STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415063	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayview Rehabilitation and Healthcare Center	860 North Quidnessett Road North Kingstown, RI 02852

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(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. Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to meet professional standards of quality relative to following physician's orders for 2 of 2 residents with medications and treatments that were not signed off as administered, Resident ID #s 1 and 6, for 1 of 3 residents observed with a non-pressure related wound, Resident ID #6, and for 1 of 3 residents reviewed with an order for a nutritional supplement, Resident ID #90.Findings are as follows:According to Mosby's 3rd Edition, Basic Nursing, states in part, .after administering a drug, the nurse records it immediately on the appropriate record form .According to Mosby's 4th 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.1. Record review revealed Resident ID #1 was readmitted to the facility in October of 2024 with diagnoses including, but not limited to, diabetes with foot ulcers, and obstructive and reflux uropathy (a condition in which the kidneys are damaged by the backward flow of urine into the kidneys). Record review revealed the following physician's orders dated 4/30/2025: - diabetic foot care: wash and dry feet, inspect for any changes, and rub lotion to feet at bedtime- measure urinary output every shift- urinary catheter care and maintain catheter for urinary retention and change as needed for obstruction every shift- urinary catheter careFurther record review revealed the following physician's orders:- 5/1/2025, apply skin prep (a skin protectant) to the left heel every day and evening- 5/15/2025, skin check after removing the left Ankle-Foot Orthosis (AFO, a brace designed to support the ankle and foot) every day and evening- 7/26/2025, enhanced barrier precautions (EBP, an infection control intervention used to prevent the spread of infection) three times a day- 8/19/2025, offload left lower extremity three times a day- 8/21/2025, monitor dressing to the left foot three times a dayRecord review of the September 2025 Treatment Administration Record (TAR) failed to reveal evidence that the resident received the following treatments and care on the evening shift of 9/6/2025 as ordered:- diabetic foot care: wash and dry feet, inspect for any changes, and rub lotion to feet at bedtime- urinary catheter care- apply skin prep to the left heel- maintained EBP- skin check after removing left AFO- offload left lower extremity- monitor dressing to the left footRecord review of the September 2025 TAR failed to reveal evidence that the resident's urinary output was documented on the evening shifts of 9/2/2025 and 9/6/2025, and on the day shift of 9/5/2025, as ordered.Additional review of the September 2025 TAR failed to reveal evidence that the resident's dressing to the resident's left foot was monitored during the day shift on 9/5/2025, as ordered.2. Record review revealed Resident ID #6 was readmitted to the facility in May of 2025 with diagnoses including, but not limited to, diabetes, back and lower extremity pain, and anxiety disorder.a. Record review revealed the following physician's orders dated 5/8/2025: - behaviors/interventions: monitor for anxiousness every shift- monitor for side effects of anti-anxiety medications every shift- monitor for signs and symptoms of bleeding and bruising every shift- non weight bearing to the right lower extremity every shift- frequent skin checks to the left wrist splint site every shiftRecord review of the September 2025 TAR failed to reveal evidence that the resident received the above-mentioned treatments and care on the evening shift of 9/6/2025, as ordered.Record review revealed a physician's order dated 5/12/2025 for Diclofenac Sodium External (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	Gel 1% (a topical medication prescribed to treat pain) apply to the left shoulder four times a day.Record review of the September 2025 TAR failed to reveal evidence that the resident received the above-mentioned medication on the day shift of 9/5/2025 and the evening shift of 9/6/2025, as ordered.Record review revealed a physician's order dated 8/26/2025 for Triamcinolone Acetonide Cream 0.1% (a topical steroid medication prescribed to treat inflammation) to apply to a rash below the knee amputation site twice a day.Record review of the September 2025 TAR failed to reveal evidence that the resident received