

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415106	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/16/2025
NAME OF PROVIDER OR SUPPLIER St Antoine Residence		STREET ADDRESS, CITY, STATE, ZIP CODE 10 Rhodes Avenue North Smithfield, RI 02896	

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it has been determined that the facility failed to ensure that a resident receives treatment and care in accordance with professional standards of practice for 1 of 1 resident reviewed with a pre-cancerous lesion to the right temple, Resident ID #1. Findings are as follows: Record review of a community reported complaint submitted to the Rhode Island Department of Health on 9/8/2025 alleges that the resident was transferred to an acute care hospital from the facility to be evaluated for a chronic malignant (cancerous) wound on his/her right scalp which was found to have maggots (worm-like creatures that feed on decaying organic matter) in it. Additionally, the report indicated that the resident receives daily wound care to the wound, however, s/he does not allow the staff to clean it. Record review revealed the resident was admitted to the facility in September of 2022 with a diagnosis, including but not limited to, dementia. Record review of a Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status Score of 0 out of 15, indicating severe cognitive impairment. Record review of a document titled Continuity of care consultation and referral form dated 12/13/2024 revealed that the resident had a dermatology appointment where a total of 11 pre-cancerous lesions were found on his/her scalp including the right temple. Additionally, the consultation form revealed that a follow-up was scheduled to recheck the lesion on the right temple in a month. Record review of a Continuity of care consultation and referral form dated 1/27/2025 revealed that the resident had a follow-up dermatology appointment where s/he was evaluated for a pre-cancerous lesion on his/her right temple. Additionally, the consultation form revealed an order for Aquaphor (an ointment) to be applied to the lesion twice daily for 14 days. Record review of the January and February 2025 Medication Administration Records revealed the Aquaphor was applied as ordered for the 14 days. Record review of an undated facility policy titled Skin Integrity Management states in part . Skin checks are completed and documented by a nurse weekly. Any wound identified is fully assessed, documented in the EMR [Electronic Medical Record] and a treatment order is obtained by the NP [Nurse Practitioner], MD [Medical Doctor] if warranted. Record review of the nursing notes revealed the following: 2/6/2025- the dermatology office called the facility and indicated that the resident required a MOHS procedure (Mohs micrographic surgery- a surgical procedure that is completed to treat skin cancer) as the biopsy results indicated squamous cell carcinoma. The MOHS procedure was scheduled for 2/25/2025. 2/24/2025- the family member cancelled the MOHS appointment and indicated that s/he no longer wanted the resident going to dermatology appointments. 6/26/2025- The facility spoke with the family member, and s/he agreed to allow wound care to assess and treat the wound and s/he felt that the resident would not tolerate going out to the dermatologist for the MOHS procedure. 6/28/2025- The facility spoke with family member again, regarding the lesion on right temple, s/he would like wound care to look at it and see if it can be treated in house. S/he does not feel that the resident would tolerate going to dermatology for the MOHS procedure. At this time an order for ointment and Primapore (a non-adherent dressing) to cover area as s/he is picking at it. Record review failed to reveal evidence that the facility monitored or assessed the lesion/wound to the right temple from 2/10/2025 until 6/28/2025 when it was documented that the resident was picking at the lesion/wound. Record review revealed the following physician orders: 6/28/2025- an antibiotic ointment to be applied to the open area on the right temple cancer lesion and cover with Primapore. 7/15/2025- Imiquimod external cream 5% (a topical medication used to treat certain skin conditions, including basal cell carcinoma apply to right temple every other day. 9/4/2025- Metronidazole external gel 0.75 % (an antibiotic medication used to treat various infections caused by bacteria and parasites) apply to the right side of head every other day. Record review of the weekly skin checks from 12/13/2024 through 9/7/2025 failed to reveal evidence that the resident had a right temple wound/lesion. Record review of a nursing progress note dated 9/7/2025 revealed that the resident was sent to the hospital as maggots were found in the right temple wound. The resident was admitted to the hospital with squamous cell carcinoma of right temple with maggots present. Record review of a nursing progress note dated 9/7/2025, authored by Licensed Practical Nurse (LPN), Staff A, indicated that the resident kept picking at the wound. Additionally, the note revealed that Staff A noticed some bloody drainage leaking onto the resident's face and right hand from the wound. When Staff A attempted to clean the wound and the resident's face, she observed some pulsating worms moving inside of the wound, so s/he was transferred to an acute care hospital. Record review of the hospital admission document dated 9/7/2025 revealed that the resident was</p>