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 _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND GROVE HEALTH CARE CENTER	560 CUMBERLAND HILL ROAD WOONSOCKET, RI 02895

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification and a complaint survey, ACTS reference numbers 97424, 97055, and 97526, was conducted at Oakland Grove Health Care Center on 9/09/2024 through 9/12/2024 to determine compliance with 42 C.F.R. Part 483, requirements for Long Term Care Facilities. A state licensure and an emergency preparedness survey was also conducted at this facility. Deficiencies were identified as a result of this survey.	F 000	F 000 This plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: 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 physicians' orders for 4 of 4 residents reviewed for intake and output (I&O), Resident ID #s 26, 30, 61, and 104. Findings are as follows: According to Mosby's 4th Edition, Fundamentals of Nursing page 314, "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm the clients."	F 658	F 658 1. Residents ID #'s 26, 30, 61 and 104 have had the Intakes and Output orders reviewed MD and modified to obtaining outputs only. 2. All residents with an order for Intake and Output monitoring have the potential to be affected by the alleged deficient practice. A facility wide audit of resident with Intake and Output orders was completed to determine if the resident needed to be on I and O's. They were reviewed with the physician and the orders were changed to reflect what monitoring was needed. In the case of residents with catheters we changed the orders to just monitor outputs. 3. The nurses received in-service training on documentation of the input or output as ordered. The intake and output forms were changed to show a week view of the intake and output. This was reviewed in the training. The focus of the training reviewed the need for the documentation on the flow sheet to be completed each shift. The nurse needs to ensure the documentation is complete prior to the end of the shift. The DNS or designee will randomly audit the residents on intake and/or output monitoring is completed. 4. The results of Intake and/ or Output audits will be reviewed at the Quality Assurance Committee meeting to ensure ongoing compliance. 5. The Director of Nursing will be responsible for ensuring ongoing compliance.	10/2/24

RECEIVED
OCT 02 2024
FACILITIES REGULATION

10/3/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 10/2/24

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.

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F 658	Continued From page 1 Review of the facility's policy and procedure for "INTAKE AND OUTPUT MONITORING" dated April, 2015 states in part, "...Intake and Output will be monitored, as indicated by the resident's hydration status, risk for dehydration, and/or per physician's order...Intake and Output is documented for each shift, beginning with the 11 to 7 shift...Intake and Output is totaled daily by the 3 to 11 shift nurse and the 24 hour totals are transcribed to the Medication Administration Record..." 1. Record review revealed Resident ID #26 was re-admitted to the facility in June of 2024 with diagnoses including, but not limited to, retention of urine and uropathy (a urinary tract blockage). Additional record review reveals the resident has a suprapubic catheter (a hollow flexible tube that is used to drain urine from the bladder). Further record review revealed a physician's order dated 6/13/2024 to document the resident's I&O on the paper flow sheet every shift for suprapubic catheter placement. Record review of the paper I&O flow sheets from 9/1/2024 through 9/10/2024. failed to reveal evidence that the resident's I&Os were documented every shift as ordered for 27 of 30 opportunities, indicating that the facility was not aware of the resident's I&Os. During a surveyor interview on 9/12/2024 at 1:54 PM with the Director of Nursing Services (DNS), she was unable to provide evidence that the physician's order to document the resident's I&O every shift, for suprapubic catheter placement, on	F 658		

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F 658	Continued From page 2 the paper flow sheets were followed. 2. Record review revealed Resident ID #30 was re-admitted to the facility in September of 2023 with diagnoses including, but not limited to, chronic kidney disease, uropathy, and heart failure. Additional record review reveals the resident has a suprapubic catheter. Record review revealed a physician's order dated 3/20/2024 to document the resident's I&O on the paper flow sheet every shift. Record review of the paper I&O flow sheets from 9/1/2024 through 9/10/2024, failed to reveal evidence that the resident's I&Os were documented every shift, as ordered, for 26 of 30 opportunities. During a surveyor interview on 9/11/2024 at 8:50 AM with Registered Nurse, Staff B, she was unable to provide evidence that the I&Os were documented. Additionally, Staff B acknowledged that the order for I&Os was not followed. During a surveyor interview on 9/11/2024 at approximately 1:30 PM with the DNS, she revealed that she would expect staff to follow the physician's orders. 3. Record review revealed Resident ID #61 was re-admitted to the facility in May of 2024 with diagnoses including, but not limited to, high blood pressure, and prostatic hyperplasia (a condition in which the flow of urine is blocked due to the enlargement of prostate gland).	F 658		

