedule posted, the cart should have arrived between 7:30 AM and 8:00 AM. The nursing staff prepared trays at 9:20 AM (1 hour and 20 minutes late), passed meals out to the dining room, then resident rooms. The last breakfast tray was delivered at 9:42 AM. Interview with Resident #28 on 2/8/26 at 9:45 AM the food tastes disgusting and is always cold, identifying the food has been running late for about a week.Interview with Resident #7 on 2/8/26 at 10:16 AM identified he/she just received breakfast, it was ice cold and will ask to have it warmed up, which is a common occurrence.Observation and review of facility documentation identified the lunch meal truck was delivered to the 4th floor on 2/8/26 at 12:45 PM, but according to the 4th floor lunch delivery schedule posted, the cart should have arrived between 12:00 PM to12:30 PM (15 minutes late and 3 hours and 3 minutes after the last breakfast tray had been delivered).Further review of facility documentation identified that the dinner meal was to be delivered to the 4th floor between 4:00 PM and 4:30 PM. This indicated that dinner was scheduled to arrive between 6 hours and 18 minutes to 6 hours and 48 minutes following the delivery of the last breakfast tray to the 4th floor and 3 hours and 15 minutes to 3 hours and 43 minutes after the lunch meal truck had been delivered. The time between the dinner meal cart delivery from 2/7/26 until breakfast would have been scheduled to be 17 hours and 12 minutes. The requirement for time between meals should be no greater than 16 hours with resident body consent and appropriate nourishing snack.Observation and interview in the kitchen with the Dietary Director on 2/9/26 at 7:45 AM identified kitchen staff started to plate the breakfast meal for delivery to the 4th floor. The Dietary Director indicated that the 4th floor food plating should have begun at 7:00 AM (45 minutes earlier), however, the cook had arrived late. The facility posted that breakfast should arrive between 7:30 AM and 8:00 AM.Observation on 2/9/26 identified the breakfast meal truck for the 4th floor arrived at 8:20 AM (20 minutes late), with the last tray delivered at 9:01 AM.Observation of the kitchen and interview with the Dietary Director on 2/9/26 at 12:28 PM identified kitchen staff began to plate the food for the 4th floor. The Dietary Director indicated that the 4th floor food plating usually began around 11:45 AM but was unable to identify the reason kitchen staff had started 43 minutes late at 12:28 PM, and that the lunch meal cart should have arrived on the 4th floor between 11:45 AM and 12:00 PM (28 minutes prior to when staff began to plate the 4th floor lunch meal). Observation on 2/9/26 identified the lunch meal truck for the 4th floor arrived at 12:42 PM, (42 minutes later than the latest posted scheduled delivery time for the 4th floor at 12:00 PM.Observation on 2/9/26 at 2:02 PM identified Nurse Aid's on the 2nd floor beginning to pass out lunch (Lunch delivery for the 2nd floor was posted as12:45 PM to 1:30 PM).Interview with the Director of Nurses on 2/9/26 at 2:05 PM identified that although there were challenges in the past with the kitchen things have gotten a lot better, however she was not aware that meals were consistently served late, or that certain residents only had 3 hours between breakfast and lunch being served. (continued on next page)

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	02/10/2026

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 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Additionally, the DNS stated there were microwaves available on the units for anyone that received their food cold, however, she could not identify how nonverbal dependent residents who could not advocate for themselves were guaranteed a timely hot meal.Interview with the Administrator on 2/9/26 at 2:48 PM identified that the elevator had not been functioning since 2/3/25 due to a water pipe burst, but that meals should still have been delivered in a timely manner. Additionally, the Administrator identified education on timely meal service was initiated earlier that day.Review of the Timely Meal Service Policy directed in part that food will be delivered promptly to assure safe, palatable and high-quality food served at the right temperature. Additionally, food will be distributed promptly with supervision as needed.

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	02/10/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on a tour of the Dietary Department, interviews, and facility documentation, the facility failed to ensure open food items were dated, failed to identify expiration dates, and failed to ensure food was stored and served under sanitary conditions. The findings included:Tour of the Dietary Department on 2/8/26 at 6:42 AM with [NAME] #1 identified the following:1. a. The outside thermometer display of the milk cooler identified a temperature reading of 55 degrees Fahrenheit, and despite taking out all the milk crates, [NAME] #1 failed locate a thermometer inside the cooler to take a temperature reading to ensure milk was being maintained at optimal temperature.b. Refrigerator #1 (juice cooler) was noted to contain a tray of sandwiches and desserts wrapped in plastic, on individual plates without the benefit of being labeled with a preparation date or expiration date.c. The walk-in cooler was noted to have the door propped open with a cart for an unidentified amount of time and was not being used by staff.d. The walk-in cooler was noted to have 4 large roast beef chucks cooling without the benefit of being covered.e. The walk-in cooler was noted to have a metal pan containing chicken thighs in marinade, covered with a plastic wrap, located on the second shelf with 2 packages of bologna being stored directly underneath on the bottom shelf.f. The walk-in freezer was noted to contain 2 bags of onion rings and 1 bag of tater tots in the original plastic containers without the benefit of being labeled with a date of opening or expiration date. g. Initial entry into the kitchen identified 1 cook and 3 dietary aids preparing breakfast without the benefit of hats, hair nets, and for 2 bearded dietary aids, no beard restraints were being used.Interview with [NAME] #1 on 2/8/26 at 7:31 AM identified it was facility policy that the cooler, refrigerator and freezer temperatures were recorded daily by the Dietary Director, and that although the thermometer could not be located it should have been in the milk cooler because the outside temperature reading was inaccurate. Additionally [NAME] #1 identified the cooler should have been closed with the roast beef chucks covered, raw chicken should have been kept on the bottom shelf when marinating, and all food items should contain a label with the date opened or prepared and the expiration date which was the responsibility of the cook. [NAME] #1 could not identify why facility policy was not followed.Subsequent to surveyor inquiry [NAME] #1 obtained a thermometer to put in the milk cooler, covered the roast beef chucks, moved the raw chicken to a lower rack, removed the frozen onion rings and frozen tater tots and staff applied hair and beard restraints as needed.Observation of the 4th floor dining room on 2/8/26 at 9:35 AM identified Resident #65 approach staff with a complaint of sour milk. Observation of the milk container identified that the milk was not expired and was well within the expiration date. Interview with the Dietary Director on 2/8/26 at 11:11 AM identified cooks were responsible for checking temperatures daily, stating that although the outside of the milk cooler had an inaccurate reading, the thermometer that was in the milk cooler was 36 degrees Fahrenheit at 6:00 AM per the record sheet. (Cook #1 had failed to locate a record sheet on 2/8/26 at 7:30 AM, failed to indicate he recorded a temperature after noting a temperature of 55 degrees Fahrenheit, and was unable to locate a thermometer inside the milk cooler when asked about the external thermometer reading). A current observation with the Dietary Director inside the milk cooler identified a reading of 20 degrees Fahrenheit. Additionally, the Dietary Director identified it was the cook's responsibility to ensure food items were covered when cooling, raw meat was kept on the bottom shelf, and refrigerator/cooler doors kept closed when not in use. The Dietary Director also specified that premade labels were utilized, to identify when food was prepared or opened and when it expired, and that everyone in the kitchen was expected to wear hair nets and beard restraints as needed. The Dietary Director could not identify why facility policies were not followed.2. Observation with the Dietary Director on 2/9/26 at 10:50 AM identified Dietary Aide (DA) #3 in the food preparation area with a tray of salads on the counter without the benefit of a beard restraint.Interview with DA #3 identified that he was aware of the facility policy on hair and beard guards and although he was just (continued on next page)

