STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415041	A. Building B. Wing	04/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woonsocket Health Centre	262 Poplar Street Woonsocket, RI 02895

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46118 47939 43987 Based on record review and staff interview, it has been determined that the facility failed to implement comprehensive person-centered care plans for 3 of 4 residents reviewed for anticoagulation therapy, relative to monitoring for bleeding (anticoagulant side effects), Resident ID #s 48, 62, and 118. Findings are as follows: Record review of the facility policy titled, ANTICOAGULATION/ANTITHROMBOTIC THERAPY MONITORING reveals in part, .Purpose To ensure appropriate anticoagulant/antithrombotic dosing and to reduce the likelihood of resident harm associated with the use of anticoagulant/antithrombotic therapy . PROCEDURE .15. Continue to monitor resident for overt/covert signs of bleeding. The most serious risks associated with oral anticoagulant therapy is hemorrhage in any tissue or organ. Suspected or overt abnormal bleeding (.appearance of blood in stools, urine .petechiae [non-blanchable small spot that indicated bleeding under the skin], excessive bruising or persistent oozing from superficial injuries), new or excessive vaginal bleeding [or bleeding] from nose or gums, spitting of blood are early manifestations of anticoagulation beyond a safe and satisfactory level . 1. Record review revealed Resident ID #48 was admitted to the facility in February of 2023 and readmitted in April of 2024 with diagnoses including, but not limited to, fracture of shaft of left tibia and hypertension. Record review of a care plan initiated on [DATE] includes a focus area for potential for abnormal bleeding related to the use of anticoagulation therapy. Additionally, it revealed interventions to observe for signs of abnormal bleeding such as unexplained bleeding, nose bleeds and bleeding gums. Record review revealed a physician's order dated [DATE] for heparin (blood thinner) solution 5000 unit/M L(milliliter) 1 ML subcutaneous (injection under the skin) every 8 hours. Record review failed to reveal evidence that the care plan for Resident ID #48 was being implemented relative to observing for signs and symptoms of abnormal bleeding. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a surveyor interview on [DATE] at 3:17 PM with Registered Nurse (RN), Staff A, she was unable to provide evidence that the care plan for Resident ID #48 was being implemented relative to observing for signs and symptoms of abnormal bleeding. 2. Record review revealed Resident ID #62 was admitted to the facility in January of 2024 with diagnoses including, but not limited to, intertrochanteric fracture of right femur, pulmonary embolism (PE- a blood clot that forms inside a deep vein in your leg, arm or pelvis), phlebitis (a condition of inflammation of veins causing pain, discomfort and swelling) and thrombophlebitis (a condition where an inflammation in a vein is caused by a blood clot, affecting normal blood flow) of lower extremities. Record review of a care plan initiated on [DATE] revealed a focus area for potential for abnormal bleeding related to history of a PE with interventions to observe for signs of abnormal bleeding such as, unexplained bruising, nose bleeds, gastrointestinal, genitourinary bleeding, bleeding gums and to report concerns. Record review revealed a physician's order dated [DATE] for Eliquis (blood thinner) 5 mg (milligrams) 1 tablet twice a day. Record review failed to reveal evidence that the care plan for Resident ID #62 was being implemented relative to observing for signs and symptoms of abnormal bleeding. During a surveyor interview on [DATE] at 10:24 AM with Staff A, she was unable to provide evidence that the care plan for Resident ID #62 was being implemented relative to observing for signs and symptoms of abnormal bleeding. 3. Record review of a closed record revealed Resident ID #118 was readmitted to the facility in April of 2015 with diagnoses including, but not limited to, venous thrombosis and embolism (referring to the development and risk of lodging blood clots in the veins), long term use of anticoagulant and gastrointestinal hemorrhage. Resident ID #118 expired in April of 2024. Record review of the care plan initiated on [DATE] included a focus area for deep vein thrombosis (DVT). Additionally, it revealed interventions including, but not limited to, monitor for signs of abnormal bleeding , observe for redness, swelling or pain to left lower extremity, signs, and symptoms of DVT, monitor labs and to report concerns to Medical Doctor or Nurse Practitioner. Record review revealed a physician's order dated [DATE] for Eliquis 2.5 mg 1 tablet twice a day. Record review failed to reveal evidence that the care plan for Resident ID #118 was being implemented relative to observing for signs and symptoms of abnormal bleeding. During a surveyor interview on [DATE] at 10:58 AM with the Director of Nursing Services (DNS), she acknowledged the above-mentioned residents received anticoagulant medications as well as have comprehensive care plans which include interventions to monitor for signs of abnormal bleeding. Additionally, she was unable to provide evidence that the care plans for Resident ID #s 48, 62, and 118 were being implemented relative to observing for signs and symptoms of abnormal bleeding.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39496 47939 Based on surveyor observation, record review and staff interview it has been determined that the facility failed to meet professional standards of quality regarding not following the facility's emergency cart equipment procedure for 4 out of 4 emergency carts observed and for 1 of 1 resident reviewed relative to psychiatric consultant orders, Resident ID # 86. Findings are as follows: 1) Record review of the facility's policy titled, Emergency Cart Equipment revealed in part, .Every unit is equipped with an emergency (crash cart). It is located behind the nurse's station. The emergency cart contains the following: Suction machine 2 oxygen connection tubing's 2 suction catheters 1 bottle of normal saline 1 medium airway Gloves 1 each oxygen cannula, mask and non-rebreather 1 ambu bag [self-inflating bag, is a hand-held device commonly used to provide positive pressure ventilation to patients who are not breathing or not breathing adequately] Gowns Infection Control Pack Carry-all containing gloves, 4x4's in zip lock bag, ice pack, and blood spill kit It is the responsibility of the 11-7 nurse to check the emergency cart nightly to ensure all equipment is available and that suction machine is in working order . During a surveyor observation on 4/25/2024 at 1:54 PM in the presence of Licensed Practical Nurse (LPN), Staff B, of the [NAME] Point unit, revealed the emergency cart failed to have a blood spill kit or normal saline. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a surveyrour interview immediately following the abocve observation, Staff B acknowledged that the above findings. During a surveyor observation on 4/25/2024 at 1:44 PM in the presence of LPN, Staff C, of the Park Square unit, revealed the emergency cart failed to have an ambu bag, or a canister for the suction machine. It also revealed the oxygen tank that was kept with the cart was empty. During a surveyrour interview immediately following the abocve observation, Staff C acknowledged that the above findings. During a surveyor observation on 4/25/2024 at 1:41 PM in the presence of Registered Nurse (RN) Staff D, of the Cold Spring unit, revealed the emergency cart failed to have a non-rebreather mask. It also revealed that there were 2 oxygen tanks that were kept with the emergency cart, one was empty and the other was nearly empty. During a surveyrour interview immediately following the abocve observation, Staff D acknowledged that the above findings During a surveyor observation on 4/25/2024 at 1:38 PM in the presence of RN, Staff E, of the [NAME] Hill unit, revealed the emergency cart failed to have a non-rebreather mask. During a surveyrour interview immediately following the abocve observation, Staff E acknowledged that the above findings During a surveyor interview on 4/26/2024 at 11:35 AM with the Director of Nursing Services, she revealed that she would expect the emergency carts to be fully always stocked. Additionally, she was unable to provide evidence that the 11:00 PM to 7:00 PM nurse checks the emergency cart nightly to ensure all equipment is available. 2) Record review revealed Resident ID #86 was admitted to the facility in March of 2024 with diagnoses including, but not limited to, anxiety and depression. Record review of a geriatric psychiatry recommendation dated 3/20/2024 revealed a recommendation to check valproic acid level (VPA- lab work to test the level of valproate in the blood used primarily for patients with epilepsy or bipolar disorder) and liver function tests (LFTs- lab work to test the functioning of the liver) with next blood draw for monitoring. Record review of a progress note dated 3/21/2024 reveals in part, .NP [Nurse Practitioner] .also reviewed psych [psychiatric] report .okay with her recom [recommendation] .VPA level, LFT's Labs booked for tomorrow . During a surveyor interview on 4/26/2024 at 2:09 PM with Licensed Practical Nurse, Staff B, she was unable to provide evidence that the orders for the labs were transcribed, or that the labs were completed. Record review failed to reveal evidence that the VPA level and LFTs were obtained as ordered until it was brought to the attention of the facility on 4/26/2024 by the surveyor. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a surveyor interview on 4/29/2024 at 10:56 AM with the Director of Nursing Services (DNS), she acknowledged that the orders for the labs were missed, and they weren't completed. Record review of a lab report printed on 4/29/2024 at 4:59 PM revealed a valproic acid level of 31 microgram/milliliter (reference values 50-100 microgram/milliliter). Of note the lab slip states the therapeutic range for patients receiving valproic acid for bipolar disorder is 50-125 microgram/milliliter indicating the resident's valproic acid level is not within the therapeutic range. During an additional surveyor interview on 4/30/2024 at 1:58 PM with the DNS, she was unable to provide evidence that the low valproic acid level was reported to the Nurse Practitioner prior to the surveyor brining it to their attention.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46118 Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to promptly identify and intervene for acute changes in a resident's condition for 1 of 1 resident reviewed, relative to a death in the facility, Resident ID #118. Findings are as follows: Review of a facility policy titled Monitoring for Acute Changes in Condition Policy & Procedure states in part, . To ensure that resident receives prompt care and treatment when overall condition deviates from baseline. To identify and treat subtle changes in condition before they develop or exacerbate into life altering changes . monitor for temperature changes .pulse rate .greater than 100, with symptoms such as .dyspnea [shortness of breath] .respirations .pain .change in level of consciousness .lethargy .unresponsiveness .weakness . significant Lab findings .Protocol prior to sending resident to ER [emergency room] ensure MD [Medical Doctor] or NP [Nurse Practitioner] is notified .have information readily available when calling ER and NP . Closed record review revealed Resident ID #118 was readmitted to the facility in April of 2015 with diagnoses including, but not limited to, Chronic Obstructive Pulmonary Disease (COPD), heart disease, and a history of gastrointestinal hemorrhage. Record review revealed the resident had a signed advanced care directive with the status of Do Not Resuscitate [DNR]. Review of a progress note from [DATE] at 5:50 PM authored by LPN Staff C on the 7 AM to 3 PM shift reported that the resident exhibited labored breathing with the use of abdominal muscles, a distended abdomen, expiratory wheezing, and expressed discomfort on that day. The note also documented the following abnormal vital signs taken twice but did not specify the times of measurement. -Temperature (T): 97.3 Fahrenheit, 96.5 F (normal temperature 98.6 F) -Blood Pressure (BP): ,d+[DATE], ,d+[DATE] (normal rage ,d+[DATE]) -Pulse (P): 100, 108 (normal rage ,d+[DATE]) -Respiratory Rate (RR): 21, 20 (normal range ,d+[DATE]) -Pulse Oximetry (Pox- oxygen saturation): ,d+[DATE]% on room air (RA), 91% RA (normal range , d+[DATE]%) Additional review of the progress note revealed the following new orders: -CBC/BMP (Complete Blood Count/Basic Metabolic Panel- blood tests that measure overall health, fluid imbalances and kidney function) -STAT (as soon as possible) CXR (chest