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 _____	**06/12/2020**

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 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** Based on a review of clinical records, review of facility documentation, and interviews for one of three residents (R #1) reviewed for accidents, the facility failed to ensure that the resident was kept safe during incontinent care which resulted in a fall from the bed. The finding include: Resident #1 was admitted to the facility on [DATE] for short term rehabilitation after a hospital stay with a positive result of Covid 19. Resident #1's [DIAGNOSES REDACTED]. The admission nursing note dated 6/2/20 identified that the resident was alert and oriented to person, place and time. Review of the nursing fall risk assessment dated [DATE] identified a score of 15, indicative of a low risk for falls. physician's orders [REDACTED]. Review of the Facility's Reportable Event dated 6/6/20 at 7:55 AM identified that Resident #1 had a fall from his/her bed to the floor during incontinent care. NA#1 was providing incontinent care and indicated that the resident was moving away from him/her while providing care due to the pain from the pressure ulcers and fell to the floor. RN#1 was notified and assessed the resident. Resident #1 had a good range of motion, vital signs were stable, and his/her [MEDICAL CONDITION] and PE[DEVICE] were intake. The resident complained of lower back pain. The APRN was contacted and instructed the facility to send the resident to the emergency room for evaluation due to his/her lower back pain. The resident did not sustain an injury from the fall. Interview with NA#1 on 6/12/20 at 10:30 AM identified that while /she was providing incontinent care to Resident #1 on 6/6/20, the resident was moving away from him/her because of pain from the Resident's multiple pressure sores. NA#1 identified s/he continued to provide care to the Resident and did not stop and notify the nurse of the Resident's pain. NA#1 further identified the Resident continued to scoot away from him/her while providing incontinent care due to the pain/discomfort and fell out of the bed to the floor. Interview with The Director of Nursing Services on 6/12/20 at 10:50 AM identified, NA# 1 should have stopped when the Resident was moving away from him/her while providing care and notified the nurse. The DNS further identified all staff are educated and instructed that if a resident is in pain/discomfort or agitated during care, the process is to stop and notify the nurse. The facility failed to ensure that the resident was kept safe during incontinent care which resulted in the resident falling from his/her bed.

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.