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	05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West View Nursing Home, Inc	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 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, and staff interview, the facility failed to ensure care and services were provided in accordance with professional standards of clinical practice for 1 of 3 residents reviewed receiving insulin therapy for diabetes mellitus, Resident ID #1. Specifically, the facility failed to ensure a complete and clinically appropriate insulin order was obtained, accurately transcribed, and safely administered, resulting in the resident receiving rapid-acting insulin during overnight hours without meal intake, causing severe hypoglycemia requiring emergent hospital transfer. Findings are as follows:Record review of a facility reported incident sent to the Rhode Island Department of Health on 5/1/2026, revealed that on 4/29/2026, the resident's Novolog order was decreased from 5 units to 4 units, to be given three times daily. However, the order was incorrectly transcribed for day, evening, and night shifts (7:00 AM - 3:00 PM, 3:00 PM - 11:00 PM, and 11:00 PM - 7:00 AM). Following an insulin dose at 12:45 AM, the resident's blood sugar dropped to a dangerously low level of 43 milligrams/deciliter (mg/dL) (severe hypoglycemia- normal blood sugar levels are 70-100), requiring emergency hospital transfer.Record review revealed the resident was admitted to the facility in August of 2024 with diagnoses including, but not limited to, type 2 diabetes mellitus, dementia, and sleep apnea.Record review of the manufacturer's instruction manual for Novolog Insulin Aspart Injection 100 units/milliliter (units/mL) last revised in February of 2023, states in part, .NOVOLOG is rapid acting human insulin.Inject subcutaneously within 5-10 minutes before a meal.WARNINGS AND PRECAUTIONS.Changes in an insulin regimen.may affect glycemic control and predispose to hypoglycemia [a condition where blood sugar drops below 70 mg/dL.the most common adverse reaction of all insulins, including NOVOLOG. Severe hypoglycemia can cause seizures, may lead to unconsciousness, maybe life threatening, or cause death.Make any changes to a patient's insulin regimen under close medical supervision with increased frequency of blood glucose monitoring.1. Review of the [NAME] Nursing Procedures Ninth Edition (2023), states in part, SAFE MEDICATION ADMINISTRATION PRACTICES.An adverse drug event (ADE) is defined as harm to the patient, including.physical harm.that results from a medication error. A medication error is a mistake that occurs during medication administration process.A preventable ADE occurs as a result of a clinician error or a systematic error and thus could have been prevented.Verifying the medication order.Verify the essential elements of the medication order are present, including the patient's name, the date and time the order was written, the name of the drug to be administered, the drug dosage, the route of administration, the frequency of administration.specific instructions for use (when applicable).According to Fundamentals Of Nursing 7th Edition by [NAME], Lillis, Lemone, and [NAME] (2011), the patient's full name is required in transcribing medication orders.Record review of a progress note authored by the Certified Family Nurse Practitioner, Staff C, on 4/28/2026 at 11:45 AM, revealed that the resident's morning blood sugars from 4/19/2026 through 4/28/2026 were between 66 -99 mg/dL. The resident had one episode where his/her blood sugar was 59 mg/dL. A new order was initiated on 4/28/2026 to decrease the Novolog from 5 units to 4 units three times daily.Review of the April 2026 Medication Administration Record (MAR) revealed a physician's order to administer Novolog Solution 100 unit/mL 5 units subcutaneously three times a day with the timing (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 - Immediate jeopardy to resident health or safety Residents Affected - Few	of after breakfast, after lunch, and in the evening at 6:00 PM was discontinued on 4/28/2026 at 4:19 PM. A new order was provided on 4/28/2026 at 11:00 PM to administer Novolog Solution 100 unit/mL three times a day with the timing of every shift for 7:00 AM - 3:00 PM, 3:00 PM - 11:00 PM, and 11:00 PM - 7:00 AM.During a surveyor interview conducted on 5/1/2026 at 1:00 PM, Staff C acknowledged that she initiated a new order to decrease the resident's Novolog dosage from 5 units to 4 units three times daily. She stated that her intent was only to change the dosage amount while maintaining the existing administration times of 8:00 AM, 1:00 PM, and 6:00 PM with meals. Staff C further revealed that she did not intend for the resident to receive a dose of rapid-acting Novolog insulin at midnight, which was the dose administered by Staff A on 4/29/2026 at approximately 12:30 AM. She added that she had written the order on a plain white sheet of paper and provided it to the nurse assigned to the resident at that time.Record review revealed a plain white paper uploaded in the resident's Electronic Medical Record (EMR) which revealed the following medication orders: .3. DC [discontinue] 5 units of aspart. 