Xray) & KUB (Xray of the abdomen) (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-DuoNeb (breathing treatment) x 1 Now (to be given immediately) -DuoNeb every 6 hours for 3 days and as needed for breathing difficulty Furthermore, the progress note revealed the CXR was positive for pneumonia and indicated the following new orders: -BMP and BNP (B-type Natriuretic Peptide-blood test that measure how the heart is working) in the morning -ST (speech therapy) to rule out aspiration (inhaling food or liquids into the lungs) -Lasix (a medication to treat excess fluid in the body) 40 milligrams (mg) daily for 3 days -KCL (potassium) 20 milliequivalents (meq) daily for 3 days -Augmentin (antibiotic) ,d+[DATE] mg twice daily for 7 days During a surveyor interview on [DATE] at approximately 9:50 AM with Nursing Assistant (NA) Staff F, she indicated that on [DATE] just before 7:00 AM she found the resident to be breathing with his/her stomach and was not him/herself. She further indicated that she notified Staff C and he entered the room to assess the resident. During a surveyor interview on [DATE] at 11:50 AM with Staff C, he indicated that he was alerted by Staff F that the resident needed to be assessed on the morning of [DATE]. He indicated that the note he authored on [DATE] at 5:50 PM included his assessment from the morning, when the resident appeared to be in respiratory distress. Additionally, he indicated that he did not notify the NP because he expected the NP to complete her routine rounds that day. Record review of the completed chest x-ray dated [DATE] at 1:44 PM revealed the following: -moderate congestive heart failure (fluid buildup around the heart) -moderate interstitial edema (swelling due to increased fluid in the spaces in between the cells) -cardiomegaly (enlarged heart) -acute pulmonary vascular redistribution (change of blood flow in the lungs) -peribranchial cuffing (can be caused by fluid around airway passages to the lungs) -right base infiltrate (substance, such as fluid, in the lung) -right plural effusion (excessive fluid buildup around the lungs) (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of an Optum provider note completed [DATE], dated [DATE], revealed the resident was seen by the provider on [DATE] for the .nursing complaints of new wheezing and abdominal distention .STAT chest x-ray showed moderate CHF [congestive heart failure], plural effusion, and right base infiltrate .Plan: . diagnosis of aspiration pneumonia per chest X-ray .No dyspnea or respiratory distress on exam .Start Augmentin ,d+[DATE] mg twice daily x[for] 7 days. Start Lasix 40 mg daily x 3 days start potassium 20 mEq daily x 3 days .Spoke to PCP [Primary Care Provider] who is in agreement with plan of care .Contingency Plan: Provide supplemental O2 [oxygen] to maintain sat [saturation] > [greater than] 88%. If unable to maintain, would need to send to ER per goals of care .Communicated Care Plan with Facility, Woonsocket Health Center, Done During Rounds, [DATE] . During a surveyor interview on [DATE] at 12:29 PM with NP, Staff G, and in the presence of the Optum NP Supervisor, she revealed that she was not notified by phone of the resident's condition on the morning of [DATE] and was only notified when she entered the unit for her routine visit to the facility at approximately 10:30 AM. She further indicated that after reviewing the CXR results in the afternoon of [DATE], she ordered Lasix, KCL, and Augmentin. Additionally, she indicated that she would have expected the ordered medications to be administered to the resident on the evening of [DATE], if available, due to the resident's condition. Record review failed to reveal evidence that Lasix 40 mg or KCL 20meq was administered to the resident as ordered on [DATE]. Record review of the facility's Omnicell (an automated system for medication administration) inventory revealed the above mentioned ordered medications were available for administration to the resident on [DATE]. Record review failed to reveal evidence that a full assessment of the resident was completed on the 3:00 to 11:00 PM shift on [DATE] that included; temperature, blood pressure, pulse, respiratory rate, or an abdominal assessment related to the resident's distended abdomen previously noted. During a surveyor interview on [DATE] at 11:14 AM with Registered Nurse (RN), Staff I, she revealed that on [DATE], she was the scheduled nurse on the resident's unit on second shift until 7:00 PM. She further indicated that she did not complete a full assessment of the resident during her shift. During a surveyor interview on [DATE] at 2:52 PM with LPN, Staff J, he revealed that on [DATE] into [DATE] he was the nurse on the resident's unit from 11:00 PM to 7:00 AM. He further revealed that he assessed the resident on [DATE] at approximately 11:45 PM and on [DATE] at approximately 4:30 AM when he administered his/her DuoNeb treatment. He indicated that the resident was very tired and not him/herself as the resident is typically alert and talkative. Additionally, he indicated that he was covering two units during his shift and that there was not a nurse on the resident's unit at all times. Furthermore, he indicated that at approximately 7:00 AM, while he was on the other unit, he observed the Infection Preventionist (IP) Nurse running to the resident's unit because the resident wasn't doing well. He indicated that when he arrived at the resident's room, the nurse was putting a nasal cannula (oxygen tubing that administers oxygen through the nose. The liter (L) flow rate for a nasal cannula is of ,d+[DATE] L on the resident. Additionally, he indicated that the resident did not appear to be breathing at that time. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a progress note dated [DATE] at 7:30 AM authored by RN, Education Coordinator, Staff K, revealed that at approximately 7:30 AM she observed the charge nurse, Staff C, exiting the resident's room and stating that we were in a crisis. The note further revealed that Staff K entered the resident's room where the IP nurse was assessing the resident .who appeared to be in and out of consciousness . The IP stated she was having difficulty obtaining the Pox and .ordered [Staff C] to get the O2 tank, she applied a re-breather to the tubing and placed it over [the resident's] face. Additionally, it was revealed that Staff K asked if she should call 911 but was told to call Optum and the ambulatory service. Furthermore, she documented that she called and left a message with Optum to call the facility immediately and left the unit. Record review of the Optum Call Log, provided by Optum, revealed a call or message was not received from the facility on [DATE] or on [DATE] regarding Resident ID #118's status or change in condition. During a surveyor interview on [DATE] at 11:54 AM with the IP, she indicated that a Nursing Assistant had notified her of the resident's change of condition on the morning of [DATE] and when she entered the resident's room she first administered O2 via a concentrator (a machine that separates O2 from the air) then 15 L via a non-rebreather [a medical device used to deliver high concentrations of oxygen in emergency situations] She further indicated that emergency services were not called because she thought that the resident was stable on oxygen. Additionally, she indicated that the resident expired within 7 minutes. Record review of a progress note dated [DATE] at 4:26 PM, authored by Staff C, revealed that at 7:30 AM the resident was .observed cold and clammy, skin pale and non-responsive, had sternal rub [a technique to test an unconscious person's responsiveness] and became responsive to verbal and stimuli. BP ,d+[DATE], BS [blood sugar] 223 [normal range= ,d+[DATE]], pox 68% RA, was placed on non-rebreather mask O2 at 10L via Oxygen bottle. POX was up to ,d+[DATE]%. Resident thereafter was unresponsive, was given sternal rub [without] effects. Resident was DNR, [Family member] was notified of status [at] 7:41 AM. By 7:40am resident was pronounced dead by RN . Further review revealed the provider was notified only following the resident's death. During a surveyor interview on [DATE] at 1:14 PM with Staff C, he indicated that when Staff G, arrived at the facility on [DATE], she was unaware of the resident's death. He further indicated that he did not call emergency medical services at the time of the resident's acute change in condition on [DATE]. During a surveyor interview on [DATE] at 12:15 PM with Staff G, she indicated that she would expect that emergency services be contacted immediately when a resident presents with respiratory distress. Additionally, she indicated that she was not made aware of the resident's change in condition on [DATE] until after the resident expired, when she entered the facility for her routine rounds. During a surveyor interview on [DATE] at 9:12 AM, with the Medical Director, he revealed that if a resident has an O2 saturation of 68% and if the resident had persistent hypoxia, he would expect the resident to be sent to the hospital unless they are do not hospitalize or comfort measures only. He also stated that he would expect the facility to call the provider and if they couldn't be reached, he would expect the resident to be sent to the hospital emergently. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review failed to reveal evidence that the resident had an advanced directive to not be hospitalized or that the resident was comfort measures only. During a surveyor interview on [DATE] at 9:59 AM with the resident's Primary Care Provider, he indicated that he would expect a NP's note to be written at the time of the visit for an acute change of condition and that the plan of care to be communicated with the facility staff. He further indicated that the in the event of a change in condition, the provider should be contacted immediately and that he would have expected the Lasix to be administered on [DATE]. Additionally, he indicated that he would expect a resident with an acute change in condition, and with a Pox of 68%, be sent to the hospital emergently. During a surveyor interview on [DATE] at 11:35 AM with the Director of Nursing Services, she would have expected the Lasix and KCL to be administered as ordered on [DATE]. She further indicated that she would expect that the provider to be contacted regarding the resident's change in condition on [DATE] and that emergency services should have been contacted on [DATE] when the change in status was observed. Additionally, she acknowledged that the resident expired on [DATE] at 7:40 AM following an acute change in condition. Furthermore, she could not provide evidence that the facility promptly identified and intervened in a resident's acute change condition. 47939

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 46118 47939 Based on record review and staff interview, it has been determined that the facility failed to provide appropriate treatment and services for 2 of 3 residents reviewed with a suprapubic catheter (a device inserted through the abdomen into the bladder to drain urine), Resident ID #s 78 and 115. Findings are as follows: According to Taylor's Textbook of Fundamentals of Nursing, 9th Edition, pages 1368 states in part, Caring for patients with an indwelling catheter .The following is important nursing measures used to care for patients with an indwelling catheter .Note the volume and character of urine .Note and record the amount of urine on the patients .record every 8 hours .Empty the urine into a graduated container that is calibrated accurately for correct determination of output . According to a Cleveland Clinic document titled Suprapubic Catheter states, .How long does a suprapubic catheter stay in .If you need to use a suprapubic catheter long-term, you should change it at least every four weeks . Record review of the facility provided document titled Foley Catheter Care revealed in part, .empty the drainage bag into the urine hat: Replace the stopper or clamp .Record the urinary output . 1. Record review revealed Resident ID #78 was admitted to the facility in November of 2022 with diagnoses including, but not limited to, chronic kidney disease stage 3, urinary tract infection, hematuria (blood in the urine), and obstructive and reflux uropathy (when urine can't flow due to an obstruction or flows in reverse back towards the kidneys). Record review revealed a physician's order dated 3/8/2023 to empty foley drainage bag every shift. Record review of the Medication Administration Record for the time period of 3/29/2024 through 4/29/2024 failed to reveal evidence of documentation of urine output measurements. Record review of the vitals report for urinary output revealed the following for the time period of 3/29/2024 through 4/29/2024: - 27 out of 90 opportunities that the facility failed to document urine output measurements - 17 out of 90 opportunities that the urine output measurements were not accurately measured. The facility was documenting his/her urine output as small, medium or large (urine output is measured in millimeters where as a bowel movement is document as small, medium or large). During a surveyor interview on 4/29/2024 at 11:06 AM with the Director of Nursing Services (DNS), she was unable to provide evidence that the resident's urinary output measurements were documented every shift per facility policy. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review revealed Resident ID #115 was admitted to the facility in November of 2023 and readmitted in April of 2024, with diagnoses including, but not limited to disorder of the urinary system, urinary tract infection, obstructive and reflux uropathy and retention of urine. Additionally, the resident has a suprapubic catheter in place. Record review of the physician's orders failed to reveal a current order to change the suprapubic catheter. Review of the March Medication Administration Record revealed that the suprapubic catheter was last changed on 3/21/2024. During a surveyor interview on 4/29/2024 at 10:50 AM with Licensed Practical Nurse, Staff C, he acknowledged there was not a current order to change the suprapubic catheter. During a surveyor interview on 4/29/2024 at 10:45 AM with the DNS, she acknowledged that there was not a current order in place to change the suprapubic catheter. Additionally, she acknowledged that she would expect an order to be in place to change Resident ID #115's suprapubic catheter once a month. 39496

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 46118 Based on surveyor observation, record review and staff interview, it has been determined that the facility failed to ensure that residents who are fed by a feeding tube receive the appropriate treatment and services to prevent complications for 1 of 3 residents reviewed relative to a gastrostomy tube (often called a G tube, which is a surgically placed device used to give direct access to the stomach for supplemental feeding, hydration or medicine) Resident ID #51. Findings are as follows: Review of the policy titled, Administration of G-Tube Feeding Policy & Procedure states in part, .To safely administer tube feeding according to physician orders .Be sure HOB [Head of Bed] is elevated at 30 degrees or more and maintained at all times when receiving feedings . Record review revealed the resident was readmitted to the facility in January of 2024 with diagnoses including, but not limited to, adult failure to thrive and gastro-esophageal reflux disease. Review of a care plan dated 1/17/2024 revealed the resident has a percutaneous endoscopic gastrostomy (PEG) tube. A PEG tube is a feeding tube that allows an individual to receive nutrition through the stomach. The care plan also indicated to elevate the head of the bed at 30 degrees. Review of the active physician's orders revealed the following: -3/6/2024- Enteral feeding (tube feeding): Elevate HOB 30 degrees, continuous -3/18/2024- Aspiration (accidentally breathing food or fluids into the lungs) Precautions -3/19/2024 Vital 1.2 feeding continuous at 60 milliliters per hour During a surveyor observation on 4/22/2024 at 11:50 AM, the resident was lying flat in his/her bed with the tube feeding running via pump into his/her PEG tube. During a surveyor interview on 4/22/2024 at 11:53 AM with Registered Nurse, Staff E, she acknowledged that the resident was lying flat in his/her bed with the tube feeding running. She immediately raised the head of the bed to 30 degrees as ordered. Additionally, she acknowledged that the head of the bed should continuously remain at 30 degrees or higher to maintain aspiration precautions. During a surveyor interview on 4/23/2024 at 12:46 PM with the Director of Nursing Services, she indicated that she would expect the head of the bed to remain at 30 degrees or more for a resident who is receiving a continuous tube feeding. Additionally, she was unable to provide evidence that the resident received the appropriate treatment to prevent complications relative to tube feedings.

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46118 39496 Based on record review and staff interview it has been determined that the facility failed to ensure nursing staff have the appropriate competencies and skill sets to provide nursing and related services to assure resident safety as identified in the plan of care for 1 of 1 resident reviewed for a change in condition, Resident ID #118. Findings are as follows: According to the State Operation Manual Appendix PP- Guidance to Surveyors for Long Term Care Facilities, last revised 2/3/2023, which states in part, .To assure that all nursing staff possess the competencies and skill sets necessary to provide nursing and related services to meet the residents' needs safely and in a manner that promotes each resident's rights, physical, mental and psychosocial well-being . 'Competency' is a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics that an individual needs to perform work roles or occupational functions successfully . Record review of the facility provided document titled, Facility Assessment revealed in part, .The purpose of the facility assessment is to determine what resources are necessary to care for its residents competently during both day-to day operations and emergencies .STAFF TRAINING/EDUCATION AND COMPETENCIES .Nurse's competencies include .transcription of orders, lab protocol and radiology protocol . Assessment, early identification of problems/deterioration, management of medical and psychiatric symptoms and conditions such as heart failure, diabetes, COPD [Chronic Obstructive Pulmonary Disease], gastroenteritis, UTI's [urinary tract infections], pneumonia . Record review revealed Resident ID #118 was readmitted to the facility in April of 2015 with diagnoses including, but not limited to, gastrointestinal hemorrhage, hypertensive heart disease without heart failure and COPD. Record review revealed the following progress notes: 4/8/2024 at 5:50 PM revealed in part, .observed with labored breathing with accessory abdominal muscles, abdomen grossly distended with bowel sound positive . 