STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415082	A. Building B. Wing	11/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverview Healthcare Community	546 Main Street Coventry, RI 02816

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect 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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident representative, and staff interviews, it has been determined that the facility failed to immediately consult with the resident's physician and inform the resident's representative when there was a change in condition for 1 of 3 residents reviewed, who was sent to the hospital and required emergency services, Resident ID #1.Findings are as follows:Review of a community reported complaint submitted to the Rhode Island Department of Health on 11/24/2025, alleges that Resident ID #1 was sent to the hospital on [DATE] with Resident ID #2's medical record.Record review revealed Resident ID #1 was admitted to the facility in June of 2023, with diagnoses including, but not limited to, chronic obstructive pulmonary disease and congestive heart failure (a chronic condition where the heart can't pump enough blood to meet the body's needs, leading to blood and fluid backing up in the body).Record review revealed Resident ID #2 was admitted to the facility in October of 2024, with diagnoses including, but not limited to, type II diabetes and chronic kidney disease.Review of a RI [Rhode Island] EMS [Emergency Medical Services] Patient Care Report dated 11/23/2025 revealed that they were dispatched to a nursing facility for report of a patient with altered mental status. Per the report when EMS arrived the resident (Resident ID #1) was short of breath, had sputum coming from his/her nose and mouth, and was unable to follow commands or keep his/her head up. Additionally, the report revealed that EMS transferred the resident to the hospital. Further review revealed that approximately 2 hours following the transfer, the hospital alerted them that the nursing facility had given them the incorrect patient identifiers and medical record.Record review of a late entry in Resident ID #1's medical record dated 11/23/2025 at 6:57 PM revealed a progress note that Resident ID #1 was significantly altered from baseline, unable to hold his/her head up, producing excessive sputum, and had cool skin.However, a review of Resident ID #2's medical record revealed a progress note and physician order directing Resident ID #2 to be sent to the hospital due to a change in condition. Although, record review confirmed that Resident ID #1 not Resident ID #2 was the resident experiencing the actual change in condition.Review of a progress note for Resident ID #1 dated 11/23/2025 at 6:58 PM further revealed, the resident was admitted to the hospital's Intensive Care Unit and would require intubation (the insertion of a tube either through the mouth or nose and into the airway to aid with breathing).Record review for Resident ID #1 failed to reveal evidence of a physician's order authorizing a transfer to the hospital. The record also did not indicate that Resident ID #1's provider was notified of the resident's change in condition; instead, the facility contacted the on-call provider for Resident ID #2. Additionally, the record did not indicate that Resident ID #1's representative was informed of the transfer to the hospital.During a surveyor interview on 11/25/2025 at 9:43 AM with Resident ID #2's next of kin, s/he stated that s/he received a phone call from the hospital informing her/him that Resident ID #2 had been admitted . S/he reported that the facility had not notified her/him that her/his relative was being sent to the hospital, prompting her/him to call the facility for clarification. When s/he contacted the facility, s/he was told that her/his relative was fine and eating Chinese food.During a surveyor interview on 11/25/2025 at 8:56 AM with Licensed Practical Nurse, Staff A, she acknowledged that at 2:35 PM she notified Resident ID #2's on-call provider about a change in condition, instead of notifying the provider for Resident ID #1, who was the resident actually experiencing the change. This indicates she contacted the wrong provider for the wrong resident. She further stated that she did not notify Resident ID #1's resident representative that the resident had been sent to the hospital.During surveyor interviews on 11/25/2025 at approximately 1:00 PM and 11/26/2025 at approximately 12:15 PM, with the Director of Nursing Services and the Administrator, they were unable to provide evidence that the facility immediately consulted with the resident's physician and informed the resident's representative when there was a change in condition. The facility notified Resident ID #2's provider and not Resident ID #1's provider of the change in condition and failed to inform the resident's representative for Resident ID #1 of their transfer to the hospital.Cross reference F 628 and F 726

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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 0628 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. (continued on next page)

