STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075198	A. Building B. Wing	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village Green Rehabilitation and Healthcare Center	23 Fair Street Bristol, CT 06010

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 of seven residents (Resident #1) reviewed for quality of care, the facility failed to ensure the clinical record was complete and accurate to include wound care documentation, and for two of seven residents (Resident #5 and #6) reviewed for quality of care, the facility failed to ensure the clinical record was complete and accurate to include resident care. The findings include: 1. Resident #1's diagnoses included dementia, and cerebral infarction with hemiplegia and hemiparesis (paralysis and weakness). The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 was unable to perform a Brief Interview for Mental Status (BIMS), indicative of severely impaired cognition and was dependent with all ADL's (activities of daily living). The Resident Care Plan (RCP) dated 7/2/2024 identified a risk for skin breakdown related to decreased activity, fail skin, history of pressure ulcer, and incontinence. Interventions directed a low air loss mattress, reposition, provide preventative skin care, monitor skin, and perform dressings as ordered. Physician order dated 8/13/2024 directed to perform the following: • Cleanse right posterior thigh with wound wash, apply Medi honey gel and calcium alginate to wound bed followed by foam dressing, change every day and evening shift. • Cleanse sacral wound with wound wash, apply collagen and calcium alginate to wound bed followed by foam dressing, change every day and evening shift. • Cleanse left lateral thigh with wound wash, apply Medi honey gel and calcium alginate to wound bed followed by foam dressing, change every day and evening shift. Review of the Treatment Administration Record (TAR) for September 2024 identified all wound care was not documented during the evening shift on 9/1, 9/4, and 9/5/2024. (continued on next page)

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

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LPN #3 on 11/20/2024 at 8:30 AM identified she always performs Resident #1's wound care, and indicated she most likely forgot to document the wound care on 9/1 and 9/4/2024. Interview with LPN #7 on 11/20/2024 at 10:15 AM identified he always makes sure Resident #1's wound care is performed during his shift, and indicated he must had forgotten to document that it was performed on 9/5/2024. a. Physician order dated 9/27/2024 directed to perform the following: • Cleanse right ischial tuberosity non-stageable pressure area with wound wash, apply gauze moistened with Dakin's ¼ strength to wound bed, followed by foam dressing, change every day and evening shift. • Cleanse sacral wound with wound wash, gently pack gauze roll moistened with ¼ strength Dakin's into wound, followed by foam dressing, change every day and evening shift. • Cleanse left ischial tuberosity pressure wound with wound wash, gently pack gauze roll moistened with 1/3 strength Dakin's into wound, change every day and evening shift. Review of the TAR for October 2024 and November 2024 identified all wound care was not documented on 10/25/2024 during the day and evening shift and on 11/9/2024 during the evening shift. Interview with LPN #3 on 11/20/2024 at 8:30 AM identified she always performs Resident #1's wound care, and indicated she most likely forgot to document the wound care on 10/25 and 11/9/2024. Interview and with DON on 11/20/2024 at 2:30 PM identified she expected the nursing staff documentation to accurately reflect a resident's care. The DON indicated the nursing staff should accurately reflect Resident #1's wound care by documenting in the electronic medical records and ensure wound care is being performed, and LPN #3 should have documented the care. Review of the facility Nursing Documentation Policy dated 5/1/2023 identified nursing documentation will be concise, clear, pertinent, and accurate based on the resident's/patient's condition, situation, and complexity. Timely entry of documentation must occur as soon as possible after the provision of care and in conformance with time frames for completion as outlined by other policies and procedures. 2. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #5's diagnoses included heart failure and an open wound of right buttock. The Resident Care Plan (RCP) dated 9/9/2024 identified resident had actual skin breakdown. Interventions directed skin care as ordered. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified that Resident #5 had a Brief Interview for Mental Status (BIMS) score of twelve out of fifteen, indicative of moderate cognitive impairment and required assistance with ADLs and was incontinent of bowel and bladder. Physician order dated 10/1/2024 directed to perform the following: • Cleanse buttocks with soap and water and apply triad paste to bilateral buttocks two (2) times a day and after incontinent care every day and evening shift for wound care. • [NAME] lotion 0.5-0.5% apply to upper/lower extremities topically every day and evening shift. Review of the TAR for 10/2/2024 identified that the wound care listed was not documented on 10/2/2024, on the day shift and on 11/6/2024 during the day shift. During an interview with LPN #5 on 11/20/2024 at 9:25 AM, LPN #5 stated she provided the care on 10/2/2024, but did not document and she should have documented the care provided. Interview with LPN #6 on 11/20/2024 at 9:04 AM identified that she provided the treatments on 11/5/2024 but she did not document the care, and stated she should have documented. a. Physician order dated 10/2/2024 directed to administer Tylenol (analgesic) 325 mg, give 975 mg oral (three) 3 times per day for pain. Review of the Medication Administration Record (MAR) for 10/8 and 10/15/2024 identified that the Tylenol 975 mg was not documented on 10/8 and 10/15/2024 during the day shift. Interview with LPN #4 on 11/19/2024 at 2:22 PM identified that she always administers the resident's care as directed on the MAR, she provided the Tylenol and she should have documented it on 10/8 and 10/15/2024. Interview failed to identify why it was not documented. 3. Resident #6's diagnoses included chronic kidney disease and heart failure. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified that Resident #6 had severe cognitive impairment and was dependent on staff for ADLs. The Resident Care Plan (RCP) dated 11/10/2024 identified resident was at risk for skin breakdown related to immobility or has actual skin breakdown and had contractures. Interventions directed to monitor skin. Physician order dated 11/2/2024 directed to perform the following: • (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Apply bilateral wrist, hand, finger splints and remove for care and checks every shift. • Apply skin prep to blister left shin every shift. • Bilateral hand, wrist, finger splints on with AM care, off with PM care every day and evening shift. • Clean open area to right inner thigh with normal saline, apply Medi honey over with dry clean dressing every other day and as needed, start 11/3/2024. Review of the TAR for 11/5/2024 identified that treatments listed above were not documented on 11/5/2024 during the day shift. Interview with LPN #6 on 11/20/2024 at 10:47 AM identified that she completed treatments as ordered during her shift on 11/5/2024 but did not document and should have documented the care was provided. Interview, clinical record review on 11/20/2024 at 1:28 PM with DNS identified the care provided should have been document for Resident #5 and #6 in accordance with physician orders; nursing staff should have documented in the medical record that the care was provided. Review of the facility Nursing Documentation Policy identified nursing documentation will follow the guidelines of good communication and be concise, clear, pertinent, and accurate based on the resident's/patient's condition, situation, and complexity. Timely entry of documentation must occur as soon as possible after the provision of care and in conformance with time frames for completion as outlined by other policies and procedures.

