

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 03/26/2026
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observation, record review, and staff interview, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety relative to the main kitchen and the satellite kitchenette. Findings are as follows: 1. Record review of the 2022 Food Code published by the U.S. Food and Drug Administration Section 4-501.114 reads in part, a chemical Sanitizer used in a SANTIZING solution for a manual operation shall meet the criteria specified (C) A quaternary ammonium compound shall (2) have a concentration as indicated by the manufacturer's use by directions. Record review of manufacturer's directions for the use of a quaternary ammonium solution as a sanitizer recommends the pH (a measure to determine the acidity or basicity of a solution based on the number of hydrogen ions in the solution) level should read between 200 and 400 PPM (parts per million). During a surveyor observation on 3/22/2026 at approximately 9:00 AM, of the main kitchen, the 3-bay sink was being used to wash and sanitize pots and pans. The test strip used to test the sanitizing solution failed to register a pH level, indicating the pots and pans were not being sanitized. During a surveyor interview immediately following the above observation with the Director of Food Service (FSD), he revealed that the sanitizing agent used is a quaternary ammonium and that the pH level of the sanitizing solution did not register the appropriate reading. During a surveyor observation on 3/23/2026 at approximately 11:10 AM, of the main kitchen, revealed a sanitizing container that held a wet cloth. The test strip that was used to test the sanitizing solution failed to register a pH level. During a surveyor interview immediately following the above-mentioned observation with the FSD, he acknowledged that the sanitizing solution did not register a pH level. 2. Review of the 2022 Food Code published by the U.S Food and Drug Administration Section 4-602.11(A) states in part, Equipment food-contact surfaces and utensils shall be cleaned (4) Before using or storing a FOOD TEMPERATURE MEASURING DEVICE. During a surveyor observation on 3/26/2026 at approximately 11:45 AM, Dietary Cook, Staff F, was observed taking a thermometer from his pant pocket and inserted the thermometer into a slice of pizza to test its temperature. Additionally, Staff F failed to clean the thermometer before he took the temperature of the pizza. 3. Review of the 2022 Food Code published by the U.S. Food and Drug Administration Section 4-601.11 (C) reads in part, .non-contact surfaces of equipment shall be free of an accumulation of .other debris .During a surveyor observation on 3/22/2026 at approximately 8:45 AM, of the main kitchen, the following was observed: grease spills along the sides of the fryolator lower shelves of worktables with food crumbsthree food carts with food crumbs on the shelvesfive food transport carts with debris noted along the lower rim and cornersDuring a surveyor observation on 3/22/2026 at approximately 9:00 AM, of the satellite kitchenette, the following was revealed:[NAME] Air refrigerator unit with dried food spills along the sides and the refrigerator door gaskets had significant build-up of a black substance. 4. Review of the 2022 Food Code published by the U.S Food and Drug Administration Section 6-101(A) reads in part, .materials for indoor floor, wall shall be.EASILY CLEANABLE for areas where FOOD ESTABLISHMENT operations are conducted. During a surveyor observation on 3/22/2026 at approximately 8:45 AM of the main kitchen, the following was (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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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>observed:The walls that surround the dish room area had noticeable streaks of a black substanceThe floors behind all kitchen equipment, stove, fryolator, and reach in refrigerators had a buildup of black colored grimeThe corners of the floors had a buildup of a black colored grimeDust accumulation was noted along the piping behind the stoveDuring a surveyor interview immediately following the above-mentioned observation with the FSD, he acknowledged the black grime in the corners of the floor and behind the mentioned appliances. He also acknowledged the dust accumulation along the pipe behind the stove. 5. Review of the 2022 Food Code published by the U.S Food and Drug Administration Section 2-402.11 (A) states in part, FOOD EMPLOYEES shall wear hair restraints.that are designed and worn to effectively keep their hair from contacting exposed FOOD, clean EQUIPMENT, UTENSILS.During surveyor observations of the satellite kitchenette, on the following dates and times, Dietary Aide, Staff G, was serving food for residents in the main dining room and she was noted to be wearing a hair net, which failed to cover the front portion of her hair:3/23/2026 at 11:30 AM3/24/2026 at 11:45 AM3/25/2026 at 11:45 AM3/26/2026 at 11:50 AMDuring a surveyor interview on 3/26/2026 at approximately 11:50 AM with the FSD, he acknowledged the equipment that needed cleaning, the cook who failed to sanitize the thermometer before testing the temperature of the pizza and the dietary aide who was not wearing her hair restraint appropriately.</p>		

