

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 03/13/2025
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 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47279</p> <p>Based on record review and staff interview, it has been determined that the facility failed to ensure that adequate pain management was provided to a resident who required such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences for 1 of 3 residents reviewed for pain, 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 3/12/2025 alleged in part that Resident ID #1 was discharged from a hospital at 11:00 AM and admitted to the facility on [DATE] after undergoing extensive back surgery. Additionally, the facility did not have any of his/her medications available, and s/he was subsequently transferred back to the hospital for pain management later that same day. Further, his/her neurosurgeon had ordered Decadron (a steroid medication prescribed to treat inflammation), however the nursing facility was unaware s/he was prescribed it.</p> <p>1. Record review revealed the resident was admitted to the facility on [DATE] with diagnoses including, but not limited to, fusion of the spine and radiculopathy (a condition caused by a pinched nerve in your spine).</p> <p>Review of a care plan focus area dated 1/31/2025 revealed the resident has pain with a goal for the resident to verbalize adequate pain relief or the ability to cope with incompletely relieved pain.</p> <p>a. Review of a hospital document titled, Continuity of Care [COC] - Post-Acute Facility dated 1/31/2025 revealed that the resident underwent spinal surgery and was to start taking oxycodone (an opioid medication proscribed to treat moderate to severe pain) one to two tablets every four hours as needed for pain (5 to 10 milligrams [mg]). Additionally, it indicated that his/her pain was well controlled with oral pain medications.</p> <p>Review of a physician's order dated 1/31/2025 revealed to administer oxycodone, one tablet (5 mg), every 4 hours as needed for pain.</p> <p>Additionally, record review failed to reveal evidence of an order for oxycodone, two tablets (10 mg), for pain, as indicated on the hospital COC form.</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 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a progress note dated 1/31/2025 at 10:20 PM revealed that the resident was admitted to the facility with his/her family member present (earlier in the day). Additionally, the resident presented with pain upon arrival, his/her pain was escalating after receiving 2 separate administrations of oxycodone 5 mg, and the provider gave a new order to administer oxycodone 10 mg for severe pain. S/he was subsequently transferred back to the hospital for pain management for 10 out of 10 pain (in the late evening).</p> <p>Review of the January 2025 Medication Administration Record (MAR) revealed that the resident received only 5 mg of oxycodone on 1/31 at the following times:</p> <ul style="list-style-type: none"> - 1:00 PM for 8 out of 10 pain - 5:36 PM for 9 out of 10 pain <p>During a surveyor interview on 3/13/2025 at 1:11 PM with Registered Nurse, Staff A, she revealed that when reviewing the hospital COC form upon admission, if there are orders to administer one to two tablets of a pain medication, she will verify that with the provider and document it. She further revealed that if a resident is admitted with an oxycodone order indicating to administer one to two tablets, the provider typically orders to administer one tablet for mild to moderate pain, and to administer two tablets for severe pain.</p> <p>b. Additional review of a hospital document titled, Continuity of Care - Post-Acute Facility dated 1/31/2025 revealed that the resident was receiving Decadron 2 mg every 8 hours in the hospital and had an end date of 1/31/2025 at 9:59 PM. Additionally, it indicated that s/he was to receive another dose on 1/31/2025 at 2:00 PM according to page 11 of the document.</p> <p>Record review failed to reveal evidence that the resident received the Decadron at 2:00 PM, that the medication had been transcribed to be administered as indicated in the hospital COC form, or that the medication was addressed with the provider.</p> <p>During a surveyor interview on 3/13/2025 at 12:37 PM with Licensed Practical Nurse, Staff B, she revealed that she reviews the entire hospital COC form and will reference all pages to ensure accuracy and timely administrations of medications, and verifies all orders with the resident's provider.</p> <p>During a surveyor interview on 3/13/2025 at approximately 1:00 PM with the Regional Director of Nursing Services, she acknowledged that the Decadron order was not listed in one section of the COC document, but was listed on page 11 of the document. Additionally, she revealed she would expect that the staff nurse would have addressed the Decadron order with the resident's provider and document the interaction in a progress note.</p> <p>During a surveyor interview on 3/13/2025 at 1:54 PM with the Nurse Practitioner, she revealed that she was the provider who verified the resident's medications upon admission and does not recall staff addressing the Decadron medication. Additionally, she revealed that for oxycodone 1-2 tablet orders, she typically will order one tablet for mild/moderate pain and two tablets for severe pain. Further, she acknowledged that if the resident had received the two tablets of oxycodone initially for his/her severe pain, his/her pain may have been better controlled and s/he may not have required transport to the hospital for pain management.</p> <p>(continued on next page)</p>		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Cross reference F 760 and F 842

