

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Received

PRINTED: 02/07/2025
FORM APPROVED
OMB NO. 0938-0391

FEB 14 2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ Facilities Regulation B. WING _____		(X3) DATE SURVEY COMPLETED 01/31/2025
NAME OF PROVIDER OR SUPPLIER WATERVIEW VILLA REHABILITATION AND HEALTH CARE CEN			STREET ADDRESS, CITY, STATE, ZIP CODE 1275 SOUTH BROADWAY EAST PROVIDENCE, RI 02914		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS A recertification survey, was conducted at Waterview Villa Rehabilitation and Healthcare Center on 1/27/2025 through 1/31/2025 to determine compliance with 42 C.F.R. Part 483, requirements for Long Term Care Facilities. State licensure and emergency preparedness surveys were also conducted at this facility. Deficiencies were identified as a result of this survey.	F 000	F 000 This plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.		
F 569 SS=B	Notice and Conveyance of Personal Funds CFR(s): 483.10(f)(10)(iv)(v) §483.10(f)(10)(iv) Notice of certain balances. The facility must notify each resident that receives Medicaid benefits- (A) When the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and (B) That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. §483.10(f)(10)(v) Conveyance upon discharge, eviction, or death. Upon the discharge, eviction, or death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the resident, or in the case of death, the individual or probate jurisdiction administering the resident's estate, in accordance with State law. This REQUIREMENT is not met as evidenced by:	F 569	F 569 Resident ID #'s 15, 18, 32 and 47 or representative have received notice of being over the Medicaid allowed amount. All residents with a PNA account receiving Medicaid benefits have the potential to be affected by the alleged deficient practice. The facility completed a facility wide audit by running a trial balance of accounts to determine current amounts and that notification to the resident or representative was completed for the month of February. The facility completed in-service training to the Accounts Receivable Assistant to review the monthly process of running the trial balance of accounts and sending notification to the resident or representative when assets are within \$200 of the Medicaid allowed maximum of \$4000. The Administrator / Regional BOM or designee will audit the Medicaid PNA trial balance of accounts to determine current amounts and that notification to the resident or representative was completed on a monthly basis. The results of the Medicaid PNA Trial Balance Audits will be reviewed at the Quality Assurance Committee Meeting to ensure ongoing compliance, until compliance is maintained.	2/11/2025	

Handwritten signature and date:
2/17/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X5) DATE 2/14/25

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.

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F 569	<p>Continued From page 1</p> <p>Based on record review and staff interview it has been determined that the facility failed to notify each resident, or resident representative, that receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the Social Security Income (SSI) resource limit for 4 of 4 residents reviewed with over \$4000 in personal needs funds handled by the facility, Resident ID #s 15, 18, 32 and 47.</p> <p>Findings are as follows:</p> <p>Record review of Title 210-Executive Office of Health and Human Services, Chapter 50-Medicaid Long-Term Services and Supports (LTSS) under section 2.4 (G) of the "Uniform Accountability Procedures for Title XIX Resident Personal Needs Funds in Community Nursing Facilities, ICF/DD Facilities, and Assisted Living Residences" requires that the facility shall: "... (10) The nursing facility must notify the resident in writing when his/her balance reaches \$200.00 less than the resource eligibility guideline, that Medicaid eligibility is jeopardized if the account exceeds the guideline [4,000]..."</p> <p>Review of a facility document titled, "Trial Balance...Balances as of 1/27/2025" for the following residents states in part:</p> <ul style="list-style-type: none"> - Resident ID #15 has a current balance of \$4,620.79. - Resident ID #18 has a current balance of \$6,188.21. - Resident ID #32 has a current balance of \$5,214.10. 	F 569	<p>F 569 con't</p> <p>The Administrator is responsible for ensuring ongoing compliance.</p>	2/11/2025

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F 569	Continued From page 2 - Resident ID #47 has a current balance of \$4,454.51.	F 569			
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on surveyor observations, record review and staff interviews, it has been determined that the facility failed to meet professional standards of quality relative to following physician's orders for 1 of 1 resident reviewed with refusals of medications, Resident ID #3, 1 of 1 resident reviewed with an order to not have straws with liquids, Resident ID #52, and 1 of 5 residents reviewed with an order for insulin parameters, Resident ID #93. Additionally, the facility failed to meet professional standards of quality relative to 1 of 2 wound dressings observed, Resident ID #272. Findings are as follows: According to Mosby's 4th Edition, Fundamentals of Nursing, page 314 states in part, "...The	F 658	F 658 1. Resident ID # 3 was discharged from the facility on 2/10/25. All residents receiving medication have the potential to be affected by the same alleged deficient practice. A facility system change was reviewed with the DNS and NP at the facility. An audit running a "refused medication listing report will be completed and reviewed to determine if there are any trends in refusals and that the provider (NP) is aware of the refusals. The NP will be signing the report to show a review of the refusals and any recommendations for order changes. The nurses and CMT's have received in-service education on Medication Refusals and the need to notify the MD of the refusal and document the notification in the progress notes. The DNS/ designee will run a refused medication report to identify any resident that is refusing medication and audit to determine that the MD was notified, and it was documented. The DNS or designee will review the report with the NP. The results of the Refused Medication Audit will be reviewed at the Quality Assurance Committee Meeting to ensure ongoing compliance, until compliance is maintained.	2/11/2025	

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F 658	<p>Continued From page 3</p> <p>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..."</p> <p>1. Record review revealed Resident ID #3 was admitted to the facility in November of 2024 with diagnoses including, but not limited to, Parkinson's disease (a chronic and progressive-movement disorder) and hypertension (high blood pressure).</p> <p>Record review revealed the following physician's orders dated 11/27/2024:</p> <ul style="list-style-type: none"> - Amlodipine (a medication prescribed to treat high blood pressure) 10 MG (milligrams), give 1 tablet daily. - Lisinopril (a medication prescribed to treat high blood pressure) 40 MG, give 1 tablet daily. - Metoprolol Succinate (a medication prescribed to treat high blood pressure) 50 MG, give 1 tablet daily. - Multivitamin, give 1 tablet daily. <p>Record review of the resident's January 2025 Medication Administration Record (MAR) revealed that s/he had not received his/her Amlodipine, Lisinopril, Metoprolol and multivitamin as ordered by the physician, secondary to refusals on the following dates:</p> <ul style="list-style-type: none"> - 1/1/2025 - 1/2/2025 - 1/4/2025 - 1/6/2025 	F 658	<p>F 658 con't</p> <p>The Director of Nursing is responsible for ensuring ongoing compliance.</p> <p>2. Resident ID # 52 has had the order for no straws discontinued after reviewing with the speech therapist.</p> <p>All residents with orders for no straws have the potential to be affected by the same alleged deficient practice. A facility wide audit of an order listing report revealed that there were 3 other residents with no straw orders. The facility had the speech therapist ensure that the orders were necessary.</p> <p>The nurses, and CMT's received in-service training on ensuring that if there is an MD order for "No straws" they are followed as ordered. The DNS / designee will run an order listing report to determine if any residents have orders for "No Straws" and randomly audit to ensure the orders are being followed by observation.</p> <p>The results of the No Straw audits will be reviewed at the Quality Assurance Committee Meeting to ensure ongoing compliance, until compliance is maintained.</p> <p>The Director of Nursing is responsible for ensuring ongoing compliance.</p> <p>3. Resident ID # 93's FS for 1/31/2025 was reported to the MD and orders for additional insulin was obtained. A Late entry note was written.</p> <p>All residents receiving insulin with a sliding scale with parameters to notify the MD have the potential to be affected by the alleged deficient practice. A facility wide audit of resident's MARs with a sliding scale insulin order with parameters to notify the MD of FS above or below a certain range was completed to determine if the MD was notified of FS results requiring reporting to the MD from 2/1/2025 to 2/8/2025.</p>	2/11/2025	

