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	01/22/2025

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 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 observations, clinical record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #5), reviewed for infection control, the facility failed to implement the required transmission-based precautions as per the facility policy. The findings include: Resident #5 was admitted with chronic respiratory failure dependent on a ventilator, dementia, amyotrophic lateral sclerosis (ALS), epilepsy (seizure disorder) and extended spectrum beta lactamase resistance (ESBL-presence of a bacteria resistant to common antibiotics). A hospital transfer document dated 5/13/2024 identified Resident #5 had a chronic methicillin (antibiotic) resistive staphylococcus aureus (MRSA)(bacteria) infection in his/her tracheostomy site. A physician's order dated 12/22/2024 directed contact precautions until further notice for positive MRSA, ESBL. A quarterly minimum data set (MDS) dated [DATE] identified Resident #5 had severely impaired cognition (BIMS of 6) and required suctioning, tracheostomy care and a ventilator. A Resident Care Plan (RCP) dated 1/2/2025 identified Resident #5 was at risk for multiple drug-resistant colonization/infection and respirator complications due to ventilator dependance and a tracheostomy. Interventions directed to use enhance barrier precautions that included use of gown and gloves when performing high contact care including device care, and listed examples of device care include tracheostomy and ventilator. A laboratory report dated 1/8/2024 at 4:34 PM identified Resident #5 had a positive axilla/groin swab for Candida auris (c. auris) (multi-drug-resistant yeast/fungus that can spread easily through contaminated surfaces, equipment or physical contact). An APRN's progress note dated 1/9/2025 directed contact precautions until further notice for positive MRSA, ESBL and C. Auris. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of Respiratory Therapist (RT) #1 on 1/21/2025 at 12:15 PM identified upon exit from the Resident #5's room, RT #1 took off her isolation gown, her mask was covering her chin, her eyeglasses were on top of her head and was observed still wearing her gloves used inside the room. RT #1 walked out of Resident #5's doorway to her respiratory cart located outside of the room by Resident #5's doorway in the unit hallway. She reached up to her eyeglasses still wearing the gloves she had exited the room with, touched her glasses with her right hand and brought her glasses over her eyes to rest on her nose. Continued observations identified RT #1 then picked up a pen that was located on the top of the respiratory cart, and while continuing to wear the same used gloves RT #1 began to document on a paper attached to a clipboard (located on top of the respiratory cart) that she held steady with her left hand that was still wearing the gloves worn inside Resident #5's room. When RT #1 completed her documentation, she put the pen down on top of the respiratory cart and using her still gloved right hand, lifted her eyeglasses and placed them back on top of her head. RT #1 was then observed to remove the used gloves and place them in the trash bin located inside Resident #5's room and then performed hand hygiene. Interview with RT #1 on 1/21/2025 at 12:17 PM identified when she was in Resident #5's room she had completed Resident #5's ventilator check, provided tracheostomy care and suctioned Resident #5. RT #1 further stated she had also changed Resident #5's HME (heat and exchange filter) on the ventilator and ventilator tubing. RT #1 stated there was a clean supply of gloves located at the entrance to Resident #5's room, and pointed to the boxes located on the wall to the right of the door to Resident #5's room. RT #1 stated she needed her eyeglasses to document the care she provided, and she touched the eyeglasses to remove them off the top of her head. RT #1 stated although she should have removed the gloves and performed hand hygiene when she exited the room, she did not know why she did not take the off the soiled gloves prior to exiting the room, or why she continued to wear the soiled gloves when touching her eyeglasses, using the pen, and documenting. Interview and review of the facility documents with the Infection Control Nurse (ICN) on 1/20/2025 at 1:30 PM identified all residents on the ventilator unit were on contact precautions due to multi-drug resistant organisms (MDROs) and an active outbreak of Carbapenem (antibiotic) resistant Acinetobacter baumannii (bacteria) or CRAB and c. auris. The ICN stated all staff were required to wear personal protective equipment (PPE) prior to providing direct care including equipment checks and care such as tracheostomy care and suction. The ICN further stated, prior to exiting a resident's room, or in between care provision if more than one resident is in the room, the PPE needed to be taken off and placed in the bins located inside a resident's room prior to exiting the resident's room, and staff must perform hand hygiene. The ICN stated RT #1 should have removed the soiled gloves and performed hand hygiene prior to exiting Resident #5's room, and should not have worn soiled gloves while using a pen, documenting and touching her eyeglasses. The ICN stated all staff had received education in the past regarding this requirement and she did not know why RT #1 did not follow the requirements for contact precautions. The facility policy MDRO's dated 1/8/2024 directed in part, that enhanced barrier precautions will be used for MDROs based on the Center for Disease Control and Prevention (CDC) guidance. If a MDRO outbreak occurs, all residents colonized (has organisms/bacteria present but actively having an infection) or infected must be placed on contact precautions. The facility policy Contact Precautions dated 5/1/2023 that the purpose of the policy was to reduce the risk of transmission of microorganisms by direct or indirect contact. The policy directed in part, that staff remove (PPE) and bag gown and gloves, and then wash hands upon exiting the room.