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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 0628 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident representative and staff interview, the facility failed to ensure that accurate and appropriate information was communicated to the receiving health care provider during an emergent discharge for Resident ID #1. When Resident ID #1 experienced a change in condition requiring emergency transfer to an acute care facility, Licensed Practical Nurse (LPN), Staff A, incorrectly identified the resident. As a result, Resident ID #1 was transferred with another resident's identifiers and medical record, placing Resident ID #1 at risk for delayed and/or inappropriate treatment.Findings are as follows:Review of a community reported complaint submitted to the Rhode Island Department of Health on 11/24/2025, alleges that Resident ID #1 was sent to the hospital on [DATE] with Resident ID #2's medical record.Record review revealed Resident ID #1 was admitted to the facility in June of 2023, with diagnoses including, but not limited to, chronic obstructive pulmonary disease and congestive heart failure (a chronic condition where the heart can't pump enough blood to meet the body's needs, leading to blood and fluid backing up in the body). Record review revealed Resident ID #2 was admitted to the facility in October of 2024, with diagnoses including, but not limited to, type II diabetes and chronic kidney disease.Review of a RI [Rhode Island] EMS [Emergency Medical Services] Patient Care Report dated 11/23/2025, revealed that they were dispatched to a nursing facility for a patient with an altered mental status. Per the report, when EMS arrived, the resident was short of breath, had sputum coming from his/her nose and mouth, and was unable to follow commands or keep his/her head up. Additionally, the report revealed EMS transferred the resident to the hospital. Further review revealed that approximately 2 hours following the transfer, the hospital alerted them that the nursing facility had given them the incorrect patient identifiers and medical record.Record review of a late entry in Resident ID #1's medical record dated 11/23/2025 at 6:57 PM, revealed that Resident ID #1 was significantly altered from baseline, unable to hold his/her head up, producing excessive sputum, and had cool skin.However, a review of Resident ID #2's medical record revealed a progress note and physician order directing Resident ID #2 to be sent to the hospital due to a change in condition. Although, record review confirmed that Resident ID #1 not Resident ID #2 was the resident experiencing the actual change in condition.Review of a progress note for Resident ID #1 dated 11/23/2025 at 6:58 PM further revealed that the resident was admitted to the hospital's Intensive Care Unit and would require intubation (the insertion of a tube either through the mouth or nose and into the airway, to aid with breathing).During a surveyor interview on 11/25/2025 at 9:43 AM with Resident ID #2's representative, s/he revealed that s/he received a telephone call from the hospital on [DATE]. Per the representative, the hospital revealed that Resident ID #2 was admitted to the hospital and would require life support and intubation. The hospital was requesting consent from the representative for the procedure. S/he revealed that the hospital asked if this was something that Resident ID #2 would want, and she responded no.Review of the emergency room admission documentation revealed that Resident ID #1 arrived at 3:47 PM registered under a different name and date of birth . EMS had been provided the incorrect identifiers by the facility for transport. Because Resident ID #1 was obtunded (decreased consciousness) and in respiratory distress on arrival, s/he was unable to correct the information. Documentation showed that medical care, including testing, was conducted under the wrong identity for approximately two hours.During a surveyor interview on 11/25/2025 at 10:17 AM with the Director of Nursing Services (DNS), she acknowledged that the wrong patient 's medical record was sent with Resident ID #1 to the hospital. Additionally, she revealed that Resident ID #1 has a history of respiratory distress requiring intubation. Furthermore, she indicated, to her knowledge the family of Resident ID #1 would have consented to intubation if they had been contacted.The facility's failure to send accurate medical records and patient identifiers during an emergent transfer placed Resident ID #1 at risk for delayed and/or inappropriate treatment. Given the resident's known history of severe respiratory compromise, this error had the potential to result in serious harm, injury, impairment, or death.Cross-reference F 726

