STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075084	A. Building B. Wing	06/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa Maria Nursing and Rehabilitation Community	20 Babcock Avenue Plainfield, CT 06374

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on clinical record review, facility documentation/policies, and interviews, for one (1) of three (3) sampled residents (Resident #4) reviewed for notification of change, the facility failed to notify the resident representative (Person #1) of a significant change in status when Resident #4 attempted to exit the facility and a Wanderguard (an electronic monitoring device that alerts staff when atˆrisk individuals approach or attempt to exit secured areas) was applied to the right wrist. The failure to notify Person #1 resulted in Resident #4's representative being unaware of the change in condition and unable to participate in care decisions. The findings include:Resident #4's diagnoses included vascular dementia with mood disturbances and chronic lymphocytic leukemia of B cell in relapse.The Clinical admission by RN #3 dated 5/14/26 at 9:08 PM identified Resident #4 was transported to the facility by Person #1, who left after arrival. Resident #4 was admitted on hospice services, was alert to person only, was confused, required cues, wandered without a goal, was pleasant, and had no impairments to the upper or lower extremities.The Elopement Evaluation by RN #3 dated 5/14/26 identified Resident #4 was at risk for elopement and a Wanderguard was applied to the right wrist. The Elopement Evaluation did not identify Person #1 was notified or that consent was obtained prior to applying the Wanderguard.A physician's order dated 5/14/26 directed staff to check placement of the Wanderguard to the right wrist every shift.A Nurse's note by RN #3 dated 5/14/26 at 9:20 PM identified Resident #4 attempted to exit through a side door, was redirected without difficulty, and a Wanderguard was applied to the right wrist without complaint. The note did not identify Person #1 was notified or that consent was obtained prior to applying the Wanderguard.The clinical record dated 5/14/26 did not identifiy that Person #1 was informed Resident #4 attempted to exit the facility or that a Wanderguard was applied.Nurse's notes dated 5/15/26 through 5/19/26 did not identify Person #1 was notified of wandering risk, exit seeking, or Wanderguard use.Interview with RN #3 on 6/8/26 at 12:12 PM identified Resident #4 pushed on the back door shortly after admission, activating a door alarm, and was easily redirected. RN #3 identified she applied the Wanderguard immediately rather than continuing to monitor Resident #4 or utilizing less restrictive interventions. She did not recall contacting Person #1 and identified her note did not document consent. She identified consent should have been obtained prior to applying the Wanderguard.Interview with the Director of Nursing Services (DNS) on 6/8/26 at 12:29 PM identified RN #3 should have attempted less restrictive interventions prior to applying the Wanderguard. The DNS identified Person #1 should have been contacted to obtain consent if Resident #4 continued exit seeking and documentation should have been completed. She identified she was unaware Person #1 had not been contacted.Interview with Person #1 on 6/8/26 at 2:53 PM identified he/she was not informed Resident #4 attempted to exit the facility or that a Wanderguard was applied. Person #1 identified he/she would not have authorized the Wanderguard and would have picked up Resident #4 if the resident was distressed or attempting to leave.The Wandering, Unsafe Resident policy dated 8/2014 identified the facility would strive to prevent unsafe wandering while maintaining the least restrictive environment. The policy directed staff to assess residents at risk for unsafe wandering, identify potentially correctable risk factors, ensure the care plan identified elopement risk, and include interventions such as a detailed monitoring plan. The policy (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	identified the importance of maintaining the least restrictive environment while ensuring safety.Although requested, the facility policies for Wanderguards and At Risk for Elopement were unavailable.