

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/20/2026
NAME OF PROVIDER OR SUPPLIER West View Nursing Home, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 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 resident and staff interviews, the facility failed to ensure services were provided in accordance with professional standards for 1 of 1 resident reviewed, Resident ID #1. Specifically, the facility failed to implement physician's orders for prescribed medications following two separate hospital discharges, including a hydrocortisone enema (a medication prescribed to treat rectal inflammation) and Veltassa (a potassium binder prescribed to treat elevated potassium levels). These repeated failures resulted in the resident missing multiple doses of hydrocortisone enemas, experiencing worsening pain, and suffering a relapse of symptoms requiring rehospitalization. The resident also missed two doses of prescribed Veltassa following the second hospital discharge despite having a critically elevated potassium level of 6.1 documented on 7/16/2026. Findings are as follows: Record review of a community complaint submitted to the Rhode Island Department of Health on 7/16/2026 alleged that the complainant's spouse was readmitted to the facility on [DATE] with a physician's order for a steroid enema twice daily for three weeks. The complaint stated that the spouse met with facility staff on 7/9/2026 to confirm the medication would be available upon readmission. However, after the resident returned on 7/10/2026, the medication was not available, resulting in missed doses from 7/10/2026 through the morning of 7/13/2026. The complaint further alleged that the resident experienced uncontrolled pain and required a transfer back to the hospital. 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 the physician's orders unless they believe that the orders are in error or would harm the clients. Record review revealed the resident was readmitted to the facility on [DATE] with diagnoses including, but not limited to, noninfective gastroenteritis (inflammation of the stomach), colitis (inflammation of the large intestine), and dependence on renal dialysis (a treatment that filters waste and excess fluids from your blood when your kidneys can no longer do so). Record review of an Annual Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status score of 15 of 15, indicating the resident is cognitively intact. 1. Record review of a hospital document titled, Continuity of Care Adult discharge date d 7/10/2026, revealed a physician's order for Hydrocortisone 100 milligrams (mg)/60 milliliters (ml) enema to be administered twice daily. Record review revealed a physician's order for Hydrocortisone 100 mg/60 ml enema to be administered twice daily for 18 days. Record review of the July 2026 Medication Administration Record (MAR) failed to reveal evidence that the Hydrocortisone rectal enema was administered to the resident on the following dates and times: -7/10/2026- PM dose-7/11/2026-AM and PM dose-7/12/2026- AM and PM dose-7/13/2026-AM dose Record review of a nursing progress note dated 7/11/2026 indicated the Hydrocortisone enema was not going to be delivered to the facility until 7/13/2026. Record review of the resident's pain assessments and progress notes revealed that the resident reported on a scale of (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 - Actual harm Residents Affected - Few	1-10, moderate to severe rectal pain, on the following dates:-7/10 at 8:09 PM, pain score of 6-7/12 at 7:19 PM, pain score of 5-7/13 at 9:26 AM, pain score of 8-7/13 at 12:58 PM, pain score of 8 -7/13 at 3:45 PM, pain score of 7 -7/14 at 4:03 PM, pain score of 6Record review of the nursing progress notes revealed the following:-7/12/2026 at 11:09 PM, the resident was observed pale in color, feeling weak and fatigued. Additionally, the Hydrocortisone enemas had yet to be delivered from the pharmacy.-7/13/2026 at 10:48 PM, the resident continued to complain of rectal discomfort and was administered an as needed pain medication, Oxycodone 5 mg, with fair effect.-7/14/2026 at 4:36 PM, the resident was complaining of severe pain and that the pain medications were not working. The resident requested to be transferred to the hospital.Record review of the hospital documentation revealed the resident was experiencing persistent pain and fever, and due to the resident missing several hydrocortisone enemas, s/he experienced a relapse in symptoms. Further review revealed that once the resident began receiving the steroid enemas, his/her pain and fever resolved.During a surveyor interview with the resident on 7/20/2026 at 11:30 AM, s/he revealed that s/he was readmitted to the facility on [DATE] from the hospital. Additionally, s/he revealed the facility failed to administer the Hydrocortisone enemas to him/her as ordered; s/he had only been administered one dose. S/he further stated that s/he requested to be transferred to the hospital due to experiencing uncontrollable rectal pain.2. Record review revealed the resident was discharged from the hospital and re-admitted to the facility on [DATE].Record review of hospital documentation revealed a progress note that revealed on 7/16/2026 at 6:45 AM, the resident's potassium level was critically high at 6.1 (a normal range 3.6-5.2) and a repeated level was obtained at 9:21 AM and indicated that it was still elevated at 5.7.Record review of a hospital document titled, Continuity of Care Adult discharge date d 7/18/2026, revealed a physician's order for Veltassa 8.4 grams daily. Record review revealed a physician's order dated 7/19/2026 for Veltassa to be administered once a day.Review of the July 2026 MAR failed to reveal evidence that the resident received the Veltassa as ordered on 7/19 and 7/20/2026.During a surveyor interview with the resident on 7/20/2026 at 11:30 AM, s/he revealed that after being discharged from the hospital on 7/18/2026, s/he was prescribed Veltassa and s/he had not received the Veltassa on 7/19 or on 7/20/2026, because it has not been delivered by the pharmacy.During a surveyor interview on 7/20/2026 at 12:03 PM with Certified Medication Technician, Staff A, she acknowledged that she did not administer the Veltassa to the resident on 7/20/2026 because it was not available. Staff A revealed that she documented a code of 12, which indicates the facility is waiting for the pharmacy to deliver the medication, because the medication was not available at the time of administration.During a surveyor interview on 7/20/2026 at 12:15 PM with the Director of Nursing Services, in the presence of the Administrator, she acknowledged that the resident did not receive the Hydrocortisone enemas as ordered. Additionally, she revealed that she was unaware the resident had not received Veltassa on 7/19 and 7/20/2026, until it was brought to her attention by the surveyor.During a surveyor interview on 7/20/2026 at 1:00 PM with the Nurse Practitioner, she revealed that she was not notified that the resident missed his/her Hydrocortisone enemas on 7/10, 7/11, 7/12, and the morning dose of 7/13/2026. She further indicated that she would have expected the facility staff to contact the on-call physician to notify them that the medication was not available or to arrange for the resident to return to the hospital, if necessary. Additionally, she revealed that she was unaware that the resident did not receive the prescribed Veltassa. The facility's failure to ensure the resident's Hydrocortisone enemas were available upon his/her readmission to the facility, resulted in Resident ID #1 experiencing moderate to severe rectal pain and required rehospitalization as a result.		