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	08/16/2024

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37158 Based on record review and staff interview, it has been determined that the facility failed to ensure licensed nurses have specific competencies and skill sets necessary to care for residents' needs, relative to indwelling urinary catheters (a thin hollow tube that is inserted through the urethra into the bladder to drain urine, which is held in place by a water filled balloon), Staff B, C and D. Findings are as follows: Record review of a community reported complaint submitted to the Rhode Island Department of Health on 8/7/2024, alleges in part that Resident ID #4's indwelling urinary catheter was placed incorrectly at the facility. According to a [NAME], [NAME], and [NAME] article found in Nursing 2024, titled, Inserting an indwelling urinary catheter in a [gender redacted] patient, states in part, .grasp the catheter two to three inches from the tip and gently insert it into the urethral opening .Continue inserting until urine flows, then advance one to two more inches . Record review revealed Resident ID #4 was admitted to the facility in July of 2024 with diagnoses including, but not limited to, urinary retention, chronic kidney disease and encephalopathy (a condition in which the brain functioning is altered). Record review of the progress notes revealed initially, the resident's indwelling urinary catheter was discontinued on 8/1/2024 after s/he reported pain and swelling. Further record review revealed the resident was experiencing abdominal discomfort, abdominal distention and urinary retention on 8/2/2024. The provider was contacted and ordered for an indwelling urinary catheter to be placed, the catheter was placed on the evening of 8/2/2024. On the morning of 8/3/2024 the resident was experiencing pain and blood in his/her urine. The provider was contacted and the resident was transferred to the hospital for an evaluation. Record review of the hospital emergency room documentation dated 8/3/2024 revealed the resident's urinary catheter had been placed incorrectly by facility staff in the urethra instead of the bladder. The catheter balloon was then deflated and then the catheter was advanced to the bladder. (continued on next page)

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

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a surveyor interview on 8/7/2024 at 2:00 PM with Licensed Practical Nurse (LPN), Staff B, she revealed that on 8/2/2024, during the day shift the resident was retaining urine and experiencing abdominal pain, which was reported to the provider. Staff B further revealed she received an order from the provider to place an indwelling urinary catheter. Staff B further revealed when she was advancing the catheter, she observed urine flow, and at that point she inflated the catheter balloon to keep it in place and did not further advance the catheter. Staff B revealed the resident eliminated 800 milliliters of urine from the catheter being placed. Additionally, Staff B revealed she was a new nurse and had recently been hired at the facility approximately 2 months ago. When asked if Staff B ever received training or completed a competency on placing an indwelling catheter, she revealed that she had not. According to the Facility Assessment, dated 11/15/2023, states in part, .The list below includes, but is not limited to the types of care that our resident population requires, and [the facility] provides for our residents . Specific Care or Practices .intermittent or indwelling or other urinary catheter . Record review revealed Registered Nurse (RN), Staff C, was hired on 7/7/2022. Additionally, her personnel file failed to reveal evidence of a competency training relative to the insertion of a urinary catheter. Record review of LPN, Staff D, was hired on 3/29/2024. Additionally, her personnel file failed to reveal evidence of a competency training relative to the insertion of a urinary catheter. Record review of LPN, Staff B, was hired on 6/5/2024. Additionally, her personnel file failed to reveal evidence of a competency training relative to the insertion of a urinary catheter. During a surveyor interview on 8/7/2024 at 2:33 PM with the facility Staff Development Coordinator, she was unable to provide evidence that a training or competency relative to the insertion of a urinary catheters was completed for the above-mentioned staff members.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. 