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F 658	Continued From page 3 Additional record review reveals the resident has a suprapubic catheter. Record review revealed the resident has a physician's order dated 3/20/2024 to document the resident's I&Os on the paper flow sheet every shift. Record review of the paper I&O flow sheets from 9/1/2024 through 9/10/2024, failed to reveal evidence that the resident's I&Os were documented every shift, as ordered, for 30 out of 30 opportunities. During a surveyor interview on 9/12/2024 at 1:50 PM with the DNS, she revealed that she would expect staff to follow the physician's orders. 4. Record review revealed Resident ID #104 was admitted to the facility in July of 2024 with diagnoses including, but not limited to, acute kidney injury and chronic kidney disease. Record review revealed the resident has a physician's order dated 8/14/2024 to monitor I&Os every shift. Review of the September 2024 Treatment Administration Record revealed that staff documented an amount of fluid but failed to indicate if the amounts documented were the resident's intake or output. Furthermore, staff on the 11:00 PM-7:00 AM shift failed to document any amount of I&Os on the TAR for 9 out of 10 opportunities. Record review of the paper I&O flow sheets from 9/1/2024 through 9/10/2024, failed to reveal evidence that the resident's I&Os were	F 658		

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F 658	Continued From page 4 documented every shift, as ordered, for 30 of 30 opportunities. During a surveyor interview on 9/11/2024 at approximately 2:00 PM with LPN, Staff C, she was unable to provide evidence that the I&Os were documented every shift. Staff C acknowledged that the order for I&Os was not followed. During a surveyor interview on 9/12/2024 at approximately 11:30 AM, with the DNS, she revealed that she would expect staff to follow the physician's orders.	F 658		
F 692 SS=E	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.	F 692		

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F 692	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to ensure that residents maintain acceptable parameters of nutritional status, such as usual body weight, for 3 of 6 residents reviewed for significant weight loss and/or gain, Resident ID #s 76, 96, and 104. Findings are as follows: Record review of the policy titled, "Weights," last revised in August 2015, states in part, "The following residents/patients are weighed weekly X4 [for four weeks]...Residents/patients with an MD [doctor] order for weekly weights...The same scale should be used for each weighing of a particular resident/patient to ensure consistency and more accurate weights...All weight loss/gain of 3 pounds or more on a resident weighing 100 pounds or less and weight loss/gain of 5 pounds or more on a resident weighing 100 pounds or more requires a reweigh for verification. A reweigh is done on the same scale with a licensed nurse present. Weights are documented in the resident's/patient's medical record and/or weight book. If a significant weight loss/gain is identified (> [greater than] 5% in 30 days or >10% in 6 months), the IDT [interdisciplinary team], Dietitian, Physician and Family are notified..." 1. Review of Resident ID #76's record revealed s/he was admitted to the facility in May of 2021 with diagnoses including, but not limited to, Alzheimer's disease, adult failure to thrive, dysphagia (difficulty swallowing), and gastrostomy status (g-tube, an opening from the abdomen into the stomach that allows a feeding tube to deliver	F 692		

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F 692	Continued From page 6 food, fluids and medications directly into the stomach). Record review revealed a physician's order to obtain weekly weights. Record review revealed the following documented weights: - 8/6/2024 90.5 pounds (lbs.) - 8/13/2024 90.8 lbs. - 9/4/2024 83.0 lbs. - 9/10/2024 80.0 lbs. Record review of the August 2024 Treatment Administration Record (TAR) revealed that the order for weekly weights was signed as completed on 8/20/2024 and on 8/27/2024. Additional record review failed to reveal evidence of documented weights for 8/20/2024 and 8/27/2024. Record review revealed the resident lost 7.8 pounds from 8/13/2024 to 9/4/2024, which is a significant weight loss of 8.59% in less than one month. A subsequent weight taken on 9/10/2024 revealed the resident lost an additional 3 pounds, resulting in a severe weight loss of 11.89% in a one-month period. During a surveyor interview with Licensed Practical Nurse, Staff D, on 9/12/2024 at 11:12 AM, she revealed that nurses document weights in the record and note if there are any significant changes in weight. She indicated she would have expected the nursing assistant to reweigh the resident the same day if there was a discrepancy, to verify the accuracy of the weight. If a discrepancy is identified on the reweigh, she	F 692		