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on record review and staff interview, the facility failed to implement a comprehensive person-centered care plan for each resident, to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment for 2 of 3 residents reviewed for falls and for transferring and lifting needs, Resident ID #s 2 and 3.Findings are as follows:Review of a community reported complaint submitted to the Rhode Island Department of Health on 10/23/2025 alleged that patient safety is at risk and that patients fall frequently at the facility.Review of an undated facility policy titled Safe Patient Handling [SPH] - RI, states in part, In order to protect the safety and well-being of staff and residents, and to promote quality of care, this facility uses appropriate techniques and devices to lift patients.Nursing staff, in conjunction with the rehabilitation staff, shall assess individual residents' needs for transfer assistance on an ongoing basis. Staff will document resident transferring and lifting needs in the care plan.1. Record review revealed Resident ID #2 was admitted to the facility in October of 2024, with diagnoses including, but not limited to, type II diabetes, and chronic kidney disease.Record review revealed a progress note dated 11/12/2025, revealed that Resident ID #2 had a fall at 10:40 AM while a Nursing Assistant (NA) and a student were transferring the resident to his/her chair.Record review of Resident ID #2's care plan revealed an intervention dated 6/8/2023 that the resident utilizes a transfer (gait) belt and two staff members for assistance with transfers. On 11/21/2024 the care plan indicated that Resident ID #2 requires a total mechanical lift, and two staff members for assistance with transfers. These interventions contain conflicting information regarding the resident's transfer needs.Record review of Resident ID #2's Kardex (a tool utilized to communicate the needs of a resident) revealed that the resident utilizes a transfer (gait) belt and two staff members for assistance with transfers using a stand and pivot technique and that Resident ID #2 requires a total mechanical lift, with two staff members for assistance with transfers. These interventions contain conflicting information regarding the resident's transfer needs.Record review of a physician's order dated 11/24/2024, revealed that the resident requires the assist of two staff members using a stand and pivot transfer with a gait belt.Record review of a Safe Patient Handling (SPH) Evaluation dated 8/25/2025 revealed that Resident ID #2 requires one staff member to assist with transfers using a gait belt.Record review of the NA unit assignment for 11/26/2025 revealed, Resident ID #2 is a one staff member assist.During a surveyor interview on 11/26/2025 at 10:04 AM, with Licensed Practical Nurse, Staff B, she revealed that there is a physician's order in each resident's medical record as to how each resident is to transfer. Additionally, she revealed that the NAs have assignments that indicate how the staff is to transfer each resident. Furthermore, she acknowledged that Resident ID #2s physician's order states that the resident requires the assist of staff members with a stand and pivot transfer using a gait belt, while the NA assignment states that Resident ID #2 is a one staff member assist. She was unable to provide evidence the communication ensuring that transfer information is consistently and accurately documented to promote safe resident transfers.During a surveyor interview on 11/26/2025 at 10:19 AM, with NA, Staff C, she revealed that she was assigned to care for Resident ID #2 and when she was helping him/her transfer out of bed to his/her chair today she utilized two staff members. She revealed that the assignments were up to date and that the resident is a two person assist for transfers.2. Record review revealed Resident ID #3 was admitted to the facility in March of 2024, with diagnoses including, but not limited to, type II diabetes and muscle weakness.Record review of a physician's order dated 8/27/2025 revealed, the resident requires the assist of two staff members with a gait belt for transfers.Record review of Resident ID #3's care plan revealed an intervention dated 8/10/2025 that the resident needs supervision for ambulation and uses a walker.Record review of Resident ID #3's Kardex revealed, the resident needs supervision for ambulation and utilizes a walker.Record review of a Safe Patient Handling (SPH) Evaluation dated 11/19/2025 revealed, Resident ID #3 requires a mechanical lift, and two staff members for transfers.Record review of the Nursing Assistants (NA) unit assignment for 11/26/2025 revealed, Resident ID #3 requires the use of two staff members using a gait belt.During surveyor interviews on 11/26/2025 at 11:28 AM and 11:48 AM with the 2nd floor Unit Manager, she revealed that each resident has an assessment that is completed for their SPH, and it is then reflected on the NA's assignments. She revealed that the nurse on the floor or NA who is handing out the assignments should be responsible for updating the SPH on the assignments. Additionally, she acknowledged that Resident ID #3's SPH does not match on all forms of communication mentioned above and that Resident ID# 3's information should all match.During surveyor interviews on 11/26/2025 at 10:40 AM and 11:44 AM with the Director of Nursing