the above-mentioned medication on the day shift of 9/5/2025 and the evening shift of 9/6/2025, as ordered.b. During a surveyor observations on 9/9/2025 at 9:20 AM and on 9/11/2025 at 9:10 AM, Resident ID #6 was observed with a white bandage to his/her right forearm dated 9/8/2025 with a moderate amount of old dried bloody drainage. Record review failed to reveal evidence of a physician's order for a treatment to the resident's right forearm. During a surveyor observation on 9/11/2025 at 9:57 AM in the presence of the Unit Manager, Staff A, she acknowledged the dressing to the resident's right forearm and that the dressing was dated 9/8. She indicated that she was unaware of any injury or dressing to the resident's right forearm. Furthermore, Staff A was unable to provide evidence of a treatment order for the dressing observed on the resident's right forearm. During a surveyor interview on 9/11/2025 at 1:38 PM with the Director of Nursing Services (DNS), she was unable to provide evidence that Resident ID #s 1 and 6 received all medications and treatments as ordered on 9/2/2025, 9/5/2025, and 9/6/2025. Additionally, the DNS indicated that she would have expected the nurse to have notified the physician when Resident ID #6's wound was identified, and that the nurse should have obtained a treatment order for the right forearm wound.3. Record review revealed Resident ID #90 was admitted to the facility in August of 2025 with diagnoses including, but not limited to, Parkinson's disease (a chronic progressive neurological disorder that affects movement) and gastroesophageal reflux disease (a chronic digestive condition where stomach acid flows back up into the esophagus causing irritation and inflammation). Record review of a care plan dated 8/23/2025 revealed the resident has a nutritional problem with interventions including, but not limited to, providing and serving a nutritional supplement, as ordered. Record review revealed a physician order dated 9/5/2025 for Ensure Plus (a nutritional supplement designed for individuals who need additional calories, protein, and nutrients) 120 milliliter (ml) three times a day. Record review of the September 2025 Medication Administration Record (MAR) failed to reveal evidence the resident is receiving the Ensure Plus 120 ml three times a day as ordered since 9/5/2025.During a surveyor interview on 9/10/2025 at 1:26 PM with Registered Nurse, Staff B, she acknowledged that the resident's order for Ensure Plus was changed on 9/5/2025 from twice a day to three times a day. Additionally, Staff B acknowledged that the resident was not receiving the Ensure Plus three times a day as ordered since 9/5/2025. During a surveyor interview on 9/11/2025 at 9:22 AM with the DNS, she was unable to provide evidence that Resident ID #90 was receiving the ensure plus, as ordered.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to provide respiratory care consistent with professional standards of practice relative to 2 of 4 residents reviewed for oxygen use, Resident ID #s 11 and 46.Findings are as follows: According to Lippincott Nursing Procedure Ninth Edition 2023, page 621, states in part, .Verify the practitioner's order for the oxygen therapy, because oxygen is considered a medication or therapy and should be prescribed . 1. Record review revealed Resident ID #11 was admitted to the facility in November of 2024 with a diagnosis including, but not limited to, chronic obstructive pulmonary disease (a lung condition caused by damage to the airways that limits airflow). Record review revealed a physician's order dated 11/22/2024 for oxygen to be administered at 2 liters per minute (LPM), via nasal cannula (a flexible tubing used to deliver supplemental oxygen directly into the nostrils), every shift. Surveyor observations revealed the resident was receiving the incorrect LPM of oxygen on the following dates and times: - 9/8/2025 at 9:53 AM, the resident was receiving 2.5 LPM - 9/10/2025 at 11:34 AM and at 2:42 PM, the resident was receiving 3 LPM During a surveyor interview immediately following the above observation at 2:42 PM with Registered Nurse, Staff B, she acknowledged that the resident was not receiving the 2 liters of oxygen, as ordered. During a surveyor interview on 9/11/2025 at 10:11 AM with the Director of Nursing Services (DNS) in the presence of the Regional Director of Clinical Services (RDCS), she could not provide evidence that resident ID #11 was receiving oxygen at 2 liters, as ordered. 