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F 692	Continued From page 7 would then contact the Registered Dietitian (RD) and the resident's provider. Additionally, she indicated that she was not aware of Resident ID #76's weight loss on 9/4/2024 or 9/10/2024 and that she would have contacted the RD and provider if she was had been aware. During a surveyor observation in the presence of Staff D on 9/12/2024 at 11:29 AM, Resident ID #76's weight was obtained via mechanical lift after the surveyor brought this concern to the facility's attention. The resident weighed 83.6 lbs., which verified a significant weight loss of 7.9% in approximately one month. During a surveyor interview with the RD on 9/12/2024 at 11:38 AM, she revealed she was not made aware of the resident's significant weight loss on 9/4/2024 or 9/10/2024 until it was brought to her attention by Staff D shortly before this interview. During a surveyor interview with the Physician, Staff E, on 9/12/2024 at 12:02 PM, he revealed that he last saw Resident ID #76 on 9/1/2024 or 9/2/2024 and that he and his Nurse Practitioner were not notified by the facility of the resident's weight loss on 9/4/2024 or 9/10/2024 until it was brought to his attention shortly before this interview. During surveyor interviews with the Director of Nursing Services (DNS) on 9/12/2024 at 1:04 PM and at 1:50 PM, she was unable to provide evidence weekly weights were obtained, as ordered, on 8/20/20244 and 8/27/2024. She also revealed that following a weight change of 3 pounds or more for a resident who is under 100 pounds, she would expect that a reweigh would	F 692	1. 1. Resident ID #76 had a reweight obtained on 9/12/2024 as stated and the MD ahd dietician was notified as stated. 2. All residents with weekly weight orders have the potential to be affected by the alleged deficient practice. A facility wide audit of residents who have weekly weights orders was completed to ensure that the weights were obtained, reweights were done, if applicable, reviewed by the dietician and if a weight loss was identified the MD was notified. 3. The Nurses received in-service training on the weight policy. This training focused on obtaining weights as ordered, reweights per policy if applicable, notifying the dietician and MD if weight loss was noted and documenting in the progress notes. The DNS or designee will complete audits of the residents with weekly weight orders to ensure that the weights are obtained, reweights done if applicable and dietician and MD were notified. 4. The results of the Weight Audits will be reviewed at the Quality Assurance Committee meeting to ensure ongoing compliance. 5. The Director of Nursing is responsible for ensuring ongoing compliance.	10/2/24

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F 692	Continued From page 8 be completed to verify the weight. Additionally, she revealed that she would expect that the RD and the Physician to have been notified following the resident's significant weight loss on 9/4/2024 and 9/10/2024. 2. Record review revealed Resident ID #96 was admitted to the facility in October of 2023, with diagnoses including, but not limited to, post-traumatic stress disorder, bipolar disorder, and anxiety disorder. Record review of a document titled "Nutrition Evaluation" dated 7/8/2024, revealed the resident's weight was "...160.4 [lbs.] up 18.9% in the past six months. This was not planned. [Weight] gain was anticipated with previous supplement, but this amount of weight gain was not anticipated...[weight] loss is anticipated." Review of the "Weight Summary" revealed on 7/16/2024 the resident weighed 157.4 lbs. and on 8/5/2024 s/he weighed 174 lbs., indicating a 16.6 lb. weight gain, a significant gain of 10.55% in less than 30 days. Additionally, the resident was weighed on 9/1/2024 and the weight obtained was also 174 lbs. Record review failed to reveal evidence that a reweigh was obtained on 8/5/2024 per the facility policy. During a surveyor interview on 9/12/2024 at 9:52 AM with the Nurse, Staff F, she revealed that weights are done by nursing assistants and if a weight reveals an increase or decrease of 3 lbs., a reweigh is indicated, and the changes in weights are documented and reported to the physician or nurse practitioner. Staff F, was	F 692	1. Resident ID # 96's reweight was obtained as stated. The NP was notified of the resident's weight gain with no new orders. Residents do not wish to be on any type of diet. 2. All residents have the potential to gain weight from month to month. A facility wide audit of resident's weights as completed to determine if there were any other residents that have had a weight gain to determine if the dietician and MD was notified of the gain. 3. The Nurses received in-service training on the weight policy with a focus on weight gains requiring reweight, notification to the dietician and MD, and documentation of notification. The DNS or designee will run a Weight Variance report to audit the weights monthly to ensure that weight gains are reviewed for reweight, dietician and MD notification. 4. The results of the Weight Variance Audit will be submitted to the Quality Assurance Committee to ensure ongoing compliance. 5. The Director of Nursing is responsible for ensuring ongoing compliance.	10/2/24

