STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075117	A. Building B. Wing	07/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nathaniel Witherell, The	70 Parsonage Rd Greenwich, CT 06830

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, facility documentation, facility policy review, and staff interviews for one of three residents (Resident #1) reviewed for accidents, the facility failed to ensure a comprehensive care plan was developed to include a resident's transfer status. The findings include:Resident #1 had a diagnosis of hemiplegia (paralysis), hemiparesis (muscle weakness) affecting the left non-dominant side, and muscle weakness. The annual Minimum Data Set (MDS) dated [DATE] identified Resident #1 was alert and oriented (Brief Interview for Mental Status - BIMS - score of 15 out of 15) and was dependent for transfers. The Resident Care Plan (RCP) dated 6/17/2025 identified a deficit in activities of daily living (ADLs) and a risk for falls. Interventions directed to praise all efforts at self-care, and to ensure the resident's call light was in reach. Facility reportable event dated 7/2/2025 at 7:45 PM identified Nurse Aide (NA) #1 transferred Resident #1 into bed with use of a mechanical lift without a second staff member present and Resident #1 fell to the floor. Record review failed to identify a physician order for transfer status or use of a mechanical lift. Record review failed to identify the RCP directed use of a mechanical lift for transfers. Additional review failed to identify any transfer status was noted in the care plan. Interview and documentation review with the Director of Nursing (DNS) on 7/28/2025 at 2:41 PM identified Resident #1 required use of a mechanical lift since admission in 2021, and stated the care plan should include a resident's transfer status. The DNS stated Resident #1's care plan did not include use of a mechanical lift, or any type of transfer status, and she did not know why. Although the DNS stated the NA assignment sheet directed use of a mechanical lift, the DNS was unable to provide a copy of the NA assignment sheet. Review of the undated facility Care Planning policy directed in part, the facility was to develop and implement comprehensive and individualized care plans for all residents to ensure the needs are being met.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(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 record review, facility documentation review, and staff interviews for one of three residents (Resident #1) reviewed for accidents, the facility failed to ensure a resident diagnosed with diabetes had routine monitoring of hemoglobin A1C blood glucose levels. The findings include: Resident #1 had a diagnosis Type 2 diabetes (non-insulin dependent). The annual Minimum Data Set (MDS) dated [DATE] identified Resident #1 was alert and oriented (Brief Interview for Mental Status - BIMS - score of 15 out of 15), had a diagnosis of diabetes, and received no insulin injections. The Resident Care Plan (RCP) dated 6/17/2025 identified diabetes. Interventions directed nutritional follow up, diet as ordered, monitor lab work as ordered per physician. Facility reportable event dated 7/2/2025 at 7:45 PM identified Nurse Aide (NA) #1 transferred Resident #1 into bed with use of a mechanical lift without a second staff member present and Resident #1 fell to the floor. Resident #1 was transferred to the hospital. Nursing note dated 7/2/2025 at 11:36 PM identified Resident #1 was sent to the hospital for further evaluation for a fall and the hospital identified an incidental finding of an elevated blood sugar level of 987 (normal 70 to 100). Hospital emergency department laboratory test dated 7/2/2025 at 8:52 PM identified Resident #1 had a glucose (blood sugar) level of 976. Hospital history and physical note dated 7/3/2025 at 6:36 AM identified Resident #1 was seen after a fall and was incidentally found to have significant hyperglycemia (high blood sugar) and was admitted to the ICU for further management. Hospital Discharge summary dated [DATE] identified Resident #1's admitting diagnoses on 7/2/2025 were for hyperosmolar hyperglycemic state (diabetes complication) and a urinary tract infection. Record review identified Resident #1 did not receive insulin, did not receive any oral antidiabetic medications, and was not on routine finger stick monitoring. Record review identified Resident #1 had BMP (Metabolic Panel) lab work with glucose levels drawn on the following dates: on 2/5/2025 glucose 167; 2/26/2025 glucose 107; 4/8/2025 glucose 127; and 5/27/2025 glucose level was 214. Record review identified although Resident #1 had routine BMP (Metabolic Panel) including the glucose levels listed above, review failed to identify any hemoglobin A1C testing (identifies average blood glucose over a 3 month time period) during the prior 17 months (review from April 2024 to current). Interview with APRN #1 on 7/28/2025 at 1:25 PM identified Resident #1 should have had hemoglobin A1C levels checked every three (3) months, and was not sure if she ever ordered a hemoglobin A1C level to be checked for Resident #1.Interview with MD #2 (attending physician) on 7/28/2025 at 2:25 PM identified Resident #1's diabetes was controlled through his/her diet and Resident #1 should have had hemoglobin A1C levels checked yearly. MD #2 stated Resident #1 should have had one drawn within the last year but stated he was not sure if it was drawn. Interview with the Director of Nursing on 7/28/2025 at 2:41 PM identified Resident #1 should have had a hemoglobin A1C done within the last year, and was unable to provide documentation of any hemoglobin A1C testing completed for Resident #1. Interview identified the facility did not have a policy regarding managing diabetic residents.

