STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415110	A. Building B. Wing	12/05/2024

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

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50004 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 orders for antibiotic therapy and an for monitoring the output of an indwelling foley catheter (a device that drains urine from your urinary bladder into a collection bag outside of your body when you can't urinate on your own), for 1 of 1 resident reviewed, Resident ID #1. Findings are as follows: Record review of two community reported complaints, both submitted to the Rhode Island Department of Health on 12/2/2024, allege that Resident ID #1 had been hospitalized 4 times in less than a month and was readmitted to the facility in November of 2024 with diagnoses of hypernatremia (sodium levels in the blood being too high. Common causes include inadequate fluid intake, or fluid loss), dehydration and sepsis pneumonia (a potentially life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs caused by pneumonia). Additionally, the complaints allege that the resident did not receive the prescribed antibiotic therapy at the facility after s/he was discharged from the hospital. Further review of the complaints allege that a family member found the resident to be non-responsive and requested additional hydration on 11/28/2024, and on 11/29/2024 was gray unresponsive and requested the resident to be sent to the hospital on 11/29/2024. A. 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. Record review revealed Resident ID #1 was readmitted to the facility in November of 2024 with diagnoses including, but not limited to, hypernatremia, dehydration, and sepsis pneumonia. Record review of the hospital Continuity of Care document dated 11/27/2024 revealed a physician's order to continue Amoxicillin-Pot Clavulanate (an antibiotic) Oral Suspension Reconstituted 250-62.5 milligram (MG)/5 milliliters (ML) two times a day for sepsis, for 3 days. Record review of a physician's order dated 11/28/2024 revealed an order for Amoxicillin-Pot Clavulanate (antibiotic) Oral Suspension Reconstituted 250-62.5MG/5ML two times a day to be given at 8:00 AM and 8:00 PM for a diagnosis of sepsis. (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the November 2024 Medication Administration Record revealed the above-mentioned medication was documented as being administered on 11/28 at 8:00 AM and then was documented as being unavailable for administration on 11/28 at 8:00 PM and 11/29/2024 at 8:00 AM. Record review of a Orders-Administration Note on 11/29/2024 at 8:41 AM revealed that it was reported to the physician that the above-mentioned medication would not be delivered from the pharmacy until later that night. Record review of a nursing progress note dated 11/29/2024 at 9:52 AM revealed that the resident had a change in condition, s/he was lethargic and noted to be wheezing, and foaming at the mouth. Record review of a nursing progress note dated 11/29/2024 at 10:57 AM revealed that the family requested that the resident be sent to the hospital. Additionally, the progress note revealed a new order from the facility's Nurse Practitioner for the resident to be sent to the hospital and 911 was called. Record review of a hospital document dated 11/29/2024 titled, Assessment states, .Patient found by [family member] to be lethargic and non responsive in the nursing home. Noted concentrated urine .Laboratory results at presentation significant for hypernatremia and acute kidney injury .Cannot exclude incomplete treatment of pneumonia as a factor noting that [the resident] missed antibiotic doses. During a surveyor interview on 12/4/2024 at 2:20 PM with the facility's Physician, he revealed that it would be his expectation to be contacted immediately if a medication was unavailable in order to select an alternative treatment and not after several doses been missed. He further revealed that he was unaware that the resident had missed doses of his/her antibiotic on 11/28/2024 and 11/29/2024. During a surveyor interview on 12/5/2024 at 11:36 AM with the Director of Nursing Services (DNS), she revealed she was unsure how the staff would have been able to administer the antibiotic to the resident on 11/28/2024, as it was not available in the facility until 11/29/2024. B. Record review of a facility policy titled Intake and Output Monitoring dated 4/2015, states in part, Intake and/or Output will be monitored as indicated by the resident's hydration status, risk for dehydration, diagnoses, and/or per physician's order . According to [NAME] Course Point Enhanced for Taylor's Fundamentals of Nursing, 9th Edition, the following are important nursing measures used to care for patients with an indwelling catheter: .make sure that the patient maintains a generous fluid intake, unless contraindicated by other health