

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475033	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/02/2024
NAME OF PROVIDER OR SUPPLIER Crescent Manor Care Ctrs		STREET ADDRESS, CITY, STATE, ZIP CODE 312 Crescent Blvd Bennington, VT 05201	

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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46135</p> <p>Based on observation, interview, and record review, the facility failed to provide safe and effective skin and wound care for 4 of 25 sampled residents (Residents #25, #30, #34, and #51) by failing to regularly and accurately perform and document weekly skin checks and non-pressure ulcer wound evaluations consistent with professional standards of practice. The facility also failed to ensure that a Resident with a wound vac received treatment and care in accordance with professional standards of practice and the person-centered care plan for 1 of 2 (Resident # 291) of the applicable sample. Findings include:</p> <p>1. Resident #25's weekly skin evaluations do not include documentation of a skin alteration on the hip and there is no wound assessment of Resident #25's skin alteration on the hip or the moisture-associated skin (MASD) damage on the leg.</p> <p>Per record review, Resident #25's care plan reads, [Resident #25] has potential for impairment to skin integrity r/t [realted to] PVD [peripheral vascular disease], immobility, HX [history]: dermatophytic skin lesions He has chronic poor skin integrity of lower extremities r/t [realted to] immobility and diabetes, revised on 8/20/24, with interventions that include, Monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, s/sx of infection, maceration etc. to MD, revised on 1/11/23 and Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations, initiated on 9/10/22. Additionally, Resident #25's care plan reveals that s/he has a self-care performance deficit requiring an extensive 2 person assist for bed mobility and care.</p> <p>Per interview on 9/29/24 6:31 PM, Resident #25 explained that s/he had sores on his/her left leg and bottom that have been there for a while. S/He explained that sometimes the sores heal but they always open right up again.</p> <p>Per observation and interview on 10/1/24 at 2:00 PM, a Licensed Nursing Assistant (LNA) showed this surveyor Resident #25's bottom. There was compromised, red skin on the left backside of his/her thigh and bottom. While the area was covered in an ointment, there were visible open spots, some being two inches long. This LNA explained that these wounds were not new for Resident #25.</p> <p>Per record review, a 9/13/24 wound care progress note reads, Currently being seen for ongoing treatment of MASD of the left hip which tends to recur. This has not been present for many weeks with fluctuations week to week. This week the area remains closed . Though the area remains fragile there is no visible open area for consecutive weeks now. Facility to manage moving forward.</p> <p>(continued on next page)</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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A 9/13/24 weekly skin evaluation reveals that a head to toe assessment was performed but the question Does the resident have any impairments in skin integrity, is left blank. A comment reads, no new skin findings. There is no documentation of Resident #25's cluster of blisters to the left hip area. This skin evaluation is not accurate as a 9/13/24 progress note reads, Resident noted to have a cluster of small clear blistered areas to left hip area. A skin evaluation was not completed the following week. Two weeks later, a 9/27/24 weekly skin evaluation reveals that a head to toe assessment was performed but the question Does the resident have any impairments in skin integrity, is left blank. A comment reads, no new skin findings. A 9/30/24 nurse note reveals that Resident #25 is still being treated for his/her wound to his/her hip.</p> <p>Resident #25's medical record does not show any weekly wound assessments since 9/13/24 and there is no documentation of his/her current wound status.</p> <p>A 10/1/24 Physician note reveals Skin: 4x5 cm MASD over intergluteal area (upper and lower parts). Left posterior inner thigh: 2x3 cm MASD area. Barrier cream noted.</p> <p>2. Resident #30's weekly skin evaluations do not include documentation of a rash.</p> <p>Per record review, Resident #30's care plan reads, [Resident #30] has potential for impairment of skin [related to diagnosis] of Diabetes Mellitus with neuropathy [nerve damage]. incontinence, falls, excoriation, revised on 9/4/24, with an intervention that reads, monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, s/sx of infection, macerations etc. to MD, revised on 10/31/22. Additionally, Resident #30's care plan reveals that s/he has a self-care performance deficit requiring a total 2 person assist for toileting and incontinence care.