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F 658	<p>Continued From page 4</p> <ul style="list-style-type: none"> - 1/7/2025 - 1/10/2025 - 1/13/2025 - 1/14/2025 - 1/16/2025 - 1/17/2025 - 1/18/2025 - 1/19/2025 - 1/21/2025 - 1/24/2025 <p>Further record review revealed a physician's order dated 11/26/2024 for Carbidopa-Levodopa (a medication prescribed to treat Parkinson's disease) 25-100 MG, give 2 tablets orally, three times a day.</p> <p>Record review of the resident's January 2025 Medication Administration Record revealed that s/he had not received his/her Carbidopa-Levodopa as ordered by the physician, secondary to refusals on the following dates and times:</p> <ul style="list-style-type: none"> - 1/1/2025 at 8:00 AM - 1/2/2025 at 8:00 AM - 1/4/2025 at 8:00 AM - 1/5/2025 at 2:00 PM - 1/6/2025 at 8:00 AM - 1/7/2025 at 8:00 AM - 1/10/2025 at 8:00 AM and 2:00 PM - 1/13/2025 at 8:00 AM - 1/14/2025 at 8:00 AM and 2:00 PM - 1/16/2025 at 8:00 AM - 1/17/2025 at 8:00 AM - 1/18/2025 at 8:00 AM - 1/19/2025 at 8:00 AM and 2:00 PM - 1/21/2025 at 8:00 AM - 1/24/2025 at 8:00 AM and 2:00 PM 	F 658	<p>F 658 con't</p> <p>The Licensed Nurses received in-service training on Insulin orders with FS that require notification to the MD if FS are above or below a certain parameter. The focus of the training included a review of the need to notify the MD per the order and document the notification in the progress notes. The DNS or designee will run an insulin order listing report weekly to Audit that the FS readings that were obtained did not require notification to the MD and if they did that the MD was notified and it was documented within the progress notes.</p> <p>The results of the Insulin FS Parameter Audits will be reviewed at the Quality Assurance Committee Meeting to ensure ongoing compliance, until compliance is maintained.</p> <p><i>EM</i> 2/1/25</p> <p>The Director of Nursing is responsible for ensuring ongoing compliance.</p> <p>4. Resident ID # 272 has had the treatment order changed on 2/4/2025 and has been seen by the wound doctor on 2/4/25 and 2/11/2025.</p> <p>All residents with treatment orders have the potential to be affected by the same alleged deficient practice. A facility wide audit of treatment orders was completed to determine which residents have treatments and that the treatments are being done as ordered by visual inspection done by regional nurse on 2/3/2025.</p> <p>The Licensed Nursing Staff have received in-service training on completion of treatments as ordered. The ICN Nurse or designee will weekly during wound rounds complete Treatment Audits to ensure the ordered treatment was done as ordered and dated appropriately.</p>	2/11/2025	

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F 658	<p>Continued From page 5</p> <p>- 1/25/2025 at 2:00 PM and 8:00 PM</p> <p>- 1/27/2025 at 2:00 PM</p> <p>Record review failed to reveal evidence that the provider was notified that the resident did not receive Amlodipine, Lisinopril, Metoprolol, Multivitamin and Carbidopa-Levodopa on the above mentioned dates and times.</p> <p>During a surveyor interview on 1/31/2025 at 9:50 AM with the Director of Nursing Services (DNS), she acknowledged the above-mentioned medications were refused. Additionally, she indicated it would be her expectation that the provider would be notified of the medication refusals.</p> <p>During a surveyor interview on 1/31/2025 at 10:45 AM with the Nurse Practitioner, she indicated that she was not made aware of the above-mentioned medication refusals.</p> <p>2. Record review revealed Resident ID #52 was re-admitted to the facility in December of 2024, with diagnoses including, but not limited to, dysphagia (difficulty swallowing) and dementia.</p> <p>Record review revealed a dietary order dated 12/17/2024, indicating no straws with liquids.</p> <p>Surveyor observations revealed the following:</p> <p>-1/27/2025 at 12:02 PM, a styrofoam cup with a straw on the bedside table</p> <p>-1/28/2025 at 12:05 PM, an Ensure chocolate supplement with a straw on the bedside table</p> <p>-1/28/2025 at 12:22 PM, an Ensure chocolate</p>	F 658	<p>F 658 con't</p> <p>The results of the Treatment Audits will be reviewed at the Quality Assurance Committee Meeting to ensure ongoing compliance, until compliance is maintained.</p> <p>The Director of Nursing is responsible for ensuring ongoing compliance.</p>	2/11/2025	

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F 658	<p>Continued From page 6</p> <p>supplement with a straw on the resident's meal tray</p> <p>-1/29/2025 at 11:52 AM, a styrofoam cup with a straw on the bedside table.</p> <p>During a subsequent surveyor observation on 1/28/2025 at 12:50 PM, Registered Nurse (RN), Staff B, was observed administering the resident his/her medication with a chocolate Ensure supplement and a straw.</p> <p>During a surveyor interview on 1/29/2025 at 11:52 AM with Nursing Assistant, Staff C, she acknowledged the straw in the styrofoam cup. Additionally, she revealed she was assigned to the resident that shift and she was unaware the resident had an order to not have straws with liquids.</p> <p>During a surveyor interview on 1/29/2025 at 11:58 AM with RN, Staff D, and Licensed Practical Nurse (LPN), Staff E, both nurses acknowledged the order for no straws. Additionally, they acknowledged they were not aware of the physician order until it was brought to their attention by the surveyor.</p> <p>During a surveyor interview on 1/29/2025 at 12:32 PM with the DNS, she acknowledged the resident's order for no straws. Additionally, she revealed it would be her expectation that straws would not be provided to the resident.</p> <p>3. Record review revealed Resident ID #93 was readmitted to the facility in September of 2024 with a diagnosis including, but not limited to, Diabetes Mellitus Type 2.</p>	F 658			

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F 658	<p>Continued From page 7</p> <p>Record review revealed a physician's order dated 9/6/2024 for Admelog solostar (insulin) 100 unit/milliliter (U/ML) solution, inject per sliding scale, and notify the provider if the blood sugar reading is greater than 400, three times per day.</p> <p>Record review of the resident's January 2025 MAR revealed that s/he had blood sugar readings greater than 400 on the following dates and times:</p> <ul style="list-style-type: none"> - 1/2/2025 407 at 11:30 AM - 1/8/2025 477 at 11:30 AM - 1/11/2025 443 at 11:30 AM - 1/14/2025 401 at 11:30 AM - 1/20/2025 444 at 11:30 AM - 1/22/2025 464 at 7:30 AM - 1/23/2025 404 at 11:30 AM - 1/24/2025 426 at 7:30 AM - 1/27/2025 406 at 11:30 AM - 1/28/2025 531 at 11:30 AM <p>Record review failed to reveal evidence that the provider was notified of the above-mentioned blood sugar readings.</p> <p>During a surveyor interview on 1/30/2025 at 10:42 AM with the DNS, she acknowledged the above-mentioned blood sugar readings. Additionally, she was unable to provide evidence that the provider was notified of the above-mentioned blood sugar readings above 400, as ordered.</p> <p>4. Record review revealed Resident ID #272 was admitted to the facility in January of 2025, with a diagnosis including, but not limited to, poliomyelitis (a viral infection causing nerve injury which leads to partial or full paralysis).</p>	F 658			

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F 658	Continued From page 8 Record review revealed a physician's order dated, 1/23/2025 to cleanse the right buttocks wound with wound cleanser, apply honey gel (a wound gel), and cover with a bordered foam daily. During a surveyor observation and simultaneous interview on 1/30/2025 at 9:34 AM with RN, Staff B, was observed removing a soiled dressing from the resident's wound dated 1/28/2025. Staff B, acknowledged that the dressing was dated 1/28/2025 and that it should have been changed on 1/29/2025. During a surveyor interview on 1/31/2025 at 11:31 AM with the DNS, she indicated it would be her expectation for the treatment to have been completed as ordered.	F 658			
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to provide an ongoing activity program to support a resident in his/her choice of	F 679 <i>EM</i> <i>2/1/25</i>	Resident ID # 90 is an auld reader and has books at bedside that both her family and facility provide and the activities department are documenting room ulsits. All residents that choose not to attend activities or are room bound have the potential to be affected by the alleged deficient practice. A facility wide audit of residents that choose not to attend activities or are room bound was completed to ensure that plan of care includes opportunities for activities. The room visit and activity participation of each resident identified was reviewed to ensure documentation of activities was in place from 2/1/2025 until current. The Activity Director and Dementia Coordinator received in-service education on ensuring the plan of care and documentation of the activities on residents that do not participate in activities and room bound residents is completed. The Activity Director and Dementia coordinator will complete Activity Audits for Room Bound Residents randomly 3 x weekly. The results of the Activities Audits will be reviewed at the Quality Assurance Committee Meeting to ensure ongoing compliance, until compliance is maintained. The Administrator is responsible for ensuring ongoing compliance.	2/11/2025	

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F 679	<p>Continued From page 9</p> <p>activities based on the comprehensive assessment, care plan, and preferences for 1 of 1 resident reviewed, Resident ID #90.</p> <p>Findings are as follows:</p> <p>Record review revealed the resident was re-admitted to the facility in September of 2024 with diagnoses including, but not limited to, mild communication deficit and major depressive disorder.</p> <p>Review of an Admission Minimum Data Set (MDS) Assessment, Section F, titled, "Preferences for Customary Routine and Activities", dated 11/21/2024, revealed that it is very important for the resident to have books, to read the newspaper and magazines, to listen to music that s/he likes, and to do activities s/he likes with groups of people.</p> <p>Review of the resident's care plan dated 8/16/2024 and revised on 11/22/2024 revealed that the resident has impaired cognition due to dementia with the intervention to encourage socialization and recreation activity.</p> <p>Surveyor observations of the resident on the following dates and times failed to reveal evidence that the resident was offered or participated in any activities while in his/her room alone.</p> <p>-1/27/2025 - 10:12 AM, resident was in bed with his/her eyes opened, without his/her television or music on.</p> <p>-1/27/2025- 1:32 PM, s/he was in bed staring at the ceiling, without his/her television or music on.</p>	F 679			

