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	07/30/2024

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47402 Based on clinical record review, review of facility policy, and interviews for one sampled resident (Resident #23) reviewed for accidents, the facility failed to notify the resident's responsible party when the resident had an incident of smoking in their room. The findings include: Resident #23's diagnoses include chronic obstructive pulmonary disease, dementia, and psychotic disorder with delusions. The quarterly MDS assessment dated [DATE] identified Resident #23 had intact cognition, utilized a walker and wheelchair for mobility, was independent for eating, utilized set up or clean up assistance with oral hygiene and toileting, and required supervision for dressing and personal care. Resident #23's care plan dated 5/20/24 identified an ADL (activities of daily living) self-care performance deficit with interventions that included: limited assistance with a rolling walker on the unit, assistance with bathing/showering, personal hygiene and oral care. The care plan further noted Resident #23 was an elopement risk/wanderer related to impaired safety awareness with an intervention to redirect negative behaviors. The nursing note dated 7/20/24 at 2:53 PM written by RN #2 (Nursing Supervisor) identified Resident #23 was found smoking in his/her room with his/her spouse in the room. The resident was educated on the smoking policy and the danger of smoking in the room, a room search was conducted with no cigarettes and lighting materials found. The note further identified that the resident's spouse was instructed to not bring smoking supplies into the facility. Additionally, the APRN was contacted, and a new order was obtained for a Nicotine patch. The reportable event report dated 7/22/24 identified the resident was found smoking in his/her room. The report did not identify that the resident's responsible party was notified of the incident. Attempts to interview RN#2 concerning the incident with Resident #23 were made on 7/24/24 at 1:01 PM and on 7/25/24 at 9:18 AM. A message was left on both occasions. All attempts were unsuccessful. Interview with Person #1(Responsible Party) on 7/29/24 at 1:08 PM identified she was not notified of the smoking incident until 7/25/24, when she was sent an email from Social Worker #1. (continued on next page)

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

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	075153	A. Building B. Wing	07/30/2024

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Social Worker #1 on 7/30/24 at 11:25 AM identified that she notified the conservator via email of the smoking incident on 7/25/24 but believes the conservator should have been notified sooner following the incident. She further noted that she would have expected the nurse on the unit to notify the resident's responsible party at the time of the incident. Interview with the DNS on 7/30/24 at 9:33 AM identified that resident responsible parties/conservators should be notified at the time of the incident. She would have expected the conservator to be notified sooner than 7/25/24 for the incident occurring on 7/20/24. The DNS further identified that she had not completed the reportable event report until 7/22/24 because she was busy when she was notified of the incident. Review of the facility Reportable Events Investigating and Reporting policy identified all accidents or incidents involving residents, employees, visitors, vendors, etc. occurring on our premises shall be investigated and reported to the Administrator. The Nurse Supervisor/Charge nurse and/or the department director of supervisor shall promptly initiate and document investigation of the accident or incident. The Nurse Supervisor/Charge nurse and/or the department director or supervisor shall complete a Reportable Event form and submit the original to the Director of Nursing Services within 24 hours of the incident or accident. The date/time the family is notified should be documented on the Reportable Event form.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47402 Based on clinical record review, review of facility policy, and interviews for one of five sampled residents (Resident #100) reviewed for Preadmission Screening and Resident Review (PASRR), the facility failed to complete a screening for a resident who required one following short-term approval. The findings include: Resident #100's diagnoses include paranoid personality disorder, delusional disorder, post-traumatic stress disorder and major depressive disorder, The quarterly MDS assessment dated [DATE] identified Resident #100 had intact cognition, utilized a wheelchair for mobility, was dependent for all activities of daily living (ADL's.) The assessment further noted the resident's diagnoses were depression, psychotic disorder, and post-traumatic stress disorder. Resident #100's care plan dated [DATE] identified the potential for behavioral problems related to paranoia, delusional, accusatory, towards staff makes fallacious statements. Interventions directed to administer medications as ordered, allow time to deescalate and reapproach if agitated, explain procedures prior to the initiation of a task. Review of PASRR screenings for Resident #100 identified a Level I screen was completed on [DATE], with an outcome to Refer for Level II onsite. The PASRR level I identified short term approval without specialized services with an end date of [DATE]. Review of the clinical record identified that a level II screen was completed on [DATE] (seven months later than the approved time for the resident to be in the facility). Interview with Social Worker #1 on [DATE] at 11:24 AM identified she should have submitted Resident #100 for a screening following the short-term approval ending on [DATE]. Social Worker #1 realized that she should have submitted Resident #100 for a Level II screen at the time of Resident #100's approval to reside in the nursing facility expired. Review of facility policy titled Pre-Admission Screen Annual Resident Review updated ,d+[DATE] directed PASARR to be completed by a Social Worker if not completed prior to admission. If the resident is admitted with a short term PASARR or time sensitive PASARR social worker will complete a new level screen and level of care if necessary. For each patient/resident requiring a Level II assessment a completed PASARR and mental illness intake form must be completed.

