STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075117	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/06/2024
NAME OF PROVIDER OR SUPPLIER Nathaniel Witherell, The		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 14448 Based on observations, review of Resident Rights and interviews, the facility failed to ensure state inspection results were readily accessible to residents. The findings include: Observation of the Residents Rights posted by the elevator's indicated resident has the right to access the state survey results. On 8/2/24 at 11:15 AM interview with Licensed Practical Nurse (LPN #6) indicated all residents must ask to get off unit and some are escorted. LPN # 6 expressed if any resident knows the code, then the code is changed. On 8/2/24 at 12:14 PM interview with Registered Nurse (RN#4) indicated she has not seen a survey finding binder on the units/floors. RN#4 confirmed with RN#3 that the only copy of the survey finding binder is located on the 1st floor of the other building. Facility only copy of state survey results was posted on the first floor (next to the mail room and across from the Admissions Office) of the administrative building.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075117	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/06/2024

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

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F 0578

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 37721

Based on clinical record reviews, facility documentation, facility policy and interviews for 3 of 40 sampled residents (Resident #25, Resident #227 and Resident #228) reviewed for advanced directives, the facility failed ensure a resident's code status was complete and accurate for a newly admitted /readmitted resident. The findings included

1. Resident #25 was readmitted to the facility on [DATE] with diagnoses that included pneumonia, asthma and chronic obstructive pulmonary disease. The admission record identified Resident #25 was not self-responsible.

The Resident Code Status Form dated 7/22/24 did not identify a code status, was signed by the physician and was not signed by the responsible party or witness.

The physician's orders dated 7/22/24 directed that Resident # 25 was to receive full code measures meaning lifesaving interventions would be initiated if necessitated.

An interview with the Director of Nursing Services, (DNS) on 8/05/24 at 11:49 AM identified she would expect that the advanced directive be completed on admission or readmission by the admitting nurse with the code status clearly identified.

2. Resident #227 was admitted on [DATE] with diagnoses that include fracture of the left femur. The admission clinical record identified Resident #227 as self-responsible.

The physician's orders dated 7/20/24 directed Resident #227 was to receive full code measures meaning lifesaving interventions would be initiated if necessitated.

The Resident Code Status Form dated 7/22/24 identified no selected code status for Resident #227. The form was signed by the Registered Nurse, Registered Nurse (RN #8) with no physician signature and no signature by the responsible party.

An interview with RN #8 on 7/29/24 at 11:59 AM identified the facility was attempting to reach the family to sign the advanced directive as Resident #227 was having periods of confusion. However, Resident #227 had full code status just prior to admission and so the facility would initiate interventions if needed until the advance directive was completed.

A subsequent interview and clinical record review on 8/1/24 at 1:50 PM identified Resident #227 signed the Resident Code Status Form on 7/29/24 noting a full code status. RN #8 further identified the form should have been completed on admission and was not timely.

An interview with the Director of Nursing Services, DNS on 8/05/24 at 11:49 AM identified she would expect the advanced directive to be completed on admission or readmission by the admitting nurse with the code status clearly identified.

(continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Resident #228 was admitted on [DATE] with diagnoses that include mild gastrointestinal hemorrhage. The admission clinical record identified Resident #228 as self-responsible. The Resident Code Status Form dated 7/11/24 identified Resident #228 wished to receive full code measures meaning lifesaving interventions would be initiated if necessitated and wished not to be intubated (artificial airway to assist with breathing) if necessitated. The form was signed by Resident #228, physician and nurse. The physician's orders dated 7/11/24 directed Resident to have a Do Not Resuscitate (DNR) order meaning no life saving measures would be implemented if necessitated. An interview with the Director of Nursing Services, DNS on 8/05/24 at 11:49 AM identified she would expect that the advanced directive be completed on admission or readmission by the admitting nurse with the code status clearly identified. A review of the facility policy Advanced Directives (no date) directed that the facility honors a resident wish expressed in their advanced directives, communicate with the responsible party/healthcare proxy/ legal representative regarding treatment decisions when necessary and document decisions related to advanced directives in the clinical record.