2. Review of a facility policy titled, Oxygen Administration, dated October 2010, states in part, .Documentation .the following should be recorded in the resident's medical record: .3. The rate of oxygen flow, route, and rationale. 4. The frequency and duration of the treatment. 5. The reason for p.r.n. [as needed] administration . Record review revealed Resident ID #46 was admitted to the facility in August of 2023 with diagnoses including, but not limited to, pneumonia. Record review revealed the resident was diagnosed with pneumonia on 9/7/2025. Record review revealed a physician's order dated 9/7/2025 for supplemental oxygen at 1 to 2 liters (L) via nasal cannula to maintain oxygen above 90% as needed for wheezing, coughing and shortness of breath. Additional record review failed to reveal evidence that the resident's oxygen saturation level was obtained each shift as ordered. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During surveyor observations on 9/8/2025 at 2:27 PM and on 9/9/2025 at 9:13 AM, the resident was observed to be receiving oxygen via nasal cannula at 2 L. Surveyor observations on 9/11/2025 at 9:32 AM, 9:41 AM, 9:48 AM and at 9:53 AM revealed the resident was receiving oxygen at 5 L. Record review of the September 2025 Treatment Administration Record failed to reveal documentation that the resident was receiving oxygen on the above-mentioned dates. During a surveyor interview immediately following the above observation at 9:53 PM with Registered Nurse, Staff B, she acknowledged that the resident was receiving 5 liters of oxygen and should have been receiving 1-2 liters. She also acknowledged that the order for oxygen was not signed off as given in the TAR for the above-mentioned dates and times. During a surveyor interview with the DNS and RDCS on 9/11/2025 at 10:13 AM, they indicated that staff should be documenting oxygen saturation each shift to ensure that the resident's saturation level is maintained per the order. Additionally, the DNS could not provide evidence that the resident was receiving oxygen at 1-2 liters, as ordered.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on record review and staff interview, it has been determined that the facility failed to ensure that residents are free of any significant medication errors for 3 of 4 residents reviewed for insulin administration, Resident ID #s 1, 2, and 6. Findings are as follows:1a. Record review revealed Resident ID #1 was admitted to the facility in October of 2024 with a diagnosis including, but not limited to, type 2 diabetes mellitus. Record review revealed the following physician's orders: -8/7/2025, Insulin Glargine (a long-acting insulin) 100 units per milliliter (ml) pen injector, inject 18 units subcutaneously daily at bedtime (HS). -8/20/2025, Insulin Aspart (a rapid acting insulin) 100 units per ml, inject per the sliding scale (insulin that is administered according to parameters for a blood sugar reading) subcutaneously before meals and at HS.Record review of the September 2025 Medication Administration Record (MAR) revealed that the Insulin Glargine was not signed off as administered on 9/6/2025 at HS. Further review of the MAR failed to reveal evidence that the resident's blood sugars were obtained or that Insulin Aspart was signed off as administered on 9/5 at 11:00 AM, 9/6 at 4:00 PM and 9/6 at 9:00 PM.1b. Record review revealed a progress note dated 9/4/2025 indicating that the resident's blood sugar was 412 and the provider was notified. Further review revealed an order was given for Lispro insulin (a rapid acting insulin) 12 units to be administered once. Record review of the September 2025 MAR failed to reveal evidence that the order was transcribed or that the Lispro 12 units was administered as ordered. During a surveyor interview on 9/11/2025 at 2:27 PM with the Regional Director of Clinical Services, she acknowledged that the above order had not been transcribed to the MAR and had not been documented as administered. 2. Record review revealed Resident ID #2 was admitted to the facility in July of 2025 with a diagnosis including, but not limited to, type 2 diabetes mellitus.Record review revealed a physician's order dated 9/1/2025 for Insulin Lispro 100 unit/ml inject per sliding scale if the blood sugar is;150-200, administer 2 units201-250, administer 4 units251- 300, administer 6 units301-350, administer 8 units351-400, administer 10 unitsIf blood sugar is less than 70 or greater than 400 notify the physicianRecord review of the September 2025 MAR revealed that on 9/9/2025 at 5:00 PM the resident's blood sugar was 431.Record review of a progress note dated 9/9/2025 at 5:53 PM states in part, .NP [Nurse