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	02/10/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	talking to the cook, because he was in the prep area he should have been wearing a beard restraint.Subsequent to surveyor inquiry DA #3 applied a beard restraint.Review of the Employee Sanitary Practices Policy directed in part that employees will wear hair restraints (hair nets, hats, and/or beard restraint) to prevent hair from contacting exposed food.Review of the Food Storage Policy directed in part that all foods will be labeled with a use by date when opened and stored in an appropriate manner. Additionally, all foods not labeled with an expiration date will be discarded.The General Guidelines for Food Safety Policy directed in part to label and date foods and put foods away promptly.

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	02/10/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of clinical records, facility documentation, facility policies and interviews for 1 of 3 sampled residents (Resident #22) reviewed for a Peripherally Inserted Central Catheter (PICC line) the facility failed to adhere to the Enhanced Barrier Precaution (EBP) policy, for 1 of 3 sampled residents (Resident #23) reviewed for pressure ulcers, the facility failed to ensure a peripherally inserted Intravenous (IV) site was rotated according to physician orders or infection control standards, for 1 of 3 sampled residents (Resident #108) reviewed for pressure ulcers, the facility failed to perform appropriate hand hygiene during a dressing change, and during a review of the facility infection control tracking practices, the facility failed to maintain an accurate up-to-date list of residents who required Enhanced Barrier Precautions (EBP) or Transmission Based Precautions (TBP) and failed to implement the facility policy for residents with a Multi-Drug-Resistant Organism. The findings include: 1. Resident #22's diagnoses included acute osteomyelitis (bone infection), of the left ankle and foot, cellulitis of the left lower foot, and Klebsiella Pneumoniae (bacterial) infection. The admission Minimum Data Set assessment dated [DATE] identified Resident #22 had a Brief Interview of Mental Status score of 15 indicating intact cognition, and was independent with eating and drinking, and required minimal/moderate assistance with bathing and dressing. The Resident Care Plan dated 1/8/26 identified Resident #22 had impaired skin integrity related to osteomyelitis, a limb alert related to Intravenous (IV) access and was on antibiotic IV therapy for 6 weeks related to osteomyelitis. Interventions included administering medication as ordered, monitor for effects, provide protective/preventive skin care per protocol, check placement of the IV site for limb alert on right side, and monitor skin integrity and signs and symptoms of infection during daily care. A physician's order dated 1/14/26 directed EBP during high-contact resident care activities for residents with indwelling medical devices such as a PICC line. Observations and interview on 2/8/26 at 12:03 PM, identified an EBP sign posted on the door of Resident #22's room and a cart outside of the room containing Personal Protective Equipment (PPE). LPN #6 was observed to enter the room with an IV bag in her hand without the benefit of placing on PPE. LPN #6 proceeded to administer Resident #22's IV fluid and exited the room. LPN #6 indicated that the EBP sign on the door indicated that Resident #22 was on EBP precautions and when she administered the IV, she should have been dressed in a gown with gloves on and should have washed or sanitized her hands, but she had missed a few steps. Interview with Infection Preventionist, Registered Nurse (RN) #1, on 2/9/26 at 8:55 AM identified that staff education for EBP was completed on 2/2/26 and 2/6/26 as a review of annual competencies. RN #1 stated that a gown and gloves should have been used during the administration of Resident # 22's IV. Interview with the Director of Nursing Services on 2/10/26 at 8:48 AM identified that any resident being administered an IV through a PICC line (a high contact activity) required a gown and gloves, including Resident #22. (continued on next page)