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation, facility policies, and interviews, for two (2) of five (5) sampled residents (Residents #1 and #2) reviewed for allegations of abuse, the facility failed to ensure Resident #2 was free from abuse when Resident #1 entered Resident #2's room and touched Resident #2 inappropriately. The findings include:1.Resident #2's diagnoses included affective mood disorders, Parkinson's disease, depression, and anxiety.The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had intact cognition (Brief Interview for Mental Status (BIMS) score of 15), required partial assistance for bed mobility and transfers, did not ambulate, and did not exhibit behaviors.The Resident Care Plan (RCP) dated 5/7/26 identified Resident #2 had a mood problem related to depression and anxiety and utilized psychotropic medications. Interventions directed staff to encourage Resident #2 to express feelings, provide a calm and quiet atmosphere when restless or anxious, provide psychological services as needed, administer psychotropic medications as ordered, and observe and document effectiveness and side effects. The RCP identified a history of Resident #2 making physical accusations towards another resident.2.Resident #1's diagnoses included conversion disorder with seizures or convulsions and anxiety disorder.The 5ˆday Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had intact cognition (BIMS score of 15), required partial assistance with transfers, did not ambulate, and was independent with wheelchair mobility. No behaviors were identified.The Resident Care Plan (RCP) dated 5/8/26 identified Resident #1 had a mood problem related to mild depression and utilized psychotropic medications. Interventions directed staff to encourage Resident #1 to express feelings, provide psychological services as needed, administer psychotropic medications as ordered, and observe and document effectiveness and side effects.A Nurse's note by RN #1 dated 5/8/26 at 8:07 PM identified Resident #1 was accused of touching Resident #2 over clothing and blankets. Resident #1 denied the interaction. The provider was notified and an order was obtained to send Resident #1 to the Emergency Department (ED) for psychiatric clearance. Resident #1 was placed on oneˆtoˆone observation until Emergency Medical Services (EMS) arrived, and the police were notified of the alleged incident.The Reportable Event (RE) form by RN #1 dated 5/8/26 identified that at 7:00 PM Resident #2 alleged Resident #1 touched him/her in the private area over clothing and blankets and denied direct skin contact. Resident #2 was fully clothed with blankets on and no injuries were observed. The police and provider were notified. The provider ordered an additional 25 milligrams (mg) of trazodone to be administered one time with Resident #2's regularly scheduled bedtime medications. Resident #2 had no emotional distress at the time and was sitting at the nurse's station per Resident #2's request. Resident #1 was placed on oneˆtoˆone observation and an order was obtained to send Resident #1 to the ED for psychiatric evaluation.Resident #1's clinical record did not identify any history of sexual or aggressive behaviors prior to 5/8/26. Resident #1 did not return to the facility following ED transfer.A written statement by Resident #1 dated 5/8/26 identified Resident #1 denied touching Resident #2 but said Resident #2 asked him/her to.Interview with the Director of Nursing Services (DNS) on 6/5/26 at 12:57 PM identified she had been the dayˆshift supervisor prior to the 7:00 PM allegation on 5/8/26. She identified Resident #1 selfˆpropelled in a wheelchair, and she had not observed Resident #1 entering or exiting other residents' rooms. She identified that if staff observed a resident wandering into rooms, they should have checked on the residents and notified the nursing supervisor immediately. Following the allegation, she identified it was determined the facility's admission policy and checklist had not been followed and Admissions had not completed a sexual offender screening for Resident #1 prior to admission. She identified a later review determined Resident #1 had a previous sexual assault charge and that correct screening would have prevented Resident #1's admission to the facility.Interview with Resident #2 on 6/5/26 at (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1:16 PM identified that at approximately 6:15 PM on 5/8/26 Resident #1 entered the room in a wheelchair and touched Resident #2's feet. Resident #2 told Resident #1 not to touch him/her, and Resident #1 left. At approximately 7:00 PM Resident #1 returned, reached under the sheets, touched Resident #2's feet and legs, and placed hands on top of Resident #2's brief without touching skin of the private area. Resident #2 identified telling Resident #1 to stop and Resident #1 responded that most people like that and left. Resident #2 identified feeling violated, wanting to crawl up into a ball and cry, and was relieved when Resident #1 was removed from the facility. Resident #2 identified attempting to press charges.Interview with the Admissions