

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415063	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/01/2025
NAME OF PROVIDER OR SUPPLIER Bayview Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 860 North Quiddnessett Road North Kingstown, RI 02852	

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 - Some</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>Based on 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 reviewed with an order for Midodrine (a medication prescribed to increase a person's blood pressure) and an order for a wound treatment, Resident ID #1. 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 physicians' orders unless they believe the orders are in error or would harm the clients. Record review revealed the resident was admitted to the facility in November of 2025 with a diagnosis including, but not limited to, hypotension (low blood pressure). 1. Record review of the provider's progress note dated 11/18/2025 at 11:53 PM, states in part, Orders: midodrine 5mg [milligrams] PO [by mouth] TID [three times daily] prn [as needed] for systolic [the top number of a blood pressure reading] < 100 or diastolic [the bottom number of a blood pressure reading] < 60 x [times] 7 days. Record review revealed a physician's order dated 11/19/2025 for Midodrine 5 mg three times daily as needed for a systolic blood pressure less than 100, a diastolic blood pressure less than 60 (the normal blood pressure reading is 120/80). Record review revealed an additional physician's order dated 11/18/2025 for vital signs every shift for 7 days. Record review of the documented blood pressures revealed the following: -11/19/2025 at 2:08 AM, 84/60 -11/19/2025 at 6:19 AM, 76/59-11/19/2025 at 10:12 AM, 82/58-11/19/2025 at 10:34 PM, 99/62-11/20/2025 at 8:30 AM, 80/54-11/20/2025 at 10:30 AM, 79/51-11/20/2025 at 8:12 PM, 80/49-11/21/2025 at 5:40 AM, 96/68 Record review of the November 2025 Medication Administration Record (MAR) failed to reveal evidence that the resident received the Midodrine as ordered, for the above-mentioned blood pressure readings. During a surveyor interview on 12/1/2025 at 3:04 PM with Registered Nurse, Staff A, she acknowledged that she did not administer the Midodrine when indicated, on 11/19/2025 for a blood pressure reading of 82/58 and on 11/20/2025 for a blood pressure reading of 79/51. During a surveyor interview on 12/1/2025 at 3:45 PM with the Director of Nursing Services (DNS), she acknowledged the Midodrine was not administered as ordered, for the above-mentioned blood pressure readings. 2. Record review revealed a physician's order dated 11/19/2025 to cleanse the left posterior (back) calf with normal saline, pat dry, apply calcium alginate (a type of wound treatment), and cover with a bordered gauze, every evening shift. Record review of the November 2025 Treatment Administration Record revealed on the evening shift of 11/20/2025, the wound treatment was not completed, and the nurse had documented that the resident was sleeping. During a surveyor interview on 12/1/2025 at 3:45 PM with the DNS, she could not provide evidence that the resident's left posterior calf wound treatment was completed on 11/20/2025, as ordered.</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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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>Based on record review and staff interview, the facility failed to ensure the resident's drug regimen was free from unnecessary medications for 1 of 1 resident reviewed receiving Metoprolol Tartrate (a medication prescribed to treat cardiac conditions and assists in lowering the blood pressure and heart rate), Resident ID #1. Findings are as follows: Record review revealed the resident was admitted to the facility in November of 2025 with diagnoses including, but not limited to, atrial fibrillation (an irregular and often rapid heart rhythm) and hypotension (low blood pressure). Record review of a nursing admission progress note dated 11/18/2025 revealed the resident's vital signs were obtained upon admission, and the highest blood pressure (BP) reading was 78/48 (normal blood pressure 120/80). The on-call provider was notified of his/her low blood pressure and parameters were ordered for the medication Metoprolol. Record review revealed a physician's order dated 11/18/2025 for Metoprolol Tartrate, give 12.5 milligrams (mg) by mouth twice daily, with parameters to hold the medication for a systolic blood pressure (the top number of a blood