Practitioner] notified of resident's elevated FBS [fasting blood sugar] new orders to administer 14 units of Lispro.Record review of the physician's orders failed to reveal evidence of a one-time order to administer the insulin Lispro 14 units on 9/9/2025.Record review of the MAR failed to reveal evidence that the resident received the one-time order for 14 units of the insulin Lispro on 9/9/2025.During a surveyor interview on 9/11/2025 at 11:37 AM with the Unit Manager, Registered Nurse, Staff A, she was unable to provide evidence that the resident was administered the 14 units of insulin Lispro on 9/9/2025.3. Record review revealed Resident ID #6 was readmitted to the facility in May of 2025 with a diagnosis including, but not limited to, type 2 diabetes mellitus.Record review revealed the following physician's orders:-5/8/2025, Insulin Lispro 100 units/ml, inject insulin per the sliding scale, subcutaneously four times a day.-7/15/2025, Insulin Lispro 100 units/ml, inject 3 units subcutaneously with meals, hold for a blood sugar less than 100.-7/21/2025, Insulin Glargine 100 units/ml pen injector, inject 30 units subcutaneously daily at bedtime.a. Record review of the September 2025 MAR failed to reveal evidence that the resident's blood sugars were obtained on 9/6/2025 prior to his/her dinner meal and at HS for administration of his/her sliding scale insulin Lispro. Additionally, the insulin Lispro was not signed off as administered for those above-mentioned times.Additional review of the MAR revealed that the Insulin Glargine was not signed off as administered on 9/6/2025 at HS and the Insulin Lispro was not signed off as administered on 9/6/2025 at 5 PM.During a surveyor interview on 9/11/2025 at 11:53 with Unit Manager, Licensed Practical Nurse, Staff D, she revealed that if a medication is administered it should be signed off in the record as administered and if a medication is not signed off as administered, that indicates that the medication was not given. During a surveyor interview on 9/11/2025 at 12:42 AM with Licensed (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Practical Nurse, Staff E, she indicated that if the medications were not signed off as administered, then they were not completed by her on the above dates and times. b. Record review of the MAR revealed that on 9/8/2025 at 8:00 AM the resident's blood sugar was documented as 94 and the nurse documented on the MAR that she administered 3 units of the insulin Lispro to the resident's right upper arm.During a surveyor interview on 9/11/2025 at 11:26 AM with Registered Nurse, Staff C, she acknowledged that she signed off administration of the Lispro on 9/8/2025 for the 8:00 AM shift. Furthermore, she could not provide evidence that the Lispro was held for a blood sugar less than 100 on 9/8/2025, as ordered.During a surveyor interview with the DNS on 9/11/2025 at 1:38, she was unable to provide evidence that the above-mentioned residents received their insulin as ordered.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to maintain an infection prevention and control program to help prevent the transmission of communicable diseases and infection, relative to 1 of 2 residents observed during a wound dressing change, Resident ID #2.Findings are as follows:Review of a facility policy titled Wound Care states in part, .Steps in the procedure.pour liquid solutions directly on gauze sponges.Wash tissue around the wound that is usually covered by the dressing.remove dry gauze. Apply treatment as indicated .Record review revealed Resident ID #2 was admitted to the facility in July of 2025 with diagnoses including, but not limited to, cellulitis (a bacterial infection involving the skin) of left lower limb, and infection and inflammation to internal left knee prosthesis (an artificial device that replaces a missing body part).Record review of the wound care progress note dated 9/10/2025 revealed the following:-Deep tissue injury (DTI- pressure-induced damage to the underlying tissues occurring beneath the skin's surface) to the 5th right toe with a scab -Right midfoot lateral (away from the middle of the body) pressure wound stage 4 (full-thickness tissue loss that extends through the skin and underlying soft tissue, exposing muscle, tendon, ligament, cartilage, or bone) containing 100% Eschar (dead tissue that can develop in wounds)-Right lateral ankle vascular wound (a type of wound that develops due to problems with blood circulation) containing 100% EscharRecord review revealed the following physician orders for the wounds on the resident' right foot:-9/11/2025, Right