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	10/02/2024

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 - Some	Ensure services provided by the nursing facility meet professional standards of quality. 47279 Based on record review and staff interview, it has been determined that the facility failed to provide appropriate treatment and services for 2 of 2 residents reviewed for an indwelling catheter (foley; a flexible tube that drains urine from the bladder), Resident ID #s 1 and 2. Findings are as follows: 1) According to the 2022 Brunner & Suddarth's Textbook of Medical-Surgical Nursing 15th Edition, page 1542 states, .the average person voids 1-2 L [Liters, equal to 1000 milliiters (mL) - 2000 mL] of urine in 24 hours . Review of a community report complaint submitted to the Rhode Island Department of Health on 10/1/2024 alleges that Resident ID #1 was admitted to the facility and accidentally removed his/her foley the following day. Additionally, Resident ID #1 was transferred to the hospital 3 days after admission to the facility for a fever and infection. Review of a facility policy titled, INTAKE AND OUTPUT last revised 12/2019 states in part, .Record any output as soon as possible after collecting .Resident should be provided a hat [urinary collection device for measuring] for accurate output measurement .At the end of your shift, total the amounts .and any amount of output obtained .Documentation .The date and time the resident's intake and output was measured and recorded . a) Record review revealed Resident ID #1 was admitted to the facility in September of 2024 with diagnoses including, but not limited to, urinary tract infection (UTI), bacteremia (the presence of bacteria in the blood which can be serious and requires antibiotics), and sepsis (a life-threatening reaction to an infection). Record review revealed that the resident was admitted to the facility with a foley. Record review revealed the following progress notes: -9/25/2024 at 6:46 AM the resident removed his/her foley and a provider was made aware -9/25/2024 at 1:22 PM the Nurse Practitioner was notified of the foley removal and ordered staff to monitor urinary output (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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NAME OF PROVIDER OR SUPPLIER Oak Hill Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 544 Pleasant Street Pawtucket, RI 02860	

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review revealed the following physician's orders relative to urinary output monitoring: -9/25/2024 Monitor urinary output every shift -9/26/2024 Monitor urinary output and use a hat to measure every shift due to foley removal Review of the September 25th through September 27th, 2024, Treatment Administration Record (TAR) revealed the following relative to urinary output: -9/25 Evening shift (3:00 PM - 11:00 PM): Documented as completed without a measurement -9/25 Night shift (11:00 PM - 7:00 AM): Documented as completed without a measurement -9/26 Morning shift (7:00 AM - 3:00 PM): Documented as completed (600mL output per a progress note) -9/26 Evening shift: Documented as completed without a measurement -9/26 Night shift: 200 mL output documented -9/27 Morning shift: 200 mL output documented (progress note indicated one wet brief) Additional record review revealed the resident's total urinary output on the following days: -9/25/2024: No output recorded -9/26/2024: 800 mL -9/27/2024: 200 mL (prior to the resident being transferred to the hospital at approximately 2:00 PM) Record review failed to reveal evidence that a provider was made aware of the resident's low urinary output on the above-mentioned dates until the resident had a change in condition and was transferred to the hospital. Review of the hospital Emergency Department notes dated 9/27/2024 revealed that the resident required a foley to be placed for strict urinary intake and output monitoring. During a surveyor interview on 10/2/2024 at 12:49 PM with Licensed Practical Nurse, Staff B, she revealed that she would contact the provider if a resident's urinary output was less than 200-300 mL in one shift (8 hours). b) Record review revealed Resident ID #2 was admitted to the facility in September of 2024 with a diagnosis including, but not limited to, neuromuscular dysfunction of the bladder. Review of a care plan focus area dated 9/13/2024 revealed that the resident has a foley with an intervention to monitor and document intake and output. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review revealed a physician's order dated 9/13/2024 to monitor urinary output every shift due to a foley catheter. Review of the September 13th through September 25th, 2024, TAR revealed the resident's urinary output was not documented on the following dates and shifts: -9/20 morning shift -9/21 morning shift -9/22 evening shift An attempt to reach the Nurse Practitioner and Physician were made on 10/2/2024 at 2:51 PM and 3:18 PM, respectively. Voice messages were left; however, no return calls were received. During a surveyor interview on 10/2/2024 at approximately 1:00 PM with the Director of Nursing Services (DNS) and the Administrator, they revealed that they would have expected the resident's urinary output to be measured and documented as ordered. Additionally, the DNS would not acknowledge that a provider should have been notified for Resident ID #1's low urinary output.