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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, and staff and resident interviews, the facility failed to allow a resident to participate in his or her treatment for 1 of 2 residents reviewed, relative to the resident requesting a hospital transfer, Resident ID #25. Findings are as follows:Review of a facility policy titled, Resident Rights last revised 3/2017 states in part, .Respect the right of the resident/patient and/or their designated representative to participate in and make healthcare decisions.Record review revealed that the resident was admitted to the facility in September of 2025 with diagnoses including, but not limited to, chronic respiratory failure and anxiety.Review of a Quarterly Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status score of 10 of 15 indicating moderate cognitive impairment.Review of a progress note dated 3/19/2026 revealed that the resident complained of chest pain and was medicated with nitroglycerin (a medication prescribed to prevent or treat chest pain) 0.4 milligrams without any relief. Additionally, the note revealed that the resident requested to go to the hospital. Further review revealed that the resident was treated with oxycodone (a pain medication) and clonazepam (an antianxiety medication), and the resident fell asleep. Finally, the progress note revealed that the resident was not transferred to the hospital.Review of a progress note dated 3/20/2026 revealed that the resident was angry that s/he did not get sent to the hospital the previous day as requested.During a surveyor interview on 3/25/2026 at 10:16 AM with the resident, s/he revealed that recently s/he had bad chest pain and asked to go to the hospital. Additionally, s/he revealed a nurse told him/her that s/he would not be transferred to the hospital.During a surveyor interview on 3/25/2026 at 1:26 PM with Registered Nurse, Staff A, she acknowledged that the resident complained of chest pain, requested to be transferred to the hospital and was not sent. Additionally, Staff A revealed that she did not notify the doctor of the resident's request to go to the hospital.During a surveyor interview on 3/25/2026 at 10:56 AM with the Director of Nursing Services she acknowledged that the resident was not sent to the hospital at his/her request. Additionally, she acknowledged that the resident's rights were not observed per the facility policy or the regulation.During a surveyor interview on 3/26/2026 at 9:45 AM with Physician, Staff B, he revealed that the resident should have been transferred to the hospital at his/her request.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>Based on surveyor observation, clinical record review, and staff interview, the facility failed to ensure that services provided by the facility meet professional standards of quality relative to following physician's orders for 1 of 2 residents observed for wound care, Resident ID #4. Findings are as follows: Review of an undated facility policy titled, Clean Dressing Technique states in part, PROCEDURE: 1. Check the physician order for current, correct treatment. Record review revealed Resident ID #4 was readmitted to the facility in August of 2025 with a diagnosis including, but not limited to, brain damage. Record review revealed s/he has a wound to his/her right thumb and is followed by a wound specialist. Review of a physician's order dated 3/2/2026 indicated to cleanse his/her right thumb with wound cleanser, pat dry, apply skin prep to the perimeter of the wound, then apply calcium alginate with silver (an antibiotic treatment) to the wound bed, and to cover with a foam dressing daily and as needed. During a surveyor observation on 3/24/2026 at 10:06 AM of the resident's right thumb dressing change, Registered Nurse (RN), Staff C, failed to apply the calcium alginate with silver as ordered. During a surveyor interview immediately following the above observation with Staff C, she acknowledged that she failed to apply the calcium alginate with silver as ordered. During a surveyor interview on 3/24/2026 at 1:20 PM with the Director of Nursing Services, she revealed that she would expect the physician's order to be followed.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>Based on clinical record review and staff interview, the facility failed to ensure that resident records are complete and accurately documented for 1 of 1 resident reviewed for hemodialysis (a treatment that removes excess fluid, waste, and toxins from the blood when the kidneys are no longer functioning properly), Resident ID #39. Findings are as follows: 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 physician's orders unless they believe the orders are in error or would harm the clients." Record review revealed the resident was readmitted to the facility in January of 2026 with diagnoses including, but not limited to, end stage renal disease and dependence on renal dialysis. Record review revealed the resident was on a 1500 milliliter fluid restriction daily. Further record review revealed a physician's order dated 2/4/2026 to total the 24-hour fluid intake, which is to be completed on third shift between 11:00 PM to 7:00 AM. Review of the March 2026 Licensed Nurse Administration Record revealed the resident's daily fluid intake was not accurately totaled, for 24 out of 24 opportunities, until this concern was brought to the facility's attention by the surveyor. During a surveyor interview on 3/25/2026 at 9:59 AM with Licensed Practical Nurse, Staff H, she acknowledged the above order and acknowledged that the amounts documented do not accurately reflect the resident's 24-hour fluid intake. During a surveyor interview on 3/25/2026 at 10:53 AM, with the Director of Nursing Services, she acknowledged the inaccurate documentation and revealed that she would expect third shift nurses to accurately calculate the residents' total 24-hour fluid intake. Record review revealed a physician's order dated 3/25/2026, after this concern was brought to the facility's attention by the surveyor, which states to Add all fluid intake for all 3 shifts document total for 24 hours.</p>		