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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 record review, facility documentation review, facility policy review, and staff interviews for one of three residents (Resident #1) reviewed for accidents, the facility failed to ensure the resident was transferred in accordance with facility policy during a mechanical lift resulting in a resident fall. The findings include: Resident #1 had a diagnosis of hemiplegia (paralysis), hemiparesis (muscle weakness) affecting the left non-dominant side, and muscle weakness. The annual Minimum Data Set (MDS) dated [DATE] identified Resident #1 was alert and oriented (Brief Interview for Mental Status - BIMS - score of 15 out of 15) and was dependent for transfers. The Resident Care Plan (RCP) dated 6/17/2025 identified a deficit in activities of daily living (ADLs) and a risk for falls. Interventions directed to praise all efforts at self-care, and to ensure the resident's call light was in reach. Facility reportable event dated 7/2/2025 a5 7:45 PM identified Resident #1 was alert and oriented and required use of a mechanical lift for transfers. Nurse Aide (NA) #1 transferred Resident #1 into bed with a mechanical lift without a second staff member present. NA #1 hooked the sling onto the lift, but the right upper side did not lock completely and as NA #1 lifted Resident #1 off the chair, the right upper side separated from the hook. Resident #1 then proceeded to slide onto the floor. Resident #1 complained of right should pain after the fall and was transferred to the hospital for evaluation. The report indicated NA #1 did not follow facility protocol when transferring Resident #1 using a mechanical lift alone. Hospital emergency department note dated 7/3/2025 at 6:36 AM identified Resident #1 was seen after a fall from a mechanical lift. Left shoulder x-ray identified a left anterior shoulder dislocation without any fracture. The note further indicated previous x-rays appeared similar, and the x-ray represented a chronic subluxation (dislocation). Nursing note dated 7/9/2025 at 7:54 PM identified Resident #1 was readmitted to the facility. Facility incident summary dated 7/10/2025 identified Resident #1 returned from the hospital on 7/9/2025 with no injuries. NA #1 attempted the mechanical lift transfer without another NA; NA #1 did not ask another NA to assist with the transfer and Resident #1 sustained a fall. NA #1 was provided education that two (2) staff are required for a mechanical lift transfer. Interview with Nurse Aide (NA) #1 on 7/28/2025 at 12:31 PM identified Resident #1 required two (2) staff members for transferring with a mechanical lift, but there was no staff available at the time, and she decided to transfer Resident #1 into bed with the mechanical lift by herself. NA #1 stated the lift pad was already underneath Resident #1 and she attached the pad to the mechanical lift and then raised Resident #1 out of the wheelchair. When Resident #1 lifted off the wheelchair, one of the hooks came off the mechanical lift hook, and Resident #1 slid out of the lift pad and onto the floor. NA #1 stated she should have waited for another staff member to assist her with the transfer. Interview and documentation review with the Director of Nursing (DNS) on 7/28/2025 at 2:41 PM identified Resident #1 required use of a mechanical lift since admission in 2021, and all residents that require use of a mechanical lift require two (2) staff for transfers. NA #1 did not have another staff member present when she transferred Resident #1 using the mechanical lift and she should have had another staff to assist with the transfer; NA #1 should not have transferred the resident alone. Resident #1 slid out of the lift pad onto the floor and was transferred to the hospital, with no related injuries identified. Review of facility Use of Mechanical Lifts for Transfers policy directed two (2) staff members must be present while transferring the resident using a mechanical lift.