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	02/10/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Enhanced Barrier Precautions Policy dated 7/23 directed, in part, that the facility will implement enhanced barrier precautions to include any resident with a PICC line. Staff will perform hand hygiene and don (place) PPE before providing high-contact care to the residents and will perform hand hygiene after providing high-contact care. 2. Resident #23's diagnosis included dementia, adult failure to thrive and functional quadriplegia. A quarterly Minimum Data Set assessment dated [DATE] identified Resident #23 had short and long-term memory problems and required total assistance with dressing, bed mobility, and transfers. A Resident Care Plan dated 1/29/26 identified Resident #23 received Intravenous (IV) therapy for hydration. Interventions included administer IV infusion per physician orders, per physician order may extend site use 5-7 days if there were no complications. Change the IV bag every 24 hours. Change the IV tubing every 72 hours. Change site dressing/cap every week. A physician's order dated 1/28/26 directed to administer dextrose 5% at 75 milliliters per hour for 1 day. Observation on 2/8/26 (12 days after insertion) at 6:55 AM, 9:41 AM, and 12:20 PM identified a peripheral IV remained in Resident #23's right hand without the benefit of a dressing secured only by tape and lacked a date Observation on 2/9/26 (13 days after insertion) at 8:25 AM identified a peripheral IV remained in Resident #23's right hand. Review of the clinical record failed to indicate a new physician order to extend the peripheral insertion site time frame or documentation that the peripheral IV site was changed after the 5–7-day physician ordered time limit. Interview and review of the intravenous Infusion Therapy Log with the DNS on 2/9/26 at 1:07 PM indicated that Resident #23 might have needed further IV fluids and the peripheral IV could remain in place for 7 days. The DNS was unaware how long the IV site remained in place. Interview with the DNS and Advanced Practice Registered Nurse (APRN) #2 on 2/9/26 at 1:36 PM indicated that APRN #2 did not know why Resident #23 continued to have a peripheral IV catheter placed to the right hand. APRN #2 indicated she would review the resident's record and that when she was notified of the prolonged IV peripheral line placement on 2/9/26, she had ordered repeat laboratory studies on 2/9/26 when this was brought to her attention, and the peripheral IV catheter needed to be removed. The CDC guidelines indicate that peripheral intravenous catheters are typically replaced every 72 to 96 hours to minimize risk of infection and phlebitis. Although requested, a facility policy for changing IV catheters was not provided. 3. Resident #108's diagnosis included a stage 4 (full thickness wound with extensive tissue loss exposing underlying muscle, tendon, ligament, cartilage or bone) pressure ulcer of the sacral region, legal blindness, and low back pain. (continued on next page)

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	02/10/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The quarterly Minimum Data Set assessment dated [DATE] identified Resident #108 had a Brief Interview for Mental Status (BIMS) score of 10 indicating moderate cognitive impairment, and required set-up assistance with eating, moderate assistance with bed mobility, substantial maximal assistance with dressing, and total dependance on staff with transfers. A physician's order dated 11/3/25 and in effect on 2/9/26 directed to clean the stage 4 pressure ulcer with normal saline or wound cleanser, pat dry with gauze, apply calcium alginate to the wound bed, cover with a foam dressing every 8 hours and as needed if the dressing was missing or soiled. Observation on 2/9/26 at 12:44 PM identified LPN #3 performed Resident #108's sacral wound treatment. After removing the old dressing, she failed to cleanse or sanitize her hands prior to placing new gloves and cleansing the wound. Interview with LPN #3 on 2/9/26 at 12:44 PM indicated that she should have cleansed her hands prior to placing clean gloves and cleansing Resident #108's wound. Subsequent to surveyor inquiry, LPN #3 washed her hands with soap and water prior to applying clean gloves. Interview with Director of Nursing Services on 2/9/26 at 1:07 PM indicated that during a dressing change, hand hygiene would be performed following removal of the old dressing, removing gloves and placing on new clean gloves. Although requested a facility policy for hand hygiene during dressing changes was not provided. 4. Observations during a facility tour on 2/8/26 and 2/9/26 throughout the day identified signage outside resident rooms 102, 108, 112, 119, 209, 210, 234, 321, 331, 427, and 440 required Enhanced Barrier Precautions. A review of the Infection Control program with Registered Nurse (RN) #1 (Infection Preventionist) on 2/9/26 at 9:44 AM identified a current list of residents who required Enhanced Barrier Precautions (EBP) by unit and 2 current residents who required Transmission Based Precautions (TBP). Although signage outside resident rooms 102, 108, 112, 119, 209, 210, 234, 321, 331, 427, and 440 had been identified as requiring EBP precautions during the program review, RN #1 had failed to include these room numbers as residents who required EBP. Additionally, RN #1 provided a list of residents who had a history of a Multi Drug Resistant Organisms (MDRO). Interview with RN #1 on 2/9/26 at 9:44 AM indicated that residents with a history of MDRO's did not need to be on any precautions because they were colonized. Review of the EBP policy with RN #1 contradicted her statement and that residents with MDRO colonization should be placed on EBP. Interview on 2/9/26 at 1:07 PM with the DNS indicated if the residents were colonized with Methicillin Resistant Staphylococcus Aureus (MRSA), an MDRO, they did not need to be on EBP. Review of the EBP policy with the DNS contradicted her statement indicating that residents with a history of an MDRO would need to be placed on EBP. Additionally, The DNS could not explain why the list of EBP residents did not match the signage on the doors of the residents' rooms but suggested that those residents may have been newly admitted or recently had room changes. The DNS could not explain why the EBP list was not accurate, indicated that RN #1 was responsible for updating the EBP list, and that the supervisors on the weekend would place residents on precautions but would fail to update the list. The EBP and MDRO lists would be updated in the weekly Standards meeting. (continued on next page)

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	02/10/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 2/9/26 at 1:36 PM with the DNS and RN #1 identified the EBP list did not match because RN #1 was responsible and in the process of updating the list. Subsequent to surveyor inquiry, an updated EBP list was provided. Subsequent review of the residents who had sign placement without being added to the current list of residents who required EBP failed to identify that they had been admitted over the weekend. A review of the Enhanced Barrier Precaution policy, in part directed, Enhanced Barrier Precautions involve gown and glove use during high contact resident care activities which provide opportunities for transfer of MDROs to staff hands and clothing when caring for residents known to be colonized or infected with a MDRO. The Infection Preventionist keeps an ongoing list of residents with colonized MDROs and distributes the list of residents colonized with a MDRO to other disciplines. Signage (will be placed) on the door or wall outside the resident room indicating the type of precautions and required Personal Protective Equipment (PPE). Signage should also clearly indicate the high contact resident care activities that require the use of gowns and gloves.