4. Start Aspart 4 units TID [three times a day]. Further review revealed that the handwritten medication order lacked essential elements necessary to minimize the risk of an adverse drug event (ADE), including the resident's first name, the date and time the order was written, the route of administration, and specific instructions clarifying that Staff C intended for the resident to receive 4 units of Novolog three times daily with meals, rather than three times daily every shift, which was how the order was ultimately transcribed. During a follow-up interview conducted on 5/4/2026 at 9:27 AM, Staff C acknowledged that she failed to specify the administration timing in the Novolog order she wrote on 4/28/2026. She stated that she believed it was understood that a rapid-acting insulin ordered three times daily would be administered with meals at breakfast, lunch, and dinner when the resident consumed food to assist with blood glucose regulation. Staff C further stated that her only intention was to decrease the Novolog dose from 5 units to 4 units and that she did not intend to change the established administration times.Staff C additionally acknowledged that she would not expect staff to administer a rapid-acting insulin dose in the middle of the night without first assessing the resident's blood glucose level or providing a meal with the medication. She stated that she did not receive any requests for clarification regarding her medication order from Registered Nurse Staff B, who transcribed the order, or from Staff A, who administered the Novolog on 4/29/2026 at approximately 12:30 AM.2. According to Fundamentals Of Nursing 7th Edition by [NAME], Lillis, Lemone, and [NAME] (2011), it is a nursing responsibility to check that times for medication administration correspond to safe practice for that drug. Nurses are legally responsible for carrying out the orders of the physician in charge of a patient unless an order would lead a reasonable person to anticipate injury if carried out. Nurses should question any physician order that is contraindicated by normal practice and/or contraindicated by the patient's present condition.Record review of a nursing progress note dated 4/28/2026 at 4:46 PM authored by Registered Nurse, Staff B, revealed that she received the order from Staff C to discontinue the Novolog 5 units and start the Novolog 4 units three times a day.During a surveyor interview conducted on 5/4/2026 at 9:00 AM, Staff B acknowledged that she received the above medication orders from Staff C written on a plain white sheet of paper and transcribed the order into the EMR as TID, meaning three times daily. She stated that she sought clarification from Staff C regarding the order and alleged that Staff C instructed her to enter the order exactly as written on the paper as TID, without specifying whether the medication was to be administered three times daily with meals or every shift.Further interview with Staff B revealed that she also sought assistance from an agency nurse when entering the order and was similarly instructed to enter the Novolog order as written on the plain white paper. When asked whether she questioned the appropriateness of scheduling a rapid-acting insulin, such as Novolog, for administration at 11:00 PM, Staff B stated that she was a new nurse and entered the order as directed by the nurse practitioner and the agency nurse.3. Record review of the Fundamentals Of Nursing 7th Edition by [NAME], Lillis, Lemone, and [NAME] (2011), states in part, .Questioning the Medication Order. Nurses are legally responsible for the drugs they administer. Any drug order (continued on next page)