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F 679	<p>Continued From page 10</p> <p>-1/27/2025 - 3:00 PM s/he was laying in bed, without his/her television or music on.</p> <p>-1/28/2025 - 11:30 AM, the resident was observed sitting on the bed, without his/her television or music on.</p> <p>-1/29/2025 - 10:45 AM, the resident was observed lying in bed with her eyes opened, without his/her television or music on.</p> <p>- 1/29/2025 - 2:53 PM, the resident was observed sitting up on the bed, without his/her television or music on.</p> <p>Review of the resident's daily activity report sheet failed to reveal any documented activity on 1/27/2025, 1/28/2025 and 1/29/2025.</p> <p>Review of the January 2025 Activity staff schedule revealed a daily assigned staff member was on the third floor (dementia unit), from 9:30 AM to 4:30 PM.</p> <p>During a surveyor interview on 1/30/2025 at 9:11 AM with a Nursing Assistant, Staff H, she revealed that the resident does not like to come out of his/her room so whenever s/he stays in his/her room, someone from the activities department is supposed to go into the room for an activity session. Further, Staff H, revealed that the resident likes to read, listen to music, and watch television when s/he stays in their room.</p> <p>During a surveyor interview on 1/30/2025 at 10:52 AM with the assigned unit Activities Aide, Staff I, she acknowledged that she failed to visit the resident on the above-mentioned dates.</p>	F 679		

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F 679	Continued From page 11	F 679			
F 686 SS=G	<p>Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(I)(II)</p> <p>§483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-</p> <p>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and</p> <p>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on surveyor observation, record review, resident and staff interview, it has been determined that the facility failed to provide necessary treatment and services, consistent with professional standards of practice to prevent new ulcers from developing for 1 of 1 resident reviewed, who was admitted to the facility for respite care, Resident ID #272.</p> <p>Findings are as follows:</p> <p>According to an article published in the National</p>	F 686	<p>F 686</p> <p>Resident ID # 272 has a new MD order in place to have the nurse ask daily if resident wishes to get OOB 2/7/2025. Therapy has screened the resident on 1/30/2025.</p> <p>All residents have the potential to be affected by the alleged deficient practice. The facility completed a facility wide audit of new admissions from 2/1/2025 to ensure a therapy screen or active therapy orders were completed.</p> <p>The Director of Rehab received in-service education to screen all residents (including respite) upon admission. The Licensed Nursing Staff received in-service training on ensuring treatments are completed as ordered. The Director of Rehab will audit new admissions to determine that the new admissions were screened or are receiving skilled therapy as ordered.</p> <p>The results of the Therapy New Admission Screening and Treatment Audits will be reviewed at the Quality Assurance Committee Meeting to ensure ongoing compliance, until compliance is maintained.</p> <p>The Director of Nursing is responsible for ensuring ongoing compliance.</p>	2/11/2025	

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F 686	<p>Continued From page 12</p> <p>Library of Medicine titled, Pressure ulcers: Learn More - Preventing pressure ulcers, last updated on August 19, 2022, states in part, "...Regularly changing a person's lying or sitting position is the best way to prevent pressure ulcers. Special mattresses and other aids can help to relieve pressure on at-risk areas of skin...Most pressure ulcers (bedsores) arise from sitting or lying in the same position for a long time without moving. Most people keep changing their position when they sit for a long time or are asleep, consciously or subconsciously. But people who are very weak, ill, paralyzed or unconscious move much less or not at all. This means that the parts of their body that they are sitting or lying on are constantly under more pressure...People who are confined to a wheelchair or have to stay in bed for a long time are at greater risk. Then it's critical to relieve pressure on the skin by regularly changing the position they sit or lie in. People who develop pressure ulcers often say that they can feel parts of their body becoming sore...It is also important to move if possible - even if you have to lie in bed or sit in a wheelchair. If you are able to sit up, leave the bed, or even walk a few steps with a bit of help, it ' s a good idea to do that as often as possible..."</p> <p>Review of the facility policy titled "Admission of A Resident" states in part, "...obtain sufficient, accurate information that will be required to properly care for the resident..."</p> <p>Record review revealed Resident ID #272 was admitted to the facility in January of 2025 with diagnoses including, but not limited to, reduced mobility and a history of poliomyelitis (a viral infection that causes nerve injury which leads to partial or full paralysis).</p>	F 686		

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F 686	<p>Continued From page 13</p> <p>Record review revealed a Brief Interview for Mental Status assessment dated 1/17/2025 with a score of 14 out of 15, indicating the resident's cognition was intact.</p> <p>During a surveyor interview on 1/27/2025 at approximately 10:00 AM with the resident, s/he indicated that s/he had not been out of bed since his/her admission. Additionally, the resident revealed that s/he enjoyed sitting in his/her recliner at home. Furthermore the resident indicated that s/he had an uncomfortable area on his/her buttocks.</p> <p>Review of a hospital continuity of care form dated 1/16/2025 revealed activity instructions including, but not limited to, "Bed and wheel chair bound", (if someone is bedbound, it means they are not able to move around safely or comfortably. They may need to help to get to and from the toilet, to sit up in bed or to move from the bed to a chair, and help to change their position in bed to prevent bed sores).</p> <p>Review of the "...Admission Screening Tool" dated 1/16/2025 revealed the resident was admitted to the facility for a 2-3 month respite stay, due to his/her caregiver having surgery. Further review revealed the resident requires the assistance of two people for transfers. Additional review failed to reveal evidence that the resident had a wound upon admission.</p> <p>Review of the resident's care card, a document used by direct care staff for pertinent care information, revealed the resident was dependent on the assistance of two staff members for bed mobility and transfers.</p>	F 686			

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F 686	<p>Continued From page 14</p> <p>Review of a Norton assessment (a tool used to determine a person's risk of developing a pressure ulcer) dated 1/23/2025 revealed the resident was chair bound with very limited mobility. Further review revealed the resident was at a moderate risk of developing a pressure ulcer.</p> <p>Review of a care plan dated 1/27/2025 revealed the resident was at risk for skin breakdown related to impaired mobility.</p> <p>Record review of an admission skin assessment dated 1/16/2025 failed to reveal evidence of any open areas to the resident's buttocks.</p> <p>Record review of a skin assessment dated 1/22/2025, 6 days after his/her admission, revealed the resident was found to have a facility acquired wound to his/her right buttocks, that measured 3.5 centimeters(cm) by 3.5 cm by 0.1 cm.</p> <p>Record review revealed a physician's order dated 1/23/2025 to cleanse a right buttocks wound with wound cleanser followed by honeygel (a wound gel) and cover the wound with a bordered foam dressing daily.</p> <p>Review of a wound physician's progress note dated 1/28/2025 revealed the resident had a moisture associated wound which measured 2 cm by 3 cm by 0.2 cm. Further review revealed the surrounding area of the wound was "normal."</p> <p>During multiple surveyor observations on 1/27, 1/28, 1/29, and 1/30/2025, all days of the survey, the resident was noted to be lying in bed, flat on his/her back.</p>	F 686			

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F 686	<p>Continued From page 15</p> <p>During a surveyor interview on 1/30/2025 at 9:28 AM with Nursing Assistant (NA), Staff J, she indicated that she had been assisting the resident this past week and had not transferred the resident out of bed. She further indicated that she thought that the resident preferred to stay in bed.</p> <p>During a surveyor interview on 1/30/2025 at 9:31 AM with the resident in the presence of Staff J, the resident stated that s/he would "love" to get out of bed. S/he then stated that the staff have never offered to transfer him/her out of bed.</p> <p>During an interview on 1/30/2025 at 11:04 AM with Registered Nurse (RN), Staff B, she indicated that she was unaware if the resident had been transferred out of bed since admission.</p> <p>During a surveyor observation of the resident's buttocks wound on 1/30/2025 at 9:43 AM, in the presence of Staff B, she removed the soiled dressing from the resident, this dressing was dated 1/28/2025 indicating that it was not changed on 1/29/2025, as ordered. Observation of the wound revealed two dark colored areas around the wound with non-blanchable redness (when you push the skin, and the area stays red, indicating there is little or no blood flow going to that area) to the proximal peri wound (around the wound). Staff B acknowledged these observations.</p> <p>During a surveyor interview on 1/30/2025 at 10:31 AM with the Wound Nurse, Staff K, she indicated that a moisture associated wound is typically blanchable (when the skin loses its color when pressure is applied and quickly returns) where a pressure ulcer (injury to the skin caused by</p>	F 686			

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F 686	Continued From page 16 prolonged pressure) is characterized by a non-blanchable area. During a surveyor interview and observation of the resident's buttocks wound on 1/30/2025 at 10:40 AM with Staff K, she indicated that the darkened areas and the non blanchable redness on the resident's buttocks were not present on 1/28/2025, and that these pressure areas were new. She further indicated that the approximate measurements of the two darkened areas were each 0.5 cm by 0.5 cm and that the non-blanchable area was approximately 3 cm by 5 cm. During a surveyor interview on 1/30/2025 at 11:31 AM with the Director of Nursing Services, she indicated that she would expect staff to offer a resident to get out of bed. The facility's failure to transfer the resident out of bed for 15 consecutive days resulted in the resident developing a pressure ulcer, as evidenced by the resident not having a wound to his/her buttocks upon admission.	F 686			
F 688 SS=H	Cross reference F-688 Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and	F 688		2/11/2025	