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	02/10/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observations, review of clinical records, and review of facility policy for 2 of 5 sampled residents, (Resident #23 and #128) reviewed for dignity, the facility failed to assist residents to eat in a dignified manner and for the entire facility failed to ensure appropriate food plating to maintain a dignified dining experience. The findings include: 1. Resident #23's diagnoses included unspecified dementia, functional quadriplegia (paralysis of all 4 extremities and torso), and adult failure to thrive. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #23 had short-and long-term memory problems, was dependent on staff for eating, and required partial/moderate assistance for chair/bed-to-chair transfers. The Resident Care Plan (RCP) dated 1/15/26 identified Resident #23 had a self-care deficit related to dementia and functional quadriplegia. Interventions included that he/she was dependent on staff for eating. Interview and observation with Nurse Aid (NA) #1 on 2/8/26 at 9:40 AM identified that Resident #23 was in bed with the head of the bed raised, and his/her breakfast on the bedside tray table. NA #1 was observed standing on the left side of Resident #23's bed, over and above eye level assisting him/her to eat. NA #1 indicated that she normally sat down when feeding residents, but no chair was available in which to sit. Additionally, NA #1 identified that she should have been sitting down when assisting Resident #23 to eat per the facility policy. 2. Resident #128's diagnoses included vascular dementia, hypertension, and pain in the joints of the left hand. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #128 had a Brief Interview of Mental Status score of 4 out of 15 indicating severe cognitive impairment, required setup or clean-up assistance with eating, and was independent for bed mobility and transfers. The Resident Care Plan (RCP) dated 12/11/25 identified Resident #128 was at risk for nutritional deficit related to pain. Interventions included for staff to monitor the percentage (%) of meals and fluids consumed and encourage the resident to consume greater than 75% of meals. Additionally, Resident #128 was at risk for dehydration and/or fluid overload. Interventions included providing diet and appropriate staff assistance with meals. Interview and observation with Nurse Aid (NA) #6 on 2/8/26 at 8:13 AM identified that Resident #128 was sitting down in a chair at a table in the dining room with his/her breakfast. NA #6 was observed standing next to Resident #128, above, and not at eye level, and assisting him/her with breakfast. NA #6 indicated that it was the NA's responsibility to assist residents with eating as needed or if required per the facility policy. NA #6 indicated that she always stood when feeding the residents because it was easier and she thought it was permissible to stand while assisting a resident to eat. Subsequent to surveyor inquiry, NA #6 moved an empty chair next to Resident #128 and assisted the resident to eat his/her breakfast while sitting down. Interview and policy review with the Assistant Director of Nurses (ADNS) on 2/8/26 at 9:49 AM (continued on next page)

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	02/10/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	identified that NAs should follow the Activities of Daily Living policy and Resident Care Plan when assisting residents to eat. Additionally, the ADNS indicated that both NA #1 and NA #6 should have been seated while assisting Resident #23 and #128 to eat instead of standing as that was an undignified way to assist with meals. Review of the facility's dignity policy dated 11/17 directed, in part that that staff are to sit next to a resident when assisting to feed and converse with the resident. Review of the facility's meal service-assistance of resident's policy dated 4/16, directed, in part that staff members are seated when feeding residents. The policy directed staff to sit next to or face resident while assisting with the meal to promote socialization and correct feeding techniques. 3. Interview and observation with [NAME] #1 on 2/8/26 at 6:45 AM noted food plated into disposable cardboard to go containers. [NAME] #1 identified that due to the elevator not functioning for approximately a week, food was plated onto the disposable to-go containers, placed in black plastic container on wheels, then taken outside and around the facility onto the units by kitchen staff. Interview with Resident #7 on 2/8/26 at 9:38 AM described the food as terrible, always late and cold, stating he/she usually asks for the food to be warmed up. Interview with Resident #28 on 2/8/26 at 9:45 AM identified the food tastes disgusting and is always cold. Interview with Resident #140 on 2/08/26 at 9:39 AM identified the food as being low quality, not tasting good and always cold. Observation on 2/8/26 at 9:01 AM identified the breakfast meal truck delivered to the 4th floor, with all food within disposable cardboard to go containers then placed onto the table. The nursing staff served residents their meals by placing the disposable to go containers on plastic trays, adding beverages, then proceeded to pass out the meals to the residents in the dining room. Remaining disposable to go container meals were placed into a metal frame food truck with curtains that was taken onto the unit to give to residents dining in their rooms. Observation on 2/8/26 at 12:45 PM identified the lunch meal truck delivered to the 4th floor with food on porcelain plates, with lids and warming bases. Interview with the Regional Dietary Director on 2/8/26 at 1:35 PM identified that the facility tried to make it easier on staff by serving meals in the disposable to go cardboard containers, however it was an undignified dining experience for the residents, so they switched back to the porcelain plates with heated bases and covers. Interview and observation with the Regional Dietary Director on 2/9/26 at 12:28 PM noted lunch being plated onto disposable cardboard to go containers, identifying that due to heavy nature of the plates, and lack of support during transportation of the food from the kitchen, then outside, then to the units might cause the porcelain plates to break. The Regional Dietary Director further identified it was safer for residents to receive the food in disposable cardboard to go containers, despite the impact of suboptimal temperatures affecting food quality and the lack of a dignified resident dining experience. Interview with the Director of Nurses on 2/9/26 at 2:05 PM identified that although there were (continued on next page)