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	suspected to be in error should be questioned. The suspected error may be in any part of the order. When preparing to administer a medication, ask: Do the patient's condition, symptoms, health status warrant receiving this medication? Does it make sense for the patient to have this medication? On occasion, the nurse may not think that there is an error in the order but may not understand why the medication has been prescribed. In such instances, ask the prescriber how the order relates to the patient's plan of care. This may prevent a medication error if the wrong medication has been ordered.The nurse is also responsible for double checking the dosage and appropriateness of the medication.Record review of the facility policy titled Medication Administration; Safety with an effective date of 4/7/2008, states in part, .Residents shall receive medications in a safe and timely manner and in accordance with established regulations and guidelines.Should there be any doubt concerning the administering of medication(s), the physician's order must be verified before the medication is given.Review of the April 2026 Medication Administration Record (MAR) revealed a medication order for Novolog Solution 100 units/mL, 4 units every shift, with a start date and time of 4/29/2026 at 11:00 PM. Further review revealed that the dose was documented as administered by Registered Nurse Staff A.Record review of a nursing progress note from 4/29/2026 at 6:45 AM, authored by Staff A, describes an emergency response after the resident's blood sugar dropped to 43 mg/dL. Staff A found the resident pale, unresponsive, and with a dangerously low oxygen level of 82% (normal level of 95% to 100%). Emergency Medical Services was notified and upon arrival, emergency responders noted the resident's blood sugar had risen slightly to 63 mg/dL, and they transferred the resident to the emergency room (ER) for further treatment.During a surveyor interview conducted on 5/1/2026 at 11:51 AM, Staff A acknowledged that she administered rapid acting insulin to the resident just after midnight on 4/29/2026. Staff A admitted that she did not assess the resident's blood glucose level or provide a snack before or after administering the Novolog, stating that she was following the provider's order as entered. She further acknowledged that she did not question the appropriateness of administering a rapid-acting insulin during the nighttime hours without a meal and failed to monitor the resident's blood glucose level. Record review of the ER note dated 4/29/2026 revealed the resident arrived o the ER at 7:40 AM and had a blood sugar level of 52 mg/dL and was admitted with a diagnosis of hypoglycemia and metabolic acidosis (a serious medical condition characterized by an excessive buildup of acid in the body fluids which may be caused by low oxygen or low blood sugar).During a surveyor interview on 5/4/2026 at 9:14 AM with the resident's physician, Staff E, he revealed that he would expect the Nurse Practitioner to write a complete order with all its components necessary to prevent an adverse drug event. Additionally, he would expect the nurses to know that a rapid-acting insulin should be given with meals, or at minimum, assess the resident's blood sugar if it is clinically indicated when administering a rapid-acting insulin in the middle of the night without offering a meal or a snack. Lastly, he would expect nurses to know that the appropriate scheduling times for a rapid-acting insulin is usually within breakfast, lunch, and dinner, and that any other order that was scheduled outside those times should have been reconciled with him or another provider.During a surveyor interview on 5/4/2026 at approximately 10:00 AM with the Director of Nursing Services, the Administrator, and the Regional Nurse, they were unable to provide evidence that the facility staff provided care consistent with professional standards of practice related to writing, transcribing, and administering of a rapid-acting insulin medication order.The facility failed to ensure the safe writing, transcription, clarification, reconciliation, and administration of a rapid-acting insulin medication order, resulting in the resident receiving Novolog at an inappropriate time without blood glucose monitoring or concurrent nutritional intake. This failure led to severe hypoglycemia requiring emergency hospitalization. As a result, Resident ID #1 was placed at risk for serious harm, serious impairment, or death. Facility staff failed to exercise clinical judgment and adhere to fundamental standards of safe medication administration, as the use of rapid-acting insulin without concurrent food intake is contraindicated and places a resident at immediate risk for hypoglycemia and loss of consciousness.During a surveyor interview with the Administrator on 5/4/2026 at (continued on next page)

