STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075421	A. Building B. Wing	02/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edgehill Health Center	122 Palmers Hill Rd Stamford, CT 06902

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** Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 3 residents (Resident #8) reviewed for falls, the facility failed to ensure that the resident's clinical record reflected complete and accurate information related to falls and frequent monitoring. The findings include:Resident #8 was admitted to the facility in June 2025 with diagnoses that included Parkinson's disease, dementia, and repeated falls. The quarterly MDS dated [DATE] identified Resident #8 had severely impaired cognition, was frequently incontinent of bowel and bladder and was dependent on staff for bathing, toileting, and transfers. The care plan dated 9/3/25 identified Resident #8 was at risk for falls due to Parkinson's disease, cognitive deficits, and history of falls. Interventions included floor mats to both side of the bed, bed in the lowest position, monitoring out of bed activity, and visually check every 15 minutes.Review of a facility accident and incident (A&I) report identified Resident #8 had an unwitnessed fall on 10/27/25 at 8:00 AM. The report identified Resident #8 was observed kneeling on a floor mat in his/her room with his/her arm stuck in a bedrail. The report further identified that an x-ray of the right shoulder was ordered by the APRN which was negative.An immediate needs care plan for falls dated 10/27/25 included interventions of every 30 minutes checks for 3 days and that Resident #8 also had a private duty aide in place from 9:00 AM - 6:00 PM daily. Review of the 15-minute check documentation form dated 10/27/25 identified that Resident #8 was in the facility's dining room at 8:00 AM. The 15-minute check documentation form also identified Resident #8 was in the facility's dining room at 8:15 AM, 8:30 AM, and 8:45 AM.Review of a facility A&I report identified Resident #8 had a 2nd unwitnessed fall on 10/27/25 at 8:45 AM. The report identified Resident #8 was observed sitting on a floor mat leaning against the bed. The report further identified Resident #8 had no visible injuries.A subsequent immediate needs care plan for falls dated 10/27/25 directed for checks every 15 minutes for 3 days. Review of a facility A&I report identified Resident #8 had an unwitnessed fall on 11/20/25 at 10:35 PM. The report identified Resident #8 was observed on the floor lying on his/her right side, with the resident's lower body on the floor mat and upper body on the floor. An immediate care plan for falls dated 11/20/25 identified Resident #8 had a fall. Interventions included initiation of checks every 15 minutes for 3 days.Review of the 15-minute check documentation form dated 11/20/25 failed to identify any checks were done following Resident #8's fall at 10:35 PMReview of a facility accident and incident A&I report identified Resident #8 had 2nd unwitnessed fall on 11/20/25 at 11:10 PM. The report identified Resident #8 was observed with the right side of his/her face on the floor mat, and the resident's lower body on the bed. A subsequent immediate needs care plan for falls dated 11/20/25 directed for checks every 15 minutes for 3 days.Review of the 15-minute check documentation form dated 11/20/25 failed to identify any checks were done following Resident #8's fall at 11:10 PM. Further review of the form failed to identify any checks were done until 7:30 AM the following day. Interview with the DNS on 2/10/26 at 11:40 AM identified that there was an issue with documentation on the facility monitoring forms and that the forms should have been filled out completely and accurately. The DNS identified that there was some confusion among the staff about who should be documenting on the forms (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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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(nurses or nurse aides) and that in addition, Resident #8 had a private duty aide for several hours during the day and evening shifts. The DNS identified that while Resident #8 did have either 1:1 care with his/her private duty aide or from facility staff, Resident #8 did have frequent checks, but the staff was not documenting the checks accurately. The DNS identified that the facility was working on addressing the issue and the facility would likely be moving away from 15 and 30 minute checks in the future. The DNS also identified the Resident #8's falls on 10/27/25 occurred in the resident's room and not in the dining room, and that the 15-minute documentation was incorrect. Although requested, the facility failed to provide a policy on 15-minute checks, 30-minute checks, frequent monitoring and clinical documentation. The facility policy on falls directed that staff would monitor and document the resident's responses to interventions intended to reduce falling or risk of falling.