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	01/23/2026

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

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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 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to manage his or her financial affairs. Based on record review and staff interview, the facility failed to obtain written authorization of residents who choose to deposit personal funds with the facility relative to 4 of 7 residents reviewed, Resident ID #s 2, 6, 77, and 111.Findings are as follows: 1. Record review revealed Resident ID #2 was admitted to the facility in April of 2022. Further review revealed his/her personal funds are held by the facility with a balance of $425.17.Further record review failed to reveal evidence that a written authorization was obtained from the resident or his/her representative to hold his/her funds. 2. Record review revealed Resident ID #6 was admitted to the facility in December of 2022. Further review revealed his/her personal funds are held by the facility with a balance of $603.75.Further record review failed to reveal evidence of a completed authorization form including the date, resident's name, Medicaid number, and a witness signature. 3. Record review revealed Resident ID #77 was admitted to the facility in April of 2023. Further review revealed his/her personal funds were held by the facility with a balance of $2265.68.Further record review failed to reveal evidence that a written authorization was obtained from the resident or his/her representative to hold his/her funds. 4. Record review revealed Resident ID #111 was admitted to the facility in April of 2017. Further review revealed his/her personal funds were held by the facility with a balance of $2607.32.Further record review failed to reveal evidence that a written authorization was obtained from the resident or his/her representative to hold his/her funds.During a surveyor interview on 1/22/2026 at 10:45 AM with the Business Office Manager, he was unable to provide evidence that written authorization forms were completed in their entirety for the above-mentioned residents whose personal funds are held by the facility.

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. Based on surveyor observation, clinical record review, and staff interview, the facility failed to ensure that services provided meet professional standards of quality relative to following physician's orders for 1 of 1 resident who has an order for simvastatin (a medication prescribed to treat high cholesterol), Resident ID #45, for 1 of 2 residents recently admitted that were reviewed for weekly weights, Resident ID #14, and for 1 of 3 residents observed receiving a skin treatment, Resident ID #27.Findings are as follows: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 #45 was re-admitted to the facility in August of 2025 with a diagnosis including, but not limited to, hyperlipidemia (a condition characterized by an abnormally high level of fats, such as cholesterol and triglycerides, in the blood).Record review revealed a physician's order dated 8/11/2025 for simvastatin, 10 milligrams every night at bedtime, for cholesterol control. Further record review revealed that the simvastatin was discontinued on 9/24/2025.Record review failed to reveal evidence of a provider order or a rational for discontinuing the simvastatin.Record review of the September 2025 Medication Administration Record (MAR) revealed that the simvastatin order was signed off as administered daily, until 9/23/2025. Further review of the October, November, December 2025 and January 2026 MARs, failed to reveal evidence of an order for simvastatin. During a surveyor interview on 1/23/2026 at 11:29 AM and at 12:28 PM with Registered Nurse, Staff C, she was unable to provide evidence why the resident's simvastatin was discontinued, she was also unable to provide evidence that a lipid panel (a laboratory test that measures the levels of cholesterol in the blood) was obtained. Additionally, after Staff C was informed by the surveyor that the resident's simvastatin was discontinued in September, she revealed that she notified the resident's physician and he ordered a lipid panel to be obtained.During a surveyor interview on 1/23/2026 at 1:25 PM with the Director of Nursing Services (DNS), she revealed that the simvastatin had been discontinued in error, and that the resident's physician has now ordered a lipid panel to be obtained to test the resident's cholesterol level.2. Record review revealed Resident ID #14 was admitted to the facility in November of 2025 with a diagnosis including, but not limited to, abnormalities of gait and mobility.Record review