STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415029	A. BUILDING _____ B. WING _____	08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CREST NURSING CENTRE	100 SMITHFIELD ROAD NORTH PROVIDENCE, RI 02904

(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, Complaint, and COVID-19 Vaccine Compliance Surveys were conducted at Golden Crest Nursing Center from 08/01/2022 through 08/05/2022 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. A State licensure and emergency preparedness surveys were also conducted at this facility. As a result of this survey, the Facility was determined not to be in compliance with these requirements. Census: 142. Bed Count: 152	F 000	RECEIVED AUG 24 2022 FACILITIES REGULATION **Completion date for optimal compliance will be August 24th, 2022.** **Tag F658:** Physician orders were followed by nursing staff. We do not feel this deficiency existed but are filing a POC to continue our commitment to quality care and to be in full compliance with state and federal guidelines.	
F 658 SS=D	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 the services provided by the facility meet professional standards of quality for 1 of 8 residents reviewed relative to physician's order for pain medication, Resident ID #81. Findings are as follows: According to Mosby's 4th Edition, Fundamentals of Nursing, page 314 states, "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		

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

ADM | 8/24/22

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
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F 658	Continued From page 1 Record review revealed the resident was admitted to the facility in March of 2022 with diagnoses including, but not limited to, fracture of right patella (kneecap), right great toe amputation and difficulty in walking. Record review of physician's orders dated 6/14/2022 revealed the following: - Oxycodone- 5 milligram (mg). Take 1 tablet by mouth every 6 hours PRN (as needed) for pain rating 5-7 - Oxycodone -5 mg; Take 2 tablets by mouth every 6 hours PRN for pain rating 8-10 Record review of the July and August Medication Administration Record from 7/3/2022 through 8/3/2022 revealed the resident incorrectly received Oxycodone 5 mg 1 tablet instead of 2 tablets on the following dates and times: - 7/7/2022 at 12:38 PM for pain rating 8 out of 10 - 7/8/2022 at 1:05 PM for pain rating 9 out of 10 - 7/22/2022 at 1:14 PM for pain rating 8 out of 10 - 7/26/2022 at 2:59 AM for pain rating 8 out of 10 - 8/1/2022 at 4:43 PM for pain rating 8 out of 10 During a surveyor interview with the Director of Nursing on 8/3/2022 at 11:27 AM, he acknowledged that the resident did not receive the above pain medication as ordered.	F 658	**POC for Tag F658.** a.) Resident received correct dose of oxycodone according to narcotic book documentation. b.) Education provided to nursing staff regarding pain policy and correct documentation. c.) Audit created and completed by DNS to determine 100% compliance with pain medication. d.) Audit will be completed Monthly x 3 months to Determine 100% compliance.	8/18/22 8/23/22 8/23/22 r On-going
F 686 SS=E	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers.	F 686		

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	415029	A. BUILDING _____ B. WING _____	08/05/2022

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F 686	Continued From page 2 Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. 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 that are at risk for pressure ulcers and residents with pressure ulcers receive necessary treatment and services, consistent with professional standards of practice, to promote healing and prevent new pressure ulcers from developing for 4 of 10 residents reviewed, Resident ID #'s 40, 70, 110, and 482. Findings are as follows: Record review of the 2001 facility's policy titled "Pressure Ulcer Risk Assessment" with a revision date of 2013 states in part: "...Assessment: 3. Monitoring: c. Nurses will conduct skin assessments at least weekly to identify changes ...4....Because a resident at risk can develop a pressure ulcer within 2 to 6 hours of onset of pressure, the at-risk resident needs to be identified and have interventions implemented promptly to attempt to prevent pressure ulcers ...13. Documentation in medical record addressing MD [medical doctor] notification if	F 686 MR 8/23/22	**POC for Tag F686:** a.) Education provided to all nurses regarding weekly skin assessments, low air loss mattresses usage, adaptive equipment for wound care, and weekly measuring of wounds. b.) Weekly skin Assessment complete for all residents to determine resident skin baseline. c.) Weekly skin assessment schedule for all Residents reviewed with nurses and placed on all units. d.) Audit created and completed by DNS to monitor completion of weekly skin assessments. Audit will be on-going and 2 residents from each unit will be randomly selected to determine compliance and accuracy of skin assessment.	8/18/22 8/23/22 8/24/22 8/23/22 + monthly on-going