4/9/2024 at 4:26 PM revealed in part, .7:30 AM resident was observed cold and clammy, skin pale and non-responsive, had sternal rub and became responsive to verbal and stimuli .pox [pulse oximetry-measures the amount of oxygen in the blood. Normal range 96-99 %] 68 % RA [room air] was placed on nonrebreather mask O2 [oxygen] at 10 L [liters] via oxygen bottle. Pox was up to 80-81%.Resident there after was unresponsive, was given sternal rub [without] effects. Resident was a DNR [Do not resuscitate] .By 7:40 AM resident was pronounced dead . Record review failed to reveal evidence that the Nurse Practitioner was notified at the time of the above nursing assessments. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During surveyor interviews on 4/24/2024 at 12:29 PM and 4/25/2024 at 12:15 PM with the Optum Nurse Practitioner, Staff G, she revealed that she wasn't called and notified of the change in condition that occurred on the morning of 4/8/2024. She further revealed that she was notified only after arriving to the facility for her routine rounds on 4/8/2024, that the resident had been in respiratory distress earlier that morning. Additionally, she revealed that she wasn't notified of the change in condition on the morning 4/9/2024 until after the resident had passed away. Furthermore, she revealed that if the resident was not a do not hospitalize, she would have expected that in an emergency situation, the resident would have been sent out to the hospital via 911. During a surveyor interview on 4/26/2024 at 9:12 AM, with the Medical Director, he revealed if a resident had an O2 saturation of 68% and if the resident had persistent hypoxia, he would expect the resident to be sent to the hospital unless they are a do not hospitalize or comfort measures only. He also stated that he would expect the facility to call the provider and if they couldn't be reached, he would expect the resident to be sent to the hospital emergently. Competencies related to a change in condition were requested for a sample of nurses who had cared for Resident ID #118 on 4/8/2024 and 4/9/2024. The Education Coordinator, Staff K, was unable to provide evidence of education or competencies, related to residents change in conditions, for the nurses listed below: Licensed Practical Nurse (LPN), Staff C Registered Nurse (RN) Education Coordinator, Staff K LPN, Staff J RN, Infection Preventionist RN, Staff I During a surveyor interview on 4/29/2024 at 11:12 AM with Staff K, she revealed that the facility does not provide an education or competency to nurses related to a change in condition. During a surveyor interview on 4/29/2024 at 11:29 AM with the Director of Nursing Services she revealed that she was unaware that assessment, early identification of problems/deterioration was under the STAFF TRAINING/EDUCATION AND COMPETENCIES section of the facility assessment. Further she was unable to provide evidence that education or competencies related to a change in condition was completed with the above mentioned staff.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 46118 47939 Based on record review and staff interview, it has been determined that the facility failed to ensure that the irregularities identified by the Clinical Consultant Pharmacist during the monthly pharmacist Medication Regimen Review (RR) were acted upon for 1 of 1 resident reviewed related to phenytoin (a medication that is used to control seizures) , Resident ID #118. Findings are as follows: Record review revealed Resident ID #118 was readmitted to the facility in April of 2015 with diagnoses including, but not limited to, vascular dementia and epilepsy. Record review of the document titled [Pharmacy] Consultation Report dated 2/27/2024, revealed a recommendation to monitor phenytoin trough concentration (indicates drug levels in an individual's body) on the next convenient lab day. Further review of this document revealed the resident .does not have a trough concentration documented in the medical record within the previous 6 months. Phenytoin has a narrow therapeutic index and requires close monitoring to help prevent adverse events. Further record review revealed the nurse practitioner accepted and authorized the above laboratory test recommendation on 2/28/2024. Record review of the document titled [Pharmacy] Consultation Report dated 3/27/2024, states in part, . prescriber accepted a pharmacy recommendation to obtain phenytoin concentration on 2/28, but the order has not yet been processed . Record review failed to reveal evidence that the above-mentioned pharmacy recommendation was obtained until 4/1/2024. Additionally, the phenytoin concentration result on 4/1/2024 was 25 micrograms (ug)/milliliter(ml) (normal range 10-20), indicating a high concentration of the medication. During a surveyor interview on 4/24/2024 with Nurse Practitioner, Staff G, she indicated that she would have expected the phenytoin trough level to have been obtained after the order was given on 2/28/2024. During a surveyor interview on 4/26/2024 at 11:35 AM with the Director of Nursing Services, she acknowledged that the ordered phenytoin trough level was not obtained until 4/1/2024 and had revealed a high result. She further indicated that she would expect that the phenytoin trough level would have been obtained the following day after it was ordered on 2/28/2024.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46118 47939 43987 Based on record review and staff interview it has been determined that the facility failed to keep residents free from significant medication errors for 2 of 2 closed records reviewed, Resident ID #s 118 and 119. Findings are as follows: 1. Closed record review revealed Resident ID #118 was last admitted to the facility in April of 2015 with diagnoses including, but not limited to, hypertensive heart disease and chronic obstructive pulmonary disease. Further review revealed that the resident expired at the facility on [DATE]. Record review of a progress note dated [DATE] at 5:50 PM revealed, that on [DATE] the resident was observed with labored breathing with use of accessory abdominal muscles, his/her abdomen was grossly distended, expiratory wheezing, and verbalized general discomfort. Further review revealed that a STAT (as soon as possible) CXR (chest x-ray) was ordered on [DATE]. Record review of the completed chest x-ray dated [DATE] at 1:44 PM revealed the following: -moderate congestive heart failure (fluid buildup around the heart) -moderate interstitial edema (swelling due to increased fluid in the spaces in between the cells) -cardiomegaly (enlarged heart) -acute pulmonary vascular redistribution (change of blood flow in the lungs) -peribranchial cuffing (can be caused by fluid around airway passages to the lungs) -right base infiltrate (substance, such as fluid, in the lung) -right plural effusion (excessive fluid buildup around the lungs) Record review revealed the following physician's orders dated [DATE]: -Lasix 40 mg (milligrams)(diuretic use to treat excessive fluid accumulation), daily for 3 days. - Potassium 20 mEq (milliequivalent) (electrolyte that helps with heart contractions) daily for 3 days. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of an Optum provider note completed [DATE], dated [DATE], revealed the resident was seen by the provider on [DATE] for the .nursing complaints of new wheezing and abdominal distention .STAT chest x-ray showed moderate CHF [congestive heart failure], plural effusion, and right base infiltrate .Plan . diagnosis of aspiration pneumonia per chest X-ray .No dyspnea or respiratory distress on exam .Start Lasix 40 mg daily x 3 days start potassium 20 mEq daily x 3 days .Communicated Care Plan with Facility, Woonsocket Health Center, Done During Rounds, [DATE] . Record review failed to reveal evidence that Lasix or Potassium were administered to the resident on [DATE], as ordered. During a surveyor interview on [DATE] at 12:29 PM with the Optum Nurse Practitioner (NP), Staff G, and in the presence of the Optum NP Supervisor, she indicated that after reviewing the CXR results on the afternoon of [DATE], she ordered Lasix, Potassium, and Augmentin. Additionally, she indicated that she would have expected the ordered medications to be administered to the resident on the evening of [DATE], if available, due to the resident's condition. Record review of the facility's Omnicell (an automated system for medication administration) inventory revealed that Lasix and Potassium were available in the facility on [DATE]. During a surveyor interview on [DATE] at 11:35 AM with the Director of Nursing Services (DNS), she indicated that she would have expected the Lasix and Potassium to be administered as ordered on [DATE]. Further record review revealed the resident expired at the facility on [DATE]. 2. Closed record review revealed that Resident ID #119 was admitted to the facility in January of 2024 with diagnoses including, but not limited to, hepatic encephalopathy (brain dysfunction due to liver dysfunction), essential tremor, COVID-19, and alcoholic cirrhosis of the liver (chronic liver damage) with ascites (fluid in the abdomen). Record review revealed the following physician's orders: -Benztropine 0.5 mg (milligrams) once a day for essential tremor -Lactulose solution 45 ml (milliliter) three times a day for hepatic encephalopathy -Lagevrio (antiviral) 400 mg two times a day for COVID-19 -Xifaxan (antibiotic) 550 mg two times a day for alcoholic cirrhosis of the liver Review of the January and February 2024 MAR's revealed the following medications were not administered on the following dates: - Xifaxan- [DATE] AM dose, a total of 1 missed dose - Lactulose- [DATE] 9 PM dose, [DATE] 9 AM dose, a total of 2 missed doses - Benztropine- [DATE] AM dose, a total of 1 missed dose (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Lagevrio- [DATE] PM dose, [DATE] AM & PM dose, a total of 3 missed doses Record review failed to reveal evidence that the provider was notified of the missed doses of Xifanac, Lactulose and Benztropine. Further record review failed to reveal evidence that the provider was notified of the missing doses of Lagevrio until [DATE]. During a surveyor interview on [DATE] at 11:09 AM with the DNS, she acknowledged that the above-mentioned medications were not administered as ordered. Additionally, she stated that she would have expected the provider to be notified if medications are unavailable and not administered as ordered. Cross reference F 684

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F 0841 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a physician to serve as medical director responsible for implementation of resident care policies and coordination of medical care in the facility. 46118 47939 39496 Based on record review and staff interview, it has been determined that the Medical Director failed to implement a resident care policy to coordinate care for residents related to the transcription and implementation of orders by providers. Findings are as follows: Record review of the facility provided document titled Medical Director Agreement revealed in part, .The Medical Director's responsibilities include .Directing and coordinating medical care in the organization . participating in establishing policies, procedures, and guidelines to ensure adequate,comprehensive services .participating in training programs as needed .Consulting with the administrator and Education Director about the organization's ability to meet the resident's needs . This document was signed by the Medical Director on 7/1/2023. Record review of the facility policy titled, Obtaining Physician Orders-Policy and Procedure revealed in part, To ensure orders are accurately completed and put in Matrix for completion .The nurse will receive verbal order from MD [Medical Doctor] or NP [Nurse Practitioner] and will transcribe it in the notepad indicating physician orders. Or .The MD or NP will transcribe the order in the book .The nurse will promptly transcribe the order upon receiving it, then place it on shift report, and in the Progress notes .The oncoming nurse will double check the order and ensure that the order was correctly transcribed and followed through . Record review of the facility policy titled, Transcription of new orders for Non-controlled Substances Policy and Procedure revealed the following, To ensure that all resident information is complete and accurate, has been reconciled and is verified by physician/prescriber before transmitting order to pharmacy .Authorized facility staff should enter new EMAR [Electronic Medication Administration Record] orders as soon as they are received . Record review of the facility assessment states in part, .The Purpose of the facility assessment is to determine what resources are necessary to care for its residents competently during both day-to day operations and emergencies .WORKING WITH MEDICAL PRACTITIONERS .recruits and maintains enough medical practitioners who are adequately trained and knowledgeable in the care of our residents to meet the needs and scope of our population .Medical practitioners are given written guidance with regard to current regulations pertaining to care, as well as any protocols developed by our medical director . During a surveyor interview on 4/25/2024 at 11:50 AM, with Licensed Practical Nurse (LPN), Staff C, he revealed that the practitioner usually writes orders on lab slips, and the Nurse Practitioners from Optum use the verbal/telephone order book to write orders. He further revealed that when verbal orders are given, they are put into the verbal/telephone order book. (continued on next page)