revealed a nursing progress note dated 1/6/2026 indicating that the resident had experienced an unfavorable weight gain of 10 pounds (lbs.) in one month. After reporting the weight gain to the provider, the provider ordered the resident's weight to be obtained weekly, for 4 weeks.Record review revealed a physician's order dated 1/5/2026, incorrectly transcribed for Weekly weights every 4 weeks [monthly] on Monday for 4 weeks, and to notify the physician if there is a weight loss/gain of 3 lbs. in one day or 5 lbs. in 1 week.Record review of the weight documentation failed to reveal evidence that the resident's weights were obtained weekly, as ordered.During a surveyor interview on 1/22/2026 at 3:38 PM with the DNS, she acknowledged that weekly weights were not obtained, and she would have expected that the resident would be weighed weekly, as ordered. 3. Record review revealed Resident ID #27 was admitted to the facility in May of 2023 with a diagnosis including, but not limited to, erythema intertrigo (an inflammatory skin condition characterized by red, inflamed skin to the skin folds. It is caused by friction, moisture, and heat, creating an environment conducive to bacterial and fungal growth).Record review revealed a physician's order dated 1/9/2026 to cleanse the right and left buttocks with normal saline (a mixture of a water and salt solution), followed by triple antibiotic ointment (a topical ointment containing three antibiotics), and a dry sterile dressing.During a surveyor observation on 1/23/2026 at approximately 10:45 AM with Registered Nurse, Staff A, revealed that Staff A applied Triad cream (a topical cream prescribed to treat various skin conditions) to the resident's buttocks rash instead of the ordered triple antibiotic ointment.During a surveyor interview on 1/23/2026 at 12:28 PM with Staff A, she acknowledged that she had applied the Triad cream to the resident's buttocks, instead of the ordered triple antibiotic ointment. During a (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	surveyor interview on 1/23/2026 at 12:59 PM with the DNS, she acknowledged that the resident did not have a treatment order for Triad cream, and she would have expected that the resident receive the triple antibiotic ointment, as ordered.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observations, clinical record review, and staff interview, the facility failed to store and label drugs and biologicals in accordance with currently accepted professional principles for 1 of 1 central (medication) supply closet and 2 of 3 medication carts reviewed. Findings are as follows:Record review of the facility policy titled, Medication Storage states in part, .Medications and biologicals are stored properly, following manufacturers or provider pharmacy recommendations.Outdated, contaminated, discontinued or deteriorated medications.are immediately removed from stock, disposed of according to procedures for medical disposal. 1. A surveyor observation on [DATE] at approximately 8:55 AM, of the first-floor central supply area in the presence of Licensed Practical Nurse (LPN), Staff H, revealed the following:-One unopened box of Prosource Tube Feeding (TF) Liquid neutral flavor with 100 pieces of 1.5 fluid ounce container labeled with the manufacturer's expiration date of [DATE].-One opened box of Prosource Tube Feeding (TF) Liquid neutral flavor with 100 pieces of 1.5 fluid ounce container labeled with the manufacturer's expiration date of [DATE].-Three bottles of Pink Bismuth 8 fluid ounce with expiration dates of 11/2025.-Two bottles of Gerimox Regular strength 12 ounce, with expiration dates of 6/2025.During a surveyor interview following the observation with Staff H, she acknowledged that the above-mentioned items were expired and should have been discarded.2. During a surveyor observation on [DATE] at 9:30 AM, of the East and South Unit medication carts in the presence of LPN, Staff I, revealed the one bottle of Nitroglycerin (a medication prescribed to treat chest pain) 0.4 milligrams tablets prescribed for Resident ID #100, with an expiration date of [DATE].During a surveyor interview immediately following the above observation with Staff I, she acknowledged the medication should be discarded.3. During a surveyor observation on [DATE] at 9:55 AM, in the presence of Certified Medication Technician (CMT), Staff J, of the lower-level medication cart, revealed one bottle of Gerilanta 12 fluid ounces with an expiration date of 11/2025.During a surveyor interview on [DATE] at 1:21 PM with the Director of Nursing Services, she revealed it would be her expectation that the above-mentioned items would have been removed from central supply and medication carts upon expiration.

