STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415110	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakland Grove Health Care Center	560 Cumberland Hill Road Woonsocket, RI 02895

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 0684

Level of Harm - Actual harm

Residents Affected - Few

Provide appropriate treatment and care according to orders, resident's preferences and goals.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 46671

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 and the comprehensive person-centered care plan relative to monitoring and identifying a change in a resident's condition. Additionally, the facility failed to follow physician's orders relative to weekly weights, for 1 of 1 resident reviewed who exhibited increased swelling to his/her left leg and was diagnosed with a deep vein thrombosis (DVT- a blood clot). Resident ID #1.

Findings are as follows:

1. Record review of a community reported complaint submitted to the Rhode Island Department of Health on 6/19/2024, alleges in part, Resident ID #1's left leg doubled in size due to increased swelling, was not having his/her weight monitored, and the facility was not ruling out blood clots, despite him/her having a history.

According to Lippincott Manual of Nursing Practice 10th edition, 2014 published by Wolters Kluwer, pages 118 - 119 indicates that standards of care guidelines relative to preventing and recognizing complications after a person has surgery includes, but are not limited to, .Providing measures to enhance circulation of the lower extremities, such as .compression .and assess [monitor] for tenderness, swelling, and red streaking which may indicate DVT . Additionally, clinical signs of DVT include swelling of the entire leg. Prevention and management include assessing the lower extremity for circulation and sensation by checking for pulses of the leg and foot and for pain in the calf when the foot is moved upwards [Homan's sign] which may indicate DVT.

Record review revealed that the resident was readmitted to the facility in May of 2024 with a diagnosis including, but not limited to, surgical repair of a left hip fracture and history of DVT.

Record review of a nursing admission assessment dated [DATE] revealed, the resident presented with 3+ non-pitting edema (swelling that occurs in your feet, ankles, or legs. Non-pitting edema refers to when the edema is pressed with a finger and there is no lasting indentation in the skin. 3+ edema indicates severe edema and can take up to 30 seconds or more to rebound) to his/her left leg.

Further record review of the care plan revealed the following:

5/8/2024, A focus area that indicates s/he has a history of DVT with interventions including, but not limited to:

