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	01/15/2026

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **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 #2) reviewed for abuse, the facility failed ensure staff did not move a resident after a fall resulting in resident complaint of pain. The findings include: Based on record review, facility documentation review, and staff interviews for one of three residents (Resident #2) reviewed for abuse, the facility failed ensure staff did not move a resident after a fall resulting in resident complaint of pain. The findings include: Resident #2 had diagnoses that included a history of dementia, falls, muscle weakness, and difficulty in walking. The quarterly Minimum Data Set (MDS) dated [DATE] identified Resident #2 had a BIMS of 10, indicating moderately impaired cognition, had no behaviors, required maximal assistance with toileting and ambulation, partial assistance with transfers, and was independent with mobility in a wheelchair. The Resident care plan dated 1/2/26 identified a self-care deficit and risk for falls. Interventions directed to encourage to use the call bell and assist of one (1) with transfers (stand and pivot). Facility reportable event form dated 1/3/26 at 4:10 PM identified the charge nurse heard a loud noise from the shower room. Upon entering the shower room, Resident #2 was observed lying on the floor, his/her right leg bent at the knee and under his/her left leg and the commode frame was on top of Resident #2. Resident #2 had wheeled him/herself into the shower room to use the toilet and did not call for assistance. the right hip appeared to be dislocated and the hip area was swelling. Resident #2 complaint of right hip pain. NA #1 was observed standing over Resident #2 and lifted the commode frame off Resident #2, and proceeded to kick his/her right foot which made him/her call out in pain. The Report indicated NA #1 was directed to stop what she was doing and was sent home pending an investigation. Nursing note dated 1/3/26 at 6:04 PM identified Resident #2 fell while attempting to self-transfer in the shower room, the fall was not witnessed by staff, and the APRN was notified and Resident #2 was transferred to the hospital for evaluation. The facility investigation summary dated 1/6/26 identified Resident #2 was wearing sneakers, and after the fall, staff observed Resident #2 attempt to re-position him/herself. NA #1 placed the sole of her sneaker on the sole of his/her left foot and helped him/her move his/her leg. When the nurse observed the action, NA #1 was directed to not move Resident #2 and to wait for Emergency Medical Services (EMS). NA #1 denied kicking Resident #2. Interview and record review with the Director of Rehabilitation on 1/15/26 at 9:43 AM identified Resident #2 was independent with wheelchair mobility, was unstable when standing without assistance, had the ability to independently enter the shower room, and required assist of one (1) staff for transfers. Interview and record review with RN #2 on 1/15/26 at 11:15 AM identified she was the supervisor on shift when Resident #2 fell on 1/3/26. RN #2 observed NA #1 remove the commode frame from Resident #2, and directed NA #1 to not move Resident #2. After NA #1 was directed to not move Resident #2, RN #2 observed NA #1 try to move Resident #2's foot/leg using her foot, and Resident #2 then called out in pain. NA #1 was removed from the room, and Resident #2 was (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	transferred to the hospital for evaluation. Interview with NA #1 on 1/15/26 at 11:30 AM identified Resident #2 fell in the shower room on 1/3/26. The commode chair over Resident #2's right side, the wheelchair was on left side of the toilet, and Resident #2 stated his/her waist and head hurt. NA #1 removed the wheelchair and took the commode off Resident #2. NA #1 stated Resident #2's legs were crossed and he/she was trying to move Resident #2' legs by uncrossing his/her legs using her foot on his/her left foot to guide Resident #2's left foot/leg off of his/her right leg. NA #1 denied kicking the resident, and stated she was not supposed to move the resident after a fall. Interview failed to identify why NA #1 attempted to move the resident, and why she used her foot to attempt to move the resident. Interview with the Director of Nursing (DNS) on 1/15/26 at 1:13 PM identified around 4 PM on 1/3/26 staff observed Resident #2 on the floor in the shower room. NA #1 saw Resident #2 was trying to move his/her legs and NA #1 tried to move Resident #2's legs to uncross them in an attempt to make the resident more comfortable. Moving Resident #2's leg caused the resident pain and the nurse told her not to move the resident after they saw NA #1 trying to move his/her legs. The DNS stated NA #1 should not have moved Resident #2. Further, the DNS stated NA #1 should not have used her foot to move Resident #2, instead she should have used her hands. Interview failed to identify why NA #1 attempted to move Resident #2 and failed to identify why NA #1 would use her foot in an attempt to move Resident #2 after the fall. Review of Falls, Management and Prevention Policy dated 2/7/23 directed in part, following a fall, not to move the resident prior to an assessment from the nurse. the nurse.