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	075153	A. Building B. Wing	07/30/2024

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46117 Based on observations, review of clinical records, review of facility policy, and interviews for two of two sampled residents (Resident #23 & #45) reviewed for accidents and splints/medical equipment, the facility failed to develop and implement a comprehensive care plan following an incident of unauthorized smoking in the facility and for the use of an Aspen neck collar (a neck brace that limits movement of the neck) and an implanted loop recorder (a small device that monitor heart's electrical activity that is inserted under the chest skin). The findings include: 1. Resident #23's diagnoses include chronic obstructive pulmonary disease, dementia, and psychotic disorder with delusions. The quarterly MDS assessment dated [DATE] identified Resident #23 had intact cognition, utilized a walker and wheelchair for mobility, was independent for eating, utilized set up or clean up assistance with oral hygiene and toileting, and required supervision for dressing and personal care. Resident #23's care plan dated 5/20/24 identified an ADL (activities of daily living) self-care performance deficit and utilized limited assistance with a rolling walker on the unit, requires assistance for bathing/showering, personal hygiene and oral care. The nursing note dated 7/20/24 at 2:53 PM written by RN #2 (Nursing Supervisor) identified Resident #23 was found smoking in his/her room with his/her spouse in the room. The resident was educated on the smoking policy and the danger of smoking in the room, a room search was conducted with no cigarettes and lighting materials found. The note further identified that the resident's spouse was instructed to not bring smoking supplies into the facility. Additionally, the APRN was contacted, and a new order was obtained for a Nicotine patch. Review of Resident #23's care plan dated 5/20/24 failed to reflect that it was updated and/or revised following the incident of unauthorized smoking in the facility. Interview with RN#2 was attempted on 7/24/24 at 1:01 PM and on 7/25/24 at 9:18 AM, message left both times with no return call received. Interview with NA #5 on 7/25/24 at 9:46 AM identified she smelled smoke near Resident #23's room and knew that the next-door neighbor was on Oxygen, so she went into Resident #23's room and found Resident #23 in the bathroom flushing what she believed to be a cigarette down the toilet. The smell of the cigarette was stronger in the bathroom. NA #5 asked Resident #23 where he/she obtained the cigarette from and was told his/her spouse. At that time Resident 23's spouse was not in the room, however had been previously prior to the incident. NA#5 further identified that she notified the charge nurse on the unit, who in turn notified the nursing supervisor. Interview on 7/25/24 at 11:22 AM with the Director of Nursing (DON) identified the care plan had not been updated following the incident on 7/20/24 and she had not had time to update the care plan regarding this incident. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Social Worker #1 on 7/25/24 at 11:40 AM identified that the care plan had not been updated but Social Worker #1 identified it probably should have and that she could go in and update it. Social Worker #1 identified that she, the Nurse Supervisor, or DON could update the care plan, however she had been so busy she hadn't done it yet. APRN #2's (psychiatric aprn) psychosocial note dated 7/22/24 indicated Resident #23 was childlike in presentation and once he/she had a drag he/she could not stop. APRN #2 identified Resident #23 had little to no executive decision-making capabilities and does not or is unable to focus on the consequences of his/her actions. Review of the Care Planning policy reviewed April 2024, directed the facilities Care Planning/Interdisciplinary team responsible for the development of an individualized comprehensive care plan for each resident. 2. Resident #45 's diagnoses included fracture of sixth cervical vertebrae, type 2 diabetes mellitus, dementia, chronic kidney disease, and syncope and collapse. The physician's progress note dated 5/29/24 at 2:20 PM identified Resident #45 was admitted to the facility for short term rehabilitation on 5/28/24 related to a unwitnessed fall with loss of consciousness. The note further identified Resident #45 had a fracture to the 6th cervical vertebrae requiring the use of an Aspen hard neck collar. The admission MDS assessment dated [DATE] identified Resident #45 had a moderate cognitive impairment and required extensive assistance for bed mobility, hygiene, toileting, transfer, non-ambulatory and utilized a wheelchair for mobility. The Resident Care Plan (RCP) dated 6/17/24 failed to identify interventions related to the use of the Aspen neck collar. The physician's consultation notes dated 6/21/24 identified Resident #45 went for follow-up consultation related to the placement of a cardiac loop recorder for syncope. The consult identified Resident #45's incision site was clean and steri-strips (a thin sicky bandage that is used to help small cuts and wounds close) was applied. Further, the notes instructed to not remove the steri-strips and allow them to fall off on their own. Additionally, the note directed to not submerge the incision site, allow showers, monitor for signs and symptoms of infection including but not limited to redness, bleeding, exudate, escalating pain and fever, and to place an abdominal binder for orthostatic hypotension. Review of the RCP dated 6/10/24 failed to reflect the implementation of interventions to direct the care that was necessary for the surgical chest incision. Review of nursing notes from 6/21/24 to 7/24/24 failed to reflect that the left chest surgical incision was monitored for signs and symptoms of infection. Observation on 7/23/24 at 9:43 AM identified Resident #45 in his/her room, sitting in a wheelchair with a hard collar to his/her neck. (continued on next page)

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	075153	A. Building B. Wing	07/30/2024

