

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  06/14/2024
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 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 37158</p> <p>Based on record review and staff interview, it has been determined that the facility failed to ensure that residents' advance directives were consistent with the residents' electronic medical record (EMR) for 3 of 19 residents reviewed, Resident ID #s 2, 68 and 398. Additionally, the facility failed to ensure that the resident's advance directive was formulated for 1 of 4 new admissions reviewed, Resident ID #3.</p> <p>Findings are as follows:</p> <p>Review of a facility policy dated [DATE], titled, Advance Directives, states in part,</p> <p>.This facility is required to comply with state and federal regulations .including the right to formulate Advance Directives .to see that the resident's wishes are properly documented and carried out .</p> <p>1. All residents (or their responsible party) shall, upon admission, shall be asked about their advanced directives/wishes and educational materials which explain the right of the individual to make decisions concerning medical care including .the right to make advance directives which are to be carried out when and if the resident becomes incapable of making his/her wishes known .</p> <p>5. If the resident does not have an advance directive, the resident or his/her responsible party will be asked as soon as possible after admission, to indicate the resident's code status by completing the code status form .</p> <p>7. In the absence of a specified code status, or/an advance directive, the resident is to be considered a full code .all residents in cardiac arrest should receive resuscitation unless the resident has a valid 'Do Not Resuscitate (DNR) order .</p> <p>10. A copy of the advance directive is to be maintained in the resident's record .</p> <p>1. Record review for Resident ID #2 revealed s/he was readmitted to the facility in May of 2024.</p> <p>Record review revealed a MOLST (Medical Orders for Life Sustaining Treatment) dated [DATE] which indicates, Cardiopulmonary Resuscitation (CPR) Full Code.</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 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review revealed a physician's order dated [DATE], indicating a code status of DNR.</p> <p>Record review revealed the EMR code status banner, derived from the data entered onto the resident's face sheet, identified the resident as a DNR.</p> <p>Additional, record review revealed an advance directive document, dated [DATE] from a previous admission, which indicated DNR.</p> <p>During a surveyor interview on [DATE] at 2:52 PM with Licensed Practical Nurse (LPN), Staff A, when reviewing the above resident's record with her, she was unable to determine if the resident was truly a Full Code and further revealed she would refer to the MOLST for his/her code status.</p> <p>2. Record review for Resident ID #3 revealed s/he was readmitted to the facility in May of 2024.</p> <p>Record review failed to reveal evidence of an advance directive or any indication of the resident's code status.</p> <p>Record review revealed a physician's order dated [DATE] for Code Status with no further instructions.</p> <p>Additional, record revealed an Advance Directive document dated [DATE] from a previous admission, which indicated DNR.</p> <p>During a surveyor interview on [DATE] at 2:52 PM with LPN, Staff A, after reviewing the above resident's record with her, she was unable to provide evidence that upon admission the resident was able to formulate his/her advance directives. Further, she acknowledged the resident's advance directive from his/her previous admitted d [DATE], indicating a DNR. Additionally, she revealed that she would treat the resident as if s/he was a full code as she has nothing to verify his/her code status.</p> <p>3. Record review for Resident ID #68 revealed s/he was admitted to the facility in May of 2024.</p> <p>Record review revealed a MOLST dated [DATE], unsigned by the resident's healthcare provider, indicating Do Not Attempt Resuscitation/DNR. Further review of the MOLST indicated Do Not Intubate [DNI].</p> <p>Record review of the EMR banner only identified the resident as a DNR and not DNI.</p> <p>Additional, record review revealed a physician's order dated [DATE] for Code Status with no further instructions.</p> <p>4. Record review for Resident ID #398 revealed s/he was admitted to the facility in July of 2024.</p> <p>Record review revealed a MOLST dated [DATE], unsigned by the resident's healthcare provider, indicating Do Not Attempt Resuscitation/DNR and Comfort Measures Only. Further review of the MOLST did not indicate DNI.</p> <p>Record review of the EMR banner identified the resident as a DNR/DNI.</p> <p>(continued on next page)</p>