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	02/10/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	challenges in the past with the kitchen, such as delays and cold food, things had gotten a lot better. The DNS noted she was not aware that meals were consistently served late or that they were currently being served in disposable cardboard to go containers. Additionally, the DNS identified she felt it was undignified to serve residents cold meals in disposable to go containers, but stated there were microwaves available on the units, and she was under the impression that the kitchen resumed plate service subsequent to surveyor inquiry on 2/8/26. Interview with the Administrator on 2/9/26 at 2:48 PM identified she was not aware that the kitchen staff went back to serving resident meals in disposable cardboard to go containers, and although it was more work for the kitchen staff, it was undignified dining experience, and she would contact the kitchen to go back to appropriate use of dishware for plating meals. Subsequent to surveyor inquiry, observation on 2/10/26 at 9:13 AM identified meals were being served on plates rather than disposable to go containers. Review of the meal service assistance of residents directed in part that is was facility protocol to provide each resident with a nourishing, palatable diet at proper temperatures.

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	02/10/2026

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, review of clinical records, review of documentation and facility policy for 2 of 5 residents, (Residents #30 and #36) reviewed for abuse, the facility failed to investigate an allegation of resident-to-resident abuse. The findings include:1. Resident #30's diagnoses included vascular dementia with agitation, anxiety disorder, and major depressive disorder.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #30 had a Brief Interview of Mental Status (BIMS) score of 0 indicating severe cognitive impairment, required substantial/maximal assistance with upper/lower body dressing and partial/moderate assistance with transfers.The Resident Care Plan (RCP) dated 1/27/26 identified Resident #30 had a mood state problem related to diagnosis of anxiety and depression. Interventions included to orient to facility/staff and validate feelings by offering emotional support and reassurance. Additionally, the RCP identified Resident #30 had the potential to demonstrate verbally abusive behaviors related to screaming and yelling. Interventions included analyzing key times, places, circumstances, triggers, and what de-escalated the behavior.2. Resident #36's diagnoses included unspecified dementia, depression, and anxiety disorder.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #36 had a Brief Interview of Mental Status (BIMS) score of 6 indicating severe cognitive impairment, was dependent on staff for toileting, upper/lower body dressing, and transfers.The Resident Care Plan (RCP) dated 1/22/26 identified Resident #36 was at risk of being a victim of abuse, neglect and/or mistreatment. Interventions included staff to advise the resident to seek out staff for assistance if they had difficulty with others. Review of a health status note dated 1/27/26 at 11:49 AM identified that Resident #36 was observed with dark red bruising around both eyes. The physician and responsible party were notified. Resident #36 stated I don't know what happened.Review of a nurse progress note dated 1/27/26 at 6:15 PM identified that Resident #36 was transferred to the hospital per a physician order for evaluation of redness around his/her eyes. The resident responsible party was notified.Review of the Emergency Department (ED) discharge note dated 1/27/26 at 10:43 PM identified that Resident #36 presented to the ED for evaluation of facial trauma. Resident #36 stated that he/she was hit in the face by another resident and was unsure when it happened. The ED note identified that the ED physician spoke with the nursing supervisor at the facility, who stated that the bruising was first noticed several days before, did not believe that Resident #36 was hit by anyone, and was unsure how the bruising happened.Review of the state agency's incident reporting system identified the facility reported the observations of bruises of unknown origin on 1/28/26 later adding a summary to include the allegation of resident-to-resident abuse.Review of the facility's Accident and Incident (A&I) report dated 1/28/26 identified that Resident #36 stated to facility staff that a girl with long hair hit her and her roommate hit her. The A&I failed to identify an investigation to the allegation of resident-to-resident abuse. Interview with the Director of Nurses (DNS) on 2/10/26 at 10:27 AM identified that the DNS and ADNS were responsible for ensuring allegations of abuse were investigated thoroughly. Initially in the interview, the DNS indicated that she was aware of the allegation of resident-to-resident abuse involving Resident #30 and Resident #36. The interview then identified that an investigation was not completed because the DNS was unaware of the allegations of resident-to-resident abuse.Review of the facility's reporting and investigation of resident abuse, neglect, misappropriation/ exploitation and mistreatment policy dated 10/22 directed, in part, that the administrative and nursing department will assist in the coordination of the investigation of all allegations of exploitation, neglect, mistreatment, physical, sexual, mental or verbal abuse. Additionally, it identified that staff involved and other witnesses will be identified and interviewed regarding any known knowledge of the allegation.

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	02/10/2026

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and review of the clinical record for 1 of 5 sampled residents (Resident #60) reviewed for Preadmission Screening and Resident Review (PASRR), the facility failed to coordinate with the state designated authority following the initial 30-day Level 1 PASRR approval. The findings include:Resident #60 was admitted to the facility on [DATE] with diagnoses that included anxiety disorder and bipolar disorder.The comprehensive Minimum Data Set assessment dated [DATE] identified a diagnosis of bipolar disorder.The comprehensive Minimum Data Set assessment dated [DATE] (39 days after admission) identified a diagnosis of bipolar disorder but failed to identify a Level II PASRR had been completed.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #60 was moderately cognitively impaired and required total dependence for oral hygiene, toileting hygiene, eating, and bathing. Resident #60 received antipsychotic, antianxiety, and antidepressant medication, and identified a diagnosis of bipolar disorder.Review of the clinical record identified a PASRR Level I assessment dated [DATE]. A diagnosis of bipolar disorder was noted, and the Level I PASRR directed that a PASRR Level II assessment must be conducted if Resident #60 was to remain in the facility past 30 days.Review of the clinical record failed to identify a completed PASRR Level II assessment. Interview and clinical record review with the Social Worker (SW #2) on 2/10/26 at 1:37 PM identified a Level II PASRR was not in the clinical record as the facility never sent notification to the state designated authority that a Level II PASRR was required when Resident #60's initial 30 days had been completed by 9/17/25 and was 173 days past due. SW #2 stated that Resident #60 was self-pay and, therefore, did not require a PASRR Level II Screen to be completed.Center for Medicaid Services (CMS) in the Long Term Care Resident Assessment Instrument (RAI) stated that all individuals who are admitted to a Medicaid certified nursing facility, regardless of the individual's payment source, must have a Level I PASRR completed to screen for possible mental illness (MI), intellectual disability (ID), developmental disability (DD), or related conditions. Individuals who have or are suspected of having MI or ID/DD or related conditions may not be admitted to a Medicaid-certified nursing facility unless approved through Level II PASRR determination.