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LPN #3 on 7/25/24 at 11:00 AM identified Resident #45 was using an Aspen neck collar related to his/her cervical fracture and had an implantable loop recorder to the left chest because of cardiac problems. She also identified there would be a care plan related to the use of the Aspen neck collar and for the monitoring of the surgical incision to the left chest for the loop recorder. She further identified Resident #45 had gone to the cardiologist for a follow-up visit on 6/21/24 related to the implanted loop recorder and returned with instructions to monitor and for care of the left chest incision. Additionally, LPN #3 identified the charge nurses are responsible for ensuring that orders from a consultation are added to the RCP; however, she could not identify why the RCP did not address the use of the Aspen neck collar and the monitoring/care of the surgical incision. She further noted that she thought there was a physician's order related to the Aspen neck collar and monitoring of the surgical incision for the implant loop recorder. Interview and review of the physician's consultation with the DNS on 7/25/24 at 11:30 AM identified that it is an interdisciplinary approach between all departments to ensure that individualized comprehensive care plans are developed for each resident. She identified Resident #45 utilized an Aspen neck collar related to his/her cervical fracture and she would expect the RCP to address the use of the Aspen neck collar. She identified that the cardiologist had specific information on how to monitor the surgical chest incision that should have been added to the RCP. Although, she could not state a reason for why the RCP was not developed, she expected to have a care plan created for the use of Aspen neck collar and the implanted loop recorder. The Care Planning Interdisciplinary Team policy identified that the interdisciplinary team is responsible for the development of an individualized comprehensive care plan for each resident. 47402

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	075153	A. Building B. Wing	07/30/2024

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46117 Based on clinical record reviews, facility policy review, and interviews for one sampled resident (Resident #28) reviewed for dental services and for one sampled resident (Resident #45) with a surgical incision, the facility failed to follow dental orders as a prerequisite for a tooth extraction, and failed to administer the prescribed treatment to the left chest in accordance with the physician's order, The findings include: 1. Resident #28 was admitted to the facility on [DATE]. Diagnoses included dysphagia, oropharyngeal phase, cellulitis of face, unspecified protein-calorie nutrition, other psychoactive substance dependence, in remission, and other specified anxiety disorders. The speech screen dated 1/19/2021 identified the resident had a mechanically altered diet related to complaints of difficulty or pain when swallowing and the summary identified the resident had a mechanically altered diet, and a swallowing disorder. A recommendation was made for a swallow evaluation. Review of the Speech Therapy treatment encounter notes dated 1/30/2021 and 2/5/2021 identified Resident #28 was not happy with the modified diet and was able to successfully chew, swallow and had adequate oral clearance, at which time the diet was upgraded. The Dentist's note dated 2/23/24 identified Xray results indicated that root tip for tooth #21 needed to be extracted and would be done at the facility. Action required by nursing home staff identified the resident was to continue daily oral care and treatment planned for extraction at the facility with orders to administer Ativan 1mg one hour prior to procedure for anxiety and discontinue aspirin two days prior to procedure date. The procedure was scheduled for 3/22/24. Review of the Dentist's note dated 3/22/24 identified that the facility had not prepared the resident for the scheduled procedure as ordered, the aspirin had not been discontinued, and there was not an order in place for Ativan as requested for sedation. The note further identified another appointment was set for 5/1/24 The Dentist's note dated 5/30/2024 identified the extraction of root tip #21 had not been completed due to the facility not discontinuing the aspirin as previously ordered. Review of physician's orders for June and July 2024 identified an order for Aspirin 81 mg with directions to give 1 table by mouth at bedtime related to cachexia. The Physician's orders did not contain orders to hold the Aspirin and failed to identify an order for Ativan. Review of the Medication Administration Records for the months of June and July 2024 identified the resident received Aspirin 81 mg every day. Review of a signed paper pharmacy prescription dated 6/6/2024 identified an order for Ativan 1mg by mouth one hour prior to extraction on 6/17/2024, the order was signed by the provider and acknowledged by the nurse. (continued on next page)

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	075153	A. Building B. Wing	07/30/2024