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, facility documentation, facility policy, and interviews for 1 of 3 residents (Resident #7) reviewed for pressure ulcers, the facility failed to ensure a resident with a chronic wound was placed on enhanced barrier precautions (EBP), and for 1 resident (Resident #17) reviewed for transmission-based precautions, the facility failed to utilize Personal Protective Equipment (PPE) in accordance with policy and infection control standards of practice for a resident requiring contact precautions. The findings include: Resident #7 was admitted to the facility in May 2025 with diagnoses that included dementia, spinal stenosis, and ataxia. A physician's order dated 5/14/25 directed to admit Resident #7 to hospice level of care. The quarterly MDS dated [DATE] identified Resident #7 had severely impaired cognition, was dependent for rolling left to right and chair/bed to chair transfers, was at risk of developing pressure ulcers/injuries, and had one -Stage 3 pressure ulcer. The care plan updated 2/3/26 identified Resident #7 had an alteration in skin integrity related to a right foot heel wound and left foot wound, with interventions that included administering treatments per the physician's order, monitoring and documenting wound condition, and observing wounds for signs of infection or deterioration. The care plan failed to identify Resident #7 was on EBP. The Weekly Pressure Ulcer Report dated 2/3/26 identified Resident #7 had a stage 4 facility acquired pressure ulcer (onset date 10/27/25) to the left heel measuring 1.8 x 1.0 x 0.5cm and an unstageable pressure injury to the right foot, (onset date 1/6/26) measuring 1.0 x 1.8 x 1.8cm. A physician's order dated 2/6/26 directed to cleanse the left heel wound with normal saline and pat dry, apply Medi honey gel followed by Calcium Alginate, and cover with a foam dressing, daily. Further, the physician's order directed to apply Medi honey gel, followed by Calcium Alginate to the right foot superficial heel wounds, and cover with a foam dressing daily. The physician's orders did not identify an order for EBP. Observations on 2/8/26 at 8:35 AM and 2/9/26 at 12:15 PM identified no signage or PPE outside the resident's room regarding EBP. Observation of LPN #1 and NA #1 on 1/9/26 at 12:15 PM failed to identify LPN #1 and NA #1 were wearing gowns during Resident #7's wound care, (a high-contact resident care activity) which included: the removal of a lightly soiled foam dressing to the left heel and dressing removal of the right foot wound, wound cleansing, the application of the prescribed wound treatments, and new foam dressing applications to the left heel and right foot. Interview with the facility's Nurse Consultant (to become the DNS) on 2/10/26 at 7:30 AM identified that she would expect Resident #7 to have been placed on EBP, and she would expect staff to wear the appropriate PPE, which would include a gown and gloves, while providing wound care to an open area. Observation on 2/10/26 at 8:10 AM of Resident #7's door identified signage directing staff to adhere (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to enhanced barrier precautions and indicating the type of personal protective equipment (PPE) required while performing high-contact resident care activities,. Interview with the current DNS/Wound Nurse on 2/10/26 at 8:37 AM identified that Resident #7 was just placed on EBP and he was not sure why enhanced barrier precautions were not in place prior to surveyor inquiry. The DNS/Wound Nurse indicated that it was realized after the fact, and that he would expect staff to wear PPE, including a gown and gloves, during a chronic wound dressing change. The DNS/Wound Nurse further indicated that he would have to check with the facility's Infection Control/Staff Development Nurse to see what type of education had been provided to the nursing staff about EBP. Interview with the Infection Control/Staff Development Nurse (RN #1) on 2/10/26 at 8:45 AM identified that he did not place Resident #7 on enhanced barrier precautions because the area started off as a blister and he did not realize that it had opened and progressed to a stage 4. RN #1 indicated that it was his responsibility to review the resident's clinical record for such updates, and he did not keep up on that. RN #1 identified that he would obtain documentation regarding EBP in-servicing for the nursing staff. Interview with RN #1 on 2/10/26 at 12:27 PM identified that after further review, the annual Infection Control: Essential Principles on-line learning module assigned to the nursing staff did not include educational content related to enhanced barrier precautions. RN #1 indicated that the last in-service related to enhanced barrier precautions was completed in July 2022. RN #1 further indicated that he initiated EBP education for nursing staff, this morning. The facility's Enhance Barrier Precautions policy directs for EBP to be