Director on 6/5/26 at 1:28 PM identified the facility's process required completing a sexual offender screening prior to admission. She identified that a regional Admissions staff member filling in for her processed Resident #1's referral and failed to complete the screening. She identified that if the screening had been completed and the criminal history known, Resident #1 would not have been admitted to the facility.Interview with LPN #1 on 6/5/26 at 1:53 PM identified that on 5/8/26 Resident #1 was self^propelling throughout the facility. At approximately 6:45 PM she observed Resident #1 watching pornography on a cellphone. Following the allegation, she notified RN #1. She identified no other behaviors by Resident #1 and had not seen Resident #1 entering or exiting other residents' rooms.Interview with LPN #2 on 6/5/26 at 2:17 PM identified she worked both day and evening shifts on 5/8/26 and saw Resident #1 self^propelling throughout the building. She identified that she never saw Resident #1 entering or exiting rooms but that NA #2 reported seeing Resident #1 coming out of Resident #2's room earlier. She identified Resident #2 was visibly upset, shaking, and crying the following day.Interview with RN #1 on 6/5/26 at 2:56 PM identified Resident #1 had been self^propelling and wandering prior to the 5/8/26 allegation, though she had not seen Resident #1 entering or exiting rooms. At approximately 7:00 PM she answered Resident #1's roommate's call bell and saw Resident #1 in the doorway. Resident #2 reported Resident #1 touched the private area over blankets and later reported Resident #1 reached under the sheets and touched the legs and private area over the brief. Resident #2 was visibly upset but denied injuries.Interview with NA #2 on 6/5/26 at 3:03 PM identified Resident #1 self^propelled throughout the hall and she saw Resident #1 in Resident #2's doorway prior to the allegation. She denied seeing Resident #1 go into or come out of other residents' rooms.Interviews with NA #1, NA #3, and NA #4 on 6/5/26 identified they saw Resident #1 self^propelling on 5/8/26 and had no interactions with Resident #1. NA #1 identified NA #2 reported seeing Resident #1 coming out of Resident #2's room.A follow^up interview with the DNS on 6/8/26 at 12:29 PM identified the facility did not ensure residents were protected from abuse when Resident #1 was admitted without completing a sexual offender screening. She identified the police report had not been finalized, as Resident #2 continued efforts to press charges.Attempts to interview Resident #1 were unsuccessful.The Abuse Prohibition & Quality Assurance/Reporting Reasonable Suspicion of Crime^Elder Justice Act policy dated 4/12/25 identified the facility maintained zero tolerance for abuse, would provide a safe environment free from harassment or abuse, required staff to know resident whereabouts, required sufficient staffing, and required assessment and planning to identify behaviors that could lead to conflict or harm. The policy directed immediate notification of the Administrator for alleged abuse, immediate police notification for allegations of sexual assault, and required ED evaluation. The policy defined sexual abuse as non^consensual sexual contact of any type with a resident.The Admissions policy dated 7/15/17 identified a sexual offender screening would be completed for each potential resident prior to admission using the Connecticut sex offender registry; documentation of the search would be maintained.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. Based on clinical record review, facility documentation, facility policies, and interviews, for one (1) of three (3) sampled residents (Resident #4) reviewed for elopement risk, the facility failed to ensure Resident #4 was free from restraint. After a single, easily redirected attempt to exit the facility, staff applied a Wanderguard without obtaining prior consent from the responsible party and without attempting less^restrictive interventions, despite no further documented wandering or exit^seeking behaviors. This resulted in unnecessary restriction of Resident #4's freedom of movement. The findings include:Resident #4's diagnoses included vascular dementia with mood disturbances and chronic lymphocytic leukemia of B^cell in relapse.The Clinical admission by RN #3 dated 5/14/26 at 9:08 PM identified Resident #4 was transported to the facility by the responsible party (Person #1), who left after arrival. Resident #4 was admitted on hospice services, was alert to person only, was confused, required cues, wandered without a goal, was pleasant, and had no impairments to the upper or lower extremities.The Elopement Evaluation completed by RN #3 