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F 688	<p>Continued From page 17</p> <p>§483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.</p> <p>§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on surveyor observation, record review, resident, and staff interview, it has been determined that the facility failed to ensure a resident with limited range of motion (ROM) received appropriate treatment and services to increase ROM and/or to prevent further decrease in ROM for 2 of 2 residents reviewed with contractures (the shortening of muscles, tendons, skin, and nearby soft tissues that cause the joints to become very stiff, which prevents normal movement), Resident ID #s 67 and 79. Additionally, the facility failed to ensure a resident with limited mobility received appropriate services and equipment for 1 of 1 resident reviewed who was admitted to the facility for respite care, Resident ID #272.</p> <p>Findings are as follows:</p> <p>Review of a facility policy titled "Admission of A Resident" states in part, "...obtain sufficient, accurate information that will be required to properly care for the resident...Perform Admission Evaluation/Screen...Review with the Interdisciplinary Team: diet orders, rehabilitation orders, and social services concerns..."</p>	F 688	<p>F 688</p> <p>1. Resident ID # 67 was screened by therapy on 2/7/2025 and is receiving OT for assessment and treatment of ROM to the left hand.</p> <p>All residents have the potential to be affected by the alleged deficient practice. A facility wide audit of all residents will be completed over the next quarter with the screening of all residents based on the MDS quarterly schedule to assess any limitations in ROM and potential contracture management. A facility wide audit of all residents was also conducted on 2/10/2025 by DNS, Regional Nurse and Rehab director visually inspect each resident for potential contractures.</p> <p>The Director of Rehab has received in-service training on ensuring all residents are screened for limitations in ROM /potential contractures quarterly with the screening process to be done in conjunction with the MDS assessment schedule. The Director of Rehab will ensure that Rehab Screens for Potential Contractures, based on the MDS quarterly schedule, are completed to ensure the resident was assessed for limited ROM and potential splinting if applicable.</p> <p>The results of the Screens for potential Contractures will be reviewed at the Quality Assurance Committee Meeting to ensure ongoing compliance, until compliance is maintained.</p> <p>The Director of Rehab is responsible for ensuring ongoing compliance.</p>	2/11/2025	

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F 688	<p>Continued From page 18</p> <p>Review of a facility policy titled "Screens", last revised January 2012, states in part, "...All patients/residents will be screened annually...the purpose of the screen is to determine if the patient/resident would benefit from a therapy evaluation..."</p> <p>1. Record review revealed Resident ID #67 was admitted to the facility in November of 2023 with diagnoses including, but not limited to, anoxic brain damage (caused by a lack of oxygen to the brain) and muscle wasting.</p> <p>Record review of a Minimum Data Set Assessment (MDS) dated 11/8/2024 revealed a Brief Interview for Mental Status (BIMS) score of 3 out of 15, indicating severe cognitive impairment. Further review revealed the resident had impaired range of motion of one side of his/her upper extremities. Additional review revealed the resident is dependent on staff for activities of daily living (ADLs).</p> <p>Record review of a "Rehab Screen" dated 5/17/2024 failed to reveal documentation of any contractures.</p> <p>During surveyor observations on the following dates and times, the resident was noted to have a contracted left hand, without any intervention in place:</p> <ul style="list-style-type: none"> - 1/27/2025 at 11:45 AM - 1/28/2025 at 9:52 AM - 1/30/2025 at approximately 1:15 PM - 1/31/2025 at 9:41 AM <p>Review of a care plan dated 11/28/2023 revealed the resident has pain related to impaired mobility</p>	F 688	<p>F 688 con't</p> <p>2. Resident ID # 79 67 was screened by therapy on 2/7/2025 and is receiving OT for assessment and treatment of ROM to the right and left 4th and 5th fingers.</p> <p>All residents have the potential to be affected by the alleged deficient practice. A facility wide audit of all residents will be completed over the next quarter with the screening of all residents based on the MDS quarterly schedule to assess any limitations in ROM and potential contracture management. A facility wide audit of all residents was also conducted on 2/10/2025 by DNS, Regional Nurse and Rehab director, to visually inspect each resident for potential contractures.</p> <p>The Director of Rehab has received in-service training on ensuring all residents are screened for limitations in ROM /potential contractures quarterly with the screening process to be done in conjunction with the MDS assessment schedule. The Director of Rehab will ensure that Rehab Screens for Potential Contractures, based on the MDS quarterly schedule, are completed to ensure the resident was assessed for limited ROM and potential splinting if applicable.</p> <p>The results of the Screens for potential Contractures will be reviewed at the Quality Assurance Committee Meeting to ensure ongoing compliance, until compliance is maintained.</p> <p>The Director of Rehab is responsible for ensuring ongoing compliance.</p> <p>3. Resident ID # 272 was screened by therapy and was provided with a wheelchair and did not want to sit in it. There is an MD order to offer resident to get OOB on both the 7-3 and 3-11 shift and document if resident accepts or refuses.</p>	2/11/2025

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F 688	<p>Continued From page 19 with interventions including, but not limited to, offer non-pharmacological interventions to reduce pain. Further review revealed the resident is at risk for skin breakdown.</p> <p>Additional review of the care plan failed to reveal evidence the resident had a left-hand contracture, limited range of motion, or that there were interventions implemented to prevent a further decrease in his/her range of motion.</p> <p>Record review of the physician's orders failed to reveal evidence of any orders to prevent a further decrease in range of motion for the resident.</p> <p>During a surveyor interview on 1/30/2025 at 1:20 PM with Licensed Practical Nurse, Staff M, he acknowledged that the resident's left hand was contracted and indicated that the resident is not currently working with physical (PT) or occupational therapy (OT).</p> <p>Additionally, he acknowledged that there were no interventions in place to prevent a further decrease in the resident's range of motion.</p> <p>During a surveyor interview on 1/31/2025 at 9:08 AM with Physical Therapist, Staff N, she acknowledged that when the resident was screened by rehab on 5/17/2024, it was not documented that s/he had a left hand contracture. Additionally, she could not provide evidence that any interventions have been put in place to prevent a further decrease in the resident's range of motion.</p> <p>During a surveyor interview on 1/31/2025 at 9:41 AM with Resident ID #67, s/he indicated that his/her left hand was painful and that s/he could</p>	F 688	<p>F 688 con't</p> <p>All new admissions have the potential to be affected by the alleged deficient practice. A facility wide audit of new admissions from 2/1/2025 to ensure a screening from therapy was completed on admission or the resident is receiving therapy.</p> <p>The Director of Rehab has received in-service training on ensuring all new admissions are screened at time of admission for equipment needs or therapy services. The Director of Rehab will complete the Admission Screening Audit based on the admit report weekly to ensure all new admissions are screened or are on therapy.</p> <p>The results of the Admission Therapy Screening Audits will be reviewed at the Quality Assurance Committee Meeting to ensure ongoing compliance, until compliance is maintained.</p> <p>The Director of Rehab is responsible for ensuring ongoing compliance.</p>	2/11/2025	

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F 688	<p>Continued From page 20</p> <p>not move it. The resident further indicated that s/he does not work with therapy but would wear a splint if it would help with the pain his/her hand.</p> <p>During a surveyor interview on 1/31/2025 at 9:44 AM with Registered Nurse (RN), Staff F, she indicated that the resident does complain of pain to his/her left hand when staff are providing care.</p> <p>During a surveyor interview on 1/31/2025 at 9:49 AM with the Director of Nursing Service (DNS), she indicated that the resident has impaired cognition however, s/he knows information about him/herself. She further indicated that she was aware that the resident had a left hand contracture and would expect the contracture and limited range of motion to be addressed in the care plan and to have interventions should be in place to prevent a further decrease in the resident's range of motion.</p> <p>2. Record review revealed Resident ID #79 was admitted to the facility in September of 2024 with diagnoses including, but not limited to, spinal stenosis (spinal narrowing which compresses the spinal cord) and peripheral autonomic neuropathy (nerve damage).</p> <p>Review of a MDS Assessment dated 9/10/2024 revealed a BIMS score of 15 out of 15, indicating intact cognition. Further review revealed the resident was documented as not having any range of motion impairments to his/her upper extremities.</p> <p>Record review of a "Rehab Screen" dated 11/11/2024 failed to reveal documentation of any contractures.</p>	F 688			

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F 688	<p>Continued From page 21</p> <p>During a surveyor interview and observation on 1/27/2025 at 11:44 AM, with Resident ID #79, s/he indicated that s/he is not receiving therapy services. The resident was observed to have limited range of motion and bilateral hand contractures.</p> <p>Review of the care plan dated 9/18/2024 revealed the resident has an ADL deficit related to weakness. Further review failed to reveal evidence that the resident has bilateral hand contractures, limited range of motion, or that there were interventions in place to prevent further decrease in the resident's range of motion.</p> <p>Record review revealed the following physician's orders:</p> <ul style="list-style-type: none"> -OT evaluation and treatment as indicated dated 11/30/2024 -PT evaluation and treatment as indicated dated 12/30/2024 <p>During a surveyor interview on 1/29/2025 at approximately 10:00 AM with the Interim Director of Rehab, Staff O, she indicated that rehab screens are completed quarterly and that due to the resident being "bed bound" (if someone is bedbound, it means they are not able to move around safely or comfortably. They may need to help to get to and from the toilet, to sit up in bed or to move from the bed to a chair, and help to change their position in bed), s/he does not require therapy services. Additionally, she was unable to provide evidence of a therapy screen upon Resident ID #79's admission in September 2024.</p> <p>During a surveyor interview and observation on</p>	F 688			