utilized to prevent the spread of multi-drug-resistant organisms (MDROs) to residents. EBP is used as an infection prevention and control intervention to reduce the spread of MDRO's to residents. EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. Glove and gowns are applied prior to performing the high contact resident care activity, PPE is changed before caring for another resident, and face protection may be used if there is also a risk of splash or spray. Examples of high contact resident care activities requiring the use of gown and gloves for EBP include wound care, dressing, bathing, providing hygiene, device care, and changing linens. EBPs are indicated for residents with wounds and/or indwelling medical devices regardless of MDRO colonization. Signs are posted on the door or wall outside the resident room indicating the type of precautions and PPE required. 2. Resident #17 was admitted to the facility in 8/2025 with a diagnosis that included enterocolitis related to clostridium difficile or C-diff (spore spreading bacterium causing severe diarrhea and colitis). The quarterly MDS dated [DATE] identified Resident #17 was severely cognitively impaired and required one person assist with bed mobility, two persons for transfers and toileting. The care plan dated 12/9/25 identified Resident #17 had active c-diff infection with sepsis. Interventions included contact precautions for an active infection and administer antibiotics as ordered. Physician's order dated 1/23/26 (original 11/7/25) directed contact isolation precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Observation on 2/8/26 at 8:25 AM identified a Contact Precautions sign was posted outside Resident #17's door (gown and gloves required before entering the room) with an isolation cart containing PPE (gowns, masks, no gloves). Housekeeper #1 was in Resident #17's room sweeping the floor wearing gloves and a mask but without the benefit of an isolation gown. Interview with Housekeeper #1 on 2/8/26 at 8:25 AM identified that she was aware an isolation gown was required for contact precautions but indicated one was not necessary prior to entering Resident #17's room because she was cleaning the environment with no direct resident contact. Interview with the Director of Operations on 2/8/26 at 8:30 AM identified he also observed Housekeeper #1 enter Resident #17's room without an isolation gown and identified she should have been wearing the required PPE before going into the room. b. Observation on 2/10/26 at 7:57 AM identified the Program Coordinator entered Resident #17's room without PPE. The Program Coordinator had a brief conversation with Resident #17, provided an activity schedule and exited the room. Person #1, a private duty nurse aide was also observed at Resident #17's bedside assisting the resident with breakfast without PPE. Interview with Person #1 on 2/10/26 at 7:57 AM identified she was aware Resident #17 was on contact precautions and should have been wearing PPE while in the room but had used the bathroom and did not replace the PPE before resuming care with Resident #17. Interview with the Program Coordinator on 2/10/26 at 8:07 AM identified he was aware Resident #17 was on contact precautions but assumed PPE was not required if not providing direct care. Interview and policy review with the DNS on 2/10/26 at 8:10 AM identified for a resident on contact precautions PPE was only required when providing direct care but indicated she wanted to consult with the infection preventionist (IP). An interview with RN #1 on 2/10/26 at 8:10 AM identified he was the IP for the facility and responsible for infection control education. RN #1 indicated a disposable isolation gown, and gloves were to be put on prior to entering the room for a resident on contact precautions. This was required for all staff including those not having direct contact. For Resident #17, this was especially important because the infecting bacteria formed spores that remained on environmental surfaces. Proper use of PPE prevents the spread of infection from the environment. A review of the Transmission-Based Precautions policy directed that contact precautions are to be implemented for residents known or suspected of being infected with microorganisms that can be transmitted by direct contact or indirect with environmental surfaces. The individual on contact precautions is placed in a private room if possible. Staff and visitors wear a disposable (isolation) gown upon entering the room and remove before leaving the room and avoid touching potentially contaminated surfaces with clothing after the gown is removed. Signage for contact precautions for staff and visitors directed that all providers and staff must put on gloves and a gown before room entry and before room exit and do not wear the same gown to care for other residents. A review of the facility policy for Precaution Room Cleaning Best Practices directed that staff entering the room wear gloves and protective clothing.