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	03/02/2026

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 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 resident record review, facility documentation review, and staff interviews for one of three residents (Resident #1) reviewed for accidents, the facility failed to develop new fall interventions timely following a fall. The findings include:Resident #1 had a diagnosis of metabolic encephalopathy, dementia, and glioblastoma. Nursing admission Note dated 12/19/2026 at 6:48 PM identified Resident #1 had a fall prior to admission to the facility, had impaired cognition and required assistance with personal hygiene. Physician order dated 12/19/2026 directed Aspirin (prevents blood clots) 81 mg daily. Facility incident report dated 12/19/2025 at 10:20 PM identified Resident #1 was observed sitting on the floor and sustained an abrasion to his/her mid back, was able to perform active and passive range of motion to all extremities and had no discomfort. The Resident Care Plan dated 12/19/2025 identified a high risk for falls. Interventions directed to ensure the call light was in reach and to ensure appropriate footwear (brown leather shoes and non-skid socks) when ambulating (walking). The admission Minimum Data Set, dated [DATE] identified Resident #1 had a Brief Interview Mental Status (BIMS) score of 5, indicating severely impaired cognition, and required maximal assistance with toileting and transfers. Facility incident report dated 1/7/2026 at 5:10 AM identified Resident #1 was found on the floor in a prone (face down) position in his/her room with no visible injury noted and denied pain. The report directed the RCP was updated to ensure Resident #1 had non-skid socks on every shift. Nursing note dated 1/7/2026 at 5:27 AM identified Resident #1 was wearing regular socks at the time of the fall, hit his/her head, and was transferred to the hospital for further evaluation. Record review identified Resident #1 returned to the facility. Facility incident report dated 1/19/2026 at 4:50 PM identified Resident #1 was observed on the floor on his/her left side and reported he/she hit their head. Resident #1 was assessed, had no bumps or redness to the head, was able to perform active and passive range of motion, and a left ankle abrasion was noted. Resident #1 was transferred to the hospital for evaluation. Nursing note dated 1/19/2026 at 5:52 PM identified Resident #1 was found on the floor around 4:50 PM, stated that he/she hit his/her head and had vomited, and Resident #1 was transferred to the hospital for evaluation. Record review identified the RCP was updated to indicate Resident #1 was transferred to the hospital, directed neurological checks and to provide treatment to the abrasion. Additional review failed to identify an intervention was put into place to attempt to prevent another fall. Record review identified Resident #1 was readmitted to the facility. Record review identified after Resident #1 was readmitted from the hospital, review failed to identify any additional interventions were put into place to mitigate a risk of falls. Interview and record review with Director of Nursing (DNS) #2 and Assistant Director of Nursing (ADNS) on 3/2/2026 at 10:52 AM identified Resident #1 had an abrasion after the 12/19/2025 fall, and had no injuries identified after the falls on 1/7 and 1/19/2026. Resident #1 was care planned on 12/19/2025 to wear non-skid socks, and he/she was not wearing the non-skid socks at the time of the fall on 1/7/2026. Interview indicated Resident #1 should have been wearing non-skid socks on 1/7/2026, but failed to identify why staff did not follow the care plan to ensure Resident #1 was wearing the non-skid socks in accordance with the plan of care. Further, the care plan was updated (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	after the 1/7/2026 fall with a repeat intervention, that directed use of the non-skid socks. Although the DNS and ADNS stated after the 1/19/2026 fall the care plan was updated to conduct neurological checks and to treat the abrasion, they were unable to provide documentation that a new intervention was put into place after the fall on 1/19/2026 to reduce the risk of another fall. Interview identified new interventions should be put into place after each fall to attempt to reduce the risk of falls. Review of Facility Falls, Management and Prevention Policy dated 1/16/2026 directed in part, if a fall does occur, the care plan was to be updated with appropriate interventions.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - 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 and staff interviews for one of three residents (Resident #1) reviewed for accidents, the facility failed to provide supervision for a resident with dementia and known risk of falls to prevent a fall with injury. The findings include:Resident #1 had a diagnosis of metabolic encephalopathy, dementia, and glioblastoma. Nursing admission Note dated 12/19/2025 at 6:48 PM identified Resident #1 had a fall prior to admission to the facility, had impaired cognition and required assistance with personal hygiene. Physician order dated 12/19/2026 directed Aspirin (prevents blood clots) 81 mg daily. Facility incident report dated 12/19/2025 at 10:20 PM identified Resident #1 was observed sitting on the floor and sustained an abrasion to his/her mid back, was able to perform active and passive range of motion to all extremities and had no discomfort. The Resident Care Plan dated 12/19/2025 identified a high risk for falls. Interventions directed to ensure the call light was in reach and to ensure appropriate footwear (brown leather shoes and non-skid socks) when ambulating (walking). The admission Minimum Data Set, dated [DATE] identified Resident #1 had a Brief Interview Mental Status (BIMS) score of 5, indicating severely impaired cognition, and required maximal assistance with toileting and transfers. Facility incident report dated 1/7/2026 at 5:10 AM identified Resident #1 was found on the floor in a prone (face down) position in his/her room with no visible injury noted and denied pain. The report directed the RCP was updated to ensure Resident #1 had non-skid socks on every shift. Nursing note dated 1/7/2026 at 5:27 AM identified Resident #1 was wearing regular socks at the time of the fall, hit his/her head, and was transferred to the hospital for further evaluation. Nursing note dated 1/7/2026 at 10:30 AM identified the hospital notified the facility that Resident #1 was returning to the facility, and had no injuries identified (CT scan and x-rays were negative). Record review identified Resident #1 returned to the facility. Facility incident report dated 1/19/2026 at 4:50 PM identified Resident #1 was observed on the floor on his/her left side and reported he/she hit their head. Resident #1 was assessed, had no bumps or redness to the head, was able to perform active and passive range of motion, and a left ankle abrasion was noted. Resident #1 was transferred to the hospital for evaluation. Nursing note dated 1/19/2026 at 5:52 PM identified Resident #1 was found on the floor around 4:50 PM, stated that he/she hit his/her head and had vomited, and Resident #1 was transferred to the hospital for evaluation. Record review identified Resident #1 was readmitted to the facility. Facility reportable event dated 1/25/2026 at 11 PM identified during rounds, a NA heard a loud sound and found Resident #1 lying on the floor. Resident did not call for assistance prior to getting up, complained of pain on the back of his/her head, and was transferred to the hospital for evaluation. Facility reportable event summary dated 1/25/2026 identified Resident #1 was admitted to the hospital with an acute (new) subarachnoid hemorrhage (bleeding in the space between the brain and the surrounding membrane), a subdural hemorrhage (bleeding between the brain and the membrane covering of the brain), and bifrontal contusion (bruising on both frontal lobes of the brain). Record review identified Resident #1 had the following falls: 12/19/2025 at 10:20 PM, 1/7/2026 at 5:10 AM, 1/19/2026 at 4:50 PM and 1/25/2026 at 11 PM. Additional review identified Resident #1 was not readmitted to the facility after the fall on 1/25/2026. Interview and record review with Director of Nursing (DNS) #2 and Assistant Director of Nursing (ADNS) on 3/2/2026 at 10:52 AM identified the care plan was updated after falls occurred on 12/19/2025 and 1/7/2026 to direct use of non-skid socks. Interview failed to identify additional measures were put into place to prevent additional falls after the fall on 1/19/2026, and failed to identify additional supervision was provided to prevent the fall with injury on 1/25/2026. No facility policy was provided for surveyor review.