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F 688	<p>Continued From page 22</p> <p>1/31/2025 at 8:58 AM with RN, Staff B, she acknowledged that both of the resident's hands were contracted.</p> <p>During a surveyor interview on 1/31/2025 at 11:14 AM with Staff O, she indicated that she was unaware that the resident had any limited range of motion or contractures to his/her bilateral hands. Additionally, she could not provide evidence that a PT or OT evaluation had been completed as ordered, or that interventions were put into place to prevent a further decrease in the resident's range of motion.</p> <p>During a surveyor interview on 1/31/2025 at 11:16 AM, with the DNS, she was unaware that the resident's bilateral hands were contracted or that s/he had limited range of motion in his/her upper extremities. She further indicated that she would have expected the contractures and limited range of motion to have been identified by therapy and that a care plan would be implemented to prevent a further decrease in the resident's range of motion.</p> <p>3. Record review revealed Resident ID #272 was admitted to the facility in January of 2025 with diagnoses including, but not limited to, reduced mobility and a history of poliomyelitis (a viral infection that causes nerve injury which leads to partial or full paralysis.)</p> <p>Record review revealed a BIMS dated 1/17/2025 with a score of 14 out of 15, indicating the resident's cognition was intact.</p> <p>During a surveyor interview on 1/27/2025 at approximately 10:00 AM with the resident, s/he indicated that s/he had not been out of bed since</p>	F 688			

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F 688	<p>Continued From page 23</p> <p>his/her admission. Additionally, the resident revealed that s/he enjoyed sitting in his/her recliner at home. Furthermore s/he indicated that s/he had an uncomfortable area on his/her buttocks.</p> <p>Review of a hospital continuity of care form dated 1/16/2025 revealed activity instructions including, but not limited to, "Bed and wheel chair bound."</p> <p>Review of the "...Admission Screening Tool" dated 1/16/2025 revealed the resident was admitted to the facility for a 2-3 month respite stay, due to his/her caregiver having surgery. Further review revealed the resident requires the assistance of two people for transfers.</p> <p>Review of a care plan dated 1/27/2025 revealed the resident has a self-care deficit related to impaired mobility with interventions including, but not limited to, encourage the resident to get out of bed with all meals.</p> <p>Record review failed to reveal evidence that the resident had been screened by Physical or Occupational therapy since his/her admission to the facility.</p> <p>During multiple surveyor observations on 1/27, 1/28, 1/29, and 1/30/2025, all the days of the survey, the resident was lying in bed, flat on his/her back. Further observations failed to reveal that the resident had a wheelchair in his/her room.</p> <p>During a surveyor interview on 1/30/2025 at 9:28 AM with Nursing Assistant (NA), Staff J, she indicated that she had been assisting the resident with care this past week and had not transferred</p>	F 688			

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F 688	<p>Continued From page 24</p> <p>the resident out of bed. She further indicated that she thought that the resident preferred to stay in bed.</p> <p>During a surveyor interview on 1/30/2025 at 9:31 AM with the resident in the presence of Staff J, the resident stated that s/he would "love" to get out of bed. S/he then stated that the staff have never offered to transfer him/her out of bed.</p> <p>During an interview on 1/30/2025 at 11:04 AM with Registered Nurse (RN), Staff B, she indicated that she was unaware if the resident had been transferred out of bed since his/her admission. She further indicated that the resident did not have a wheelchair and would need to be screened by therapy to receive a wheelchair from the facility.</p> <p>During a surveyor interview on 1/30/2025 at 11:07 AM with the Regional Therapy Director, she indicated that she would expect a therapist to screen each resident within 24 to 48 hours of admission to establish a baseline and to provide the resident with any adaptive equipment needed, including a wheelchair. Additionally, she could not provide evidence that a therapy screen had been completed for the resident since his/her admission.</p> <p>During a surveyor interview on 1/30/2025 at 11:31 AM with the DNS, she indicated that she would expect a therapy screen to be completed to establish safe transfer status for the resident, and to identify if a resident needs a wheelchair.</p> <p>During a surveyor interview on 1/31/2025 at 1:09 PM with Physician, Staff L, he indicated that he would expect an elderly resident who is admitted</p>	F 688			

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F 688	Continued From page 25 to the facility for more than a few days, to be screened by therapy for safety. Record review revealed a Rehab Screen was conducted for this resident on 1/30/2025, after the above concerns were brought to the facility's attention by the surveyor, 15 days after the resident's admission. Additional review of the Rehab Screen revealed that the resident required the assistance of one staff for transfers to a wheelchair. Further review revealed that the resident was provided with a wheelchair.	F 688			
F 692 SS=D	Cross reference F-686 Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.	F 692	F 692 1. Resident ID # 52 is being followed by the Risk Team for weight loss and is receiving Remeron as an appetite stimulant as well as Ensure for a supplement. All residents have the potential to be affected by the alleged deficient practice. A facility wide audit of the residents on weekly weights was completed to ensure that the weekly weights are being obtained as ordered. The Licensed Nurses received in-service training on the Weight Policy. The DNS and Dietician or designee will Audit the weekly Weights to ensure they are obtained and assessed for weight loss, reweights if applicable and followed by the risk team. The results of the Weight Audits will be reviewed at the Quality Assurance Committee Meeting to ensure ongoing compliance, until compliance is maintained.	2/11/2025	

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F 692	<p>Continued From page 26</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interview, it has been determined that the facility failed to ensure that residents maintain acceptable parameters of nutritional status, such as usual body weight for 2 of 4 resident reviewed for weight loss, Resident ID #s 52 and 272.</p> <p>Findings are as follows:</p> <p>Record review of a facility's policy titled, "WEIGHTS" states in part, "...The following resident/patients are weighed weekly X4 [times 4 weeks]...Newly admitted residents/patients...Newly weight loss/gain of 5 pounds [Lb] or more on a resident weighing 100 pound or more requires a reweight for verification...Weight are documented in the resident's/patient's medical record and/or the weight book. If a significant weight loss/gain is identified (>5% in 30 days or >10% in 6 months), the IDT [interdisciplinary Team], dietician, physician and family are notified. All residents with a significant weight loss are reviewed by the interdisciplinary team and the resident/responsible party and interventions implemented as appropriate and are monitored weekly..."</p> <p>Record review of a facility policy titled, "Food & Dining Service" states in part, "...The objective of food service is to supply the resident/patient a diet comparable with his needs...a record of food and fluid intake will be kept on the appropriate form...Each resident is seen by the dietician to review their diet on admission, quarterly and significant change..."</p>	F 692	<p>F 692 con't</p> <p>The Director of Nursing is responsible for ensuring ongoing compliance.</p> <p>2. Resident ID # 272 weight on 2/3/2025 was 85.2 and 87.9 on 2/11/2025 showing an increase in weight. Supplements were trialed with the resident who has refused them.</p> <p>All residents have the potential to be affected by the alleged deficient practice. A facility wide audit of new admissions from 2/1/2025 was completed to ensure that the weekly weights x 4 on new admissions are being obtained as ordered.</p> <p>The Licensed Nurses received in-service training on the Weight Policy. The focus was on obtaining the weights as ordered and following the re-weight policy as stated. The DNS and Dietician or designee will Audit the weekly Weights to ensure they are obtained and assessed for weight loss, reweights if applicable and followed by the risk team.</p> <p>The results of the Weight Audits will be reviewed at the Quality Assurance Committee Meeting to ensure ongoing compliance, until compliance is maintained.</p> <p>The Director of Nursing is responsible for ensuring ongoing compliance.</p>	2/11/2025	

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F 692	<p>Continued From page 27</p> <p>1. Record review revealed Resident ID #52 was re-admitted to the facility in December of 2024, with diagnoses including, but not limited to, dementia and dysphagia (difficulty swallowing).</p> <p>Review of a care plan dated 11/20/2023 revealed, the resident is at risk for malnutrition due to dementia and a history of dysphagia.</p> <p>Additionally, the care plan was revised on 12/14/2024 indicating mild protein calorie malnutrition (This occurs when you are not consuming enough protein and calories. This can lead to muscle loss and fat loss.) Further review revealed interventions including, but not limited to, staff are to obtain weekly weights per policy and consult the dietician as needed for changes in weight.</p> <p>Record review of a nutritional assessment completed by the Dietitian on 12/14/2024, revealed that the resident has been noted with a decline in intake since his/her admission and requires weekly weights.</p> <p>Record review revealed the following weights:</p> <p>-12/23/2024 167 lbs. -1/6/2025 159 lbs.</p> <p>Record review failed to reveal weights were obtained during the weeks of 12/29/2024 through 1/4/2025.</p> <p>Indicating the resident had a 8 lb. weight loss in 2 weeks.</p> <p>Record review revealed the following documentation of the resident's intakes for meals</p>	F 692			

