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	03/12/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on surveyor observation, record review, and staff interview, the facility failed to ensure that food is stored, served, and distributed, in accordance with professional standards for food service safety, relative to the main kitchen.Findings are as follows:1. Review of the Food and Drug Administration (FDA) Food Code 2022 Edition, Section 5-202.13 states in part, An air gap between the water supply inlet and the flood level rim of the PLUMBING FIXTURE .may not be less than 25mm [millimeter] (1 inch).During a surveyor observation on 3/9/2026 at approximately 9:30 AM, of the main kitchen during the initial walk through, in the presence of Cook, Staff H, the ice machine did not have a one-inch air gap, as required.During a surveyor interview immediately following the above observation with Staff H, he acknowledged that the ice machine did not have a one-inch air gap. 2. Review of the FDA Food Code 2022 Edition, Section 6-305.11(B) states in part, .lockers or other suitable facilities shall be provided for the orderly storage of EMPLOYEES' .possessions.During a surveyor observation on 3/9/2026 at approximately 9:30 AM, of the main kitchen during the initial walk through, in the presence of Staff H, a cell phone and portable speaker were observed lying on top of a food preparation worktable.During a surveyor interview immediately following the above observation with Staff H, he acknowledged the cell phone and portable speaker on the food preparation worktable. During a surveyor interview on 3/9/2026 at 12:48 PM with the Food Service Director, he acknowledged that the ice machine did not have an air gap, as outlined in the FDA Food Code. Additionally, he acknowledged that staff's personal possessions should not be stored on food preparation areas.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. Based on clinical record review and staff interview, the facility failed to ensure that residents are free of any significant medication errors for 1 of 1 resident reviewed who was treated with antibiotics for infected heel wounds, Resident ID #3.Findings are as follows:1. According to Mosby's 4th Edition, Fundamentals of Nursing, page 314 states in part, The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe that the orders are in error or would harm the clients.Record review revealed the resident was readmitted to the facility in January of 2026 with diagnoses including, but not limited to, pressure ulcer of the right and left heels.a. Record review revealed the following progress notes:-2/4/2026 at 4:45 PM: The resident's bilateral heel wounds were noted to be tender, reddened, and had a foul odor. Additionally, the resident's physician ordered wound cultures to be obtained.-2/8/2026 at 3:55 PM: The resident's wound cultures were positive for an infection and the resident's provider ordered two oral antibiotics, ciprofloxacin 250 milligrams (mg) twice daily for ten days and metronidazole 250 mg three times daily for ten days.Record review revealed the physician's order for metronidazole 250 mg was incorrectly transcribed to be administered twice daily, instead of three times daily.Review of the February 2026 Medication Administration Record (MAR) revealed the resident was administered only 20 doses of the metronidazole 250 mg due to the transcription error, rather than the 30 doses as intended.During a surveyor interview on 3/12/2026 at 10:47 AM with the Unit Manager, Registered Nurse, Staff E, she acknowledged that the metronidazole 250 mg order was incorrectly transcribed to be administered twice daily, rather than the 30 doses as intended.During a surveyor interview on 3/12/2026 at 11:09 AM with the resident's Physician, he revealed that the metronidazole 250 mg order should have been transcribed to be administered three times daily, as that is the typical treatment course.b. Review of a progress note dated 2/10/2026 at 5:33 PM revealed that the resident's provider ordered an additional antibiotic, metronidazole 500 mg to be sprinkled directly onto the right and left heel wounds.Review of an undated document titled, Physician Information Sheet revealed to administer metronidazole sprinkles for 14 days.Review of a physician's order dated 2/10/2026 revealed to sprinkle metronidazole 500 mg to both heel wounds once a day. Additionally, the order was discontinued on 2/23/2026.Review of the February 2026 MAR revealed the resident was administered 13 total doses of the metronidazole 500 mg sprinkles, rather than the 14 doses as intended.During a surveyor interview on 3/12/2026 at 10:47 AM with Staff E, she revealed that the metronidazole 500 mg was ordered to be administered once daily for 14 days and acknowledged that the resident only received 13 of the 14 doses.During a surveyor interview on 3/12/2026 at 12:25 PM with the Director of Nursing Services, she was unable to provide evidence that the resident was kept free from significant medication errors.Cross reference F 842 and F 881

