

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  415050	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/15/2024
NAME OF PROVIDER OR SUPPLIER  The Dawn Hill Home for Rehab & Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE  1 Dawn Hill Bristol, RI 02809	

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 0550</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 a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>39496</p> <p>Based on record review and staff interview, it has been determined that the facility failed to treat each resident with respect and dignity in an environment that promotes maintenance of his or her quality of life for 1 of 3 residents reviewed, Resident ID #1.</p> <p>Findings are as follows:</p> <p>Review of a community reported complaint submitted to the Rhode Island Department of Health on 10/10/2024 alleged that Resident ID #1 was found by his/her family on 10/6/2024, in bed, covered in large amount of dried blood and feces.</p> <p>Additional review of the complaint revealed a photograph of Resident ID#1 lying in bed with dark brown matter, which appeared to be dry and cracking on both of his/her legs, on the bed sheet and on his/her shirt.</p> <p>During a surveyor interview on 10/11/2024 at 11:42 AM with the complainant, s/he stated that when a family member arrived on 10/6/2024 the resident was found in bed with his/her legs covered in stool. The complainant stated the stool was so dry it was cracking on his/her skin.</p> <p>Record review revealed the resident was readmitted to the facility in September of 2024 with diagnoses including, but not limited to, presence of joint implant (hip replacement), diabetes mellitus, and congestive heart failure. The resident was receiving hospice care.</p> <p>The resident was unable to be interviewed because s/he passed away on 10/7/2024.</p> <p>During a surveyor interview on 10/11/2024 at approximately 1:00 PM with Licensed Practical Nurse, Staff A, she revealed that she was called to the resident's room on 10/6/2024 and found the resident's legs covered in what they thought was feces. She revealed 2 nursing assistants (NA) cleaned the resident up in bed. Additionally, she revealed that after the resident was cleaned up in bed, she and a NA took the resident to have a shower. During the shower Staff A realized that it was blood and not feces. Staff A stated to this surveyor, That's why it was drying like that because it was blood.</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a surveyor interview on 10/15/2024 at 9:45 AM with NA, Staff B, she revealed that a family member approached her at approximately 4:30 or 5:00 PM on 10/6/2024 and asked to speak to a supervisor. Staff B revealed she followed the family member to the resident's room, and when she entered the room, she observed that the resident had a large amount of stool that was dried and stuck to him/her. Staff B further revealed that it took 3 staff members to clean the resident. Additionally, Staff B revealed that the resident was on her assignment, but this was the first time she had seen the resident during that shift.</p> <p>During a surveyor interview on 10/15/2024 at 1:45 PM, with the Director of Nursing Services, she revealed that usually the NA's complete rounds to check on the residents at the start of the shift, around dinner time, and around 10:00 PM. She was unable to provide evidence that the resident was checked on at the start of the shift.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>39496</p> <p>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 insulin use, Resident ID #1.</p> <p>Findings are as follows:</p> <p>Review of a community reported complaint submitted to the Rhode Island Department of Health on 10/10/2024 alleged that the failed to manage the resident's insulin.</p> <p>Record review revealed the resident was readmitted to the facility in September of 2024 with diagnoses including, but not limited to, presence of joint implant (hip replacement), type 2 diabetes mellitus, and congestive heart failure. The resident was receiving hospice care.</p> <p>Record review of a physician's order dated 9/27/2024 for Humalog (insulin) 50/50 kwikpen 100 units/milliliter, inject 6 units at bedtime for diabetes mellitus.</p> <p>Record review of the Medication Administration Record failed to reveal evidence that the resident received his/her Humalog on 9/27, 9/28, 9/29, and 9/30/2024. It was documented that the insulin was unavailable.</p> <p>Further record review failed to reveal evidence that the provider was notified that the resident failed to receive his/her Humalog on 9/27, 9/28, 9/29, and 9/30/2024.</p> <p>During a surveyor interview on 10/11/2024 at 12:25 PM, Licensed Practical Nurse, Staff C, who signed off that the Humalog was unavailable on 9/28/2024, revealed that she didn't remember if she called the pharmacy or the provider to notify them that the Humalog was unavailable.</p> <p>During a surveyor interview on 10/15/2024 at 12:36 PM with the Nurse Practitioner, she revealed that she was unaware that the Humalog was unavailable on 9/27, 9/28, 9/29, and 9/30/2024. She indicated that she would have expected the nurse to notify the pharmacy that the medication was unavailable and notify the provider.</p> <p>During a surveyor interview on 10/15/2024 at approximately 1:45 PM with the Director of Nursing Services, she revealed that if the insulin hadn't come from the pharmacy her expectation would be that the nurses call the pharmacy to order the medication and the provider notified. She stated that the facility has an insulin emergency kit, and the order could have been changed if the Humalog kwikpen was unavailable. She could not provide evidence that the pharmacy or the provider were notified that the Humalog was unavailable on 9/27, 9/28, 9/29, and 9/30/2024.</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>39496</p> <p>Based on record review and staff interview, it has been determined that the facility failed to maintain medical records on each resident that are complete and accurately documented, in accordance with accepted professional standards and practices, for 1 of 3 residents reviewed, Resident ID #1.</p> <p>Findings are as follows:</p> <p>Record review revealed the resident was readmitted to the facility in September of 2024 with diagnoses including, but not limited to, presence of joint implant (hip replacement), diabetes mellitus, and congestive heart failure. The resident was receiving hospice care.</p> <p>Record review of a Health Status Note dated 9/30/2024 written by the Nurse Practitioner reveals in part, . Hospice level of care- Focus on comfort .use Ativan for anxiety. The note indicated that the resident continued to have an order for Ativan.</p> <p>Record review of the Health Status Note dated 10/4/2024 written by the Nurse Practitioner reveals in part, . Hospice level of care- Focus on comfort .use Ativan for anxiety. The note indicated that the resident continued to have an order for Ativan.</p> <p>Record review failed to reveal an order for Ativan at the time of the above documentation by the Nurse Practitioner on 9/30 and 10/4/2024. The resident's Ativan order was discontinued on 9/13/2024 and the Ativan wasn't reordered for the resident until 10/6/2024.</p> <p>During a surveyor interview on 10/15/2024 at 12:36 PM with the Nurse Practitioner, she revealed that when she wrote the above notes, she would have expected the resident to be on Ativan because s/he was on hospice. She acknowledged that the resident failed to have an order for Ativan at the times of her notes.</p> <p>During a surveyor interview on 10/15/2024 at 1:45 PM, with the Director of Nursing Services, she revealed that she would expect the Nurse Practitioner to complete a review of the resident's current medication as a part of her visit.</p>		