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Annual Minimum Data Set (MDS) dated [DATE] identified Resident #28 had intact cognition, was independent with all mobility, transfers, ambulation, dressing, and hygiene, and that the resident's oral/dental status indicated the resident did not have any concerns with dental and was not edentulous. Review of the nursing progress notes dated 6/18/24 at 2:42 PM written by RN #2 (nursing supervisor) identified the facility was notified that the tooth extraction will be on June 24th and the dentist will be at the facility by 9:00 AM. Review of the nursing progress notes dated 6/24/24 at 4:18 PM identified the resident was supposed to have a tooth extraction but was unable to do so due to aspirin was not held for 3 days. The Dentist's note dated 6/24/24 identified that the extraction of tooth #21 was again not completed because the aspirin had not been held two days prior to the scheduled procedure. The note further noted that the extraction was necessary for the fabrication of dentures. The care plan dated 5/7/2024 identified Resident #28 had potential for oral health problems related to edentulous and does not wear dentures with goals to be free of infection, pain or bleeding in the oral cavity and be able to chew food without discomfort. Interventions included to monitor/document/report PRN any signs or symptoms of oral/dental problems needing attention, provide mouth care as per ADL personal hygiene and refer to dietician for adjustment in diet related to oral/dental condition but failed to identify the resident's ongoing work with the dentist in being fitted for dentures. Interview with Resident #28 on 7/22/24 at 11:48 AM identified he/she had no teeth and needed dentures. Resident #28 indicated that the dental appointments had been cancelled several times and the resident had not been fitted for dentures that the dentist indicated would happen in February 2024. Resident #28 identified there is some difficulty with foods, but the resident knows what to stay away from. Interview and chart review with LPN #2 on 7/24/24 at 11:00 AM identified that when the facility received new orders from a provider, the orders go into the 24-hour report and the medication is entered on the MAR. The nurses are able to go into the MAR and hold the medication for whatever dates it should be held. The doctors or consultants leave the paper flagged and whoever is working is responsible to take the order and follow through. Review of the dental notes (in the paper chart) dated 2/23/24 identified the dentist ordered Ativan and to stop the aspirin two days prior to the next scheduled treatment. LPN #2 identified the order did not seem like it was done and referred this writer to the nursing supervisor who handles the dental visits. Interview with the Nursing Supervisor (RN#2) on 7/24/24 at 11:25 AM identified the nurses input the medications in the computer when directed by the doctor's note. Based on her recollection, she indicated the dentist only cancelled the June appt and had to reschedule. The resident is scheduled for [DATE]th for the extraction. RN#2 stated she had surgery 1/29/24 and was out for approximately 6 weeks. She is not sure who was covering for her at the time. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the DNS on 7/24/24 at 11:42 AM identified that RN #2 was out of work from 1/31/24 through 4/1/24 and noted that the other two nursing supervisors were responsible for managing the consult orders during that time. The DNS identified that all consultation correspondence goes through her, and that she is responsible for making sure the recommendations are followed through. She stated that the resident refused the dental care, however, was unable to provide documentation that the resident refused. Review of the dental notes identified the facility did not follow through on the recommendations/orders from the dentist on three different occasions. The nursing note dated 7/24/2024 at 2:29 PM identified an appointment for the tooth extraction scheduled for August 5th at 9:00 AM. Review of Physician's orders dated 7/24/24 identified an order to hold ASA 81mg 3 days before dental procedure with specific dates of 8/2/24 through 8/5/2024 and resume after procedure. Order was added by the nursing supervisor. Review of the facility dental policy identified the resident was able to be seen by the facility's consultant dentist, records of dental care provided shall be made part of the resident's medical record, and a resident needing dental services will be promptly referred to the dentist. 2. Resident #45 's diagnoses included fracture of sixth cervical vertebrae, type 2 diabetes mellitus, dementia, chronic kidney disease, and syncope and collapse. The admission MDS assessment dated [DATE] identified Resident #45 had moderate cognitive impairment and required extensive assistance for bed mobility, hygiene, toileting, and transfers, was non-ambulatory and utilized a wheelchair for mobility. The Resident Care Plan (RCP) dated 6/17/24 identified Resident #45 with syncope and collapse. Care plan interventions directed to monitor resident for side effects of medication, medications as physician's orders, provide a safe environment, and update physician and family for resident condition as needed. The physician's order dated 6/27/24 directed to cleanse a small medial blister and apply 1 percent sulfadiazine cream (topical anti-bacterial medication) to the left chest twice per day. Review of the Treatment Administration Record (TAR) from 6/27/24 to 7/24/24 failed to identify that the 1 percent sulfadiazine cream was administered as directed by the physician. Interview with LPN #3 on 7/25/24 at 11:00 AM identified that the charge nurses are responsible for ensuring physician's orders are transcribed and administered properly. Review of the physician's orders dated 6/27/24 with LPN #3 identified the treatment order directing the administering of 1 percent sulfadiazine cream to the left chest twice per day to surgical incision. Further review of the medication record and the treatment administration record from 6/27/24 to 7/24/24 failed to reflect that the order was transcribed or administered as ordered. Interview with the DNS on 7/25/24 at 11:30 AM identified that she expects all of the licensed staff to follow the physician's orders. She identified that the 1 percent sulfadiazine cream should have been administered to the resident in accordance with the physician's order. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Physician Medication Orders policy identified that all medications would be administered upon the written order of a person duly licensed and authorized to prescribe in this state. 47489

