

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 06/23/2025
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)
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation review, facility policy review, and interviews for one sampled resident (Resident #1) reviewed for weight loss, the facility failed to ensure the clinical record was complete and accurate to include timely meal intake documentation. The findings include:</p> <p>Resident #1 had diagnoses that included Alzheimer's disease and anxiety.</p> <p>The Annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 was unable to complete the Brief Interview for Mental Status (BIMS), indicative of being severely cognitively impaired and required maximum assistance for eating.</p> <p>The Resident Care Plan (RCP) dated 6/23/25 identified Resident #1 had an ADL deficit related to Alzheimer's disease and tardive dyskinesia. Interventions directed to feed resident meals.</p> <p>Review of meal intake documentation for Resident #1 identified from 5/25 through 6/23/2025 the meal intakes identified the following:</p> <p>&bull;</p> <p>Resident #1's breakfast was not documented on: 5/27, 5/31, 6/1, 6/10, 6/13, and 6/14/25.</p> <p>&bull;</p> <p>Resident #1's lunch was not documented on: 5/27, 5/31, 6/1, 6/10, 6/13, and 6/14/25.</p> <p>&bull;</p> <p>Resident #1's dinner was not documented on: 5/25, 5/30, 5/31, 6/1, 6/2, 6/5, 6/7, 6/10, 6/11, 6/13, 6/15, 6/19, and 6/21/25.</p> <p>Interview with Dietician #1 on 6/23/25 at 10:25 AM identified Resident #1 was at risk for weight loss, and her observations and reviews had identified Resident #1 was a good eater. Further, the Dietician #1 indicated the staff should document meal intakes accurately after each meal.</p> <p>(continued on next page)</p>

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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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview and record review with the DON (Director of Nursing) on 6/23/25 at 1:20 PM identified it was her expectation that the nursing staff document each meal intake in the electronic medical records to ensure accurate representation of each meal for a resident. interview failed to identify why the meal intakes were not documented.</p> <p>Review of the Electronic Medical Records Policy dated 2/2021 identified the facility will ensure each record will be accurate, based on knowledge of resident information.</p> <p>Interview and record review with the DON (Director of Nursing) on 6/23/25 at 1:20 PM identified it was her expectation that the nursing staff document each meal intake in the electronic medical records to ensure accurate representation of each meal for a resident. interview failed to identify why the meal intakes were not documented.</p> <p>Review of the Electronic Medical Records Policy dated 2/2021 identified the facility will ensure each record will be accurate, based on knowledge of resident information.</p>