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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. 37721 Based on clinical record review, facility documentation, facility policy and interviews for 1 of 3 sampled residents (Resident # 226) reviewed for change in condition, the facility failed ensure the physician was notified of a resident change in condition in a timely manner. The findings include: Resident #226 was admitted with diagnoses that included osteoarthritis of the left knee and hypertension. The admission clinical record identified Resident #226 as self-responsible. The hospital Inter-Agency Referral Report dated 7/22/24 identified Resident #226 was discharged with medications that include Valsartan (Anti-hypertensive) 80 Milligrams (MG) once daily. The nursing admission note dated 7/22/24 at 5:23 PM identified Resident #226 was alert and oriented to person place and time, communicated verbally, speech was clear, was able to understand and be understood when speaking. The physician's orders dated 7/22/24 directed Valsartan 80 MG once daily in the morning at 9:00 AM. The Blood Pressure log dated 7/22/24 at 4:19 PM identified Resident #226's BP was 165 / 83 (Normal Range 120/80) mmHg on admission. The Blood Pressure log dated 7/23/24 at 9:29 AM identified a recorded BP of 110 / 61 mmHg. The Medication Administration Record (MAR) dated 7/23/24 identified Valsartan 80 MG was administered as ordered. The Blood Pressure log dated 7/24/24 at 4:19 PM noted a blood pressure of 93 / 45 mmHg. The Medication Administration Record dated 7/24/24 identified Valsartan 80 MG was administered as ordered. There was no documented evidence of a nursing progress note addressing the low BP reading and any further action. Subsequent blood pressure obtained at 2:00 PM was 92 / 43 mmHg, at 4:00 PM 89 / 56 mmHg and at 4:13 PM 89 / 56 mmHg. The nursing progress note dated 7/24/2024 at 3:02 PM identified Resident#226 was seen by Advanced Practice Registered Nursed, APRN #2 for complaints of dizziness, Diovan (brand name for Valsartan) was discontinued related to hypotension, with BP and heart rate being monitored every two hours. Resident #226 was encouraged to call for assistance. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with Resident #226 on 7/25/24 at 11:10 AM identified s/he had recently experienced very low blood pressure. Resident #226 later learned s/he was administered a medication that resulted in hospitalization in the past prior to admission to the facility. The medication had since been discontinued. An interview with Registered Nurse, RN #12 on 7/30/24 at 1:26 PM identified for any BP obtained outside a baseline, the physician would be notified, or the information would be placed in a provider book to be reviewed. RN #12 identified she was the assigned Nursing Supervisor on 7/24/24 during the 7:00 AM to 3:00 PM shift when it was reported that Resident #226 had a low BP. RN #12 instructed the nurse to hold the BP medication and to recheck the BP. Resident #226 had no complaints and started eating and drinking. After a couple of hours, the BP increased to 102/?? mmHg. RN #12 then instructed the nurse to give the medication. Later in the afternoon at 2:00 PM Resident #226's BP was rechecked and was low again. RN #12 identified she did not call the physician after the first low blood pressure reading and instead held the medication then later gave the medication. RN #12 further identified she did not notify the APRN until after the second low BP pressure reading obtained hours later. It was then that Resident #226 was assessed, and medication subsequently discontinued. An interview with the Director of Nursing Services, DNS on 7/31/24 at 11:08 AM identified she would expect nursing staff to notify the physician of a blood pressure that was out of range if when rechecked after a few minutes, did not change. The DNS further identified staff should not wait just a couple of hours than administer the medication without first notifying the physician. An interview with APRN #1 on 8/1/24 at 10:25 AM identified she also provided routine services to residents at the facility. APRN #1 identified any low blood pressure should be rechecked within a few minutes. If the blood pressure was still low, she would expect staff to notify her or the physician first before taking any additional action. An interview with the Medical Director on 8/05/24 at 1:15 PM identified he would expect to be notified once blood pressure was determined to be low. A review of the facility policy for Change in Condition Process directs that the physician be notified when there is a change (in condition) requiring such notification. Notifications may include discontinuing a treatment or changing a medication due to adverse consequences or acute condition. Attempts to interview APRN #2 were unsuccessful.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37721 Based on clinical record review, facility documentation, facility policy and interviews for 1of 3 sampled residents (Resident #35) reviewed for dignity, the facility failed to follow up with a resident reported concerns in a timely manner. The findings include: Resident #35's diagnoses included obesity and Chronic Obstructive Pulmonary Disease (COPD). The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident # 35 was cognitively intact and required partial to moderate assist with Activities of Daily Living (ADL) and supervision with eating. The Resident Care Plan (RCP) dated 7/6/24 identified Resident #35 had- a concern related to psychosocial wellbeing related to anxiety. Interventions directed to provide staff assistance and support to set realistic goals. A Social Service Note dated 7/15/24 identified Resident #35 indicated s/he felt ok and was not depressed. No questions or concerns were reported, and social services would be available to provide continued support. An interview with Resident #35 on 7/24/24 at 10:58 AM identified s/he had some concerns related to (an unidentified) nurse aide staff making comments that made h/her feel chastised for having personal items in h/her room. Resident #35 had been leaving messages (with unidentified staff) requesting to speak to a nurse supervisor about the matter. Resident #35 did reach a staff member who was thought to be a nursing supervisor about a week prior and requested to speak to them about the matter. Resident #35 was told they would stop by to speak to h/er and then no one ever came. An interview with the Director of Nursing Services, DNS on 7/30/24 at 11:13 AM identified she was contacted by Resident #35 sometime the preceding week who had stated s/he had some issues s/he wished to discuss. The DNS identified she told Resident #35 she would be by to speak to h/her and that it slipped her/his mind. A second interview on with the DNS on 7/31/24 at 11:35 AM identified s/he still had not spoken with Resident #35. A subsequent interview with the DNS on 8/1/24 at 9:30 AM identified s/he did follow up with Resident #35 the evening before and discussed concerns that included feeling chastised by a Nurse Aide, (NA) # 11 who commented on the number of personal items in Resident #35's room. The DNS was going to follow up with NA # 11 on her/his next scheduled day to work. The DNS further identified s/he should have followed up with Resident #35 when s/he first learned the resident had some concerns or referred the concern to social services for timely follow up and did not. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility policy for Grievances and Concerns dated 1/2020 directed that the facility provides prompt resolution to all grievances keeping the residents informed throughout the process. The Social Worker is the Grievance Official and will investigate the identified concern or assign the proper department head. Attempts to interview NA #11 were unsuccessful.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48880 Based on observation, record review, and staff interviews for 1 of 3 residents reviewed for accidents (Resident #47), the facility failed to ensure a resident was appropriately assessed for the use of a wandering device to ensure the device was free from a physical restraint. The findings include: Resident #47 was admitted on [DATE] with diagnoses that included mild cognitive impairment and major depressive disorder. A quarterly Elopement Evaluation dated 4/3/2024 identified Resident #47 wandered and had a history of elopement or attempted to leave the facility without informing staff. The annual MDS assessment dated [DATE] identified the resident as severely cognitively impairment and the resident did not exhibit acute onset of mental status changes. Additionally, the MDS identified Resident #47 did not exhibit behaviors related to rejection of care or wandering. A quarterly Elopement Evaluation dated 7/2/2024 identified Resident #47 did not wander or have a history of elopement or attempted leaving the facility without informing staff. A psychiatry note dated 7/24/2024 indicated that the resident had mild cognitive impairment and was oriented to person, place, and time with fair memory. An observation on 7/31/2024 at 11:11 AM identified Resident #47 had a wandering device attached to her/his wheelchair. Resident #47 wheeled him/herself through the doors of the nursing unit, and the wandering alarm sounded. NA#3 and NA#4 were observed searching for the resident and locating the resident on the first floor of the building. The resident was then observed to be taken by Recreation Aide #1 to an activity. On 7/31/2024 at 12:15 PM an interview with NA#3 who had been assigned to care for the resident on 7/31/2024 indicated Resident #47 had a wandering device in place and Resident # 47 required supervision when leaving the unit. On 7/31/2024 at 12:34 PM, an interview with Recreation Aide #1 indicated s/he knew the resident required supervision from having taken care of her/him in the past and by noticing the wandering device. A review of progress notes from 7/2/2024 through 7/31/2024 identified Resident #47 as self-responsible with mild cognitive impairment. A review of the medical record also identified that the resident had an active care plan initiated on 3/14/2020 for the use of wandering device. A review of the medical record also identified only two quarterly assessments for elopement risk dated 4/3/2024 and 7/2/2024. However, there were no physician's or treatment orders for the wandering device identified in the clinical record. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 8/1/2024 at 11:00 AM, an interview with the DNS identified Resident #47 as having a wandering device in place to prevent the resident from leaving the building unsupervised. The DNS indicated that the resident had a history of exiting the building to go outside and would not want to return inside when directed. The DNS indicated that the resident would be outside in the cold or the heat and sometimes would be wheeling her/ himself to the driveway which was identified by the facility as potentially dangerous. A follow-up interview and record review with the DNS on 8/5/2024 at 11:19 AM identified the resident was self-responsible and in the past year, there were only two quarterly elopement risk assessments performed. The DNS identified that the facility had switched its electronic medical record system on 8/1/2023. The DNS also indicated that the elopement risk assessment should have been done quarterly. Additionally, the DNS identified the elopement assessments dated 4/3/2024 and 7/2/2024 were accurate because the residents' behavior varied, but the facility would not be able to regularly put on and take off the wandering device. The surveyor requested a restraint policy onsite, but the DNS indicated the facility did not have a restraint policy. The facility policy for Wander guard indicated that an assessment would be conducted to determine if a resident exhibits wandering behaviors that pose a safety risk and the Interdisciplinary Team will evaluate the need for a wander guard device based on the resident's assessment and care plan.

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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. 50094 Based on record review and staff interview for one of three residents (Resident #227) reviewed for abuse, the facility failed to ensure an alleged staff member was removed from the schedule after an allegation of mistreatment. The findings include: Resident #227 had a diagnosis of anxiety and history of a fall. Incident report dated 7/25/2024 at 2 PM identified Resident #227 alleged he/she rang the call bell around 3 AM and the NA stated, you know it is 3 in the morning. Resident #227 had been incontinent of urine and stool and alleged while the NA was giving care she pushed the towel into me and was rough. When the NA turned Resident #227 over, Resident #227 alleged he/she was nervous and reached out to hold onto the NA's arm for comfort, saying I am very nervous. The NA was alleged to respond by saying do not touch me. Nursing note dated 7/25/24 identified abuse was reported, and an investigation was started. The resident alleged the NA was rough on him/her. The supervisor and Director of Nursing (DNS) were notified. Record review identified NA #8 was not working when the allegation was made; the allegation was for 3 AM. The DNS called NA #8 and told NA #8 not to come to work until she was notified by the DNS that the investigation was completed. Record review of the staffing schedule on 8/2/2024 identified NA #8 worked from 11 PM on 7/25 until 7 AM on 7/26/2024. Review of the time clock documentation identified NA #8 punched in at 11:32 PM on 7/25/2024 and punched out at 7:32 AM on 7/26/2024. Record review identified NA #8 worked after the allegation of mistreatment, prior to the completion of the facility investigation for the allegation of abuse on 7/25/2024. Interview with NA #8 on 8/2/2024 at 11:12 AM identified NA #8 came back to work because the facility called her to come into work for the 11 PM to 7 AM shift on 7/25 into 7/26/2024. NA #8 stated that since the facility called her into work, she thought the investigation was completed. Interview with the DNS on 8/2/2024 at 12:02 PM identified NA #8 was suspended after the allegation was made on 7/25/2024. The DNS further stated NA #8 should not have been called into work for the 11 PM to 7 AM shift ending on 7/26/2024. The DNS stated she forgot to put on the schedule to notify the supervisors that NA #8 was on administrative leave and not to schedule the NA until the investigation was complete. Review of facility policy of Elder Abuse, Neglect and Prevention dated 10/9/2023 identified the alleged staff member will be immediately removed from the premises while an investigation into the allegation of abuse is conducted. The staff member will be suspended from employment until the completion of the investigation.