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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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47279</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 3 residents reviewed for medication administration, 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 3/12/2025 alleged in part that Resident ID #1 was discharged from a hospital at 11:00 AM and admitted to the facility on [DATE] after undergoing extensive back surgery. Additionally, the facility did not have any of his/her medications available, and s/he was subsequently transferred back to the hospital for pain management later that same day.</p> <p>Review of an undated facility provided document titled, Medication Administration/Ordering Education states in part, .To avoid medications being unavailable it is important for nursing staff to order medications in a timely manner and/or utilize all other avenues of obtaining medication such as the Ekit [Emergency medication kit] and RXNow machine [Pyxis machine; an onsite medication dispensing system that securely stores commonly prescribed medications] .When a medication is due to be administered, and it is not in the cart to administer what should be done .Check all other carts/locations where the medication could have been placed. Other carts, all other drawers, med [medication] room, refrigerator, e-kit, RxNow machine. Call the pharmacy to inquire about the medication that is unavailable .Document conversation with pharmacy in a progress note .The MD/NP [Medical Director/Nurse Practitioner] must be made aware if the medication will not be administered timely. Ask provider for new orders .alternative medication or hold medication until ordered medication is available. Progress note must be written to reflect communication with provider . Please remember that medications are doctors orders and if a medication is not available to give then the MD must be made aware that the medication has not been administered so that an alternative may be ordered if appropriate.</p> <p>1. Record review revealed the resident was admitted to the facility on [DATE] with diagnoses including, but not limited to, fusion of the spine, radiculopathy (a condition caused by a pinched nerve in your spine), type II diabetes, high blood pressure, gastro-esophageal reflux disease (GERD), and hyperlipidemia (high fat levels in the blood).</p> <p>a) Additional record review revealed the following physician's orders:</p> <ul style="list-style-type: none"> - 1/31/2025 Atorvastatin, give 10 milligrams (mg) at 4:00 PM for hyperlipidemia - 1/31/2025 Calcium Carbonate, give 1200 mg at 7:00 AM and 4:00 PM for supplement - 1/31/2025 Carvedilol, give 12.5 mg at 7:00 AM and 4:00 PM for high blood pressure - 1/31/2025 Polyethylene Glycol powder, give 17 grams at 7:00 AM and 4:00 PM for constipation - 1/31/2025 Metformin, give 1000 mg at 7:00 AM and 4:00 PM for diabetes type II <p>(continued on next page)</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>- 1/31/2025 Senna-Docusate Sodium, give 17.2-100 mg at 7:00 AM and 4:00 PM for constipation</p> <p>Review of a progress note dated 1/31/2025 at 10:20 PM revealed that the resident was admitted to the facility with his/her family member present (earlier in the day). Additionally, the resident presented with pain upon arrival, was treated with several doses of pain relief medication, and was subsequently transferred back to the hospital for pain management (in the late evening) on the same day.</p> <p>Record review revealed that s/he returned to the facility on [DATE].</p> <p>Review of the January 2025 Medication Administration Record (MAR) failed to reveal evidence that the resident received his/her Atorvastatin, calcium carbonate, carvedilol, polyethylene glycol, Metformin, or senna-docusate sodium medication on 1/31/2025 at 4:00 PM, when the resident was still present at the facility.</p> <p>During a surveyor interview on 3/13/2025 at 11:38 AM with Registered Nurse, Staff A, she revealed that if a medication for a resident is unavailable or has yet to be delivered by the pharmacy, she will check the Pyxis machine to see if the medication is available. Additionally, she would notify the provider if a resident missed a medication administration and document it in his/her progress notes.