

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415082	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/03/2025
NAME OF PROVIDER OR SUPPLIER Riverview Healthcare Community		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46338</p> <p>46539</p> <p>47279</p> <p>Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to ensure that services being provided meet professional standards of practice for 2 of 2 residents observed for wound care, Resident ID #s 33 and 77, 1 of 2 residents reviewed for the utilization of a Freestyle Libre sensor (a continuous glucose monitoring system that is designed to replace finger sticks and lessen the need for test strips for people with diabetes), Resident ID #20, 1 of 1 resident reviewed for hand splints, Resident ID #33, and 1 of 1 resident reviewed for the use of a hot pack (a pack that delivers heat to relax the muscle), Resident ID #103.</p> <p>Findings are as follows:</p> <p>1. Record review for Resident ID #77 revealed that s/he was readmitted to the facility in December of 2024 with diagnoses including, but not limited to, Methicillin Resistant Staphylococcus Aureus (MRSA, an antibiotic resistant infection) and type 2 diabetes mellitus.</p> <p>Review of the care plan revealed that the resident has bilateral foot wounds with an intervention to administer treatments, as ordered.</p> <p>Record review revealed that Resident ID #77 had increased drainage to his/her left foot on 12/23/2024 and the physician was contacted. Additionally, an order was obtained to complete the wound dressing to the resident's left foot wounds twice a day.</p> <p>Review of the resident's Minimum Data Set assessment dated [DATE] revealed a Brief Mental Status score of 15 out of 15, indicating intact cognition.</p> <p>Review of the December 2024 Treatment Administration Record (TAR) revealed the wound dressing was not changed twice a day per the physician's order on 12/24/2024, 12/29/2024 and 12/30/2024.</p> <p>(continued on next page)</p>

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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a surveyor observation and interview on 12/31/2024 at approximately 11:00 AM with Licensed Practical Nurse (LPN), Staff C and Unit Manager, Staff D, the left foot dressing was dated 12/30/2024 with the initials of LPN, Staff U. Staff C and D revealed, Staff U worked the first shift on 12/30/2024, indicating that this dressing was not changed on 12/30/2024 on the second shift, as ordered. Additionally, during this observation, the dressing had dried drainage on the outside of the dressing.</p> <p>During a surveyor interview on 12/31/2024 at approximately 11:00 AM during the dressing change with Resident ID #77, the resident revealed to the surveyor that his/her dressing should be changed twice a day and that it has not been.</p> <p>During a surveyor interview on 1/2/2025 at 1:21 PM with Nurse Practitioner, Staff B, she revealed that she would expect the dressing to be changed twice a day, per the physician's order.</p> <p>During a surveyor interview on 1/2/2025 at 1:31 PM with the Director of Nursing Services (DNS), she revealed that she would expect the dressing to have been completed twice a day, per the physician's order. Additionally, she was unable to provide evidence that the physician's order was followed on 12/24/2024, 12/29/2024 and 12/30/2024.</p> <p>2. Record review revealed Resident ID #33 was admitted to the facility in November of 2012 with a diagnosis including, but not limited to, persistent vegetative state.</p> <p>Review of the care plan revealed that the resident has a stage 4 pressure ulcer (the most severe stage, with full-thickness tissue loss and exposed bone or muscle) to his/her coccyx (tailbone) with an intervention to administer treatments, as ordered.</p> <p>Review of a physician's order dated 12/19/2024 revealed to wash his/her coccyx wound with vashe (wound cleanser) and allow it to soak for 5 minutes, followed by silvagel and calcium alginate with silver (wound treatments) followed by a silicone bordered gauze (wound dressing), twice daily.</p> <p>During a surveyor observation of the resident's wound treatment on 12/31/2024 at 11:38 AM, with LPN, Staff A, she was observed to soak the wound with vashe for approximately 2 minutes, instead of allowing the vashe to soak for 5 minutes, as ordered.</p> <p>During a surveyor interview following the above-observation with Staff A, she would not acknowledge that did she not follow the order.