

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  415084	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/01/2025
NAME OF PROVIDER OR SUPPLIER  Elmhurst Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  50 Maude Street Providence, RI 02908	

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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review and staff interview, it has been determined that the facility failed to provide the necessary treatment and care in accordance with professional standards of practice relative to implementing a surgical wound treatment order for 1 of 1 resident reviewed, Resident ID #1. Findings are as follows:Record review of a community reported complaint submitted to the Rhode Island Department of Health on 10/8/2025 alleges in part, that the facility did not properly care for the resident's wound. Record review revealed Resident ID #1 was admitted to the facility on [DATE] with a diagnosis including, but not limited to, sepsis (an infection in the body) due to Serratia (a type of germ).Record review of a hospital continuity of care document dated 9/12/2025, provided to the facility upon the resident's admission revealed, General Discharge Instructions indicating to cleanse the resident's left hip incision site wound with Vashe cleanser (a special wound cleaning solution that removes germs, dirt, and dead tissue without stinging or damaging healthy tissue), pat dry, cover the wound with an antibacterial dressing and protective cover daily, and as needed.Record review revealed a physician's order dated 9/15/2025, indicating to cleanse the resident's left hip incision with Vashe cleanser, pat dry, apply a dressing and secure daily, and as needed.Further record review failed to reveal evidence that a physician's order for a treatment to the resident's left hip surgical wound was implemented prior to 9/15/2025. This indicates that the resident went approximately 3 days without surgical wound care orders on 9/12, 9/13, and 9/14/2025.During a surveyor interview on 11/13/2025 at 1:32 PM, with the Unit Manager, Licensed Practical Nurse, Staff A, she acknowledged that the surgical wound care instructions were noted on the hospital continuity of care document received by the facility on 9/12/2025 when the resident was admitted and was not implemented until 9/15/2025.During a surveyor telephone interview on 11/13/2025 at 2:10 PM, with Nurse Practitioner, Staff B, she stated that based on the information reviewed on the continuity of care document regarding the general discharge instructions for surgical wound care, she would have expected the order for the treatment to have been implemented on 9/12/2025, when the resident was admitted to the facility.During a surveyor interview with the Director of Nursing Services on 11/13/2025 at 2:14 PM, she was unable to provide evidence that a surgical wound treatment order was implemented upon the resident's admission to the facility on 9/12/2025.</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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