STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415031	A. Building B. Wing	01/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Creek Rehab & Healthcare Center	7 Creek Lane Bristol, RI 02809

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48928 46241 Based on surveyor observation, record review, and resident and staff interview it has been determined that the facility failed to ensure that the residents' environment remains as free from accident hazards as possible, as the facility experienced a fire incident. Findings are as follows: Review of a facility reported incident form submitted to the Rhode Island Department of Health on 1/24/2025 revealed that at approximately 7:25 AM on 1/24/2025, a Nursing Assistant was completing rounds and found a piece of paper on fire in a resident's room. A code red was initiated, and the fire was extinguished. The form further revealed that at the time of the fire, the room was unoccupied. Review of a manufacturer's booklet, for the electric baseboard heaters installed in the facility, titled, [NAME] Electric Baseboard Heaters states in part, .WARNING .This heater is hot when in use. To avoid burns, do not let bare skin touch hot surfaces. Keep combustible materials, such as furniture, pillows, bedding, papers, clothes, and curtains away from heater .Furniture: maintain at least 6 inches (152 mm [millimeter]) space between furniture and heater to allow for proper air flow . A. Surveyor observation of photographs submitted to the Rhode Island Department of Health on 1/24/2025 at 10:06 AM by the Office of the State Fire Marshal revealed a reclining chair with areas of charring to the right side of the chair and arm rest. The chair was positioned in close proximity of an electric baseboard heater. Additionally, the area on the wall above the baseboard heater was observed to have notable charring and the damage extended up the wall to the window ledge, with charred matter scattered across the floor. Review of an email submitted to the Rhode Island Department of Health on 1/24/2025 at 11:36 AM received from the Office of the State Fire Marshal states in part, Investigators .responded to .a fire in a nursing home. The fire was confined to a chair and blankets in a patient room. The chair and/or blankets w[ere] in direct contact with an electric baseboard heating unit. The fire is accidental, due to lack of clearance to a heating unit . (continued on next page)

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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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During a surveyor interview on 1/24/2025 at 11:25 AM with the Administrator, Director of Nursing Services (DNS), and the Regional Infection Preventionist, they revealed that a fire occurred in Resident ID #1 and 2's room around 7:25 AM, while both residents were out of the room. Record review revealed Resident ID #1 was admitted to the facility in January of 2021 with diagnoses including, but not limited to, dementia and the need for assistance with personal care. Review of a Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 9 out of 15, indicating Resident ID #1's cognition was moderately impaired. Further review revealed the resident is dependent upon staff for transfers. Record review revealed Resident ID #2 was readmitted to the facility in August of 2024 with diagnoses including, but not limited to, muscle weakness and the need for assistance with personal care. Review of an MDS assessment dated [DATE], revealed a BIMS score of 15 out of 15, indicating Resident ID #2's cognition was intact. During a surveyor interview on 1/27/2025 at 12:23 PM with Resident ID #2, s/he revealed that s/he recently moved to a new room, due to a fire in his/her previous room. S/he revealed that recently staff moved his/her roommate's (Resident ID #1's) bed away from the wall towards to the center of the room, and placed a recliner against the wall, where the bed was previously located. The resident indicated that it was his/her interpretation that the facility moved the furniture due to the cold weather. B. During a surveyor interview on 1/24/2025 at 1:20 PM with the Administrator, he revealed that the facility was going to ensure that all electric baseboard heaters would have the required 6-inch clearance from all furniture and bedding. He further indicated the facility was going to move all resident's beds away from the electric baseboard heating units and chairs would be placed in the center of the rooms. During the initial tour of the facility on 1/24/2025 from approximately 11:30 AM to 2:30 PM, revealed approximately 46 resident rooms with electric baseboard heaters located along the exterior walls and under the windows. Many rooms were noted to have combustible items, such as beds, chairs, tray tables, trash cans and bedding, directly touching the electric baseboard heaters or closer than the required 6-inch clearance from the electric baseboard heater, per the manufacturer instructions. During a surveyor observation of room [ROOM NUMBER] on 1/24/2025 at approximately 12:20 PM, the electric baseboard heater was in use. Additionally, the heater was too hot to touch. During a surveyor observation and subsequent interview on 1/24/2025 at approximately 2:20 PM with the Administrator, he acknowledged that the facility had failed to move all of the facility's residents' furniture away from the electric baseboard heating units. Additionally, he acknowledged that many resident rooms still had combustible items, such as beds, chairs, tray tables, trash cans and bedding that were closer than 6-inches to the electric baseboard heaters. Of note, this was approximately seven hours after the facility had experienced a fire incident. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During a surveyor interview on 1/24/2025 at approximately 3:14 PM with the Administrator, Regional Director of Operations, and Regional Infection Preventionist, they were unable to provide evidence that the facility ensured that the residents' environment remained as free from accident hazards as possible. The facility's failure to ensure that there was a clearance between the resident's chair and the electrical baseboard heating unit resulted in a fire. In addition, after the fire had occurred, the surveyor observed furniture on 1/24/2025 from approximetly 11:30 AM to 2:30 PM that was placed in a manner that if a resident utilized the furniture for lying or sitting it would place him/her at risk for serious harm, serious impairment, serious injury or death.