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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145602 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 01/29/2025 |
| NAME OF PROVIDER OR SUPPLIER Village at Victory Lakes, The | | STREET ADDRESS, CITY, STATE, ZIP CODE 1055 East Grand Avenue Lindenhurst, IL 60046 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| <p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>37232</p> <p>Based on interview and record review the facility failed to provide a resident with the bed hold policy when transferring a resident to a hospital for 1 of 2 residents (R23) reviewed for transfers in the sample of 20.</p> <p>The findings include:</p> <p>A facility assessment done on 12/13/24 showed R23's mental status was intact.</p> <p>R23's Progress Note dated 1/10/25 showed R23 was sent to the hospital because he was having abdominal pain.</p> <p>R23's SNF/NF to Hospital Transfer Form dated 1/10/25 showed R23 was being transferred to a local hospital for evaluation of abdominal pain. The same document showed R23 was capable of making decisions.</p> <p>On 01/27/25 at 11:43 AM, R23 stated when he was sent to the hospital on 1/10/25 he was not given the bed hold policy or informed what the facility's bed hold policy was.</p> <p>On 01/28/25 at 12:44 PM, V5 (Licensed Practical Nurse) said she was the nurse that sent R23 to the hospital on 1/10/25. V5 said she did not provide or inform R23 of the facility's bed hold policy on transfer.</p> <p>The facility's Bed Hold Notices policy dated 5/1/19 showed the facility support the resident's rights to be informed of the policy regarding holding a bed prior to and/or upon a resident's transfer to the hospital. The same policy showed before transfer the resident will be informed regarding the facility's bed hold period.</p> |

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 |
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| <p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35178</p> <p>Based on interview and record review the facility failed to ensure R36 and R54's PASRR-Preadmission, Screening & Resident Review was reassessed after being newly diagnosed with a mental illness for 2 of 5 residents (R36, R54) reviewed for PASRR in the sample of 20.</p> <p>The findings include:</p> <p>On 01/29/25 at 9:12 AM, V12 Director of Admission/Community Outreach said, PASRR is usually completed at the hospital prior to admission. If the resident comes from out of state or from their home, it is completed as part of the admission process at the facility. The facility has not been performing the PASRR when a resident is diagnosed with a mental illness after admission. Every resident will be assessed with Level 1 PASRR. That assessment will cue the facility if an additional screening is needed. Diagnosis of a mental illness, psychotropic medications, and behavioral documentation facilitates the need for the type of PASRR the resident needs. I was just notified yesterday of the need for PASRR reassessments with changes in medications and mental health diagnosis. We have been using the current PASRR system but have not been educated on all the details.</p> <p>R36's EMR-Electronic Medical Record on 01/29/25 shows, R36 was admitted to the facility on [DATE]. R36's EMR on 01/29/25 shows, R36 has a Primary Diagnosis of Parkinson's Disease without dyskinesia, without mention of fluctuations, 03/11/24. R36 was diagnosed with anxiety disorder, 04/20/24. R36's PASRR is dated 04/19/23.</p> <p>R54's EMR on 01/29/25 shows, R54 was admitted to the facility on [DATE]. R54's EMR on 01/29/25 shows, R54 has a Primary Diagnosis of Hemiplegia and Hemiparesis following cerebral infarction affecting left non-dominant side. R54 was diagnosed with delusional disorder, 09/02/24. R54's PASRR is dated 01/30/23.</p> <p>The facility PASRR policy dated, 06/01/23 shows, if the individual has a sole diagnosis of dementia, s/he is excluded from further PASRR evaluations. If the person has both a dementia diagnosis and another psychiatric condition, the dementia must be confirmed as primary.</p> |