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F 686	Continued From page 3 changes of plan of care if indicated..." 1) Record review revealed Resident ID #40 was admitted to the facility in November of 2021 with diagnoses that include, but are not limited to; pressure ulcer of sacral region (portion of your spine between your lower back and tailbone) and an abscess to the right buttocks. Record review of the wound clinic notes revealed the following: - on 7/15/2022, wound on right buttock, measurements are 2 cm length x 0.2 cm width x 0.3 cm depth. - on 7/29/2022, wound on right buttock, measurements are 3 cm length x 0.5 cm width x 0.3 cm depth. Record review failed to reveal evidence that measurements of the wound were obtained on 7/8/2022 and 7/22/2022. During a surveyor interview with the Director of Nurses (DON) on 8/4/2022 at approximately 9:15 AM, he was unable to provide evidence that wound measurement were obtained on 7/8 and 7/22/2022. 2) Record review revealed Resident ID #70 was admitted to the facility in April of 2022 with diagnoses which include, but are not limited to, stage 4 pressure ulcer (most severe form of bedsores that reaches the muscles, ligaments, or bone) of the sacral region/left buttock, and osteomyelitis (inflammation of the bone caused by infection) of vertebra, and sacral region.	F 686	e.) Audit created and completed by DNS to monitor wounds weekly Measurements and new orders from wound nurse/MD. Audit to be completed weekly x4 weeks and then monthly x 3 months if 100% compliance achieved. f.) Audit created and completed by DNS to ensure low air loss mattress and adaptive equipment in place, functioning, and correct settings. Audit to be completed monthly x3 months if 100% compliance achieved.	8/23/22 ongoing 8/23/22 On-going

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F 686	Continued From page 4 Record review of a continuity of care consultation form from the wound clinic dated 7/26/2022 revealed the following recommendations: - "...Wound #13, Right, lateral Ischial (5 o'clock) [lower part of your hip bone]: Dressings: Discontinue Santyl ointment [a medication that removes dead tissues from wounds]... - ...Wound #14 Left buttock...Dressings: Discontinue Santyl ointment... - ...Wound #15 Right, distal buttock (buttock/Thigh crease)...Dressing: Discontinue Santyl ointment... - ...Wound #16 Right, Lateral, superior buttock (1o'clock)...Dressings: Discontinue Santyl..." Record review of the Treatment Administration Record (TAR) from 7/26/2022 through 8/3/2022 failed to reveal evidence that the Santyl was discontinued per the wound clinic recommendations. During a surveyor interview on 8/3/2022 at 10:37 AM with the Registered Nurse, Staff A, she was unable to provide evidence that the Santyl was discontinued per the wound clinic recommendations. During a surveyor interview on 8/4/2022 at 10:50 AM with the Nurse Practitioner (NP), Staff B, she indicated that she would expect staff to notify her of the recommendations as she would have approved of the recommendations from the wound clinic. She further revealed that she was not made aware of the recommendations from the wound clinic on 7/26/2022. 3) Record review revealed Resident ID #110 was admitted to the facility in August of 2019 and has	F 686		

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F 686	Continued From page 5 diagnoses which include, but are not limited to; pressure ulcer of the right ankle and peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs). Record review of a physician's order dated 5/26/2022 states, "Boot in place while in wheelchair. Document refusals. Twice A Day AM 07:00 AM-03:00 PM, HS [at bedtime]03:00 PM-11:00 PM." Surveyor observation of the resident while in his/her wheelchair on 8/2/2022 at approximately 1:30 PM, and on 8/3/2022 at 11:29 AM, 12:51 PM, and at 1:12 PM, revealed him/her not wearing the boot while in his/her wheelchair. Although, record review of the TAR revealed it was signed off as being completed on 8/2/2022 and 8/3/2022 between 7:00 AM-3:00 PM. During a surveyor interview with the resident on 8/3/2022 at 9:30 AM s/he stated s/he hasn't been offered the boot in a while. The resident who is alert and oriented further stated that s/he does not refuse to wear the boot. During a surveyor interview with LPN, Staff C, on 8/3/2022 at 1:16 PM, she indicated that it is the certified nursing assistants responsibility to put the boot on in the morning when doing care and the nurse's responsibility to sign off on it. Staff C acknowledged she signed off on the TAR before seeing that the boot was applied on 8/2/2022 and 8/3/2022. She further revealed that it is her expectation for the resident to have the boot on while in his/her wheelchair. During a surveyor interview with Nursing	F 686		

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F 686	Continued From page 6 Assistant, Staff D, on 8/4/2022 at 9:30 AM, indicated the nursing assistants are expected to put the boot on in the morning when the resident is in his/her wheelchair and that the resident does not refuse to wear the boot. 4) Record review for Resident ID #482 revealed s/he was admitted to the facility in July of 2022 with diagnoses that include, but are not limited; to sacral wound, pressure ulcer of left buttock and pressure induced deep tissue damage of unspecified site. During a surveyor observation of the resident's room on 8/1/2022 at 12:10 PM and on 8/2/2022 at 12:20 PM revealed an air mattress sitting on the floor. Record review of the physician order dated 7/24/2022 revealed in part "...check air mattress gauge every shift for accuracy..." Further record review revealed the wound care doctor covering in the facility, on 7/21/2022 and 7/27/2022, recommended the use of Prevalon Boots for off-loading of his/her heels. During a surveyor interview with the resident on the following dates, s/he revealed the air mattress was not in place and s/he was not wearing any type of boot on his/her feet. -8/1/2022 at approximately 9:00 AM, -8/2/2022 at approximately 10:30 AM -8/3/2022 at approximately 9:30 AM, Record review of the TAR revealed the air mattress was signed off on 8/1/2022 and 8/2/2022 on all 3 shifts as having been checked	F 686		