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F 692	Continued From page 9 unable to provide evidence that the above-mentioned weights obtained were documented and reported, per policy. During a surveyor interview on 9/12/2024 at 10:03 AM with the Nurse Practitioner, Staff G, she revealed she was not aware of the resident's weight gain. During a surveyor interview on 9/12/2024 at 11:41 AM with the RD, she revealed that she was not aware of Resident ID #98's significant weight gain. 3. Record review revealed Resident ID #104 was admitted to the facility in July of 2024 with diagnoses including, but not limited to, diabetes mellitus, acute kidney injury, and chronic kidney disease. Review of the "Weight Summary" revealed the resident's weight was 248.3 lbs. on 8/6/2024 and 231.2 lbs. on 9/1/2024, indicating a 17.1 lb. weight loss in less than a month. Record review failed to reveal evidence that the reweigh was obtained, per the facility policy, on 9/1/2024. During a surveyor interview on 9/12/2024 at 11:46 AM with the LPN, Staff C, she was unable provide evidence that the reweight was obtained on or after 9/1/2024. During a surveyor interview on 9/12/2024 at 12:21 PM with the DNS, she revealed that the reweigh should obtained within the next day. She acknowledged the weight was not obtained per the facility's policy.	F 692	3. 1. Resident ID # 104 had a reweight done on 9/12/2024. Residents NP was notified of weight change. 2. All residents have the potential to be affected by the alleged deficient practice. A facility wide audit of resident's weights as completed to determine if there were any other residents that have had a weight loss to determine if the dietician and MD was notified of the loss. 3. The Nurses received in-service training on the weight policy with a focus on weight loss requiring reweight, notification to the dietician and MD, and documentation of notification. The DNS or deginee will run a Weight Variance report to audit the weights monthly to ensure that weight losses are reviewed for reweight, dietician and MD notification. 4. The results of the Weight Variance Audit will be submitted to the Quality Assurance Committee to ensure ongoing compliance. 5. The Director of Nursing is responsible for ensuring ongoing compliance.	10/2/24

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F 692	Continued From page 10 During a surveyor interview on 9/12/2024 at 12:51 PM with the RD, she revealed she would expect staff to reweigh the resident after a significant weight change.	F 692		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to ensure that residents who are fed by a feeding tube receive the appropriate treatment and services to prevent complications for 1 of 2 residents reviewed relative to a	F 693		