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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 - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 47279 Based on record review and staff interview, it has been determined that the facility failed to ensure that residents are free of any significant medication errors for 1 of 1 resident reviewed for antibiotic use, Resident ID #1. Findings are as follows: Review of community reported complaint submitted to the Rhode Island Department of Health on 10/1/2024 alleges that the resident was admitted to the facility from the hospital. Additionally, 3 days later the resident had returned to the hospital due to a fever and infection. Record review revealed the resident was admitted to the facility in September of 2024 with diagnoses including, but not limited to, urinary tract infection (UTI), bacteremia (the presence of bacteria in the blood which can be serious and require antibiotics), and sepsis (a life-threatening reaction to an infection). Review of a hospital document titled, Continuity of Care - Post-Acute Facility dated 9/24/2024 revealed that the resident was to continue receiving an antibiotic, Sulfamethoxazole-trimethoprim (Bactrim) 200-40 milligrams (mg)/5 milliliters (mL) oral suspension (liquid), 20mL (to equal 800-160mg) twice daily for 21 days for bacteremia. Additional review of the hospital document revealed that the resident last received his/her Bactrim on 9/24/2024 at 8:39 AM and was scheduled to receive his/her next dose of Bactrim on 9/24/2024 at 8:00 PM. Record review of a progress note dated 9/24/2024 authored by Licensed Practical Nurse, Staff A, revealed that the resident arrived on the unit at 5:30 PM and all medications were verified with a provider without any changes to the resident's medications. Record review revealed a physician's order for Bactrim oral suspension 200-40mg/5mL and to give 20mL (to equal 800-160mg) with a start date of 9/25/2024 at 8:00 PM. Additional review of the order revealed the start date was transcribed incorrectly for 9/25/2024 instead of 9/24/2024 at 8:00 PM which caused the resident to miss 2 doses of his/her Bactrim on 9/24/2024 (evening dose) and 9/25/2024 (morning dose). Review of the September 2024 Medication Administration Record (MAR) revealed that the resident did not receive his/her Bactrim on 9/25 (evening dose) or 9/26 (morning dose), the reasoning documented as other. Review of the progress notes revealed the following relative to the Bactrim: -9/25/2024: .on order -9/26/2024: .waiting for pharmacy. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Additional review of the September 2024 MAR revealed that the resident did not receive 4 consecutive doses of his/her Bactrim. Record review failed to reveal evidence that a provider was made aware of the missed Bactrim doses. Review of a progress note authored by the Physician dated 9/26/2024 at 5:22 PM, revealed the resident was to complete a course of Bactrim for bacteremia. Additionally, the resident's vital signs were reviewed and s/he was considered stable at present. Further review of the progress notes revealed that the resident had experienced a change in condition as evidenced by the following: -9/27/2024 at 1:59 PM: The resident complained of severe abdominal pain, increased weakness and fatigue, difficulty urinating, chills, and was noted to have the following abnormal vital signs: Blood pressure (BP):144/89 (Normal BP 120/80) Heart rate (HR): 137 (Normal HR 60-100) Respiratory rate (RR): 24 (Normal RR 12-20) Temperature (T): 103.9 (Normal T 98.6) Additionally, a provider ordered the resident to be transferred to the hospital for an evaluation. Review of the hospital Emergency Department notes dated 9/27/2024 revealed that the resident presented with findings consistent with urosepsis (a serious condition that happens when a UTI spreads to the kidneys causing sepsis). Additionally, the resident required 2 intravenous antibiotics, intravenous fluids, and placement of a urinary catheter (a flexible tube that drains urine from the bladder). During a surveyor interview on 10/2/2024 at 12:49 PM with LPN, Staff B, she revealed that the facility has a Pyxis machine (a machine securely stores an emergency supply of medication) that nursing staff has access to in the event that a resident requires medication that has not been delivered by the pharmacy or if a medication runs out. She further revealed that the Pyxis machine currently has 16 tablets of Bactrim 800-160mg tablets and she indicated that she would have called a provider to ask if the Bactrim tablet form could have been substituted for the liquid Bactrim to prevent the resident from missing a dose. Additionally, she revealed that she would notify a provider if the resident missed a dose of medication, especially an antibiotic, and would also document it. During a surveyor interview on 10/2/2024 at 2:43 PM with Staff A, she was unable to explain why the Bactrim order start date was transcribed incorrectly and revealed that she did not notify the provider to inquire if the Bactrim tablet form, which was available to administer, could be substituted for the Bactrim liquid form (the resident was receiving other medications in tablet form). An attempt to reach the Nurse Practitioner and Physician were made on 10/2/2024 at 2:51 PM and 3:18 PM, respectively, and voice messages were left. No return calls were received. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	During a surveyor interview on 10/2/2024 at approximately 1:00 PM with the Director of Nursing Services and the Administrator, they revealed that they would have expected the resident to receive his/her Bactrim as ordered or notify a provider if the Bactrim was not administered to the resident.