(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 0684 Level of Harm - Actual harm Residents Affected - Few	- Apply compression stockings if ordered - Monitor for pain in the leg, tenderness in the calf, leg tenderness, swelling of the leg, increased warmth, redness, skin discoloration or discomfort when the foot is pulled upwards may indicate a DVT 6/4/2024, A focus area that indicates s/he has a left hip fracture with interventions including, but not limited to: - Monitor circulation, motion, and sensation as ordered Record review revealed the following physical therapy treatment notes authored by Physical Therapy Assistant, Staff B, which states in part: 6/10/2024 - .Pt [patient] has L [left] lower leg/pedal [foot] edema. Pt noted throbbing pain left hip at rest, constant 10/10 pain during gait [walking]. Pt also made comment that [s/he] felt like hip 'the bone' would pop out. Nursing notified . 6/13/2024 - .L LE [lower extremity] with excessive swelling, Nursing notified . 6/14/2024 - .Pt notes L LE feels 'heavy' during gait . 6/17/2024 - .Pt was up in w/c [wheelchair] at time of rx [treatment]. Pt noted left knee pain during gait. Pt continues with excessive L LE swelling . Additional record review revealed the following progress notes which states in part: 5/25/2024 9:00 PM - nursing admission note, .+3 nonpitting edema to LLE .Pedal pulses are present and regular . 5/26/2024 2:53 PM - .Resident has LE discolorations, 2-3+edema, left> [greater than] R [right] . 5/27/2024 5:33 PM - provider telemedicine note, .Physical Exam: Exam findings per nurse Physical Exam - Notes: General resting comfortably in no acute distress CARDIO no edema . 5/28/2024 1:18 PM - .bilateral LE edema . 5/29/2024 2:51 PM - .left hip swollen, 2+ bilateral LE edema . 6/13/2024 5:42 PM - authored by LPN, Staff A, .Swelling present to residents LLE, NP evaluated this shift. NO [new order] for Lasix [a medication used to remove a buildup fluid in the body; also referred to as a water pill] .x [times] 14 days . 6/18/2024 3:59 PM - authored by LPN, Staff C, .LLE remains swollen, follow up with the Surgeon today, returned .order STAT [immediate] U/S [ultrasound] of LLE to R/O [rule out] DVT . 6/18/2024 6:10 PM - authored by Staff A, .Resident ultrasound to LLE, + [positive] DVT. MD contacted, new orders to send resident out to ER [emergency room] . (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Further record review failed to reveal evidence that the resident's left leg was monitored for increased warmth, redness, discoloration, or for discomfort when the foot is pulled upwards all of which would indicate the presence of a DVT, when s/he was noted with increased swelling. Additionally, the record failed to reveal evidence that an order was implemented for monitoring of circulation, motion, or sensation per the care plan. Lastly, the record failed to reveal evidence that the NP documented her evaluation of the resident on 6/13/2024. During a surveyor interview on 6/21/2024 at 11:41 AM with the NP, she revealed that she ordered the Lasix on 6/13/2024 when she was notified of the resident's increased left leg edema. She indicated that she evaluated the resident on 6/13/2024, however, she was unable to provide evidence of documentation of her assessment and findings. She indicated that she did not order an ultrasound on 6/13/2024 despite the resident having a history of DVT and recent surgery for the repair of a hip fracture. She acknowledged that she did not order the ultrasound until it was recommended by the resident's surgeon on 6/18/2024, 5 days after s/he was noted to have increased swelling of his/her left leg. During a surveyor interview on 6/21/2024 at 2:10 PM, with Licensed Practical Nurse, Staff A, the following was revealed: - On 6/13/2024 a physical therapist asked Staff A to see the resident because his/her left leg was swollen. Staff A indicated that she saw the resident's leg and notified the NP who gave an order for Lasix. - Additionally, Staff A was unable to provide evidence that she monitored the resident's circulation, motion, sensation, or for additional symptoms that may indicate a DVT. Furthermore, Staff A indicated that she was one of the nurses on duty when the resident was seen by his/her surgeon on 6/18/2024 for a follow up appointment. Staff A revealed that the resident returned to the facility with recommendations for an ultrasound to be completed immediately from the surgeon, to rule out a DVT. Staff A further revealed the ultrasound results were critical indicating multiple DVTs of the left lower extremity, which required the resident's transfer to an acute care hospital. Record review of the hospital documents revealed the following: - An ED triage note dated 6/18/2024 at 6:34 PM, indicates that the resident reported that s/he had been telling the nursing staff at the facility that his/her left leg was getting swollen. - An ultrasound of the resident's left lower extremity for DVT completed on 6/19/2024, which was positive for acute occlusive (blocked blood flow) blood clots in four major veins of the left lower extremity. S/he required high intensity intravenous blood thinning medication and transfer to a different acute care hospital for further management. - The resident was transferred to the other acute care hospital on 6/19/2024 and underwent a mechanical thrombectomy (medical procedure to remove blood clots). During a surveyor interview on 6/24/2024 at 10:21 AM with the Medical Director, he indicated that he would have expected the nurses would have monitored the resident for circulation, motion, and sensation in the residents left leg due to the increased swelling with his/her known history of DVT and recent surgery for a hip fracture. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During surveyor interviews on 6/21/2024 at 12:12 PM and 6/24/2024 at 10:03 AM with the Assistant Director of Nursing (ADON), she revealed that she saw the resident before s/he left for his/her follow up appointment on 6/18/2024 and indicated that his/her left leg was discolored with increased swelling. She acknowledged and indicated that she would have expected the nurses to monitor the resident for signs that may indicate a DVT per the care plan and document the findings in the resident's medical record when s/he was noted with increased swelling on 6/13/2024. Additionally, the ADON was unable to provide evidence that the resident was monitored every shift since s/he was noted with increased swelling on 6/13/2024. Furthermore, she acknowledged that an ultrasound was not ordered until the surgeon recommended it on 6/18/2024, 5 days after the resident was noted with increased swelling. 2. Record review revealed a physician's order with a start date of 5/25/2024 indicating that the resident's weight should be obtained weekly for 4 consecutive weeks. Further record review of the May and June 2024 Treatment Administration Records revealed the following weights: 5/25/2024, 202.0 pounds (lbs.) 6/4/2024, 204.8 lbs. 6/11/2024, no evidence of a weight was documented. 6/18/2024, no evidence of a weight was documented. During a surveyor interview on 6/24/2024 at 10:03 AM, with the ADON, she was unable to provide evidence that the resident's weight was obtained as ordered on the above-mentioned dates. Additionally, she indicated that she would have expected the nurses to obtain the resident's weight as ordered. During a surveyor interview on 6/24/2024 at 10:21 AM with the Medical Director, he indicated that he would expect nursing staff to obtain the resident's weight as ordered. Additionally, he acknowledged that the resident's weight could have assisted in monitoring the change in his/her increased swelling and the effect of the water pill that the resident was prescribed.