STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415064	A. Building B. Wing	03/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pawtucket Falls Healthcare Center	70 Gill Avenue Pawtucket, RI 02861

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49184 Based on record review and staff interview, it has been determined that the that the facility failed to ensure that the resident's Advanced Directive requesting to refuse lifesaving treatment was followed for 1 of 5 residents reviewed, Resident ID #1. Findings are as follows: Review of the facility policy titled Resident's Rights Regarding Treatment and Advance Directives [a legal document in which a person specifies what actions should be taken for their health if they are no longer able to make decisions for themselves because of illness or incapacity] states in part .ensure resident's wishes are met regarding Advanced Directives .it is the resident's right to accept or refuse medical or surgical treatment .on admission the facility will determine if the resident has executed an Advanced Directive . Closed record review for Resident ID #1 revealed diagnoses that include, but are not limited to, Gangrene (death of body tissue due to a lack of blood flow or a serious bacterial infection) and chronic obstructive pulmonary disease. Further record review revealed the resident was admitted to the facility in February of 2024. Record review of the nursing progress notes for Resident ID #1 dated [DATE] indicated the following: - 3:57 PM- Resident evaluated by staff/Code Blue initiated - 3:59 PM- Cardiopulmonary resuscitation (CPR) started on the resident - 4:00 PM- Rescue called to assist with the resident's condition - 4:10 PM- Rescue arrived at resident and took over resident care - 4:45 PM- Resident transported to hospital by rescue (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of an Emergency Medical Service run report dated [DATE] at 4:20 PM, states in part .upon arrival at facility, staff advised patient maybe DNR [do not attempt resuscitation], paperwork incomplete without medical doctor signature. CPR continued by emergency medical staff, pt moved from bed to floor . Record review of the resident's face sheet indicated that the resident wished to be a DNR. Record review of the resident's paper medical record revealed an undated document titled, Medical Orders for Life Sustaining Treatment (MOLST- The MOLST form is a set of medical orders for residents with advanced illness who might die within ,d+[DATE] years; require long-term care services; or wish to avoid and/or receive specific life-sustaining treatments now. In order for the MOLST to be valid it should be signed by a qualified medical professional and the resident or his/her representative). The MOLST form indicated that Resident ID #1 wished to be a DNR. The MOLST form was signed by the resident's representative, but it did not have a signature from a qualified medical professional. Additional record review revealed a second MOLST was in the medical record. This MOLST again revealed the resident wished to be a DNR. This MOLST was signed by a Nurse Practitioner and the resident's representative. During a surveyor interview on [DATE] with the Medical Records Supervisor, she was unable to explain why the resident had two MOLST's in his/her medical record. She was also unable to explain why one MOLST was not signed by a qualified medical professional. During a surveyor interview with the Director of Nursing Service on [DATE] at 2:48 PM she was unable to explain why there were two different MOLST forms in the resident's record. Additionally, she was unable to explain why CPR was started when the resident was a DNR as indicated on his/her MOLST and face sheet.