</p> <p>Further record review revealed that the resident is followed by a wound physician for his/her coccyx wound. Additionally, the wound was reevaluated on 1/1/2025 with recommendations to continue with the 5-minute soak of vashe.</p> <p>During a surveyor interview on 1/2/2025 at 1:10 PM with the Nurse Practitioner, Staff B, she indicated that she would expect that staff would follow the physician order and allow the wound to soak with vashe for the full 5 minutes.</p> <p>During a surveyor interview on 1/2/2025 at 1:21 PM with the DNS, she indicated that she would expect the staff to follow the physician's order.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. Record review revealed Resident ID #20 was readmitted to the facility in November of 2024 with diagnoses including, but not limited to, type 2 diabetes, and chronic kidney disease.</p> <p>During a surveyor observation and interview on 1/2/2025 at approximately 12:00 PM, the resident was observed to have a freestyle libre2 system placed on his/her upper posterior (back) left arm. The resident indicated that it is used daily to check his/her blood glucose.</p> <p>Record review of the physician's orders failed to reveal an order for the freestyle libre2, how often to change the device, or to monitor for any complications such as, infection or if the device is not working.</p> <p>Record review of the care plan failed to reveal the use of the freestyle libre2 as the method of glucose (blood sugar) monitoring or any interventions to mitigate risk.</p> <p>During a surveyor interview on 1/2/2025 at approximately 3:00 PM with the Assistant Director of Nursing Services, she acknowledged that the resident was utilizing a freestyle libre2 sensor for glucose monitoring and that there was no physician's order or a care plan in place.</p> <p>4. Record review revealed Resident ID #33 was admitted to the facility in November of 2012 with a diagnosis including, but not limited to, persistent vegetative state.</p> <p>Review of a physician's order dated 8/14/2024 revealed an order to apply resting hand splints to both hands with morning care and remove them during evening care, daily.</p> <p>Surveyor observations revealed the resident was without either hand splint in place on the following dates and times:</p> <p>-12/30/2024 at 11:10 AM</p> <p>-12/31/2024 at 11:38 AM</p> <p>-1/2/2025 at 9:11 AM and 11:34 AM</p> <p>During a surveyor interview following the above observation on 1/2/2025 at 11:34 AM with Nursing Assistant (NA), Staff F, he acknowledged that the resident was not wearing either hand splint. He revealed that he was the NA assigned to his/her care that morning and revealed that he had already completed his/her morning care. Further, he acknowledged that both hand splints were observed on the nightstand and revealed that he was unsure if the resident utilizes them.</p> <p>During a surveyor interview on 1/2/2025 at 11:37 AM with the LPN, Staff A, she revealed that the resident wears hand splints daily and that they should be on.</p> <p>During a surveyor interview on 1/2/2025 at 1:21 PM with the DNS, she revealed that she would expect the staff to follow the physician's order.</p> <p>5. Record review revealed Resident ID #103 was admitted to the facility in February of 2021 with diagnoses including, but not limited to, type 2 diabetes and pain.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of a physician's order dated 12/10/2024 revealed to apply a hot pack for 15 minutes, as needed every 8 hours, for back pain.</p> <p>During the Medication Administration Task on 1/2/2025 at 10:20 AM with the Certified Medication Technician, Staff G, she was observed applying the hot pack to the resident's back.</p> <p>During further observation on 1/2/2025 at 12:07 PM, Staff G was observed entering the resident's room where she removed the hot pack from the resident's back, which was approximately two hours later.</p> <p>During a surveyor interview with Staff G following the removal of the hot pack, she indicated that she placed the hot pack on the resident's back at 10:20 AM and that she does not know how long the hot pack was supposed to be applied for.</p> <p>During a surveyor interview on 1/3/2025 at approximately 11:00 AM with the Director of Nursing Services, she indicated that she would expect the staff to follow the physician's order.