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	06/17/2026

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 0689 Level of Harm - 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 clinical record review, review of facility documentation, review of facility policy, and staff interviews for 1 of 3 sampled residents (Resident #30) reviewed for accidents, the facility failed to ensure that a resident who required physical assistance with toileting received the necessary handsˆon supervision/support to prevent a fall. This failure resulted in the resident falling and sustaining an injury that required staples. The findings include:Resident #30 was admitted to the facility on [DATE] with diagnoses that included mild cognitive impairment, spinal stenosis, anxiety, seizure disorder, and traumatic subdural hemorrhage.The Morse Fall Risk assessment dated [DATE] identified Resident #30 was at high risk for falls with a score of 80 (a score of 0-24 indicates no risk, a score of 25-50 indicates low risk and a score of 51 or higher is indicative of high risk). The Resident Care Plan (RCP) dated 2/11/26 identified Resident #30 was at high risk for falls and had an activity of daily living (ADL) deficit related to deconditioning and stroke. The care plan interventions directed staff to anticipate and meet the resident's needs, ensure the call light is within reach, physical and/or occupational therapy evaluation as indicated, follow facility fall protocol, and review fall information of past falls to attempt to determine the cause of the fall, discuss with the resident and/or family any concern related to the loss of independence and decline in ability to perform self-care and praise resident's efforts at self-care.The admission MDS assessment dated [DATE] identified Resident #30 had intact cognition, required extensive assistance with bed mobility, dressing, toileting, transfers and ambulation, utilized a rolling walker and wheelchair for mobility, was always incontinent of bladder and frequently incontinent of bowel. The assessment further noted that the resident had experienced a fall within the 30 days prior to admission to the facility.The Occupational Therapy (OT) progress report for the period of 3/20/26 - 4/2/26 identified that Resident #30 required maximum staff assistance for toileting hygiene and demonstrated decreased standing balance, reduced upperˆbody strength, decreased activity tolerance, decreased safety awareness during mobility and transfers, and decreased functional performance in selfˆcare tasks.The Nurses' Aide (NA) care card in place prior to 4/6/26 indicated that the resident required a standˆpivot transfer with oneˆperson assistance, as well as extensive assistance with activities of daily living (ADL). Pattern of Falls (2/10/26-4/6/26):A review of the clinical record and facility documentation identified the following falls: The Accident and Incident Report dated 2/13/26 at 8:30 PM identified Resident #30 sustained an unwitnessed fall in his/her room. The resident was found lying on his/her back behind the door. An assessment revealed that the resident was able to perform active and passive range of motion in all four extremities, and pupils were equal and reactive to light. No injuries were noted at the time. The resident reported hitting his/her head. The physician was notified and ordered the resident to be transferred to the hospital for further evaluation.A hospital Discharge summary dated [DATE] identified Resident #30 was discharged with a diagnosis of an acute subdural hematoma. The Accident and Incident Report dated 2/21/26 at 5:15 PM identified Resident #30 slid from his/her bed while attempting to stand and go to the bathroom. Redness was noted on the midˆupper back. The facility's action plan was to post a reminder in the resident's room instructing the resident to call for (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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F 0689 Level of Harm - Actual harm Residents Affected - Few	staff assistance before attempting to use the bathroom. The Accident and Incident Report dated 2/26/26 at 9:50 PM identified Resident #30 was found on the floor with his/her back resting against a recliner chair. The resident stated he/she had attempted to transfer from the chair to the bed independently. No injuries were noted. The facility action plan included assisting the resident to bed after supper and placing a mattress on the floor once the resident was in bed. The facility Accident and Incident Report dated 3/3/26 at 3:28 PM identified Resident #30 was found lying on the floor in his room with his head leaning against the wall. The resident identified he walked out of the bathroom, lost his balance, and fell. No injuries were noted. The APRN evaluated the resident and ordered transfer to the hospital for further evaluation.A hospital Discharge summary dated [DATE] identified Resident #30 was discharged with a diagnosis of acute subdural hematoma. A CT scan of the cervical spine without contrast showed degenerative changes without acute fracture. A CT scan of the head without contrast showed a stable 8ˆmm mixed-attenuation left frontal subdural hematoma and a new 5ˆmm left anterior falx subdural hematoma, with no intraˆaxial hemorrhage. The facility Reportable Event dated 4/6/26 at 12:00 PM identified Resident #30 requested to use the restroom while at a scheduled medical appointment. Nursing Assistant (NA) #2 positioned the wheelchair at the men's urinal, locked the brakes, and assisted the resident to stand. While providing privacy, NA #2 turned her head away and heard the resident say Whoa she turned back