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observation, clinical record review and staff interview, the facility failed to meet professional standards of quality related to following physician's orders for 1 of 1 resident reviewed with an order for a cervical collar, Resident ID #11, for 1 of 1 resident reviewed with an order for no straws, Resident ID #70 and for 2 of 2 residents reviewed for non-pressure wounds, Resident ID #s 88 and 98.Findings are as follows:According to Mosby's 4th Edition, Fundamentals of Nursing, page 314 states in part, .The physician is responsible for directing medical treatment, Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm the clients .1. Record review revealed Resident ID #11 was admitted to the facility in November of 2022 with diagnoses including, but not limited to, Parkinson's disease (a progressive neurological disorder that primarily affects movement), scoliosis (a condition characterized by an abnormal side to side curvature of the spine), and abnormal posture.Record review revealed a physician's order with a start date of 10/10/2025 for a cervical collar to be applied when out of bed and remove at 3:00 PM as tolerated by the resident. Further review of the order revealed the collar is to be applied daily with a start time of 7:00 AM and an end time of 3:00 PM. This order was discontinued on 3/11/2026.Further review of the physician's orders revealed the following orders dated 3/11/2026:-Apply cervical collar as tolerated between 5:00 AM to 7:00 AM-Remove cervical collar between 3:00 PM to 4:00 PMDuring surveyor observations on 3/10/2026, the resident was observed without his/her cervical collar in place at 9:11 AM, 9:31 AM, 9:44 AM and 10:35 AM.During a surveyor interview on 3/10/2026 at 10:36 AM, the resident stated that staff had not offered or applied his/her cervical collar and expressed a desire to wear it.During a surveyor interview on 3/10/2026 at 10:39 AM with Licensed Practical Nurse, Staff A, she acknowledged that the collar was not applied to the resident and when the nurse went to put the collar on, the resident stated, I'd be delighted if you put it on.During a surveyor interview on 3/10/2026 at 12:51 PM, with the Director of Nursing Services (DNS), she was unable to provide evidence that the cervical collar was applied as ordered.During an additional surveyor observation on 3/12/2026 at 8:46 AM, the resident was observed without his/her cervical collar in place. 2. Record review revealed Resident ID #70 was readmitted to the facility in February of 2026 with diagnoses including, but not limited to, cerebral infarction (stroke) and dysphagia (difficulty swallowing). Further review revealed the resident is receiving hospice services.Record review indicated that the resident was evaluated by a hospice nurse on 2/28/2026, who recommended modifying the diet to ground solids with nectar-thickened liquids, no use of straws, teaspoon-only intake, and one-to-one staff assistance.Record review revealed a physician's order dated 3/4/2026 for a house diet, ground consistency, nectar thick liquid and special instructions which include extra gravy and no straws.During a surveyor observation on 3/9/2026 at approximately 10:00 AM, Resident ID #70 was noted to have cups of thickened juice and thickened water, both with straws in them, on his/her bedside table.During a surveyor observation on 3/9/2026 at approximately 1:00 PM, Resident ID #70 was being assisted with lunch by Nursing Assistant, Staff C, and a straw was observed to be in the resident's drink.During a surveyor interview on 3/9/2026 at 1:14 PM, with Staff C, she acknowledged assisting the resident with his/her lunch meal today and the day before. She acknowledged the resident had a straw in his/her cup and when asked by the surveyor if the resident was allowed to use a straw, she responded yes and indicated the resident likes to use them.During a surveyor interview on 3/11/2026 at 12:43 PM, with the DNS, she revealed that she would expect the