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	05/13/2024

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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 48928 Based on record review and staff interview, it has been determined that the facility failed to provide written notice of bed-hold policy to the resident or resident representative, prior to the transfer of the resident to the hospital, for 1 of 5 residents reviewed, Resident ID #2. Findings are as follows: Record review of a community reported complaint reported to the Rhode Island Department of Health on 5/6/2024 alleges, Resident ID #2 was discharged from the facility on 5/2/2024 to the hospital. On 5/3/2024 the hospital case manager was informed by the facility that the resident did not place a bed hold and the facility had already filled his/her bed. The resident was not provided with a bed hold form prior to exiting the building. Record review for Resident ID #2 revealed s/he was admitted to the facility in April 2024 with diagnoses including, but not limited to, acute pyelonephritis (bacterial infection causing inflammation of the kidneys) morbid obesity, type 2 diabetes mellitus, major depressive disorder, and post-traumatic stress disorder. Record review of a progress note dated 5/2/2024 at 4:03 PM, revealed the resident had reported that s/he felt wetness on his/her pants on the right side. The nurse and the facility AGNP (Adult-Gerontology Nurse Practitioner) went into the resident's room to assess him/her, at which time it was discovered the PCN (small tube that helps drain urine from the kidney) tube on his/her right side was leaking. The resident was non emergently transferred to the hospital for further evaluation at approximately 2:00 PM. Additional record review revealed that the resident was admitted to the hospital with a diagnosis of abdominal pain. Record review of an email dated 5/3/2024 at 7:03 AM, authored by the resident and sent to the Admissions Director states in part .Barring disaster during my procedure this morning, I should be back this afternoon . Record review of a progress note dated 5/3/2024 at 8:28 AM authored by the Admissions Director Bed Hold Note; Text: The wireless caller is unavailable. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of an email attachment that was sent to the resident by the Admissions Director on 5/3/2024 at 9:16 AM, revealed a document enclosed titled Bed Hold Policy which state The minimum 5-day condition for the per diem rate applies (meaning, its re-starts), EACH time a resident, who is covered under Medicaid LTSS, is transferred for hospitalization or other institutional therapeutic leave. The rate, for a minimum of 5 days for the Bed Hold period, should not exceed the current Medicaid daily rate at the RUG code in effect at the time of transfer for hospitalization or other institutional therapeutic leave, for the applicable Bed Hold days. Further review of the above-mentioned email attachment failed to provide information to the resident that explains the duration of bed-hold, how long the facility will hold the bed for, if any, and the reserve bed payment policy, as well as the daily room rate for the bed hold. Additionally, the document did not address permitting the return of resident to the next available bed provided prior to and upon transfer. Record review failed to reveal evidence that the resident was provided in writing, information that explains the facility bed hold policy, including the duration of a bed-hold, the daily room rate, as well as information to address permitting the resident to return to the facility in the next available bed, prior to being sent to the hospital on 5/2/2024. During a surveyor interview on 5/13/2024 at approximately 9:35 AM with the Admissions Director, she acknowledged that the facility did not present the resident with a bed hold policy in writing with the required information prior to being sent out on 5/2/2024. Additionally, she endorsed the facility did have bed availability on the morning of 5/3/2024 when contacted by the hospital case manager to make arrangements for the skilled Medicaid resident to return to the facility for long term care. She further revealed the facility declined to accept the resident back to the facility and indicated concerns with behaviors that were not previously addressed or revealed to the resident.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48928 Based on record review and staff interview, it has been determined that the facility failed to develop and implement a baseline care plan within 48 hours of the resident's admission that includes instructions needed to provide effective and person-centered care that meets professional standards of quality care, the resident's immediate health and safety needs, physician and dietary orders as well as therapy and social services for 1 of 2 residents reviewed, Resident ID # 2. Findings are as follows: Record review of a community reported complaint reported to the Rhode Island Department of Health on 5/6/2024, revealed that a resident was discharged from the facility on 5/2/2024 to the hospital and on 5/3/2024 the hospital case manager was informed by the facility that the resident did not place a bed hold and the facility had already filled his/her bed. Record review revealed Resident ID #2 was admitted to the facility on [DATE] with diagnoses including, but not limited to, acute pyelonephritis (bacterial infection causing inflammation of the kidneys) morbid obesity, type 2 diabetes mellitus, major depressive disorder, and post-traumatic stress disorder. Record review failed to reveal evidence of a baseline care plan for Resident ID #2 from 4/22/2024 through 4/29/2024. Further record review revealed a care plan initiated 4/29/2024 indicating, Resident is independently capable of pursuing their own activities without intervention from the facility. Record review failed to reveal evidence of a care plan that includes instructions needed to provide effective and person-centered including, but not limited to, the the following care prior to the resident's discharge on 5/2/2024: - Initial goals based on admission orders. - Physician orders. - Dietary orders. - Therapy services. - Social services. - PASARR recommendation, if applicable. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a surveyor interview on 5/10/2024 at 3:45 PM with the Director of Nurses Services, in the presence of the Administrator, she acknowledged that Resident ID #2 did not have a baseline care plan which included instructions needed to provide effective and person-centered care, prior to his/her discharge from the facility on 5/2/2024.