</p> <p>Per observation on 9/29/24 at 4:45 PM, Resident #30 is seen from the hallway sitting in a wheelchair in his/her room. S/He is not wearing any pants and his/her groin area is dark red on the edges of his/her brief. Per observation and interview on 10/1/24 at 2:49 PM, two LNAs are helping Resident #30 with incontinence care. The LNAs remove Resident #30's brief and his/her groin area has a red rash at least two inches on each side of his/her legs. When the LNAs wash Resident #30's groin area, Resident #30 begins to yell out in pain. The LNAs explained that Resident #30's groin area had been like that for at least a month and it does seem to hurt him/her when they provide him/her incontinence care.</p> <p>Per record review, Resident #30 has a physician order for Miconazole Nitrate Powder . Apply to buttocks, groin legs topically two times a day for fungal rash, with a start date of 7/9/24.</p> <p>Resident #30's care plan does not address the actual skin impairment to his/her groin area or the need for treatment.</p> <p>Record review reveals that Resident #30's skin evaluations do not have documentation of his/her fungal rash. Resident #30's last skin evaluation, dated 9/23/24, reveals the only documented skin alteration is a left lower leg excoriation.</p> <p>3. Resident #34 does not have weekly skin evaluations and there is no evaluation of his/her multiple bruises.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Per record review, Resident #34's care plan reads, [Resident #34] has potential for impairment to skin integrity r/t decreased mobility, fragile skin, incontinence bowel/bladder. [Resident #34] is at high risk for injury, such as bruising due to [his/her] impulsive behavior and poor safety awareness. [S/He] can become easily agitated and ambulate hurriedly causing contact injury with walker, furniture, bed, etc. 8/16/24 right upper arm bruising, revised on 8/16/24.</p> <p>Per observation on 9/30/24 at 10:49 AM, Resident #34 is sitting in a chair by the nursing station. A couple scabs and a couple small open spots that are freshly open and bright red are noticeable on his/her arms.</p> <p>Per interview on 10/1/24 at 9:23 AM, an LNA explained that in addition to the scabs that can be seen on Resident #34's arms, he has some scabs on his legs and bruises which have been there for a while.</p> <p>Per observation and interview on 10/2/24 at 4:04 PM, an LNA was providing care to Resident #34. Resident #34 had three dark bruises about 1 inch in diameter and multiple faded bruises on both legs. The LNA explained that the bruising has been there for a long time.</p> <p>Per a list of standard assessments in Resident #34's electronic medical record, Resident #34's last weekly skin evaluation was completed on 8/15/24. There was no documentation of Resident #34's skin alterations in his/her medical record.</p> <p>4. Resident #51 does not have weekly skin evaluations.</p> <p>Per record review, Resident #51 was admitted [DATE] following a hip surgery. An 8/16/24 Nurse Practitioner note reads that Resident #51 has multiple open lesions (various healing stages) on fingers, arms, torso, pubic area, beltline [and a] right surgical incision. Resident #51's care plan reads [Resident #51] has potential for impairment to skin integrity r/t decreased mobility, fragile skin, incontinence bowel/bladder, surgical wound, pickers pustules, revised on 9/4/24 with the following intervention, Monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, s/sx of infection, maceration etc. to MD, initiated on 8/17/24.</p> <p>Per a list of standard assessments in Resident #51's electronic medical record, Resident #51 does not have any completed weekly skin evaluations since his/her admission on 8/16/24.</p> <p>5. The facility does not have a system to ensure that residents are getting accurate weekly skin assessments and weekly wound evaluations. There are no written procedures for staff to follow.</p> <p>Per interview on 10/1/24 at 10:44 AM, the Director of Nursing (DON) confirmed that skin evaluations and wound evaluations should be completed weekly. S/He confirmed that when they are done, all skin impairments will be entered into the weekly skin evaluation form and any non-pressure wound and any wound not being followed by the contracted wound team would have a weekly wound evaluation which would also be included in the weekly wound evaluation. When asked how a nurse would know that skin and wound management has been transferred to the facility, s/he replied that s/he was unsure.