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. Based on surveyor observation, clinical record review, and staff interview, the facility failed to ensure that residents have a right to be treated with respect and dignity, related to providing privacy during a skin treatment for 1 of 3 treatments observed, Resident ID #27. Findings are as follows:Record review revealed the resident was admitted to the facility in May of 2023 with a diagnosis including, but not limited to, erythema intertrigo (an inflammatory skin condition characterized by red, inflamed skin to the skin folds).During a surveyor observation on 1/23/2026 at 11:45 AM of Registered Nurse, Staff A, revealed the resident was lying on his/her back while in bed, with only a towel draped over his/her pelvic region and the rest of his/her body exposed. Staff A walked from the resident's bed to the doorway to access the treatment cart, located in the hallway, leaving the resident's door completely open and the privacy curtain only partially closed, leaving the resident visible to people from the hallway. Staff A returned to the resident to complete the treatment, exited the room leaving the resident wearing only a brief with his/her pants left around his/her ankles, with the door still open, leaving the resident visible from the hallway where staff were observed walking by.During a surveyor interview with Staff A, immediately following the observation, she acknowledged that the resident's privacy curtain was only partially closed and that the door was completely open, leaving the resident visible from the hallway. During a surveyor interview on 1/23/2026 at 12:59 PM with the Director of Nursing Services, she indicated that the privacy curtain should have been drawn completely, providing privacy to the resident.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observation, clinical record review, and resident and staff interview, the facility failed to ensure the assessments accurately reflect the resident's status for 2 of 4 residents reviewed with dental concerns, Resident ID #s 6 and 9, and for 1 of 1 resident reviewed who is prescribed clozapine (an antipsychotic medication), Resident ID #27.Findings are as follows: 1a. Record review revealed Resident ID #6 was readmitted to the facility in January of 2025 with diagnoses including, but not limited to, type 2 diabetes mellitus, dysphagia (difficulty swallowing), and the need for assistance with personal care.During a surveyor interview and simultaneous observation with the resident on 1/21/2026 at 11:26 AM, s/he indicated that s/he has dental concerns and revealed several teeth that are either broken or missing.Record review of a dental consult dated 10/9/2025 indicated the resident has eight missing teeth and three broken teeth.Record review of an annual Minimum Data Set (MDS) assessment dated [DATE], Section L, Oral/Dental Status, revealed that the resident did not have any oral or dental problems, including broken natural teeth.Additional record review failed to reveal evidence that the resident's dental status was accurately reflected in his/her care plan.During a surveyor interview on 1/22/2026 at 12:36 PM with the Regional MDS Coordinator, she acknowledged that the resident's annual MDS dental status was not accurately coded and that she would expect the resident's dental status to be reflected on his/her care plan. 1b. Record review revealed Resident ID #9 was admitted to the facility in March of 2025 with a diagnosis including, but not limited to, muscle weakness.During a surveyor interview and simultaneous observation with the resident on 1/22/2026 at approximately 12:30 PM, s/he indicated that s/he was edentulous (without teeth).Record review of an admission MDS assessment dated [DATE], Section L, Oral/Dental Status, revealed that the resident was Unable to examine and did not indicate that s/he was edentulous.Additional record review revealed an Admission/readmission Evaluation dated 3/7/2025, which indicated that during the physical evaluation, the resident's oral cavity was marked as Unable to examine.Record review failed to reveal evidence that the resident's dental status was accurately reflected in his/her care plan.During a surveyor interview on 1/23/2026 at 11:13 AM with the MDS Coordinator, she was unable to provide evidence that the resident was accurately coded for his/her MDS Assessment.During a surveyor interview on 1/23/2026 at 11:29 AM with the Regional MDS Coordinator, she acknowledged that the resident's dental status was not coded accurately on his/her admission MDS assessment. Furthermore, she indicated she would expect that it would be reflected on the resident's care plan. 2. Record review revealed Resident ID #27 was admitted to the facility in May of 2023 with diagnoses including, but not limited to, schizophrenia and depression.Record review revealed a physician's order dated 4/30/2025 for clozapine (an antipsychotic medication), 75 milligrams every evening.Record review of an annual MDS assessment dated [DATE], Section N, Medications, failed to reveal evidence that the resident was coded as receiving antipsychotic medications.During a surveyor interview on 1/23/2026 at 2:05 PM with the Director of Nursing Services, she acknowledged that Resident ID #27's MDS assessments were coded inaccurately and failed to reflect the resident's status.