

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  415064	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/28/2023
NAME OF PROVIDER OR SUPPLIER  Pawtucket Falls Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46671</p> <p>Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to provide the necessary care and services in accordance with activities of daily living relative to providing necessary assistance with feeding and to provide a functional communication system to assist residents with communicating their basic needs for 1 of 1 residents reviewed, Resident ID #9.</p> <p>Findings are as follows:</p> <p>Record review revealed the resident was readmitted to the facility in November of 2022 with diagnoses including but not limited to; dysphagia (difficulty swallowing) and protein calorie malnutrition.</p> <p>A. Record review of a Minimum Data Set (MDS) assessment dated [DATE] revealed the resident requires extensive assistance of one staff member for eating and drinking. Additionally, s/he is documented as having limitation which interferes with daily functions in both of his/her upper extremities (shoulder, elbow, wrist, hand).</p> <p>Additional record review revealed a physician's order dated 2/21/2023 which indicated that the resident is to receive 1 on 1 assistance with eating.</p> <p>During a surveyor observation on 2/23/2023 from approximately 11:50 AM until approximately 12:15 PM, the resident was observed in his/her room with the lunch meal tray noted to be sitting on the over-the-bed table, with the dietary cover still in place, without a staff members present in the room assisting the resident. At approximately 11:57 AM, Nursing Assistant (NA) Staff A, was observed entering the resident's room and step up his/her meal before exiting the room. From approximately 12:00 PM to 12:15 PM, the resident was observed eating some of his/her meal while in bed, without a staff member present to provider ne-on-one assistance with eating.</p> <p>During a surveyor interview with Staff A on 2/23/2023 immediately following the above-mentioned observation, she acknowledged that she was the staff member that the surveyor observed entering and exiting the resident's room. Additionally, she acknowledged that she did not provide the resident with one-on-one assistance for eating and indicated that she was not aware that the resident required one-on-one assistance for eating. She stated [s/he] usually feeds [him/herself] but today [s/he] needs help so I will .</p> <p>(continued on next page)</p>

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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  415064	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/28/2023
NAME OF PROVIDER OR SUPPLIER  Pawtucket Falls Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a surveyor interview on 2/23/2023 at approximately 12:15 PM with Registered Nurse, Staff B, she indicated that she was unaware of an order in place for the resident to receive one-on-one assistance with eating. When prompted by the surveyor she reviewed the order in the electronic medical record and acknowledged that the resident has an order in place for one-on-one assistance with eating and indicated that she would expect staff to assist the resident.</p> <p>Record review revealed the following Speech Language Pathologist (SLP) evaluation and notes authored by SLP, Staff C:</p> <p>-1/18/2023 titled, Speech Therapy SLP Evaluation and Plan of Treatment, states in part, .Assessment Summary .Pt [patient] did report that [s/he] is not having enough assistance to be fed. SLP communicated this with staff .Risk Factors: Due to the documented physical impairments and associated functional deficits . the patient is at risk for: malnutrition, dehydration and further decline in function .</p> <p>-1/20/2023 progress note states in part, .Pt requested more assistance with self-feeding. Please assist patient during meals to facilitate intake/nutritional needs.</p> <p>-1/23/2023 titled, Speech Therapy Treatment Encounter Note(s), states in part, .Pt does require assist to feed and continues to ask SLP to somehow communicate this with staff. SLP put order in computer .to communicate this .</p> <p>Record review of the resident's paper medical record revealed a document titled, NURSING PLACEMENT HOSPICE AND PALLIATIVE CARE LLC dated 2/21/2023 which states in part, .Pt bed bound .dependent . Recommendation .Pt 1:1 feed . Additionally, the document had notation on it that states OK with a set of initials.</p> <p>During a surveyor interview with the resident's family member on 2/24/2023 at 11:30 AM, she indicated that the resident does require and ask for assistance with eating and that she and other members of the family try to visit during meal times to assist because staff do not assist the resident.</p> <p>During a surveyor interview with the Director of Nursing Services (DNS) on 2/23/2023 at 2:37 PM, she indicated that she discontinued the order and stated, because the nurse was an agency nurse and it was an incorrect order. Additionally, she indicated that she would expect the resident to receive one-on-one assistance if the order was entered correctly.