</p> <p>Record review failed to reveal evidence that the provider was notified of the above-mentioned missed medication administrations.</p> <p>During a surveyor interview on 3/13/2025 at 12:30 PM with a Registered Pharmacist, he revealed that Atorvastatin, Carvedilol, and Metformin are all available in the Pyxis machine. Additionally, he revealed that calcium carbonate, polyethylene glycol, and senna-docusate sodium are over the counter medications and are available as facility stock.</p> <p>b) Review of a physician's order dated 2/5/2025 revealed to inject Mounjaro 2.5 mg every Wednesday at 7:00 AM for diabetes type II.</p> <p>Review of the February 2025 MAR revealed that Mounjaro was documented as 9 by Licensed Practical Nurse, Staff C, indicating Other / See Progress Notes.</p> <p>Review of a progress note dated 2/5/2025 at 9:48 AM authored by Staff C, revealed that the Mounjaro was not available.</p> <p>Record review failed to reveal evidence that the pharmacy was contacted or that the provider was notified that the resident's Mounjaro was unavailable to be administered.</p> <p>During a surveyor interview on 3/13/2025 at 12:45 PM with Staff C, she acknowledged that the Mounjaro was unavailable to be administered and that she did not notify the resident's provider, and she should have.</p> <p>During a surveyor interview on 3/13/2025 at approximately 1:00 PM with the Regional Director of Nursing Services, she revealed that she would expect the resident to have received the above-mentioned medications as ordered and would expect that staff would have contacted the provider and documented in the progress notes if the resident did not receive his/her medication.</p> <p>(continued on next page)</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>During a surveyor interview on 3/13/2025 at 1:54 PM with the Nurse Practitioner, she revealed that she would expect staff to follow provider's orders and to notify her if a resident does not receive his/her medications.</p> <p>Cross reference F 697 and 842</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47279</p> <p>Based on record review and staff interview, it has been determined that the facility failed to accurately maintain the resident's medical record in accordance with accepted professional standards and practices for 1 of 1 newly admitted resident 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 3/12/2025 alleged in part that Resident ID #1 was discharged from a hospital at 11:00 AM and admitted to the facility on [DATE] after undergoing extensive back surgery. Additionally, the facility did not have any of his/her medications available, and s/he was subsequently transferred back to the hospital for pain management later that same day. Further, the resident's neurosurgeon had ordered Decadron (a steroid medication prescribed to treat inflammation), however the nursing facility was unaware s/he was prescribed it.</p> <p>Record review revealed the resident was admitted to the facility on [DATE] with diagnoses including, but not limited to, fusion of the spine and radiculopathy (a condition caused by a pinched nerve in your spine).</p> <p>Review of a hospital document titled, Continuity of Care [COC] - Post-Acute Facility dated 1/31/2025 revealed that the resident underwent spinal surgery and was to start taking oxycodone (an opioid medication prescribed to treat moderate to severe pain) one to two tablets every four hours as needed for pain (5 to 10 milligrams [mg]).</p> <p>Review of a physician's order dated 1/31/2025 revealed to administer oxycodone, one tablet (5 mg), every 4 hours as needed for pain.</p> <p>Additionally, record review failed to reveal evidence of an order for oxycodone, two tablets (10 mg), for pain, as indicated in the hospital COC form, or that the order for multiple tablets was addressed with the provider.</p> <p>Further review of the hospital COC form revealed that the resident was receiving Decadron 2 mg every 8 hours in the hospital and had an end date of 1/31/2025 at 9:59 PM. Additionally, it indicated that s/he was to receive another dose on 1/31/2025 at 2:00 PM according to page 11 of the document.</p> <p>Record review failed to reveal evidence that the resident received the Decadron at 2:00 PM, that the medication was transcribed to be administered as indicated in the hospital COC form, or that the medication was addressed with the provider.</p> <p>During a surveyor interview on 3/13/2025 at approximately 1:00 PM with the Regional Director of Nursing Services, she revealed that she would expect that staff would have addressed the Decadron medication and oxycodone order with the resident's provider and document the interaction in a progress note. Additionally, she was unable to provide evidence that the facility maintained medical records that are accurate.</p> <p>(continued on next page)</p>		

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