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47489 Based on observations, review of the clinical record, review of facility policy and interviews for one sampled resident (Resident #1) or who utilized splints, the facility failed to ensure the resident had splints in place daily as outlined in the physician's orders. The findings include: Resident #1's diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, legal blindness, rheumatoid arthritis, and vascular dementia. The Occupational Therapy Evaluation dated 4/1/2024 identified the upper extremity assessment was not tested due to contracture. The evaluation did not contain a rating that identified the degree/severity of the contracture. The MD/APRN progress note dated 6/19/2024 identified Resident #1 was evaluated by Occupational Therapy and identified physical exam findings of right hand in splint due to spasticity, Left hand with carrot. Strength was documented for bilateral upper extremities. The quarterly MDS assessment dated [DATE] identified Resident #1 had moderately impaired cognition, an upper and lower extremity impairment on one side, was dependent for all position changes, oral hygiene, toile [NAME], showering, dressing and personal hygiene. The care plan dated 6/27/2024 identified Resident #1 required assistance with ADL task performance related to left hemiplegia with interventions that included: soft collar on when out of bed, left resting hand orthotic on in the AM and off in the PM, right resting hand orthotic and left elbow extension orthotic on in the PM and off in the AM, perform skin checks when donning/doffing (putting on/taking off) the splints, wear as tolerated. Additionally, the care plan identified Resident #1 refuses to wear the soft collar at times. The Physician's orders for June and July 2024 identified Resident #1 had orders for a left elbow splint, right resting hand splint, left carrot, cervical collar on with AM care off with PM care as tolerated. Check skin and report breakdown or irritation with donning/doffing. Observation on 7/23/24 at 11:42 AM identified Resident #1 seated in a custom wheelchair in his/her room with a soft collar in place to the resident's neck. The left arm/hand appeared contracted and did not have a splint in place. The right arm/hand also appeared contracted and did not have a splint in place. Interview with Resident #1 at the time of the observation indicated there were splints that were not in place, and due to a visual deficit, the resident was not able to identify where in the room they might be. Resident #1 identified both hand splints and the elbow splint were not placed with morning care for a while and was unable to identify why they were not placed. Further, Resident #1 noted that he/she had not asked for the splints to be placed but had not refused to wear the splints. (continued on next page)

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	075153	A. Building B. Wing	07/30/2024