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Prepare residents for a safe transfer or discharge from the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50094 Based on clinical record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #176) reviewed for discharge planning, the facility failed to ensure Durable Medical Equipment (DME) was ordered timely for a planned discharge. The findings include: Resident # 176's diagnoses included foot drop of right and left feet, polyneuropathy (damage to nerves in the body), and hemiplegia (partial or complete inability to move a part of the body) unspecified affecting right dominant side. Physical Therapy (PT) note dated 6/16/2023 recommended that Resident #176 was to be discharged home with a Hoyer lift. The Quarterly Minimum Data Set (MDS) dated [DATE] identified Resident #176 was dependent for ADLs. The Resident Care Plan (RCP) dated 6/20/2023 identified decreased mobility and weakness, impaired ability to self-transfer, and high risk for falling. Interventions directed assist with transfers. Inter-agency patient referral report dated 9/14/2023 for a planned discharge on 9/14/2023 indicated Resident #176 had a Sara lift and did not have a Hoyer lift at home. Further review of the clinical record identified per the Discharge Instruction Form that the only medical equipment arrangements made were for a hospital bed. Record review Record review identified Resident #176 was discharged to home on 9/14/2023. Additional review failed to identify a Hoyer lift was ordered prior to Resident #176's discharge home. Interview with PT #1 on 8/1/2024 at 11:45 AM identified Resident #176 needed a Hoyer lift prior to discharge because he/she was no longer able to use the Sara lift he/she had at home. A Hoyer lift was required for transfers. Interview with Social Worker #1 on 8/2/24 at 9:30 AM failed to identify she ordered a Hoyer lift for Resident #176 prior to discharge. During an interview with the DNS on 8/2/24 at 10:30 AM the DNS was unable to provide documentation that a Hoyer lift was ordered prior to Resident #176's discharge to home. The DNS stated the facility is responsible for making sure that the resident had all DME in place prior to being discharged . Review of facility Discharge/Transfers Policy directed in part, it is essential to ensure the safe and timely discharge or transfer of residents.

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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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46117 Based on clinical record review, facility documentation, and interviews for 1 of 3 residents (Resident #109) reviewed for change in condition, the facility failed to complete a Significant Change Status Assessment (SCSA) MDS assessment when the resident was admitted to hospice. The findings include: Resident #109 's diagnoses included adult hypertrophic pyloric stenosis, atrial fibrillation, type 2 diabetes mellitus, and hypertension. Review of Consent and Election of Medicare Hospice Benefit dated 6/1/24 identified Resident #109 elected for Medicare Hospice benefit. The nurse's notes dated 6/2/24 at 2:46 PM identified the hospice nurse assessed Resident #109 for hospice care and s/he was admitted to hospice care. The recreation notes dated 6/3/24 at 2:15 PM identified Resident #109 was in hospice care and the end-of-life service would continue to provide 1 to 1 bedside support and assist as needed. The physician's order dated 6/3/24 directed Do Not Resuscitate (DNR) and noted hospice. The Significant Change MDS assessment dated [DATE] identified Resident #109 had severe cognitive impairment and was dependent on staff for assistance with dressing, toileting, hygiene and required limited assistance with transfer and non-ambulatory. Further assessment review failed to identify Resident #109 was receiving hospice care in the 14 days look back period. Review of Hospice Election Statement dated 6/11/24 identified Resident #109 elected for Medicare Hospice benefit. Review of Resident #109's MDS record from 6/11/24 through 6/24/24 failed to identify a Significant Change MDS assessment was completed when the resident was admitted to hospice. The Resident Care Plan (RCP) dated 6/25/23 identified Resident #109 had poor prognosis related to declining general condition. Care plan interventions directed assessed resident coping strategies and respect resident wishes, encourage residents to express feelings, consult with physician and social services to have hospice care for resident in the facility, and adjust provision of Activity of Daily Living (ADL) to compensate for resident's changing abilities. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075117	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/06/2024

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

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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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and clinical record review with RN #5 (MDS Coordinator) on 8/5/24 at 11:40 AM identified that she was responsible for scheduling and completion of the MDS assessment. She identified that a resident who was admitted to the hospice program should have a Significant Change MDS assessment completed within 14 days of being admitted to hospice. Review of signed hospice election form with RN#5 identified Resident #109 was admitted to hospice on 6/1/24 and she schedule the Resident #109 Significant Change MDS assessment on 6/7/24. She could not identify why Resident #109 had another signed hospice agreement form that identify Resident #109 hospice benefit was started on 6/11/24. RN# 5 was not aware that there was a mistake on the first hospice election form and was not aware there was a new hospice election form that was signed on 6/11/24. She further identified Resident #109 Significant Change MDS assessment was no longer valid because Resident #109 was not on hospice program at that time, and she should had created a new Significant Change MDS assessment on 6/11/24 and completed within 14 days. The Resident Assessment Instrument (RAI) 3.0 manual identified that a (SCSA) must be completed after a resident's enrollment in a hospice program. The Assessment Reference Date (ARD) must be set within 14 days from the effective date of the hospice election.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075117	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/06/2024
NAME OF PROVIDER OR SUPPLIER: Nathaniel Witherell, The		STREET ADDRESS, CITY, STATE, ZIP CODE: 70 Parsonage Rd Greenwich, CT 06830	

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46046 Based on clinical record reviews, observations and interviews for 2 of 3 residents reviewed for respiratory infection (Residents #91 and #276) the facility failed to ensure the care plan was revised to reflect the resident status requiring transmission-based precautions and 1 of 1 resident (#117) reviewed for Activities of Daily Living, the facility failed to ensure the residents care plan reflected the bathing preference of the resident. The findings included. 1. Resident #91's diagnoses included anemia, hypertension and dementia. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #91 was cognitively intact. The care plan dated 6/18/2024 indicated Resident #91 had impaired cognitive function related to dementia with interventions including in part to keep routine simple and consistent. A physician's order dated 7/16/2024 directed to provide transmission-based precautions for COVID 19 until 7/26/2024. Interview and record review with RN #3 the Assistant Director of Nursing Services (ADNS) on 7/31/2024 at 1:52 PM indicated Resident #91 was on isolation precautions per physician's order, for COVID 19 infection which ended on 7/26/2024. RN#3 further indicated Resident #91's care plan should have been updated to reflect the COVID 19 infection and interventions, but no care plan was put in place reflecting Resident #91's status. 2. Resident #117 diagnosis included diabetes mellitus and anemia The admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #117 required partial/moderate assistance for bathing. The care plan dated 7/31/2024 indicated Resident #117 had an ADL deficit due to fatigue and anemia with intervention for the resident prefers dressing and grooming for AM care An interview and record review on 7/31/2024 at 11:40 AM with Licensed Practical Nurse (LPN # 6) indicated per the posted shower list, not dated, Resident #117 had a shower scheduled weekly on Monday on the 3-11 PM shift. LPN # 6 was not able to find the Nurse Aides documentation of showers being provided but indicated if the resident refuses a shower s/he LPN # 6 who document the refusal in the progress notes. An interview with NA#1 on 7/31/2024 at 11:45 AM indicated the nurse aides do not document the type of bath given and if they refuse the charge nurse is notified. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075117	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/06/2024

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview and record review with RN#3 ADNS on 7/31/2024 at 12:06 PM indicated s/he could only pull up computerized data for the last 30 days for nurse aide flow sheets. RN#3 further indicated Resident #117 received bathing on 7/28/2024 (a Sunday, only bathing documented for July 2024)) and indicated the resident should receive a shower on Monday. S/he further indicated it is the charge nurse's responsibility to update the nurse aide electronic documentation flow sheet when a there is a changed and requested time ran a report for the documentation. Interview and record review with RN#3 the ADNS on 7/31/2024 at 1:55 PM indicated Resident #117 did not receive a shower from 7/3/2024 through 7/27/2024 and could not provide documentation indicating resident refusal or why a shower was not provided. RN#3 further indicated the care plan should have been updated to reflect the residents' preference for a shower. After surveyor inquiry, RN#3 indicated s/he would update the care plan to reflect the resident's preference. Resident #117's ADL care plan was revised on 8/1/2024 to reflect Resident #117's weekly shower day as Monday. 3. Resident #276's diagnoses included dementia and anxiety. The care plan initiated on 5/14/2020 with revisions on 7/16/2020 indicated Resident #276 may have been exposed to COVID 19 with interventions including in part to provide prophylactic medications as ordered, keep curtain closed between resident beds and monitor. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #276 was severely cognitively impaired. An interview and record review with RN#3, theADNS on 7/31/2024 at 1:54 PM indicated Resident #276 was placed on isolation precautions 7/20/2024 for COVID 19 which ended 7/26/2024 and although the care plan should have been updated to reflect the change in Resident #276's status the care plan had not been updated. Subject to surveyor inquiry, the care plan initiated 5/14/2020 was revised on 8/1/2024 to indicated Resident #276 tested positive for COVID 19 on 7/14/2024. 49100

