

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415008	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2025
NAME OF PROVIDER OR SUPPLIER Greenwood Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1139 Main Avenue Warwick, RI 02886	

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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>Based on record review and staff interview, it has been determined that the facility failed to meet professional standards of quality relative to following a physician's order for 1 of 1 resident reviewed with orders to check blood sugars, Resident ID #2. Findings are as follows: According to Mosby's 4th Edition, Fundamentals of Nursing, page 314 which states in part, "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." Record review revealed the resident was admitted to the facility in July of 2025 with a diagnosis including, but not limited to, type 2 diabetes mellitus with diabetic nephropathy (nerve damage that affects people with diabetes). Record review revealed an active physician's order with a start date of 7/29/2025, that states, check blood sugar four times a day for type 2 diabetes. Record review of the resident's care plan, dated 7/29/2025, revealed the resident was insulin dependent with an intervention to assess and record his/her blood glucose levels as ordered. Record review failed to reveal evidence that the resident's blood sugar had been checked four times daily between 7/29/2025 through 9/4/2025. Further record review of the resident's EMR of the recorded vitals, revealed that the resident's sugar was not obtained for 137 out of 152 opportunities. During a surveyor interview on 9/4/2025 at 10:50 AM with Registered Nurse, Staff A, she indicated that if a resident's blood sugars had been checked, it would be recorded in the resident's Electronic Medical Record (EMR) under the vitals section. She indicated that she was unaware of the physician's order. She further acknowledged that there was no record Resident ID #2's blood sugar had been checked per the physician's order. During a surveyor interview on 9/4/2025 at 1:09 PM with the Director of Nursing Services, she was unable to provide evidence that the physician's order to check the resident's blood sugar four times a day had been followed. During a surveyor interview on 9/4/2025 at 3:04 PM the Nurse Practitioner, Staff B, she indicated it was her expectation that the physician's order would have been followed.</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: 415008	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2025
NAME OF PROVIDER OR SUPPLIER Greenwood Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1139 Main Avenue Warwick, RI 02886	
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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>Based on record review and staff interview it has been determined that the facility failed to ensure that the resident's medical was accurate in accordance with accepted professional standards and practices, for 1 of 1 resident reviewed with an order for routine blood sugar monitoring, Resident ID #2. Findings are as follows: Record review revealed the resident was admitted to the facility in July of 2025 with a diagnosis including, but not limited to, type 2 diabetes mellitus with diabetic nephropathy (nerve damage that affects people with diabetes). Record review revealed an active physician's order with a start date of 7/29/2025, that states, check blood sugar four times a day for type 2 diabetes. Record review of the resident's care plan dated 7/29/2025 revealed the resident was insulin dependent with an intervention to assess and record his/her blood glucose levels as ordered. Record review failed to reveal evidence that the resident's blood sugar had been checked four times daily between 7/29/2025 through 9/4/2025. Further record review of the resident's Electronic Medical Record (EMR) revealed that the resident's blood sugar was not obtained for 137 out of 152 opportunities. During a surveyor interview on 9/4/2025 at 10:50 AM with Registered Nurse, Staff A, she indicated that she was unaware that the resident had a physician's order to monitor his/her blood sugar. Staff A acknowledged that there was an order in the system, but it did not populate on the resident's Treatment Administration Record. During a surveyor interview on 9/4/2025 at 1:09 PM with the Director of Nursing Services, she indicated that the order had been transcribed incorrectly into the resident's (EMR). Additionally, the DNS indicated that the order to check the resident's blood sugar four times a day had been transcribed as an ancillary order and not as a treatment, which is why the order failed to populate as a treatment.</p>		