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	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Crest Nursing Centre	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)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on clinical record review, and family and staff interview, the facility failed to ensure a resident received the necessary monitoring and assistance to maintain proper hydration for 1 of 3 residents reviewed, Resident ID #1.Findings are as follows:According to Fundamentals of Nursing 7th Edition (2011), .Fluid Balance.The desirable amount of fluid intake.in adult ranges from 1,500 to 3,500 milliliter (mL) each 24 hours, with most people averaging 2,500 to 2,600 mL per day.Parameters to be considered in clinical assessment for fluid, electrolyte, and acid-base balance.Records may be initiated by the nurse for any patient with a real or potential water or electrolyte problem.Intake should include all fluids taken into the body.If monitoring of a patient's intake.is required, the patient, family, and all caregivers must be alert to the need to measure all fluids entering.the body.Record review of a community reported complaint sent to the Rhode Island Department of Health on 4/2/2026 alleged in part, that the facility is short staffed and has been letting Resident ID #1's health decline.During a surveyor interview on 4/15/2026 at 11:31 AM, with the complainant, s/he alleges that the facility has not been assisting the resident with his/her hydration consistently.Record review revealed Resident ID #1 was admitted to the facility in March of 2026 with diagnoses including, but not limited to, a left femur fracture and Alzheimer's disease.Record review of Resident ID #1's care plan revealed a problem of alteration in fluid maintenance due to diuretic (a medication prescribed to help the body eliminate excess sodium and water through increased urine production) use and poor insight into hydration needs. Further review revealed an intervention initiated on 3/19/2026 to monitor his/her fluid intake.Record review of the laboratory blood work results on 4/9/2026 revealed a creatinine level of 1.47 milligrams/deciliter (mg/dL) (a blood laboratory test prescribed to assess the kidney function; 0.8 - 1.40 mg/dL is the normal level and an elevation may be a sign of dehydration). This level was higher when compared to the creatinine level of 1.25 on the 4/2/2026 blood work results.During a surveyor interview on 4/15/2026 at approximately 1:00 PM with Licensed Practical Nurse, Staff A, she acknowledged that staff are expected to monitor the resident's fluid intake and document it in the electronic medical record (EMR) every shift.Review of the EMR fluid intake documentation from 3/21/2026 through 4/14/2026 failed to reveal record of fluid intake for 53 of 75 shifts reviewed. Additionally, the resident's fluid intake failed to reflect the minimum recommended daily intake of 1,500 mL for 24 of 25 days reviewed.During a surveyor interview on 4/15/2026 at approximately 2:00 PM with the Assistant Director of Nursing Services, she revealed that she would expect staff to document the resident's fluid intake in the EMR, as required.

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
	415029	A. Building B. Wing	04/16/2026

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, and family and staff interview, the facility failed to ensure that resident records are complete and accurately documented related to assistance with activities of daily living for 2 of 3 residents reviewed, Resident ID #s 1 and 2.Findings are as follows:According to Fundamentals of Nursing, Seventh Edition dated 2011, states in part, Documenting Nursing Care .Remembering the legal truth ?It wasn't done if it wasn't documented'.Documentation Guidelines.Aim: Complete, accurate, concise, current, factual, and organized data communicated in a timely and confidential manner to facilitate care coordination and serve as a legal document.Record review of a community reported complaint sent to the Rhode Island Department of Health on 4/2/2026 alleged in part, that the facility is short staffed and has been letting Resident ID #1's health decline.During a surveyor interview on 4/15/2026 at 11:31 AM, with the complainant, s/he alleges that the facility did not have enough staff to assist Resident ID #1 during the day shift (7:00 AM to 3:00 PM) on 4/9/2026.1. Record review revealed Resident ID #1 was admitted to the facility in March of 2026 with diagnoses including, but not limited to, a left femur fracture and Alzheimer's disease.Record review of the Comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident required maximal assistance with personal hygiene and toileting.Record review of the Nursing Assistant (NA) Point of Care History 4/9/2026, failed to reveal documentation assistance with care was provided for Resident ID #1 during the day shift.2. Record review revealed Resident ID #2 was admitted to the facility in November of 2022 with a diagnosis including, but not limited to, paraplegia (paralysis of lower body).Record review of the Quarterly MDS assessment dated [DATE] revealed the resident as staff-dependent for personal hygiene and toileting.Record review of the NA Point of Care History for 4/9/2026, failed to reveal documentation assistance with care was provided for Resident ID #2 during the day shift.During a surveyor interview on 4/15/2026 at approximately 2:00 PM, the Assistant Director of Nursing Services acknowledged that the NAs failed to document in the clinical record the care provided to Resident ID #s 1 and 2 during the day shift on 4/9/2026, as required.