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| <p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>35178</p> <p>Based on observation, interview, and record review the facility failed to follow the Wound Physician's recommendations, failed to identify, report, and obtain treatment for wounds and failed to provide pressure relieving intervention to prevent the development of pressure ulcers for 4 of 9 residents (R73, R45, R135, R35) reviewed for pressure ulcers in the sample of 20. This failure resulted in R73's MASD-Moisture Acquired Skin Disease to the left and right gluteal area developing into a left gluteal Stage 3 and right gluteal Stage 4 pressure ulcer.</p> <p>The findings include:</p> <p>1. R73 Predicting Pressure Ulcer score risk dated 10/12/2024 (admission) shows, High Risk</p> <p>On 01/28/25 at 11:11 AM, V2 DON-Director of Nurse changed the dressing for R73's Stage 4 pressure wound to the left buttock and the Stage 4 pressure wound to the left heel.</p> <p>On 01/28/25 at 11:11 AM, V2 DON-Director of Nursing said, R73 did have redness to the right butt cheek upon admission but developed the pressure ulcer in the facility.</p> <p>R73 Admission assessment dated , 05/10/24 at 7:18 PM, shows, Skin MASD in buttocks - very red but intact, Dry scab at Right foot 2 x 1 cm (centimeter), Dry scab at left shoulder - no drainage noted, scattered bruises and scabs at arms and legs due to fall.</p> <p>R73's Initial Wound Evaluation by V11 Wound Doctor dated 10/16/24 shows, unstageable Deep Tissue Injury of the Left Heel, etiology Pressure, Duration Less than 2 days. Size 8.3 cm x 4.1 cm. Skin intact with purple/maroon discoloration. Recommendations: Off-Load Wound; Float Heels in Bed; Pressure Off-Loading Boots. Stage 4 Pressure Wound of the Right Buttock Full thickness. Etiology Pressure Stage 4, duration greater than 14 days. Noted to be present on admission per staff. Wound size 2.6 cm x 1.1 cm x 0.5 cm centimeters. slough 10%. Stage 3 Pressure Wound of the Left Buttock Full Thickness. Etiology Pressure Stage 3, Duration greater than 14 days, noted to be present on admission per staff. Wound size 4.5 cm x 7.3 cm x 0.3 cm. 100% subcutaneous dermis.</p> <p>R73's Current Care Plan on 01/28/25 shows, V11's Recommendation to float heels in bed and to apply pressure off-loading boots has NOT been initiated as an Intervention in R73's Care Plan.</p> <p>R73's Wound Evaluation & Management Summary dated 11/27/24 by V11 Wound Doctor shows, Stage 3 pressure wound of the left buttock full thickness etiology pressure, stage 3, duration greater than 56 days noted to be present on admission per staff, 4.5 cm x 8.1 cm x 0.5 centimeters, 30% slough, 20% granulation, 50% subcutaneous dermis. Recommendations: Cipro 500 milligrams by mouth twice a day for 10 days started yesterday by primary care physician with positive cultures of wound and urinary tract infection.</p> <p>R73's MAR dated November 2024 and December 2024 shows, R73 did not receive the wound physicians recommended antibiotic of Ciprofloxacin 500 milligrams by mouth twice a day for 10 days between November 27, 2024, to December 6, 2024, for the Stage 3 Pressure Wound.</p> <p>(continued on next page)</p> | | |

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| <p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>On 01/28/25 at 1:43 PM, V2 DON said, the nurse that is given the Physician Order is responsible to ensure it is performed. This would be the reasonability of the Wound Nurse to input the order to pharmacy, obtain the wound culture, and notify the primary care physician.</p> <p>On 01/29/25 at 11:29 AM, V11 Wound Doctor said, R73 had a wound infection. I coordinate with the Infection Control Nurse and the Primary Doctor. The Infection Control Nurse ensures the order goes through appropriately and follows up on the wound culture results.</p> <p>On 01/29/25 at 12:54 PM, V2 DON said, the facility's Infection Control Nurse left in August of 2024. I have had a few different Wound Nurses off and on over the past year. My current Wound Nurse started 3 days ago.</p> <p>The Facility's Nursing Skin Integrity policy dated 03/20/23 shows, the licensed nurse using the EMR -electronic medical record observation tool, is to complete a Head-To-Toe Assessment to identify any/all areas of loss of skin integrity. The includes pressure injuries, non-pressure injuries, skin tears, bruises .</p> <p>Notify sites the wound nurse/DON of any skin integrity issues. Evaluate areas of loss of skin integrity and complete a wound consult as appropriate. If the wound doctor is following the resident's wound, their weekly assessment is sufficient for the week. It is the wound nurse/DON's responsibility to ensure all orders and/or recommendations from the Wound Physician are carried out timely.</p> <p>On 01/28/25 at 11:11 AM, V2 DON-Director of Nursing removed R73 right pressure reduction boot. R73 had a 1 centimeter by 1 centimeter black/purple area on the bony prominence of the medial ball of his right foot that looked like a deep tissue injury.</p> <p>On 01/28/25 at 11:11 AM, V2 DON said, the discoloration to the right medial ball of his right foot was not there last week when I assessed R73 with the wound doctor.</p> <p>On 01/28/25 at 11:11 AM, R73 denied any injury to the foot.</p> <p>On 01/28/25 01:49 PM, V2 DON, said, I have not documented on R73's discoloration. None of the staff reported the discoloration. R73 has no record of recent injury. The wound doctor will see R73 tomorrow. I will call it discoloration and allow the Wound Doctor to make the determination.