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on surveyor observation, clinical record review, and staff interview, the facility failed to provide necessary treatment and services, consistent with professional standards of practice, to promote and maintain skin integrity for 1 of 1 resident reviewed, relative to a fungal rash, Resident ID #27.Findings are as follows:Record review revealed Resident ID #27 was admitted to the facility in May of 2023 with a diagnosis including, but not limited to, erythema intertrigo (a common inflammatory skin condition characterized by red, inflamed skin to the skin folds. It is caused by friction, moisture, and heat, creating an environment conducive to bacterial and fungal growth).Record review of the Wound Care Nurse Practitioner's progress note dated 1/15/2026, revealed a recommendation to cleanse the area with wound cleanser followed by nystatin (an antifungal) cream, twice daily to the resident's right buttocks fungal rash.Record review of a progress note dated 1/15/2026 authored by the Registered Nurse, Staff L, revealed the resident was seen during wound rounds with an assessment of a raised, circular diffuse area to the resident's right buttocks consistent with a fungal rash.Record review failed to reveal evidence that the Wound Care Nurse Practitioner's recommendation for nystatin cream was implemented.During a surveyor interview on 1/23/2026 at 11:30 AM with the resident's attending physician, Staff G, he indicated that he would have expected staff to implement the Wound Care Nurse Practitioner's recommendations for the nystatin cream.During a surveyor interview on 1/23/2026 at 12:59 PM with the Director of Nursing Services, she was unable to provide evidence that the nystatin cream recommended by the Wound Care Nurse Practitioner was implemented.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observation, clinical record review, and staff interview, the facility failed to ensure that a resident with limited range of motion receives the appropriate treatment to prevent further decrease in range of motion for 1 of 2 residents reviewed who utilizes a hand roll (an assistive device that helps maintain or prevent decline in mobility), Resident ID #54.Findings are as follows:Record review revealed the resident was admitted to the facility in October of 2020 with a diagnosis including, but not limited to, generalized muscle weakness.Record review of a Quarterly Minimum Data Set assessment dated [DATE] revealed the resident has an impairment to both upper extremities.Record review revealed a physician's order revised on 10/31/2025 to apply a left-hand roll daily.Surveyor observations failed to reveal evidence that the hand roll was applied, as ordered, on the following dates and times:- 1/20/2026 at 10:21 AM and 12:25 PM- 1/21/2026 at 9:05 AM- 1/22/2026 at 8:55 AM and at approximately 3:00 PMDuring a surveyor interview on 1/22/2026 at 3:16 PM with Registered Nurse, Staff A, who was assigned to the resident, she revealed that she was unaware that the resident has a physician's order for a hand roll to be applied daily. Additionally, she acknowledged that the hand roll order was not transcribed to the Treatment Administration Record (TAR) to be applied to the resident.During a surveyor observation and simultaneous interview on 1/23/2026 at 10:00 AM with Nursing Assistant, Staff D, she applied the resident's hand roll, and the resident demonstrated tolerance and maintained the device in place following the application.During a surveyor interview on 1/23/2026 at 12:33 PM with the Director of Nursing Services, she acknowledged that the hand roll order was not transcribed to the TAR. Additionally, she revealed that she would expect the hand roll order to be transcribed in the TAR for staff to document the application of the hand roll daily, as ordered.

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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 surveyor observation, clinical record review, and staff interview, the facility failed to ensure each resident's drug regimen is free from unnecessary drugs for 1 of 3 residents reviewed with a topical treatment, Resident ID #6.Findings are as follows:Record review revealed the resident was admitted to the facility in January of 2025 with a diagnosis including, but not limited to, generalized muscle weakness.Record review revealed a physician's order with a start date of 10/16/2025 for Santyl Ointment (a topical medication prescribed to remove dead tissue from chronic dermal ulcers) 250 units/gram, followed by calcium alginate (a treatment dressing), and a bordered gauze dressing to the left medial (the middle) knee every evening shift for a Stage III pressure ulcer (full thickness tissue loss, fat tissues may be visible but bone, tendon or muscle is not exposed. Slough [dead tissue] may be present but does not obscure the depth of tissue loss).Record review of the Wound Care Nurse Practitioner note dated 12/18/2025, revealed that the left medial knee wound was resolved, and she made a recommendation to discontinue the above-mentioned treatment order.During a surveyor observation on 1/22/2026 at 2:45 PM with Registered Nurse, Staff E, the resident was noted to have a dressing to his/her left medial knee. Staff E acknowledged that the wound was closed but the treatment order remained in place. Record review of the December 2025 and January 2026 Treatment Administration Records failed to reveal evidence that the Santyl ointment was discontinued as recommended and the treatment was signed off as being completed for 30 of 34 opportunities.During a surveyor interview on 1/22/2026 at 3:12 PM with the resident's physician, Staff F, he revealed that he would expect the facility staff to follow the Wound Care Nurse Practitioner's recommendations and the Santyl ointment should have been discontinued after the recommendation was made on 12/18/2025.