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46046 Based on clinical record review and interviews for 1 of 3 residents (Resident #117) reviewed for Activities of Daily Living, the facility failed to ensure a resident received a shower on per plan of care. The findings include. Resident #117 diagnosis included diabetes mellitus and anemia The admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #117 required partial/moderate assistance for bathing. The care plan dated 7/31/2024 indicated Resident #117 had an ADL deficit due to fatigue and anemia with intervention for the resident prefers dressing and grooming for AM care An interview and record review on 7/31/2024 at 11:40 AM with Licensed Practical Nurse (LPN # 6) indicated per the posted shower list, not dated, Resident #117 had a shower scheduled weekly on Monday on the 3-11 PM shift. LPN # 6 was not able to find the Nurse Aides documentation of showers being provided but indicated if the resident refuses a shower s/he LPN # 6 who document the refusal in the progress notes. An interview with NA#1 on 7/31/2024 at 11:45 AM indicated the nurse aides do not document the type of bath given and if they refuse the charge nurse is notified. Interview and record review with the ADNS on 7/31/2024 at 12:06 PM indicated s/he could only pull up computerized data for the last 30 days for nurse aide flow sheets. The ADNS further indicated Resident #117 received bathing on 7/28/2024 (a Sunday, only bathing documented for July 2024)) and indicated the resident should receive a shower on Monday. S/he further indicated it is the charge nurse's responsibility to update the nurse aide electronic documentation flow sheet when a there is a changed and requested time ran a report for the documentation. Interview and record review with the ADNS on 7/31/2024 at 1:55 PM indicated Resident #117 did not receive a shower from 7/3/2024 through 7/27/2024 and could not provide documentation indicating resident refusal or why a shower was not provided.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46117 Based on clinical record review, facility documentation, and interviews for 1 of 3 residents reviewed for accidents (Resident # 47), the facility failed to ensure that a physician's order was obtained for the use of a wandering device and for 1 of 1 sample resident (Resident #109) reviewed for hospice care, the facility failed to ensure hospice care was provided in a timely manner after admission to hospice and for . The findings included: 1. Resident #47 's diagnoses included mild cognitive impairment and major depressive disorder. The annual MDS assessment dated [DATE] identified the resident with severe cognitive impairment and did not exhibit acute onset of mental status changes. Additionally, the MDS identified Resident #47 did not exhibit behaviors related to rejection of care or wandering. A quarterly Elopement Evaluation dated 7/2/2024 identified Resident #47 did not wander or have a history of elopement or attempt leaving the facility without informing staff. A care plan revised on 7/19/2024 identified that the resident had a wandering device attached. The care plan further indicated the intervention of a wandering device was first initiated on 3/14/2020. An observation on 7/31/2024 at 11:11 AM identified Resident #47 had a wandering device attached to the back of his/her wheelchair. The resident was observed leaving the unit, and the wandering alarm sounded. A review of the medical record failed to identify a physician's order for the use of a wandering device. On 8/1/2024 at 11:00 AM, an interview with the DNS identified s/he did not know when the wandering device had been placed on the resident but indicated that it was used to prevent Resident #47 from going outside the building unsupervised. On 8/1/2023 at 1:16 PM, an interview and record review with the unit charge nurse (RN #7) identified staff were supposed to check the placement of the wandering device every shift. RN #7 also indicated there should be a physician's order for the wandering device, as well as an area in the Treatment Administration Record (TAR) that prompted nurses to check the presence of the wandering device. RN #7 indicated that s/he confirmed the placement of the wandering device for the day shift but indicated that s/he did not know why there was no physician's order or a prompt from the TAR. A copy of the facility's Secure Care Transmitter Log used to document the functionality of a wandering device for the month of July 2024 indicated Resident #47 had a wandering device from 7/1/2024 through 7/31/2024. 2. Resident #109 's diagnoses included adult hypertrophic pyloric stenosis, atrial fibrillation, type 2 diabetes mellitus, and hypertension. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of Consent and Election of Medicare Hospice Benefit dated 6/1/24 identified Resident #109 elected for Medicare Hospice benefit. The nurse's notes dated 6/2/24 at 2:46 PM identified the hospice nurse assessed Resident #109 for hospice care and s/he was admitted to hospice care. The recreation notes dated 6/3/24 at 2:15 PM identified Resident #109 was in hospice care and the end-of-life service would continue to provide 1 to 1 bedside support and assist as needed. The physician's order dated 6/3/24 directed Do Not Resuscitate (DNR) and noted hospice. The Significant Change MDS assessment dated [DATE] identified Resident #109 had severe cognitive impairment and was dependent on staff for assistance with dressing, toileting, hygiene and required limited assistance with transfer and non-ambulatory. Further assessment review failed to identify Resident #109 was receiving hospice care in the 14 days look back period. The nurse's notes dated 6/2/24 at 2:46 PM identified the hospice nurse assessed Resident #109 for hospice care and he/she was admitted to hospice care. The recreation notes dated 6/3/24 at 2:15 PM identified Resident #109 was on hospice care and staff would continue to provide 1 to 1 bedside support and assist as needed. The Social Worker (SW) #1 progress notes dated 6/4/24 at 9:29 AM identified SW #1 spoke to Resident #109 responsible party and suggested the responsible party call the hospice or the Social Worker for additional support. SW would remain involved to assist and offer support to all involved as needed. The SW #1 progress notes dated 6/4/24 at 12:04 PM identified SW #1 met with the hospice nurse and told the hospice nurse Resident #109 responsible party was waiting for a call from the hospice nurse and requested an update. The dietary notes dated 6/6/24 at 1:40 PM identified Resident #109 responsible party was requesting to have comfort meal to improve quality of life as Resident # 109 was on hospice care. The dietary notes also identify that the hospice was notified to request a change of diet and awaiting response from hospice. Review of Hospice Election Statement dated 6/11/24 identified Resident #109 elected for Medicare Hospice benefit. Review of hospice agreement dated 6/11/24 identified Resident #109 was admitted to hospice on 6/11/24. The SW #1 progress notes dated 6/12/24 at 8:17 AM identified s/he received a phone call from Resident #109 responsible party upset and identified hospice made an error in the paperwork that the responsible party could not understand. The responsible party requested assistance from SW #1 and SW#1 called the hospice supervisor. The hospice supervisor identified there was an incorrect start date to the hospice agreement that was signed on 6/2/24 and Resident #109 responsible party need to sign a new hospice agreement. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of hospice notes from 6/1/24 to 6/13/24 failed to identify that Resident #109 was assessed for comfort until 6/14/24 when the first hospice nursing visit was identified in the hospice notes. The Resident Care Plan (RCP) dated 6/25/23 identified Resident #109 had poor prognosis related to declining general condition. Care plan interventions directed assessed resident coping strategies and respect resident wishes, encourage residents to express feelings, consult with physician and social services to have hospice care for resident in the facility, and adjust provision of Activity of Daily Living (ADL) to compensate for resident's changing abilities. Interview with Business Office Administrator (BOA #1) on 8/5/24 at 11:30 AM identified Resident #109 was not on hospice care, and she was not aware of Resident #109 was admitted to hospice care on 6/2/24. She also identified the nursing department would give her the hospice agreement form to identify that the resident was admitted to hospice care. Interview and clinical record review with RN #5 (MDS Coordinator) on 8/5/24 at 11:40 AM on 6/2/24 identified s/he could not identify why Resident #109 had another signed hospice agreement form that identify Resident #109 hospice benefit was started on 6/11/24. RN# 5 was not aware that there was a mistake on the first hospice agreement form and was not aware of the new hospice agreement form on 6/11/24. Interview with RN #4 (hospice clinical supervisor) on 8/5/24 at 12:15 PM identified Resident #109 first admission to hospice was on 6/2/24; however, she identified that there was a clerical error on the start date for the first hospice agreement on 6/2/24 and new hospice agreement form was signed on 6/11/24. She also identified the first hospice nurse visit was on 6/14/24. RN #4 further identified that there was a delay on Resident #109 hospice nursing visit because of the clerical error that was made on 6/2/24. Interview with SW #1 on 8/5/24 at 12:30 PM identified Resident #109 was admitted to hospice care on 6/2/24; however, there was an error on the start date of the first signed hospice agreement on 6/2/24 by the hospice nurse and a new hospice agreement form was signed on 6/11/24. SW #1 also identified that the nursing department was responsible for ensuring the hospice nurse visits are conducted in timely manner after admission to hospice care. Interview with LPN #2 (7-3 PM charge nurse) on 8/5/24 at 1:00 PM identified Resident #109 was admitted to hospice care on 6/2/24. She/he also identified s/he was not sure who would be responsible for ensuring the hospice nurse made their visit after admission to hospice care. LPN #2 further identified the hospice nurse would make their nursing visit and would give an update to the charge nurse when there is a new recommendation. Interview with DNS on 8/5/24 at 1:15PM identified s/he would expect a timely visit from hospice nurse after a resident's admission to hospice care. She also identified s/he was just made aware of Resident #109 delay hospice care because of the clerical error made on 6/2/24 after surveyor inquiry. The DNS also indicated s/he would expect the nurse manager to ensure that the hospice visit is conducted after a resident's admission to hospice care. The DNS identified there was a delay in providing the hospice care for Resident #109 because of the clerical error that was made on 6/2/24. However, the facility did not identify that the hospice nurse visit was not being done. Attempt to interview the Nurse Manager on 8/25/24 at 1:15 PM was unsuccessful (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	48880