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 7/24/24 at 10:40 AM identified Resident #1 seated in a custom wheelchair with the soft collar in place. The left arm/hand appeared contracted, and the resident lifts the arm intermittently to an upright position (like raising the hand) with the hand toward the ear, and the elbow contracted. The right hand/arm is also contracted and was resting in the resident's lap. There are no splints in place on either of the upper extremities. The resident indicated the splints were not placed with AM care, and he/she identified that he/she had not asked for the splints to be placed. Observation on 7/25/24 at 9:31 AM identified Resident #1 being transferred out of bed and into the wheelchair. Subsequent observation on 7/25/24 at 11:00 AM identified Resident #1 in the custom wheelchair with the soft collar in place on the neck and a hand splint in place on the right hand. There was no elbow splint on the left elbow and there was not a hand splint on the left hand. Interview with the resident identified he/she had not had the splints in place for a while and that the right-hand splint was placed today, and the resident was not sure why it was the only one on. Resident #1 identified that if the neck splint was forgotten, he/she would complain about not having that due to the neck pain if the collar is not in place. Resident #1 also identified the left hand does hurt at times and indicated the fingernail pushed into the skin at times. Observation of the left hand identified there are no areas of redness or skin breakdown noted. Interview with LPN#1 on 7/25/24 at 11:09 AM identified NA#1 got the resident cleaned and out of bed this am, and she would expect the splints were placed at that time. However, both nursing and NAs are responsible for ensuring the splints are placed. Observation of the resident's room with LPN #1 identified she was not able to locate the elbow splint nor the left-hand splint (carrot). Interview with the Therapy Director on 7/25/24 at 11:41 AM identified resident therapy assessments are done quarterly for residents who required splinting or were on therapy service. He identified the expectation for the staff (nurses and NAs) are to do what they are supposed to do as outlined by orders or the plan of care. Interview with NA #1 on 7/25/24 at 12:07 PM identified that she sometimes places the hand splint on but sometimes none of the splints. When asked why the splints weren't placed, NA #1 shrugged. Subsequent to surveyor inquiry NA #1 went into the room, located the elbow splint, and placed the elbow splint on the resident. Interview with the DNS on 7/25/24 at 11:33 AM identified the splinting was on the task list for all the residents and that there should be a splint device task in the electronic health record (EHR). There is a plan of care that is printed and kept in the resident's room that outlines the splinting required for that particular resident. Observation and interview with Resident #1 on 7/29/24 at 10:29 AM identified resident in room seated in custom wheelchair, clean and dressed with soft neck collar, left elbow splint, right hand splint, and left-hand carrot splint in place. Resident #1 identified I'm trying to get used to these splints and laughed. Resident denied pain but stated her left arm and hand were a little sore. This Surveyor requested OT reevaluate as splints haven't been used in a while to assess worsening contracture. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Occupational Therapy Evaluation dated 7/29/2024 identified the upper extremity flexion and extension measured in degrees. Although requested, the facility did not provide a comparable assessment where degrees of contracture could be compared to identify worsened or improved conditions. Interview with OT #1 on 7/30/24 at 11:03 AM identified Resident #1 was re-evaluated the previous day and identified there was a 10 degree change in the elbow splint positioning indicating it was not a change in contracture but a change to the resident's comfort level of the splint. The OT identified the contractures were measured in three different positions and the splints were placed based on the passive range of motion. Review of the facility policy for Use of Orthotics for Contracture Management identified general guidelines that splints should be removed every two hours, the skin inspected and then the splint re-applied per wearing schedule. Wearing schedules were identified as individualized with the wearing tolerance determined by patient/skin tolerance, noted to be as short as one hour to as long as eight hours. The policy indicated that staff notify rehab if any splints were lost or missing to reduce the risk of further contractures.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47402 Based on clinical record review, review of facility documents, review of facility policy, and interviews for one sampled resident (Resident #23) reviewed for accidents, the facility failed to provide adequate supervision to prevent the resident from smoking in his/her room. The findings include: Resident #23's diagnoses include chronic obstructive pulmonary disease, Dementia without behavioral disturbances and psychotic disorder with delusions. The quarterly MDS assessment dated [DATE] identified Resident #23 had intact cognition, utilized a walker and wheelchair for mobility, was independent for eating, utilized set up or clean up assistance with oral hygiene and toileting, and needed supervision for dressing and personal care. Resident #23's care plan dated 5/20/24 identified the resident had an ADL self-care performance deficit and utilized limited assistance with a rolling walker on the unit, the resident requires assistance by staff for bathing/showering and requires assistance by staff with personal hygiene and oral care. The Nursing Supervisor's (RN #2) note dated 7/20/24 at 2:53 PM identified Resident #23 was found smoking in his/her room, spouse at bedside, and was educated on the smoking policy and danger of smoking in room, room was searched and no supplies were found, supplies were previously given back to spouse. Request given to spouse to not bring smoking supplies to resident. APRN contacted and new order for nicotine patch obtained. Interview with NA #5 on 7/25/24 at 9:46 AM identified she smelled smoke near Resident #23's room and knew that the next-door neighbor was on Oxygen, so she went into Resident #23's room and found Resident #23 in the bathroom flushing what she believed to be a cigarette down the toilet. The smell of the cigarette was stronger in the