</p> <p>During a surveyor interview with Licensed Practical Nurse (LPN), Unit Manager, Staff D on 2/24/2023 at 12:47 PM he acknowledged that the hospice recommendation indicates the resident should receive one-on-one assistance with eating. He indicated that the OK and initials on it were that of the Nurse Practitioner (NP), Staff E, and acknowledged that the signature indicated the NP approved the recommendation.</p> <p>During a follow-up interview with the DNS on 2/28/2023 at 11:00 AM she acknowledged that she discontinued the one-to-one assistance order and she did not call the provider prior to doing so.</p> <p>B. Review of a document titled, ADMISSION RECORD, revealed the resident's primary language is Spanish.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  415064	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/28/2023
NAME OF PROVIDER OR SUPPLIER  Pawtucket Falls Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the MDS assessment dated [DATE], revealed Section A1100, titled Language, displayed a code of 0, which indicates the resident does not need or want an interpreter.</p> <p>During a surveyor observation on 2/24/2023 at approximately 11:30 AM, of the resident's room, revealed multiple documents posted on the resident's wall, located behind his/her bed, and out of visual sight of the resident. One document contained the following English to Spanish translations: Mojada-Wet, Estomago-Stomach, Pillow-Almohada, Mesa-Table, Comida-Food, Ayuda-Help, [NAME]-Drink, Apaga La Luz, Medicina-medicine. Another document revealed information and instructions for an interpreter service.</p> <p>During a surveyor interview, immediately following the above observation, with the resident's family member, she revealed the resident indicated that the translated Spanish to English words on the wall would be helpful if staff could learn them. She further revealed that the resident stated to her that the facility does not use an interpreter service to communicate with him/her.</p> <p>During a surveyor interview on 2/24/2023 at approximately 11:35 AM, with Unit Manager, LPN, Staff D, he was unaware that the facility has an interpreter service to communicate with resident. He further indicated that staff would try to get a Spanish speaking staff member if available to communicate with the resident.</p> <p>During a surveyor interview on 2/24/2023 at approximately 12:50 PM, with Registered Nurse, Staff B, she indicated that the staff do not have to utilize an interpreter service to communicate with the resident. She further indicated that if staff do not understand the resident, they will get a Spanish speaking staff member if available to come to the resident's room and communicate with him/her.</p> <p>Review of the resident's care plan revealed a focus, initiated on 2/24/2023, after the concerns were brought to the attention of the facility by the surveyor, which revealed the resident has communication needs, relative to the resident's primary language being Spanish. Interventions included: Language line provided at bedside, and resident will have access to communication line/interpreter services 24/7, and Provide language specific basic communications cards will be provided when needed. Binder available at nurses desk.</p> <p>During a surveyor interview on 2/24/2023 at approximately 2:00 PM, with the Director of Nursing Services, she indicated that she expects staff to utilize the interpreter service to communicate with any resident whose first language is not English.</p> <p>46241</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  415064	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/28/2023
NAME OF PROVIDER OR SUPPLIER  Pawtucket Falls Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>46671</p> <p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on surveyor observation, 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 for 1 of 13 residents reviewed for physician's orders, Resident ID #3.</p> <p>Findings are as follows:</p> <p>Review of a facility document titled, Process for unavailable medications, states in part, .Prescribed medication must be administered as ordered by MD [medical doctor]/NP [nurse practitioner]. When the prescribed medication can't be administered as ordered then notification needs to be made to MD/NP at the exact time that the medication is due to be given as to avoid a med [medication] error .</p> <p>Record review revealed that the resident was admitted to the facility in October of 2022. S/he has medical diagnoses that include but are not limited to; respiratory syncytial virus (a very common virus that leads to cold-like symptoms) and glaucoma (disease of the eye that can cause vision loss and blindness due to high pressure inside the eye).