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Per interview on 10/2/24 at 2:27 PM, the DON confirmed that weekly skin evaluations should include documentation of any compromised skin including surgical, moisture, fungal, rash, skin tear, bruising and was unable to produce evidence that skin evaluations for Residents #25, #30, #34, and #51 that documented the actual status of their skin.</p> <p>Per a review of facility policy titled Preventive Skin Care Policies, dated 2020, the policy does not provide guidance on how often a nurse should complete a comprehensive skin assessment and how to document findings. Facility policy titled Wound Care and Dressing Changes, last revised 9/2020, does not provide guidance on monitoring or evaluating wounds. Per an email dated 10/2/24, the Administrator explained that they follow evidence based practices provided by the contracted wound team in addition to the polices above for pressure injuries. The facility did not provide this surveyor with evidence based practices to follow for non-pressure injuries.</p> <p>48017</p> <p>5. Per record review, Resident # 291 was admitted to the facility on [DATE] with diagnoses of Chronic Osteomyelitis, Diabetes, and Peripheral vascular disease.</p> <p>Per interview on 10/1/2024 at approximately 11:30 AM, Resident # 291 expressed concerns about the staff's knowledge of how to use and apply a wound vac (a device used to close wounds by use of suction), s/he stated the nurses are unsure, and I have to explain it to them.</p> <p>Per observation on 10/2/2024 at approximately 8:15 AM, the dressing to the wound vac was not intact, and the apparatus was not attached to suction. Several observations throughout the day revealed that the apparatus remained unattached to suction until approximately 2:30 PM.</p> <p>Per record review, of the treatment record for Resident # 291 revealed an order: wound vac dressing to left foot: gently cleanse the area, place xeroform over wound followed by black foam, cover with dressing. Wound vac settings 125 mmHg to continuous suction. Per review of a facility policy titled Wound Care and Dressing changes, page three, #3, Obtain an order for secondary dressing to be placed if unable to maintain vacuum seal.</p> <p>Per interview on 10/2/2024 at approximately 2:15 PM with the Facility Educator, s/he indicated s/he was unaware of the policy indicating a need for secondary dressing if suction could not be maintained. S/he trains the floor nurses on using a wound vac by demonstrating its use, but s/he has not yet developed a competency for the staff. When asked if the facility had a standard of practice for using a wound vac, s/he replied that they call the doctor or the vac manufacturer if they have questions but do not have a standard of practice.</p> <p>Per interview on 10/2/2024 at approximately 3:30 PM with the Nursing Supervisor, s/he states that if there is a question about using the wound vac, the DON is contacted, or they call the on-call provider. S/he confirmed she had not completed a competency for using the wound vac apparatus.</p> <p>Per an interview with the Director of Nursing (DON) on 10/03/24 at approximately 11:00 AM, s/he confirmed the wound vac dressing should be removed if the vac cannot be returned to suction at any time, s/he also confirmed that the staff does not have competencies for the use of the wound vac.</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>40258</p> <p>Based on observations, interviews, and record review, the facility failed to ensure that 1 of 25 residents in the applicable sample (Resident #87) received necessary treatment and services consistent with professional standards of practice to promote healing and prevent infection. As a result, Resident #87's pressure ulcer worsened to stage four, developed an infection, the resident required hospitalized and surgical debridement of the wound, and was not stable enough to be discharged . Findings include:</p> <p>Per record review Resident #87 was admitted to the facility in July 2024 with a goal to discharge home. An admission Minimum Data Set (MDS; a comprehensive assessment used as a care-planning tool) dated 7/30/2024 revealed that Resident #87 had a BIMS (brief interview for mental status; a cognitive assessment) of 15 on admission, indicating that s/he is cognitively intact. S/he was frequently incontinent of urine and always continent of bowel, requiring supervision or touching assistance with toileting hygiene. The MDS also revealed that s/he was admitted with an existing stage 2 pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an open/ruptured serum-filled blister). A health status note dated 8/6/2024 reveals that Resident #87 was independent with transfers and utilized a wheelchair for mobility.