resident's diet order, which includes no straws, to be followed by staff.3. Record review revealed Resident ID #88 was admitted to the facility in November of 2025 with a diagnosis including, but not limited to, mild cognitive impairment.Review of a care plan focus area initiated on 11/24/2025, revealed the resident is at risk for skin breakdown due to increased age and mild cognitive impairment.Record review revealed a progress note dated 3/6/2026 which revealed the resident (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sustained a 3.5-centimeter skin tear on the top of his/her right hand and a new order was obtained from the provider to cleanse skin tear with vashe (a wound cleanser) every day and cover with optifoam (a foam dressing for wound care).Record review revealed a physician's order dated 3/7/2026 to wash the skin tear on the top of the right hand with normal saline daily and apply optifoam until resolved.Review of the March 2026 Treatment Administration Record revealed the above order was documented as being completed on 3/8/2026, by RN, Staff D.During a surveyor observation on 3/9/2026 at 10:02 AM, the resident was noted to have an optifoam bandage on the top of his/her right hand, dated 3/7. The bandage appeared soiled with a dark discoloration visible through the bandage.During a surveyor interview on 3/9/2026 at 11:07 AM, with RN, Unit Manager, Staff E, she acknowledged the resident's bandage was dated 3/7. During a surveyor interview on 3/10/2026 at 12:43 PM, with the DNS, she revealed that she would expect wound treatments to be completed, as ordered.4. Record review revealed Resident ID #98 was admitted to the facility in March of 2026 with a diagnosis including, but not limited to, aftercare following joint replacement surgery.Review of an admission assessment dated [DATE] revealed the resident had a skin tear to his/her right upper arm.Review of a skin check dated 3/8/2026 revealed the resident had an abrasion to his/her right upper arm.During a surveyor observation on 3/9/2026 at 11:52 AM, Resident ID #98 was noted to have a 4 x 4 adhesive dressing to his/her upper right arm, dated 3/7.Record review failed to reveal evidence of a physician's order to change the resident's dressing to his/her upper right arm.During a surveyor observation and interview on 3/10/2026 at 9:41 AM, with RN, Staff F, she acknowledged Resident ID #98's dressing to his/her right upper arm dated 3/7 and acknowledged that there was not a physician's order in place to change the resident's dressing.During a surveyor interview on 3/10/2026 at 1:50 PM with the DNS, she was unable to provide evidence of a Physician's order for the treatment of Resident ID #98's right upper extremity skin tear.During a surveyor interview on 3/12/2026 at 12:07 PM, with RN, Staff G, she revealed that she had completed the resident's admission skin check and acknowledged the resident had the bandage on his/her right upper arm. She revealed that she had entered his/her admission orders but revealed that she did not call the provider to obtain an order to change the bandage to his/her right upper arm.Cross Reference: F 842

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on record review, surveyor observation and staff interview, it has been determined that the facility failed to store drugs and biologicals in accordance with currently accepted professional principles for 1 of 1 resident observed with medications at the bedside, Resident ID #9 and for 1 of 2 medication rooms observed during the medication storage task.Findings are as follows:Record review of a facility policy titled, Medication Storage states in part, .It is the policy of this facility that medications and biologicals are stored properly, following manufacturer's or provider pharmacy recommendations.to support safe effective drug administration.medications are stored in a controlled environment. This may include such containers as medication carts, medication rooms, medication cabinets, or other suitable containers. 