pressure reading) of less than 100. Additional review of the medication orders indicated that on 11/19/2025 the Metoprolol administration times were revised within the order by Registered Nurse, Staff C, and the ordered parameters to hold the medication for the systolic blood pressure readings that were initially entered, were no longer visible within the order. Record review revealed an additional physician's order dated 11/18/2025 for vital signs every shift for 7 days. Record review of the November 2025 Medication Administration Record (MAR) revealed the following BP readings: -11/18/2025, evening shift BP 84/60 -11/19/2025, day shift BP 82/58-11/19/2025, evening shift BP 82/58-11/20/2025, day shift BP 79/51-11/20/2025, evening shift BP 80/49 Record review of the November 2025 MAR revealed the Metoprolol was signed off as administered, on the following dates and shifts: -11/19/2025, evening shift-11/20/2025, day shift-11/20/2025, evening shift During a surveyor interview on 12/1/2025 at 3:28 PM with the Certified Medication Technician, Staff B, she acknowledged that the MAR indicated she signed off that she had administered the Metoprolol on the evening of 11/19/2025 with a blood pressure of 82/58. During a surveyor interview on 12/1/2025 at 3:37 PM with the Director of Nursing, she acknowledged that the resident received the Metoprolol on 11/19/2025 and 11/20/2025 with the above-mentioned blood pressure readings. During a surveyor interview on 12/1/2025 at approximately 3:50 PM with the Registered Nurse, Staff C, she acknowledged that she revised the order on 11/19/2025 to reflect the appropriate medication administration times, but she was unaware that the medication parameters were subsequently removed from the order.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>Based on record review and staff interview, the facility failed to ensure that residents are free of any significant medication errors for 1 of 1 resident reviewed receiving Warfarin/Coumadin (an anticoagulant medication prescribed to treat and prevent harmful blood clots from forming or growing larger), Resident ID #3. Findings are as follows: Record review revealed the resident was admitted to the facility in November of 2025 with a diagnosis including, but not limited to, deep vein thrombosis (a blood clot that forms in the deep veins of the leg). Record review revealed a physician's order dated 11/7/2025 for Warfarin 3 milligrams (mg) by mouth, every evening, for treating/preventing blood clots until 11/13/2025. Record review revealed a physician's order dated 11/14/2025 for a PT/INR (a blood test that determines the continued dosing for Warfarin), one time on 11/14/2025. Record review revealed the PT/INR was obtained, as ordered, and resulted on 11/14/2025. Record review for 11/14/2025 failed to reveal evidence that the PT/INR results were reviewed or that the provider was notified of the results. Additional record review failed to reveal evidence that a new order for Warfarin was obtained for the resident's continued dosing for Warfarin therapy. Record review of the November 2025 Medication Administration Record (MAR) revealed, the resident received Warfarin daily for the month of November, since his/her admission, except on 11/14/2025 and 11/15/2025. Further review of the MAR revealed a physician's order was subsequently transcribed on 11/17/2025 for a Coumadin Alert, indicating that the resident receives Coumadin therapy and to ensure that there is a current Coumadin order in place every evening shift. Additionally, the Coumadin Alert order was signed off each shift by staff, with the resident's INR results documented and the current Coumadin dose. During a surveyor interview on 12/1/2025 at 3:13 PM with Registered Nurse, Staff A, she revealed that she was the resident's nurse during the day shift on 11/14/2025 and the PT/INR may not have resulted before the end of her shift. Additionally, she was unable to provide evidence of a progress note addressing the resident's PT/INR results on 11/14/2025 or that a Warfarin order was obtained on 11/14/2025 or 11/15/2025. During a surveyor interview on 12/1/2025 at 3:36 PM with the Director of Nursing, she revealed that the Coumadin Alert order is usually transcribed to ensure staff administering medications are aware when a resident is on Coumadin therapy and she acknowledged that the order was not transcribed until 11/17/2025. Additionally, the DNS acknowledged that the resident did not receive his/her Coumadin doses on 11/14/2025 or 11/15/2025.</p>		