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49100 Based on observations, review of the clinical record and facility policy and interviews for 1 of 4 residents (Resident #426) reviewed for pressure ulcers, the facility failed to follow physicians order regarding pressure reliving device. The findings include: Resident #426's diagnoses included muscle weakness and unspecified dementia. The care plan dated 6/20/24 identified pressure ulcer. Interventions include providing wound care per treatment order. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #426 is cognitively impaired. Resident #426 requires one person to assist in bed mobility and toilet use and requires two-person physical assist in transfers. A progress notes dated 7/23/ 24 identified new Deep Tissue Injury measuring 2 Centimeter (CM) x 2 CM x 0 CM. Calculated area is 4 square CM. A physician's order dated 7/24/24 at 3:30 PM and 5:00 PM directed When available-bilateral waffle boots to bilateral feel at all times for pressure relief of heels. Remove for hygiene only. and to Sure prep to right heel twice a daily. Observation on 7/24/24 at 10:15 AM of resident in room/ in bed. Resident # 426 was observed without the benefit of pressure reliving boots per Facility Pressure Injury Matrix The progress notes dated 7/25/24 indicated Resident #426 complained of boots causing pain to her/his feet and when needed Tylenol was given around 1:30AM with effective results. Observation on 8/05/24 at12:13 PM of Resident #426 with pressure boots on the right foot and not on her/his left foot. Interview and observation with LPN #2 on 8/05/24 12:18 PM identified Resident #426 have on 1 boot; after reviewing physician's orders, LPN #2 was unable to provide explanation of why the other boot was not on After surveyors' inquiry, LPN #2 prompted staff to apply Resident # 426's left boots Review of the Medication Administration Record (MAR) from July 18, 2024, to present indicated Resident # 426 did not have boots applied on 7/24/24. Facility Pressure Ulcer Prevention policy notes in part to ensure Certified Nursing Assistants (CNA's) implement interventions to prevent skin breakdown.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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** 48880 Based on observations, record reviews, review of facility documentation, review of policy and staff interviews for 2 of 4 residents reviewed for accidents for(Resident # 22), the facility failed to implement intervention to prevent future falls and for (Resident #47), the facility failed to ensure adequate supervision of a resident who left a nursing unit unauthorized .The findings include The findings included: 1.Resident #22's diagnoses included Muscle weakness, difficulty walking and history of falls. The care plan dated 4/5/24 indicated Resident #22 was a fall risk and interventions include to place Resident #22 in the common area for close monitoring and to not leave the resident alone in the room until family member arrives. The quarterly Minimum Data Set assessment dated [DATE] indicated Resident #22 has impaired cognition. Resident #22 requires maximal assistance in toilet transfers, chair to bed transfers and sit to stand. A physician's order dated 7/30/24 directed to check placement in lowest position every shift when resident is in bed and to have Resident #22 walk 100 feet daily with wheelchair behind A nurse's note dated 7/31/24 at 10:30 AM identified Resident # 22 had a fall. Additionally, the nurse's notes noted Resident #22 was observed lying on the bathroom floor. No injuries were noted. The care plan updated 7/31/24 indicated Resident #22 as a fall risk, however, there were no interventions in place to address potential future falls. Observations on 8/01/24 at 11:30 AM identified Resident #22 sustained unwitnessed fall. The nurses were alerted by the resident crying out. Interview with LPN #2 on 8/2/24 at 11:43AM identified staff is responsible for updating interventions and could not explain why this was not done. 2 Resident #47 was admitted on [DATE] with diagnoses that included mild cognitive impairment and major depressive disorder. A quarterly Elopement Evaluation dated 4/3/2024 identified Resident #47 wandered and had a history of elopement or attempted to leave the facility without informing staff. The annual MDS assessment dated [DATE] identified the resident as severely cognitively impairment and the resident did not exhibit acute onset of mental status changes. Additionally, the MDS identified Resident #47 did not exhibit behaviors related to rejection of care or wandering. A quarterly Elopement Evaluation dated 7/2/2024 identified Resident #47 did not wander or have a history of elopement or attempted leaving the facility without informing staff. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A care plan revised on 7/19/2024 identified Resident #47 as an elopement risk/wanderer related to attempts to leave facility unattended. Interventions included the use of a wandering device attached to the back of their wheelchair. A review of the Nurse Aide Care Card also identified the resident had a wandering device and the resident needed to have an escort to activity functions. An observation on 7/31/2024 at 11:11 AM identified Resident #47 wheeled her/himself through the doors of the nursing unit after a second surveyor and Director of Dietary Services left the unit. The wandering alarm sounded. Further observations identified no unit staff members in the direct vicinity of the doors. The surveyor obtained the attention of NA#4 and indicated to her/him that the wandering alarm was sounding. NA#4 went to the door and indicated s/he did not know if Resident #47 could leave the unit. At same time LPN#4 was observed walking in front of the nurse's station holding a pitcher of water. NA#4 asked LPN #4 if Resident #47 could leave the unit unsupervised. LPN #4 indicated that s/he was informed all residents on the unit were able to leave. NA#4 again indicated that s/he was not sure if Resident #47 could leave the unit and walked down the hallway called the short hall to look for the charge nurse. LPN #4 then remained standing in front of the nurse's station, facing the short hall while continuing to hold the water pitcher. After speaking with the charge nurse (LPN#5), NA#4 returned by the door and indicated that the resident could not leave the unit without supervision and continued walking down a different hallway looking for NA#3. At 11:14 AM observations identified both NA#3 and NA#4 left the unit to search for Resident #47, who had since left the unit and taken an elevator. The surveyor accompanied NA#3 and NA#4, who went first to another unit, where it was noted Resident #47 was not there. At 11:19 AM, NA#3 and NA#4 found Resident #47 on the first floor (the exit floor) by the auditorium. Further observations noted Recreation Aide #1 had approached Resident #47 and took hold of his/her wheelchair. Recreation Aide #1 indicated to NA#3 and NA #4 s/he would take Resident #47 somewhere. The nursing aides then return to the nursing unit. On 7/31/2024 at 12:15 PM an interview with NA#3 who had been assigned to care for Resident # 47 on 7/31/2024 indicated Resident #47 had a wandering device in place and Resident # 47 required supervision when leaving the unit and this was noted on her/his assignment. On 7/31/2024 at 12:34 PM, an interview with Recreation Aide #1 indicated s/he knew the resident required supervision from having taken care of her/him in the past and by noticing the wandering device. On 7/31/2024 at 12:20 PM, an interview with LPN #4 identified s/he did not know the floor well as s/he is a float nurse, and therefore, she was not sure if Resident #47 was an elopement risk. LPN #47 indicated that although s/he gets a report in the morning, the report centers on medication pass issues, such as who is on antibiotics and who is scheduled for appointments, and not on who is an elopement risk or who has a wandering device. LPN #4 further indicated that when s/he said that residents on the unit were allowed to leave, s/he thought s/he was being asked about infection control precautions and not about elopement risk. LPN #4 further indicated that s/he did not react to the wander alarm because s/he (LPN#4) saw that NA #4 was taking care of it. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075117	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/06/2024
NAME OF PROVIDER OR SUPPLIER: Nathaniel Witherell, The		STREET ADDRESS, CITY, STATE, ZIP CODE: 70 Parsonage Rd Greenwich, CT 06830	

