STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415079	A. Building B. Wing	08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Haven Operations Holding LLC Valley View Hea	4 St Joseph Street Woonsocket, RI 02895

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Based on record review, staff and resident interview it has been determined that the facility failed to keep a resident free from neglect relative to 1 of 1 resident reviewed who was left unattended outside of the facility for approximately 3 hours and 20 minutes during a heat advisory resulting in cardiac arrest, Resident ID #1. Findings are as follows:Review of a community reported complaint submitted to the Rhode Island Department of Health on 7/30/2025 alleged that Resident ID #1 was left unattended outside of the facility for an unknown amount of time on 7/30/2025. The complaint further alleged that the resident was found unconscious, without a pulse and required cardio-pulmonary resuscitation (CPR). Additionally, the resident was transferred to the hospital for further treatment.Review of the weather report on 7/30/2025 revealed a heat advisory was in effect for the facility's area. According to the National Weather Service, a heat advisory is issued when dangerously high temperatures are expected that could potentially be harmful. Record review revealed Resident ID #1 was admitted to the facility in April of 2025 with diagnoses including, but not limited to, diabetes mellitus type 2, heart failure, chronic obstructive pulmonary disease (COPD), and cognitive communication disorder. Review of a care plan last revised on 7/21/2025 revealed the resident has a level two PASRR evaluation (a person-centered comprehensive evaluation used for people with a mental illness or intellectual disability to determine the need for specialized services) related to mental illness with interventions including, but not limited to, assessing and anticipating the resident's needs such as food, thirst, toileting needs, comfort level, body positioning, and pain. Record review revealed a physician's order dated 7/4/2025 to administer Humalog injection solution (a fast-acting insulin) per the sliding scale (the nurse obtains the resident's blood sugar via a finger stick and then administers the appropriate dose of insulin ordered for that blood sugar range) three times a day, at 8:30 AM, 11:30 AM, and 4:30 PM. Record review of the July 2025 Medication Administration Record (MAR) revealed on 7/30/2025 the nurse documented N/A -1 for the 11:30 blood sugar check insulin injection. Further review revealed the code 1 on the MAR indicated that the resident was absent from home without [medications]. Additional review failed to reveal evidence that the resident refused any medications or treatments on 7/30/2025. Record review of a progress note dated 7/30/2025 at 1:50 PM indicated that the resident was found unresponsive, sitting outside in his/her wheelchair. The resident was brought in by staff at which time s/he stopped breathing, 911 was called and CPR was initiated. Further review indicated the resident became responsive at which time emergency medical services (EMS) took over.Review of the RI EMS Patient Care Report revealed EMS arrived at the facility on 7/30/2025 at 1:29 PM after a call for an unresponsive resident. Further review revealed Resident ID #1 was extremely hot to touch on arrival with shallow breathing and pinpoint pupils. Additional review revealed a facility nurse reported that the resident was outside when s/he became slumped over in his/her wheelchair for an unknown amount of time and then moved inside where staff could not find a pulse and started CPR. Resident ID #1 was transported to the hospital. Review of a hospital document dated 7/30/2025 revealed Resident ID #1 was admitted to the hospital for suspected heat stroke resulting in cardiac arrest, aspiration pneumonia (refers to adverse pulmonary consequences due to entry of gastric or oropharyngeal fluids), secondary to cardiac arrest and myocardial infarction (heart attack) in the setting of cardiac arrest. The hospital records indicate that the resident was outside in the heat for over 3 hours when s/he was found unresponsive by nursing home staff. The resident underwent multiple rounds of CPR in the field and obtained return of spontaneous circulation (ROSC). On arrival to the emergency department, the resident's heart monitor was showing pauses, and the resident was unresponsive requiring one round of CPR for which ROSC was obtained. During a surveyor interview on 7/31/2025 at approximately 2:30 PM with Nursing Assistant (NA), Staff A, in the presence of a translator, he indicated that he was assigned to perform care for Resident ID #1 on 7/30/2025. He further indicated that he provided morning care and served his/her breakfast. Additionally, he indicated that the resident went outside at approximately 10:00 AM and that he did not check on the resident after s/he went outside. Furthermore, he acknowledged that he did not look for the resident at lunch time to offer his/her meal. During a surveyor interview on 7/31/2025 at approximately 1:30 PM with Licensed Practical Nurse, Staff B, she indicated that Resident ID #1 went outside of the facility at approximately 10:00 AM on 7/30/2025. She further indicated that she did not go outside to check on the resident or attempt to complete the ordered blood sugar check that was scheduled for 11:30 AM. Additionally, she indicated that someone, she was unaware who, had told her that the resident refused to come inside so she didn't see him/her until she was alerted that s/he was outside unresponsive at