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F 693	Continued From page 11 gastrostomy tube (G-tube, which is a surgically placed device used to give direct access to the stomach for supplemental feeding, hydration or medicine), Resident ID #76. Findings are as follows: Review of the policy titled "Enteral Feeding" dated April 2015 states in part, "PROCEDURE...Elevate head of bed 30-45 degrees..." Record review revealed the resident was re-admitted to the facility in February of 2024 with diagnoses including, but not limited to, dysphagia (difficulty swallowing) and Alzheimer's disease. Record review revealed a physician's order dated 2/17/2024 to elevate the resident 30-45 degrees at all times during feeding and for one hour after gravity feeds or resident must be elevated at all times with continuous feeding. Further record review revealed a physician's order dated 8/1/2024 to receive Nepro Carb Steady (a therapeutic nutrition specifically designed to help meet the nutritional needs of people with chronic kidney disease) 237 milliliters via g-tube four times a day at 9:00 AM, 1:00 PM, 5:00 PM, and 9:00 PM. During a continuous surveyor observation on 9/11/2024 from 8:57 AM through 9:17 AM, it was revealed that the resident's head of the bed was not elevated to a position of at least 30 degrees for one hour after receiving his/her therapeutic nutrition. During a surveyor interview on 9/11/2024 at 9:17 AM with Licensed Practical Nurse, Staff H, she	F 693	1. Resident ID # 76 HOB was elevated 30 -40 degrees after receiving the G-tube bolus on all other observations during survey. 2. All residents receiving G-tube feedings have the potential to be affected by the same alleged deficient practice. A facility wide audit was conducted to determine a list of residents receiving G-tube feedings with orders to keep HOB elevated 30- 45 degrees. Observations were then conducted to ensure the HOB was elevated as ordered. 3. The Nurses received in-service training on the Enteral Feeding Policy. This training reviewed the deficiency and focused on following the MD orders to keep the HOB elevated 30-45 degrees after feeding if applicable and ordered. The DNS or designee will randomly audit the HOB elevation on residents with orders for HOB to be elevated per MD order on residents receiving enteral feedings. 4. The results of the Weight Variance Audit will be submitted to the Quality Assurance Committee to ensure ongoing compliance. 5. The Director of Nursing is responsible for ensuring ongoing compliance.	10/2/24

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F 693	Continued From page 12 revealed that the resident completed his/her therapeutic nutrition at approximately 8:30 AM and acknowledged that the resident's head of the bed should have been elevated at least 30 degrees, as ordered. During a surveyor interview on 9/11/2024 at 2:38 PM with the Director of Nursing Services, she acknowledged that the resident's head of the bed should have been elevated to 30-45 degrees for 1 hour after receiving his/her therapeutic nutrition.	F 693		
F 699 SS=E	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-Informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by: Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to ensure that residents who are trauma survivors receive culturally competent, trauma-informed care, in accordance with professional standards of practice and accounting for residents' experiences and preferences, in order to eliminate or mitigate triggers that may cause re-traumatization for 1 of 1 resident reviewed, relative to a resident with history of post traumatic stress disorder (PTSD), Resident ID #96. Findings are as follows:	F 699		

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F 699	Continued From page 13 Record review revealed the resident was admitted to the facility in October of 2023, with diagnoses including, but not limited to, PTSD, bipolar disorder, and anxiety disorder. Review of the Minimum Data Set (MDS) assessment dated 7/8/2024 revealed a Brief Interview for Mental Status score of 14 out of 15, indicating intact cognition. Review of a document titled "Social Service Trauma-Informed Care Screening Tool" dated 10/3/2023, revealed a series of 7 questions designed to identify a resident with a history of trauma. Question number 2 asked if the resident had ever experienced any of the following: serious accident, sexual or physical assault, life threatening illness, natural disaster, or violent loss of a family member or close friend, and the resident answered "yes." Further review of this document failed to identify precisely what type of trauma the resident had experienced, or resident preferences to be implemented, in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. Record review on 9/9/2024 at approximately 1:00 PM, failed to reveal evidence that the facility completed an assessment or used a multifaceted approach to identify the resident's history of trauma as well as his/her preferences that include the triggers (defined as a psychological stimulus that prompts recall of a previous traumatic event, even if the stimulus itself is not traumatic or frightening), that may be stressors for him/her. During surveyor interviews on 9/9/2024 at 1:20 PM, and 9/11/2024 at 9:08 AM, with the resident,	F 699	1. Resident ID # 96 was reevaluated by the social worker and the resident still did not wish to disclose what the trauma was or triggers that may re-traumatize the resident. A progress note and care plan update was written to document residents preference not to divulge information and no triggers were identified. 2. All residents with the diagnosis of PTSD have the potential to be affected by the same alleged deficient practice. A facility wide audit of residents with a diagnosis of PTSD to ensure a Trauma Informed Evaluation was completed. An evaluation of information on the evaluation was done to determine if the resident shared event or triggers. A progress note was written to support a review of the assessment and care plan. 3. The Social Worker received in-service training on the Trauma Informed Care Policy. The training focused on ensuring if the resident identifies a trauma in the past we document if the resident does not wish to discuss or divulge this information or triggers. This information needs to be documented in both a progress note and care plan. The social worker or designee will complete an audit on new admissions to determine if the resident identified a history of past trauma and if the resident wishes to divulge the event and triggers, that a progress note was written and care plan updated with that information. 4. The results of the Trauma Informed Care Audit will be submitted to the Quality Assurance Committee to ensure ongoing compliance. 5. The Director of Social Services is responsible for ensuring ongoing compliance.	10/2/24