and observed the resident falling to his/her right side and striking his/her head on the floor. Active bleeding was noted, and the resident was transported to the hospital for further evaluation.Further review of the facility's reportable event documentation indicated NA #2 received reeducation on assisting residents with toileting during offˆsite medical appointments. The reeducation reinforced that while ensuring resident privacy, staff must maintain handsˆon support to stabilize the resident and prevent falls.A review of Resident #30's fall history prior to the 4/6/26 fall identified that he was unstable with independent transfers and required supervision and hands on assistance to stand and ambulate The revised RCP dated 4/6/26 identified Resident #30 had experienced falls in the facility. The care plan interventions directed staff to consistently monitor the resident in the bathroom for safety; observe, document, and report any signs or symptoms of pain to the physician; monitor for bruising, changes in mental status, or new onset of confusion; complete neurological checks per facility protocol; initiate a physical therapy consult for strength and mobility; assist resident back to bed after supper and place floor mat once resident in bed; and post a reminder in the resident's room instructing the resident to call for staff assistance before attempting to use the bathroom. The hospital emergency evaluation dated 4/6/26 identified Resident #30 underwent a computed tomography (CT) scan of the cervical spine and head, which identified no acute abnormalities. The nurse's note dated 4/6/26 at 10:27 PM identified Resident #30 returned from the hospital at approximately 7:00 PM with four staples to the frontal scalp and dried blood in the surrounding area. The resident denied headache, dizziness, lightheadedness, nausea, or visual changes.Interview with NA #2 on 6/15/26 at 10:15 AM identified that after the medical appointment on 4/6/26, Resident #30 requested to use the bathroom. The resident reported needing to urinate, so she brought the resident to the men's bathroom, which contained both a toilet and urinal. She assisted with removing the resident's belt and lowering his pants and helped the resident to stand at the urinal. She positioned the wheelchair behind the resident and locked it, then stood on the resident's left side but turned her back to provide privacy. She further identified that she was not providing handsˆon assistance at the time of the fall. She heard the resident say whoa and observed him/her fall to the right side. NA #2 reported she was aware the resident required assistance of one for toileting.Interview with the Rehabilitation Director (PT #1) on 6/15/26 at 10:25 AM identified that Resident #30 required oneˆperson assistance for toileting and should remain under direct staff observation while in the bathroom. She identified that a oneˆperson assist requires handsˆon physical support due to the resident's impaired balance. She identified that NA #2 should not have turned her back and that handsˆon assistance should have been maintained. She identified that the fall likely could have been prevented had appropriate assistance been provided. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	She also identified that she was not sure whether nursing had a gait belt policy, although rehabilitation had its own policy requiring gait belt use. She further identified she could have communicated the need for gait belt usage but was not certain.Interview with the DNS on 6/15/26 at 10:35 AM identified that NA #2 assisted the resident and had not left him/her unattended but had turned her head away to provide privacy. He identified that he did not hold NA #2 accountable because she remained present in the bathroom. He also identified that offˆsite bathrooms differed from facility bathrooms because the clinic bathroom contained a urinal. He identified that he would not expect NA #2 to provide handsˆon assistance at the urinal unless the care plan specifically required it. The DNS identified that NA #2 was educated after the incident to maintain handsˆon support while providing privacy in offˆsite settings. He identified that he was aware gait belts were not implemented facilityˆwide for nursing staffs and that he was not aware of a policy regarding gait belt use. He further identified that gait belts had been ordered and would be implemented once available.Interview with NA #3 on 6/16/26 at 12:10 PM identified that Resident #30 required oneˆperson assistance for toileting. She identified that she had never attempted to have the resident stand to urinate because the resident was unable to tolerate prolonged standing. She further identified that the resident required assistance with lowering briefs and pants.The Activities of Daily Living Supporting policy identified that the facility was required to provide care in accordance with the plan of care, including appropriate support for residents unable to perform ADLs independently. When extensive assistance was required, staff were expected to provide weightˆbearing support.The Falls Management and Prevention policy identified that the facility was responsible for providing a safe environment. All newly admitted residents were considered at risk for falls until initial evaluations were completed. The policy outlined a comprehensive approach to prevent falls and minimize injuries.The facility did not ensure appropriate handsˆon assistance during toileting while offˆsite, despite the resident's known need for oneˆperson physical assistance and documented impaired safety awareness. This failure contributed to a fall resulting in injury.