</p> <p>Additional record review revealed the following physician orders:</p> <p>1. Start date of 10/26/2023 for Brimonidine Tartrate Solution .Instill 1 drop in right eye three times a day for eye pressure .</p> <p>Record review of the February 2023 Medication Administration Record (MAR) revealed that the Brimonidine eye drops were documented as not administered for two out of three of the daily doses on 2/10, 2/11, and 2/12/2023.</p> <p>2. Start date of 2/3/2023 Albuterol Sulfate .Aerosol Solution .2 puff inhale orally every 4 hours for SOB [shortness of breath] until 2/11/2023 .</p> <p>Record review of the February 2023 MAR revealed that the Albuterol inhaler was not administered for two doses on 2/3/2023 and one dose on 2/4/2023.</p> <p>3. Start date of 2/12/2023 for guaFENesin Oral Liquid .Give 10 ml [milliliters] by mouth every 4 hours for cough for 5 days .</p> <p>Record review of the February 2023 MAR revealed that the order for guaifenesin was documented as not administered for two doses on 2/12/2023 and one dose on 2/13/2023.</p> <p>Further record review revealed that the above-mentioned medications were documented as not administered because the medications were not available. Additionally, the record failed to reveal evidence that the physician was notified that the medications were not administered as ordered.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  415064	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/28/2023
NAME OF PROVIDER OR SUPPLIER  Pawtucket Falls Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a surveyor interview with the Director of Nursing Services on 2/24/2023 at 2:08 PM, she indicated that she would have expected that staff would follow the facility protocol for medications unavailable which she indicated she implemented six months ago. Additionally, she was unable to provide evidence that the resident's received the above-mentioned medications as ordered.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  415064	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/28/2023
NAME OF PROVIDER OR SUPPLIER  Pawtucket Falls Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0692</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>46241</p> <p>Based on record review, and staff interview, it has been determined that the facility failed to ensure residents maintain acceptable parameters of nutritional status, such a usual body weight or desirable body weight and failed to follow their policy relative to weight loss, for 1 of 12 residents reviewed, Resident ID #4.</p> <p>Findings are as follows:</p> <p>Review of the facility policy titled, Weight Assessment and Intervention, state in part, .The nursing staff will measure resident weights on admission and weekly for four weeks thereafter .Any weight change of 5% or more since the last weight assessment will be retaken the next day for confirmation. If the weight is verified, nursing will immediately notify the Dietician in writing. Verbal notification must be confirmed in writing .The threshold for significant unplanned and undesired weight loss will be based on the following criteria .1 month - [minus] 5% weight loss is significant; greater than [&gt;] 5% is severe .</p> <p>Record review revealed the resident was admitted to the facility in October of 2022 and was readmitted in January of 2023, with diagnoses including, but not limited to, acute posthemorrhagic anemia (a condition that develops when you lose a large amount of blood quickly) and moderate protein-calorie malnutrition.</p> <p>Review of the resident's care plan revealed a focus initiated on 11/10/2022 and revised on 2/15/2023, that states in part, The resident has nutritional problem or potential nutritional problem .hx [history] of sig wt [significant weight] changes .Interventions .Monitor/record/report to MD [medical doctor] PRN [as needed] s/sx [signs and symptoms] of malnutrition .significant weight loss .&gt;5% in 1 month .</p> <p>Further record review revealed the resident was admitted to the hospital in January 2023 for 4 days with a diagnosis of anemia (deficiency of healthy red blood cells in blood). On 1/17/2023, the resident underwent a thoracentesis (procedure to remove excess fluid accumulated in the chest cavity), removing 1 L (liter) of fluid. Additionally, the resident's weight was obtained at the hospital on 1/19/2023 after the thoracentesis and was documented at 197 lbs. (pounds) and 1.5 oz (ounces).</p> <p>Review of a documents titled Weights and Vitals Summary, revealed the following weights documented in 2023:</p> <ul style="list-style-type: none"> <li>- 1/5/2023 205 lbs.</li> <li>- 2/10/2023 163.6 lbs.</li> <li>- 2/11/2023 158.8 lbs.</li> <li>- 2/15/2023 158.2 lbs.</li> <li>- 2/16/2023 160.6 lbs.</li> </ul> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  415064	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/28/2023