bathroom. NA #5 asked Resident #23 where he/she obtained the cigarette from and was told his/her spouse. At this time Resident 23's spouse was not in the room, however had been previously prior to the incident there for lunch. NA#5 indicated Resident #23 was a previous smoker. Interview with the Admission's Director on 7/25/24 at 10:10 AM identified upon admission residents are notified of their policies to include the no smoking policy during the admissions agreement process, however, could not locate the signed agreement for Resident #23 who was conserved. The Admissions Director indicated that she was originally admitted in 2020 and the agreement would have been signed at that time. Even though a discharge occurred on 3/11/21 return not anticipated, and the resident returned on 6/26/23 a new agreement would not have been signed because she knew Resident#23 was a previous resident and should have had those documents signed already. The admissions director indicated that she would only sign these documents with new admissions who have never been at the facility before. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Medical Records on 7/29/24 at 10:40 AM indicated that medical records are kept for ten years for all patients and that years ago medical records were sent out to a central location, however now they keep them and that she has been working there since 2019 and since then they are kept in the building. She had already pulled Resident #23's information and looked for the signed admission paperwork from the facility and could not locate it and was not sure why it could not be located. Interview on 7/25/24 at 11:22 AM with the Director of Nursing (DON) identified that residents out of the facility for greater than 30 days would typically be new admissions into the facility, and she believed should have new facility admission paperwork signed. A resident such as Resident #23 who had been out of the facility discharged return not anticipated and gone for the two-year period would be a new admission. The DON also identified that she was still working on the Accident and Incident (A&I) report for the incident that occurred on 7/20/24 as she had been too busy to complete it, and although her and the social worker had just talked about what could be done nothing formally had been implemented. The DON had not had time to update the care plan either for this resident regarding this incident. Interview with Social Worker #1 on 7/25/24 at 11:40 AM identified that she and the DON spoke that morning about potential plans for the visit, however had not implemented anything formally. She said she had met with Resident #23 and their spouse separately about the dangers of the situation of smoking both medically and physically in the building. When asked to produce documentation of these conversations Social Worker #1 could not provide any documentation regarding these conversations. Social Worker #1 indicated that she must have not documented it and it must down on scratch paper. When a request for the scratch paper was requested documenting these conversations none could be located by Social Worker #1. Social Worker #1 identified that she told the spouse that he/she should see her first before visiting to ensure no smoking materials were brought to the resident however realized she was not always there when the spouse came. The care plan had not been updated but Social Worker #1 identified it probably should have and that she could go in and update it. Review of the A&I report on 7/25/24 provided by the DON dated 7/22/24 failed to include family notification or whether there was an investigation initiated into the incident. Disposition/comments included new order for nicotine patch, attached to the incident report was the nurses note from RN#1 from the original 7/20/24 incident. Review of Psychosocial note dated 7/22/24 from APRN #2 indicated Resident #23 was childlike in presentation and indicated once he/she had a drag he/she could not stop. Psych APRN #2 identified Resident #23 has little to no executive decision-making capabilities. Does not or is unable to focus on the consequences of his/her actions. On 7/25/24 at 2:04 PM a meeting was conducted with the DON and Regional Director of nursing from the facility in conjunction with DPH surveyors as well as DPH Supervisor to request a written plan be put into place to ensure the residents of the facilities safety. On 7/25/24 at 3:37 PM a written plan was received/approved by DPH supervisor. Interview with Resident #23 on 7/29/24 at 9:10 AM identified he/she was caught smoking in the bathroom and that he/she obtained the cigarettes and lighter from his/her spouses jacket pocket. Resident #23 identified the aide smelled the smoke and came in and that he/she had a craving for it and that he/she used to smoke but hadn't smoked in a long time. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Person #2 on 7/29/24 at 9:28 AM identified he/she did not see Resident #23 take the smoking materials but that they were located in his/her coat pocket. Person #1 was upset with Resident #23 for doing this because he/she did not want to jeopardize their visits or Resident #23's ability to live in the facility. Review of the facility Reportable Events Investigating and Reporting policy reviewed April 2024, identified all accidents or incidents involving residents, employees, visitors, vendors, etc. occurring on our premises shall be investigated and reported to the Administrator. The Nurse Supervisor/Charge nurse and/or the department director of supervisor shall promptly initiate and document investigation of the accident or incident. The Nurse Supervisor/Charge nurse and/or the department director or supervisor shall complete a Reportable Event form and submit the original to the Director of Nursing Services within 24 hours of the incident or accident. Review of the facility Smoking Policy- Residents reviewed April 2024, identified prior to, or upon admission, residents shall be informed that we are a smoke free policy. Smoking restrictions shall be strictly enforced. Staff/residents are not allowed to smoke within the facility or on the grounds. Review of the facility Location and Storage of Medical Records reviewed April 2024 identified the facility shall protect and safeguard its medical records. Closed and or thinned medical records will be stored in a locked room and protected from fire, water damage, insects and theft. Medical records may be scanned into Point Click Care (PCC) for long term retention. Records will be maintained for a minimum of [AGE] years.