dated 5/14/26 identified Resident #4 was at risk for elopement and a Wanderguard was applied to the right wrist. The Elopement Evaluation did not identify that the responsible party was notified or that consent was obtained prior to applying the Wanderguard.A physician's order dated 5/14/26 directed staff to check placement of the Wanderguard to the right wrist every shift.A Nurse's note by RN #3 dated 5/14/26 at 9:20 PM identified Resident #4 was a new hospice admission, was walking independently, was alert and confused, oriented to self only, pleasant, cooperative, and wandered aimlessly but was easily redirected. The note identified Resident #4 attempted to exit through a side door, was redirected without difficulty, and a Wanderguard was applied to the right wrist without complaint. The note did not identify that consent from Person #1 was obtained prior to applying the Wanderguard.The clinical record dated 5/14/26 did not demonstrate that less^restrictive interventions were attempted prior to applying the Wanderguard.The Resident Care Plan (RCP) dated 5/15/26 identified Resident #4 had impaired cognitive function/dementia and was receiving hospice care. Interventions included providing orientation, providing validation, explaining care before providing it, and providing comfort measures.The Brief Interview for Mental Status (BIMS) Evaluation dated 5/15/26 identified Resident #4 had severely impaired cognition, as indicated by a BIMS score of 4.Nurse's notes dated 5/15/26 through 5/19/26 did not identify further wandering, independent ambulation, or exit^seeking behaviors.The May 2026 Documentation Survey Report dated 5/15/26 through 5/19/26 did not identify Resident #4 ambulated independently.The May 2026 Medication Administration Record (MAR) did not identify monitoring of wandering or exit^seeking behaviors despite application of the Wanderguard.The RCP dated 5/16/26 identified Resident #4 was an elopement risk due to cognitive impairment and independently ambulating. Interventions included applying the Wanderguard to the right wrist and using verbal cues for direction to minimize exit^seeking behaviors.Interview with RN #3 on 6/8/26 at 12:12 PM identified Resident #4 was admitted during the evening shift on 5/14/26 and ambulated independently. She identified Resident #4 pushed on the back door shortly after admission, activating a door alarm, and was easily redirected. RN #3 identified she applied the Wanderguard immediately rather than continuing to monitor Resident #4, utilizing less^restrictive interventions, or allowing Resident #4 time to settle into the unit. She did not recall contacting Person #1 and identified her note did not document consent. She identified consent should have been obtained prior to applying the Wanderguard. She further identified she did not observe additional wandering or exit^seeking and that she forgot to initiate an RCP addressing wandering and the Wanderguard use on 5/14/26. She identified the care RCP should have been initiated prior to the end of her shift.Interview with the Director of Nursing Services (DNS) on 6/8/26 at 12:29 PM identified RN #3 should have attempted less^restrictive interventions prior to applying the Wanderguard, especially because Resident #4 was easily redirected. She identified Person #1 should have been contacted to (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	obtain consent if the resident continued exitˆseeking and documentation should have been completed. She identified Resident #4 should have been monitored for wandering and exitˆseeking behaviors after the Wanderguard was applied and an RCP should have been initiated on 5/14/26. She was unaware the RCP was not initiated until 5/16/26.Interview with Person #1 on 6/8/26 at 2:53 PM identified Resident #4 was admitted for five (5) days of respite care. Person #1 identified he/she was not informed Resident #4 attempted to exit the facility or that a Wanderguard was applied. Person #1 identified he/she would not have authorized the Wanderguard and would have picked up Resident #4 if the resident was distressed or wanted to leave.The Wandering, Unsafe Resident policy dated 8/2014 identified the facility would strive to prevent unsafe wandering while maintaining the leastˆrestrictive environment. The policy directed staff to assess residents at risk for unsafe wandering, identify potentially correctable risk factors, ensure the care plan identified elopement risk, and include interventions such as a detailed monitoring plan. The policy identified the importance of maintaining the leastˆrestrictive environment while ensuring safetyAlthough requested, the facility policies for Wanderguards and At Risk for Elopement were unavailable.