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	02/10/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of the clinical record, facility policy, and interviews for 1 of 3 sampled residents (Resident #108) reviewed for pressure ulcers, the facility failed to follow the physician's order for an air mattress inflation setting and for 1 of 3 sampled residents, (Resident #132) reviewed for respiratory care, the facility failed to set a residents oxygen liter flow per the physician's order. The findings include: 1.Resident #108's diagnosis included a stage 4 (full thickness wound with extensive tissue loss exposing underlying muscle, tendon, ligament, cartilage or bone) pressure ulcer of the sacral region, legal blindness, and low back pain. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #108 had a Brief Interview for Mental Status (BIMS) score of 10 indicating moderate cognitive impairment and required partial/moderate assistance with bed mobility, substantial maximal assistance with dressing, and total dependence with transfers and toileting. The Resident Care Plan dated 12/30/25 identified Resident #108 with an impairment to skin integrity related to a stage 4 sacrum pressure ulcer that was present upon admission. Interventions included providing an air mattress, skin assessments and care interventions per protocol and physician orders, preventative pressure relief devices and turn and reposition measures. The physician's order in effect from 12/30/25 through 2/9/26 directed to check the air mattress for proper functioning and settings and set to weight every shift. A review of Resident #108's weights identified that on 1/30/26 a weight of 182.2 pounds was documented and on 2/6/26 a weight of 184.8 pounds was documented. A review of the clinical record and monthly Medication Administration Records and Treatment Administration Records for January and February 2026, failed to indicate Resident #108's air mattress was checked for functioning, settings, or weight every shift as directed on the physician's orders. Observations on 2/8/26 at 10:28 AM, 2/9/26 at 9:36 AM, and 2/9/26 at 12:44 PM identified the air mattress setting was set between 280 and 320. Interview and clinical record review with the Director of Nursing Services (DNS) on 2/9/26 at 1:07 PM identified that Resident #108's air mattress setting was between 280 and 320 (at 300). The DNS indicated that the facility practice was to set an air mattress per a resident's weight and that Resident #108's current weight was 184 pounds. The DNS additionally stated that this may have been Resident #108's preference but the physician order directed the mattress to be set to the resident's weight and not per the resident's preference. Review of the use of specialty mattress replacement surfaces policy directed, in part, residents will be evaluated to determine the need for placement on or use of a specialty mattress replacement surface, obtain a physician order and nursing will adjust the settings per the manufacturer instructions. The settings will be checked by a licensed nurse and documented every shift. 2.Resident #132's diagnoses included congestive heart failure, type 2 diabetes, and atrial fibrillation. (continued on next page)

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	02/10/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #132 had a Brief Interview of Mental Status (BIMS) score of 4 indicating severe cognitive impairment, was dependent on staff for upper body dressing, personal hygiene, and transfers and that Resident #132 required continuous oxygen therapy. The Resident Care Plan (RCP) dated 12/17/25 identified Resident #132 had an altered respiratory status evidenced by shortness of breath, dyspnea, decreased endurance, and anxiety. Interventions included maintaining a clear airway and providing the over-bed table for positioning comfort while sleeping. A physician's order dated 11/30/25 directed to administer oxygen at 3 liters per minute via nasal canula as needed. Observation on 2/8/26 at 7:16 AM and 2/9/26 at 9:18 AM identified Resident #132 lying in bed with the head of the bed elevated being administered oxygen at 2 liters per minute. Interview, clinical record review, and observation with the Licensed Practical Nurse (LPN) #7 on 2/9/26 at 9:23 AM identified oxygen administration should be set according to the physician's order, and it was the responsibility of the assigned nurse to ensure the correct oxygen setting. LPN #7 identified that Resident #132's had a physician's order directing oxygen administration at 3 liters per minute as needed but upon observation, Resident #132 was lying in bed, receiving oxygen at 2 liters per minute. LPN #7 indicated that the oxygen administration was set incorrectly, that she had not checked Resident #132's oxygen administration setting at the beginning of the shift as she was busy providing care to other residents and she would change the oxygen setting to the correct rate of oxygen administration 3 liters per minute. Interview Director of Nursing (DNS) on 2/9/26 at 10:35 AM identified oxygen administration should be set according to the physician's order and that it was the responsibility of the unit nurse to ensure the correct oxygen setting. The DNS could not identify why Resident #132's oxygen administration was set incorrectly and would begin re-educating the nurses on how to properly check and set oxygen administration per physician's order. Review of the facility's oxygen therapy policy dated 6/17 directed, in part that a physician's order is needed for oxygen administration and will specify the concentration (liter flow), type and duration of therapy. Additionally, the policy directed that nursing staff will set up, check and supervise all treatments.