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F 692	<p>Continued From page 28 from 12/24/2024 through 1/6/2025 were as follows:</p> <p>-12/24/2024- Only 1 meal was documented with 26-50% consumed.</p> <p>-12/25/2024- Only 1 meal was documented with 26-50% consumed.</p> <p>-12/26/2024- 2 meals were documented with 76% to 100% consumed, 1 meal was documented with 26-50% consumed.</p> <p>-12/27/2024- 1 meal was documented as refused, 1 meal was documented with 0% to 25% consumed and 1 meal was documented with 51% to 75% consumed.</p> <p>-12/28/2024- 3 meals were documented with 0 to 25% consumed.</p> <p>-12/29/2024- 2 meals were documented with 0% to 25% consumed, and 1 meal was documented with 26% to 50% consumed.</p> <p>-12/30/2024- 1 meal was documented as refused and 2 meals were documented with 0% to 25% consumed.</p> <p>-12/31/2024- 2 meals were documented with 0% to 25% consumed, and 1 meal was documented with 26-50% consumed.</p> <p>-1/1/2025- 1 meal was documented with 0% to 25% consumed, 1 meal was documented with 26% to 50% consumed, and 1 was meal documented with 76% to 100% consumed.</p> <p>-1/2/2025- 2 meals were documented with 51% to</p>	F 692			

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F 692	<p>Continued From page 29</p> <p>75% consumed and 1 meal was documented with 26% to 50% consumed.</p> <p>-1/3/2025- 1 meal was documented with 26% to 50% consumed, and 2 meals were documented with 76% to 100% consumed.</p> <p>-1/4/2025- 1 meal was documented with 26% to 50% consumed, and 2 meals were documented with 76% to 100% consumed.</p> <p>-1/5/2025- Only 1 meal was documented with 76-100% consumed.</p> <p>-1/6/2025- 2 meals were documented with 51% to 75% consumed, and 1 meal was documented with 76% to 100% consumed.</p> <p>Record review failed to reveal evidence that the resident was re-weighed on 1/6/2025 when s/he had a documented weight loss of 8 lbs. Additional record review failed to reveal evidence any additional interventions or weights implemented for the resident from 1/6/2025 through 1/30/2025, until it was brought to the facility's attention by the surveyor.</p> <p>During surveyor interviews on 1/30/2025 at 10:38 AM and 11:23 AM with the Dietitian, she acknowledged that the resident had a weight loss of 8 lbs. in 2 weeks. She revealed that it would be her expectation that the resident would have been re-weighed to ensure the accuracy of the weight. Further, she revealed that as part of her assessment process she does review the weights weekly but had not reviewed the resident's weight obtained on 1/6/2025. Additionally, she revealed that she had not been notified of the weight loss documented on 1/6/2025, and that she</p>	F 692			

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NAME OF PROVIDER OR SUPPLIER WATERVIEW VILLA REHABILITATION AND HEALTH CARE CEN			STREET ADDRESS, CITY, STATE, ZIP CODE 1275 SOUTH BROADWAY EAST PROVIDENCE, RI 02914		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 692	<p>Continued From page 30</p> <p>re-weighed the resident on 1/30/2025 and his/her weight was recorded as 158 lbs., confirming the previous weight loss and the loss of an additional pound.</p> <p>2. Record review revealed Resident ID #272 was admitted to the facility on January 16, 2025, with diagnoses including, but not limited to, poliomyelitis (a viral infection causing nerve injury which leads to partial or full paralysis) and depression.</p> <p>Record review revealed the following weights:</p> <p>-1/16/2025 86.3 lbs. -1/27/2025 85 lbs.</p> <p>Record review failed to reveal weights were obtained during the weeks of 1/19/2025 through 1/25/2025.</p> <p>Indicating the resident lost 1.3 lbs. in 10 days.</p> <p>Record review failed to reveal evidence of that any additional weights were obtained for the resident after 1/27/2025.</p> <p>Further record review failed to reveal evidence of an order to obtain Resident ID #272's weekly times four weeks upon his/her admission, per the facility's policy.</p> <p>Record review revealed documentation of the resident's intakes for meals and snacks from 1/16/2025 through 1/28/2025 as follows:</p> <p>-1/16/2025- Only 1 meal was documented with 76-100% consumed.</p>	F 692			

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F 692	Continued From page 31 -1/17/2025- Only 2 meals were documented with 76-100% consumed. -1/18/2025- Only 2 meals were documented, 1 meal with 26% to 50% consumed and 1 meal with 76-100% consumed. -1/19/2025- 2 meals were documented with 76% and 100% consumed. -1/20/2025- 2 meals were documented with 51% to 75% consumed, and 1 meal was documented with 0% to 25% consumed. -1/22/2025- 1 meal was documented with 0% to 25% consumed, and 2 meals were documented with 26% to 50% consumed. -1/23/2025- 2 meals were documented with 26% to 50% consumed, and 1 meal was documented with 51% to 75% consumed. -1/24/2025- 1 meal was documented as refused, 1 meal was documented with 51% to 75% consumed, and 1 meal was documented with 76% to 100% consumed. -1/25/2025- 3 meals were documented with 26% to 50% consumed. -1/26/2025- 3 meals were documented with 26% to 50% consumed. -1/27/2025- 3 meals were documented with 26% to 50% consumed. -1/28/2025- Only 1 meal was documented with 76% and 100% consumed.	F 692			

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F 692	Continued From page 32 Record review failed to reveal evidence of a nutritional care plan for the resident. Further record review failed to reveal evidence that an admission nutritional assessment was completed by the Dietitian for Resident ID #272. During a surveyor interview on 1/30/2025 at 10:52 AM with the Dietitian, she acknowledged the resident experienced a weight loss. Additionally, she revealed that she assessed the resident on 1/20/2025, and recommended Ensure (a nutritional supplement) twice a day, however she was unable to provide evidence of an assessment or that the Ensure recommendation was communicated to the facility. During surveyor interviews on 1/30/2025 at 10:52 AM and 11:31 AM with the Director of Nursing Services (DNS) she revealed that she would have expected the staff to re-weigh Resident ID #52 after his/her weight was obtained on 1/6/2025. Additionally, the DNS could not provide evidence that the Dietitian, family, or provider were notified of the resident's weight loss, as indicated in the facility's policy. Furthermore, she could not provide evidence of an admission nutritional assessment completed for Resident ID #272 or that any intervention were implemented for him/her.	F 692			
F 740 SS=E	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial	F 740		2/11/2025	

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F 740	<p>Continued From page 33</p> <p>well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to ensure that a resident who is diagnosed with a mental disorder or has a history of trauma, receives appropriate treatment and services to attain the highest practicable mental and psychosocial well-being relative to 1 of 1 resident reviewed for suicidal ideations, Resident ID #113.</p> <p>Findings are as follows:</p> <p>Record review revealed the resident was admitted to the facility in January of 2025 with diagnoses including, but not limited to, suicidal ideations, bipolar disorder, and Post Traumatic Stress Disorder.</p> <p>Review of a Brief Interview for Mental Status Assessment dated 1/11/2025 revealed a score of 13 out of 15, indicating the resident is cognitively intact.</p> <p>Review of a mood interview dated 1/11/2025 revealed a score of 15 out of 27, indicating the resident has moderately severe depression.</p> <p>Record review of a document titled, "Nursing Home Consult Service," dated 1/6/2025 states in part, "...long history of psych illness...history of multiple suicide attempts...12/10 in patient psych</p>	F 740	<p>F 740</p> <p>Resident ID # 113 has a behavioral monitoring order placed for monitoring of SI on 1/30/2025.</p> <p>All residents with a diagnosis of Suicidal Ideation have the potential to be affected by the alleged deficient practice. A diagnosis listing report reviewing all current residents was run to determine if there were any other residents with a diagnosis of Suicidal Ideation or attempts. There were 2 other residents identified, and the behavioral monitoring orders were placed to monitor for SI.</p> <p>The DNS and Social Workers were involved on reviewing all new admissions to determine if any new admission has a diagnosis of Suicidal Ideation or attempts to ensure that orders were placed for behavior monitoring for Suicidal Ideation. The Director of Social Services will complete a Suicidal Ideation Audit on new admissions to ensure if the resident has a diagnosis of Suicidal Ideation or hx of attempt the behavioral monitoring order is in place.</p> <p>The results of the Suicidal Ideation Audit will be reviewed at the Quality Assurance Committee Meeting to ensure ongoing compliance, until compliance is maintained.</p> <p>The Social Service is responsible for ensuring ongoing compliance.</p>	2/11/2025	

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F 740	<p>Continued From page 34.</p> <p>for ingestion of 2 handfuls of gabapentin [a medication used to treat nerve pain] and lisinopril [a medication used to treat high blood pressure] with the intent to end [his/her] life...denies suicide ideation [SI] at skilled nursing center...admits to chronic suicide ideation which is exacerbated in the setting of social stressors...no acute psych concerns but at chronic risk...Recommendation...monitor for SI, if any active urges would send out to ED [Emergency Department]...discussed behavioral plan with staff..."</p> <p>Record review of the care plan dated 1/8/2025 revealed a focus area related to signs and a history of major depression, bipolar disorder and recent suicidal ideation. Further review failed to reveal interventions including to monitor for suicidal ideation. Additional review failed to reveal evidence of a behavioral plan related to suicidal ideation.</p> <p>Record review of the January 2025 Treatment Administration Record failed to reveal any evidence of behavioral monitoring related to suicidal ideation.</p> <p>Record review of the nursing progress notes failed to reveal reveal any evidence of behavioral monitoring related to suicidal ideation.</p> <p>During a surveyor interview on 1/30/2025 at 8:55 AM with Registered Nurse, Staff B, she was unable to provide evidence of the facility was monitoring the resident's behavior related to suicidal ideation for Resident ID #113.</p> <p>During a surveyor interview on 1/30/2025 at 11:23 AM with the Director of Nursing Services, she</p>	F 740			

