

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415029	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/15/2024
NAME OF PROVIDER OR SUPPLIER Golden Crest Nursing Centre		STREET ADDRESS, CITY, STATE, ZIP CODE 100 Smithfield Road North Providence, RI 02904	

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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>48928</p> <p>Based on surveyor observation, record review, and staff interview, it has been determined the facility failed to provide person centered care in accordance with a resident's plan of care for 1 of 2 residents reviewed relative to his/her call light being within reach, Resident ID #67.</p> <p>Findings are as follows:</p> <p>Record review revealed the resident was admitted to the facility in April of 2024 with diagnoses including, but not limited to, adult failure to thrive, paroxysmal atrial fibrillation (a type of irregular heartbeat) and muscle weakness.</p> <p>Record review of a care plan dated 4/18/2024 revealed in part, .Potential for falls/injury r/t [related to]: impaired mobility, impaired cognition, impaired vision, incontinence, weakness and FTT [failure to thrive] . This care plan has interventions including, but not limited to, .Call light within reach & remind to call for assist as needed .</p> <p>During a surveyor observation on 7/15/2024 at 12:40 PM, the resident was observed to be seated in his/her wheelchair between the bed and wall, closest to the doorway, and more than halfway down the length of the bed. S/he had his/her rolling bedside table in front of him/her containing his/her meal tray, his/her bilateral lower extremities were slightly elevated on the wheelchair leg rest. Additionally, the resident's call light was tied to the bed rail on the opposite side of the bed, out of sight and reach of the resident.</p> <p>During a surveyor interview immediately following the above-mentioned observation with the resident, s/he revealed that s/he felt trapped, just trapped here, I have to yell for help and hope they hear me due to his/her inability to locate and utilize his/her call light for assistance.</p> <p>During a surveyor interview and observation on 7/15/2024 at 12:45 PM with Nursing Assistant, Staff A, she acknowledged the call bell for Resident ID #67 should be within his/her reach and it was not. Staff A, relocated the call bell so that it was within reach for the resident to use.</p> <p>During a surveyor interview on 7/15/2024 at 1:53 PM with the Director of Nursing Services, he acknowledged that the care plan regarding the call light being within reach had not been not followed for Resident ID #67.</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
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