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	02/10/2026

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 - Minimal harm or potential for 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 interviews, observations, review of the clinical record, and facility policy for 1 of 2 sampled residents, (Resident #11) reviewed for elopement (wandering away), the facility failed to ensure placement of an anti-wandering (Wander guard) transmission device per the physician order for a resident at high risk for elopement. The findings include:Resident #11's diagnoses included Parkinson's disease, unspecified dementia, and anxiety disorder.The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #11 had a Brief Interview of Mental Status score of 11 indicating moderate cognitive impairment, was independent for oral and personal hygiene, and required supervision or touching assistance for walking.The Resident Care Plan (RCP) dated 1/27/26 identified Resident #11 was an elopement risk/wanderer related to confusion and dementia. Interventions included placement of an Wander guard transmission device to the right ankle and to check placement of the device every shift.A physician's order dated 3/12/25 and in effect on 2/9/26 directed to check the Wander guard transmission device function every night shift. Wander guard transmission device with an expiration date of 11/7/25, and to check placement of the Wander guard transmission device every shift.Review of an Unsafe Wandering/Elopement Risk assessment dated [DATE] identified Resident #11 was at risk for elopement.Observation on 2/9/26 at 11:29 AM identified Resident #11 was sitting in a chair at a table in the dining room. A Wander guard device was not present on his/her right or left ankle.Interview, observation, and clinical record review with Licensed Practical Nurse (LPN) #8 on 2/9/26 at 11:31 AM identified that it was the assigned nurses responsibility to ensure residents with a physician's order for a Wander guard transmission device (indicating to her an elopement risk) had the device in place. Review of Resident #11's clinical record identified an active physician order for a Wander guard transmission device to be present on his/her right ankle. Observation of Resident #11 identified him/her sitting in the dining room without the benefit of the Wander guard to the right ankle or other extremity, adding that she had not yet checked placement this shift. Resident #11 indicated that I took that off months ago. After receiving permission, LPN #8 searched Resident #11's room, but was unable to locate a Wander guard device. Subsequent to surveyor inquiry, LPN #8 indicated that she would contact the provider for a new Wander guard transmission device order to be placed on Resident #11. Interview with the Medical Director on 2/9/26 at 11:45 AM identified that an active order for a Wander guard transmission device meant the device needed to be on the resident. The MD indicated that the expiration date on the order was a reminder the resident needed to be re-assessed for the risk of elopement.Interview with the Director of Nursing (DNS) on 2/9/26 at 12:45 PM identified that residents with physician orders for a Wander guard transmission device should have the device placed on the resident and it was the unit nurse's responsibility to check and document placement every shift. The DNS indicated she was made aware that Resident #11 was observed without his/her Wander guard transmission device but did not believe Resident #11's statement indicating I took it off months ago to be true. The interview failed to identify how long the Wander guard transmission device had not been present on Resident #11 and that a new Wander guard device had been placed per the physician order.Subsequent to surveyor inquiry, a physicians order dated 2/9/26 for Resident #11 was obtained and directed to check the Wander guard transmission device function every shift with an expiration date of 7/25/26.Review of the facility's Elopement Prevention Policy dated 7/18 directed, in part that the Wander guard transmission device is placed on residents with an elopement risk and is to be worn twenty-four (24) hours a day. Additionally, the policy identified that the Licensed Nurse should initiate an emergency CCP meeting if the resident removes or refuses the wander guard transmission device.

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	02/10/2026

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility policy, and interviews for 1 of 3 sampled residents (Resident #48) reviewed for nutrition, the facility failed to follow physician orders to monitor intake and output accurately for a resident receiving hemolytic treatments. The findings include:Resident #48?s diagnoses included hypertensive chronic kidney disease stage 5, dependence on hemolytic treatments and diabetes with chronic kidney disease.The quarterly Minimum Data Set assessment dated [DATE] identified Resident #48 had a Brief Interview for Mental Status Score of 14 indicating intact cognition, required supervision with bed mobility, partial moderate assistance with dressing and transfers, and was dependent on staff for toileting.The Resident Care Plan dated 12/14/25 identified a potential for fluid volume overload related to end stage renal disease on hemolytic treatments. Interventions included administering medications and diet as ordered, monitor, document, and report to the physician signs and symptoms of fluid overload, anorexia, anxiety, difficulty breathing, increased respirations, edema and sudden weight gain.Physician's order in effect from 1/1/26 through 2/10/26 directed a fluid restriction of 1000 milliliters (ml) in 24 hours and to monitor intake and output for a total of 1000 ml fluid restriction and, if not met, notify the physician.A review of the Medication Administration Record (MAR) dated 1/1/26 through 1/31/26 identified total 24-hour fluid intake amounts as follows:1/1/26 -300 ml1/2/26 -200 ml1/3/26, 1/19/26, and 1/30/26 -0 ml1/4/26, 1/8/26, 1/14/26, 1/18/26, 1/21/26, 1/27/26, and 1/29/26 -240 ml1/5/26 -40 ml1/6/26, 1/7/26, 1/9/26, 1/12/26, 1/13/26, 1/23/26, and 1/26/26 -480 ml1/10/26 -250 ml1/15/26, 1/16/26, and 1/22/26 -280 ml1/20/26 and 1/28/26 -360 ml1/24/26 -220 ml1/25/26 -700 ml1/31/26 -120 ml(Resident #48 failed to meet his/her fluid restriction any day in January)A review of the nursing progress notes from 1/1/26 through 1/31/26 failed to identify fluid intakes or notification of the physician when the fluid restriction minimum was not met.A weight change note written by the facility dietician dated 1/30/26 at 5:03 PM identified a weight change of 5 percent (%) 9.3 pounds. The Advanced Practice Registered Nurse (APRN) was notified of Resident #48's weight status with fluctuations anticipated related to fluid.A review of Medication Administration Record dated 2/1/26 through 2/10/26 identified total intakes as follows:2/1/26 -180 ml2/2/26 -280 ml2/3/26 -160 ml2/4/26, 2/5/26 and 2/9/26 -480 ml2/6/26 -240 ml2/7/26 -0 ml2/8/26 -300 ml(Resident #48 failed to meet his/her fluid restriction any day as yet in February)A review of the nursing progress notes from 2/1/26 through 2/9/26 failed to identify fluid intakes or notification of the physician when the fluid restriction minimum was not met.A weight change note written by the facility dietician dated 2/6/26 at 11:09 AM identified the hemolytic treatment dietitian was updated of Resident #48's total weight increased from 174.16 pounds to 179.01 pounds and reported that Resident #48 continued to come in over the target weight. Further, the facility dietician recommended to continue to encourage and educate the importance of fluid restriction.Observation on 2/8/26 a 12:33 PM, identified an intake and output binder located at the nursing station with intake and output worksheets for individual residents. A worksheet for Resident #48 was not present in the binder.Interview and record review with the facility Dietitian on 2/10/26 at 9:46 AM identified that she was responsible for monitoring intake, output, and fluid restrictions by reviewing the information entered in the electronic medical record in the task section completed by Nurse Aids (NA)'s. The facility Dietician identified that although Resident #48 had fluid intakes recorded on the Medication Administration Record (noted to be well below the fluid restriction allowed) she indicated that the amounts could not accurately reflect Resident #48's fluid intake as evidenced by the fluctuations in Resident #48's weight and weight gain. Although a binder labeled intake and output was noted at the nurses' station, the Dietician stated she was not aware of any paper worksheets used to monitor intake, output, or fluid restriction amounts. The Dietician stated she had spoken with the hemolytic treatment center dietitian because Resident #48's weights were over the target amount indicating that this was (continued on next page)