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>46715</p> <p>Based on record review, surveyor observation, and staff interview, it has been determined that the facility failed to ensure that a resident is provided assistive devices to prevent accidents relative to smoking for 1 of 1 resident reviewed, Resident ID #41.</p> <p>Findings are as follows:</p> <p>Review of a facility policy revealed that a smoking assessment will be completed upon admission, quarterly, and when a resident chooses to change their smoking decision. Additionally, it reveals that the resident must be dressed appropriately per the care plan.</p> <p>Record review revealed that the resident was admitted to the facility in April of 2023 with diagnoses including, but not limited to, traumatic brain injury, schizoaffective disorder, and epilepsy.</p> <p>Review of a Smoking Evaluation dated 10/15/2024 revealed that the resident utilizes a smoking apron.</p> <p>Review of a care plan dated 10/14/2024 revealed that the resident is a smoker with an intervention including, but not limited to, s/he is able to smoke safely with a smoking apron in place at times. Further review failed to reveal evidence when a smoking apron would need to be applied.</p> <p>During a surveyor observation on 1/2/2025 at 10:38 AM in the presence of Registered Nurse (RN), Staff H, of the resident smoking, s/he was not wearing a smoking apron. During the observation the ashes from the resident's cigarette were observed to be landing on his/her pajama pants.</p> <p>During a surveyor interview immediately following the above observation with Staff H, he acknowledged that the resident was not wearing a smoking apron and that the ashes had been landing on his/her pajama pants. Additionally, Staff H acknowledged that the resident's care plan revealed s/he is able to smoke safely with a smoking apron at times. Staff H, indicated they were not aware of when the resident should wear a smoking apron.</p> <p>During a surveyor interview on 1/2/2025 at 11:06 AM with the Assistant Director of Nursing she acknowledged that the resident's smoking assessment revealed that s/he should be utilizing a smoking apron.</p> <p>Record review revealed an order was put in place on 1/2/2025 to utilize a smoking apron with all smoking breaks after it was brought to the facility's attention by the surveyor.</p> <p>During a surveyor interview on 1/2/2025 at 11:20 AM with the Director of Nursing Services (DNS) she acknowledged that the care plan and the most recent smoking assessment revealed the resident should be utilizing a smoking apron. The DNS further revealed that the resident refuses use of the smoking apron at times but was unable to provide evidence of the refusals.</p>		

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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>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>47279</p> <p>Based on surveyor observation, record review, and staff interview, it has been determined that 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 1 of 2 ice machines observed without an air gap (gap between the water supply inlet and the flood level rim of the plumbing fixture).</p> <p>Findings are as follows:</p> <p>1. Review of the Rhode Island Food Code 2018 Edition 2-402.11, states in part, .food employees shall wear hair restraints, beard restraints that are designed and worn to effectively keep their hair from contacting exposed food .</p> <p>During a surveyor observation of the main kitchen on 12/30/2024 at approximately 8:25 AM, Dietary Aide, Staff I, and Cook, Staff J, were observed with full facial hair and not wearing a beard restraint while in the main kitchen. Additionally, Staff J was observed plating the breakfast meal for the residents.</p> <p>During a surveyor interview following the above observation on 12/30/2024 with the Food Service Director (FSD), she acknowledged that Staff I and J were not wearing a beard restraint, as required.</p> <p>2. Review of the Rhode Island Food Code 2018 Edition 5-202.13 states in part, .An air gap between the water supply inlet and the flood level rim of the PLUMBING FIXTURE, EQUIPMENT, or non FOOD EQUIPMENT shall be at least twice the diameter of the water supply inlet and may not be less than 25mm [millimeter] (1 inch) .</p> <p>During a surveyor observation of the first-floor kitchenette on 1/2/2025 at 11:08 AM with the Director of Maintenance in the presence of the FSD, revealed an ice machine without an air gap.