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	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West View Nursing & 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **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 residents receive treatment and care in accordance with professional standards of practice and the comprehensive care plan relative to 1 of 2 residents reviewed with non-pressure wounds, Resident ID #1. Findings are as follows: Record review revealed Resident ID #1 was admitted to the facility in May of 2025 with a diagnosis including, but not limited to, dependence on a ventilator (a device that assists in breathing). Record review of the admission skin assessment dated [DATE] revealed the resident had the following skin impairments: -A rash to the upper-mid vertebrae (an area of the spine) -An excoriation (the mechanical removal of the skins surface caused by scratching, rubbing, or picking) to his/her groin Record review of the physician's orders revealed an order dated 5/13/2025 for Miconazole Nitrate (a medicated powder prescribed to treat a fungal rash) to be applied to the groin twice daily. Additional review of the physician's orders failed to reveal evidence of a treatment order for the resident's rash to his/her vertebrae. Record review revealed the resident was transferred to the hospital on 5/17/2025 and was readmitted to the facility on [DATE]. Record review of the re-admission skin assessment dated [DATE] revealed the following skin impairments: - A rash to the vertebrae -An excoriation to the groin Record review of the physician's orders revealed an order dated 5/21/2025 for Miconazole Nitrate Powder 2%, to be applied to the groin twice daily. Additional review of the physician's orders failed to reveal evidence of a treatment order for the resident's rash to his/her vertebrae. (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 - Minimal harm or potential for actual harm Residents Affected - Few	Record review revealed the resident was transferred to the hospital on 5/22/2025 due to elevated blood pressure. Record review of the hospital admission paperwork dated 5/22/2025, revealed the resident complained about and was found to have a fungal rash to his/her back and a fungal infection to his/her groin and genital area. Additionally, the hospital paperwork indicated that the resident presented to the hospital after s/he was found to have a blood pressure of 240/120 (a normal blood pressure reading is 130/80) on the morning of 5/22/2025. Further review revealed documentation that indicated the cause of the resident's labile blood pressures (a condition where the blood pressure fluctuates significantly) was likely due to fungal infection. During a surveyor interview on 6/10/2025 at 2:43 PM with the admitting nurse, Registered Nurse, Staff A, she revealed that on 5/20/2025 Resident ID #1 was re-admitted with a reddened rash to his/her groin and his/her entire back. Additionally, Staff A revealed that the resident was readmitted from the hospital with a treatment order for his/her groin rash and Staff A did not obtain a treatment order for the rash that she identified on the resident's entire back. During a surveyor interview on 6/10/2025 at 2:57 PM with the Director of Nursing Services, she acknowledged that there were no treatment orders initiated for the rash that was identified on the resident's vertebrae when s/he was admitted to the facility on 5/12 and re-admitted on [DATE]. Additionally, she revealed that upon admission to the facility, she would expect that the nurse would complete a skin assessment and obtain orders for all areas requiring treatments.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to ensure that a resident receives care, consistent with professional standards of practice, to promote wound healing for 1 of 4 residents reviewed who is at risk for skin breakdown, Resident ID #1, and for 1 of 2 residents reviewed with actual pressure ulcers (a localized injury to the skin and/or underlying skin usually over a bony prominence), Resident ID #2. Findings are as follows: 1. Record review revealed Resident ID #1 was admitted to the facility in May of 2025 with a diagnosis including, but not limited to, dependence on a ventilator (a device that assists in breathing). Record review of the facility's admission skin assessment dated [DATE] revealed the resident had an excoriation (an excoriation is a linear erosion caused by scratching, rubbing, or picking) to his/her sacrum. Record review of the physician's orders failed to reveal evidence of a treatment order for the resident's excoriated sacrum. Further record review revealed Resident ID #1 was transferred to the hospital on 5/17/2025 and was readmitted to the facility on [DATE]. Record review of the re-admission skin assessment dated [DATE] revealed s/he had an excoriated sacrum. Record review of a care plan dated 5/20/2025 revealed the resident is at risk for skin breakdown with interventions including, but not limited to, pressure areas and interventions are to be placed. Record review of the physician's orders failed to reveal evidence of a treatment order for the excoriated sacrum. Record review revealed the resident was transferred to the hospital on 5/22/2025. Record review of the hospital admission physician's progress note dated 5/22/2025 indicated that Resident ID #1 presented to the hospital with a Stage II (a shallow open ulcer with a red-pink wound bed) pressure injury to his/her sacrum. During a surveyor interview on 6/10/2025 at 2:43 PM with the admitting nurse, Registered Nurse, Staff A, she acknowledged that on 5/20/2025 the resident was re-admitted with an excoriated sacrum and that she did not obtain a treatment order for the area. During a surveyor interview on 6/10/2025 at 2:57 PM with the Director of Nursing Services (DNS), she acknowledged that there was no treatment order for the excoriated sacrum. Additionally, she revealed that upon admission to the facility, she would expect that the nurse would complete a skin assessment and obtain treatment orders for any skin impairments. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review revealed Resident ID #2 was admitted to the facility in June of 2025 with diagnoses including, but not limited to, pressure ulcer of the sacral region and diabetes mellitus. Record review of the facility's admission skin assessment dated [DATE] revealed the following: - A sacral stage II pressure ulcer - A left gluteal fold (located at the bottom border of the buttocks) stage II pressure ulcer - A right gluteal fold pressure ulcer - A right lateral (towards the side) gluteal fold pressure ulcer Record review of the physician's orders revealed the following wound treatment orders dated 6/6/2025: - Sacrum/bilateral buttocks, (the sacral, left gluteal fold, right gluteal fold and the right lateral gluteal fold pressure ulcers), cleanse with normal saline and apply zinc oxide-based paste to the wound bed and cover with bordered foam dressing daily. Additional record review of the sacrum/buttocks treatment order revealed that the order was entered into the computer system without being designated to the Treatment Administration Record (TAR), therefore the wound treatment order was not transcribed onto the TAR; therefore, the treatments for the sacral stage II pressure ulcer, left gluteal fold, right gluteal fold and the right lateral gluteal fold was not available for the staff to see and complete daily as ordered. During a surveyor interview with the DNS on 6/10/2025 at 4:20 PM, she was unable to provide evidence that the treatment was implemented for the above-mentioned wounds as ordered for Resident ID #2.