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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 review of the clinical record, facility documentation, facility policy, and interviews, for two (2) of five (5) sampled residents (Residents #1 and #2) reviewed for allegations of abuse, the facility failed to conduct a thorough investigation of an allegation of sexual abuse. Specifically, the facility did not interview residents who had the potential to be affected, despite the alleged perpetrator self^propelling throughout the building in a wheelchair. The findings include:1.Resident #2's diagnoses included affective mood disorders, Parkinson's disease, depression, and anxiety.The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had intact cognition (Brief Interview for Mental Status (BIMS) score of 15), required partial assistance for bed mobility and transfers, and did not ambulate. No behaviors were identified.The Resident Care Plan (RCP) dated 5/7/26 identified Resident #2 had a mood problem related to depression and anxiety and utilized psychotropic medications. Interventions included encouraging Resident #2 to express his/her feelings and providing psychological services as needed.2.Resident #1's diagnoses included conversion disorder with seizures or convulsions and anxiety disorder.The 5^day MDS assessment dated [DATE] identified Resident #1 had intact cognition (BIMS score of 15), required partial assistance with transfers, did not ambulate, and was independent with wheelchair mobility. No behaviors were identified.The RCP dated 5/8/26 identified Resident #1 had a mood problem related to mild depression and utilized psychotropic medications. Interventions included encouraging the resident to express feelings and providing psychological services as needed.The Reportable Event (RE) form dated 5/8/26 at 7:00 PM identified Resident #2 alleged Resident #1 touched him/her in the private area over clothing and blankets and denied direct skin contact. No injuries were observed. The police and provider were notified. An order was obtained to administer Resident #2 an additional 25 milligrams (mg) of trazodone one time at bedtime. Resident #1 was placed on one^to^one monitoring, and an order was obtained to send Resident #1 to the ED for psychiatric evaluation.A Nurse's note by RN #1 dated 5/8/26 at 8:07 PM identified Resident #1 was accused of touching Resident #2 over clothing and blankets. Resident #1 denied the interaction. The provider was updated and an order was obtained to send Resident #1 to the Emergency Department (ED) for psychiatric clearance. Resident #1 was placed on one^to^one monitoring until Emergency Medical Services (EMS) arrived, and the police were notified.Interviews with NA #1, LPN #1, RN #1, NA #2, NA #3, and NA #4 on 6/5/26 identified they saw Resident #1 self^propelling throughout the building on 5/8/26. NA #2 reported seeing Resident #1 in Resident #2's doorway on 5/8/26.Interview with the Director of Nursing (DON) on 6/5/26 at 12:57 PM identified Resident #1 self^propelled in a wheelchair throughout the building. She identified staff should have checked on residents and notified the nursing supervisor if they observed Resident #1 entering or exiting rooms.Despite the allegation and Resident #1's mobility throughout the building, the facility's investigation did not include interviews with other residents on the Annex unit who could have been affected.On 6/8/26, twelve (12) residents were identified as residing on the Annex unit on 5/8/26. Six (6) residents were male with BIMS scores ranging from 5-15. Six (6) residents were female with BIMS scores ranging from 2-15, three (3) of whom were severely cognitively impaired. Facility documents did not identify any interviews with these residents as part of the abuse investigation.Re^interview with the DON on 6/8/26 at 12:29 PM identified other residents on the Annex unit were not assessed or interviewed following the allegation. The DON was unable to explain why this was not completed.Although attempted, an interview with Resident #1 was not obtained.The Abuse Prohibition & Quality Assurance/Reporting Reasonable Suspicion of Crime - Elder Justice Act policy dated 4/12/25 directed the facility to maintain a zero tolerance for abuse, protect residents from abuse by anyone including other residents, and conduct a thorough investigation of all allegations to determine if conduct violated standards of care. The policy directed staff to assess and monitor behaviors that could lead to conflict or abuse, including wandering into other residents' rooms.