

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415059	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/03/2024
NAME OF PROVIDER OR SUPPLIER Orchard View Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 135 Tripps Lane East Providence, RI 02915	

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)
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>47939</p> <p>Based on record review and staff interview it has been determined that the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice, relative to following physician's orders for 1 of 1 resident reviewed relative to X-ray orders, Resident ID #1.</p> <p>Findings are as follows:</p> <p>Record review of a community reported complaint submitted to the Rhode Island Department of Health on 11/27/2024, alleges that the resident fell , experienced increased pain, and impaired mobility. New orders were given by the provider for x-rays. The resident was subsequently sent out to the hospital and was diagnosed with two new fractures to his/her back.</p> <p>According to Mosby's 4th Edition, Fundamentals of Nursing page 314, which states in part, The physician is responsible for directing medical treatment. Nurses are obligated to follow physicians' orders unless they believe the orders are in error or would harm the clients.</p> <p>Record review revealed that the resident was admitted to the facility in May of 2023 with diagnoses including, but not limited to, dementia, unsteadiness on his/her feet, and a history of falls.</p> <p>Record review of a progress note dated 11/23/2024 at 4:23 PM, authored by the on-call provider, revealed the resident had a fall and was found on the floor of his/her room. Initially s/he denied pain and later had complaints of lower back pain.</p> <p>Record review revealed a physician's order dated 11/23/2024 at 6:07 PM, for a stat (immediate) x-ray of the lumbar spine (lower back) and thoracic spine (region of the back between the neck and abdomen) two views (frontal and lateral), for back pain post fall.</p> <p>During a surveyor interview on 11/29/2024 at 2:13 PM, with Registered Nurse (RN), Staff A, she indicated she was assigned as the resident's nurse on 11/23/2024 during the 3:00 PM to 11:00 PM shift and indicated the resident stated s/he was having pain. Additionally, she indicated the x-ray technician arrived during her shift to perform the x-rays, as ordered.</p> <p>(continued on next page)</p>

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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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of a mobile x-ray Radiology Interpretation report dated 11/23/2024 revealed only a lumbar x-ray single view (frontal view) was obtained. Further review revealed the second view (lateral view) of the lumbar spine was not obtained. The report failed to indicate information about the lateral view of the lumbar spine or the thoracic spine.</p> <p>During the surveyor interview with Staff A, she revealed that she read the Radiology Interpretation Report to the provider indicating that the x-ray was negative. When the surveyor questioned Staff A if she reported that the lateral view of the lumbar spine and the two views of the thoracic spine were not obtained, she stated I read them the impression report.</p> <p>During a surveyor interview on 12/2/2024 at 9:46 AM with the contracted Nurse Practitioner, she indicated that the facility reported to the on-call provider on 11/24/2024 at 6:42 AM that the x-rays were obtained as ordered and were negative.</p> <p>Record review of a RN Acute/Reassessment note dated 11/25/2024 authored by contracted provider, Registered Nurse (RN), Case Manager, revealed in part, the resident was in his/her room sitting on the edge of the chair when asked to move up and back s/he complained of lower back pain and was yelling out oh lordy! S/he was taking deep breaths and exhaling in pain upon movement. S/he yelled out in pain when his/her lower lumbar area was mildly touched. Further the resident yelled out when attempts were made to move his/her left leg. Lastly, a pain assessment was completed indicating s/he was experiencing 10 out of 10 pain (severe pain) to his/her lower lumbar area and left leg and was unable to bear weight on his/her left leg. This RN called the provider, and an order was given to send the resident to the hospital for additional x-rays to be obtained, as the facility's elevator was down and additional x-rays could not be obtained.</p> <p>Record review of a hospital document titled emergency room to Hospital Admission report revealed the resident was admitted to the hospital on 11/25/2024 status post fall. Additional review revealed a CT scan was obtained that resulted in the resident being diagnosed with new mild compression fractures (small breaks in the vertebrae of the spine) to his/her L4 (lumbar vertebrae 2 and 4) and T9 (thoracic vertebrae 9).</p> <p>During a surveyor interview with the contracted provider, RN, Case Manager, on 12/2/2024 at 9:00 AM she was unable to recall if the facility communicated to her that all of the x-rays that were ordered were not obtained.</p> <p>During a surveyor interview on 12/2/2024 at 10:15 AM with the Assistant Director of Nursing Services (ADNS), she was unable to provide evidence that the two views of the resident's lumbar and thoracic spine were obtained as ordered on 11/23/2024.</p> <p>Record review of a statement dated 11/29/2024 authored by the Radiological Technologist provided to the surveyor on 12/3/2024, one day after exiting the facility, which was not made available during the investigation, revealed that he was unable to obtain all of the x-rays as ordered.</p>		