37158 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 medication administration, Resident ID #5. Findings are as follows: Record review revealed the resident was admitted to the facility in July of 2024 with diagnoses including, but not limited to, acute respiratory failure with hypoxia (the impairment of gas exchange between the lungs and the blood causing a lack of oxygen), atrial fibrillation (afib; a condition in which the heart pumps irregularly), alcohol dependence, urinary retention and hypertension (high blood pressure). Record review of a hospital Continuity of Care - Post-Acute Facility document dated 7/15/2024 indicated the resident was diagnosed with urinary retention and failed voiding trials on various occasions. During his/her hospital stay, s/he had a urology consult and a urinary catheter was placed and ordered to remain in place until the resident was seen by urology for an evaluation. Additional review of the document revealed that the resident is to continue Flomax (a medication to treat symptoms of an enlarged prostate and helps to relaxes the muscles of the bladder). Further review of the hospital Continuity of Care - Post-Acute Facility document revealed the following medication orders: START taking these medications. -Vitamin B-12 (a supplement for vitamin B deficiency) 500 mcg (micrograms) by mouth once daily. -Folic acid (a supplement that helps with forming red blood cells) 1 mg (milligram) by mouth once daily. -Lasix 40 (a medication to treat fluid retention) mg by mouth once daily. -Flomax 0.4 mg by mouth at bedtime. CHANGE how you take these medications. -Metoprolol tartrate (a medication to treat high blood pressure and to assist with heart rate control) 50 mg by mouth two times a day CONTINUE taking these medications. -Aspirin (a medication that helps to lower the risk of a heart attack or stroke) 81 mg enteric coated by mouth once daily STOP taking these medications. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Heparin (an anticoagulant medication often used to prevent blood clots from forming or an obstruction in an artery) 5000 units/mL (milliLiter) injection Record review of the physician's orders failed to reveal evidence that the Aspirin, Vitamin B-12, Folic acid or Lasix were implemented upon admission as ordered, indicating the resident had not received these medications for 24 days. Additionally, the Flomax was not initiated as ordered until 7/25/2024, after s/he was seen by the urologist, indicating the resident missed 9 doses of the medication. Record review revealed an order with a start date of 7/16/2024 for Metoprolol tartrate 50 mg, give 3 tablets (150 mg total dose) by mouth one time a day in the morning. Further review revealed an additional order was implemented for Metoprolol 50 mg by mouth at bedtime with a start date of 7/17/2024, indicating the resident received an extra 50 mg of the medication on 7/16/2024 and an extra 100 mg of the medication for 22 days. Record review revealed an order dated 7/16/2024 for Heparin 5000 units/ml, inject 1.5 ml subcutaneous (under the skin) every eight hours, indicating the resident has been receiving this medication for 23 days and it was not discontinued as ordered. Record review of the provider's progress note dated 7/18/2024 states in part, .Assessment and Plan .History of afib .Continue aspirin. Patient off Metoprolol due to bradycardia [when the heart beats more slowly than usual]. Not on anticoagulation . During a surveyor interview on 8/8/2024 at 3:28 PM with the Director of Nursing Services (DNS), after the above multiple medication errors were brought to her attention, she was unable to explain why the hospital Continuity of Care - Post-Acute Facility medication orders were not followed. During a surveyor interview on 8/8/2024 at 4:00 PM with the resident's physician, after he was made aware of the surveyor's findings by the DNS, he revealed that he was unaware of the medication discrepancies and he would review the resident's medications in detail.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 37158 42399 Based on record review and staff interview, it has been determined that the facility failed to prepare, serve and distribute food in accordance with professional standards for food service safety as the facility failed to have any certified food protection managers available during the preparation of evening meals on 7/1, 7/7, 7/15, 7/20 and 8/3/2024 or during the preparation of all the meals on 8/4/2024. Findings are as follows: Review of the Rhode Island Food Code, 2018 Edition, section 2-102.12, Certified Food Protection Manager states in part, (A) At least one employee that has supervisory and management responsibility and the authority to direct and control food preparation and service shall be a certified food protection manager who has shown proficiency of required information through passing a test that is part of an accredited program . Additional review of the Rhode Island Food Code, 2018 Edition, section 2-102.20, Food Protection Manager Certification, states in part, (A) A person in charge who demonstrates knowledge by being a food protection manager that is certified by a food protection manager certification program that is evaluated and listed by a Conference for Food Protection-recognized accrediting agency . Record review of a community reported complaint submitted to the Rhode Island Department of Health on 8/5/2024 alleges that the Director of Housekeeping had been cooking for the residents for the past 2 days with no food service license. During a surveyor interview with Dietary Aide, Staff E, on 8/6/2024 at 10:30 AM, she revealed that the Director of Housekeeping, Staff A, had been acting as a Food Service