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	06/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 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 clinical record review, facility documentation review, facility policy review, and interviews for one sampled resident (Resident #1) reviewed for weight loss, the facility failed to ensure the clinical record was complete and accurate to include timely meal intake documentation. The findings include: Resident #1 had diagnoses that included Alzheimer's disease and anxiety. The Annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 was unable to complete the Brief Interview for Mental Status (BIMS), indicative of being severely cognitively impaired and required maximum assistance for eating. The Resident Care Plan (RCP) dated 6/23/25 identified Resident #1 had an ADL deficit related to Alzheimer's disease and tardive dyskinesia. Interventions directed to feed resident meals. Review of meal intake documentation for Resident #1 identified from 5/25 through 6/23/2025 the meal intakes identified the following: • Resident #1's breakfast was not documented on: 5/27, 5/31, 6/1, 6/10, 6/13, and 6/14/25. • Resident #1's lunch was not documented on: 5/27, 5/31, 6/1, 6/10, 6/13, and 6/14/25. • Resident #1's dinner was not documented on: 5/25, 5/30, 5/31, 6/1, 6/2, 6/5, 6/7, 6/10, 6/11, 6/13, 6/15, 6/19, and 6/21/25. Interview with Dietician #1 on 6/23/25 at 10:25 AM identified Resident #1 was at risk for weight loss, and her observations and reviews had identified Resident #1 was a good eater. Further, the Dietician #1 indicated the staff should document meal intakes accurately after each meal. (continued on next page)

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

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and record review with the DON (Director of Nursing) on 6/23/25 at 1:20 PM identified it was her expectation that the nursing staff document each meal intake in the electronic medical records to ensure accurate representation of each meal for a resident. interview failed to identify why the meal intakes were not documented. Review of the Electronic Medical Records Policy dated 2/2021 identified the facility will ensure each record will be accurate, based on knowledge of resident information. Interview and record review with the DON (Director of Nursing) on 6/23/25 at 1:20 PM identified it was her expectation that the nursing staff document each meal intake in the electronic medical records to ensure accurate representation of each meal for a resident. interview failed to identify why the meal intakes were not documented. Review of the Electronic Medical Records Policy dated 2/2021 identified the facility will ensure each record will be accurate, based on knowledge of resident information.