STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415027	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Hill Health & Rehabilitation Center	544 Pleasant Street Pawtucket, RI 02860

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 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** 46118 Based on record review and staff interview, it has been determined that the facility failed to ensure that services being provided meet professional standards of practice related to notifying the physician of a change in condition and implementing hospice recommendations without physician approval for 1 of 1 hospice residents reviewed, Resident ID #1. Findings are as follows: Review of a community reported complaint submitted to the Rhode Island Department of Health on 6/5/2024 alleged in part, that the resident was found to be in extreme pain, however, due to his/her dementia, s/he was unable to verbalize where the pain was originating from. The complaint further alleges that a bruise was discovered on his/her genital area and thigh, and that the physician had not been notified. Review of a facility policy titled, Change in Condition Notification states in part, .monitor residents for changes in their condition .and to notify the physician .of changes . Record review revealed Resident ID #1 was originally admitted to the facility in February of 2022 with diagnoses including, but not limited to, dementia with behavioral disturbance, thrombophilia (a blood clotting disorder), anxiety disorder, and hypertension (high blood pressure). Review of a Minimum Data Set assessment dated [DATE] revealed the resident had severe cognitive impairment and required maximum assistance from staff for activities of daily living and transfers. Record review revealed a care plan dated 5/2/2022, indicating the resident was at risk for bleeding with interventions including, but not limited to, monitoring for signs and symptoms of abnormal bleeding .(skin bruising .). Record review revealed a physician's order dated 12/15/2022 for Rivaroxaban 20 milligrams daily (an anticoagulant medication). Further review revealed a physician's order dated 3/15/2024 to monitor for side effects of anticoagulant medications including, but not limited to, excessive bruising and if symptoms are observed to notify the physician and document in the progress note. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review revealed a progress note dated 6/1/2024 at 8:15 PM that bruises were noted on the genital area and inner thigh, Nursing Assistant (NA) noticed during care and the nurse assessed the area, the resident yelled when the area was touched, Tylenol was administered, vital signs were at baseline, and the Director of Nursing Services (DNS), hospice nurse, Staff A, and spouse were made aware. Staff A ordered to hold the anticoagulant medication for 24 hours. Record review of a hospice visit note dated 6/2/2024 and authored by Staff A, revealed .significant bruising to posterior thigh all the way down to behind [his/her] knee .resistance during ROM [range of motion] .Please consider the following .Do not send out to the hospital, mobile X-ray of left hip/pelvis, schedule morphine 5mg Q [every] 8 [hours] for 24 hrs [hours] due to pain at left hip, withhold blood thinner for 24 hrs .call with results of Xray . Record review of the June 2024 Medication and Treatment Administration Records revealed the above-mentioned hospice recommendations were entered as physician's orders and completed. Although, the record failed to reveal evidence that the provider was notified. During a surveyor interview on 6/6/2024 at 1:08 PM with Licensed Practical Nurse, Staff B, she indicated that the NA alerted her to a reddened area to the resident's left leg on 6/1/2024 at approximately 6:30 AM. She further indicated that a bruise was noted to that area on 6/1/2024 on the 3:00 PM - 11:00 PM shift. Additionally, she indicated that she notified the hospice nurse who gave multiple recommendations including to hold the anticoagulant medication however Staff B acknowledged that she did not notify the physician of the bruising or of the hospice recommendations and put these recommendations in the electronic medical record as orders without provider authorization. During a surveyor interview on 6/6/2024 at 1:19 PM with the Nurse Practitioner, Staff C, she indicated that she would have expected the provider to be notified on 6/1 and 6/2/2024 of the resident's condition and the hospice recommendations prior to them being implemented as orders. She further indicated that she was unaware of the resident's condition until 6/3/2024, while she was routinely at the facility. During a surveyor interview on 6/6/2024 at approximately 2:48 PM with the DNS, she was unable to provide evidence that the provider was notified or authorized the hospice recommendations that were entered on 6/2/2024 prior to implementing them. She further indicated that she would consider the injury a change of condition and would expect that the provider to be notified.