Director in the kitchen for approximately one month. She further revealed that when she worked the morning shift, 6:30 AM - 2:30 PM, on Sunday, 8/4/2024, Staff A was the only cook in the kitchen. During surveyor interviews with Staff A on 8/6/2024 at 2:01 PM and on 8/7/2024 at 10:25 AM, she revealed she had been helping oversee the kitchen with scheduling and ordering food since 7/16/2024 and was responsible for ensuring that there was coverage for at least one cook in the morning and one for the afternoon/evening. On Thursday, 8/1/2024, she made the Administrator aware that there was not a cook scheduled to work in the kitchen the evening of 8/3 and for both the morning and evening of 8/4. Staff A indicated that she called several cooks throughout the day on Saturday 8/3, all of whom could not fill in the missing shifts on 8/3 and 8/4. She indicated that she was directed by the Administrator on Saturday, 8/3 to cover the kitchen as it was her responsibility to do so. She further revealed that she worked on the kitchen the evening of 8/3/2024 and for all three meals on 8/4/2024. Additionally, Staff A indicated that she prepared mechanically altered diets per the residents' diet orders. Record review revealed 31 of 89 residents in the facility required mechanically altered diets. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a surveyor interview with the Director of Human Resources on 8/8/2024 at 11:25 AM, she revealed that there was an additional date where Staff A was covering the kitchen as the only cook. She further revealed Staff A covered the afternoon/evening shift on 7/20/2024. In a subsequent interview on 8/8/2024 at 1:35 PM, Staff A revealed she covered the evening meal service in the kitchen as the only cook on 7/20/2024. Record review of Staff A's employee time sheets revealed she was working in the kitchen on the following dates and times: - Saturday, 7/20/2024, 3:19 PM through 5:40 PM - Saturday, 8/3/2024, 3:20 PM through 6:00 PM - Sunday, 8/4/2024, 5:23 AM through 5:49 PM Record review failed to reveal evidence that Staff A was a Certified Food Protection Manager (CFPM). Record review failed to reveal evidence that a Certified Food Protection Manager was working in the kitchen during its hours of operation on the following dates and times: - 7/1/2024, after 2:20 PM - 7/7/2024, after 4:06 PM - 7/15/2024, after 2:55 PM - 7/20/2024, after 1:30 PM - 8/3/2024, after 1:30 PM - 8/4/2024, both morning and evening shifts During a surveyor interview with the Regional Director of Operations on 8/8/2024 at 1:43 PM, she acknowledged that there was not a Certified Food Protection Manager in the kitchen during all hours of operation for the above dates and times.

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 42399 37158 Based on record review and staff interview, it has been determined that the facility was not being administered in a manner that enabled it to utilize resources effectively and efficiently to maintain the highest practicable physical, mental and psychosocial well-being of each resident related to infection control. This failure resulted in immediate jeopardy for F 880. Additionally, the Administrator directed an employee, who did not have a Food Safety Manager Certification, to work as the only cook in the main kitchen for all of the facility's residents. Findings are as follows: As a result of the survey investigation, it was determined that the Director of Housekeeping, Staff A, who tested positive for COVID-19 on 7/31/2024, was directed by the Administrator to report to the facility and work as the [NAME] on 8/3/2024 and 8/4/2024. Additionally, Staff A does not have a Food Safety Manager Certification to work as a cook. During a surveyor interview on 8/7/2024 at 10:24 AM with Staff A, she indicated that she was directed by the Administrator on 8/3/2024 to come into work on 8/3/2024 and 8/4/2024 as the Cook, due to no other certified dietary staff members being available during those shifts. Staff A revealed that she did work on those dates, while COVID-19 positive. Record review failed to reveal evidence that Staff A has a Food Safety Manager Certification. Record review revealed there were 13 residents who tested positive for COVID-19 on 8/6/2024 and another 13 residents tested positive on 8/8/2024, indicating a total of 26 residents were now positive for COVID-19. Of note, there were no COVID-19 positive residents prior to this COVID-19 positive staff member working. Record review of the text messages exchanged between Staff A and the Administrator dated 8/3/2024 revealed the Administrator was aware that Staff A had tested positive for COVID-19 and ordered her to cover the open shifts in the kitchen as the cook for 8/3 and 8/42024. During a surveyor interview on 8/7/2024 at 11:40 AM with the Administrator, she acknowledged that Staff A was COVID-19 positive and worked on 8/3/2024 and 8/4/2024. The Administrator further acknowledged that it is not the expectation for staff, who are COVID-19 positive, to report to work during their COVID-19 quarantine period. Cross reference F 812 and F 880

