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	02/25/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation and policy, and staff interviews for one (1) of two (2) residents (Resident #2) reviewed for controlled substances, the facility failed to ensure controlled substances were secured under double lock immediately upon receipt in accordance with facility policy. Specifically, controlled substances delivered by the pharmacy were left unsecured on top of a medication cart and were not verified and secured at the time of receipt, resulting in a discrepancy in which one (1) blister pack of Oxycodone was unaccounted for. The findings include:Resident #2 was admitted to the facility on [DATE] with diagnoses that included fracture of the right femur.The Nursing admission assessment dated [DATE] identified Resident #2 had pain or hurting within the last five (5) days and what appeared to relieve the pain included pain medications.The Physician's Orders dated 10/7/25 directed Oxycodone 5 mg tablet every four (4) hours as needed for pain and Lyrica (Pregabalin) 200 mg capsule two (2) times a day for nerve pain.The Resident Care Plan (RCP) dated 10/8/25 identified Resident #2 had a fracture of the right hip. Interventions included to administer pain medication as ordered.The Packing Slip Proof of Delivery dated 10/8/25 at 5:58 AM identified two (2) Oxycodone 5 mg tablet thirty (30) count packets. The slip was signed by RN #1.The Packing Slip dated 10/7/25, delivered 10/8/25, identified two (2) Pregabalin 200 mg capsule thirty (30) count packets. The slip was signed by RN #1.The Controlled Substance Disposition Record (CSDR)(139039) date received of 10/8/25 identified Resident #2 had Lyrica 200 mg capsules with a total of thirty (30) capsules.The CSDR (139038) date received of 10/8/25 identified Resident #2 had Lyrica 200 mg capsules with a total of thirty (30) capsules.The CSDR (139036) date received of 10/8/25 identified Resident #2 had Oxycodone 5 mg tablets with a total of thirty (30) tablets.The Reportable Event form completed by the DNS dated 10/13/25 identified on 10/8/25 the pharmacy delivered four (4) blister packs of Narcotics; two (2) Lyrica and two (2) Oxycodone in Resident #2's name. On 10/13/25 a medication discrepancy was identified due to one (1) blister pack of Oxycodone which was unaccounted for. The investigation and facility video review identified RN #1 received four (4) blister packs (two (2) Lyrica and two (2) Oxycodone) from the pharmacy driver. RN #1 delivered them to LPN #1. LPN #1 is observed on video with four blister packs of medication at the nursing station and then the medication cart; however, LPN #1 documented only one (1) Oxycodone blister pack was received.LPN #1's statement dated 10/14/25 identified on 10/8/25 near the end of her shift, RN #1 went to the unit she was working on and signed in controlled substances with her. She took four (4) blister packs (confirmed by facility camera) to the medication cart and then rushed to administer another resident's medication. She returned to the medication cart to put the controlled substances away and signed in three (3) blister packs.Interview and review of LPN #1's documented statement with LPN #1 on 2/25/26 at 2:18 PM identified she worked on 10/8/25 for the 11:00 PM to 7:00 AM shift. She identified near the end of her shift, RN #1 approached her with the controlled substance medication delivery. She (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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	identified the controlled substance blister packs were placed on the top of her medication cart, which was positioned in the unit hallway. She identified RN #1 transferred the blister packs to her, but she did not verify the number of blister packs during the transfer because she was in a rush. She identified she left the controlled substance blister packs unsecured on top of the medication cart. She identified she then went to administer medication to another resident. She identified she returned to the medication cart and signed the controlled substances into the Controlled Substance and Narcotics book which included two (2) blister packs of Lyrica and one (1) blister pack of Oxycodone. She identified that in the statement she wrote for the facility, she noted that she was given two (2) blister packs of Lyrica and two (2) blister packs of Oxycodone because that is what was identified on the facility footage, but she did not verify the controlled substances that were given to her from RN #1. She further identified controlled substances are locked in the medication cart and locked again in a stationary lock box (double lock). She identified the controlled substances should have been secured and not left on top of the medication cart unsupervised. Interview with the DNS on 2/25/26 at 3:04 PM identified the process for receiving controlled substances from the pharmacy was as follows: the pharmacy driver brings the delivery to the Supervisor and the Supervisor signs a pharmacy provided hand-off form for each blister pack. The Supervisor then goes to each unit to deliver the controlled substances. The Supervisor should verify each blister pack one by one with the unit nurse. A white hand-off form goes into the facility medication binder and a yellow copy goes into the DNS folder for review. The unit nurse creates a CSDR for each blister pack that is received (this is the form that the nursing staff use to sign out administered medications and compare what the medication cart should have available, to what is actually inside the medication cart during hand-off). She further identified the Controlled Substance Shift Inventory form is completed for each unit that compares the amount of blister packs in the medication cart to the amount on the CSDRs. She identified the discrepancy was identified when LPN #2 attempted to order additional Oxycodone for Resident #2. The pharmacy reported Resident #2 was not due for a refill and should still have a supply. She identified when she investigated the discrepancy on 10/8/25, Resident #2 had a delivery of two (2) 30 count Lyrica blister packs and two (2) 30 count of Oxycodone blister packs; however, there was only one (1) CSDR for a 30 count of Oxycodone. She identified there should have been a second CSDR to account for the second 30 count of Oxycodone. She further identified controlled substances should not be left unattended and should always be secured. Review of the Controlled Substance Administration & Accountability policy directed that controlled substances are stored in a separate compartment of a locked storage unit with access limited to approved personnel. In all cases, the dose noted on the usage form must match the dose recorded on the Medication Administration Record, Controlled Drug Record or other facility specified form. Areas without automated dispensing systems utilize a substantially-constructed storage unit with two locks and a paper system for 24-hour recording of controlled substance use. Patient specific controlled substances (e.g. narcotics) are stored under double lock until administration to the patient. The policy identified for ordering and receiving controlled substances that the medications delivered are immediately recorded on the appropriate drug deposition record and stored in the controlled drug storage area by the nurse accepting the delivery.