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 7/31/2024 at 12:26 PM an interview with NA #4 indicated s/he was not sure if Resident #47 could leave the unit unaccompanied and therefore looked for the charge nurse when the wander alarm sounded. Additionally, when the charge nurse had informed her/him Resident #47 could not leave by her/himself, NA#4 went to look for NA#3 since NA #3 had a better rapport with the resident. On 7/31/2024 at 12:34 PM, an interview with Recreation Aide #1 indicated that she knew the resident required supervision from having taken care of him in the past and noticing the resident had a wandering device. On 7/31/2024 at 2:18 PM, an interview with the DNS indicated that staff should know who is at risk of elopement because it would be on the staff assignment. The DNS also indicated that all staff should be aware of who was at risk of elopement and that the expectation was that there would be a relatively quick response to a wander alarm. A review of progress notes from 7/2/2024 through 7/31/2024 identified Resident #47 as self-responsible with mild cognitive impairment. A review of the medical record also identified that the resident had an active care plan initiated on 3/14/2020 for the use of wandering device. A review of the medical record also identified only two quarterly assessments for elopement risk dated 4/3/2024 and 7/2/2024. On 8/1/2024 at 11:00 AM, an interview with the DNS identified Resident #47 as having a wandering device in place to prevent the resident from leaving the building unsupervised. The DNS indicated the resident had a history of exiting the building to go outside and not wanting to return inside when directed. The DNS indicated Resident # 47 would be outside in the cold or the heat and sometimes would be wheeling her/ himself to the driveway which was identified by the facility as potentially dangerous. A follow-up interview and record review with the DNS on 8/5/2024 at 11:19 AM identified the resident was self-responsible and in the past year, there were only two quarterly elopement risk assessments performed. The DNS also indicated that the elopement risk assessment should have been done quarterly. Additionally, the DNS identified the elopement assessments dated 4/3/2024 and 7/2/2024 were accurate because the residents' behavior varied, but the facility would not be able to regularly put on and take off the wandering device. . The facility policy for elopement indicated that staff involved in resident care will receive training on the proper use and monitoring of wander guard devices, including emergency procedures. 49100 50094

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37721 Based on clinical record reviews, facility documentation, facility policy and interviews for 1 of 3 sampled residents (Resident #35) reviewed for nutrition, the facility failed to confirm weight loss according to policy. The findings include: Resident #35 's diagnoses included obesity and Chronic Obstructive Pulmonary Disease. The admission Minimum Data Set (MDS) dated [DATE] identified Resident # 35 as cognitively intact and required partial to moderate assist with activities of daily living and supervision with eating. The Resident Care Plan dated 7/6/24 identified Resident #35 had a nutritional problem related to comorbidities. Interventions directed to assist with meals as needed and monitor weight weekly. The weight record log dated 7/14/24 identified a recorded weight of 156.8 lbs. The weight record dated 7/20/24 identified a recorded weight of 144.2 lbs. reflecting a -8.16 % loss with no documented re-weight. An interview with the Dietitian on 8/01/24 01:34 PM identified nursing staff were responsible for monitoring weight changes and reporting. A repeat weight would be obtained to confirm weight loss. Once confirmed, the Dietitian would address the weight change within that week. The electronic medical record (EMR)system also usually alters when there is a significant weight change and did not on this occasion. The Dietitian further identified s/he noted the weight discrepancy upon return to the facility and requested a re-weight for Resident #35 upon her/his return on 8/30/24 which was not completed and should have been. An interview and facility documentation review with Registered Nurse, RN #8 on 8/01/24 at 1:50 PM identified a re-weight was to be completed for any weight discrepancy at the time the discrepancy was noted and documented as a re-weight. Once confirmed, the physician, dietitian, and family were to be notified. Any weights unable to be obtained would be communicated though a shift-to-shift calendar to be completed by the next shift. The request for the re-weight was not added to the calendar for Resident #35. An interview with the Director of Nursing Services, DNS on 8/01/24 at 2:38 PM identified s/he would expect nursing staff to obtain a re-weight for Resident #35 to confirm weight loss. The family, dietitian and physician should be notified once confirmed. An interview with Licensed Practical Nurse, LPN #8 on 8/05/24 at 12:23 PM identified s/he obtained Resident #35's weight on 7/20/24 that reflected the discrepancy. Although s/he was unable to recall details, LPN #8 identified s/he would normally request a re-weight to be completed the following day and document her/his actions. A review of the facility policy for Weight Management (no date) directed re-weights be completed for any weight discrepancy and documented in the EMR. Weight changes of 5%.in one month, 7.5% in three months and 10% in 6 months are to be reported to the physician and dietitian.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 46046 Based on interviews and review of facility documentation, the facility failed to ensure staff received ongoing education for Intravenous (IV) Therapy and perform competency evaluations to ensure staff remained competent to provide IV therapy. The findings include. Interview and facility document review with the DNS on 7/30/2024 at 12:05 PM identified s/he was unable to locate ongoing IV therapy education and competency evaluations for licensed nursing staff that provide IV therapy at the facility. The DNS further indicated the Infection Preventionist who was the only staff member who had access to the electronic files was not on duty and s/he now realized other staff members should have access in the event of his/her absence.

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	075117	A. Building B. Wing	08/06/2024

