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	09/24/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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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F 0684 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 record review, resident, family, and staff interview, it has been determined that the facility failed to provide appropriate treatment and services for 1 of 1 resident reviewed who sustained a fall, Resident ID #2.Findings are as follows:During the investigation of a community reported complaint on 9/24/2025, a surveyor interview was completed at 8:38 AM with Resident ID #2's family member. The family member alleged that Resident ID #2 fell on Friday, 9/19/2025, and was sent to the hospital on 9/21/2025, where s/he was diagnosed with a spinal fracture. The family further revealed that when they questioned the nurse on Sunday about the fall, the nurse revealed that there was no fall documented in Resident ID #2's medical record.Review of a policy titled, Fall Management states in part, .A fall risk evaluation will be conducted by the 'nurse on duty/supervisor' on any resident/patient sustaining a fall with or without injury.Post fall, once a resident/patient is clinically evaluated as being stable, vital signs, neurological signs, range of motion, and evaluation of cognitive status will be documented. Neurological checks are to be documented on the neurological flow sheet for 72 hours in the following circumstances: resident/patient states that he/she hit head, physical evidence resident hit head, and unwitnessed fall. Resident/patient should continue to be monitored for 72 hours after a fall evaluation for latent injury, with documentation in the medical record. Review of a policy titled, Condition: Significant Change states in part, .The physician, resident/patient and/or responsible party will be notified by the nurse in the event of a change in condition.This notification shall be documented in the clinical record.Record review revealed the resident was readmitted to the facility in May of 2024 with diagnoses including, but not limited to, unsteadiness on feet and history of falling. Record review revealed a Minimum Data Set assessment dated [DATE] which revealed a Brief Interview for Mental Status score of 15 out of 15, indicating intact cognition.During a surveyor interview with the resident on 9/24/2025 at 10:31 AM, s/he revealed that on Friday, 9/19/2025 s/he had fallen from his/her wheelchair to the floor, landed on his/her butt and staff members picked him/her back up. S/he further revealed s/he did not have pain at that moment but that it developed the next day. Lastly, s/he revealed that s/he went to the hospital on Sunday because s/he was in so much pain it hurt to move. Record review of the resident's medical record from Friday, 9/19/2025 failed to reveal documentation of a fall occurring, an assessment of the resident including initial vital signs and initial neurological checks, 72-hour vital signs and neurological checks, 72-hour monitoring after a fall for latent injury and/or notification to a provider about a fall per the facility policy. Review of the Medication Administration Record revealed that the resident received Acetaminophen 1000 milligrams (mg) for pain of a six out of ten on 9/20/2025 and nine out of ten pain on 9/21/2025.Review of a progress note dated 9/21/2025 at 9:34 AM Central Standard Time, authored by an on-call provider, revealed that the resident had a fall on Friday where s/he fell from his/her wheelchair and onto the floor on his/her bottom. At that time, s/he reported no pain. The progress notes further revealed that on 9/20 and 9/21/2025, the resident was having pain when moving and complained of 10 out of 10 pain to his/her lower back. Additionally, the progress note revealed that the resident is not able to get out of bed or lift his/her head up without excruciating pain to the back area. His/her baseline is up and out of bed often. The resident is almost in tears on exam from pain.Review of a progress note dated 9/21/2025 at 11:45 AM, authored by Licensed Practical Nurse, Staff A, revealed she overheard the resident screaming in his/her room. Upon entry, the resident stated that s/he had back pain. Staff A revealed that, .upon entering the room resident was lying in bed crying, reports pain localized to lower back rated 10/10. When asked what happened resident stated [s/he] had slipped and fell out of wheelchair Friday 9/19/25. Residents' roommate also stated '[s/he] fell out of [his/her] wheelchair the other day'. [range of motion] in lower extremities elicits pain/discomfort during flexion and extension. Redness and warmth area noted in lower back. No swelling or open areas noted.Review of a hospital Discharge summary dated [DATE], revealed that the resident had a compression fracture (a type of break in the vertebrae that causes the bone to collapse) of the L2 vertebrae (a bone in your lumbar region). Further review of the discharge summary revealed that the cause of a compression fracture includes, but is not limited to, a fall or trauma.Record review revealed a physician's order dated 9/23/2025 for tramadol (a narcotic medication used for pain management) 25 mg, to be administered twice daily for pain for 1 week.Review of a statement provided by Nursing Assistant (NA), Staff B, revealed that Resident ID #2 fell on the floor on 9/19/2025 and she helped him/her up to his/her chair with another NA and nurse.During a surveyor interview on 9/24/2025 at 10:19 AM with Staff B, she revealed that