</p> <p>A wound consult progress note dated 8/1/2024 revealed that on exam the Resident had moisture associated skin damage (MASD) measuring as Length (L) 5.5 centimeters (cm), Width (W) 4.5cm, and 0.1cm depth (D). An active problem is listed as irritant contact dermatitis due to friction or contact with body fluids.</p> <p>On 8/9/2024 the wound care Nurse Practitioner (NP) recommended a Flexi Seal (a temporary containment device indicated for immobilized, incontinent patients with liquid or semi-liquid stool) to minimize contamination of the wound.</p> <p>Review of a wound consult progress note dated 8/9/2024 revealed that the wound had declined since 8/1/2024, related to constant stool contamination of wound. The note also states Unable to secure dressing due to constant loose stool contamination . Concern that this wound will not heal with no way to prevent stool contamination. Please refer to PCP [primary care provider] for evaluation. ? [Question] Flexi Seal and/or need for [antibiotics]. A new active problem was added as full incontinence of feces. The wound was not measured during this visit however, the NP wrote, Will re-eval size next week.</p> <p>A Physician progress note dated 8/9/2024 reads The patient was seen by wound care today, where a stage 1 decubitus ulcer was identified in the intergluteal area. This ulcer appears to be exacerbated by fecal material. [The] patient denies any pain in the affected area, which is likely due to decreased sensation in the gluteal region. There is no drainage noted from the ulcer site . Previously, the wound was being treated with Medihoney and a barrier dressing, but this approach has not been successful in managing the ulcer. The wound care team is now recommending a Flexi Seal System for improved fecal management . Agree w/ Flexi Seal System for fecal management .</p> <p>- Order placed for further recommendations</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>- Follow as chronic condition</p> <p>Orders: -Flexi Seal System</p> <p>The facility did not obtain the Flexi Seal as recommended, the wound worsened and became infected . There is no documentation in the medical record regarding follow-up to obtain the Flexi Seal.</p> <p>A NP progress note dated 8/16/2024 indicates that the reason for the visit is a worsening sacral wound. The note states History:</p> <ul style="list-style-type: none"> - Previously [diagnosed with] moisture associated skin dermatitis - Progressed significantly due to chronic stool contamination - Flexi-seal fecal management system ordered, not arrived - Significant sacral skin breakdown - Unstageable ulcer [a type of ulcer that has full thickness tissue loss but is covered by slough or eschar [dead tissue], which prevents the assessment of the true depth of the ulcer]: top of sacrum to rectal area, ~8-9 inches - L [Left] intergluteal fold: necrotic area w/significant malodor - R [Right] upper gluteal cleft: surrounding warmth, induration, hardened fluctuant area . <p>There are also measurements for MASD Buttock bilateral 6.5cm L x 10cm W x 0.3cm D.</p> <p>Per a Health Status Note written on 8/16/2024 Resident #87 had been seen in the emergency department (ED) for treatment of a wound infection of her/his coccyx. S/he returned with orders for Amoxicillin (antibiotic) for seven days.</p> <p>A Physician Progress note dated 8/20/2024 states Patient seen for follow- up of worsening sacral ulcer in the intergluteal area. The ulcer continues to be contaminated with stools. Flexi Seal System for fecal management is pending arrival. Patient reports no pain. Seen by wound care today. Patient was placed on antibiotic therapy over the weekend after ED visit for possible debridement and treatment . ASSESSMENT AND PLAN:</p> <ol style="list-style-type: none"> 1. Stage 2 acute sacral ulcer/intergluteal superimposed infection with sloughing tissue <ul style="list-style-type: none"> - Continue wound care - Santyl ointment for chemical debridement - Consider mechanical debridement if necessary - Awaiting Flexi Seal system to manage fecal material <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>- Switch to IV antibiotics (Zosyn).</p> <p>On 8/25/2024 Resident #87 was seen by a provider via telehealth for evaluation of diarrhea. A new order to hold Bisacodyl (laxative), and an order for Loperamide (antidiarrheal medication) as needed was obtained. The facility still had not obtained the Flexi-Seal that was recommended on 8/9/2024.