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F 0841 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a surveyor interview on 4/25/2024 at 11:55 AM with LPN, Staff B, she revealed that if there is a lab slip, the providers write the orders on the lab slip and the nurses transcribe the orders into the EMAR. If the NP comes to the unit and sees the patient, they will verbally tell the nurse the orders or write them in the verbal/telephone orders book. If the doctors come in, they will verbally tell the nurse the orders and the nurse will enter the orders in the EMAR. During a surveyor interview on 4/25/2024 at 12:09 PM with Registered Nurse, Staff D, she revealed that she receives verbal orders from the providers, and she enters the orders into the EMAR. During a surveyor interview on 4/26/2024 at 8:53 AM with Nurse Practitioner (NP), Staff L, she revealed that she gives verbal orders to the nurse, the nurse repeats it back then puts it in the computer. If there is a lab, she revealed that she writes the order on a lab slip. She further revealed that she thinks the nurses have a book where they write down the orders, but she is not exactly sure how they do it. During a surveyor interview on 4/26/2024 at 9:12 AM with the Medical Director, he revealed that the process for communication of orders is that the provider would give a verbal order and the nurse enters the order into the computer. If it is a verbal order, the nurse also writes it down on a piece of paper. During a surveyor interview on 4/26/2024 at 9:59 AM with Physician, Staff H, he indicated that he thinks the Nurse Practitioner communicates orders to the nurse and the nurse enters the orders into the EMAR. During a surveyor interview on 4/26/2024 at 4:20 PM with NP, Staff G, she revealed that if she is at the facility, she will write her orders in the verbal/telephone order book or on a lab slip, if reviewing labs. She will read the order with the nurse or have the nurse read back the orders. She further revealed that occasionally she will give verbal orders that are not transcribed into the verbal/telephone order book. During surveyor interviews on 4/26/2024 at 11:35 AM, and on 4/29/2024 at 2:23 PM, with the Director of Nursing Services, she revealed the provider will communicate the order verbally to the nurse and the nurse should write the order into the verbal/telephone order book, or the provider will write the orders down themselves. She further revealed that the book is the system that the facility utilizes for obtaining orders. Additionally, she was unable to provide evidence that all nurses were educated regarding the use of the verbal/telephone orders book. During a surveyor interview on 4/26/2024 at 11:03 AM with NP, Staff M, she revealed that she verbally communicates orders with the nurses or writes them on lab slips. Additionally, she revealed that she will sometimes write the orders down on a piece of paper. She further revealed that she hasn't seen the verbal/telephone order book lately. (continued on next page)

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F 0841 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a surveyor interview on 4/26/2024 at 12:43 PM with the Administrator, Staff N, when asked about the Medical Director's oversight of the facility, she revealed that it was his NP, Staff M, that implemented the verbal/telephone orders book, as a good tool for the facility to use. She further revealed that she would expect the Medical Director to have knowledge of the verbal/telephone order book protocol. Additionally, she was unable to provide evidence that the Medical Director effectively implemented the policy related to protocols and ensured education and training's regarding the use of the verbal/telephone order book.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woonsocket Health Centre	262 Poplar Street Woonsocket, RI 02895

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46118 47939 Based on surveyor observations and staff interview, it has been determined that the facility failed to maintain a sanitary and comfortable environment relative to 4 of 4 kitchenettes observed. Findings are as follows: During a surveyor observation on 4/22/2024 at 9:28 AM of the 1st floor, [NAME] Point unit kitchenette, revealed a toaster oven with a buildup of food debris in the bottom of the toaster oven. During a surveyor observation on 4/22/2024 at 9:37 AM of the 2nd floor, Cold Spring Place kitchenette, revealed the following: - a freezer with an accumulation of brown debris and a pooling of a dry sticky red substance - a refrigerator with a pooling of a red colored sticky substance in the bottom - a toaster oven with a buildup of food debris in the bottom During a surveyor observation on 4/22/2024 at 9:59 AM of the 2nd floor, Park Square unit kitchenette, revealed the following: - a countertop with an accumulation of a brown sticky substance - a microwave with the top of the inside with an accumulation of brown food debris - flooring with an accumulation of a brown and gray substance - a freezer with an accumulation of brown debris and a pooling of a dry sticky brown substance - a refrigerator with a dry white substance observed along the left bottom drawer and a pooling of a sticky yellow and red substance in the bottom - a toaster oven with a buildup of food debris in the bottom During a surveyor observation on 4/22/2024 at 10:05 AM of the 3rd floor, [NAME] Hill unit kitchenette, revealed the following: - a freezer with a pooling of a dry sticky brown substance - a refrigerator with a clear sticky substance observed along the bottom drawers, shelving, and drawer handle (continued on next page)

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- a toaster oven with a buildup of food debris in the bottom During a surveyor interview on 4/22/2024 at 11:01 AM with the Director of Environmental Services, he acknowledged the above-mentioned observations and indicated that they needed to be cleaned.