STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415059	A. Building B. Wing	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Orchard View Manor	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)
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. 45263 Based on record review and staff interview, it has been determined that the facility failed to meet professional standards of quality, relative to following a physician's order to obtain daily weights for 1 of 1 resident reviewed, Resident ID #1. Findings are as follows: According to Mosby's 4th Edition, Fundamentals of Nursing, page 314 states in part, .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 a physician's order with a start date of 3/27/2025 for the resident to be weighed daily. Record review failed to reveal evidence of documented weights from 3/28/2025 through 4/1/2025. Additional, record review failed to reveal evidence that the physician was notified of the missed weights. During a surveyor interview on 4/2/2025 at approximately 11:30 AM, with the DNS she was unable to provide evidence that daily weights were obtained for Resident ID #1 from 3/28/2025 through 4/1/2025.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. 45263 Based on record review, surveyor observation, and staff interview, it has been determined that the facility failed to ensure a resident received a therapeutic diet as ordered by the physician for 1 of 2 residents reviewed who had orders for a therapeutic diet, Resident ID #1. Findings are as follows: Resident ID #1 was admitted to the facility in March of 2025 with diagnoses including, but not limited to, acute and chronic respiratory failure and diastolic heart failure (when the left ventricle of the heart becomes stiff and does not beat properly). Record review of a physician order with a start date of 3/26/2025 revealed a Low Sodium Diet (2-4 grams of Sodium) diet. During a surveyor observation of the resident on 4/2/2025 at approximately 12:30 PM, revealed that the lunch meal that was served to the resident contained a double portion of ham. Record review of the tray ticket that was on the resident's tray revealed the following in part: - Regular Texture, Low Sodium - Notes: Double Portions - No Ham During a surveyor interview on 4/2/2025 at approximately 2:00 PM with the Dietitian, Staff B, she acknowledged that the prescribed diet was not served to the served to the resident. She further revealed that s/he should have received baked chicken. B. Record review of a physician order dated 3/26/2025 revealed a 2000 milliliters (ml) daily fluid restriction, dietary to provide 830 ml of the 2000 ml fluid restriction. Record review of the tray ticket for 4/2/2025 revealed the following in part: Breakfast: 4 ounces (oz) of Milk 8 oz of Orange Juice Lunch: 8 oz of Cranberry Juice (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8 oz of Ginger Ale Dinner 8 oz of Cranberry juice 8 oz of Ginger Ale This indicates that a total fluid amount provided to the resident by the dietary department was 1320 ml's, which exceeded the 830 ml's that is allotted to be provided by the dietary department in a 24 hour period. During a surveyor observation on 4/2/2025 at 12:30 PM of the resident's lunch tray, revealed the resident was provided with 8 ounces of gingerale, that was placed in a 16 ounces styrofoam container of ice, and 8 ounces of cranberry juice. During a surveyor interview with the resident immediately following the above mentioned observation, s/he revealed that s/he placed the gingerale that was on his/her lunch tray into the cup of ice. Additionally, s/he acknowledged that s/he was on a fluid restriction. During a surveyor interview on 4/2/2025 at 1:30 PM, with the Dietitian, Staff B, she indicated that the Dietary staff provide the beverages that are listed on the meal tickets. She acknowledged that beverages listed on Resident ID #1's meal ticket indicates that s/he exceeds his/her daily dietary fluid allotment, as she was receiving 1320 ml from dietary, and should only be receiving 830 ml.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 45263 Based on surveyor observation, record review, resident and staff interview, it has been determined that the facility failed to maintain medical records in accordance with professional standards and practices for 1 of 1 resident reviewed for a fluid restriction and for a complete and accurate medical record, Resident ID #1. Findings are as follows: 1a. Record review of a facility policy titled, Nursing Policy & Procedure Manual, April 2015 reads in part maintain accurate intake and output and no water pitchers are to be left at the bedside. Record review for Resident ID #1 revealed that s/he was admitted to the facility in March of 2025 with diagnoses including, but not limited to, diastolic congestive heart failure (when the left ventricle of the heart becomes stiff and does not beat properly) and acute and chronic respiratory failure. Record review revealed a physician order dated 3/26/2025 for a fluid restriction of 2000 milliliters (ml) daily, to be as administered on the following nursing shifts: - 11:00 PM -7:00 AM 290 ml - 7:00 AM -3:00 PM 440 ml - 3:00 PM -11:00 440 ml - Dietary 830 ml across three meals Surveyor observation on 4/2/2025 at 10:45 AM, revealed the resident was lying in bed with a 16 ounce styrofoam pitcher of water, a 16 ounce styrofoam pitcher of ice and a 16.9 ounce bottle of water at his/her bedside. Record review of the Medication Administrator Records (MAR) for March 2025 and April 2025 failed to reveal evidence of the amount of fluids the resident received during each shift. Further review of the MARs revealed a check mark for the amount of fluids consumed each shift. During a surveyor interview on 4/2/2025 at 2:30 PM, with the Director of Nursing Services she revealed fluid intake amounts are not documented in the medical records with the amount of fluid the resident receives each shift. Additionally, she revealed that outputs are not accurately documented in the medical record per the facility's policy. Furthermore, the DNS she was unable to explain why there was a bottle of water, a styrofoam pitcher of water and a styrofoam pitcher ice at the resident's bedside. 1b.Record review of a care plan that was developed on 3/26/2025 revealed that the resident was assessed as having verbal expressions of anger with others and accusatory behaviors towards staff. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review revealed the resident was assessed on 3/27/2025 by the facility's social worker and the evaluation revealed that the resident had no behavioral concerns and was adjusting to his/her recent nursing home placement. Record review failed to reveal evidence that the social service assessment completed on 3/27/2025 addressed the care plan concerns that were identified of verbal expressions of anger, anxiety and accusatory behaviors towards staff. During a surveyor interview on 4/1/2025 at approximately 11:00 AM with the DNS she revealed the resident's concerns are addressed every morning at clinical meeting with the team. She indicated the team includes Social Worker, Staff A. During a surveyor interview with Staff A on 4/2/2025 at 11:26 AM, she revealed that she was unaware of any concerns with the resident until this morning when the DNS spoke with her, after the surveyor discussed the resident with the DNS. During a surveyor interview on 4/2/2025 at 11:30 AM, with the DNS she was unable to provide evidence that the resident's medical record was accurately documented.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 45263 Based on surveyor observation, resident and staff interview, it has been determined that the facility failed to maintain a safe, functional, and comfortable environment for residents, staff, and the public, relative to a cracked glass panel on the inner door of the facility's entrance. Findings are as follows: Surveyor observation on 4/2/2025 at approximately 12:30 PM, revealed that upon entering the facility, the lower glass panel of the main vestibule's inner door had approximately eight one foot by one-foot cracked glass segments. Further observation revealed that the cracked glass segments were covered with white medical tape. During a surveyor interview on 4/2/2025 at 2:00 PM with the Director of Nursing Services, she acknowledged the damage to the door. Additionally, she indicated that the damage occurred approximately three to four weeks ago. Furthermore, she was unable to provide evidence of a plan to repair the door.