lateral 5th toe paint with betadine and cover with kerlix (a type of bandage) daily-9/11/2025, Right lateral ankle paint with betadine and wrap with kerlix daily-9/11/2025, Right lateral midfoot paint ulcer with betadine and wrap with kerlix dailyDuring a surveyor observation on 9/11/2025 at 9:39 AM of the wound dressing changes to the above-mentioned wounds, in the presence of the Assistant Director of Nursing Services (ADNS) and Licensed Practical Nurse, Staff G, Staff G removed the soiled dressings, sanitized her hands, and donned new gloves. She then sprayed wound cleanser onto a gauze and proceeded to wash the wound on the midfoot, the wound on the lateral ankle and then the wound on the lateral toe using the same gauze. Staff G then sanitized her hands, applied new gloves, and applied betadine to some gauze, and proceeded to paint the wound on the midfoot, the wound on the lateral ankle and then the wound on the lateral toe with the betadine using the same gauze for all three wounds.During a surveyor interview on 9/11/2025 at 10:23 AM with Staff G, she acknowledged that she had used the same gauze to wash all three of the above-mentioned wounds. She further acknowledged that she used the same gauze to apply betadine to all three of the wounds.During a surveyor interview on 9/11/2025 at 10:29 AM with the ADNS, she acknowledged the above observation. She further indicated her expectation would be for staff to clean each wound with a separate piece of gauze, and to apply the betadine to each wound with a separate piece of gauze to help prevent the transmission of infection.

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review and staff interview, it has been determined the facility failed to maintain medical records on each resident that are complete and accurately documented in accordance with accepted professional standards and practices, for 2 of 6 residents reviewed for pressure injuries (a localized area of the skin and/or underlying soft tissue damage caused by prolonged pressure), Resident ID #s 53 and 114. Findings are as follows: 1. Record review revealed Resident ID #53 was admitted to the facility with diagnoses including, but not limited to, mild protein-calorie malnutrition and dementia. Record review revealed a physician's order dated 10/21/2024 for weekly skin checks every Friday. Record review revealed the resident had a pressure injury to his/her left ischium (the lower back part of the hip bone) that was documented as healed by the Wound Physician on 8/6/2025. Record review revealed the following skin assessments indicated the resident had a pressure ulcer, after the documentation indicated that the resident's pressure ulcer had healed: -8/15/2025 -8/29/2025 During a surveyor interview on 9/11/2025 at 1:33 PM with the Director of Nursing Services (DNS), she revealed that she would expect nurses to document accurately, and that if a resident's pressure ulcer had healed, the weekly skin assessments should indicate that there are no active skin impairments. 2. Record review revealed Resident ID #114 was admitted to the facility in June of 2025 with diagnoses including, but not limited to, cerebral infarction (stroke), dementia, and an intact blister to his/her right heel. Record review revealed a physician's order dated 6/24/2025 for weekly skin checks Additional record review revealed that the blister to his/her right heel had opened and was identified as a deep tissue injury (DTI, pressure-induced damage to the underlying tissues occurring beneath the skin's surface) on 7/22/2025. Record review revealed the following skin assessments indicated the resident had no skin impairments, although additional documentation in the resident's record indicated that the resident had a blister to the right heel which was later identified as a DTI on 7/22: -7/1/2025 -7/8/2025 -7/21/2025 (continued on next page)

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	-7/28/2025 Further record review failed to reveal evidence that a skin check was completed weekly on 7/14/2025, as ordered. During a surveyor interview with the Unit Manager and Wound Nurse, Staff D, on 9/11/2025 at 12:17 PM, she was unable to provide evidence that the resident's blister on his/her right heel was included in the above-mentioned weekly skin checks. Additionally, she was unable to provide evidence that a weekly skin check was completed the week of 7/14/2025. During a surveyor interview on 9/11/2025 at 1:07 PM with the DNS, she acknowledged that the documentation for Resident ID #114's weekly skin checks was inaccurate and incomplete.