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Additional, record review revealed a physician's order dated [DATE] for Code Status with no further instructions.</p> <p>During a surveyor interview on [DATE] at 2:52 PM with LPN, Staff A, when asked what she would refer to for the resident's code status in the event of an emergency, she revealed she would refer to the resident's MOLST.</p> <p>During a surveyor interview with Registered Nurse, Staff B, on [DATE] at 2:33 PM, when asked what she would refer to for a resident's code status in the event of an emergency, she revealed she would refer to the resident's EMR banner.</p> <p>During an interview on [DATE] at 10:30 AM with the Director of Nursing Services, she acknowledged that Resident ID #s 2 and 3 had an advance directive from a previous admission. However, it is expected that an updated advance directive would have been completed upon their re-admission. She also acknowledged that Resident ID #3 did not have documentation of an advance directive from their current admission. Furthermore, she was unable to explain why Resident ID #s 68 and 398 did not have a signed MOLST document. Additionally, she was unable to explain the above-mentioned inconsistencies between the MOLST documents, orders and EMR banners. Lastly, she revealed staff should always refer to the resident's paper document for code status instructions.</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 37158</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 relative to following physician's orders for 1 of 1 resident with waffle boots (an off-loading device), Resident ID #60 and 1 of 1 resident receiving Nystatin powder (antifungal treatment), Resident ID #3.</p> <p>Findings are as follows:</p> <p>1. According to Mosby's 4th Edition, Fundamentals of Nursing, page 314 states in part, The physician is responsible for directing medical treatment, Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm the clients.</p> <p>Record review revealed Resident ID #60 was admitted to the facility in February of 2023 with diagnoses including, but not limited to, weakness and the need for assistance with personal care.</p> <p>Record review revealed a physician's order dated 3/14/2024 for bilateral waffle boots as tolerated, remove and reapply for care.</p> <p>During a surveyor observation on 6/14/2024 at 10:29 AM, in the presence of Licensed Practical Nurse, Staff C, revealed the resident was lying in his/her bed without his/her waffle boots applied. Additionally, Staff C acknowledged that the resident's waffle boots had not been applied and she was unable to locate the resident's waffle boots.</p> <p>Record review of the Treatment Administration Record (TAR) from 6/1/2024 to 6/13/2024 revealed the waffle boots were documented as unavailable for 18 out of 39 opportunities.</p> <p>During a surveyor interview on 6/14/2024 at approximately 1:00 PM with the Director of Nursing Services (DNS), she was unable to explain why the waffle boots were not applied as ordered and had been documented as unavailable, as the resident's waffle boots were located in the laundry room after it was brought to the facility's attention.</p> <p>2. According to Mosby's Fundamentals of Nursing Concepts, Process and Practice, 4th Edition, page 809, states in part, .a Registered Nurse checks all transcribed orders against the original order for accuracy and thoroughness .</p> <p>Record review revealed Resident ID #3 was admitted to the facility in May of 2024 with diagnoses including, but not limited to, cerebral infarction (stroke) and diabetes mellitus.</p> <p>Record review of an admission skin assessment dated [DATE], revealed skin alterations of dermatitis and moisture associated skin damage. Further review of the assessment revealed a description of the skin integrity conditions including, but not limited to, nystatin powder to his/her bilateral groin.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review revealed a physician's order dated 5/21/2024 for Nystatin powder to fungal rash twice daily for 30 days. Further review of the order failed to indicate the affected area for the treatment.</p> <p>Record review of the May and June 2024 TARs revealed the treatment was signed off as administered, without an affected area indicated for treatment.</p> <p>During a surveyor interview on 6/14/2024 at 2:16 PM with Licensed Practical Nurse, Staff A, when asked where she applies the resident's Nystatin powder, she revealed she applies the powder to the reddened areas under the resident's chest folds.</p> <p>During a surveyor interview on 6/14/2024 at approximately 1:00 PM with the DNS, she acknowledged that the Nystatin powder order was incomplete and that the order should have indicated the affected area to apply the treatment.</p> <p>41542</p>

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p>46715</p> <p>Based on surveyor observation, record review and staff interview, it has been determined that the facility failed to provide food that accommodates resident allergies for 1 of 1 resident reviewed, Resident ID #29.</p> <p>Findings are as follows:</p> <p>Record review revealed the resident was readmitted to the facility in March of 2023 with diagnoses including, but not limited to, dementia and anxiety.</p> <p>Review of the resident's listed allergies revealed s/he has an allergy to blueberries.</p> <p>During a surveyor observation on 6/11/2024 at approximately 8:15 AM, revealed a breakfast tray on Resident ID #29's bedside table with Resident ID #41's name on the diet ticket. Further surveyor observation revealed Resident ID #29 consumed all of the food on the tray that was given to him/her.</p> <p>Review of the diet ticket revealed the following food was served to Resident ID #29:</p> <p>.blueberry coffeecake .</p> <p>During a surveyor interview on 6/11/2024 at 8:16 AM with Certified Medication Technician (CMT), Staff D, she acknowledged that Resident ID #29 was given the wrong breakfast tray and was served blueberry coffeecake, and that s/he has an allergy to blueberries.</p> <p>During a surveyor interview on 6/11/2024 at 9:20 AM with the Cook, Staff E, in the presence of the Food Service Director, she revealed that if blueberry coffeecake was listed on the meal ticket, then that is what the resident received.</p> <p>During a surveyor interview on 6/11/2024 at 9:23 AM with Nursing Assistant, Staff F, she acknowledged that she served the resident the incorrect breakfast tray.</p> <p>During a surveyor interview on 6/11/2024 at 9:31 AM with the Director of Nursing Services, she acknowledged that the resident has an allergy to blueberries. Additionally, she revealed that Resident ID #29 should not have received another resident's breakfast tray.</p>		