STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075153	A. BUILDING _____ B. WING _____	08/01/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0585 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.** **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 resident (Resident #1) reviewed for grievances, the facility failed to ensure a concern reported by the resident representative was documented, and included steps taken to investigate the grievance, a summary of corrective actions, or written response. The findings include: Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The quarterly MDS dated [DATE] identified Resident #1 had severely impaired cognition, required extensive assistance with transfers, and was independent with locomotion with the use of a wheelchair. Review of a Reportable Event Form dated 6/18/20 identified Resident #1's representative (Person #1) reported that during an outside visit, there was a marked change in the appearance of the resident's eyebrows, in that they were shaved off and penciled in. Resident #1 was unable to tell Person #1 what had happened due to impaired cognition and staff were unable to say what had happened. Staff indicated they were trying to make Resident #1 look nice. Person #1 emailed the facility supervisor and included a picture with a request for resolution that would include disciplinary action. The care plan dated 7/10/20 identified Resident #1 had impaired though process related to dementia with interventions that included asking yes or no questions to determine the residents needs and communicate with the resident/family/care givers regarding residents' capabilities. Review of Nursing Progress Notes dated 7/16/20 through 7/22/20 failed to reflect information regarding the concern by Person #1 about the resident's eyebrows or any follow up to the reported event. Review of Social Worker Progress notes dated 7/14/20 through 7/20/20 failed to reflect information regarding the concern by Person #1 about the resident's eyebrows or any follow up to the reported event. Interview with Person #1 on 8/1/20 at 8:09 AM identified it may have been possible that Resident #1 had attempted to shave his/her own eyebrows but thought the resident may have cut him/herself in doing so. Person #1 indicated there was also a concern with missing items following discharge. While Person #1 reported having emailed the Administrator and Social Worker on a few occasions regarding the missing items, there had been no follow up. Interview and review of electronic communication with the Administrator on 8/1/20 at 9:54 AM identified he received an email from Person #1 on 7/19/20 informing him/her of the incident regarding the resident's eyebrows and received additional details from the DNS. The Administrator indicated he/she was involved with other responsibilities that limited access to emails and indicated he/she spoke to Person #1 on 7/22/20. The Administrator apologized and assured Person #1 that the matter was being investigated by the DNS. The Administrator indicated any shaving of the eyebrows would be considered more of a beauty routine and not part of ADL care and questioned if Resident #1 was able to shave his/her own eyebrows. The Administrator also indicated there were reports of missing items reported by Person #1 on 7/23/20 at 8:18 AM and on 7/31/20 at 12:22 PM inquiring about Resident #1's missing laundry. The Administrator responded on 7/31/20 at 12:30 PM indicating an outside vendor washes the laundry and that the order was due back on Sunday (8/1/20) adding staff continue to look for the reported missing item(s). The Administrator indicated Resident #1 would be reimbursed if the items were not found. According to the Administrator, the facility social worker was also contacted on 7/20/20 with the same concern regarding the resident's shaved eyebrows and that nursing staff did not know how it happened. Interview with the DNS on 8/1/20 at 10:12 AM identified he/she was contacted by Person #1 who reported the incident regarding the resident's eyebrows. The DNS indicated one eyebrow was partially shaved and the other completely shaved. The DNS spoke with assigned staff from the previous three shifts and was unable to determine the root cause as all nursing staff denied having shaved Resident #1's eyebrows. Additionally, Resident #1 did mobilize independently on the unit, was cognitively impaired, and had a tendency towards hoarding items. However, the DNS was unable to find any razors in the resident's room, immediate area or shower room and not able to see where Resident #1 would have access to razors. The DNS indicated he/she followed up with Person #1 who stated he/she figured as much and was discharging Resident #1 the following day. The DNS also verbally spoke with staff to make sure consent was obtained as a matter of dignity. While the DNS did have written interviews with some of the staff, there was no documented nursing progress note, no documented investigation and no documented education pertaining to resident grooming and/or ensuring the security of sharps. Additionally, there was no written follow up to Person #1. Interview with Social Worker (SW) #1 on 8/1/20 at 10:50 AM identified he/she received an email from Person #1 on 7/20/20 reporting Resident #1's eyebrows had been shaved. SW #1 spoke with the nursing staff who said they did not know what happened and that the DNS was looking into the matter. SW #1 inquired to nursing if the matter should be looked at as a grievance and was informed by the DNS that it was a nursing matter. There also was no documented outcome regarding the matter. Review of the Grievance/Concern Policy identified encourage residents or concerned parties to report grievances/concerns to facility workers timely. The social worker /designee initiates a grievance form including the resident name, date and description of concern. The department head will address the concerns and complete the form with a resolution. The social worker is to maintain the form in the grievance log for reference.

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

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.