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Provide and implement an infection prevention and control program. 37158 42399 Based on record review and staff interview, it has been determined that the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections by allowing a staff member who tested positive for COVID-19 on 7/31/2024, to work as the cook in the kitchen during the evening shift on 8/3/2024 and during the morning and evening shifts on 8/4/2024. Findings are as follows: Record review of the current guidance from the Center for Disease Control (CDC) titled, Interim Guidance for Managing Healthcare Personnel [HCP] with SARS-CoV-2 [COVID-19] Infection or Exposure to SARS-COV-2 states in part, Return to Work Criteria for HCP with SARS-CoV-2 Infection .HCP with mild to moderate illness who are not moderately to severely immunocompromised could return to work after the following criteria have been met: - At least 7 days have passed since symptoms first appeared if a negative viral test* is obtained within 48 hours prior to returning to work (or 10 days if testing is not performed or if a positive test at day 5-7), and - At least 24 hours have passed since last fever without the use of fever-reducing medications, and - Symptoms (e.g., cough, shortness of breath) have improved. *Either a NAAT (molecular) or antigen test may be used. If using an antigen test, HCP should have a negative test obtained on day 5 and again 48 hours later . Record review of a community reported complaint submitted to the Rhode Island Department of Health on 8/5/2024 alleges in part, that the Housekeeping Director, Staff A, is positive for COVID-19; and the Administrator forced Staff A to come to the building and cook for the residents because there are no cooks, for two days while positive for COVID-19. Record review of a laboratory report dated 7/31/2024, revealed that Staff A tested positive for COVID-19 via an antigen-based test. Record review of Staff A's employee time sheets revealed that she was working in the facility on the following dates: - Saturday, 8/3/2024, 3:20 PM through 6:00 PM - Sunday, 8/4/2024, 5:23 AM through 5:49 PM (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During surveyor interviews with Staff A on 8/6/2024 at 2:01 PM and on 8/7/2024 at 10:25 AM, she revealed that she started to become symptomatic for COVID-19 on Tuesday, 7/30/2024 with body aches and congestion, but tested negative for COVID-19 on a home antigen-based test. She further revealed she had taken another test at the facility, on 7/31/2024, which revealed a positive result for COVID-19. She indicated she informed the facility's Infection Preventionist, who instructed her to leave the facility and that she would be able to return to work on Wednesday, 8/7/2024 if she tested negative for COVID-19 on Sunday, 8/4/2024. Additionally, Staff A revealed she had been helping oversee the kitchen with scheduling and ordering food since 7/16/2024 and was responsible for ensuring that there was coverage of at least one cook for the preparation of all meals. On 8/1/2024, she made the Administrator aware that there was not a cook scheduled to work in the kitchen for the evening of 8/3 and both the morning and evening of 8/4. Additionally, Staff A indicated that she was directed by the Administrator on Saturday, 8/3/2024 to report to work and cover the kitchen as it was her responsibility. She further revealed that she was worked in the kitchen the evening of 8/3/2024 and on 8/4/2024 for 12 hours, while she was positive for COVID-19. Staff A further revealed that while she was preparing dinner on 8/3 and all three of the meals on 8/4, she did not wear a surgical or a N95 (respirator) mask. During a surveyor interview with the Infection Preventionist (IP) on 8/6/2024 at 1:41 PM, she revealed that she follows the CDC guidance regarding staff returning to work after testing positive for COVID-19. She acknowledged that Staff A tested positive for COVID-19 on 7/31/2024 and left the facility immediately after receiving the positive result. She revealed she had instructed Staff A to take a test on Sunday, 8/4/2024 (Day 5) and she would be able to return to work on Wednesday, 8/7/2024 if her test on 8/4 was negative. The IP revealed she was unaware that Staff A was in the facility, working in the kitchen, on 8/3/2024 and 8/4/2024, during her 7-day isolation period. During a surveyor interview with the Administrator on 8/7/2024 at 11:40 AM, she revealed that she was aware that Staff A had tested positive for COVID-19, and was working in the kitchen on Saturday, 8/3/2024 and on Sunday, 8/4/2024. She further revealed that she would not expect staff to return to work in the facility while still in their 7-day isolation period for COVID-19. Record review of surveillance testing for residents on 8/6/2024 revealed 13 residents tested positive for COVID-19 and another 13 residents tested positive on 8/8/2024, indicating a total of 26 residents were now positive for COVID-19. Of note, there were no COVID-19 positive residents in the facility prior to this staff member working while COVID-19 positive. Cross reference F 812 and F 835.

