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	01/28/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40172 Based on review of the clinical record, facility documentation, facility policy, and interviews for two (2) of two (2) residents (Resident #1 and Resident #2) reviewed for abuse, the facility failed to ensure that a resident (Resident #1)who had a history of speaking to another resident (Resident #2) in a deragatory manner were free from physical abuse. The findings include: 1. Resident #1 had diagnoses that included impulse disorder, unspecified intellectual disabilities, schizophrenia, and delusional disorder. The annual MDS dated [DATE] identified Resident #1 had short and long-term memory problems, was always incontinent of bowel and bladder, independent with wheeling the wheelchair, and dependent with ADLs. The care plan dated 12/12/24 identified Resident #1 has behavioral problems cries out frequently, diagnoses of developmental delay impulse disorder and delusions, accusatory towards other residents and staff, inappropriate hand gestures and language towards staff and other residents with interventions directed to allow time to de-escalate and re-approach if agitated, encourage the resident to express feelings appropriately, psych consult as needed, caregivers to provide opportunities for positive interaction and attention stop and talk to the resident when passing by, and praise any indication of the resident's progress/ improvement in behavior. 2. Resident #2 had diagnoses that included vascular dementia and adjustment disorder with anxiety. The care plan dated 10/15/24 identified Resident #2 has the potential to be physically/verbally inappropriate with staff and other residents related to dementia with interventions that directed to redirect negative behaviors, update MD and family as needed, and remove resident from situations triggering behavior, provide a calm environment during periods of agitation. The quarterly MDS dated [DATE] identified Resident #2 had a Brief Interview for Mental Status (BIMS) score of one (1) indicative of severely impaired cognition, was always continent of bowel and bladder, independent with locomotion and ADLs. A nurse's note dated 1/3/25 at 12:17 P.M. written by the DNS identified she was called to the unit at 10:40 A. M. to assess Resident #1 following an incident with Resident #2 witnessed by LPN #1. The DNS identified Resident #1 was quietly sitting in h/her wheelchair in the social service office, upon seeing this writer Resident #1 began to cry and repeatedly striking the right side of h/her cheek stating, he hit me. The DNS indicated Resident #1 would alternately calm down with some direction and then would immediately start striking h/her cheek again. The DNS indicated Resident #1 was unable to state more than he hit me. The DNS identified on initial exam slight redness to Resident #1's cheek bone was noted. (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

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 01/28/2025
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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nurse's note dated 1/3/25 at 12:23 P.M. written by the DNS identified she was called to the unit at 10:40 A. M. to assess Resident #2. The DNS identified LPN #1 witnessed Resident #2 hitting Resident #1 hitting the cheek. The DNS indicated the residents were already separated. The DNS indicated upon investigation Resident #2 was unable to state what had occurred and Resident #2 was ambulating in hallway with no apparent injuries. A social worker's note dated 1/3/25 at 12:37 P.M. written by SW #1 identified she was informed Resident #2 hit Resident #1. SW #1 indicated she first spoke with Resident #2 who was unable to communicate details of the incident. SW #1 indicated she then asked Resident #1 what happened, and Resident #1 reported Resident #2 hit h/her in the face. SW #1 identified Resident #1 was smacking h/herself on h/her cheek stating Resident #2 hit h/her on the cheek. SW #1 identified Resident #1 reported h/she hit Resident #2 first because h/she does not like Resident #2. Review of the facility's accident and incident report dated 1/3/25 identified at 10:40 A.M. LPN #1 heard yelling coming from down the hallway and went to investigate. LPN #1 observed both Resident #1 and Resident #2 with their arms raised, LPN #1 called out 'stop' prior to reaching the residents, LPN #1 witnessed Resident #2 hit Resident #1 on the right cheek, and the residents were immediately separated. The facility's summary dated 1/8/25 identified upon investigation and interviews Resident #1 told SW #1 that h/she hit Resident #2 because h/she does not like h/her and Resident #2 had no recollection of the event. The findings identified Resident #1 struck out at Resident #2 as h/she walked by and Resident #2 who is cognitively impaired reacted. The facility's indicated the corrective action is in place and being implemented psychiatry and psychology review with support services implemented, staff educated to separate residents if they are in the same vicinity. Interview with LPN #1 on 1/28/25 at 10:25 A.M. identified on 1/3/25 she heard yelling coming from down the hallway and went to investigate the yelling. LPN #1 identified she observed Resident #1 seated in h/her wheelchair with h/her hands raised as though she was ready to hit Resident #2 who was standing next to Resident #1. LPN #1 indicated she yelled 'stop' as she walked toward the residents and witnessed Resident #2 with a closed fist hit Resident #1's right cheek. LPN #1 identified she immediately separated the residents, and she remained with Resident #2 until the DNS came to the unit. LPN #1 identified prior to 1/3/25 there has been issues for some time with Resident #1's behaviors towards Resident #2. LPN #1 identified Resident #1 tells Resident #2 I don't like you, Resident #1 has put h/her hands up towards Resident #2 as though she wanted to hit h/her, and Resident #1 has spit in the direction of Resident #2. LPN #1 identified in the past Resident #2 has always been non-reactive to Resident #1's comments and gestures and at times Resident #2 will just stop, stand, look at Resident #1 for a moment then keep walking in the hallway. Interview with LPN #2 on 1/28/25 at 11:14 A.M. identified prior to 1/3/25 whenever she was caring for Resident #1 she had to keep an 'eye' on h/her because Resident #1 would say to Resident #2 I don't like you while Resident #1 made hand gestures or had h/her hands raised at Resident #2. Interview with NA #2 on 1/28/25 at 11:30 A.M. identified prior to 1/3/25 on many occasions Resident #1 wheel h/herself towards Resident #2 telling Resident #2 I don't like you and has witnessed Resident #1 spitting towards Resident #2. (continued on next page)