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. Based on surveyor observation, clinical record review, and staff interview, the facility failed to ensure that residents receive laboratory services relative to diagnostic testing, for 1 of 1 resident reviewed with a physician's order for clozapine (an antipsychotic medication) level (a laboratory test that measures the amount of medication in the blood to ensure that the medication is at a therapeutic range), Resident ID #27.Findings are as follows:Record review revealed Resident ID #27 was admitted to the facility in May of 2023 with a diagnosis including, but not limited to, schizophrenia (a serious mental health condition that affects how people think, feel and behave).Record review revealed the following physician's orders:-4/30/2025 for clozapine 75 milligrams (mg) daily.-12/12/2025 obtain a clozapine level.Record review of the December 2025 Treatment Administration Record revealed that the clozapine level was signed of as completed 12/12/2025.Record review of a lab slip dated 12/12/2025 indicates additional testing: clozapine level.Record review of a Lab Results Report dated 12/12/2025, revealed that a clonazepam blood level (a medication prescribed to treat anxiety) was obtained for the patient instead of a clozapine level, as ordered.During a surveyor interview on 1/21/2026 at 2:47 PM and 1/22/2026 at approximately 8:30 AM, with the Director of Nursing Services, she acknowledged that the laboratory completed a clonazepam level and not a clozapine level as ordered.During a surveyor interview on 1/23/2026 at 9:37 AM with the Nurse Practitioner, Staff K, she indicated it would be her expectation for the clozapine level to have been obtained as ordered on 12/12/2025.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on surveyor observations, clinical record review, and staff interview, the facility failed to ensure a sanitary environment to help prevent the transmission of infections for 2 of 3 residents observed during treatments, Resident ID #s 27 and 122.Findings are as follows:1. Record review revealed Resident ID #27 was admitted to the facility in May of 2023 with a diagnosis that including, but is not limited to, erythema intertrigo (a skin condition that manifests as a red, inflamed rash, often accompanied by a burning or itching sensation).During a surveyor observation on 1/23/2026 at approximately 10:45 AM, Registered Nurse (RN), Staff A, was observed applying Triad cream, a topical treatment for skin conditions, to the resident's left and middle buttocks, groin, and armpit without changing gloves or performing hand hygiene between applications. The nurse proceeded from the dirtiest area to the cleanest area of the resident's body.2. Record review for Resident ID #122 revealed the following physician's orders:-1/16/2026, cleanse right posterior (back) calf wound with normal saline, apply Xeroform (a medicated bandage used to cover, protect, and help heal wounds) and cover with dry dressing every day shift.-1/21/2026, cleanse right forearm skin tear with normal saline or wound wash, apply xeroform followed by bordered gauze every day shift.During a surveyor observation of the above-mentioned treatments on 1/23/2026 11:38 AM, with RN, Staff A, the following was observed:Staff A was observed wearing two pairs of gloves on each hand. She removed the resident's soiled dressing from the right lower leg and cleansed the wound. Staff A then removed only the outer pair of gloves and proceeded to complete the treatment without removing all gloves, performing hand hygiene, or donning (putting on) new clean gloves prior to applying the clean dressing During a surveyor interview immediately following the observation, Staff A acknowledged that she removed only the outer pair of gloves and did not perform hand hygiene until after completing the treatment.During a surveyor interview on 1/23/2026 at 12:59 PM with the Director of Nursing Services (DNS), she revealed that she would expect Staff A to change gloves and perform hand hygiene when applying the ordered cream to different sites. Additionally, she revealed that she would expect staff to remove their gloves and perform hand hygiene prior to applying the new treatment.

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Silver Creek Rehab and 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 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on surveyor observation and staff interview, the facility failed to post in a place readily accessible to residents, family members, and legal representatives of residents, the results of the most recent surveys conducted of the facility.Findings are as follows:During a surveyor observation of the facility on 1/20/2026 at approximately 9:00 AM, the results of the most recent surveys conducted in the facility were not available to be reviewed without asking for staff assistance.During a surveyor interview on 1/22/2026 at 11:33 AM with the front desk attendant, Staff B, she revealed that the survey results binder is in the rack located inside the front desk office.During a surveyor interview on 1/23/2026 at 12:48 PM with the Administrator, he revealed that he was unaware that the survey results were supposed to be available without asking for staff assistance.