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F 686	Continued From page 7 for accuracy. During a surveyor interview with the Staff B on 8/4/2022 at approximately 10:50 AM she revealed she was not aware of the Prevalon Boot recommendation and if she had been made aware she would have approved it. During a surveyor interview with the DON on 8/4/2022 at approximately 2:30 PM, he revealed the resident did not have a physician order for Prevalon Boot and the air mattress was not in place per physician order.	F 686		

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	415029	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/04/2022**

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K 000	INITIAL COMMENTS The annual Federal Life Safety Code survey was conducted by the State Survey Agency. The facility 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. Deficiencies were identified.	K 000	RECEIVED AUG 25 2022 FACILITIES REGULATION	
K 161 SS=F	Building Construction Type and Height CFR(s): NFPA 101 Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111)	K 161	Golden Crest Nursing Centre has had a Fire Safety Evaluation System (FSES) on file with CMS to address a construction type deficiency. The FSES was previously completed utilizing the 2001 Edition of NFPA 101A. In light of the CMS adoption of the 2012 Edition of the Life Safety Code® (NFPA 101) and as directed by CMS Survey & Certification Memo 17-15-LSC, the facility has gone through an updated Life Safety Code compliance assessment and updated the FSES to the 2013 Edition of NFPA 101A. The original onsite evaluation was completed in January 2018 by Wade A. Palazini, CFI Senior Consultant. Per conversations with Region I CMS, an annual Life Safety Code® Assessment is required and FSES documentation updated accordingly. As such, Wade conducted the annual assessment on 9/27 /19. The items identified during this assessment were corrected and the results of the corrected items are reflected in the FSES documentation contained within this correspondence. Facility Overview: The facility is considered an Existing Healthcare Occupancy as outlined in the 2012 Edition of the Life Safety Code®. The building is two (2) stories in height above grade. The building construction type most closely resembles Type III (200), as defined by NFPA 220, Standard on Types of Building Construction. The building is protected throughout with a supervised automatic sprinkler system. 8/30/22 Continues to page 2	

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	415029	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/04/2022

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K 161	Continued From page 1 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. This REQUIREMENT is not met as evidenced by: Based on surveyor observation and staff interview, it was determined that the facility failed to meet the minimum construction requirements as required by NFPA 101 2012 edition section 19.1.6. Findings are as follows: NFPA 101 Life Safety Code, 2012 section 19.1.6.1 states in part "Health care occupancies shall be limited to the building construction types specified in Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7. (See 8.2.1.)." Existing, Building Construction Type and Height, Sections 19.1.6.2 through 19.1.6.7 states that a two (2) story fully sprinklered healthcare occupancy with a construction type of Type III (200) is not permitted. Surveyor observations that were made of the facility during the life safety tour conducted on 8/4/2022 revealed that the building is constructed of Type III (200) ordinary construction. This	K 161	Applicable Code Sections: Section 19.1.6.1 of the 2012 Edition of the Life Safety Code® outlines the requirement for allowable construction types. Deficiencies: Based upon the number of stories in height of the building and the fact that the building is fully sprinklered, the minimum compliant construction type is Type III (211). Type III (200) construction is not permitted. FSES Notes & Assumptions: While completing the 2013 NFPA 101A / FSES worksheets, the appropriate negative points for "Construction" have been taken in each applicable zone. FSES Results: An updated FSES has been developed for the facility with a separate worksheet completed for each smoke compartment/ zone. The worksheets show that all FSES zones receive a "passing" score. Completion of the FSES shows that while the existing situation does not meet the prescriptive requirements of the 2012 Edition of the Life Safety Code®, the building nonetheless provides a level of life safety equal to or exceeding what is required by the Life Safety Code®. A. See above explanation for construction type and sprinkler system coverage. B. Patients are located on both floors of the facility. C. Please see attached FSES for location of all smoke barriers and compartments in the facility.	1/20/2018 + ongoing 1/20/2018 + ongoing 1/20/2018 + ongoing

VR
8/30/22

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K 161	Continued From page 2 construction type is not permitted for a healthcare occupancy to be over one story. During interview on 8/4/2022 at approximately 9:00 am, the Maintenance Director acknowledged that the nursing home is a two story (sloped sight) building with a lower-level resident floor, which exits to grade, with a construction type of Type III (200).	K 161		