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	06/17/2026

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that residents are free from significant medication errors. **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 residents were free from significant medication errors for 1 of 1 resident reviewed. The facility failed to ensure Resident ID #1's identity was verified prior to medication administration, resulting in Resident ID #1 allegedly receiving insulin prescribed for Resident ID #3. The facility's failure to follow medication administration practices, including verifying the resident's identity prior to medication administration, placed Resident ID #1 at risk for serious injury, serious impairment, serious harm or death. Findings are as follows:Record review of a community reported complaint received by the Rhode Island Department of Health on 6/11/2026 alleges that Resident ID #1 was administered 10 units of insulin by the nurse and that the nurse also attempted to administer two other medications not prescribed to him/her, and she did not verify his/her name prior to administering the insulin injection. Furthermore, the complaint indicates that Resident ID #1 is not prescribed insulin. According to the facility policy titled Administering Medications, states in part, Medications are administered in a safe and timely manner, and as prescribed .9. The individual administering medications verifies the resident's identity before giving the resident his/her medication. Methods of identifying the resident include: a. checking identification band; b. checking photograph attached to medical record; and c. if necessary, verify resident identification with other facility personnel. 10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication . According to the manufacturer's instructions for Insulin Lispro, states in part, Lispro is a rapid acting human insulin analog indicated to improve glycemic control in adult and pediatric patients with diabetes mellitus. This insulin has a rapid onset of glucose-lowering activity as well as a shorter duration of action. When used as mealtime insulin, the dose of insulin should be given within 15 minutes before or immediately after a meal. Peak serum levels (the highest concentration of the insulin in your blood) for Lispro insulin are seen 30 to 90 minutes after dosing. Hypoglycemia (low blood sugar) is one of the most frequent adverse events experienced by insulin users, which can be brought about by missing or delaying meals, taking too much insulin, an infection or illness. Symptoms of mild to moderate hypoglycemia may occur suddenly and include, but are not limited to dizziness, lightheadedness, restlessness and anxiety. Record review revealed Resident ID #1 was admitted to the facility in June of 2026 with a diagnosis including, but not limited to, type 2 diabetes mellitus with hyperglycemia (a metabolic condition when the body can't use insulin correctly and sugar builds up in the blood).Record review of Resident ID #1's admission Minimum Data Set assessment dated [DATE], revealed a Brief Interview for Mental Status score of 15 out of 15, indicating s/he is cognitively intact.Record review failed to reveal evidence that Resident ID #1 had an order for insulin.Record review revealed Resident ID #3 was admitted to the facility in January of 2026 with a diagnosis including, but not limited to, type 1 diabetes mellitus (an autoimmune disease where the body's immune system attacks and destroys the insulin-producing cells in the pancreas).Record review revealed the following physician's orders for Resident ID #3:-4/23/2026, check FSBG levels before each meal and at bedtime every day.-4/26/2026, Insulin Lispro Pen-injector 100 unit/milliliter, inject 10 units subcutaneously before (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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The resident told Staff A that s/he does not have seizures and is prescribed a low sodium diet. Staff A then asked the resident if his/her name was that of another resident who resides in the room across the hall from him/her, Resident ID #3. The resident revealed that when she told Staff A that that was not his/her name, Staff A left the room; the resident then put his/her call light on to inform staff of what had transpired with Staff A and that s/he had been administered insulin in error. The resident stated that after s/he received the insulin s/he ate the dinner meal and had candy. Record review of Resident ID #1's blood glucose levels revealed the following:-5:00 PM = 192-6:10 PM = 185-6:30 PM = 148-7:00 PM = 172-7:42 PM = 152-8:05 PM = 112-8:30 PM = 112-8:51 PM = 114-9:05 PM = 114-9:35 PM = 114During a surveyor interview on 6/12/2026 at 12:32 PM with Registered Nurse, Staff A, she revealed that she entered Resident ID #1's room to administer medications to the roommate. While in the room, Resident ID #1 attempted to speak with her, and Staff A believed s/he stated a first name matching that of Resident ID #3, who resided across the hall. Staff A stated that she left the room and searched the electronic medical record (EMR) using the name she believed she heard, identifying Resident ID #3. She revealed that Resident ID #3 was prescribed multiple medications, including Insulin Lispro, Keppra (a medication used to treat seizures), and a sodium tablet (a medication used to treat low sodium levels). Staff A stated that she removed these medications from the medication cart, returned to Resident ID #1's room, and explained the medications she intended to administer. According to Staff A, Resident ID #1 