</p> <p>A Nurse Practitioner (NP) Progress Note dated 8/29/2024 revealed an unstageable wound to coccyx and gluteal cleft extending down bilateral gluteal folds approximately 4.5 x 8 inches. The NP wrote, - Request wound care provider assessment for bedside debridement - Consider wound VAC [vacuum assisted closure, a type of therapy that helps wounds heal] to facilitate healing - Hold antibiotics, monitor closely - Chronic incontinence (urine and loose stools) causing contamination which is complicating healing and creating constant risk of infection.</p> <p>1.- Requested Flexi-seal stool diversion system (not yet arrived)</p> <p>- Not stable for discharge due to wound complexity and infection risk</p> <p>- Continue close monitoring</p> <p>2. Chronic incontinence</p> <p>- Requested Flexi-seal stool diversion system (multiple times, not yet arrived)</p> <p>Per a nurse health status note written on 9/4/2024, Resident #87 had an increase in redness to peri wound along with an odor to the wound. New orders for a wound culture and blood work were obtained.</p> <p>A wound consult note dated 9/6/24 states, Wound Care is consulted for evaluation and treatment of a pressure ulcer of the buttocks, present on admission. Initially with rapid deterioration. Concern for frequent stool contamination. Significant in severity . Incontinent of urine and frequent loose stool leading to recurring stool contamination of the wound . Per staff - Concern that wound has new onset odor. WBCs [white blood cells, indicating possible infection] showing elevations again. PCP [primary care provider] to start IV Abx [intravenous antibiotics]. Per Staff Nurse - PCP wonders if a wound vac would be an option. At this time I would discourage use of wound vac provided the wound bed is still [approximately] 50% slough. Still trying to manage frequent stool contamination of wound. Prior discussion about a flexi seal - at this time the facility is still waiting for the equipment. The biggest concern is preventing the wound from constant fecal contamination to prevent infection/sepsis.</p> <p>A NP progress note also dated 9/6/2024 reads follow-up for unstageable sacral/coccyx gluteal wound - Recently completed IV antibiotics course, off for ~1 week - Nursing concerns: returning wound malodor-requested wound swab and lab work. At that time according to nursing vital signs were stable and patient was afebrile. - Denies fevers/chills - Reports increased fatigue and weakness - Appears weak, requires assistance to stand (new in last 10-12h) . - Skin: - Significant malodor from sacral/coccyx wound - Increased surrounding induration and warmth extending to outer gluteal area and lower back - Coccyx/sacral wound: - Significant necrotic slough at top of wound (gluteal cleft/coccyx area) - Tunneling at 2 and 3 o'clock</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>Impression & Plan: 1. Worsening sacral/coccyx wound - Elevated WBC - Continued contamination from feces due to chronic incontinence. Flexi-seal still has not arrived. - Failed recent IV antibiotics - Significant changes: increased weakness, expanding induration/warmth, malodor</p> <p>- Plan: - Immediate, urgent transfer to hospital for surgical evaluation and likely debridement - Communicated with nursing staff and ED - Requested surgical consult for debridement .</p> <p>Hospital discharge notes dated 9/12/2024 indicate that Resident #87 was admitted to the hospital on 9/6/2024 with a necrotic infected stage IV (full thickness) pressure ulcer that required surgical debridement to the bone, and prolonged antibiotic therapy due to osteomyelitis (infection of the bone).</p> <p>A Nurse Practitioner progress note dated 9/13/2024 reveals that the NP continued to recommend a fecal management system due to loose stool contaminating the wound bed and increasing infection risk.</p> <p>Per review of NP progress notes and wound consult progress notes written between 8/9/2024 and 9/13/2024 the NP mentions the need for, and lack of availability of a Flexi Seal to minimize wound contamination from stool on 8/16, 8/20, 8/29, 9/6, and 9/13/2024.</p> <p>During an interview on 10/2/2024 at 4:20 PM the Director of Nursing (DON) confirmed that the facility did not obtain the Flexi Seal per wound care recommendations and physician orders. recommendations .