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F 740	Continued From page 35 indicated that she would expect the staff to be monitoring the resident's behavior relative to suicidal ideation and contacting the physician as needed. Additionally, she was unable to provide evidence the facility was monitoring the resident's behavior related to suicidal ideation.	F 740			
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on surveyor observation, record review, and staff interview, it has been determined that	F 761	F 761 There were no residents identified in this deficiency. The facility removed the key from the nurses/CMT's key ring and placed it on a separate ring with a large tag identifying it as the Bathroom Key. With this change there was no need to provide training, it eliminated the risk with the change. Key was placed in the draw at the nurse's station. The Administrator is responsible for ensuring ongoing compliance.	2/11/2025	

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F 761	<p>Continued From page 36</p> <p>the facility failed to store drugs and biologicals in accordance with currently accepted professional principles relative to 1 of 1 secured unit observed.</p> <p>Findings are as follows:</p> <p>Record review of a facility policy titled, "Medication storage room/Medication cart policy" dated February 2018, revealed in part, "...The facility provides pharmaceutical services that are conducted in accordance with accepted ethical and professional standards of practice and that meet applicable Federal, State and Local Laws, rules and regulations...Medications are stored primarily in a locked mobile medication cart which is accessible only to licensed nursing personnel...Storage for other medications will be limited to a locked medication room..."</p> <p>During a surveyor observation of the medication administration pass on 1/29/2025, with Certified Medication Technician (CMT), Staff P, the following was observed:</p> <ul style="list-style-type: none"> - At approximately 9:35 AM Licensed Practical Nurse, Staff M, asked Staff P, for the medication technician key ring, because another staff member had to use the bathroom. - At approximately 9:40 AM, Staff M, walked back towards the medication cart where Staff P, was administering medications. Staff P, asked Staff M, if she could have the keys to her cart back. Staff M, indicated that a housekeeper had the medication cart keys because she needed to use the bathroom. - At approximately 9:45 AM the keys were returned to Staff P, by housekeeper, Staff Q. 	F 761			

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F 761	Continued From page 37 During a surveyor interview on 1/29/2025 at 10:04 AM with CMT, Staff P, she revealed that the medication technician key ring contains the only key to unlock the bathroom on the unit. Additionally she revealed that the keys for the two medication carts and the key for the medication storage room are on the same key ring. She acknowledged that staff members take the keys so they can use the locked bathroom, and that they "need to find a better system." During a surveyor interview on 1/29/2025 at approximately 10:10 AM with Staff M, he acknowledged that when anyone must use the unit's bathroom, they must use the medication technician's key ring because it contains the only bathroom key. During a surveyor interview on 1/29/2025 at approximately 10:15 AM with housekeeper, Staff Q, she acknowledged that she must get the key ring from the medication technician when she needs to use the bathroom. During a surveyor interview on 1/29/2025 at 1:48 PM with the Director of Nursing Services, she acknowledged that the bathroom key should be separate from the medication storage keys. She could not provide evidence that the medication storage areas were only accessible to licensed nurses or medication technicians, as required.	F 761			
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		2/11/2025	

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F 812	<p>Continued From page 38</p> <p>§483.60(l)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.</p> <p>§483.60(l)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: 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 the main dining room.</p> <p>1. The Rhode Island Food Code 2018 Edition 4-601.11 states in part, "...Nonfood contact surfaces shall be kept free of an accumulation of dirt, dust, food residue, and other debris..."</p> <p>Surveyor observations of the main kitchen on 1/27/2025 at approximately 8:45 AM and on 1/28/2025 and 1/29/2025 at 9:40 AM revealed the following:</p> <ul style="list-style-type: none"> - Grease accumulation along the sides and the corners of the steamer - Grease accumulation along the corners and 	F 812	<p>F 812</p> <p>There were no residents identified in this deficiency.</p> <p>All areas of the kitchen have the potential to be affected by the alleged deficient practice. A complete deep cleaning of the areas identified was completed prior to the exit of the surveyors.</p> <p>The facility hired a new Food Service Director who started on 2/3/2025. The Food service director received in-service training on the cleanliness needs of the kitchen equipment and a review of the deficiency. A Cleanliness Audit was created and will be completed weekly (or as needed) by the food service director or designee.</p> <p>The results of the Cleanliness Audit will be reviewed at the Quality Assurance Committee Meeting to ensure ongoing compliance, until compliance is maintained.</p> <p>The Food Service Director is responsible for ensuring ongoing compliance.</p> <p>2. There was no resident identified in this deficiency statement. The eggs were removed from the kitchen.</p> <p>The staff member that the eggs belonged to received in-service training on not bringing in or storing farm eggs in the kitchen. The Food Service Director will randomly audit the kitchen refrigerators to ensure that there are no eggs except those purchased from the facility vendor.</p> <p>The results of the Farm Egg Audit will be reviewed at the Quality Assurance Committee Meeting to ensure ongoing compliance, until compliance is maintained.</p> <p>The Food Service Director is responsible for ensuring ongoing compliance.</p>	2/11/2025	

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F 812	<p>Continued From page 39 sides of the food warmer</p> <ul style="list-style-type: none"> - Grease accumulation along the sides and the corners of the stove - Utility cart that stored containers of spices with crumbs and debris in the corners - 4 food meal delivery carts with grease and grime accumulation along the lower edges <p>Surveyor observations on 1/29/2024 at 12:15 PM and on 1/30/2025 at 9:15 AM, of the main dining room, revealed the steam table with grease accumulation on the knobs and food spills on the front of the unit.</p> <p>2. The Rhode Island Food Code 2018 Edition 3-201.11 states in part, "...Food shall be obtained from sources that comply with Law..."</p> <p>During a surveyor observation on 1/29/2025 at 9:40 AM the main kitchen reach in refrigerator unit revealed a dozen of eggs stored in a gray egg container, with a use by date of 12/14/2024.</p> <p>Immediately following the above-observation, dietary cook, Staff R, revealed the eggs were for a staff member and that they were fresh farm eggs from his farm raised chickens.</p> <p>During a surveyor observation and interview on 1/30/2025 at 9:15 AM with the Administrator, he acknowledged that the above-mentioned food service equipment was in need of cleaning and that the eggs that were brought in from home were improperly stored.</p>	F 812			
F 842 SS=D	Resident Records - Identifiable Information	F 842		2/11/2025	

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F 842	Continued From page 40 CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) in accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert	F 842	F 842 1. Resident ID # 83 heels were offloaded with booties as ordered since 1/28/2025. All residents with orders for off-loading heels with booties have the potential to be affected by the same deficient practice. A facility-wide assessment of residents with orders for off-loading of heels with booties was conducted to ensure that the residents with that order were off loaded with booties in place. The Licensed Nurses received in-service training on signing off orders for off loading of heels with booties must only be done if the nurse verifies that the heels are off loaded with the booties in place. A focus on the deficiency was reviewed at the time of the training. The DNS or designee will randomly audit the residents with orders for off loading heels and booties to ensure the orders were followed as ordered. The results of the Offloading heels and booties Audit will be reviewed at the Quality Assurance Committee Meeting to ensure ongoing compliance, until compliance is maintained. The Director of Nursing is responsible for ensuring ongoing compliance. 2. Resident ID # 46 heels have been off loaded as ordered since 1/29/2025. All residents with orders for off-loading heels have the potential to be affected by the same deficient practice. A facility-wide assessment of residents with orders for off-loading of heels was conducted to ensure that the residents with that order were off loaded as ordered. The Licensed Nurses received In-service training on signing off orders for off-loading of heels which must only be done if the nurse verifies that the heels are off loaded. A focus on the deficiency was reviewed at the time of the training. The DNS or designee will randomly audit the residents	2/11/2025	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/31/2025
NAME OF PROVIDER OR SUPPLIER WATERVIEW VILLA REHABILITATION AND HEALTH CARE CEN			STREET ADDRESS, CITY, STATE, ZIP CODE 1275 SOUTH BROADWAY EAST PROVIDENCE, RI 02914		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 842	<p>Continued From page 41</p> <p>a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.</p> <p>§483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.</p> <p>§483.70(h)(4) Medical records must be retained for-</p> <p>(i) The period of time required by State law; or</p> <p>(ii) Five years from the date of discharge when there is no requirement in State law; or</p> <p>(iii) For a minor, 3 years after a resident reaches legal age under State law.</p> <p>§483.70(h)(5) The medical record must contain-</p> <p>(i) Sufficient information to identify the resident;</p> <p>(ii) A record of the resident's assessments;</p> <p>(iii) The comprehensive plan of care and services provided;</p> <p>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;</p> <p>(v) Physician's, nurse's, and other licensed professional's progress notes; and</p> <p>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on surveyor observation, record review, and staff interview it has been determined that the facility failed to maintain medical records on each resident that are accurately documented for 1 of 2 residents reviewed for heel boots, Resident ID #83, for 2 of 2 residents reviewed for off-loading heels, Resident ID #s 46 and 83 and for 1 of 2 residents observed for wound dressings, Resident ID #272.</p>	F 842	<p>F 842 con't</p> <p>with orders for off- loading heels to ensure the orders were followed as ordered.</p> <p>The results of the Offloading heels and booties Audit will be reviewed at the Quality Assurance Committee Meeting to ensure ongoing compliance, until compliance is maintained.</p> <p>The Director of Nursing is responsible for ensuring ongoing compliance.</p> <p>3. Resident ID # 272 was seen by the wound doctor and the treatment order was changed to a treatment that does not require a protective dressing.</p> <p>All residents that require wound treatments have the potential to be affected by the same alleged deficient practice. The facility completed a facility wide assessment on residents with treatment orders and completed a visual inspection of each treatment to determine that the treatment was completed as ordered on 2/3/2024 by the regional nurse.</p> <p>The Licensed Nursing Staff have received in-service training on completion of treatments as ordered. The ICN Nurse or designee will weekly during wound rounds complete Treatment Audits to ensure the ordered treatment was done as ordered and dated appropriately.</p> <p>The results of the Treatment Audits will be reviewed at the Quality Assurance Committee Meeting to ensure ongoing compliance, until compliance is maintained.</p> <p>The Director of Nursing is responsible for ensuring ongoing compliance.</p>	2/11/2025	