NAME OF PROVIDER OR SUPPLIER  Pawtucket Falls Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0692</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>- 2/17/2023 158.8 lbs.</p> <p>- 2/22/2023 155.8 lbs.</p> <p>Additional review of the document titled, Weights and Vitals Summary revealed the resident's weight was documented at 200 lbs. on the day of his/her readmission to the facility but was struck out by the Registered Dietician (RD) on 2/14/2023 with a note that revealed it was a mistaken entry.</p> <p>Record review failed to reveal evidence of an accurate weight documented upon the resident's readmission to the facility.</p> <p>Additional record review revealed the resident lost 33.4 lbs. from 1/19/2023 to 2/10/2023, indicating a severe weight loss of 16.95%.</p> <p>Review of the resident's January 2023 Medication Administration Record (MAR) revealed a physician's order with a start date of 1/21/2023 and an end date of 1/22/2023 to Obtain weight every day shift x 4 weeks then monthly every day shift every 7 day(s) for 4 Weeks, which was signed off as being completed.</p> <p>Review of the resident's documented weights failed to reveal evidence that a weight was obtained on 1/21/2023, per the physician's order.</p> <p>Additional review of the resident's January 2023 MAR revealed a physician's order with a start date of 1/23/2023 and an end date of 2/14/2023 to Obtain weight every day shift x 4 weeks then monthly every day shift every 7 day(s) for 4 Weeks, which was signed off as being completed on 1/23/2023 and 1/30/2023.</p> <p>Review of the resident's documented weights failed to reveal evidence that the weights were obtained on 1/23/2023 and 1/30/2023, per the physician's order.</p> <p>Review of the resident's February 2023 MAR revealed a physician's order with a start date of 2/3/2023 and an end date of 2/14/2023 to Obtain weight every day shift x 4 weeks then monthly every day shift every 1 month(s) starting on the 3rd for 1 day(s) for monthly weight, which was signed off as being completed on 2/3/2023.</p> <p>Review of the resident's documented weights failed to reveal evidence that a weight was obtained on 2/3/2023, per the physician's order.</p> <p>Additional review of the February MAR revealed a physician's order with a start date of 1/23/2023 and an end date of 2/14/2023 to Obtain weight every day shift x 4 weeks then monthly every day shift every 7 day(s) for 4 Weeks, which was signed off as being completed on 2/6/2023 and 2/13/2023.</p> <p>Review of the resident's documented weights failed to reveal evidence that the weights were obtained on 2/6/2023 and 2/13/2023, per the physician's order.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  415064	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/28/2023
NAME OF PROVIDER OR SUPPLIER  Pawtucket Falls Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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 0692  Level of Harm - Actual harm  Residents Affected - Few	<p>During a surveyor interview on 2/24/2023 at 8:41 AM, with the RD, she acknowledged that a weight was entered into the system upon the resident readmission to the facility, but indicated she struck it out, 3 weeks later, because it was an error. She revealed the resident's weight was not obtained until 2/10/2023, and at which time, the severe weight loss was identified. She further indicated intervention were then put in place following the identification of the resident's weight loss.</p> <p>Record review failed to reveal evidence of interventions put in place until 2/14/2023, four days after the severe weight loss was identified.</p> <p>During a surveyor interview on 2/24/2023 at 12:45 PM, with the Director of Nursing Services, she was unable to provide evidence that the resident's weights were obtained on the above-mentioned dates, per the physician orders.</p> <p>During an additional surveyor interview on 2/28/2023 at 10:45 AM, with the DNS and Administrator, they were unable to provide evidence that the RD was notified in writing, on 2/10/2023 regarding the resident's severe weight loss, per facility policy. Furthermore, they were unable to provide evidence of any interventions that were put in place on 2/10/2023 when the resident's severe weight loss was identified.</p>		



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  415064	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/28/2023
NAME OF PROVIDER OR SUPPLIER  Pawtucket Falls Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46241</p> <p>Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to assess the resident for risk of entrapment from bed rails for 1 of 1 residents reviewed, Resident ID #9.</p> <p>Findings are as follows:</p> <p>Review of a facility policy titled, Side Rail Use last revised October 2022, states in part, .Procedure .On admission, readmission, quarterly and with a significant change in condition, the resident will be assessed for the need for side rails to assist in bed mobility .The use of side rails for bed mobility will be documented in the resident' plan of care .