</p> <p>On 01/29/25 at 9:43 AM, V10 Wound Doctor said, the wound on the right medial ball of R73's foot is a deep tissue injury. Deep tissue injuries are caused from the tissue resting against a surface for too long. R73 also has a diagnosis of diabetes which increases his risk for wound development. I will classify the wound as a pressure ulcer.</p> <p>The Facility's Nursing Skin Integrity policy dated 03/20/23 shows, evaluate areas of loss of skin integrity and complete a wound consult as appropriate. Complete the appropriate entry on the wound care log.</p> <p>2. R45 Predicting Pressure Ulcer score risk dated 05/21/24 (admission) shows, At Risk</p> <p>On 01/27/25 at 10:00 AM, R45 observed lying on her back.</p> <p>(continued on next page)</p> | | |

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| <p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>On 01/28/25 at 1:48 PM, R45 observed lying on back, the positioning wedge was sitting on a chair in her room.</p> <p>On 01/29/25 at 9:55 AM, R45 observed laying on her back with the head of the bed up at 45 degrees.</p> <p>On 01/29/25 at 10:08 AM, V10 Wound Care Doctor said, R45's wound was acquired in the facility. It currently measures 1.8 cm (centimeters) x 1.4 cm x 0.2 cm deep.</p> <p>On 01/29/25 11:02 AM, V2 said, on 5/14/24, R45 was Care Planned that she prefers to lay on her back, identified on admission. On 09/07/24 it was observed that R45 had an open area to her coccyx, we added the pressure reducing mattress that day (09/07/24).</p> <p>On 01/29/25 at 11:29 AM, V11 Wound Doctor said, it is not normal for skin to progress from intact tissue to a stage 4 pressure ulcer, it can happen. Skin can break down quickly and then the muscle. Perhaps the air mattress would have prevented the opening of the wound.</p> <p>R45's Admission Skin Observation Tool dated 05/14/24 shows, Skin is intact .</p> <p>R45's Care Plan initiated 05/14/24 shows, R45 likes to lay on her back that can further increase risk of skin breakdown. Care Plan Initiated 05/21/24 R45 is in need of assistance with ADL's-Activities of Daily Living. She insists to stay in bed and needs staff encouragement and substantial maximal assist from staff to roll left and right.</p> <p>R45's Initial Wound Assessment by V11 Wound Care Doctor dated 09/11/2024 shows, Stage 4 Pressure Wound Sacrum Full Thickness, Etiology Pressure, Duration greater than 4 days, Wound Size 3.5 cm x 2.6 cm x 0.4 cm.</p> <p>The facility's Nursing Skin Integrity policy dated 03/20/23 shows, validate a care plan with appropriate interventions initiated.</p> <p>R45's Physician's Orders dated 09/07/24 shows, R45's Pressure Redistribution Mattress was ordered 09/07/24.</p> <p>The facility did not provide R45 with a pressure reducing mattress until after she developed a Stage 4 pressure ulcer.</p> <p>34117</p> <p>3. R135's face sheets shows he has diagnosis including respiratory failure, dehydration, emphysema, urine retention, and protein calorie malnutrition.</p> <p>On 1/27/25 at 9:43 AM, R135 was observed lying in bed. V8 (Certified Nursing Assistant-CNA) provided incontinence care. V8 removed his incontinent brief, his sacrum was red with an open area without a protective dressing in place.</p> <p>On 1/28/25 at 10:44 AM, V2 (DON) went to provide wound care to R135. V2 removed his incontinent brief R135's sacrum remained without a dressing in place, his sacrum was red with an open area. V2 said R135 has a pressure ulcer to his sacrum and should have a dressing in place.</p> <p>(continued on next page)</p> | | |

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| <p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>R135's Admission Evaluation dated 1/21/25 documents an open area to his buttock measuring 0.8 cm (centimeters) x .5 cm.</p> <p>R135's Physician Order Sheets dated January 2025 shows orders including sacrum open area-cleanse with normal saline dry and cover with a foam dressing daily.</p> <p>37232</p> <p>4. On 01/27/25 at 01:15 PM, R35 observed in bed. There was an air mattress pump hanging on the foot of the bed. The power switch to the air mattress pump was in the off position. The green power button was not lit up.</p> <p>On 01/28/25 at 08:54 AM, V3 (Registered Nurse) confirmed the air mattress pump on R35's bed was off. V3 added that the pump should be on while R35 was in bed.</p> <p>R35's Order Summary Report printed on 1/28/25 showed an order for an air mattress.</p> <p>R35's Care Plan with an initiated date of 9/11/24 showed R35 was at risk for developing pressure injuries. Listed under interventions was for R35 to receive a pressure relieving/reducing mattress.