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	06/11/2026

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 - Actual harm 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 provide services that meet professional standards relating to following the prescribed physical therapy treatment plan for 1 of 2 Residents reviewed, ID #1. Resident ID #1 sustained a left femoral (the long bone of the upper leg) fracture when a Physical Therapy Assistant (PTA) performed rotational exercises of the resident's left hip that were not included in the resident's therapy treatment plan. The facility's investigation determined that the PTA failed to follow the established treatment plan and performed interventions outside the scope of the treatment directives. Following the incident, the facility immediately removed the PTA from resident care duties pending the outcome of the investigation and provided education to all therapy staff regarding adherence to therapy plans and the requirement to seek clarification when treatment instructions are unclear. Surveyor verification confirmed these corrective actions had been implemented prior to the survey, and no evidence was identified that the deficient practice continued to exist at the time of the survey. Findings are as follows:Record review of facility reported incident submitted to the Rhode Island Department of Health on 5/22/2026 states in part, .Resident was found to have closed left femoral fracture. X ray imaging done in facility. Sent to [NAME] Hospital for further evaluation. Injury etiology remains unknown but early investigation may show possible link between therapy treatment provided and the injury .Clinical record review for Resident ID #1's revealed that s/he was admitted to the facility in December of 2025 with diagnoses of, but not limited to nontraumatic intra cerebral hemorrhage, cerebral edema, compression of brain and cognitive communication deficit. Additionally, record review revealed that the resident is nonverbal and unable to make his/her needs known. Clinical record review of Resident ID #1's Physical Therapy PT Evaluation & Plan of Treatments revealed the following: - certification period 12/18/2025 - 1/14/2026 with a short-term goal for the resident to increase active movement of his/her lower left extremity with range of motion (hip rotation) and strengthening exercises with a target date of 12/31/2025. - certification period 12/23/2025 - 1/19/2026 revealed a short-term goal for the patient to continue with range of motion (hip rotation) and strengthening exercises. - certification period 12/18/2025 - 4/13/2026 revealed a short-term goal revealed a short term to discontinue with range of motion (hip rotation) and strengthening exercises. - certification period 5/8/2026 - 6/4/2026 revealed a short-term goal for the patient to improve left knee extension (extension and retraction of the lower leg) and hip extension (raising and lowering the upper leg towards the chest) exercises to with a target a date of 5/21/2026.- certification period 5/8/2026 - 6/4/2026 revealed that the Resident ID #1 had a left hip limited internal and external rotation of 15 degrees in each direction from a neutral position. A left hip external rotation of 15 degrees is an outward turning of your left thigh away from your body's midline. Compared to the standard or normal adult range of 40 degrees to 60 degrees, 15 degrees indicates a significantly limited or restricted range of motion. Clinical record review of Resident ID #1's Physical Therapy Treatment Encounter Note(s) failed to reveal evidence that rotational exercises of the resident's left hip were indicated in any of the plans of treatment. Record review of the facility's 5-day investigation report revealed that the facility's review of the therapy documentation revealed that the Physical Therapy Assistant (PTA) that had worked with the resident (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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(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 - Actual harm Residents Affected - Few	was distraught, as she heard a pop sound while doing therapy on the patient. Additionally, the report revealed that the PTA did not properly follow the plan of care for Resident ID #1, as the plan of care did not have a goal or directive to rotate the resident's left hip. Furthermore, the report revealed that it was when the resident's left hip was being rotated, that the resident sustained the femur fracture to his/her left leg. During surveyor interviews with the Certified Occupational Therapy Assistant (COTA) in the presence of the Administrator on 6/11/2026 at approximately 12:00 PM, she indicated that she reviewed the incident and all documentation regarding the resident's plan of care lacked sufficient information which left room for the PTA to interpret what the expected exercises were that should have been conducted with the resident. She further indicated that it is out of the scope of practice for a PTA to interpret a plan of treatment and would have expected the PTA to seek clarification prior to conducting the exercises. During an interview conducted with the Administrator on 6/11/2026 at approximately 12:30 PM, he confirmed that the facility implemented corrective actions following the incident, including staff education and personnel actions, and that these measures had been implemented prior to the survey.a. The Physical Therapy Assistant (PTA) involved in the resident's care was suspended pending the outcome of the facility's investigation.b. Education was provided to all therapy staff regarding adherence to residents' plans of care, including the requirement to follow prescribed treatment interventions and seek clarification when treatment directives are unclear.This deficient practice resulted in a severe and avoidable injury to a highly vulnerable resident who was nonverbal and unable to advocate for him/herself. The facility's own investigation determined that a Physical Therapy Assistant performed a left hip rotation exercise that was not included in the resident's plan of care and was outside the PTA's authority to independently interpret. During the unauthorized maneuver, a pop was reportedly heard, and the resident subsequently sustained a left femoral fracture requiring hospital evaluation. Despite the resident's significantly limited left hip range of motion and complex neurological impairments, the facility failed to ensure that therapy services were provided in accordance with the treatment plan and accepted professional standards of practice. This failure exposed the resident to actual harm and demonstrates a serious breakdown in clinical oversight, care planning, and the delivery of rehabilitative services.