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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.</p> <p>39496</p> <p>Based on record review and staff interview, it has been determined that the facility failed to ensure that hospice services meet professional standards of principles that apply to individuals providing services in the facility for 1 of 2 residents reviewed who are receiving hospice services, Resident ID #1.</p> <p>Findings are as follows:</p> <p>Record review revealed a physician's order dated 9/27/2024 for Hospice Evaluation and admit as indicated.</p> <p>Further record review of the Hospice Certification and Plan of Care revealed the resident had a start of care date of 9/28/2024. It reveals that the resident will be seen by the Nurse 3 times a week for the first week, then 1 time a week for the next 10 weeks. It further reveals the Hospice nurse will observe and assess signs and symptoms of declining status and imminent death and coordinate plan of care with facility staff.</p> <p>Review of the Hospice paperwork provided by the facility failed to reveal evidence of the Hospice Recommendation forms for all hospice nursing visits. These forms are used by hospice to communicate recommendations and resident assessments completed by the hospice nurse.</p> <p>The resident was unable to be interviewed because s/he passed away on 10/7/2024.</p> <p>During surveyor interviews on 10/11/2024 and 10/15/2024 with Hospice Nurse, Staff D, she revealed that the resident was seen by another hospice nurse on 10/6/2024, the day before s/he passed away. She further revealed that she had seen the resident on 9/30/2024 and could not explain why the facility did not have a copy of the Hospice Recommendation forms.</p> <p>During a surveyor interview on 10/15/2024 at approximately 10:00 AM with Hospice Nurse, Staff E, she revealed that she was the nurse on call on 10/6/2024. She came to the facility to assess the resident after s/he had an episode of bleeding. She said she spoke to the nurse and gave them the Hospice Recommendation form. She could not explain why the facility did not have the form on file.</p> <p>During a surveyor interview on 10/15/2024 at approximately 12:36 PM with the Nurse Practitioner, she revealed that she reviews the Hospice Recommendation forms during her record review. She further reviewed she was unable to review all the visits because they were unavailable. Additionally, she stated she would expect the hospice documentation to be complete so she could review their notes.</p> <p>During a surveyor interview on 10/15/2024 at approximately 1:45 PM with the Director of Nursing Services, she revealed that she would expect the hospice notes for each visit to be in the resident's hospice binder.</p>		