1. During surveyor observations of Resident ID #9, s/he was observed with one bottle of AREDS (an eye vitamin) and one 16-ounce bottle of chlorhexidine mouthwash (an antibacterial mouthrinse) on his/her bedside table on the following dates and times:3/9/2026 at approximately 1:00 PM3/9/2026 at 2:38 PM3/10/2026 at 9:27 AMDuring a surveyor interview on 3/10/2026 at 9:27 AM with Registered Nurse (RN), Staff F, she acknowledged that Resident ID #9 had the AREDS and Chlorhexidine mouthwash on his/her the bedside table and acknowledged that the medications should not have been stored at the bedside.2. During a surveyor observation on 3/10/2026 at 12:30 PM of the Specialty Care Unit medication refrigerator in the presence of RN, Staff B, revealed the following medications:one 30 milliliter (ml) bottle of Ativan Intensol concentrate (a medication prescribed to treat anxiety), opened and undated.one 30 ml bottle of Ativan Intensol concentrate, opened and undated.Record review of the manufacturer's instructions revealed that in-use (opened) Ativan should be discarded after 90 days.one bottle of tuberculin purified protein solution (a solution used as a diagnostic tool to determine if a person is infected with Tuberculosis- a lung infection) opened, undated and in use.Record review of the manufacturer's instructions revealed that in-use (opened) tuberculin solution should be discarded after 30 days.During a surveyor interview immediately following the above observation, RN, Staff B, acknowledged that the Ativan and the tuberculin purified protein solution were opened, undated and in use.During surveyor interviews on 3/10/2026 at 1:50 PM and 3/11/2026 at 12:43 PM with the Director of Nursing Services, she acknowledged that Resident ID #9 should not have medications at his/her bedside. Additionally, she was unable to provide evidence that the facility ensured storage of drugs and biologicals in accordance with currently accepted professional principles and per the facility policy.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on surveyor observation, clinical record review and staff interview, the facility failed to ensure that resident records are complete and accurately documented, for 1 of 1 resident reviewed who was treated with an antibiotic for infected heel wounds, Resident ID #3 and for 1 of 2 residents reviewed for a non-pressure wound, Resident ID #88.Findings are as follows:1. Record review revealed the resident was readmitted to the facility in January of 2026 with diagnoses including, but not limited to, pressure ulcer of the right and left heels.Record review revealed the resident had wound cultures obtained of his/her right and left heel wounds.Review of a progress note dated 2/8/2026 at 3:55 PM revealed that the resident's wound cultures were positive for infectious organisms and the resident's provider ordered two oral antibiotics, ciprofloxacin 250 milligrams (mg) twice daily for ten days and metronidazole 250 mg three times daily for ten days.Record review revealed the physician's order for metronidazole 250 mg was incorrectly transcribed to be administered twice daily, instead of three times daily.Review of the February 2026 Medication Administration Record (MAR) revealed the resident was administered only 20 doses of the metronidazole 250 mg due to the transcription error, rather than the 30 doses as intended.During a surveyor interview on 3/12/2026 at 10:47 AM with the Unit Manager, Registered Nurse (RN), Staff E, she acknowledged that the metronidazole 250 mg order was incorrectly transcribed to be administered twice daily instead of three times daily for ten days.During a surveyor interview on 3/12/2026 at 11:09 AM with the resident's Physician, he revealed that the metronidazole 250 mg order should have been transcribed to be administered three times daily, as that is the typical treatment course.During a surveyor interview on 3/12/2026 at 12:25 PM with the Director of Nursing Services (DNS), she was unable to provide evidence that the resident's metronidazole 250 mg order was accurately transcribed. 2. Record review revealed Resident ID #88 was admitted to the facility in November of 2025 with a diagnosis including, but not limited to, mild cognitive impairment.Record review revealed a progress note dated 3/6/2026 which revealed the resident sustained a 3.5-centimeter skin tear on the top of his/her right hand and a new order was obtained from the provider to cleanse the skin tear with vashe (a wound cleanser) every day and cover with optifoam (a foam dressing for wound care).Record review revealed a physician's order dated 3/7/2026 to wash the skin tear on the top of the right hand with normal saline daily and apply optifoam until resolved.Review of the March 2026 Treatment Administration Record revealed the above order was documented as being completed on 3/8/2026, by RN, Staff D.During a surveyor observation on 3/9/2026 at 10:02 AM, the resident was noted to have an optifoam bandage on the top of his/her right hand, dated 3/7. The bandage appeared soiled with a dark discoloration visible through the bandage.During a surveyor interview on 3/9/2026 at 11:07 AM, with RN, Unit Manager, Staff E, she acknowledged the resident's bandage was dated 3/7. Surveyor interviews were attempted with RN, Staff D on 3/10/2026 at 11:11 AM, 11:47 AM and on 3/12/2026 at 11:14 AM, but voicemails were unable to be left, and a return call was not received.During a surveyor interview on 3/10/2026 at 12:43 PM, with the DNS, she revealed that she would expect wound treatments to be completed, as ordered. Further, she revealed that she would expect the nurses to only sign off on treatments they complete themselves.Cross Reference: F 658, F 760 and F 881.