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on record review and staff interview, it has been determined that the facility failed to ensure that services provided by the facility meet professional standards of quality relative to following physician's orders for 1 of 3 residents reviewed, Resident ID #1.Findings are as follows:According to Mosby's 4th Edition, Fundamentals of Nursing, page 314, The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm the clients. Record review revealed Resident ID #1 was readmitted to the facility in August of 2025 with a diagnosis including, but not limited to, diabetes mellitus.1a. Record review revealed a physician's order dated 8/7/2025 for Humalog Insulin (a short acting insulin); 100 unit/milliliter (mL); before meals inject as per sliding scale:-Blood Sugar is 150 to 199, give 2 Units. -Blood Sugar is 200 to 249, give 4 Units. -Blood Sugar is 250 to 299, give 6 Units. -Blood Sugar is 300 to 349, give 8 Units. -Blood Sugar is greater than 350, call MD (medical doctor).Record review of the August 2025 Medication Administration Record (MAR) failed to reveal evidence that the resident's blood sugar was obtained to determine if the Humalog insulin was required to be administered on the following dates and times: -8/7/2025 at 11:30 AM -8/10/2025 at 6:30 AM 1b. Record review revealed a physician's order dated 8/20/2025 for a high protein snack at bedtime for nutritional support.Record review of the August 2025 MAR revealed the high protein snack was documented as not available and not provided to the resident on the following dates:-8/20/2025-8/21/2025During a surveyor interview on 8/22/2025 at 2:04 PM with Licensed Practical Nurse, Staff A, he was unable to explain why the resident did not receive his/her high protein snack as ordered and acknowledged that the items were available in the facility to provide to the resident. Additionally, he was unable to provide evidence that the resident blood sugar was obtained on 8/7/2025 at 11:30 AM and 8/10/2025 at 6:30 AM as ordered. During a surveyor interview at 8/22/2025 at 3:40 PM with the [NAME] President of Operations, she revealed that items are available in the facility to give residents high protein snacks and would have expected the snack to be given as ordered. Additionally, she was unable to provide evidence that the resident's blood sugar was obtained on 8/7/2025 at 11:30 AM and 8/10/2025 at 6:30 AM as ordered to determine if the resident required his/her insulin to be administered.Cross reference F760

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review and staff interview, it has been determined that the facility failed to ensure that residents are free from significant medication errors for 1 of 1 resident reviewed receiving amoxicillin-clavalanate (an antibiotic) and divalproex (a medication used to treat mood disorders) and 1 of 2 residents reviewed requiring insulin, Resident ID #1. Findings are as follows:Review of a facility policy titled, Medication Administration dated 10/11/2017 states in part, It is the intent of this policy to ensure that resident medication administration is managed to ensure for resident quality of life, timeliness and safety .When transcribing an order to the MAR [Medication Administration Record].the nurse will take into consideration the purpose of administering the medication and assign the appropriate time.Medications are administered within one hour of the time noted on MAR .Record review revealed Resident ID #1 was readmitted to the facility in August of 2025 with diagnoses including, but not limited to, diabetes mellitus, mood disorder, and sepsis (a serious condition resulting from the presence of harmful microorganisms in the blood or other tissues and the body's response to their presence, potentially leading to the malfunctioning of various organs, shock and death).1a. Record review revealed a physician's order dated 8/6/2025 for amoxicillin-clavalanate 875-125 milligram (mg), take one tablet by mouth in the morning for sepsis for 9 days. Record review of the August 2025 Medication Administration Record (MAR) revealed that the amoxicillin-clavalanate was documented as not administered as ordered on 8/7/2025 with a reason code of 5 which indicates to see the progress notes. Review of a progress note dated 8/7/2025 revealed the above medication was not administered due to being on order.1b. Record review of a hospital Discharge Summary document dated 8/6/2025 revealed a physician's order to continue divalproex ER (extended release) 2,000 mg by mouth nightly. Additionally, the hospital discharge document revealed the last time the medication was administered was on 8/5/2025 at 10:27 PM indicating the next required daily dose would be on 8/6/2025 in the evening. Record review of an undated Medication Reconciliation document revealed the resident was to continue with the divalproex ER upon his/her readmission to the facility.Record review revealed a physician's order dated 8/6/2025 for divalproex ER 500 mg- give four tablets (for a total dose of 2,000 mg) by mouth at bedtime.Additional review of the August 2025 MAR failed to reveal evidence that the resident received his/her divalproex ER 2,000 mg as ordered on 8/6 or 8/7/2025.1c. Record review revealed a physician's order dated 8/7/2025 for Lantus (a long-acting insulin) 100 unit/milliliter (mL); inject 5 units in the morningFurther review of the August 2025 MAR failed to reveal evidence that the Lantus insulin was administered as ordered on 8/7/2025.During a surveyor interview on 8/22/2025 at 2:04 PM with Licensed Practical Nurse, Staff A, he acknowledged that he worked the 7:00 AM to 3:00 PM shift on 8/7/2025 and was assigned to care for the resident. Additionally, he was unable to recall if he administered the Lantus insulin to the resident as ordered. Further, he acknowledged the amoxicillin-clavalanate was not administered as ordered 8/7/2025 and that there is an in house pyxis (an automated medication dispensing system) that contained the amoxicillin-clavalanate. Furthermore, he was unable to provide evidence that the resident received the divalproex ER 2,000 MG as ordered on 8/6/2025 and 8/7/2025.During a surveyor interview on 8/22/2025 at approximately 2:30 PM and 2:56 PM with the resident's Nurse Practitioner, Staff B, she acknowledged that she was unaware that the amoxicillin-clavalanate was not administered for the full 9-day course as ordered. Additionally, she revealed that she was not aware that the resident did not receive his/her divalproex ER and Lantus as ordered and would have expected the resident to have received the medications as ordered. During a surveyor interview on 8/22/2025 at 3:40 PM with the [NAME] President of Operations, she indicated it would have been her expectation that the medication aide would have asked the nurse to remove the amoxicillin-clavalanate from the pixus to administer the medication to the resident 8/7/2025 and that the resident would have received his/her Lantus as ordered on 8/7/2025. Further she was unable to provide evidence why the residents divalproex ER was not administered on 8/6/2025 and 8/7/2025. Cross Reference- F658