</p> <p>*https://learning.iww.com/files/BacktotheBasicsWoundAssessmentManagementandDocumentation-1662480009184.pdf</p> <p>** https://www.ncbi.nlm.nih.gov/books/NBK593201/</p> <p>*** https://www.hhs.texas.gov/sites/default/files/documents/pi-care-plan-highlights.pdf</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>48017</p> <p>Based on staff interview and record review, the facility failed to ensure that all licensed nurses have the specific competencies and skill sets necessary to care for the resident's needs identified through resident assessments and the care plan for 2 of the 2 sampled residents (Resident # 291 and Resident # 87). Findings include:</p> <p>Per record review, both Resident # 291 and Resident # 87 had wound vacs while admitted to the facility. (A wound vac is an apparatus that promotes wound healing using suction).</p> <p>Per record review, 5 of 5 records sampled for direct care staff caring for the residents did not contain competencies for using a wound vac.</p> <p>Per interview on 10/2/2024 at approximately 2:30 PM, the facility Nurse Educator stated that the facility had not yet developed a competency for wound vacs. S/he stated that s/he had shown some of the staff nurses how to change the dressing and use the specific dressing materials that are required in the vac application, but they have not developed a competency checklist for each nurse for wound vac use that outlines the facility's procedure for wound vac use.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475033	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/02/2024
NAME OF PROVIDER OR SUPPLIER Crescent Manor Care Ctrs		STREET ADDRESS, CITY, STATE, ZIP CODE 312 Crescent Blvd Bennington, VT 05201	
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 0730</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Observe each nurse aide's job performance and give regular training.</p> <p>48017</p> <p>Based on interviews and employee files, the facility failed to ensure that Licensed Nursing Assistants (LNAs) received annual performance evaluations for 2 of the 2 LNAs employee files reviewed. Findings Include:</p> <p>Per review of employee files for LNAs who have worked at the facility for longer than a year, no nurse aide performance evaluations were completed within the past year.</p> <p>Per interview on 10/2/2024 at approximately 11:00, the Administrator confirmed that employee annual performance evaluations for the LNAs had not been completed.</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>46135</p> <p>Based on observation, interview, and record review, the facility failed to implement an infection prevention and control program designed to help prevent the development and transmission of communicable diseases and infections related to the use of personal protective equipment for 3 of 12 residents on precautions (Residents #51, #25, and #30). Findings include:</p> <p>Per observation on 10/1/24 at 1:55 PM, roommates Resident #51 and Resident #25 have a personal protective equipment caddy on their door. Per record review, Resident #51's care plan reads [Resident #51] has dx [diagnosis] of MRSA+ [Methicillin-resistant Staphylococcus aureus positive, a bacteria that can cause infections] right hip surgical wound, revised on 9/3/24 with an intervention for CONTACT ISOLATION [wearing gowns and gloves when touching the patient or their environment], initiated on 9/3/24. Resident #25's care plan reads, [Resident #25] has ESBL [extended-spectrum beta-lactamase; bacteria resistant to antibiotics] to left hip and is on Enhanced Barrier precautions [wearing gowns and gloves during high-contact resident care activities], revised 9/17/24, with an intervention that reads, resident to be maintained on Enhanced Barrier precautions, revised 9/17/24.</p> <p>Per observation on 10/1/24 at 1:55 PM, a Licensed Nursing Assistant (LNA) assisted Resident # 51 with toileting and was not wearing a gown. A few minutes later, at 2:00 PM, this LNA was observed touching a wound on Resident #25 and was not wearing a gown.</p> <p>Per interview on 10/1/24 at 2:08 PM a Licensed Practical Nurse confirmed that Residents #51 and #25 were both on precautions and the LNA should have been wearing a gown while doing any kind of personal care for Residents #51 and #25.</p> <p>Per observation on 10/1/24 at 2:45 PM, Resident #30 had a personal protective equipment caddy on his/her door. Per record review, Resident #30's care plan reads, [Resident #30] has potential for impairment of skin [related to diagnosis] of Diabetes Mellitus with neuropathy [nerve damage]. incontinence, falls, revised on 9/4/24, with an intervention that reads, Enhanced Barrier Precautions for [lower left extremity] open areas, initiated on 7/25/24.</p> <p>Per observation on 10/1/24 at 2:49 PM, two LNAs were observed assisting Resident #30 with toileting. Neither of the LNAs were wearing gowns.</p> <p>Per interview on 10/2/24 at 9:31 AM, the Infection Preventionist confirmed that Residents #25, #30 and #51 were on precautions and that the LNAs should be wearing gowns and gloves for personal care.</p>		