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F 699	Continued From page 14 s/he was noted to avoid making eye contact with the surveyor when speaking. Additionally, s/he indicated that s/he was willing to participate in a conversation regarding her care. During a surveyor interview on 9/9/2024 at 1:20 PM with the Medication Technician , Staff N, she revealed that she was unaware of the resident's history of trauma or his/her potential triggers. During a surveyor interview on 9/11/2024 at 11:53 AM with Licensed Practical Nurse (LPN), Staff A, she indicated that she was unaware of any triggers the resident may have. During a surveyor interview on 9/12/2024 at 9:52 AM with the LPN, Staff F, she indicated that she was unaware of the resident's history of trauma or his/her potential triggers. During a surveyor interview on 9/11/2024 at 12:05 PM with the Social Worker, Staff I, he was unable to provide evidence that a comprehensive assessment was completed to identify the nature of or the triggers for the resident's trauma, to eliminate or mitigate triggers that may cause re-traumatization to the resident. Record review of a document titled "Optum Behavioral Health Advanced Practice Clinician [APC] Follow Up" dated 8/5/2024 revealed a recommendation to obtain the resident's outpatient psychiatric records to confirm history or diagnoses and prior treatments. During an additional interview with Staff I on 9/12/2024 at 12:19 PM, he indicated that he was unaware of the recommendation from Optum Behavioral Health APC dated 8/5/2024 to obtain	F 699		

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F 699	Continued From page 15 the resident's outpatient psychiatric records. During a surveyor interview on 9/12/2024 at 10:25 AM, with the Director of Nursing Services, she indicated that she would expect a completed Trauma-Informed Care Assessment that identifies the nature of the trauma for residents with a diagnosis of PTSD.	F 699		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify	F 880		

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F 880	Continued From page 16 possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on surveyor observation, record review,	F 880		

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F 880	Continued From page 17 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 by failing to implement appropriate precautions, documentation of follow-up activity in response and comply with state and local public health authority requirements for identification, reporting, and containing communicable diseases and outbreaks. Furthermore, the facility failed to don [put on] the required Personal Protective Equipment (PPE) prior to entering resident rooms that required precautions for 1 of 2 units reviewed. Findings are as follows: 1. Review of a facility policy titled, "RI CORONAVIRUS (COVID-19) exposure" states in part, "This facility follows the professional standards and recommendations set forth by the Center of Disease Control [CDC], CMS [Centers for Medicare and Medicaid Services] and state health care agencies regarding coronavirus...The facility will actively screen all employees, vendors, and delivery personnel upon entrance to the facility during outbreak periods...The facility will monitor residents for COVID-19 symptoms daily and will increase monitoring to QS [every shift] on affected units during an outbreak...The facility will follow all CDC and State specific guidance for vaccinations and testing...All residents will be screened for COVID-19 symptoms daily..." Upon surveyor entrance to the facility on 9/9/2024 at approximately 8:00 AM the survey team was informed by the Receptionist, Staff O, that the facility is experiencing a COVID-19 outbreak. The survey team was not screened for COVID-19 and	F 880		

