

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415045	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/31/2025
NAME OF PROVIDER OR SUPPLIER Overlook Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 14 Rock Avenue Pascoag, RI 02859	

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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47939</p> <p>Based on record review and staff interview, it has been determined that the facility failed to ensure that services provided meet professional standards of quality relative to a post fall transfer for 1 of 1 resident reviewed for injury, Resident ID #1.</p> <p>Findings are as follows:</p> <p>Record review of a facility provided document titled Fall Protocol states in part, A fall is an unintentional CHANGE IN POSITION COMING TO REST ON THE GROUND, FLOOR OR ON THE NEXT LEVEL SURFACE .Assess ROM [Range of motion] of all extremities for changes .Once you are sure the PT [patient] is stable you may move the patient If the PT is not able to get up on their own, you will use the hooyer lift [a mechanical device used to transfer] and two assist to get back into bed .</p> <p>Review of a community reported complaint submitted to the Rhode Island Department of Health on 3/28/2025 alleges in part, the resident often fell because [s/he] had been incontinent .so when [s/he] would stand up to walk [him/herself] to the bathroom [s/he] would have falls .</p> <p>Review of a facility reported incident resulting in hospitalization received by the Rhode Island Department of Health on 3/28/2025 revealed that on 3/25/2025 at 10:50 PM, the resident experienced a fall with complaints of right hip pain. Additionally, the report revealed an x-ray was obtained on 3/27/2025 which showed a right hip fracture, and the resident was subsequently transferred to the hospital.</p> <p>Record review revealed that the resident was admitted to the facility in October of 2024 with diagnoses including, but not limited to, severe dementia with behavioral disturbance, muscle weakness, numerous falls, and abnormalities of gait and mobility.</p> <p>Review of a Minimum Data Set assessment dated [DATE], revealed a Brief Interview for Mental Status score of 4 out of 15, indicating the resident has severe cognitive impairment. Additionally, it revealed that the resident requires supervision/touching assistance of one staff to transfer from a sitting to a standing position.</p> <p>Review of a progress note dated 3/26/2025 at 12:12 AM, authored by Registered Nurse (RN), Staff A, revealed the resident was observed in his/her doorway laying on the floor. Additionally, the progress note indicated that the resident was guarding his/her right leg and complaining of right hip and leg pain. Further, the progress note indicated the resident required staff assistance to stand.</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>Record review of a Safety events fall SBAR [Situation Background Assessment Recommendation] form completed on 3/26/2025 revealed the resident experienced a pain level of 7-severe pain-horrible, intense with painful and limited ROM at the time of his/her fall.</p> <p>Record review revealed that a portable x-ray was completed at the facility on 3/26/2025 which resulted in a right hip fracture. The resident was subsequently transferred to the emergency roiaognom on [DATE] due to his/her fracture.</p> <p>Review of the hospital emergency room visit notes dated 3/27/2025, revealed that the resident was diagnosed with a right femur (thigh bone) fracture.</p> <p>During a surveyor interview on 3/31/2025 at 2:54 PM, with RN, Staff A, she acknowledged that the resident experienced an unwitnessed fall on 3/25/2025 and upon assessment the resident was guarding his/her right extremity and was complaining of right hip and leg pain. Additionally, she revealed that the resident was assisted to a standing position from the floor with two staff members. Additionally, she revealed she was not aware of the facility's fall protocol to utilize a Hoyer lift if the resident is not able to stand independently.</p> <p>During a surveyor interview with the Assistant Director of Nursing Services on 3/31/2025 at 2:47 PM she revealed that it would be her expectation that staff would utilize a Hoyer lift to assist a resident off the floor that is unable to get up on their own. Additionally, she acknowledged that the resident was experiencing severe pain and sustained a fracture to his/her right femur.</p>		