

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415027	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/07/2025
NAME OF PROVIDER OR SUPPLIER Oak Hill Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>42399</p> <p>Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to ensure that services being provided meet professional standards of practice for 1 of 3 residents reviewed for wound treatment orders, Resident ID #2.</p> <p>Findings are as follows:</p> <p>Review of a facility policy titled, Wound Care, last revised in January of 2023, states in part, .Procedure: 1. Verify that there is a physician's order for this procedure .Steps in Procedure .13. Dress wound .Mark tape with initials, time, and date and apply to dressing .</p> <p>Review of the resident's record revealed s/he was admitted to the facility in October of 2022 with diagnoses which include, but are not limited to, dementia and moderate protein-calorie malnutrition.</p> <p>1. Record review of a Wound Evaluation & Management Summary dated 4/2/2025, authored by the Wound Physician, revealed the resident has a non-pressure wound (open sore caused by poor circulation or other underlying condition other than prolonged pressure) of the left, anterior (top) shin.</p> <p>Further record review of the above document revealed a treatment order recommendation by the wound physician for the above mentioned wound to apply a collagen sheet (wound dressing to promote healing) with calcium alginate (a dressing that absorbs excess exudate [cells and fluid that seep out of blood vessels, pus], creating a moist wound bed to promote healing) followed by a gauze island with bordered dressing twice daily for 30 days.</p> <p>Record review failed to reveal evidence a physician order was in place for the non-pressure wound on the resident's left shin.</p> <p>During a surveyor observation of the resident on 4/7/2025 at 2:40 PM, in the presence of Registered Nurse, Staff A, the resident had a dressing applied to the top of his/her left shin. The dressing was not labeled with a date or initials.</p> <p>During a surveyor interview with Staff A immediately following the above observation, she revealed that she did not apply the dressing to the resident's left shin and was not aware of who did. She acknowledged that the dressing was not dated or initialed and that there was not a physician's order in place for the treatment of the wound on the shin.</p> <p>(continued on next page)</p>

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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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Record review revealed the resident has an unstageable pressure wound (full thickness pressure injury where the base of the wound is obscured by slough [yellowish tissue] or eschar [brown, leathery tissue] making it impossible to determine depth or stage of the wound) to his/her left posterior (back) calf.</p> <p>Record review revealed a physician order dated 3/13/2025 to apply Santyl (an ointment used to debride wounds) topically to the left posterior calf every day shift. The order was discontinued on 4/3/2025 at 9:44 AM.</p> <p>Record review revealed a physician order dated 4/5/2025 to cleanse the wound on the left posterior calf with normal saline, pat dry, apply a collagen sheet followed by a calcium alginate sheet to the wound bed followed by a gauze island dressing every day and evening shifts.</p> <p>Additional record review of the Wound Evaluation & Management Summary dated 4/2/2025, revealed a treatment order recommendation to discontinue Santyl and begin applying a collagen sheet to the wound followed by calcium alginate and a gauze island dressing twice daily.</p> <p>Record review of the April 2025 Treatment Administration Record failed to reveal evidence that a treatment order for the left posterior calf wound was in place on the following dates/times:</p> <ul style="list-style-type: none"> - 4/3/2025, evening shift - 4/4/2025, day and evening shift - 4/5/2025, day shift <p>During surveyor interviews with the Wound Nurse in the presence of the Administrator on 4/7/2025 at 2:55 PM and 3:24 PM, she revealed the wound physician's treatment orders are transcribed by the nurse when received. If they are received after hours she completes them herself the following day. She acknowledged that there was not a treatment order in place for Resident ID #2's non-pressure wound on his/her left anterior calf as ordered by the wound physician. Additionally, she would expect the dressing to be dated and initialed, per facility policy. Further, she acknowledged that there was no treatment in place for the resident's unstageable pressure ulcer on his/her posterior calf on the above-mentioned dates and times, as recommended by the wound physician.</p>