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F 880	Continued From page 18 was directed to the conference room. Surveyor observations between 9/9-9/11/2024 and record review, failed to reveal evidence that employees and/or visitors were screened for COVID-19 symptoms upon entering the building per the local public health authority recommendations. During a surveyor interview on 9/10/2024 at 9:15 AM with Nursing Assistant (NA), Staff K, NA Staff L, and the unit secretary, Staff M, they indicated they have not been screened for signs and symptoms of COVID-19 upon entering the building for the last several weeks. During a surveyor interview on 9/9/2024 at approximately 9:00 AM with the Director of Nursing Services (DNS), she revealed that during an outbreak, it is the facility's policy to follow the recommendations provided by the CDC and the local public health authority. She further revealed that the local public health authority was contacted via email on 9/1/2024 relative to the facility's COVID-19 outbreak. During a surveyor telephone interview on 9/10/2024 at approximately 10:29 AM with the local public health authority, they indicated the following recommendations were given to the facility in response to the facility's COVID-19 outbreak through email correspondence on 9/1/2024: - Screen visitors and employees for signs and symptoms of COVID-19 upon entering the building - All staff to wear a N95 in the resident care areas - COVID-19 testing two times a week for staff and	F 880		

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F 880	Continued From page 19 residents - Monitor residents for signs and symptoms of COVID-19 Record review of an undated facility document titled, "Residents" revealed a list of 21 residents who tested positive for COVID-19 from 9/1/2024 through 9/8/2024. Record review failed to reveal evidence that the facility's staff were being tested for COVID-19 twice a week per the recommendations. Record review revealed Resident ID #71 tested positive for COVID-19 on 9/5/2024. A surveyor observation on 9/9/2024 at 11:29 AM, revealed that NA, Staff J, was wearing two surgical masks and not a N95 mask upon entering Resident ID #71's room. Further observation revealed Resident ID #71 had an isolation cart outside of the room with a droplet/contact precaution sign that states in part, "Isolation Droplet/Contact...clean hands...gowns...N95 Respirator...Eye protection (goggles or face shield)...Gloves..." During an interview following the above observation with Staff J, she acknowledged that Resident ID #71 was positive for COVID-19 and that there was a sign indicating the proper PPE use which includes a N95 mask. Staff J acknowledged that she was not wearing a N95 mask when she entered Resident ID #71's room. During a surveyor interview on 9/10/2024 at 12:27 PM with the Regional Director of Clinical Services in the presence of the Regional Director of	F 880		

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F 880	Continued From page 20 Infection Control, the Infection Preventionist, and the DNS, she acknowledged that the facility was not following the facility policy, or the recommendations provided by the public health authority to screen visitors and employees for signs and symptoms of COVID-19. Additionally, she could not provide evidence that the staff were being tested for COVID-19 twice weekly. During a surveyor interview on 9/10/2024 at approximately 2:00 PM with the DNS, she was unable to provide evidence that the facility implemented appropriate precautions to prevent further transmission of the illness, as well as documentation of follow-up activity in response, and comply with state and local public health authority requirements for identification, reporting, and containing COVID-19. 2. Review of a facility policy titled, "Enhanced Barrier Precautions Policy" states in part, "Enhanced barrier precautions (EBP) require the use of a gown and gloves for certain residents during specific high-contact resident care activities in which there is risk for transmission of multidrug-resistant organisms. High-contact resident care activities include bathing/showering, providing hygiene, dressing, transferring, linen changes..." Record review revealed that Resident ID #104 was admitted to the facility in July of 2024 with diagnoses including but not limited to, diabetes, hyperlipidemia, and Methicillin-resistant Staphylococcus aureus (MRSA, a type of infection resistant to several antibiotics). Record review revealed the resident has a physician's order dated 8/14/2024, which states	F 880	1. 1. The facility implemented a screening tool to screen visitors and employees for signs and symptoms of Covid-19. The facility has been testing the staff per recommendations from DPH using a testing form to identify testing was completed. The facility entered orders on the effected units to monitor residents for symptoms. 2. All residents have the potential to be affected by the alleged deficient practice. The facility reached out to the Infection Prevention and Control Field Team with DPH to do a facility wide assessment of the facilities Covid outbreak practices and policies on 9/17/2024. The IPCFT came back to the facility on 9/18/2024 and 9/27/2024 from 12 to 4 pm to complete training on PPE doffing and donning and N95 use open to all staff at the facility. 3. The nursing staff received in-service training on the Covid -19 policy and N-95 use. The DNS or designee will randomly complete unit rounds to audit for compliance with precautions including proper N-95 use. 4. The results of the Covid -19 Precaution /N95 Audit will be submitted to the Quality Assurance Committee to ensure ongoing compliance. 5. The Director of Nursing is responsible for ensuring ongoing compliance.	10/2/24