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F 0730 Level of Harm - Potential for minimal harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 46117 Based on facility documentation review and staff interviews for Three of Three Nurse Aides (NA #2 and NA #3, and NA#4), the facility failed to complete an annual performance evaluations. The findings include: Review of NA #2 personnel file identified a hire date of 7/24/2006 and failed to identify that a yearly performance evaluation was completed for 2023. Review of NA #3 personnel file identified a hire date of 4/29/2002 and failed to identify that a yearly performance evaluation was completed for 2023. Review of NA #4 personnel file identified a hire date of 12/7/2021 and failed to identify that a yearly performance evaluation was completed for 2023. Interview with DNS on 7/30/24 at 9:35 AM identified that each employee should have a performance review completed on their anniversary date and she was responsible for ensuring that the employee annual performance reviews were completed. She further identified that there was no annual performance review completed for NA #2, NA #3, and NA #4 for 2023. Review of facility Annual Employee Evaluations policy identified all employees would be subject to a written annual review by the department supervisor on their anniversary date.

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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** 47900 Based on review of the clinical record, review of facility documentation, review of facility policies/procedures and interviews for one of three sampled residents (Resident #32), reviewed for transmission-based precaution (TBP) the facility failed to implement the appropriate transmission-based precaution for a resident actively infected with a multi-drug resistant organism (MDRO). The findings include: Resident #32's diagnoses included lymphedema, sepsis, Methicillin Resistant Staphylococcus Aureus (MRSA) infection and schizoaffective disorder. The quarterly MDS assessment dated [DATE] identified Resident #32 had intact cognition, required moderate assistance with transfers and toileting, independent with bed mobility and personal hygiene, ambulatory with the utilization of a walker and a wheelchair. The assessment further identified Resident #32 active diagnoses in the last 7 days included MDRO, and wound infection. The care plan dated 2/20/24 identified Resident #32 had enhanced barrier precaution related to left extremity wound with interventions that included to utilize gloves, and gown following proper donning and doffing when providing high contact activities. The care plan further identified Resident #32 was resistive and non-compliant with care related to refusing dressing changes and wound treatment with interventions that included accept resident's right to refuse, leave and return 5 to 10 minutes later to try again. Review of Resident #32's clinical records identified laboratory testing of a wound culture collected on 4/5/24 with a reported result dated 4/9/24 identified heavy growth of pseudomonas aeruginous, and moderate growth of MRSA. The physician's order dated 4/10/24 directed Vancomycin 1 gram every 12 hours intravenous for left leg wound infection and Cefepime 2 gram every 8 hours intravenous for left leg wound. The physician's order for the month of April 2024 also directed enhance barrier precautions (EBP) due to lower extremity wound and cleans both lower extremity wounds with normal saline, apply Medihoney (wound healing and debridement) to wound bed followed by non-adhesive dressing abdominal pad wrap with a kerlix from foot to knee daily and as needed related to MRSA. The physician's orders for the month of April 2024 failed to identify that Resident #32 was directed to be placed on contact precautions. Review of the facility's infection control active MDRO tracking sheet for the month of April 2024 identified Resident #32 had signs and symptoms of wound drainage, site of infection was a wound, positive culture for MRSA dated 4/9/24, treated with intravenous antibiotics, and isolation type for Resident #32 identified enhanced barrier precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the Centers for Disease Control and Prevention (CDC) Appendix A which provides the type and duration of precautions recommended for selected infections and conditions recommendations for MDRO such as MRSA required contact and standard precautions. CDC further recommends that contact precautions should be used for all residents infected or colonized with a MDRO in situations such as the presence of acute diarrhea, draining wounds or other sites of secretions or excretions that are unable to be covered or contained, and gloves and gown are required to be don and worn before entering the resident's room. In addition, CDC recommends the utilization of Enhanced Barrier Precautions when infection or colonization with an MDRO when contact precautions do not otherwise apply, and gown and gloves are to be don and worn prior to high contact care activities such as dressing, providing hygiene, transferring, bathing/showering, wound care and toileting hygiene. Review of the facility weekly wound tracking documentation sheet dated 4/9/24 identified left medial calf and left lateral calf had heavy blue/green serous drainage. Also, the left inferior ankle had heavy blue/green drainage. The nurse's note dated 4/10/24 at 10:32 AM written by the ADNS (RN #4) identified the treatment nurse reported increase drainage from the left leg wounds and a call place to APRN to update. The nurse's note dated 4/11/24 at 3:01 PM written by Charge Nurse (LPN #5) identified that Resident #32 dressing changed to left lower leg wound had copious amount of greenish drainage noted and resident was encouraged to elevate leg. The Nurse's note dated 4/23/24 at 12:36 PM written by RN #4 identified heavy serious drainage noted on old dressing. Wound progress note dated 4/23/24 written by Wound Physician MD #2 identified that Resident #32 continues to be aggressive during treatments, actively slapping examiner hands and putting his/her own hands into the wound beds. Interview with the Infection Preventionist (RN #3) on 7/25/24 at 10:57 AM identified that Resident #32 was positive for MRSA in the month of April 2024 where the resident was treated with intravenous antibiotic. RN #3 added that during this period active infection Resident #32 remained on enhance barrier precautions and not contact precautions. RN #3 identified that she kept Resident #32 on enhance barrier precaution as the resident's wound drainage was contained and she had not received any reports from the wound nurses or the charge nurse that Resident #32's wound drainage could not be contained or was the resident having large amounts of drainage from the wound. Interview with the DNS on 7/25/24 at 1:20 PM identified that if a resident was actively being treated for MRSA, he/she should be placed on contact precautions as it changes the mindset of the staff. The DNS further identified that Resident #32 should not have remained on EBP, and it was the responsibility of the Infection Preventionist nurse to review and make the decision as to the type of transmission-based precaution a resident should be placed on. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the LPN #5 on 7/25/24 at 1:55 PM identified whether Resident #32 had any infection in April 2024 in which she identified that he/she had MRSA and cellulitis and was treated with intravenous antibiotics. LPN#5 was asked if Resident #32 was placed on contact precautions in April 2024 in which she stated she had to review the records. After LPN #5 review the clinical records, she responded that she was unable to identify that the resident was ever on contact precaution but rather was on EBP precautions. LPN #5 further identified that Resident #32's dressing was required to be changed daily. LPN #5 was asked to explain her note written on 4/11/24 as it relates to copious amount of drainage in which LPN #5 identified that the old dressing removed was saturated during the dressing change and she had placed a padding underneath to protect the bed during dressing change. She further identified that if Resident #32 required extra dressing change, he/she might not had allowed the nurse to perform the treatment as often times it would depend on the resident's mood at the time. LPN #5 was asked if there was a difference between contact precautions and EBP, in which she indicated yes as contact precautions is used for active infection wherein personal protective equipment (PPE) to worn when entering the room while EBP precautions is use for residents with wounds, gastrostomy tube, and foley tubes, and required the use of PPE when providing direct care activities. Interview with NA #6 and NA#7 on 7/25/24 at 2:20 PM identified was asked if they recalled Resident #32 ever being placed on contact precaution in the month of April 2024, wherein they identified that they could not recall Resident #32 was ever on contact precautions and that he/she has only on EBP. NA #7 and NA #8 asked if there was a difference between contact precautions and EBP in which they both responded that there is a difference as contact precautions required you to put on your PPE before entering the room while EBP required donning PPE only when we are about to do care any direct care with the resident. Interview with the RN #3 on 7/29/24 at 12:40 PM identified when asked if she had reviewed the nurse's notes dated 4/11/24 would she had place Resident #32 on contact precautions and she responded absolutely. RN #3 was also asked if Resident #32 had a history of weeping legs and often refuses or was compliant with dressing changes in which she indicated that Resident #32 had weeping legs and does refuse wound treatment at times. RN #3 also indicated that she was responsible for selecting the appropriate TBP for residents. Review of the Multidrug-Resistant Organisms policy and procedure identified that appropriate precautions will be taken when caring for individuals with known or suspected infection with a MDRO. The policy further identified that infection means that the organism is present and is causing illness and colonization means the organism is present in or on the body but not causing illness. The policy adds that the infection control committee may implement or consider the following to determine if contact precautions are need when individual's ability to contain the infected or colonized body fluids or site, keeping hands away from the infected or colonized areas, draining wounds, and behaviors that may increase the risk of transmission may indicate the need for contact precautions. Review of the Contact Precautions policy identified contact precautions are intended to prevent the transmission of infectious agents, like MDRO's that are spread by direct or indirect contact with the resident or resident's environment.