STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415032	A. Building B. Wing	09/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Crest Nursing Centre Inc	125 Scituate Avenue Cranston, RI 02920

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 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 relative to 1 of 3 residents reviewed with a physician's order for lorazepam (a medication prescribed to treat anxiety), Resident ID #11, and for 1 of 1 wound dressings observed for a pressure ulcer, Resident ID #159. 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. 1. Record review revealed Resident ID #11 was re-admitted to the facility in August of 2025 with a diagnosis including, but not limited to, anxiety disorder. Record review of a care plan dated 9/2/2025 revealed the resident is receiving hospice services with an approach to administer medications as ordered for comfort. Further review of the care plan with an approach start date of 9/27/2024 revealed, the resident is receiving Ativan (lorazepam).Record review of a Hospice Care Coordination Note dated 9/17/2025 revealed a recommendation to continue lorazepam 0.5 milligram (mg) by mouth at bedtime and every one hour as needed.Record review of a progress note dated 9/17/2025 revealed the physician approved the above-mentioned hospice recommendations. Record review failed to reveal evidence that the physician's order for lorazepam 0.5 mg every one hour as needed was transcribed, as ordered. During a surveyor interview on 9/25/2025 at 9:22 AM with Registered Nurse (RN), Staff A, she acknowledged that the physician's order for lorazepam 0.5 mg every hour as needed was not transcribed as ordered. Additionally, she indicated that the resident's anxiety has increased, and s/he has recently needed the lorazepam more often. During a surveyor interview on 9/25/2025 at 9:47 AM with the Director of Nursing Services (DNS) she acknowledged that the physician had approved the hospice recommendation for lorazepam 0.5 mg every hour as needed on 9/17/2025 and that the facility failed to put the order in place until it was brought to the nurse's attention by the surveyor. 2. Record review revealed Resident ID #159 was re-admitted to the facility in September of 2025 with a diagnosis including, but not limited to, ulceration (an open wound) of the right mid foot. Record review revealed a physician's order dated 9/19/2025 to cleanse the right plantar (sole of the foot) wound with normal saline and apply Calcium Alginate AG (a wound dressing that is infused with silver that provides antimicrobial protection, preventing bacterial growth) daily.During a surveyor observation on 9/25/2025 at 11:37 AM of a wound care dressing change to Resident ID #159's right foot with RN, Staff A, she cleansed the resident's wound with normal saline then applied Calcium Alginate, instead of Calcium Alginate AG, as ordered. During a surveyor interview with Staff A immediately following the above-mentioned observation, Staff A acknowledged that she applied Calcium Alginate to the resident's wound, instead of Calcium Alginate AG, as ordered. During a surveyor interview on 9/25/2025 at 11:52 AM with the DNS, she was unable to provide evidence that the resident had received the appropriate wound care treatment, as ordered.

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415032	A. Building B. Wing	09/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Crest Nursing Centre Inc	125 Scituate Avenue Cranston, RI 02920

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. 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 drugs for 1 of 3 residents reviewed who were receiving an antihypertensive (a medication prescribed to lower blood pressure) medication with parameters, Resident ID #93. Findings are as follows:Record review revealed the resident was readmitted to the facility in July of 2024 with a diagnosis including, but not limited to, pulmonary hypertension (a type of high blood pressure that affects the arteries in the lungs and the right side of the heart).Record review revealed a physician's order dated 4/30/2025 for Diltiazem HCL extended release (a medication prescribed to lower blood pressure) 180 milligram (mg) daily, hold the medication if the systolic blood pressure (SBP, refers to the top number of a blood pressure reading that indicates the pressure in the arteries when the heart contracts) is less than 110. Record review of the August and September 2025 Medication Administration Records (MARs) revealed the Diltiazem was administered when the SBP was less than 110, on the following dates:- 8/22/2025: SBP of 108- 8/25/2025: SBP of 108- 8/20/2025: SBP of 108- 9/4/2025: SBP of 106- 9/14/2025: SBP of 108- 9/17/2025: SBP of 105During a surveyor interview on 9/24/2025 at 11:30 AM with Certified Medication Technician, Staff B, she acknowledged that she had signed off the resident's Diltiazem order on 8/25/2025 and 9/4/2025 as administered when his/her SBP was less than 110.During a surveyor interview on 9/24/2025 at 9:51 AM with the Director of Nursing Services (DNS), she acknowledged the Diltiazem should have been held, as ordered, on the above-mentioned dates the resident's SBP was less than 110.