</p> <p>Record review revealed Resident ID #9 was admitted to the facility in April of 2022 and was readmitted in November of 2022 with a diagnosis including, but not limited to, myasthenia gravis (a neuromuscular disorder that leads to weakness of skeletal muscles).</p> <p>Review of a Significant Change Minimum Data Set (MDS) assessment dated [DATE], revealed section P0100 titled, Physical Restraints displayed a code of 0 for bed rail which indicates the resident does not have or utilize bed rails in bed.</p> <p>Record review failed to reveal evidence of a side rail assessment completed upon the resident's readmission, quarterly, or after the resident had a significant change in condition, per the facility policy.</p> <p>Additional record review revealed the resident's last side rail assessment was completed in July of 2022.</p> <p>Review of the resident's care plan failed to reveal evidence of side rails documented, per facility policy.</p> <p>During surveyor observations on 2/24/2023 at 11:30 AM and at 2:43 PM, revealed the resident was in bed with the side rails up.</p> <p>During a surveyor interview on 2/24/2023 at approximately 2:00 PM with the Director of Nursing Services, she was unable to provide evidence of a care plan relative to bed rails, or a readmission, quarterly, or significant change side rail assessment after July 2022, per facility policy.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  415064	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/28/2023
NAME OF PROVIDER OR SUPPLIER  Pawtucket Falls Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>46671</p> <p>Based on record review and staff interview, it has been determined that the facility failed to ensure that the resident's drug regimen is free from unnecessary drugs for 1 of 6 residents reviewed for medication administration, Resident ID #13.</p> <p>Findings are as follows:</p> <p>Review of the facility policy titled Medication Administration dated February 16, 2022, states in part, .It is the policy .to provide safe and effective medication management .to help eliminate any harm that could be caused at any level of the medication management process .</p> <p>Record review revealed the resident was admitted to the facility in January of 2023 with diagnoses including, but not limited to, hypertensive heart disease without heart failure (heart problems that occur because of high blood pressure that is present over a long time) and myocardial infarction (heart attack).</p> <p>Record review revealed the following physician orders with parameters to hold the medication for blood pressure less than 110 and for a heart rate less than 60.</p> <p>1. Losartan Potassium (medication to treat high blood pressure and prevent strokes in patients with an enlarged heart) 25 milligrams (mg) by mouth at bedtime, with a start date of 1/31/2023.</p> <p>Review of the February 2023 Medication Administration Record (MAR) revealed the following dates when the Losartan Potassium was administered to the resident outside of the indicated parameters.</p> <p>- 2/10/2023 administered with a documented blood pressure of 102/66</p> <p>-2/13/2023 administered with a documented blood pressure of 100/70</p> <p>-2/18/2023 administered with a documented blood pressure of 98/60</p> <p>2. Nifedipine ER [extended release] (medication to treat high blood pressure) 60 mg by mouth one time a day, with a start date of 2/1/2023.</p> <p>Review of the February 2023 MAR revealed the following date when the Nifedipine ER was administered to the resident outside of the indicated parameters:</p> <p>-2/11/2023 administered with a documented blood pressure of 101/68</p> <p>3. Metoprolol Succinate (medication to treat high blood pressure) ER 75 mg by mouth one time a day, with a start date of 2/11/2023.</p> <p>Record review of the February 2023 MAR revealed the following date when the Metoprolol Succinate was administered to the resident outside of the indicated parameters:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  415064	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/28/2023
NAME OF PROVIDER OR SUPPLIER  Pawtucket Falls Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-2/11/2023 administered with a documented blood pressure of 101/68</p> <p>-2/14/2023 administered with a documented blood pressure of 100/64</p> <p>-2/20/2023 administered with a documented blood pressure of 101/62</p> <p>During a surveyor interview with the Director of Nursing Services on 2/24/2023 at 2:03 PM, she acknowledged the medications were administered outside the ordered parameters. Furthermore, she indicated that she would have expected staff to hold the medication.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  415064	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/28/2023
