STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415042	A. Building B. Wing	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterview Villa Rehabilitation and Health Care Cen	1275 South Broadway East Providence, RI 02914

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to ensure that staff updated and implemented proper safety measures, including the use of bed rails, which resulted in the resident sustaining a significant fracture that required surgery and a significant decline from his/her prior level of function due to a preventable fall for 1 of 1 resident reviewed, Resident ID #1. Findings are as follows:Record review revealed the resident was initially admitted to the facility in January of 2018 and readmitted in November of 2025 with diagnoses including, but not limited to, dementia, left hip fracture and history of falls.Record review of a facility policy titled falls management, last revised in April 2024, revealed in part, .A fall is defined as any incident in which a resident has a change in elevation.anytime a resident is found on the floor, a fall is considered to have occurred.Record review of a facility policy titled side rails, last revised in August 2018, revealed in part, .procedure.evaluation is completed to identify potential benefits from utilizing side rails and minimize risk.consent will be obtained prior to initiation of side rails .a. Record review revealed that the resident sustained a fall while ambulating on 10/2/2025 and had pain to his/her left hip and leg.Record review of the physical therapy evaluation and plan of care dated 10/7/2025 revealed that Resident ID #1 experienced a decline in functional ability for mobility and transfers following the fall that occurred on 10/2/2025. During the evaluation the resident required moderate assistance for bed mobility using side rails, moderate assistance for functional mobility with a rolling walker, and moderate assistance for functional transfers. The resident demonstrated an unsteady gait related to decreased balance, left hip pain, and reduced activity tolerance. The therapy goals included enabling the resident to safely perform bed mobility tasks using side rails to facilitate getting in and out of bed. The physical therapy evaluation and plan of care was signed by the physician on 10/8/2025.Record review of a care plan, last revised on 10/28/2025, failed to reveal evidence that the resident required side rails for mobility and transfers after his/her fall on 10/2/2025.During an interview with the Director of Nursing Services (DNS) on 11/10/2025 at 2:30 PM she indicated that the side rails were installed on Resident ID #1's bed on 10/27/2025. This was approximately 20 days from the date the side rails were recommended by physical therapy, and the recommendation was signed by the physician. b. Record review of a facility reported incident sent to the Rhode Island Department of Health on 11/5/2025 revealed that the resident had a fall out of bed on 10/27/2025.Record review revealed the following progress notes:- 10/27/2025- the resident was found at approximately 6:45 AM lying on the floor on his/her side, a Nursing Assistant (NA) assisted the resident back to bed and reported that the resident complained of back and leg pain.- 11/1/2025, the resident continues to complain of pain. It further revealed that the pain regimen was not effective, as the resident continued to complain of pain while being transferred into bed. It further revealed that an X-ray of the hip and pelvis were ordered.- 11/4/2025, the X-ray results were reviewed by the physician, and the resident was sent to the emergency department due to the risk for bone necrosis (death of tissue due to restricted blood supply) related to the type of fractures s/he sustained.Record review of a hospital Discharge summary dated [DATE] revealed the resident would be returning to the nursing home on that day and revealed that the resident presented to the emergency department after s/he was found to have a left femoral neck fracture and pelvic fracture after a fall. Additionally, it revealed that the resident was ambulatory with a walker prior to the fall and now requires a wheelchair. Further review of the hospital document revealed that the resident was in pain with the movement of the leg and could not provide further history due to dementia. Furthermore, imaging was ordered and revealed an acute comminuted fracture of the left femur (a type of bone fracture where the bone breaks into multiple pieces that occurs suddenly and is typically caused by a traumatic event, such as a fall) and the resident was then admitted for surgery. During a surveyor observation on 11/10/2025 at approximately 11:30 AM, the resident was noted to be seated in a wheelchair. S/he was unable to stand effectively, complained of pain, and was being assisted by two staff members utilizing a gait belt.During a surveyor interview on 11/10/2025 at 11:50 AM with Licensed Practical Nurse, Staff B, she revealed that after the resident's fall on 10/27/2025, s/he was complaining of increased pain with care and was no longer using his/her walker. She further revealed that she requested an order for an X-ray from the physician on 11/1/2025 due to concerns of the resident's increased pain and a significant decrease in ADLs. Staff B further revealed that the X-ray was not completed until 11/3/2025.During a surveyor interview on 11/10/2025 at 3:51 PM with the DNS, she could provide evidence the resident received the X-ray prior to 11/3/2025

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on surveyor observation, record review and staff interview, it has been determined that the facility failed to ensure that garbage is properly disposed of in accordance with professional standards for food safety, relative to refuse being left outside the dumpster, potentially harboring and feeding pests. Findings are as follows:Review of the 2022 Food and Drug Administration (FDA) Food Code, Section 5-501.112 Outside Storage Prohibitions states in part, (A) Except as specified in (B) of this section, REFUSE receptacles not meeting the requirements specified under 5-501.13(A) such as receptacles that are not rodent-resistant, unprotected plastic bags and paper bags, or baled units that contain materials with FOOD residue may not be stored outside .Review of the 2022 FDA Food Code, Section 5-502.11 Frequency states in part, REFUSE, recyclables, and returnable shall be removed from the PREMISES at a frequency that will minimize the development of objectionable odors and other conditions that attract or harbor insects and rodents .Record review of a community report complaint submitted to the Rhode Island Department of Health on 10/10/2025 alleges that overflowing garbage at the facility was attracting pests and was creating a risk of disease for both residents and staff.Record review of an undated photograph provided by the complainant revealed multiple garbage bags accumulated next to the dumpsters. Record review of an email authored by the facility Administrator revealed that he had contacted his supervisors on 10/6/2025 and 10/7/2025 to inform them that the waste management company had placed a hold on the account due to nonpayment. It further revealed that trash bags were accumulating in the parking lot and that the company was requesting proof of payment to remove the hold.During a surveyor interview on 11/17/2025 at 11:08 PM with the Administrator he acknowledged that there were issues with the trash removal company at the beginning of October 2025 as they have stopped trash pickup without notice due to nonpayment. Additionally, he acknowledged that the garbage was accumulating in the parking lot.