STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415067	A. Building B. Wing	03/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West View Nursing and Rehabilitation Center	239 Legris Avenue West Warwick, RI 02893

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46715 Based on record review, staff and resident interview, it has been determined that the facility failed to keep a resident free from physical abuse for 1 of 7 residents reviewed, Resident ID #7. Findings are as follows: Review of a facility policy titled, Abuse Prohibition states in part, It is the policy of this facility to ensure that all residents are treated with respect and dignity and that all residents are free from abuse, mistreatment, neglect .Abuse: willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain or mental anguish . Review of a facility reported incident received by the Rhode Island Department of Health on 3/3/2025 revealed that the Administrator was informed that an Activity Aide was seen coming down the hall, wheeling Resident ID #7 very quickly and then let go of the wheelchair causing the resident to roll several more feet and hitting the wall. The resident was startled, but did not fall and was not injured. Record review revealed that Resident ID #7 was readmitted to the facility in 1/2025 with diagnoses including, but not limited to, dementia and anxiety disorder. Review of a Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status score of 7 out of 15, indicating severe cognitive impairment. Additional review of the assessment revealed that s/he self-propels independently in his/her wheelchair. Review of a statement authored by Nursing Assistant (NA), Staff F, revealed that she witnessed Activity Aide, Staff G, wheeling the resident erratically and stated get out of here and aggressively pushed the resident's wheelchair and then let go. Per Staff F, the wheelchair continued to roll and hit the wall. During a surveyor interview on 3/3/2025 at 9:15 AM with the resident, s/he revealed that somebody pushed my wheelchair. Additionally, the resident revealed that s/he was unsure why this happened and was startled by the interaction. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a surveyor interview on 3/3/2025 at 9:31 AM with Staff G, she acknowledged that she did push the resident's wheelchair and it hit the wall. Additionally, she revealed that she made a mistake and knows that the resident has dementia and she should not get upset with him/her. Staff G indicated that the resident was shutting the lights off during an activity and that her own anxiety was heightened when she pushed the resident's wheelchair. During a surveyor interview on 3/3/2025 at approximately 8:00 AM with the Administrator, she acknowledged that Resident ID #7 was pushed aggressively by Staff G and that his/her wheelchair hit the wall. She revealed that the resident was immediately assessed and did not sustain any injury. Additionally, she revealed that the staff member was immediately suspended pending her completed investigation and that all staff received additional abuse training. The Administrator was unable to provide evidence that all residents were treated with respect and dignity and kept free from abuse.

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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 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 46715 Based on record review and staff interview, it has been determined that the facility failed to ensure that residents are free from physical restraints that are not required to treat the resident's medical symptoms for 1 of 1 resident reviewed for an actual restraint, as the resident was observed in bed with a bed sheet tied across him/her, Resident ID #1. Findings are as follows: Review of a facility policy titled, Restraint Use-Physical states in part, .A physical restraint may be used only as a last resort and for a short period of time when it is documented in the medical record that the use of said restraint is in the best interests of the resident and allows the resident to receive the treatment that he/she has previously agreed to receive. Nursing documentation must specifically describe the behavior/medical symptoms that indicate the need for restraints and all the interventions that have been attempted before obtaining a doctor's order for a restraint . Record review of a facility reported incident submitted to the Rhode Island Department of Health on 2/27/2025 states in part, During first rounds on the day shift this morning, one of our CNAs [Certified Nursing Assistant] reported to the Director of Nursing (DNS) that one of the residents was found in bed with a bed sheet over [his/her] waist, seemingly placed this way to prevent [him/her] from getting out of bed; the bed sheet was loosely tied with each end tied to each (left and right) side rail . Record review revealed that the resident was admitted to the facility in February of 2025 with diagnoses including, but not limited to, epilepsy, cerebral infarction (stroke) and aphasia (a comprehension and communication disorder resulting from damage or injury to the brain). Review of a facility provided statement authored by CNA, Staff A, dated 2/27/2025 states in part, On the night of 2/26/25 at 8:00 PM I laid [Resident ID #1] in [his/her] bed and tied [him/her] from one side to the other on [his/her] stomach with a sheet, so [s/he] doesn't move or fall .I've seen [him/her] tied up in the past and I never reported it because I thought it was ok to do since [s/he] is a frequent faller. Review of a facility provided statement authored by CNA, Staff B, dated 2/27/2025 states in part, Today 2/27/25 me and [CNA, Staff C] went to get [Resident ID #1] washed for the day, while I was removing some of [his/her] blankets I notice [sic] a blanket was tied from each of the siderails restraining [him/her] to the bed . During a surveyor interview on 2/28/2025 at 1:02 PM with Staff B, she revealed that she found the resident in bed with a sheet tied from one side rail to the other. Additionally, Staff B revealed that the resident was found with pillows surrounding him/her. Per Staff B there were three pillows on each side of the resident, and they were tucked under the fitted sheet to keep them in place. Staff B revealed that the resident was unable to get out of bed due to the tied sheet and the pillows surrounding him/her. (continued on next page)

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F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a facility provided statement authored by Registered Nurse, Staff D, states, I [Staff D] have never restrained, restricted, nor tied said patient to a bed. Safety of a patient is a priority and due to recent multiple falls, impulsivity, and lack of proper staffing I have tucked patient in bed but in no way was it a restraint. During a surveyor interview on 3/3/2025 at 1:25 PM with CNA, Staff E, she revealed that she observed Staff D, roll up a flat sheet and place it across the resident's stomach, through the side rails and tuck it under the mattress. Additionally, Staff E revealed that when the sheet was across Resident ID #1 and tucked under the mattress s/he was unable to get up or roll over independently. Record review failed to reveal evidence of a physician order for a restraint, an assessment for the use of a restraint, medical symptoms being treated or interventions attempted prior to the use of a restraint. During a surveyor interview on 2/28/2025 at 11:53 AM with the Administrator and DNS, they acknowledged that Resident ID #1 was physically restrained on 2/26/2025 by Staff A. During a follow up interview on 3/3/2025 at approximately 12:00 PM with the Administrator she acknowledged that Staff D revealed she uses a flat sheet to tuck Resident ID #1 in bed to keep him/her from falling. Additionally, the Administrator acknowledged that tucking a sheet under the mattress to restrict the resident from getting out of bed is a physical restraint. This failure had the potential to cause more than minimal harm as the resident was at risk for entrapment, suffocation, strangulation injury or death.