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 49100 Based on the tour of the kitchen, observations and staff interview, the facility failed to ensure dinner and breakfast were served within the 14-hour gap. The findings include: Tour of the kitchen on 7/24/24 at 10:00AM during the initial walk through with the Food Service Director identified the following: Interview with Dietary Director on 7/24/24 at 10:00AM identified residents are served meals between 8:00 AM to 9:30 AM and dinner is served by 6:30 PM. Interview on 7/24/24 at 11:23 am with Residents #18 and #126 indicated that breakfast arrives late. Observation on 7/25/24 at 10:20 AM, Resident #50 is observed in bed, NA was getting ready to start feeding Resident #50. Observation on 7/31/24 at 7:45 AM identified food carts arriving on the units between 7:45 AM to 8:00 AM. Observation on 7/31/24 at 7:50 AM of food cart identified the cart arriving to the 2nd floor dining area. Residents #101 and #118 was noted in the dining area and observed being served at 8:50 AM. Observation at 9:23AM of residents on 2nd floor (who eat in their room) were still not served (Indicating a 15 hour gap between dinner time) On 7/31/24 at 11:11 AM Interview with Dietary Director indicated breakfast is brought up before 8:00 AM and residents should be served between 8:00 AM to 9:30 AM.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49100 Based on the tour of the kitchen, observations, facility documentation, review of policy and staff interviews, the facility failed to ensure the dietary department consistently labeled food to reflect their age or shelf life and failed to ensure the nourishment fridge and snacks cabinets on each unit were adequately stocked. The findings included: A tour of the kitchen on 7/24/24 at 10:00AM during the initial walk through with the Food Service Director identified the following: a. The Pastry freezer was observed with a Boston Cream Pie without a label and noted with no open date. The preparation fridge was observed with mashed potatoes without a label or date. Interview with Food Service Director on 7/24/24 at 10:20 AM indicated the preparation staff and/ or chef are responsible for labeling items. After surveyor inquiry, the food items were labeled. Interview with Food Service Director on 7/24/24 at 10:30 AM indicated the facility does not have a snack cart. She/he reported each floor has nourishment refrigerators. b. Observation of the nourishment refrigerator and snack cabinets on 7/30/24 at 8:00 AM and 7/31 11:20AM identified each floor/unit was not adequately stocked with snacks to provide residents with snack choices throughout the day or when the kitchen is closed. Observation of 1st floor on 7/30/24 at 6:50 AM and 7/31/24 at 11:20 AM identified 3 unopened ice cream in the freezer, 1 half-eaten ice cream, 1 sherbet and a fruit bowl and a sandwich with resident's name on it. The snack cabinet had 3 biscuits. Observation of 2nd floor's refrigerator on 7/30/24 at 8:00 AM and 7/31/24 at 11:22 AM identified foods that were preassigned to residents. The snack cabinet had 4 biscuits. Observation of 3rd floor refrigerator on 7/30/24 at 9:10 AM and 7/31/24 10:38 AM Observation of the 4th floor nourishment refrigerator on 7/30/24 at 8:30 AM and 7/31/24 at 11:09 AM identified the refrigerator with 1 pack of bread which has a resident's name on it, packaged fruits with a resident's name on it, wine with resident's name and grilled chicken with resident's name as well as a bottle of cranberry drink, 3 bottles of opened juices. The Snack cabinet had 6 biscuits and 1 bottle of orange juice and 1 bottle of apple juice. Interview on 7/31/24 at 10:42 AM with RN #11, indicated snacks and juice are in the cabinet and refrigerator. Observation of the snack cabinet showed chips and sodas. RN #11 indicated if someone wants a sandwich they will call down to kitchen. If the kitchen is closed then they call the nursing office to see if they have anything available, if not the staff will take from the other floors (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with 7/31/24 RN #6 at 10:58 AM indicated if the kitchen is closed the staff has no access, if resident wanted something staff would have to figure out a way to get it for them. RN#6 observed the snack cabinet and refrigerator on fourth floor and stated, well its empty now let me call down to the kitchen. RN #6 indicated the kitchen staff are responsible for ensuring that the snack cabinet and refrigerators are stocked. Interview with the Food Service Director on 7/31/24 at 11:09 AM indicated the refrigerators are for resident food and nursing is responsible for maintaining. The snack cabinets dietary is responsible for maintaining, food services is to be done once per week. After observing the snack cabinet, s/he indicated its running low now. The Food Service Director was unable to explain why nursing thought the kitchen was responsible for maintaining the nourishment refrigerator and cabinets. The Food Service Director indicated the kitchen is never locked and nursing staff should have access if needed. The facility's Food and Nutrition Service Department policy did not indicate who was responsible for maintaining the snack cabinets and nourishment refrigerators on the units.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50094 Based on record review and staff interview for one of three residents (Resident #227) reviewed for abuse the facility failed to ensure the clinical record was complete and accurate to include an RN assessment after an allegation of mistreatment. The findings include: Resident #227 was admitted to the facility with diagnoses of fracture of left femur, anxiety, and fall. The nursing admission assessment dated [DATE] identified Resident #227 was alert and oriented and required assistance with ADLs. Incident report dated 7/25/2024 at 2 PM identified Resident #227 alleged he/she rang the call bell around 3 AM and the NA stated, you know it is 3 in the morning. Resident #227 had been incontinent of urine and stool and alleged while the NA was giving care she pushed the towel into me and was rough. When the NA turned Resident #227 over, Resident #227 alleged he/she was nervous and reached out to hold onto the NA's arm for comfort, saying I am very nervous. The NA was alleged to respond by saying do not touch me. Clinical record review on 8/2/2024 failed to identify an RN assessment was completed after the allegation. Interview with RN #8 on 8/2/2024 at 11:45 AM identified RN #8 completed an assessment of Resident #227 after the alleged allegation of abuse and did not find any signs of injury/abuse. RN #8 further stated she forgot to document her assessment and indicated the assessment should have been documented. Interview with the DNS on 8/2/2024 at 12:02 PM failed to identify an RN assessment was completed after the alleged allegation. The DNS stated an assessment should have been documented and it was the nurses responsibility to document their assessments. Review of facility for Elder Abuse, Neglect and Prevention Policy dated 10/9/2023 identified residents will be assessed throughout the course of care for observable evidence of abuse and neglect while considering all allegations of abuse.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37721 Based on observations, clinical record reviews, facility documentation review, and interviews for 4 of 4 residents (Resident #11, #86, #117 and #137) reviewed for infection control, the facility failed to ensure that infection control practices related to glucometer cleaning and disinfection in between resident and the facility failed to ensure personal protective equipment (PPE) carts were available outside every resident room who required the use of PPE, evidence of infection surveillance, evidence of annual review of the Intravenous and Infection Control Policy books, evidence facility water management plan and for 1 of 3 residents evaluated for pressure ulcers (Resident #24), the facility failed to ensure staff used appropriate personal protective equipment (PPE) when performing dressing changes and for 1 of 6 sampled residents (Resident #25) reviewed for infection control, the facility failed to appropriate personal protection equipment (PPE) was worn while providing personal hands-on care to a resident on Transmission-Based Precautions (TBP). Also, for Resident #25, the facility failed to identify the rationale for placing a resident on TBP and the facility failed to provide documentation of water management minute meetings. The findings included: 1. Resident #11 was admitted on [DATE] with diagnosis that include type 2 diabetes mellitus. The physician's orders dated 5/3/2024 directed to obtain a blood glucose prior to meals three times a day. 2. Resident #86 was admitted on [DATE] with diagnosis that includes Type 2 diabetes mellitus. The physicians' orders dated 4/18/2024 directed to provide insulin Lispro injection per sliding scale based on blood glucose results three times per day. 3. Resident #117 was admitted on [DATE] with diagnosis that include type 2 diabetes mellitus. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified the resident's cognition was intact, dependence on staff for bath/showers and noted the utilization of insulin. The physician's orders dated 4/30/2024 directed to administer Humalog quick pen subcutaneous injector 100 units/ML (Lispro insulin) per sliding scale based of blood glucose results before meals. 4. Resident #137 was admitted [DATE] with diagnosis that include type 2 diabetes mellitus. The physicians' orders dated 5/13/2024 directed to provide insulin Lispro injection per sliding scale based on blood glucose results 4 times a day. Observation on 7/24/24 at 11:24 AM of Resident #86 identified Licensed Practical Nurse (LPN) #1 exiting Resident # 86's room and placing the glucometer back into a pouch. LPN #1 at 11:25 AM proceeded to go into Resident # 117's room to perform blood glucose testing. LPN #1 placed blood glucose testing items on the over bed table and then proceed to obtain a test strip to place into the meter without the benefit of cleaning the glucometer. The surveyor intervened and LPN #1 responded that she used alcohol to cleanse the meter after performing Resident # 86's glucose testing. LPN #1 also indicated she was unaware of the facility policy for cleaning and disinfecting the glucometer. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Further clinical record review on 7/24/24 identified Resident # 11 and Resident # 137 who resided on the same unit as Resident # 86 and Resident # 117 required blood glucose testing. Interview and observation with Registered Nurse (RN #1) on 7/24/24 at 11:45 AM identified adequate supplies for blood glucose wipes as directed by manufactures guidelines. Interview with the Director of Nursing Services (DNS) on 7/24/24 at 2:08 PM identified if she was aware of staff using alcohol pads, s/he would have directed staff to use the approved wipes and not to use alcohol. Interview with LPN #1 on 7/24/2024 at 2:15 PM indicated s/he had been working at the facility for 2 years and had never received training on how to clean the glucometer. Interview with Person # 1 (Product Support Specialist for the glucometer) on 7/24/24 at 2:50 PM identified h/she would advise the facility to stop using alcohol wipes immediately and to use approved wipes before resuming use of the glucometer. The facility policy for Glucometer Calibration and Cleaning, dated 12/2022, directed that the cleaning and disinfection of the glucometer device be completed between resident use. Manufacturers guidelines direct the glucometer test device was approved for multiple residents and cleaning and disinfection was to take place between each resident. The manufacturers guideline for EvenCare G2 Blood Glucose Monitoring System (used by the facility) directs the following: 1. Cleaning also allows for subsequent disinfection to ensure germs and disease-causing agents are destroyed in the meter and lancing devices surfaces. 