

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 04/30/2026
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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, facility documentation review, and staff interviews for one of three residents (Resident #1) reviewed for quality of care, the facility failed to ensure wound care physician recommendations were transcribed accurately. The findings include: F684Based on record review, facility documentation review, and staff interviews for one of three residents (Resident #1) reviewed for quality of care, the facility failed to ensure wound care physician recommendations were transcribed accurately. The findings include: Resident #1 had a history of Alzheimer's dementia and urinary incontinence. The Resident Care Plan (RCP) dated 4/21/23 identified a toe wound. Interventions directed to observe for signs of infection and to provide treatments and dressing changes as ordered. The quarterly Minimum Data Set (MDS) dated [DATE] identified Resident #1 had short- and long-term cognition deficits, and was dependent for ADL care. Nursing note dated 5/23/23 at 3:40 PM identified Resident #1 was seen by MD #1 and the bilateral great toes were assessed by MD #1. Per MD, both toenails were ingrown and purulent drainage (pus like fluid) was expressed from the left medial (inner edge) great toe. A discolored area was noted on right medial great toe, but no purulent drainage. The note indicated Mupirocin (topical antibiotic) treatment was ordered. Wound care provider note dated 5/23/23 identified treatment recommendation for the first toe left lateral, apply Bactroban (topical antibiotic) to the wound base with a dry clean dressing every day. Physician Order dated 5/23/23 directed to apply Mupirocin (Bactroban) External Ointment 2% to the bilateral great toes topically every day shift for wound care for 14 Days. Cleanse bilateral great toe wounds with normal saline. Record review failed to identify the wound physician had directed the Bactroban to be applied to both toes. Nursing note dated 5/30/23 at 4:30 PM identified Resident #1 was seen by MD #1 and bilateral great toes were dry with no purulent drainage noted. No swelling or erythema noted. Treatment was changed to Betadine (topical antiseptic solution). Wound care provider note dated 5/30/23 identified treatment recommendation for the first left lateral toe to paint with Betadine every day and leave open to air. Physician Order dated 5/30/23 directed staff to apply Betadine (helps prevent infection) to the bilateral great toes for seven (7) days every day shift. Record review failed to identify the wound physician had directed the Betadine to be applied to both toes. Interview and record review with MD #1 on 4/30/26 at 10:05 AM identified Resident #1 had discoloration to the right toe, but only needed a treatment to the left toe because the right toe had no drainage. MD #1 stated on 5/23/23 he only wanted Bactroban placed on the left toe with a dry clean dressing to be changed once a day, and on 5/30/23 he only wanted Betadine placed on the left toe and not the right toe. MD #1 further stated that nursing should be following his wound care recommendations and did not know why the order was placed for the bilateral toes when it should have been only the one (1) toe. Interview and record review with the Director of Nursing (DNS) on 4/30/26 at 10:45 AM identified the wound care order placed on 5/23/23 directed to apply Bactroban on the bilateral great toes, and did not match the wound treatment recommendation made on 5/23/23 by MD #1 to apply only to the first left lateral toe. Further, the wound care ordered placed on 5/30/23 directed to apply Betadine on the bilateral great toes and did not match the wound treatment recommendation made by MD #1 on 5/30/23 to apply only on the first left lateral toe. The DNS further stated the wound care orders should match the (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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>recommendations made by the wound care physician/MD #1 and did not know why the orders were entered incorrectly. Review of facility Physician Order Policy dated January 2025 directed staff to assure treatment orders are implemented accurately, timely and in accordance with the public health code and federal regulations.</p>		

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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>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 record review, facility documentation review, and staff interviews for one of three residents (Resident #1) reviewed for activities of daily living, the facility failed to ensure the clinical record was complete and accurate to include documentation of personal care. The findings include: Resident #1 had a history of Alzheimer's dementia and urinary incontinence. The quarterly Minimum Data Set (MDS) dated [DATE] identified Resident #1 had short- and long-term cognition deficits, and was dependent for ADL care. The Resident Care Plan (RCP) dated 4/21/23 identified a self-care deficit. Interventions directed to provide ADLs and mouth care. Record review of the Personal Hygiene ADL task for May of 2023 identified documentation was missing (blank) on 5/1, 5/5, 5/7, 5/10, 5/11, 5/13, 5/16, 5/17, 5/18, 5/20, 5/22, 5/23, 5/24, 5/25, 5/26 and 5/28/2023 (missing on 16 shifts for the month). Interview and record review with the Director of Nursing (DNS) on 4/30/26 at 10:45 AM identified the ADL Hygiene documentation was missing/blank on 15 shifts during 7 AM to 3 PM, and one (1) 3 to 11 PM shift during the month of May 2023, for a total of 16 shifts missing documentation. The DNS stated staff would have provided the care and staff should have documented on the ADLs provided on the ADL Personal Hygiene task, and she did not know why staff did not document the care. Review of facility Charting and Documentation Policy dated 1/14/2014 directed all services provided to the resident must be documented in the resident's medical record.</p>