

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 075153	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/24/2020
NAME OF PROVIDER OF SUPPLIER VILLA AT STAMFORD, THE		STREET ADDRESS, CITY, STATE, ZIP 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 0880 Level of harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</p> <p>Based on observation, review of facility policy, and interviews the facility failed to ensure staff utilized eye protection on an observation (resident's covid 19 status is unknown) unit. The findings include: Observation on 8/24/20 at 11:12 AM identified NA #1 was in the doorway of room [ROOM NUMBER] on the observation unit with a pair of glasses on top of her head and no eye protection. While standing in the doorway, NA #1 proceeded to speak briefly with the unit nurse and then re-enter the room a second time with her glasses on her head and without the benefit of eye protection. Observation on 8/24/20 at 11:14 AM on the observation unit identified NA #2 entered room [ROOM NUMBER] and provided the resident assistance from a chair into a wheelchair and then exited the room without eye protection. Observation on 8/24/20 at 11:20 AM on the observation unit identified the Rehabilitation Therapist (RT #1) exited room [ROOM NUMBER] to the doorway to obtain adaptive equipment located just outside of the room and then re-entered the room. RT #1 was not wearing eye protection. A subsequent observation identified RT #1 and RT #2 exited room [ROOM NUMBER] without the benefit of eye protection. Interview with NA #1 on 8/24/20 at 11:23 AM identified that although she was aware of the requirement to wear eye protection while in resident care areas on the observation unit, she had left her eye protection in her car that day. Interview on 8/24/20 at 11:27 AM with NA #2 identified that while she was aware of the requirement to use an eye shield while in resident care areas on the observation unit, she was trying to assist a resident in getting to an outside appointment timely and therefore did not wear the shield. Interview on 8/24/20 at 11:29 AM with RT #1 and RT #2 identified that while they were both aware of the requirement to maintain eye protection while in resident care areas on the observation unit, they had left their eye protection at an alternate work location. Review of the Protocol for Facility Sections related to Covid-19 Containment dated July 2020 directed staff to wear full PPE including an N95 mask when caring for residents on the observation unit. The facility failed to implement the use of eye protection per standard of care on the observation unit.</p>		
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.