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	02/10/2026

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	because Resident #48's fluid intake was over the 1000 ml fluid restriction. The facility Dietician indicated that a possibly reason for the overage was that Resident #48 had a recent room change, was attending more activities, and had increased opportunities to consume fluids.Interview and record review with the Director of Nursing Services on 2/10/26 at 10:13 AM identified that she needed to check the intake and output policy as well as the fluid restriction policy and was unable to identify knowledge of how facility intake and output or fluid restriction amounts were being maintained by her nursing staff.Review of the Assessment and Care of Residents receiving hemolytic treatment policy directed, in part, restrict fluid intake per physician orders, if on fluid restrictions, monitor intake and output if ordered.Review of the Measurement of Intake and Output policy directed, in part, the licensed nurse is responsible for calculation and recording of intake and output. Intake and output may be ordered by a physician or may be started as a nursing measure for any resident with fluid restriction. The charge nurse will enter the order/need for intake and output monitoring in the electronic MAR. The licensed nurse will record fluid intake such as fluids taken during medication pass. The charge nurse will review the NA documentation utilizing the lookback report in Point of Care (POC) and total the amount of intake and output from all sources for the shift. The charge nurse will document the shift total in their progress note. The 7:00 AM to 3:00 PM Unit Manager or designee was responsible for the 24-hour total at 7:00A M. The 24-hour period will be calculated from 7:00 AM to 7:00 AM and recorded in Point Click Care MAR/progress notes.Review of the Hydration policy directed, in part, conditions when intake and output may be indicated but not limited to fluid restriction, hemolytic treatments. The NAs shall record oral intake and output on the intake and output worksheet each shift and shall report amounts to the charge nurse. The charge nurse will document the total amount consumed every shift on the Medication Administration Record. During the collection of intake and output, if a resident has not met their 24-hour fluid requirements for 3 consecutive days, the following action should be taken: complete a hydration evaluation.

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	02/10/2026

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of the clinical record, facility policy, and interviews for the only sampled resident (Resident #48) reviewed for hemolytic treatments, the facility failed to monitor the Arteriovenous (AV) fistula site for function. The findings include:Resident #48 ?s diagnoses included hypertensive chronic kidney disease stage 5, dependence on dialysis and diabetes with chronic kidney disease.The quarterly Minimum Data Set assessment dated [DATE] identified Resident #48 had Brief Interview for Mental Status (BIMS) Score of 14 indicating intact cognition and was independent with eating, required supervision with bed mobility, and partial moderate assistance with dressing.The Resident Care Plan dated 12/16/25 identified Resident #48 needed hemolytic treatments related to end stage renal disease. Interventions included checking for AV shunt/fistula bruit and thrill and providing hemolytic treatments via left AV fistula every Tuesday, Thursday and Saturday and as needed per the hemolytic treatment center plan.The physician's orders dated 1/15/26 through 2/10/26 directed to provide hemolytic treatments on Tuesday, Thursday, and Saturday, pick up 8:45 AM, but failed to direct monitoring of the AV fistula for bruit and thrill. Observation of Resident #48 on 2/8/26 at 12:33 PM identified an AV fistula in left upper arm.A review of pre and post hemolytic treatment center notes completed by the facility and sent to the hemolytic treatment center dated 1/10/26, 1/15/26, 1/17/26, 1/20/26, 1/24/26, and 1/27/2 identified that although an area to include AV fistula monitoring was available, facility staff failed to include the area was being monitored for function per the Resident Care Plan.Interview and record review with Director of Nursing on 2/10/26 at 10:00 AM identified that she did not know if Resident #48 had an AV Fistula and was unaware if a bruit or thrill was being monitored for function. If monitoring was occurring, the documentation could have been located in the Medication Administration Record.Review of the clinical record from 1/15/26 through 2/10/26, physician's orders, nurse's notes and Medication Administration Record failed to identify monitoring of the AV fistula function for a bruit and thrill.Review of the assessment and care of residents receiving hemolytic treatment policy directed, in part, nursing to complete the pre hemolytic treatment assessment in Point Click Care (PCC). Assessment of the dialysis access site should be done upon return from dialysis and recorded on the post dialysis assessment. Check access site daily for evidence of bleeding, drainage, discoloration, redness, heat, swelling or pain. If bleeding occurs at the access site, apply manual pressure for 10 minutes. Notify physician or Nurse Practitioner for uncontrolled bleeding and prepare resident for transfer to the emergency room. Check daily for bruit and thrill. Remove Band aids within 24 hours. Notify physician or Nurse Practitioners if absence of thrill or bruit. The Medical Director and Director of Nursing and/or designee shall be responsible for ensuring compliance with this policy.