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2/11/25

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NAME OF PROVIDER OR SUPPLIER WATERVIEW VILLA REHABILITATION AND HEALTH CARE CEN			STREET ADDRESS, CITY, STATE, ZIP CODE 1275 SOUTH BROADWAY EAST PROVIDENCE, RI 02914		
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F 842	<p>Continued From page 42 Findings are as follows:</p> <p>1. Record review revealed Resident ID #83 was re-admitted to the facility in April of 2023 with diagnoses including, but not limited to, contracture of the right knee and vascular dementia.</p> <p>Review of the care plan dated 4/28/2023 revealed that s/he is at risk for skin breakdown related to limited mobility.</p> <p>Review of a Norton assessment (a tool used to determine a person's risk of developing a pressure ulcer) dated 12/10/2024, revealed a score of 6 indicating that the resident is at high risk to develop a pressure ulcer.</p> <p>Record review revealed the following physician's orders dated 4/28/2023:</p> <ul style="list-style-type: none"> - offload the resident's heels every shift as tolerated for skin integrity - wear heel protectors as tolerated while in bed every shift. <p>Surveyor observations on the following dates and times revealed that the resident's heels were not offloaded or that the boots were applied, as ordered:</p> <ul style="list-style-type: none"> - 1/27/2025 at 10:03 AM and 12:24 PM - 1/28/2025 at 9:25 AM and 12:28 PM <p>Review of the January 2025 Treatment Administration Record (TAR) revealed that the above-mentioned orders were signed off as completed.</p>	F 842			

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F 842	<p>Continued From page 43</p> <p>During a surveyor interview on 1/28/2025 at 12:52 PM with Registered Nurse, Staff G, she acknowledged that the resident's heels were not offloaded, and his/her boots were not applied as ordered. Additionally, she acknowledged that the TAR was signed off inaccurately to indicate that the orders were completed.</p> <p>2. Record review revealed Resident ID #46 was re-admitted to the facility in December of 2024 with diagnoses including, but not limited to, muscle weakness and major depressive disorder.</p> <p>Review of a physician's order dated 12/3/2024 revealed an order to offload the resident's heels every shift as tolerated for skin integrity.</p> <p>During surveyor observations on the following date and times revealed the resident's heels were not offloaded, as ordered.</p> <ul style="list-style-type: none"> - 1/27/2025 at 9:40 AM - 1/28/2025 at 12:24 PM - 1/29/2025 at 2:21 PM <p>During a surveyor interview on 1/29/2025 at 2:29 PM with Registered Nurse, Staff F, she acknowledged that the resident's heels were not offloaded as ordered. Further, she was provide evidence the TAR was documented accurately on 1/29/2025.</p> <p>3. Record review revealed Resident ID #272 was readmitted to the facility in January of 2025 with diagnoses including, but not limited to Poliomyelitis (a viral infection causing nerve injury which leads to partial or full paralysis).</p> <p>Review of a physician's order dated 1/23/2025</p>	F 842			

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F 842	Continued From page 44 indicated to cleanse the right buttock moisture-associated skin damage with wound cleanser, to apply honey gel then cover the wound with a bordered foam dressing every evening shift. During a surveyor observation on 1/30/2025 at 9:54 AM of the dressing change with Registered Nurse, Staff B, the soiled dressing was observed to have the date of 1/28/2025 which indicated that it was not changed on 1/29/2025, as ordered. Review of the January 2025 TAR revealed that the dressing change was signed off as completed on 1/29/2025. Additionally, Staff B, acknowledged the date of 1/28/2025 was on the dressing she removed and indicated that it was not changed on 1/29/2025, as ordered. During a surveyor interview on 1/30/2025 at approximately 12:00 PM with the Director of Nursing Services, she indicated that she would expect the staff to follow the physician's orders and document information accurately in the residents' medical records.	F 842			
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880	F 880 There was no resident identified in this deficiency. All residents requiring Glucose Testing using a glucometer have the potential to be affected by the same deficient practice. The facility has laminated step instructions for Glucose Testing and placed them on the nurses med carts for reference. The Licensed Nursing Staff have had a competency on Glucose Testing Completed which reviews each nurse for knowledge of when and how to appropriately complete glucose testing via glucometer which includes the cleaning of the glucometer after each use using a beach wipe. The DNS or designee will randomly complete a Glucometer Cleaning Audit to ensure that the Glucometers are being cleaned after each use per policy. The results of the Glucometer Cleaning Audits will be reviewed at the Quality Assurance Committee Meeting to ensure ongoing compliance, until compliance is maintained. The Director of Nursing is responsible for ensuring ongoing compliance.	2/11/2025	

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F 880	<p>Continued From page 45</p> <p>§483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct</p>	F 880			

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F 880	<p>Continued From page 46</p> <p>contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: 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 designed to provide a safe, sanitary environment, and to help prevent the development and transmission of communicable diseases, relative to the disinfection of a glucometer that is used to obtain blood glucose readings for multiple residents, for 1 of 2 observations of blood sugar monitoring.</p> <p>Findings are as follows:</p> <p>Record review of a facility policy titled, "Glucose Monitoring Equipment" revised in October 2018, revealed in part, "...Blood glucose monitoring equipment will be cleaned with bleach wipe before and after use and/or as per manufacturer guidelines...Glucometers will be cleaned/disinfected with bleach wipes per</p>	F 880		

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F 880	<p>Continued From page 47 manufacturer guidelines..."</p> <p>Record review of the "Embrace Pro" manufacturer instruction manual revealed that the glucometer is to be cleaned by "...using a moist (not wet) cloth or tissue with isopropyl alcohol or mild detergent with water..."</p> <p>Record review revealed Resident ID #2 was re-admitted to the facility in July of 2023 with a diagnosis including, but not limited to, type 2 diabetes mellitus.</p> <p>Record review revealed a physician's order dated 9/20/2024 for Humalog insulin 100 Unit/milliliter (ML), twice daily, to be administered according to a sliding scale based on his/her blood sugar.</p> <p>During a surveyor observation on 1/29/2025 at 11:30 AM with Registered Nurse, Staff F, she obtained Resident ID #2's blood sugar. Additionally the observation failed to reveal Staff F wiped down the glucometer before and after obtaining the resident's blood sugar. Furthermore, Staff F failed to disinfect the glucometer prior to placing it back in to the medication cart.</p> <p>During a surveyor interview on 1/29/2025 at 11:34 PM with Staff F, she acknowledged that she failed to clean the glucometer before and after using it to obtain the resident's blood sugar.</p> <p>During a surveyor interview on 1/29/2025 at 12:48 PM with the Director of Nursing Services, she revealed that she would expect Staff F to clean the glucometer with a bleach wipe prior to and after obtaining the resident's blood sugar.</p>	F 880		

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NAME OF PROVIDER OR SUPPLIER WATERVIEW VILLA REHABILITATION AND HEALTH CARE CEN			STREET ADDRESS, CITY, STATE, ZIP CODE 1276 SOUTH BROADWAY EAST PROVIDENCE, RI 02914		
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E 000	Initial Comments An Emergency Preparedness Survey was conducted by the Center for Health Facilities and Regulation on 1/27/2025. The facility was found to be in compliance with 42 CFR §483.73 related to Emergency Preparedness. Capacity: 132 Census: 123	E 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

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K 000	<p>INITIAL COMMENTS</p> <p>The annual Federal Life Safety Code survey was conducted by the State Survey Agency on 1/28/2025. Waterview Villa Nursing Rehabilitation and Healthcare Center was surveyed pursuant to the National Fire Protection Association 101 Life Safety Code, 2012 Edition as referenced in 42 CFR 483.90 (a - d) Physical Environment.</p> <p>No Life Safety Code deficiencies were identified during the survey.</p> <p>The facility is in compliance with all regulations surveyed.</p> <p>Capacity: 132 Census: 123</p>	K 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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