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on review of the clinical record, facility policy and interviews for one (1) of three (3) sampled residents (Resident #4) reviewed for Activities of Daily Living (ADLs), the facility failed to ensure the clinical record was complete and accurate to include functional/mobility status, care provided and meal percentages consumed. The findings include:Resident #4?s diagnoses included vascular dementia with mood disturbances and chronic lymphocytic leukemia of b-cell in relapse (a slow growing blood cancer that has returned/progressed after a period of improvement following initial treatment). The Clinical admission dated 5/14/26 at 9:08 PM identified Resident #4 was transported to the facility by a family member (Person #1) who left when Resident #4 entered the facility. Resident #4 was admitted to the facility on hospice and was alert to person only, was confused, required cues, was pleasant, had no impairments to the upper of lower extremities and had a steady gait. The Resident Care Plan (RCP) dated 5/15/26 identified Resident #4 has an ADL self-care performance deficit as evidenced by weakness, fatigue, activity intolerance and disease process. Interventions included providing an assist of one (1) staff participation to reposition and turn in bed, assist of 1 staff participation with transfers, assist of 1 with no device for ambulation, assist of 1 for personal hygiene, dressing and bathing and set-up assistance for eating. A nurse's note by RN #3 dated 5/14/26 at 9:20 PM identified Resident #4 was a new hospice admission transported by family and was walking independently. Resident #4 was alert and confused, oriented to self only, pleasant and cooperative and wanders aimlessly but is easily redirected. Resident #4 was conversational, though non-sensical and talked throughout the shift. Resident #4 attempted to exit the facility through a side door and was redirected without issue. A Wanderguard was placed to the right wrist without complaint. Seems to prefer group settings rather than being alone in room. Resident #4 will be in the facility for five (5) days only to provide caregiver relief. Resident #4 has his/her own healthy foods, prepared by spouse, in the refrigerator for the week for all meals and snacks with instructions. Review of the May 2026 Documentation Survey Report identified that required documentation for eating, dressing, personal hygiene, bathing, bed mobility, transfers, sitˆtoˆstand, ambulation, and snacks offered was not completed on the following shifts:2:00 PM-10:00 PM and 10:00 PM-6:00 AM on 5/15/266:00 AM-2:00 PM and 2:00 PM-10:00 PM on 5/16/266:00 AM-2:00 PM on 5/17/266:00 AM-2:00 PM on 5/18/26As a result, documentation was completed for only 9 of 15 required shifts (60 percent). The facility also failed to ensure complete documentation of meals consumed. Review showed no meal documentation on the following shifts:2:00 PM-10:00 PM on 5/15/262:00 PM-10:00 PM on 5/16/266:00 AM-2:00 PM on 5/19/26Meal documentation was completed for only 11 of 15 required shifts (73 percent). Review of the clinical record from 5/15/26 through 5/19/26 failed to identify Resident #4 had any documented refusals related to eating, dressing, personal hygiene, bathing, bed mobility, transfers, sitˆtoˆstand, ambulation, snacks or meals on the dates missing documentation. Interviews with the Director of Social Services, NA #5, NA #6, RN #3 and RN #4 on 6/8/26 identified Resident #4 was clean, out of bed and up for most meals, ate a majority of the meals and snacks provided and received assistance with ADLs. RN #3 identified Resident #4 was ambulating in the hall the morning Resident #4 discharged home on 5/19/26. Interview with the Director of Nursing (DON) on 6/8/26 at 12:29 PM identified NAs should have completely and accurately filled out their charting each day before leaving at the end of their shift. She was unaware of the lack of NA documentation for Resident #4 and identified that the interdisciplinary team monitors the completeness of NA documentation on residents regularly. She stated that Resident #4 must have been missed during this review process. Interview with Person #1 on 6/8/26 at 2:53 PM identified on 5/19/26 when Resident #4 returned home following a five (5) day respite at the facility, Resident #4 was no longer able to perform many ADL tasks that he/she could before entering the facility, such as feeding him/herself, transfers and ambulation and Resident #4 rapidly declined and subsequently passed away a few (continued on next page)

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	075084	A. Building B. Wing	06/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa Maria Nursing and Rehabilitation Community	20 Babcock Avenue Plainfield, CT 06374

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	weeks later. Review of the Charting and Documentation policy dated 7/2017 directed, in part, all services provided to the resident, progress towards the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care.Review of the Certified Nursing Assistant job description directed, in part, the primary purpose of this position is to provide residents with routine daily nursing care and services in accordance with the resident's assessment and care plan and as directed by supervisors. Duties and responsibilities include: Recording all entries on flow sheets, notes, charts, etc in an informative and descriptive manner, Assisting residents according to their needs ranging from minimal assistance to total dependent care on ADLs, assisting residents to walk with or without self-help devices as instructed, assisting residents with bathing functions as directed, assisting residents with dressing/undressing as necessary, assisting residents with personal grooming, assisting with lifting, turning, moving, positioning and transporting residents into and out of beds, chairs, wheelchairs, lifts, etc. Perform all assigned tasks in accordance with established facility policies and procedures and as instructed by your supervisors.