Printed: 07/31/2025
Form Approved OMB
No. 0938-0391

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 01/28/2025
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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with SW #1 on 1/28/25 at 9:53 A.M. identified on 1/3/25 Resident #1 came into her office following the altercation with Resident #2, Resident #1 kept hitting h/her right cheek and face approximately 15 times stating, Resident #2 did that to me. SW #1 indicated on 1/3/25 Resident #1 reported that h/she hit Resident #2 first on h/her side because h/she doesn't like Resident #2. SW #1 identified Resident #1 does have a history of aggressive behaviors. SW #1 identified that is why Resident #1 is in a private room. SW #1 identified prior to 1/3/25 Resident #1 almost daily while sitting in the hallway tells Resident #2 I don't like you as Resident #2 walks by h/her, at times Resident #1 will also raise up h/her hands up at Resident #2, and Resident #1 would spit in Resident #2's direction. SW #1 indicated when she observed or heard Resident #1 saying I don't like Resident #2 she would take Resident #1 into her office staff to reset h/her and talk to Resident #1 about h/her behaviors. SW #1 indicated staff are aware of Resident #1's behaviors towards Resident #2, staff do redirect Resident #1 and keep Resident #1 and Resident #2 separated during activities. SW #1 indicated Resident #2 has not reacted to Resident #1's behaviors in the past. Interview with APRN #2 (psychiatric) on 1/28/25 at 12:00 P.M. identified Resident #1 has a history of aggressive physical and verbal behaviors in the past which resulted in Resident #1 requiring a private room. APRN #2 identified Resident #1 is very child-like, loves to be the center of attention, and does become easily upset if h/she feels others are getting more attention than h/she is getting. APRN #2 identified she was aware prior to the altercation between Resident #1 and Resident #2 that Resident #1 exhibited verbal behaviors toward telling Resident #2 I do not like you. APRN #2 identified she herself has heard Resident #1 stating I don't like Resident #2 with Resident #2 being within hearing distance. APRN #2 identified during her visit with Resident #1 on 1/ 3/25 Resident #1 reported that h/she punched Resident #2 first because h/she does not like Resident #2. APRN #2 indicated on 1/3/25 when Resident #1 struck out at Resident #2 h/she reactively punched Resident #1 back. Review of Resident #1 and Resident #2's plan of care failed to address the frequent negative comments and actions by Resident #1 to Resident #2 prior to 1/3/25 until after the incident when Resident #1's care plan identified to keep Resident #2 away from Resident #1. Interview with the DNS on 1/28/25 at 12:30 P.M. identified she was aware prior to 1/3/25 that Resident #1 would say h/she doesn't like Resident #2 in the hallway while Resident #2 walked by and at times Resident #1 would make inappropriate hand gestures and spit towards Resident #2. The DNS identified Resident #1 is care planned for h/her behaviors that include spitting, use of inappropriate hand gestures and language towards staff and other residents with interventions. LPN #1 witnessed Resident #2 hit Resident #1 on h/her right cheek. The DNS identified on 1/3/25 Resident #1 reported to SW #1 that h/she hit Resident #2 first because h/she doesn't like Resident #2. The DNS identified based on the investigation the allegation of resident-to-resident abuse was substantiated Resident #1 did hit Resident #2 on h/her side and Resident #2 reacted to being hit by hitting Resident #1's right cheek. Review of the facility Abuse Prevention policy, in part, identified the facility is committed to protecting residents from abuse by anyone including but not limited to facility staff, other residents, family members, legal guardians, surrogates, sponsors, friends, visitors, or any other individual.