STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415032	A. Building B. Wing	06/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Crest Nursing Centre Inc	125 Scituate Avenue Cranston, RI 02920

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 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. **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 residents received treatment and care in accordance with professional standards of practice, for 1 of 1 resident reviewed for a recommended neurosurgery (a doctor who specializes in diagnosing and treating conditions that affect the brain) follow-up following a hospitalization, Resident ID #1. Additionally, the facility failed to implement a physician's order for a foot cradle (a medical device designed to hold heavy sheets and blankets off legs and feet) for Resident ID #2.Findings are as follows:1. Record review of a facility reported incident dated 5/4/2026, states in part, Resident ID #1 was noted to have questionable seizure activity for approximately 7 minutes, became unresponsive and was sent to the hospital for evaluation. S/he returned to the facility with multiple rib fractures.Record review revealed Resident ID #1 was admitted to the facility in January of 2023, with diagnoses including, but not limited to, dementia, osteopenia (low bone density), and unspecified convulsions (involuntary and sudden muscle contractions or shaking that lack a clear diagnosis).Record review of the progress notes revealed that the resident was readmitted to the facility on [DATE], following a hospitalization for possible seizure activity.Record review of a hospital document titled Department of Trauma Discharge Instructions dated 5/4/2026, states in part, .please call for additional appointment - neurosurgery .Review of a progress note authored by the Nurse Practitioner, dated 5/5/2026, revealed that the resident was recently transferred to the hospital following a 7-minute period of full body rigidity, stiffness, and unconsciousness, the resident required a neurological follow up. Further record review of the progress notes revealed an entry dated 5/12/2026, authored by Minimum Data Set Nurse, Registered Nurse (RN), Staff B, that revealed, the resident was to have a follow up appointment with Neurosurgery. Further record review from 5/4/2026 through 6/23/2026, failed to reveal evidence that a neurosurgery appointment had been scheduled for the resident.During a surveyor interview on 6/23/2026 at 11:36 AM with RN, Staff A, she acknowledged that a neurosurgery follow-up appointment had not been scheduled for the resident, as recommended following his/her hospitalization.During a surveyor interview on 6/23/2026 at 2:19 PM, with the Nurse Practitioner, she revealed that she was unaware the recommended appointment had not been scheduled. She stated that it was her expectation that the appointment would have been scheduled. She further acknowledged that there was no documentation in the resident's record that indicated the resident or his/her representative had declined the recommended appointment. She again stated that the appointment should have been scheduled.During a surveyor interview on 6/23/2026 at 4:04 PM, with the Director of Nursing Services (DNS), she acknowledged that an appointment for neurosurgery had not been scheduled and should have been.Additionally, following the conclusion of the survey, the DNS provided this surveyor with an email dated 6/23/2026 at 5:21 PM, documenting that she had contacted the resident's representative regarding the hospital's recommendation for a follow-up with a neurosurgeon. According to the email, the resident's representative declined to have the follow-up appointment scheduled and stated that this decision had previously been discussed during a care plan meeting. This information was not available during the survey, was not identified through medical record review, and was provided only after the survey had concluded.2. According to Mosby's 4th (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Edition, Fundamentals of Nursing, page 314 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 Resident ID #2 was admitted to the facility in January of 2024, with diagnoses including, but not limited to, long term use of anticoagulants (blood thinners), and hereditary and idiopathic neuropathy (nerve damage in the extremities causing numbness).Record review of a care plan dated 3/9/2025, revealed the resident was at risk for impaired skin integrity, with an intervention for the use of a foot cradle.Record review of the physician's orders revealed, an order for a foot cradle when in bed; to offload the sheets, to be checked on each shift, and documented by the nurse.Surveyor observations on 6/23/2026 at 9:46 AM, 11:42 AM, and 1:33 PM, revealed the resident's blankets were lying on the resident's legs and feet and were tucked into the bottom of his/her bed. The foot cradle was attached to the bottom of the bed however; it was not in use.Record review of the June 2026 Medication Administration Record (MAR) revealed, foot cradle in bed to offload sheets had been documented as completed on 6/23/2026 by RN, Staff A during the 7:00 AM to 3:00 PM shift. During a surveyor interview on 6/23/2026 at 1:42 PM, with Staff A, she indicated that she was unaware whether the residents foot cradle was properly utilized to offload the sheets and blankets as ordered, despite documenting that it was.Subsequently, during the interview with Staff A, the Nursing Assistant assigned to provide care for the resident, overheard the conversation. The NA went into the resident's room and after exiting approached Staff A, stating to her that the resident's sheets were tucked under the resident's mattress and not on the foot cradle, as they should have been, Additionally, the NA reveled to Staff A that he had adjusted the blankets over the foot cradle.During a surveyor interview on 6/23/2026 at 4:17 PM with the DNS, she revealed that it was her expectation that prior to documentation in the MAR, nursing staff would ensure that the foot cradle was properly utilized to offload the blankets, as ordered.