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure that licensed nurses possessed the necessary competencies and skills to meet resident needs. When Resident ID #1 experienced a change in condition requiring emergency transfer to an acute care facility, Licensed Practical Nurse (LPN), Staff A, incorrectly identified the resident. Consequently, Resident ID #1 was transferred with another resident's identifiers and medical record, placing Resident ID #1 at risk for delayed and/or inappropriate treatment.Findings are as follows:Review of a facility policy titled, Acute Condition Changes-Clinical Protocol dated March 2018, states in part, .before contacting a physician about someone with an acute change of condition, the nursing staff will collect pertinent details to report to the physician: for example, the history of present illness and previous or recent test results for comparison. Phone calls to attending or on-call physicians should be made by an adequately prepared nurse who has collected and organized pertinent information, including the resident/patient's current symptoms and status.Review of a community reported complaint submitted to the Rhode Island Department of Health on 11/24/2025, alleges that Resident ID #1 was sent to the hospital on [DATE] with Resident ID #2's medical record.Record review revealed Resident ID #1 was admitted to the facility in June of 2023, with diagnoses including, but not limited to, chronic obstructive pulmonary disease and congestive heart failure (a chronic condition where the heart can't pump enough blood to meet the body's needs, leading to blood and fluid backing up in the body).Record review revealed Resident ID #2 was admitted to the facility in October of 2024, with diagnoses including, but not limited to, type II diabetes and chronic kidney disease.Review of a RI [Rhode Island] EMS [Emergency Medical Services] Patient Care Report dated 11/23/2025 revealed that they were dispatched to a nursing facility for a patient with altered mental status. Per the report, when EMS arrived, the resident was short of breath, had sputum coming from his/her nose and mouth and was unable to follow commands or keep his/her head up. Additionally, the report revealed EMS transferred the resident to the hospital. Further review revealed that approximately 2 hours following the transfer, the hospital alerted them that the nursing facility had given them the incorrect patient identifiers and medical record.Record review of a late entry in Resident ID #1's medical record dated 11/23/2025 at 6:57 PM, revealed that Resident ID #1 was significantly altered from baseline, unable to hold his/her head up, producing excessive sputum, and had cool skin.However, a review of Resident ID #2's medical record revealed a progress note and physician order directing Resident ID #2 to be sent to the hospital due to a change in condition. Although, record review confirmed that Resident ID #1 not Resident ID #2 was the resident experiencing the actual change in condition.Review of a progress note for Resident ID #1 dated 11/23/2025 at 6:58 PM further revealed that Resident ID #1 was admitted to the hospital's Intensive Care Unit and would require intubation (the insertion of a tube either through the mouth or nose and into the airway, to aid with breathing).Record review revealed LPN, Staff A, reported to an on-call provider that Resident ID #2 was having a change in condition and not Resident ID #1. Record review failed to reveal evidence that Staff A reported to Resident ID #1's provider that s/he had a change in condition and required emergent transfer to the hospital.During a surveyor interview on 11/25/2025 at 8:56 AM with Staff A, she revealed that she did report to an on-call provider at 2:35 PM that Resident ID #2 was having a change in condition, not Resident ID #1, who was the actual resident who required the notification of change and emergent transfer. Additionally, she revealed that she sent Resident ID #2s medical record at the time of transfer with the EMS to the hospital. Per Staff A, she realized at approximately 5:30 PM, that she sent the wrong medical record with Resident ID #1, indicating that for approximately 2 hours the hospital was treating Resident ID #1 as if s/he was Resident ID #2. Furthermore, Staff A revealed that she did not call the hospital to give a verbal report on the resident she transferred to the hospital at the time of the transfer.During a surveyor interview on 11/25/2025 at 10:17 AM with the Director of Nursing Services, she acknowledged that the wrong resident's medical record was sent with Resident ID #1 to the hospital. Additionally, she was unable to provide evidence that LPN, Staff A was competent with the Acute Condition Changes-Clinical Protocol when she transferred Resident ID #1 to the hospital with the wrong medical record or when reporting a change in condition to the wrong provider about the wrong resident.The facility's failure of Staff A to send accurate medical records and patient identifiers during an emergent transfer placed Resident ID #1 at risk for delayed and/or inappropriate treatment. Given the resident's known history of severe respiratory compromise, this error had the potential to result in serious harm, injury, impairment, or death.Cross