questioned why s/he was receiving Keppra and sodium tablets, stating that s/he did not take those medications. Staff A stated that, at that point, she stepped back and asked Resident ID #1 to identify himself/herself because she believed she may have the wrong resident.Staff A acknowledged that she failed to verify Resident ID #1's identity using any of the resident identifiers required by facility policy prior to accessing the EMR or preparing medications. Instead, she relied solely on the first name she believed she heard Resident ID #1 state, which led her to access Resident ID #3's medical record and prepare Resident ID #3's prescribed medications. Staff A acknowledged that the medications she prepared, including Insulin Lispro, Keppra, and a sodium tablet, were prescribed for Resident ID #3. Staff A denied administering the insulin injection or any of the prepared oral medications to Resident ID #1. During a surveyor interview on 6/12/2026 at 1:47 PM with Unit Manager, RN, Staff B, she revealed that on the evening of 6/10/2026 at approximately 6:00 PM she was informed that Staff A administered 10 units of insulin in error to Resident ID #1. Staff B further indicated that Staff A was a new orientee training with another nurse that evening, and that Staff A was administering medications to the residents while her preceptor, Staff C, was admitting a new resident. Staff B further revealed that when she spoke to Staff A regarding the administration of insulin, Staff A revealed that she had entered Resident ID #1's room in error but denied administering Resident ID #1 the insulin. Subsequently, Staff B spoke with Resident ID #1, who revealed to her that Staff A had given him/her insulin in error, and in response Staff B notified the on-call provider of the allegation, and the provider ordered for the resident's blood glucose levels to be monitored. Record review of a nursing progress note, dated 6/10/2026 at 10:14 PM and authored by Staff B, indicated that Resident ID #1 reported receiving 10 units of insulin in his/her left thigh, which s/he does not have an order for and has never taken. Resident ID #1 reported feeling lightheaded and dizzy and the on-call provider was contacted. The provider ordered to monitor the resident's blood glucose levels (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	every 30 minutes for 4 hours, via finger stick. Additionally, the note indicated that Staff B had obtained the resident's FSBG at 7:00 PM, which was 172. During a surveyor interview on 6/12/2026 at 1:02 PM with Licensed Practical Nurse, Staff C, she revealed that she was the nurse that was training Staff A on the night on 6/10/2026 and was notified that Resident ID #1 reported receiving insulin in error. When she questioned Staff A about administering insulin to Resident ID #1, she revealed that Staff A indicated that she had asked the resident where to administer the insulin, and the resident suggested his/her thigh. Staff A further stated that she put the insulin pen to the resident's leg and then asked Resident ID #1 what his/her name was, and after the resident stated what his/her name was, she took the insulin pen away and took a step back. Staff A denied administering insulin to Resident ID #1Subsequently, Staff C revealed that she spoke with Resident ID #1 about the insulin administration and the resident revealed that Staff A brought the insulin and a cup with pills to his/her room. She asked him/her where s/he takes the insulin, which the resident responded that s/he does not take insulin, but then offered to have it in his/her thigh. Staff A gave him/her the insulin and then asked him/her what his/her name was, s/he revealed his/her name and Staff A left. Additionally, Staff C revealed the resident kept pointing to his/her left thigh for Staff C to observe the insulin needle mark, but no markings were visible. Staff C further revealed that the on-call provider was notified and ordered for the resident's FSBG to be checked every 30 minutes, which was completed. During a surveyor interview on 6/16/2026 at 3:44 PM with the resident's physician, he revealed that after staff notified him of the insulin administration allegation, he came to the facility to assess the resident and s/he was doing well. The facility's failure to ensure medication administration practices, including verification of the resident's identity prior to medication preparation and administration, resulted in a significant medication error. A reasonable person, after considering the totality of the evidence, would conclude that Resident ID #1 received the 10-unit Insulin Lispro injection intended for Resident ID #3. This conclusion is supported by Resident ID #1's consistent account that Staff A obtained his/her finger-stick blood glucose, asked where s/he preferred the insulin injection, administered the injection into his/her thigh, and then attempted to administer two oral medications prescribed for Resident ID #3 before recognizing the resident identification error. Resident ID #1 immediately reported the event to staff, consistently reported the incident during multiple interviews, and subsequently developed symptoms of dizziness and lightheadedness. Although Staff A denied administering the injection, the totality of the evidence supports that the resident received insulin intended for another resident. The administration of rapid-acting insulin to a resident without a physician's order created an IJ because it caused, or was likely to cause, serious injury, serious harm, impairment, or death due to the risk of severe hypoglycemia, loss of consciousness, coma, or death.