STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415082	A. Building B. Wing	12/05/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observation, and resident and staff interview, it has been determined that the facility failed to have sufficient nursing staff to assure resident safety and attain the highest practicable, physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care, relative to 2 of 2 residents reviewed on the One East Unit, Resident ID #s 4 and 5. Findings are as follows:Review of a community reported complaint submitted to the Rhode Island Department of Health on 9/20/2025 alleged that on 9/19/2025 on the 11:00 PM - 7:00 AM shift there was only one Nursing Assistant (NA) and one nurse working on the subacute (short term care) unit with 24 residents. The complaint further alleged that residents on the unit were fall risks, required 15-minute checks, and one to one supervision. Additionally, the complaint alleged that management was aware of the unsafe staffing.Review of the Facility Assessment, last reviewed on 9/19/2025 revealed in part, .Our facility had created a base staffing pattern to ensure a sufficient number of qualified staff to meet the needs of our residents on a consistent basis.During a surveyor interview on 10/2/2025 at 8:45 AM with the Assistant Director of Nursing Services, she indicted that she is currently responsible for scheduling the nursing staff and scheduling is based on the census of the unit. She further indicated that the One East Unit is minimally staffed with one nurse and two NAs on the 11:00 PM - 7:00 AM shift. Additionally, she indicated that staffing a unit with less than two NAs would not be safe especially if residents require a lift for transfers, however the nurse is expected to help the NAs. Furthermore, she indicated the following 11:00 PM - 7:00 AM staffing minimums by unit:-1 East- 1 nurse and 2 NAs-1 North/South- 1 nurse and 2 NAs-2 North/South- 1 nurse and 3 NAs-3 North/South- 1 nurse and 3 NAs-A total of 4 nurses and 10 NAs.Record review of the 9/19/2025 11:00 PM- 7:00 AM schedule revealed only 9 NAs worked in the facility that shift, under the above-mentioned facility's staffing minimum.During a surveyor interviews via telephone on 10/1/2025 at 9:20 AM and on 10/2/2025 at 10:11 AM, with NA, Staff A, s/he indicated that there was the only one NA working on the One East Unit on 9/19/2025 for the 11:00 PM - 7:00 AM shift. S/he further indicated that s/he only had time to complete one round of care for each resident on the unit due to insufficient staffing. The surveyor attempted to interview the nurse who worked the One East Unit on the 9/19/2025 11:00 PM - 7:00 AM shift, however the staff member did not return the surveyor's phone call.1a. Record review revealed Resident ID #4 was admitted to the facility in August of 2025 with diagnoses including, but not limited to, dementia, lack of coordination, and a history of falls. Review of a Minimum Data Set (MDS) assessment dated [DATE] revealed, the resident was incontinent of bowel and bladder and required maximum assistance from staff with toileting and hygiene. Review of a care plan dated 8/29/2025 revealed the resident had the potential for skin break down related to incontinence with interventions including, but not limited to, checking the resident approximately every two hours and providing incontinence care as needed. Further review of the care plan revealed the resident had a self-care performance deficit related to dementia with interventions including, but not limited to, requiring a total mechanical lift and the assistance of two staff members for transfers.Record review revealed Resident ID #4 was at risk for falls and had multiple falls during his/her admission to the facility on the following dates: 9/6, 9/14, and 9/20/2025. 1b. Record review revealed Resident ID #5 was admitted to the facility in September of 2025 with diagnoses including, but not limited to, cerebral infarction (stroke) and schizoaffective disorder. Review of a MDS assessment dated [DATE] revealed, the resident was incontinent of bowel and bladder. Further review revealed the resident required maximum assistance with hygiene. Additional review revealed the resident had impaired range of motion on one side of his/her body, affecting his/her upper and lower extremities. Review of a care plan revised 9/18/2025 revealed, the resident had a stage two pressure ulcer (an open wound or blister caused by prolonged pressure to a particular area which requires prompt treatment to prevent further complications) with interventions including, but not limited to, repositioning at least every two hours or more as needed.Record review of the resident's progress notes revealed the resident had multiple falls at the facility on the following dates: 9/6, 9/12, 9/17, 9/30, 10/1/2025.During a surveyor interview on 10/2/2025 with Licensed Practical Nurse, Staff B, she indicated that Resident ID #5 requires 15-minute checks for safety following multiple falls. She further indicated that NAs are expected to complete rounds as soon as they start their shift and then every two hours after. Additionally, she indicated that one NA would not be sufficient to complete the required care on the One East Unit. During a surveyor interview with the Director of Nursing Services, on 10/2/2025, she indicated that she would not expect only