</p> <p>During a surveyor interview directly following the above observation with the FSD, she acknowledged that the ice machine failed to have an air gap as outlined in the Rhode Island Food Code.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>46539</p> <p>Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to maintain an infection prevention and control program to help prevent the transmission of communicable diseases and infections, relative to contact precautions (a type of precaution utilized when a resident is known or suspected to be infected with a Multidrug Resistant Organism, MDRO, that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces in the resident's room) for 4 of 4 residents observed for contact precautions, Resident ID #s 77, 153, 330, and 332.</p> <p>Findings are as follows:</p> <p>Review of a facility policy titled Isolation-Categories of Transmission-Based Precautions revealed in part, Contact precautions .staff and visitors wear gloves (clean, non-sterile) when entering the room .Staff and visitors wear a disposable gown upon entering the room and remove before leaving the room and avoid touching potential contaminated surfaces with clothing after gown removed .</p> <p>1. Record review for Resident ID #77 revealed that s/he was readmitted to the facility in December of 2024 with diagnoses including, but not limited to, Methicillin Resistant Staphylococcus Aureus (MRSA, an MDRO) and type 2 diabetes mellitus.</p> <p>Record review revealed that the resident has wounds to his/her bilateral feet.</p> <p>Record review revealed a physician's order dated 12/12/2024 for contact precautions for MRSA in the wounds.</p> <p>Review of the signage posted outside of the resident's room on 12/30/2024 revealed the resident was on contact precautions and indicated to wear a gown and gloves prior to room entry.</p> <p>During a surveyor observation on 12/30/2024 at 12:04 PM revealed Nursing Assistant, Staff P, enter Resident ID #77's room without wearing a gown and gloves prior to entering the room.</p> <p>During a surveyor interview immediately following the above mentioned observation, Staff P acknowledged the signage outside of Resident ID #77's room and that she failed to wear a gown and gloves prior to entering the room.</p> <p>2. Record review for Resident ID #153 revealed that s/he was admitted to the facility in June of 2024 with a diagnosis including, but not limited to, MRSA.</p> <p>Record review revealed a physician's order dated 12/5/2024 for contact precautions for MRSA in the resident's urine.</p> <p>Review of signage posted outside of the resident's room on 12/30/2024 revealed the resident was on contact precautions and indicated to wear a gown and gloves prior to entering the room.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a surveyor observation on 12/30/2024 at 10:34 AM revealed Licensed Practical Nurse, Staff C, enter Resident ID #153's room without wearing a gown or gloves prior to entering the room.</p> <p>During a surveyor interview immediately following the above mentioned observation, Staff C, acknowledged the signage posted outside of Resident ID #153's room and that she failed to wear a gown and gloves prior to entering the room.</p> <p>3. Record review for Resident ID #330 revealed that s/he was admitted to the facility in December of 2024 with a diagnosis including, but not limited to, Extended-spectrum beta-lactamases (ESBL, an MDRO).</p> <p>Record review revealed a physician's order dated 12/30/2024 for contact precautions for ESBL in the resident's urine.</p> <p>Review of the signage posted outside of the resident's room on 12/30/2024 and 12/31/2024 revealed the resident was on contact precautions and indicated to wear a gown and gloves prior to entering the room.</p> <p>During a surveyor observation on 12/30/2024 at 12:06 PM revealed Maintenance Staff, Staff Q, enter Resident ID #330's room without wearing a gown prior to entering the room and removed the resident's mattress from his/her bed.</p> <p>During a surveyor interview immediately following the above mentioned observation, Staff Q acknowledged the signage posted outside of Resident ID #330's room and that he failed to wear a gown prior to entering the room.</p> <p>During a surveyor observation on 12/31/2024 at 10:45 AM revealed an Occupational Therapist, Staff R, enter Resident ID #330's room without wearing gown or gloves prior to entering the room and placed her laptop on the resident's dresser in his/her room.