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. Based on clinical record review and staff interview, the facility failed to establish an Infection Prevention and Control Program that must include, at a minimum, an antibiotic stewardship program which includes antibiotic use protocols and a system to monitor antibiotic use to ensure that residents who require an antibiotic, are prescribed the appropriate antibiotic for 2 of 5 residents reviewed for antibiotic use, Resident ID #s 2 and 3.Findings are as follows:Review of a facility policy titled, Antibiotic Stewardship Program, last reviewed 12/31/2024, states in part, It is the policy of this facility to recognize the need to monitor antibiotic use in order to optimize the treatment of infections while reducing the adverse events associated with antibiotic use. The antibiotic stewardship program is directed toward the correct use of an antibiotic- the five D's.the right dose, the duration.1. Record review revealed Resident ID #3 was readmitted to the facility in January of 2026 with diagnoses including, but not limited to, pressure ulcer of the right and left heels.Record review revealed the following progress notes:2/4/2026 at 4:45 PM: The resident's bilateral heel wounds were noted to be tender, reddened, and had a foul odor. Additionally, the resident's physician ordered wound cultures to be obtained.2/8/2026 at 3:55 PM: The resident's wound cultures were positive for infection and the resident's provider ordered two oral antibiotics, ciprofloxacin 250 milligrams (mg) twice daily for ten days and metronidazole 250 mg three times daily for ten days.2/10/2026 at 5:33 PM: The resident's provider ordered an additional antibiotic, metronidazole 500 mg to be sprinkled directly onto the right and left heel wounds.1a. Additional record review revealed the physician's order for metronidazole 250 mg was incorrectly transcribed to be administered twice daily, instead of three times daily, as indicated in the progress note.Review of the February 2026 Medication Administration Record (MAR) revealed the resident was administered only 20 doses of the metronidazole 250 mg due to the transcription error, rather than receiving 30 doses as intended. 1b. Review of a physician's order dated 2/10/2026 revealed to sprinkle metronidazole 500 mg to both heel wounds once a day. Additionally, the order was discontinued on 2/23/2026.Review of the February 2026 MAR revealed the resident was administered 13 total doses of the metronidazole 500 mg sprinkles instead of receiving the ordered 14 doses.Record review failed to reveal evidence that the three above-mentioned antibiotics were monitored or re-evaluated to ensure accuracy and the appropriateness for use.2. Record review revealed Resident ID #2 was readmitted to the facility in December of 2025 with a diagnosis including, but not limited to, acute kidney failure.Review of a progress note dated 2/14/2026 at 1:02 PM revealed the provider ordered the resident to start Augmentin (an antibiotic) twice daily for seven days for a urinary tract infection.Review of the February 2026 MAR revealed the resident was administered 15 doses of the Augmentin, instead of receiving 14 doses, as ordered.Record review revealed an Appropriateness of Antibiotics Assessment was completed on 2/16/2026 for Augmentin. Additionally, the assessment failed to identify that the duration of the Augmentin was incorrect leading to the resident receiving an extra dose.During surveyor interviews on 3/12/2026 at 12:25 PM and approximately 1:45 PM with the Director of Nursing Services, she acknowledged Resident ID #3's three antibiotics were not re-evaluated and should have been. Additionally, she was unable to provide evidence that the incorrect duration of Resident ID #2's antibiotic was identified despite completing the assessment for it.Cross reference F760 and F842