STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415074	A. Building B. Wing	08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village House Nursing & Rehabilitation Center	70 Harrison Avenue Newport, RI 02840

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48928 Based on record review and staff interview, it has been determined that the facility failed to ensure that the resident's environment remains as free from accident hazards as possible, relative to the implementation of an intervention indicated on the Safe Resident Handling document, for 1 of 2 residents reviewed who had sustained a fracture while in the facility, Resident ID #1. Findings are as follows: According to an article published by STATPEARLS found in the National Library of Medicine National Center for Biotechnology Information titled, Avulsion Fractures, last updated on 8/7/2023, states in part, . Pathophysiology .An avulsion fracture occurs when a ligament or other soft tissue attachment to bone overcomes the stress capacity of the bony attachment and tears off a portion of the bone. This usually occurs with forces applied from trauma . Record review of a facility reported incident received by the Rhode Island Department of Health on 7/28/2024, revealed in part, .x-ray returned of left femur with positive fracture . Review of a written statement dated 7/29/2024, authored by NA, Staff B, stated after putting [the resident] to bed, I found [him/her] in the crack of the bed between the wall and the bed. I moved [him/her] to the center of the bed and left for the night. (Reported the resident was found between the wall and the bed to the nurse) Record review of a document titled Safe Resident Handling dated 6/11/2024, the safety and quality tool revealed the resident requires substantial/maximum assistance to roll left to right and right to left in bed, transition from sitting to lying in bed and from lying in bed to a sitting position on the edge of the bed, assistance needed to aid in transitions from a sitting position to standing and transfers. The document further indicated, that based on the resident's required assistance calculated using the safety and quality tool found on the Safe Resident Handling document, the amount of care giver assistance necessary to perform the above-mentioned tasks, which includes bed mobility, for this resident is the Assist of 2. (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 0689 Level of Harm - Actual harm Residents Affected - Few	Record review of a document provided to Nursing Assistants (NAs) that indicates each residents' necessary level of assistance required for care, titled 1st FLOOR/LIST 2/ CARE PLAN, dated 7/26/2024, fails to address how the residents are able to move in bed, the level of assistance needed, or the required number of staff needed for assistance with bed mobility for 14 of the 15 residents that reside on Resident ID #1's unit, including Resident ID #1. During a surveyor interview on 8/6/2024 at 12:10 PM with the Administrator, she acknowledged that Staff B was not assisted by another staff member when she had repositioned the resident after finding him/her wedged between the bed and the wall. Additionally, she was unable to provide evidence that the injury was not a result of this incident. Record review revealed Resident ID #1 was admitted to the facility in November 2021 with diagnoses including, but not limited to, Alzheimer's disease, vitamin D deficiency, and heart failure. Record review of a Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident requires Substantial [and/or] maximal assistance - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort for rolling left and right in bed, sitting up from the lying position, and for sitting on the side of the bed to lying down flat on the bed. Record review of a care plan dated 9/28/2023 reveals a focused care area for activities of daily living (ADL) indicating the resident is not independent with care due to advancing Alzheimer's disease, impaired mobility, and strength, with an approach that includes s/he is to be extensively assisted with bed mobility. Record review of the progress notes revealed the following: - 7/26/2024 at 4:54 PM, the resident complained of discomfort in his/her left leg and hip, left leg was noted with internal rotation and difficulty noted with straightening leg, and pain noted with palpitations. The resident was also noted with several new bruises that were reported by a Nursing Assistant (NA), on 7/25/2024. Bruising and a skin tear were noted on his/her left hand, a bruise on his/her left forearm, a faint bruise noted on his/her left cheek and a black and blueish bruise on the back of his/her left knee and upper leg. -7/27/2024 at 11:20 AM, an x-ray was performed at the facility on 7/26/2024 and the results showed that the resident had an acute fracture of the proximal left femur with avulsion of the lesser trochanter. Additionally, the note indicates that the resident was found on evening rounds on 7/24/2024 to be positioned with the left side of his/her body wedged between the bed and the wall. The NA,Staff B, indicated that she alone repositioned the resident back to the center of the bed at that time. -7/27/2024 at 12:50 PM, the resident's son was informed of the x-ray results and indicated he did not want the resident to be sent to the hospital. He requested for Resident ID #1 to remain in the facility and receive pain management there. A new order was obtained for Roxanol (Morphine; an opioid medication used to relieve moderate to severe pain) 20 milligrams (mg) per milliLiter (mL), give 0.25 mL every four hours as needed for pain was ordered. -7/27/2024 at 6:47 PM, the first dose of morphine was obtained from the emergency kit and given to the resident for his/her comfort. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-7/28/2024 at 6:09 AM, the resident did not display any non-verbal signs of pain. Morphine was administered for comfort and pain control. The resident was responsive to verbal and physical stimuli and was speaking in word salad (a jumble of extremely incoherent speech), as is his/her baseline. -7/28/2024 at 4:51 PM, the resident continues to speak in word salad, received morphine twice for non-verbal signs and symptoms of pain. S/he was moaning, grimacing and restless. Pain medication was effective. -7/28/2024 at 7:49 PM, the resident refused all food, drinks and supplements. Morphine was given with good effect. -7/29/2024- no documented progress notes found in the resident's record for this date. -7/30/2024 at 4:38 AM, the resident was in bed noted to be grimacing during the night. Morphine was administered with good effect. Resident is responsive to verbal and physical stimuli. -7/30/2024 at 10:25 AM, the resident was noted with congestion and coughing. S/he had frothy sputum on his/her chest and bedding. His/her diet order was downgraded to puree, was previously on a mechanical soft diet, for breakfast and only took two bites. Morphine was administered. -7/31/2024 at 5:54 AM, the resident was in bed and wide awake all night. When s/he was asked if s/he was in pain s/he would respond with Yup and continue speaking in word salad per his/her baseline. Morphine was administered with good effect. -8/1/2024 at 12:16 AM, the resident displayed facial grimacing and received morphine for pain management. -8/1/2024 at 4:39 AM, the resident was administered morphine for comfort as facial grimacing was observed. -8/1/2024 at 2:40 PM, the resident did not eat breakfast and had only 20 mLs of a supplement for lunch. Noted to grimace occasionally and morphine was administered. -8/2/2024 at 10:11 PM, the resident was alert and speaking in word salad most of the time, but when receiving care, s/he was in a lot of pain, grimacing and yelling out. The physician was notified and an order to increase the resident's morphine from every 4 hours to every 2 hours was obtained. -8/3/2024 6:03 AM, the resident displayed facial grimacing and groaning. Morphine was administered three times. The surveyor attempted to interview Staff B on 8/6/2024 at 10:07 AM via a telephone call, a voicemail was left, and a return phone call has not been received as of 8/16/2024.