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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** Based on clinical record review, observations, facility documentation review, facility policy review, and interviews for one of three residents (Resident #6) reviewed for wound care treatment, the facility failed to ensure wound care was provided in accordance with accepted infection control practices. The findings include: Resident #6's diagnoses included chronic kidney disease and heart failure. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified that Resident #6 had severe cognitive impairment and was dependent on staff for ADLs. The Resident Care Plan (RCP) dated 11/10/2024 identified resident was at risk for skin breakdown related to immobility or has actual skin breakdown and had contractures. Interventions directed to monitor skin. A physician order dated 11/8/2024 directed to cleanse an open blister on the back of the left calf and right calf with wound wash, apply xeroform and foam dressing change daily and as needed. Continuous observation of Resident #6's wound care on 11/20/2024 at 10:55 AM with LPN #6 identified that while LPN #6 performed wound care to Resident #6's bilateral calves, she wore two (2) pair of gloves (wore two gloves on each hand). After LPN #6 removed the soiled dressings from both calves, she removed the outer layer of gloves and then proceeded to apply clean dressings to the resident's left calf while still wearing the same gloves. LPN #6 was then observed to remove the glove and apply a new glove and proceeded to provide wound care to the right calf. Observations identified LPN #6 failed to perform the treatment to each wound separately and failed to wear only one (1) pair of gloves at a time. Further, LPN #6 failed to remove gloves and perform hand hygiene after removing the soiled dressings, cleansing the wounds, and prior to applying the clean dressings. Interview with LPN #6 on 11/20/2024 at 1:09 AM identified that she did not know if she should or should not wear two (2) pairs of gloves, when to perform glove changes and hand hygiene and if she should perform each wound dressing one (1) at a time. LPN #6 stated she did not know if she should have removed the gloves and performed hand hygiene, and applied new gloves after removing the soiled dressing, after cleansing the wounds, and before applying Resident #6's clean dressing. LPN #6 stated she wore two (2) pair of gloves because the gloves were vinyl and tore easily. Interview, review of clinical record, facility documentation review and facility policy review with RN #1/wound nurse on 11/20/2024 at 12:05 PM identified that when a nurse performs aseptic (clean) wound care, he/she should remove soiled/dirty gloves, apply new gloves before proceeding with the dressing change. RN #1 further stated the facility policy for wound dressings directs if a patient has multiple wounds in separate locations treat each as a separate procedure. RN #1 further indicated that nurses should not be double gloving, only one (1) pair of gloves should be worn. Interview, review of clinical record, facility documentation review with the DNS on 11/20/2024 at 1:28 PM identified that LPN #6 should have removed her gloves after removing the dirty dressing, washed her hands and applied new clean gloves prior to applying the clean dressing and that each wound should have been treated separately. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy and procedure for Wound Dressings Aseptic directed in part, if a patient has multiple wounds in separate locations to treat each as a separate procedure. Apply clean gloves, discard the soiled dressing and gloves according to infection control policy, perform hand hygiene, apply gloves, perform wound care, secure dressing, remove gloves and discard according to infection control procedure, perform hand hygiene.