NAME OF PROVIDER OR SUPPLIER  Pawtucket Falls Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>46671</p> <p>Based on record review and staff interview, it has been determined that the facility failed to ensure a resident's drug regimen is free from unnecessary psychotropic drugs for 1 of 1 residents reviewed for antipsychotic medication, Resident ID #12.</p> <p>Findings are as follows:</p> <p>Review of the facility policy with a revision date of December 2018, titled Antipsychotic Medication Use states in part, .Antipsychotic medications will be prescribed at the lowest possible dosage .and are subject to gradual dose reduction and re-review .</p> <p>Record review revealed the resident was readmitted to the facility in November of 2022 with diagnoses including, but not limited to, major depressive disorder, anxiety, and delusional disorder.</p> <p>Record review revealed a current physician's order dated 12/29/2022 for OLANzapine [antipsychotic medication used to treat certain mental/mood conditions] Tablet 2.5 MG [milligrams] .one time a day for GDR [gradual dose reduction] .RE EVAL IN 14 DAYS .</p> <p>Record review failed to reveal evidence that the order was reevaluated by the provider 14 days after the order was written.</p> <p>Additionally, review of the December, January and February MARs revealed the resident received the OLANzapine daily.</p> <p>During a surveyor interview with the Director of Nursing Services on 2/24/2023 at approximately 2:00 PM, she was unable to provide evidence that the order was reevaluated after 14 days, per the physician's order.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  415064	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/28/2023
NAME OF PROVIDER OR SUPPLIER  Pawtucket Falls Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p>21613</p> <p>Based on surveyor observation, record review, resident and staff interview, it has been determined that the facility failed to accommodate residents' food preferences for 1 of 3 residents reviewed for food preferences, Resident ID #5.</p> <p>Findings are as follows:</p> <p>Record review revealed that the resident was admitted to the facility in October of 2021 with diagnoses including but not limited to stroke and dysphagia (difficulty swallowing).</p> <p>Record review revealed a care plan revised on 9/7/2022 which states in part, The resident has a nutritional problem or potential nutritional problem r/t [related to] dysphagia .2/2 [secondary to] CVA [stroke] .poor oral intake hx [history] of sig [significant] wt [weight] loss . The interventions for this care plan include but are not limited to .honor/update dietary preference as necessary .Likes .mac and cheese, jello .Dislikes .pudding .</p> <p>Additional record review revealed the following Nutrition/Dietary notes;</p> <p>-3/1/2023 .Family requesting rt [resident] receive mac and cheese at meals-kitchen notified of request .</p> <p>-3/8/2023 .Food Preference: likes: .mac &amp; cheese, jello .Dislikes: .pudding .</p> <p>-3/8/2023 .Resident to cont [continue] receiving meal tray/pleasure tray with jello daily and mac and cheese with lunch/dinner as resident wishes .</p> <p>Review of the resident's tray ticket revealed .Dislike: .pudding .coffee .</p> <p>Surveyor observations of the resident during the meals revealed the following:</p> <p>-3/20/2023 and 3/21/2023 no jello, no mac and cheese were observed on the resident's lunch trays</p> <p>-3/21/2023 coffee was observed on the resident's breakfast tray</p> <p>-3/22/2023 pudding was observed on the resident's lunch tray</p> <p>During the above observations, it was revealed that the resident did not eat the meals or the pudding that was served to him/her and did not drink the coffee.</p> <p>During a surveyor interview on 3/22/2023 at 3:22 PM, the resident revealed s/he likes jello and mac and cheese. The resident further revealed s/he does not like coffee or pudding.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  415064	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/28/2023
NAME OF PROVIDER OR SUPPLIER  Pawtucket Falls Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a surveyor interview with a Nursing Assistant, Staff B, on 3/23/2023 at 12:45 PM, she revealed that she has been taking care of the resident and that the resident likes jello, and mac and cheese.</p> <p>During a surveyor interview with the Regional Food Service Director, Staff C, on 3/22/2023 at 1:30 PM, he revealed that they will try to accommodate the resident's likes and dislikes as much as possible.</p> <p>During an additional interview with Staff C on 3/23/2023 at 8:50 AM, he revealed he was unaware that the resident's family requested the resident to receive mac and cheese at meals. When questioned, why coffee and pudding were on the resident's tray when the tray ticket indicated that s/he disliked coffee and pudding, Staff C stated I will take care of it.</p> <p>During a surveyor interview with the Director of Nursing on 3/23/2023 at 10:00 AM, she was unable to provide evidence that the resident received meals according to his/her preference.</p> <p>During a surveyor observation and interview on 3/22/2023 at approximately 1:00 PM with the resident s/he indicated that s/he did not eat his/her lunch and the facility later served him/her mac and cheese which s/he was observed eating by the surveyor.</p>