concerns. This helps prevent infection and irrigates the catheter naturally by increasing urine output .note and record the amount of urine on the patient's intake-and-output record every 8 hours . Record review of a physician's order dated 11/27/2024 revealed an order to document the resident's intake and output, every shift for 72 hours. Record review of the resident's care plan revealed that s/he has a foley catheter with interventions including, but not limited to, Monitor output for odor, color, consistency, amount, blood and sediment . (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review failed to reveal evidence that the resident's urine output was being documentation per the physician's order. During a surveyor interview on 12/4/2024 at 11:30 AM with Registered Nurse, Staff B, he acknowledged that there was no documentation of the resident's output being monitored from his/her last readmission from 11/27/2024 through 11/29/2024 or since the resident's current admission on 12/3/2024. During a surveyor interview on 12/4/2024 at 1:30 PM with the DNS, she acknowledged that the resident has a foley catheter. Additionally, she was unable to provide evidence that the resident's output was being monitored according to the physician's order, facility policy, and the care plan. Cross reference F 842

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 50004 Based on record review and staff interview it has been determined that the facility failed to maintain the resident's medical record in accordance with accepted professional standards and practices, for 1 of 1 resident reviewed, Resident ID #1. Findings are as follows: Record review of two community reported complaints, both submitted to the Rhode Island Department of Health on 12/2/2024, allege that Resident ID #1 had been hospitalized and that the resident did not receive his/her prescribed antibiotic therapy at the facility after s/he was discharged from the hospital. Record review revealed Resident ID #1 was readmitted to the facility in November of 2024 with diagnoses including, but not limited to, hypernatremia, dehydration, and sepsis pneumonia. Record review of the hospital Continuity of Care document dated 11/27/2024 revealed a physician's order to continue Amoxicillin-Pot Clavulanate (an antibiotic) Oral Suspension Reconstituted 250-62.5 milligram (MG)/5 milliliters (ML) two times a day for sepsis, for 3 days. Record review of a physician's order dated 11/28/2024 revealed an order for Amoxicillin-Pot Clavulanate (antibiotic) Oral Suspension Reconstituted 250-62.5MG/5ML two times a day to be given at 8:00 AM and 8:00 PM for a diagnosis of sepsis. Record review of the November 2024 Medication Administration Record (MAR) revealed the above-mentioned medication was documented as being administered to the resident on 11/28 at 8:00 AM, by Licensed Practical Nurse, Staff A. Further review of the November 2024 MAR revealed the order for Amoxicillin-Pot Clavulanate (antibiotic) Oral Suspension Reconstituted 250-62.5MG/5ML was documented as being unavailable for administration on 11/28 at 8:00 PM and 11/29/2024 at 8:00 AM. During a surveyor interview on 12/5/2024 at 1:02 PM with Staff A, she was unable to recall if she administered the above-mentioned antibiotic to the resident on 11/28/2024, as was documented in the resident's record. She further revealed that this medication is not in the facility's emergency kit and was unaware of when the pharmacy had delivered the medication to the facility. During a surveyor interview on 12/5/2024 at 11:36 AM with the Director of Nursing Services (DNS), she revealed she was unsure how Staff A would have been able to administer the antibiotic to the resident on 11/28/2024, as it was not available in the facility until 11/29/2024. Cross reference F 658

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 50004 Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to maintain an infection prevention and control program to help prevent the transmission of communicable diseases and infections, relative to Enhanced Barrier Precautions (EBP; involves using a gown and gloves during high-contact resident care activities), an enteral feeding (a method of delivering nutrition directly into the gastrointestinal tract through a feeding tube) syringe and the storage of a nebulizer mask, for 1 of 1 resident reviewed, Resident ID #1. Findings are as follows: Review of a facility policy titled, Enhanced Barrier Precautions Policy states in part, Enhanced Barrier precautions require the use of a gown and gloves for certain residents during high-contact resident care activities .High-contact resident care activities include bathing/showering, providing hygiene, dressing, transferring, linen changes, toileting, device care and wound care . Enhanced Barrier precautions will also be implemented for residents with wounds, or indwelling medical devices (catheter, feeding tube, etc.) .Signage will be posted on the door or wall outside of the residents room indicating the need for enhanced barrier precautions, the required personal protective equipment (PPE), and the high-contact resident care activities that require the use of gown and gloves . A. Record review revealed the resident was readmitted to the facility in November of 2024 with diagnoses including, but not limited to, hypernatremia (sodium levels in the blood being too high. Common causes include inadequate fluid intake, or fluid loss), dehydration and sepsis pneumonia (a potentially life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs caused by pneumonia). Record review revealed a care plan with a revision date of 11/4/2024 that indicated the resident is on enhanced barrier precautions related to the presence of a gastrostomy tube (a surgically placed device used to give direct access to the stomach for supplemental feeding, hydration or medicine). Record review revealed a care plan with a revision date of 12/4/2024 that revealed a care focus area for an indwelling foley catheter (a device that drains urine from your urinary bladder into a collection bag outside of your body when you can't urinate on your own). During a surveyor observation on 12/4/2024 at 10:02 AM, Nursing Assistant (NA), Staff C, was observed providing morning hygiene to the resident in his/her room, without wearing a gown. Further observation revealed signage posted at the resident's door which indicated to wear a gown and gloves during high contact care activities. During a surveyor interview and observation of Staff C, on 12/4/2024 at 10:05 AM, with Registered Nurse, Staff B, he acknowledged that the resident was on EBP related to his/her indwelling foley catheter and gastrostomy tube and then instructed Staff C that she is required to wear a gown and gloves while performing care. Staff C, then exited the resident's room and placed a gown on. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Additional surveyor observation on 12/4/2024 at 12:50 PM, of Staff C and Staff B, they were observed providing hygiene care, including changing the bed linens for Resident ID #1. Further observation revealed that Staff C was not wearing a gown. Immediately following the above observation Staff B acknowledged that Staff C was not wearing a gown while providing care to and changing the bed linens for Resident ID #1. During a surveyor interview on 12/4/2024 at 1:24 PM with the Director of Nursing Services (DNS), she acknowledged that the resident was on EBP, and it would be her expectation that staff would wear the appropriate PPE as required per the facility policy. B. Record review of a physician's order dated 2/19/2024 states, Change the tube feeding syringe every night shift . Additional record review revealed that the above order was discontinued when the resident was admitted to the hospital on 11/24/2024. During a surveyor observation on 12/4/2024 at 10:30 AM, revealed an undated gastrostomy tube syringe on the resident's side table. Further observation revealed the syringe had an accumulation of dry, crusted white and red debris covering the inside surface area of the syringe. During a surveyor interview on 12/4/2024 at 10:35 AM, with Staff B, he acknowledged that the syringe was not dated and was unsure when it was last replaced. Additionally, he indicated that he had used the syringe that morning to administer the resident his/her medications. Record review of the November 2024 Medication Administration Record revealed the last time the facility staff had signed off that the syringe was replaced was on 11/23/2024, approximately 10 days prior to the above surveyor observation. During a surveyor interview on 12/4/2024 at approximately 1:30 PM with DNS, she revealed that she would have expected the syringe to be changed every 24 hours. C. Record review reveals that the resident receives treatments administered via a nebulizer machine. During a surveyor observation on 12/4/2024 at 10:30 AM, the resident's mask for his/her nebulizer machine treatments was located on the floor. Further observation revealed the tubing connected to the mask was dated, 11/20/2024, indicating the mask had not been changed in approximately 13 days. During a surveyor interview and observation on 12/4/2024 at 10:35 AM, with Staff B, he acknowledged that the nebulizer mask was on the floor in the resident's room and was dated 11/20/2024. Additionally, he acknowledged that the mask should not be on the floor and it should have been placed in a bag on the resident's side table. He further revealed that the mask and tubing should be changed once a week. During a surveyor interview on 12/4/2024 at approximately 1:30 PM with the DNS, she acknowledged that the resident's nebulizer mask should not be on the floor and would have expected the tubing and mask to be changed every 7 days.