2. The following products are validated for disinfecting the EvenCare G 2 meter: a. Dispatched hospital cleaner disinfectant towels with bleach (EPA Registration). b. Medline Micro Kill Disinfection Deodorizing cleaning wipes with alcohol (EPA Registration). c. Clorox Health Care Bleach Germicidal Disinfectant wipes (EPA Registration) d. Medline Micro Kill -Bleach Germicidal Bleach wipes with (EPA Registration) 3. Other EPA Registration wipes may be used for disinfecting EvenCare G2 system, however, these wipes have not been validated and could affect the performance of the meter The facility submitted a Removal Plan on July 24, 2023, including the following: 1. The Director of Nursing began in-service, and education of nursing staff present on Wednesday, July 24, 2024, at 5:15 P.M. (Evening shift) on all nursing units. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	2. The Night Nursing Supervisor will continue in-service and education of nursing staff on July 24, 2024-7/25/2024 throughout the night shift. 3. All licensed nursing staff will be educated on the proper process of cleansing glucometers with the completion of regular, full-time staff education completed Wednesday, July 31, 2024. 4 .Medication Nurse will check every shift to assure the appropriate/approved disinfectant wipes are available. 5. The contact time will be placed on the canister to display the required contact time. 6. Adequate supplies of disinfectant wipes will be maintained in the Nursing Administration suite storeroom. 7. The need for re-stocking the disinfectant wipes will be carried out by the personnel who re-stock the nursing units. 8. Observations for adherence/compliance to the cleansing of the glucometers and maintaining adequate supplies will be conducted on each nursing unit on a weekly basis for three (3) months and bi-annually thereafter. 9. Review and revision of the current Policy and Procedure will be completed by Thursday, July 25, 2024 10. A reference card with a list of the approved disinfectant wipes will be affixed to each medication cart. 2. On 7/24/2024 at 10:00 AM PPE carts were note outside resident rooms on the hall side of and including Resident # 36's room. Residents with signage outside their door indicating requiring PPE before entering the rooms on the opposite side of the hall had no carts outside their rooms. An interview with the Infection Preventionist (IP) on 7/24/24 at 10:54 AM indicated the staff shares the PPE supplies from the carts outside the other rooms. 3. An interview and review of the Infection Control Program with the DNS on 7/30/2024 at 12:30 PM indicated s/he could not provide information related to the facility's infection control surveillance as the Infection Preventionist (IP) was not on duty and s/he was the only one with access to the electronic records. 4. An interview with the DNS on 7/30/2024 at 12:30 PM indicated the infection control policy with a binder clip on the table needed to be reviewed for policies requested and s/he would need to find annual signature sheets indicating review of the Infection Control and Intravenous Policy book annually since last survey (3/9/2022). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075117	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/06/2024
NAME OF PROVIDER OR SUPPLIER Nathaniel Witherell, The		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	4 . Interview and facility document review with the DNS on 7/30/2024 at 12:05 PM indicated s/he had a monthly antibiotic report supplied by the pharmacy but was unable to locate any infection control surveillance completed by the IP since the last survey , evidence of the Intravenous Therapy Infection Control Policy. The DNS further indicated the need for other staff to have access to the electronic records when the IP is not available. 6. An interview on 7/30/24 at 1:10 PM an interview with the Director of Nursing Assistant #1, indicated the Maintenance Director, the regional manager and the Administrator were unable to locate the facility water management program but would contact the regional manager regarding surveyor need for interview. On 7/30/24 at 1:45 PM an interview and facility document review with the Maintenance Supervisor indicated s/he was unable to locate the facility water management plan. 7. Resident #24's diagnoses included dementia and muscle weakness. The quarterly MDS assessment dated [DATE] identified Resident #24 had severe cognitive impairment and was dependent for toileting, personal hygiene, and rolling left to right on the bed. The MDS also identified the resident as had an indwelling urinary catheter and did not have any unhealed pressure ulcers. An initial wound evaluation by a wound specialist dated 5/10/2024 identified a new stage 2 pressure ulcer to the right heel. The wound measured 1.2 CM x 1.2 CM x 0 CM with moderate amount of serous exudate. A care plan dated 5/24/2024 indicated Resident #24 had a urinary catheter and had a potential for pressure ulcer development related to immobility. Interventions included administering treatments as ordered and monitoring wound healing. A physician's order dated 7/24/2024 directed the right heel to be cleansed with normal saline solution, apply a calcium alginate with silver dressing, and cover with a foam dressing every day. A review of the Treatment Administration Record for July 2024 identified the resident had the dressing changed from 7/24/2024 to 7/31/2024. An observation was made of LPN #5 changing Resident #24's right heel dressing on 7/31/2024 at 11:32 AM. LPN # 5 applied gloves during the dressing change but did not wear an isolation gown. Further observation identified that there was no sign before entering the resident's room that the resident required any special isolation precautions. After the dressing change was completed, an interview with LPN #5 at 11:39 AM identified s/he had not been told that s/he needed to wear a gown when changing a pressure ulcer dressing or that Resident #24 was on any special isolation precautions. Additionally, LPN #5 indicated s/he was told s/he only needed to wear a gown for residents who had a history of an infection with a Multidrug-Resistant Organism (MDRO). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	An interview with the Nursing Educator (RN#13) indicated that staff had been educated on enhanced barrier precautions two years ago and had in services on 7/18/2024. RN #13 indicated staff are required to wear gowns for residents with a history of a MDRO. Additionally, RN#13 also indicated residents with a small wound and that do not have a history of a MDRO, staff are not required to wear a gown. The facility policy for Transmission Based Precautions identified that the use of gown and gloves for high-contact resident care activities is indicated, when contact precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of MDRO status. Examples of high-contact resident care activities included wound care of any skin opening requiring a dressing. 8. Resident #25 's diagnoses included pneumonia, asthma and Chronic Obstructive Pulmonary Disease. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #25 as moderately cognitively impaired and required total assist with activities of daily living. The Resident Care Plan dated 6/12/24 identified Resident #25 had a deficit in activities of daily living with interventions that included discussions with resident and responsible party related to loss of independence and decline in the ability to perform self-care. a. An observation on 7/29/24 at 12:10 PM identified signage that indicated a resident was on Contact Precautions with instructions that included a gown, gloves, mask were required before entering the room. There were no receptacles for Personal Protective Equipment (PPE) outside the room and no hazardous waste receptacles set up inside the room or immediately outside the room. Trash receptacles inside the room also did not have any discarded isolation gowns inside. Nurse Aide, NA #7 was observed exiting the room without PPE. NA #13 was also observed inside the room providing directed personal hygiene care to Resident #25 without the benefit of an isolation gown. An interview with NA #7 on 7/29/24 at 12:10 PM identified NA #13 was assisting Resident # 25 with personal hygiene without an isolation gown. NA #7 further identified s/he was aware Resident #25 was on TBP and should have been wearing a gown while providing personal hygiene. An interview with NA #13 identified she also was aware Resident #25 was on Transmission-Based Precautions(TBP)which required the use of an isolation gown while providing care. NA #13 further identified s/he did not don the isolation gown prior to providing care because the PPE was not readily available outside Resident #25's when s/he needed care. An interview with Registered Nurse, RN #6 on 7/29/24 at 12:10 PM identified s/he was the Unit Manager for the floor. RN #6 identified there were not enough isolation bins to place outside of resident's rooms for staff to don PPE prior to entering a resident's room on TBP. RN #6 further identified the staff should be donning PPE according to the signage placed outside Resident #25's door. An interview with the Director of Nursing Services, DNS on 7/29/24 at 12:42 PM identified s/he would expect staff to be wearing the appropriate PPE when providing care for a resident on TBP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	The facility policy for Transmission Based Precautions dated 4/22/24 directed that for a resident placed on Contact Precautions, PPE should be donned upon entry into the room/patient space and used for all interactions that may involve contact with the resident and properly discarded before leaving the room to contain pathogens. b. An observation on 7/29/24 at 12:10 PM identified signage that indicated a resident was on Contact Precautions with instructions that included that a gown, gloves, mask were required before entering the room. A review of the clinical record and facility documentation review that tracked residents with transmission-based precautions did not include a documented rationale for placement of the Contact Precautions An interview with Registered Nurse, RN #6 on 7/29/24 at 12:10 PM identified s/he was the Unit Manager for the floor. RN #6 further identified s/he did not know why Resident #25 was placed on Contact Precautions. An interview and clinical record review with the DNS on 8/01/24 at 2:26 PM identified s/he did not know why Resident #25 was placed on Contact Precautions and was unable to determine the rationale from the clinical record review. A review of the facility policy for Transmission Based Precautions directed to use Contact Precautions for residents with known or suspected infections that represent an increased risk for contact transmission. Attempts to interview the Infection Preventionist were unsuccessful. 46046 48880

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. 46046 Based on review of the facility Infection Control program, review of facility document, facility policy and staff interview, the facility failed to ensure an Antibiotic Stewardship Program was in place and available for review. The findings include. An interview and facility document review on 7/30/2024 with the DNS indicated the Infection Preventionist (IP) was out of the facility and the Antibiotic Stewardship information along with the infection control program was on the computer and the IP was the only person who had access. The DNS was able to provide a facility policy for Antibiotic Stewardship, unknown date of last annual review, and the pharmacy list of antibiotics used for the last month. The DNS was also unable to provide evidence of an Antibiotic Stewardship Program actively in place. The DNS further indicated that in lieu of the absence of the IP other staff should be able to gain access to the files for the infection control program. On 7/31/2024 at 12:15 PM the Assistant Director of Nursing Services (ADNS) indicated the Staff Development Nurse (IP back up Wednesday and Thursday) was working and paged him/her, but s/he was unavailable for interview.