</p> <p>On 01/28/25 at 01:39 PM, V4 (Certified Nursing Assistant) said an air mattress/pump is a pressure relieving intervention.</p> |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Provide and implement an infection prevention and control program.</p> <p>40085</p> <p>Based on observation, interview, and record review the facility failed to ensure staff wore the required PPE (Personal Protective Equipment) in a contact isolation and enhanced barrier precaution room, and failed to ensure gloves were changed during incontinence care to prevent cross contamination. This applies to 4 of 10 residents (R24, R54, R63, R135) reviewed for infection control in the sample of 20.</p> <p>The findings include:</p> <p>1.) On 1/27/25 at 9:35 AM, outside of R24's open door were two isolation signs, one for Contact Isolation indicating gloves and gowns must be applied when entering the resident room. The second sign was for Enhanced Barrier precautions that showed when providing cares such as dressing, bathing, transferring, providing hygiene, changing briefs or assisting with toileting staff must wear gloves and gowns. Outside of R24's doorway was also a cart containing PPE including gowns, gloves, and masks as well as a bin to place linens and garbage. At 9:37 AM, V7 (Certified Nursing Assistant/CNA) went into the room of R24 without applying a gown or gloves, she proceeded to carry linens and go into the bathroom inside the room where R24 was. At 9:45 AM, V7 exited R24's room to get supplies and when asked by this surveyor about R24 being on isolation V7 responded she did not get any report that R24 was on any type of isolation. V7 said she had been assisting R24 to the bathroom and to wash up for the day. V7 re-entered R24's room without applying a gown.</p> <p>On 1/27/25 at 9:39 AM, V6 (Registered Nurse/RN) said that R24 was on contact isolation due to a MRSA (Methicillin Resistant Staphylococcus aureus) infection in her wound and staff should be wearing gowns and gloves when inside her room.</p> <p>On 1/27/24 at 12:02 PM, V24 said she is afraid the CNA's at the facility do not really know what infection a resident has because before today they were not wearing gowns in the room when they provide care to her. V24 said she has had chronic MRSA infections in her body.</p> <p>On 1/28/25 at 9:43 AM, V2 (Director of Nursing/DON) said for residents on Enhanced Barrier Precautions staff should be wearing gowns and gloves when providing cares. V2 said, I know what you saw yesterday and yes the staff should have been wearing gowns when they went into her (R24's) room she is on contact isolation for MRSA in a wound. The Enhanced Barrier sign was originally on her door for the wound incision and then when MRSA was found she was placed on contact isolation.</p> <p>R24's active Care Plan and Physician Order Summary both show R24 was placed on contact isolation on 1/22/25 due to MRSA in her surgical incision.</p> <p>The facility provided Initiating Transmission Based Precautions policy effective 3/27/23 shows contact isolation should be used where there is potential to spread a microorganism to other persons and the facility should ensure the proper PPE is available and worn when in isolation rooms.</p> <p>35178</p> <p>(continued on next page)</p> | | |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>2. On 01/27/25 at 1:29PM, V14 CNA-Certified Nursing Assistant and V15 CNA provided incontinent care to R54. R54 had a bowel movement. After V14 CNA cleaned R54 she failed to change her gloves before applying a clean incontinent brief, placing clean positioning pillows, and pulling up R54's blankets.</p> <p>3. On 01/27/25 at 9:55 AM, there was a sign posted to R63's door that showed enhanced barrier precautions. As V14 CNA and V15 CNA provided care to R63 they did not wear gowns. V14 CNA used a urinal to empty R63's urine collection bag without putting on a gown.</p> <p>On 01/27/25 at 10:23 AM, V16 LPN-Licensed Practical Nurse said, when staff are caring for residents on enhanced barrier precautions, they should wear gown and gloves when emptying a catheter.</p> <p>34117</p> <p>4. On 1/27/25 at 9:43 AM, V8 (CNA) provided incontinence care to R135. R135's incontinent brief was soiled with stool. V8 cleansed his buttocks, and used the same contaminated gloves and touched multiple surfaces including placing a new brief, adjusted his gown, blanket, his call light and the bed control.</p> <p>On 1/28/25 at 1:41 PM, V2 (DON) said staff should change their gloves after cleaning a soiled body part.</p> <p>The undated facility's Perineal Care Policy states, The purpose of this procedure are to provide cleanliness and comfort to the resident, to prevent infections wash and rinse the rectal area thoroughly .remove gloves . wash and dry your hands thoroughly .</p> | | |