</p> <p>During a surveyor interview immediately following the above mentioned observation, Staff R acknowledged the signage posted outside of Resident ID #330's room but thought that it was only for direct contact and not upon room entry.</p> <p>During a surveyor observation on 12/31/2024 at 11:00 AM revealed Activity Aide, Staff S, enter Resident ID #330's room without wearing a gown or gloves prior to entering the room.</p> <p>During a surveyor interview immediately following the above mentioned observation, Staff S acknowledged the signage posted outside of Resident ID #330's room and that she failed to wear a gown and gloves prior to entering the room.</p> <p>4. Record review for Resident ID #332 revealed that s/he was admitted to the facility in December of 2024 with a diagnosis including, but not limited to, MRSA.</p> <p>Record review revealed a physician's order dated 12/24/2024 for contact precautions for MRSA in the resident's nares.</p> <p>(continued on next page)</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47279</p> <p>Based on surveyor observation, record review, staff and resident interview, it has been determined that the facility failed to be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area for 3 of 3 floors observed.</p> <p>Findings are as follows:</p> <p>During the resident council task completed on 12/31/2024 at approximately 1:00 PM multiple residents complained of waiting for long periods of time for their call lights to be answered due to the staff no longer carrying walkie talkies.</p> <p>During surveyor observations of all the units from 12/30/2024 to 1/3/2025, revealed that not all resident rooms' call lights are visible from the nurse's station.</p> <p>During a surveyor observation of the first floor on 1/3/2025 at approximately 10:20 AM, revealed lights above the resident doors signaling a call light had been engaged. Further observation failed to reveal that the call light relayed the call directly to staff members or to a centralized staff work area.</p> <p>During a surveyor interview on 1/3/2025 at 10:29 AM with Licensed Practical Nurse (LPN), Staff K, she revealed that previously the call lights would communicate with walkie talkies carried by the Nursing Assistants (NA) but that they no longer work. Additionally, she acknowledged that the call lights do not call directly to a staff member or to a centralized staff work area.</p> <p>During a surveyor interview on 1/3/2025 at 10:33 AM with Unit Manager, Staff D, she revealed that the NA's carry walkie talkies that the call lights communicate directly with. However, Staff D was unable to locate an NA that was carrying a walkie talkie and was unable to provide a functioning walkie talkie.</p> <p>During a surveyor observation on 1/3/2025 at approximately 10:40 AM of the second floor, revealed a call light above room [ROOM NUMBER] engaged. Further surveyor observation of the unit failed to reveal an NA in the hallway at the time the light was engaged.</p> <p>During a surveyor interview on 1/3/2025 at 10:42 AM with LPN, Staff A, she revealed that the NA's carry walkie talkies to alert them when a call light is engaged. During a follow up interview at approximately 10:50 AM Staff A, acknowledged that the staff no longer carry walkie talkies.</p> <p>During a surveyor interview on 1/3/2025 at 10:45 AM with NA, Staff L, he revealed that he does not carry a walkie talkie and the only way he is aware a call light is engaged is by the light above the door.</p> <p>During a surveyor interview on 1/3/2025 at 10:51 AM with NA, Staff M, she revealed that the staff do not utilize walkie talkies and there is no centralized staff area that the call lights alert to.</p> <p>(continued on next page)</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During a surveyor interview on 1/3/2025 at 11:09 AM with LPN, Staff N, she revealed that the staff on the third floor do not use walkie talkies and the call lights do not alert to a centralized location.</p> <p>During a surveyor interview on 1/3/2025 at 11:10 AM with NA, Staff O, she acknowledged that the only way she is aware a call light is engaged is by the light above the door.</p> <p>During a surveyor interview on 1/3/2025 at 12:33 PM with the Administrator, she acknowledged that the call lights in the facility do not communicate the call directly to a staff member or to a centralized staff work area.</p>