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F 880	Continued From page 21 enhanced barrier precautions related to history of MRSA. During a surveyor observation on 9/11/2024 at approximately 9:05 AM, two nursing students, Students 1 and 2, were observed assisting Resident ID #104 change his/her hospital clothes and assist him/her to transfer to a wheelchair. The students then changed the residents' linens and brought the dirty linens outside of the room. During the above observation both students failed to wear a gown. Further surveyor observation of the signage posted on the resident's door revealed in part, "Enhanced Barrier Precautions; Attention: Caregivers, staff and visitors...Wear gloves and a gown for the following High-Contact Resident Care Activities: Dressing Bathing/Showering Transferring Changing linens..." During a surveyor interview on 9/11/2024 with Student 1 at 9:08 AM, and Student 2 at 9:14 AM, they both acknowledged that they failed to wear a gown. During a surveyor interview on 9/11/2024 at 12:27 PM with the Infection Preventionist in the presence of the DNS, she stated that she would expect for staff and visitors to follow infection control practices and wear all required PPE to enter rooms under isolation precautions.	F 880	2. 1. The students received immediate education at the time of identification related to Enhanced Barrier Precautions and the requirement to wear gowns and gloves. 2. All residents that are on Enhanced Barrier Precautions have the potential to be affected by the same alleged deficient practice. A facility wide audit of those residents identified as being on Enhanced Barrier Precautions was completed to ensure appropriate signage was posted. 3. The nursing students received education on following precaution signs that are posted throughout the facility which identify what PPE is needed while caring for a resident on precautions of any kind. The DNS or designee will randomly audit residents on Enhanced Barrier Precautions to ensure the staff and/ or students are following the PPE requirements when providing care. 4. The results of the Enhanced Barrier Precaution PPE Audit will be submitted to the Quality Assurance Committee to ensure ongoing compliance. 5. The Director of Nursing is responsible for ensuring ongoing compliance.	10/2/24 10/3/24

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E 000	Initial Comments An Emergency Preparedness Survey was conducted by the Center for Health Facilities and Regulation. The facility was in compliance with 42 CFR §483.73 related to Emergency Preparedness. No Emergency Preparedness deficiencies were identified during the survey.	E 000		

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

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.

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K 000	INITIAL COMMENTS The annual Federal Life Safety Code survey was conducted by the State Survey Agency. Oakland Grove Health Care Center was surveyed pursuant to the National Fire Protection Association 101 Life Safety Code, 2012 Edition as referenced in 42 CFR 483.90 (a - d) Physical Environment. Life Safety Code deficiencies were identified during the survey.	K 000		
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30,or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2	K 324		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 10/2/24

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415110	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	09/12/2024

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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K 324	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it has been determined that the facility failed to maintain the kitchen's hood suppression system in accordance with National Fire Protection Association (NFPA) 101 Life Safety Code 2012 Edition section 9.2.3 and NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations 2011 Edition section 11.2. This deficient practice has the potential to impact 109 of 109 residents, as well as an indeterminable number of staff and visitors. Findings are as follows: Record review of NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations 2011 Edition section 11.2 states in part, "...11.2.1* Maintenance of the fire-extinguishing systems and listed exhaust hoods containing a constant or fire-activated water system that is listed to extinguish a fire in the grease removal devices, hood exhaust plenums, and exhaust ducts shall be made by properly trained, qualified, and certified person (s) acceptable to the authority having jurisdiction at least every 6 months." Record review of the main building's kitchen suppression system service reports revealed that it was last serviced on 6/19/2023, a span of 14 months between servicing. During a surveyor interview with the Administrator and Regional Maintenance Director on 9/10/2024	K 324		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 324	Continued From page 2 at 11:00 AM, they acknowledged that the kitchen suppression system had exceeded the 6-month time requirement for the suppression system to be serviced.	K 324	1. There were no residents identified in this deficiency. 2. The facility has scheduled the kitchen suppression system servicing on 9/19/2024. 10/2/24 3. The facility placed the kitchen suppression system servicing on a preventative maintenance schedule every 6 months to ensure ongoing compliance. 4. The Maintenance Director is responsible for ensuring ongoing compliance. 10/3/24	