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	approximately 1:45 PM the Administrator explained to the surveyor that the facility had already corrected and implemented a plan for this deficient practice. He provided the surveyor with an immediate removal plan which included:-The conducting of a root cause analysis that determined the etiology of variables that lead to the improper insulin administration. -All licensed nurses were educated concerning the transcription of orders.-All providers were educated on what a complete order is and the proper transcription of an order.-An audit of all residents receiving short acting insulin was conducted to ensure that insulin is administered with meals and that blood sugars are checked prior to the administration of insulin. -The education provided to all licensed nursing staff has been added to the new hire orientation process for the onboarding of licensed nurses. The Administrator alleged compliance as of 4/30/2026; which was verified by the surveyor. Therefore, this deficient practice will be cited under F 658 as past noncompliance at a scope and severity of J. Cross reference F 695

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, the facility failed to provide respiratory care in accordance with professional standards of practice for 1 of 1 resident reviewed. Emergency Medical Services (EMS) observed Resident ID #1 receiving oxygen at 5 liters per minute (LPM) via a non-rebreather mask, a delivery method that requires a minimum flow rate of 10 LPM to maintain proper reservoir inflation and effective oxygen delivery. The use of a non-rebreather mask below the required flow rate rendered the device ineffective, resulting in inadequate oxygenation and placing the resident at immediate and significant risk for respiratory failure, hypoxia, and cardiopulmonary decompensation.As a result of this deficient practice, Resident ID #1 experienced clinical deterioration requiring emergent transfer to the emergency room (ER), where the resident was admitted with metabolic acidosis, a serious life-threatening condition characterized by excessive acid accumulation in the body that may result from prolonged hypoxia. Findings are as follows:Record review of a facility reported incident sent to the Rhode Island Department of Health on [DATE], revealed that on [DATE], the resident's Novolog order was decreased from 5 units to 4 units, to be given three times daily. However, the order was incorrectly transcribed for day, evening, and night shifts (7:00 AM - 3:00 PM, 3:00 PM - 11:00 PM, and 11:00 PM - 7:00 AM). Following an insulin dose at 12:45 AM, the resident's blood sugar dropped to a dangerously low level of 43 milligrams/deciliter (mg/dL) (severe hypoglycemia- normal blood sugar levels are 70-100), requiring emergency hospital transfer.According to the ScienceDirect Journal article, titled Emergency Oxygen Administration, dated 2008, states in part, .Non-Rebreather Mask 1. The non-rebreather mask is the first choice when considering constant flow supplemental oxygen in an acute medical emergency. It consists of a mask, reservoir bag, and two or three one-way valves, one separating the reservoir from the mask and the other one or two on the sides of the mask. Oxygen flows into the reservoir bag so that when the [resident] inhales, he or she inhales O2 from the reservoir. The one-way valves on the sides of the mask keep air from coming into the mask and diluting the O2. When the [resident] exhales, expired air goes out of the mask through the one or two valves on the face and is prevented from entering the reservoir .3. To use the mask, it is attached to the O2 supply at a flow rate of 10 to 15 liters/minute. The reservoir bag must be inflated or primed before placing it on the person .Care must be taken to not allow the O2 supply to be depleted while the mask is on the person. Because of the one-way valves, if there is no O2 supply, suffocation may result .Record review of the facility policy titled Oxygen Administration states in part, .If using a Non-rebreather Mask: This method is a high-concentration oxygen delivery device used in acute emergencies for patients who can breathe spontaneously but need high levels of oxygen. An oxygen cylinder with a 15L gauge must be used. 10L/min is the minimum to prevent rebreathing of CO2 [carbon dioxide] and 15L is maximum.Record review revealed the resident was admitted to the facility in August of 2024 with diagnoses including, but not limited to, type 2 diabetes mellitus, dementia, and sleep apnea.Record review of a progress note dated [DATE] at 6:45 AM authored by Registered Nurse, Staff A, revealed the resident had a hypoglycemic episode (a condition where blood sugar drops below 70 milligrams/deciliter [mg/dL]. Severe hypoglycemia can cause seizures, may lead to unconsciousness, maybe life threatening, or cause death). The resident's oxygen level (SpO2 - peripheral oxygen saturation that measures the percentage