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program for all new and existing staff members. 37158 Based on record review and staff interview it has been determined that the facility failed to develop, implement, and maintain an effective training program for all newly hired employees and annual training for existing employees consistent with their expected roles, relative to education involving abuse, infection control, dementia behavioral health management, trauma informed care and QAPI (Quality Assurance and Performance Improvement) per the facility assessment, for 9 of 9 newly hired or existing employees, Staff A, B, C, D, F, G, H, I and J. . Findings are as follows: Review of the Facility Assessment, dated 11/15/2023, reveals in part, .[The facility] provides the following training topics .that include, but are not limited to: In-Service Resident's Rights . Abuse, neglect, and exploitation . Care/management for persons with dementia . QAPI . Infection Control (PPE-personal protective equipment), Hand Hygiene) . Behavioral Health . Record review revealed the Director of Housekeeping, Staff A, was hired on 5/21/2021. Additionally, her personnel file failed to reveal evidence that she received education or training relative to resident's rights, abuse, dementia and behavioral health management, trauma informed care, infection control and QAPI since 2021. Record review revealed Registered Nurse (RN), Staff C, was hired on 7/7/2022. Additionally, her personnel file failed to reveal evidence that she received education or training relative to resident's right's, abuse, dementia and behavioral health, trauma informed care, infection control, and QAPI since 2022. Record review revealed Licensed Practical Nurse (LPN), Staff D, was hired on 3/29/2024. Additionally her personnel file failed to reveal evidence that she received education or training relative to trauma informed care and QAPI. (continued on next page)

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review revealed LPN, Staff B, was hired on 6/5/2024. Additionally her personnel file failed to reveal evidence that she received education or training upon hire relative to trauma informed care and QAPI. Record review revealed Housekeeper, Staff F, was hired on 9/18/2023. Additionally her personnel file failed to reveal evidence that she received education or training relative to trauma informed care and QAPI. Record review revealed Cook, Staff G, was hired on 9/17/2019. Additionally her personnel file failed to reveal evidence that she received education or training relative to trauma informed care and QAPI. Record review revealed Nursing Assistant (NA), Staff H, was hired on 7/28/1998. Additionally her personnel file failed to reveal evidence that she received education or training relative to resident's rights, abuse, dementia and behavioral health management, trauma informed care, infection control and QAPI since 2022. Record review revealed NA, Staff I, was hired on 6/19/2024. Additionally her personnel file failed to reveal evidence that she received education or training upon hire relative to resident's rights, abuse, dementia and behavioral health management, trauma informed care, infection control and QAPI since 2022. Record review revealed NA, Staff J, was hired on 7/3/2024. Additionally his personnel file failed to reveal evidence that he received education or training upon hire relative to trauma informed care. During a surveyor interview on 8/8/2024 at 1:56 PM with the facility's Staff Development Coordinator, she was unable to provide evidence that the above-mentioned staff members were provided education for the above mentioned in-services annually or upon hire, as per the facility assessment.