



Department of Health  
Three Capitol Hill  
Providence, RI 02908-5097  
TTY: 711  
[www.health.ri.gov](http://www.health.ri.gov)

June 9, 2008

Mr. Hugh Hall, Administrator  
West View Health Care Center  
239 Legris Avenue  
West Warwick, RI 02893

Dear Mr. Hall:

Thank you for the courtesy to the staff of HEALTH/Facilities Regulation who surveyed West View Health Care Center on June 6, 2008. The results of this survey indicates your facility is in compliance with Medicare/Medicaid certification requirements. Enclosed is your copy of the CMS-2567 which is notably deficiency free.

Based on the results of this survey, our certification of your compliance with Medicare/Medicaid requirements will be forwarded to the Rhode Island Department of Human Services.

Thank you for your cooperation during this process, and for your continued participation in the Medicare/Medicaid program. If we can be of assistance at any time in the future, please do not hesitate to contact our office.

Sincerely,

A handwritten signature in black ink, appearing to read "Ray Rusin".

Raymond Rusin, Chief  
Facilities Regulation  
(401) 222-2566

Enclosures: CMS 2567  
AP

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

PRINTED: 06/09/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  415067	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  06/06/2008
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NAME OF PROVIDER OR SUPPLIER  WEST VIEW HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 239 LEGRI\$ AVENUE WEST WARWICK, RI 02893
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(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
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F 000	<p>INITIAL COMMENTS</p> <p>The Annual State and annual Federal Recertification surveys were conducted at this facility.</p> <p>The West View Health Care Center is in compliance with 42 CFR Part 483 requirements for Long Term Care Facilities.</p>	F 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>ARTHUR R. PULLARO</i>	TITLE <i>PHYS</i>	(X6) DATE <i>6/9/08</i>
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A deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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.