STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415050	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Dawn Hill Home for Rehab & Healthcare	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)
F 0635 Level of Harm - Actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46671 Based on record review and staff interview, it has been determined that the facility failed to obtain complete admission orders for the resident's immediate care for 1 of 1 resident reviewed who was not administered the prescribed medications after being readmitted to the nursing facility from the hospital, Resident ID #1. Findings are as follows: Record review of a community reported complaint submitted to the Rhode Island Department of Health on 10/29/2024 alleges that the resident was not administered the prescribed amiodarone (a medication that treats a fast or irregular heart rhythm by reducing symptoms and helps avoid life-threatening complications) on his/her readmission to the facility from the hospital on 10/11/2024. Additionally, the allegation indicates that the failure resulted in his/her return to the hospital. Record review revealed that Resident ID #1 was initially admitted to the facility on [DATE] with diagnoses including, but not limited to, congestive heart failure (CHF, a condition that happens when a person's heart can't pump blood well enough to give the body a normal supply. Blood and fluids collect in the lungs and legs over time) and persistent atrial fibrillation (A-fib, a serious fast and irregular heart rhythm that requires medical intervention. If left untreated, a person is placed at risk of developing blood clots that can lead to heart attack or stroke). Further record review revealed that the resident transferred from the facility to the hospital on 9/28/2024 and subsequently transferred to a different hospital for further management of difficulty breathing and an irregular heart rhythm. S/he was readmitted to the facility on [DATE]. Record review revealed that 22 files containing hospital documents, labeled Admission Documents were scanned into the resident's electronic medical record on 10/11/2024. Additional record review revealed that one of the 22 files contained a 7-pages long document dated 10/9/2024 titled, Patient Information. Page 2 of this document revealed a section titled, Patient's Medications Prior To Admission. Further record review failed to reveal evidence of a hospital continuity of care form or discharge summary which would include the medication's Resident ID #1 should receive upon readmission to the facility. Additionally, the record failed to reveal evidence of a physician's order for amiodarone dated 10/11/2024. (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 0635 Level of Harm - Actual harm Residents Affected - Few	During a surveyor interview on 10/29/2024 at 2:16 PM, with Registered Nurse, Staff A, she revealed that she was Resident ID #1's Unit Manager. Additionally, she was unable to provide evidence of a hospital discharge summary or continuity of care form that included medications the resident was to receive upon readmission to the facility on [DATE]. Additionally, she acknowledged that the 7-page document revealed a list of medications the resident was on prior to admission to the hospital and did not indicate what s/he was to receive after readmission to the facility. During a surveyor interview on 10/29/2024 at 2:19 PM, with the Director of Nursing Services (DNS), she revealed that Resident ID #1's medication orders upon readmission to the facility on [DATE] were transcribed from the document titled Patient's Medications Prior To Admission. She indicated that those were the documents the admitting nurse received from the hospital upon the resident's readmission. She indicated that she was made aware of the missed medications concerns after the resident was sent back to the hospital on 10/26/2024. At this time the facility obtained the DISCHARGE SUMMARY form from the 10/11/2024 hospital discharge which included the medications the resident was prescribed to take. A telephone interview was attempted with the admitting nurse, Licensed Practical Nurse, Staff B on 10/30/2024 at 9:35 AM, however she was unable to be reached. A voicemail was left, and a return telephone call has not been received. Further record review of the hospital document dated 10/11/2024 titled, DISCHARGE SUMMARY revealed that Resident ID #1 should start taking the following medications on 10/11/2024: - amiodarone 400 milligrams (mg) one tablet by mouth three times a day for 2 days, then one tablet once daily for 90 days until s/he follows up with his/her heart specialist. - Anora Ellipta (inhaler medication used to help improve difficulty with breathing) 62.5-25 micrograms, one puff by mouth once daily. - furosemide (water pill, used to treat patients diagnosed with heart failure by removing excessive water from the body) 20 mg once daily. Further record review failed to reveal evidence of physician's orders for the amiodarone, Anora Ellipta, or furosemide dated 10/11/2024 which indicates s/he was not administered the above medications for a total of 16 days. Additional record review revealed that Resident ID #1 was transferred back to the hospital on 10/26/2024 due to complaints of difficulty breathing. Review of the hospital Emergency Department (ED) document dated 10/26/2024 revealed that his/her treatment plan includes admission for management of conditions including, but not limited to, A-fib with rapid ventricular rate (a type of irregular heart rhythm, when the heart doesn't have a normal signaling process telling the heart when to beat) CHF and possible aspiration pneumonia. Additionally, the document indicates that the hospital contacted the nursing facility concerning the missed discharge orders from 10/11/2024. (continued on next page)

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F 0635 Level of Harm - Actual harm Residents Affected - Few	During a surveyor interview with Resident ID #1's physician on 10/30/2024 at 11:30 AM, he indicated that he would expect that the nurse would have contacted the hospital and request the correct continuity of care form and follow the instructions. During a surveyor interview on 10/31/2024 at 10:51 AM, with the DNS, she stated that the admitting nurse transcribed the orders from the document she received upon the resident's admission and acknowledged that the documents were not the discharge orders. Additionally, she stated that she would have expected that the nurse would have requested the correct discharge documents. She also acknowledged that the resident missed 16 days of his/her Anora Ellipta and furosemide.