STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415042	A. Building B. Wing	12/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterview Villa Rehabilitation and Health Care Cen	1275 South Broadway East Providence, RI 02914

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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F 0684 Level of Harm - Actual harm Residents Affected - Few	**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 ordered diagnostic testing was obtained and failed to ensure significant laboratory results were reviewed and reported to the practitioner for 1 of 1 resident reviewed (Resident ID #1) who was treated for a herpes simplex outbreak (viral infection that can cause painful blisters or ulcers and is spread through skin to skin contact). The facility's failures in following practitioner orders, reviewing and reporting abnormal laboratory results, and ensuring timely communication with the resident's responsible party led to a delay in treatment and resulted in the need for a more invasive course of treatment. Findings are as follows:Review of a community reported complaint submitted to the Rhode Island Department of Health on 12/1/2025 alleged that Resident ID #1's genital area was observed to be .severely swollen, red, and extremely painful. The complaint further alleged that after this observation of the resident's genital area, the family was notified that the resident had been treated for a herpes outbreak approximately a month prior and that the family had not been made aware of this new diagnosis. Additionally, the complaint alleged potential neglect and misconduct and questioned how this virus was contracted at the facility. Record review revealed Resident ID #1 was readmitted to the facility in October of 2023 with diagnoses including, but not limited to, dementia and malignant neoplasm of the colon (colon cancer).Review of a Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status score of 8 out of 15, indicating a moderate cognitive impairment. Further review revealed the resident is dependent of staff for activities of daily living, including incontinence care. Record review of a care plan revised 6/13/2022 revealed the resident is at risk for skin breakdown related to limited mobility and incontinence with an intervention to inspect the skin for redness, irritation and breakdown during care. Record review revealed the following progress notes:-8/26/2025- [genitals] discharge and swollen [genitals] noted, reported to Nurse Practitioner (NP) with a new order for warm compresses four times a day for three days. -8/28/2025- Evaluated by NP, new order given for antifungal and barrier cream to be mixed and applied during incontinence care to peri area.-9/10/2025- Nursing reports redness and open areas to [genitals], assessed by NP, swelling, redness and lesions noted to [genitals]. New orders given to obtain a urinalysis with culture and sensitivity (UA C&S), obtain a [genitals] swab, and apply Clotrimazole cream (antifungal cream) twice a day for seven days for suspected fungal infection. -9/10/2025- [genitals] swab and UA obtained, put into fridge on 4th floor, lab notified.-9/17/2025- Positive urinary tract infection (UTI), results reported to NP. New order given for Ertapenem (antibiotic) 1 gram intramuscularly for seven days. -11/2/2025- [genitals] red, irritated, blotches on both [genitals], some [genital] discharge, picture sent to NP. New order for Valacyclovir 1,000 milligrams by mouth every 12 hours for 10 days to start as soon as possible. -11/3/2025, authored by the NP, Staff A, .being seen for edema [swelling] and lesions to [genitals] bilaterally.evaluated and presents with Herpes simplex outbreak.to start treatment.[genitals] is edematous and has multiple lesions bilaterally.please [continue] to keep [relative] informed of any changes in POC [plan of care] .-11/29/2025- [Relative] reports that s/he changed the resident's brief and noticed redness on his/her buttocks. S/he stated that s/he applied cream after washing the resident. -12/1/2025- Spoke with the resident's [relative] about the blister on the resident's [genitals], educated that the resident was treated a month ago and now the area looks like it's back. NP, Staff A, made aware and will evaluate again this evening. -12/1/2025- Resident's [relative] had the resident sent out to the emergency room via 911 related to lesions on [genitals].Record review failed to reveal evidence that the [genitals] swab was completed, as ordered. Further review failed to reveal evidence of any laboratory results pertaining to a [genital] swab. Record review of the UA revealed a positive UTI on 9/13/2025. This result was not reviewed or reported to a provider until 9/17/2025, four days after the results and seven days after the UA C&S was obtained.Record review failed to reveal evidence that the resident's relative, listed as the responsible party, was notified of the resident's change in condition in September or November of 2025 pertaining to the UTI or the new diagnosis and medication prescribed related to Herpes simplex. During a surveyor interview on 12/2/2025 at 12:16 PM with the NP, Staff A, she indicated that she was not aware of the genital issues identified in August and September of 2025 and that she had only been made aware of the lesions on the genitals in November of 2025. She further indicated that she evaluated the resident on 11/3/2025 and visually diagnosed the genital lesions as a Herpes simplex outbreak. She indicated that she was not contacted after the treatment was ordered until the resident's relative voiced concerns about the