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	12/12/2024

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48928 Based on surveyor observation, record review, resident, and staff interview, it has been determined that the facility failed to ensure that assessments accurately reflect the residents' status for 1 of 1 resident reviewed relative to a fall with injury, Resident ID #75. Findings are as follows: Record review revealed Resident ID #75 was readmitted to the facility in September of 2024 with a diagnosis including, but not limited to, unspecified fracture of the lower end of the left radius (a long bone in the forearm that helps you move your arm and wrist). Review of a Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident has a Brief Interview for Mental Status score of 14 out of 15 indicating intact cognitive function. Record review of Residents ID #75's progress notes revealed the following: - 9/18/2024 at 5:22 AM revealed the resident was found in a sitting position on the floor in his/her room and was complaining of pain to his/her left wrist with swelling noted. - 9/18/2024 at 6:55 PM x-rays were completed at the facility and showed possible left wrist fracture. - 9/19/2024 at 7:24 PM the resident presented with increased confusion, irregular cardiac rhythm and was sent out to the hospital. - 9/24/2024 at 5:34 AM the resident was transported to the hospital on 9/19/2024 with a change in mental status and a left wrist fracture secondary to a fall. The resident returned to the facility on [DATE] with a soft cast and instructions for non-weight bearing to his/her left upper extremity. Record review of the residents's Quarterly MDS assessment dated ,d+[DATE], section J, failed to reveal documentation of the above mentioned falls, as required. During a surveyor interview on 12/10/2024 at 1:30 PM with Registered Nurse, Staff A, he revealed the MDS Assessment should have reflected the resident's fall sustained on 9/18/2024 and it did not. (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Subsequent record review following the above interview with Staff A revealed, the resident's Quarterly MDS dated [DATE] had been revised on 12/10/2024 to include the resident's fall on 9/18/2024. However, the revision did not include that the resident sustained an injury from the fall. During a surveyor interview on 12/12/2024 at 10:08 AM with the resident, s/he revealed that the fracture to his/her left wrist was not an old injury as s/he had no issues with his/her wrist until after s/he fell on [DATE]. During a surveyor interview on 12/11/2024 at 12:11 PM with the Director of Nursing Services she acknowledged that the MDS assessment was coded inaccurately, and she would have expected the MDS to accurately represent the resident status during the observation period.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 41729 Based on record review and staff interview, it has been determined that the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice relative to following physician's order for obtaining orthostatic blood pressure (a form of low blood pressure that happens when standing up from a sitting or lying down position) for 1 of 1 resident reviewed, Resident ID #76. Findings are as follows: According to Mosby's 4th Edition, Fundamentals of Nursing, page 314, states in part, The physician is responsible for directing medical treatment. Nurses are obligated to follow physicians' orders unless they believe the orders are in error or would harm the clients. According to Jensen's 4th Edition, Nursing Health Assessment, A Clinical Judgement Approach page 118 states in part, Orthostatic vital signs are measured in patients to assess for a drop in blood pressure and heart rate with position changes .Assess BP [blood pressure] with patient supine [lying position] sitting, and then standing. The patient should rest supine for at least 2 minutes before the assessment of the baseline reading. Repeat measurements with the patient sitting and standing, wait 1-2 minutes after each position change to assess the readings . Record review revealed the resident was admitted to the facility in October of 2024 with diagnoses including, but not limited to, dementia and repeated falls. Record review of a physician's order dated 10/12/2024 through 11/12/2024 and a new start date of 11/13/2024 through 11/19/2024, revealed an order to check the resident's orthostatic blood pressure two times a day, on the morning and evening shifts. Record review of the November 2024 Medication Administration Record (MAR) failed to reveal evidence that orthostatic vital signs had been completed. During a surveyor interview with the Director of Nursing Services (DNS) on 12/12/2024 at 10:05 AM, she indicated that the orthostatic blood pressures were ordered due to the amount of recurrent falls that the resident had sustained. The DNS indicated that she would expect the staff to check and document the resident's orthostatic blood pressure, as ordered. During a surveyor interview with Nurse Practitioner, Staff B, on 12/12/2024 at 11:24 AM, she indicated that she had ordered the orthostatic blood pressures to be obtained because the resident has complained of severe vertigo (a sudden internal or external spinning sensation, often triggered by moving your head too quickly) and it has resulted in the resident having multiple falls. Staff B indicated that she would expect the resident's orthostatic blood pressure to be obtained, as ordered.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41729 Based on surveyor observation, record review, resident, and staff interview, it has been determined that the facility failed to ensure a resident with limited range of motion (ROM) receives appropriate treatment and services to increase ROM and/or to prevent further decrease in ROM for 1 of 2 residents reviewed with contractures, Resident ID #13. Findings are as follows: Review of the facility's policy titled Splints/Orthotics/Prosthetics [medical devices used to assist when physical impairments or limitations are present] states in part, Residents will receive splint/orthotics/prosthetics as deemed appropriate by the physician and rehabilitation services .Nursing staff will apply/remove the designated splint/orthotics/prosthetic device during scheduled wearing times . Record review revealed the resident was readmitted to the facility in November of 2024 with diagnosis including, but not limited to, Parkinson disease (a progressive neurological disorder that causes nerve cells in the brain to die which affects movement including stiffness, and loss of balance). Record review of a Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status Score of 10 out of 15 indicating a moderate cognitive impairment. Record review of a Quarterly MDS assessment dated [DATE] revealed the resident has upper extremities impairments on both sides. Further review of this assessment revealed the resident is totally dependent on staff for all activities of daily living, including transfers, eating, dressing, toileting, and bed mobility. Record review of a care plan with revision dates of 3/5/2024 and 6/12/2024 revealed the resident is at risk for a decline in physical function. Staff interventions include, but are not limited to, provide carrot (a device used to prevent contractures) to left hand and bilateral palm guards (devices that are used as a barrier between the fingers and the palm to prevent injury to the palm from severe finger contractures). Record review revealed a physician's order initiated on 8/7/2023 to place the carrot in the resident's left hand every shift, as tolerated. During surveyor observations of the resident on 12/10/2024 at 9:08 AM, 10:46 AM, 11:37 AM, and 2:01 PM, s/he was observed in bed with bilateral hands contracted and the carrot was not applied to his/her left hand, as ordered. Further record review of the Treatment Administration Record for December 2024 revealed the order for the carrot was signed off by Licensed Practical Nurse (LPN), Staff C as being completed on 12/10/2024, although the carrot was not observed to be in his/her left hand. Additionally, the record failed to reveal evidence the resident had refused the carrot. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Additional surveyor observations on the following dates and times revealed that the bilateral palm guards were not applied as indicated in his/her care plan: - 12/09/2024 9:48 AM - 12/10/2024 9:08 AM - 12/10/2024 10:46 AM - 12/10/2024 11:20 AM - 12/10/2024 11:37 AM - 12/10/2024 02:01 PM - 12/10/2024 03:01 PM - 12/11/2024 08:15 AM - 12/11/2024 09:59 AM During a surveyor interview with the resident on 12/10/2024 at 2:05 PM, s/he indicated that s/he was not utilizing the carrot or bilateral palm guards and stated that s/he had not been offered these devices by the staff on this date. During a surveyor interview with LPN, Staff C, on 12/11/2024 at 9:16 AM, she indicated that she is responsible for applying the carrot to the resident's left hand as ordered. She indicated that she was not aware that the resident should have been wearing bilateral palm guards. Additionally, Staff C could not provide evidence the resident was using the carrot as ordered though she had signed off the carrot was in place on 12/10/2024. During a surveyor interview with the Director of Nursing Services (DNS) on 12/11/2024 at 11:47 AM, she could not provide evidence as to why the resident's bilateral contractures were not being addressed. The DNS indicated that she would expect the staff to apply the carrot to the resident's left hand as ordered and the bilateral palm guards as indicated in the care plan. Additionally, the DNS indicated that if the resident refuses either of these devices, the staff should document the refusals in the resident's record.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48928 Based on record review, resident, and staff interview, it has been determined that the facility failed to ensure that residents who require dialysis (a treatment that removes excess fluid, waste, and toxins from the blood when the kidneys are no longer functioning properly) receive such services, consistent with professional standards of practice for 1 of 2 residents reviewed for fluid restrictions, Resident ID #30. Findings are as follows: Record review of a facility policy titled Fluid Restrictions states in part, .The fluid restriction breakdown should be documented in the Medication Administration Record (MAR), as well as dietary or tray card . Record review revealed the resident was admitted to the facility in July of 2024 with diagnoses including, but not limited to, end stage renal disease (a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life) and cerebral infarction (a condition when blood flow to the brain is blocked, causing brain cells to die). Further record review revealed the resident receives outpatient dialysis three times a week on Monday, Wednesday, and Fridays. Review of a Quarterly Minimum Data Set assessment dated [DATE], revealed the resident has a Brief Interview for Mental Status score of 13 out of 15 indicating intact cognitive function. Record review of a care plan revised on 12/8/2024 included an intervention for fluid restrictions per the physician's order. Record review revealed the resident has a physician's order that was initiated on 10/25/2024 for a fluid restriction of 1000 milliliters (mL) daily. Record review of the Medication Administration Records (MAR) for November 2024 and December 2024 failed to reveal evidence that the resident's 1000 mL daily fluid restriction was documented per the facility's policy. During a surveyor observation of the resident on 12/9/2024 at approximately 10:00 AM, revealed s/he was waiting to be picked up for dialysis and had received a 240 mL cup of coffee provided to him/her by Activities Aide, Staff D. During a surveyor interview on 12/9/2024, following the above observation with Staff D, she indicated that she was unaware of Resident ID #30's fluid restriction order. During a surveyor interview with the resident on 12/10/2024 at 2:36 PM, s/he indicated that s/he was unaware of the physician's order for a fluid restriction. Additionally, s/he was observed to be drinking from a 480 mL travel mug. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a surveyor interview on 12/11/2024 at 9:23 AM with Nursing Assistant, Staff E, she revealed that she was unaware that Resident ID #30 had an order for a fluid restriction. During a surveyor interview on 12/11/2024 at 9:48 AM with Unit Manager, Staff F, she acknowledged that Resident ID #30 has a physician's order for a 1000 ml daily fluid restriction. Staff F was unable to provide evidence that the resident's daily fluid intake was being monitored. During a surveyor interview on 12/11/2024 at 11:59 AM with the Director of Nursing Services she indicated it was her expectation that the staff would be aware of all residents with orders for a daily fluid restriction, that the resident's daily total fluid intake would be monitored, documented in the MAR. Record review failed to reveal evidence that the facility was monitoring Resident ID #30's total daily fluid intake from 10/25/2024 per the physician's order, until after it was brought to the facility's attention by the surveyor, on 12/11/2024.