Printed: 05/28/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075153	A. Building B. Wing	10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa at Stamford, The	88 Rockrimmon Road Stamford, CT 06903

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 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 clinical record review, facility documentation, and staff interviews for one of three residents (Resident #1) reviewed for abuse the facility failed to ensure the medical record was complete and accurate to include documentation of visits provided by social services following an allegation of abuse. The findings include: Resident #1 was admitted on [DATE] with diagnosis of hemiplegia/hemiparesis (weakness of one side of the body) following a cerebral infarction. The nursing admission assessment dated [DATE] identified Resident #1 was alert and oriented. The Resident Care Plan (RCP) dated 9/4/24 identified Resident #1 had a self-care deficit. interventions directed to provide assistance with ADLS (ADL) and use of 1/4 side rails for bed mobility. Facility incident report dated 9/6/2024 identified Resident #1's family reported an allegation that a NA slapped Resident #1 on the back on 9/4/2024 about midnight. An assessment was completed with no injuries noted. The facility summary dated 9/11/2024 identified the accused NA denied the allegation, there were no witnesses to the alleged incident, Resident #1 did not report the allegation to any staff prior to the family report on 9/6/2024 at 4:30 PM, and the facility was unable to substantiate the allegation. Resident #1 and the family member were notified the facility was unable to substantiate the allegation and indicated they were satisfied with the results of the investigation. Clinical record review failed to identify the social worker documentation following up with Resident #1 after the allegation of abuse. Interview and record review with Social Worker (SW) #1 on 10/1/24 at 2:10 PM identified she saw Resident #1 for a follow up support visit on 9/10/2024 (after the allegation on 9/6/2024). SW #1 stated that she failed to write a note on the incident because she forgot, and stated she should have written a note after her visit with Resident #1. Interview with the DNS on 10/1/24 at 3:03 PM identified SW #1 should have written a note after her visit with Resident #1, and she stated she did not know why SW #1 did not write a note. (continued on next page)

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

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075153	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/01/2024
NAME OF PROVIDER OR SUPPLIER Villa at Stamford, The		STREET ADDRESS, CITY, STATE, ZIP CODE 88 Rockrimmon Road Stamford, CT 06903	

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility Charting and Documentation Policy dated April 2008, directed in part, to document all observations, medications administered, and services performed in the resident's clinical record.