of oxygen-saturated hemoglobin in the blood with the normal reading of 95% to 100%. Readings below 90% is considered hypoxemia which can be dangerous and often signals a serious respiratory issue) dropped to a dangerously low level of 82% on room air, indicating hypoxemia. Staff A administered 5 LPM of supplemental oxygen and the emergency responders arrived to transport the resident to the ER.Record review of a statement dated [DATE] at 12:32 PM written by Staff A revealed that she responded to the resident's hypoglycemic emergency with assistance from Licensed Practical Nurse Staff D, who initiated supplemental oxygen at 5 LPM. Staff A further stated (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	that she subsequently transitioned the resident to a non-rebreather mask while maintaining the oxygen flow at 5 LPM. This indicates an inappropriate flow rate for the device, as non-rebreather masks require a minimum of 10 LPM to adequately fill the reservoir bag and prevent rebreathing of exhaled carbon dioxide. Maintaining oxygen at 5 LPM in this delivery system may result in inadequate oxygenation and CO2 rebreathing, thereby placing the resident at risk for clinical deterioration and respiratory compromise.During a surveyor interview on [DATE] at 1:58 PM, Staff A confirmed she cared for the resident during the 11:00 PM to 7:00 AM shift on [DATE] into [DATE]. She revealed that at 6:45 AM, she found the resident pale and unresponsive with severe hypoglycemia and hypoxemia (82% SpO2). Staff A acknowledged that she applied a non-rebreather mask at 5 LPM. Staff A admitted that she was unaware that this mask requires a minimum of 10 LPM to prevent the rebreathing of CO2. She further acknowledged that she failed to recheck the resident's oxygen levels before EMS arrived.Record review of the Rhode Island Emergency Medical Services (EMS) report dated [DATE] at 7:20 AM revealed that emergency responders were dispatched to the facility for Resident ID #1, who was unresponsive and not breathing. Upon arrival at 7:29 AM, EMS found the resident with snoring respirations (agonal breathing; occurs when someone who is not getting enough oxygen is gasping for air. It's not true breathing. It's a natural reflex that happens when your brain is not getting the oxygen it needs to survive. Agonal breathing is a sign that a person is near death) and an SpO2 (peripheral oxygen saturation; is the measurement of the percentage of oxygen-saturated hemoglobin in the blood, a normal reading falls between 95% to 100%) of 77% (low) while facility staff provided only 5 Liters Per Minute (LPM) of oxygen via a non-rebreather mask (the required oxygen flow rate for the use of this mask is a minimum of 10 liters/minute). Once EMS increased the oxygen flow rate to an appropriate level, 15 LPM, the resident's SpO2 improved to 99%. The resident was then transferred to the emergency room.Review of the emergency room (ER) records dated [DATE] indicated that the resident's venous blood gas results were abnormal, with a pCOˆ (partial pressure of carbon dioxide) level of 54 mmHg (normal range: 41-51 mmHg) and a blood pH level of 7.21 (normal range: 7.31-7.45), indicating acid-base imbalance. Further record review revealed that the resident was diagnosed with metabolic acidosis, a serious condition characterized by excessive acid accumulation in the body fluids, which may result from inadequate oxygenation or severe hypoglycemia.During a surveyor interview on [DATE] at 3:57 PM with the Director of Nursing Services, the Administrator, and the Regional Nurse, they were unable to provide evidence that respiratory services were provided consistent with professional standards of practice.During a surveyor interview on [DATE] at 9:14 AM with the resident's physician, Staff E, he revealed that he would expect that staff would know how to use the non-rebreather masks.The facility failed to ensure the safe provision of respiratory care in accordance with professional standards of practice, resulting in Resident ID #1 receiving oxygen via a non-rebreather mask at an insufficient flow rate of 5 LPM instead of the required minimum of 10 LPM. This inappropriate use of the device compromised its intended function, resulting in inadequate oxygen delivery and potential rebreathing of carbon dioxide. This failure contributed to hypoxemia and respiratory compromise requiring emergency medical intervention and hospital transfer. As a result, Resident ID #1 was placed at immediate risk for serious harm, serious impairment, serious injury or death due to staff failure to apply basic clinical knowledge and adhere to established standards for safe oxygen administration. Cross reference F 658