

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415039	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2024
NAME OF PROVIDER OR SUPPLIER Heritage Hills Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 80 Douglas Pike Smithfield, RI 02917	

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 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39496</p> <p>Based on record review and staff interview it has been determined that the facility failed to ensure nursing staff have the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical well-being of each resident, as determined by resident assessments and individual plans of care, for 1 of 3 residents reviewed for medication administration, Resident ID #1.</p> <p>Findings are as follows:</p> <p>Review of a community reported complaint submitted to the Rhode Island Department of Health on 4/1/2024 alleges in part, On March 21st [Resident ID #1] was given the wrong medications .because there were people in training .[Resident ID #1] was given oxycodone and a blood pressure medicine .[Resident ID #1's] blood pressure is low so that was not good and also the oxycodone put [him/her] in a bad state of mind .</p> <p>According to the State Operation Manual Appendix PP- Guidance to Surveyors for Long Term Care Facilities, last revised 2/3/2023 which states in part, .To assure that all nursing staff possess the competencies and skill sets necessary to provide nursing and related services to meet the residents' needs safely and in a manner that promotes each resident's rights, physical, mental and psychosocial well-being . 'Competency' is a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics that an individual needs to perform work roles or occupational functions successfully .</p> <p>The facility policy titled Administering Medications, states in part, .Medications are administered in accordance with prescriber orders .The individual administering medications verifies the resident's identity before giving the resident his/her medications. Methods of identifying the resident include .checking identification band .checking photograph attached to medical record .verifying resident identification with other facility personnel .The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication .New personnel authorized to administer medications are not permitted to prepare or administer medications until they have been oriented to the medication administration system used by the facility .</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 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review revealed Resident ID #1 was readmitted to the facility in March of 2024 with diagnoses including, but not limited to, hypertension, acute kidney failure, acute pyelonephritis(sudden and severe inflammation of kidney due to a bacterial infection), and chronic obstructive pulmonary disease.</p> <p>Review of a medication incident report provided by the facility revealed that on March 21, 2024, the nurse administered the wrong medication to Resident ID #1. It revealed, .Wrong medication was given to the wrong resident. Standard protocol for medication administration was not followed .Did not follow medication administration procedures (5 rights) .rushing through [medication] pass .preceptor [Licensed Practical Nurse (LPN), Staff B] was preparing medications and handing them off to trainee [Licensed Practical Nurse, Staff C] . Additionally, the report reveals that Staff C was instructed that the medications were for the resident in one room and she brought them to the wrong room and administered them to the wrong resident. The medications administered to Resident ID #1 in error included- Aspirin 81 milligrams (mg), Duloxetine (used to treat depression and anxiety) 30 mg, Linezolid (an antibiotic) 600 mg, Oxycontin ER (extended release-a strong narcotic pain medication) 10 mg, Flomax (used to shrink an enlarged prostate) 0.8 mg and Metoprolol Succinate ER (used to treat high blood pressure) 25 mg.</p> <p>Review of a statement authored by Staff B on 3/21/2024, revealed in part, This writer training new nurse . administering medications. I instructed nurse to give [room number redacted] his/her medication I did not go to the room with her as she has been training for over 1 week and wanted her to get a sense of what it is like going in room alone .Error reported to [Nurse Practitioner (NP)] .</p> <p>Review of a statement authored by Staff C on 3/21/2024, revealed while she was training with Staff B there was a medication error. Staff B handed Staff C medications that were meant to be administered to the resident in one room, Staff C misheard the room number, went to the wrong room and administered the medications to Resident ID #1 instead. The error was realized later when Staff B gave Staff C Resident ID #1's medication, and Staff C stated that she had already given Resident ID #1 his/her medications.</p> <p>Multiple attempts were made to interview Staff B or Staff C by phone; however, neither staff member was able to be reached.</p> <p>During a surveyor interview on 4/2/2024 at 1:20 PM with the Unit Supervisor, Staff Nurse A, she revealed that because Staff C was still training Staff B should have been with her at all times during the medication administration.</p> <p>During a surveyor interview on 4/2/2024 at 3:15 PM with the Director of Nursing Services (DNS) she acknowledged that Staff B should not have been pouring medications then having Staff C administer them. Her expectation would be the nurse who pours the medication would be the nurse to administer the medication to the resident. She further acknowledged that since Staff C was still in training, Staff B should have been with her, observing during the entire medication administration. Further, she could not provide evidence that Staff C had demonstrated competency in medication administration at the time of the medication error.</p> <p>Upon further interview with the DNS she provided evidence of the interventions which were initiated after the medication error was identified by the facility on 3/21/2024. The following interventions were completed prior to the date of this complaint survey:</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>a) The resident was assessed for any adverse consequences.</p> <p>b) An audit was completed for all residents' rooms to make sure that names and room numbers are posted outside of the door.</p> <p>c) Electronic records were audited to ensure that the residents pictures were present.</p> <p>d) All nurses were educated on medication administration, along with the responsibility of a preceptor.</p> <p>e) A Quality Assurance and Performance Improvement action plan was put in place and random audits of resident identification measures were conducted.</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>39496</p> <p>Based on record review and staff interviews, it has been determined that the facility failed to ensure that residents are free of any significant medication errors for 1 of 3 residents reviewed, Resident ID #1.</p> <p>Findings are as follows:</p> <p>Review of a community reported complaint submitted to the Rhode Island Department of Health on 4/1/2024 alleges in part, On March 21st [Resident ID #1] was given the wrong medications .because there were people in training .[Resident ID #1] was given oxycodone and a blood pressure medicine .[Resident ID #1's] blood pressure is low so that was not good and also the oxycodone put [him/her] in a bad state of mind .</p> <p>The facility policy titled Administering Medications, states in part, .Medications are administered in accordance with prescriber orders .The individual administering medications verifies the resident's identity before giving the resident his/her medications. Methods of identifying the resident include .checking identification band .checking photograph attached to medical record .verifying resident identification with other facility personnel .The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication .New personnel authorized to administer medications are not permitted to prepare or administer medications until they have been oriented to the medication administration system used by the facility .</p> <p>Record review revealed Resident ID #1 was readmitted to the facility in March of 2024 with diagnoses including, but not limited to, hypertension, acute kidney failure, acute pyelonephritis (sudden and severe inflammation of kidney due to a bacterial infection), and chronic obstructive pulmonary disease.</p> <p>Review of a medication error report provided by the facility revealed that on 3/21/2024, Resident ID #1 received Aspirin 81 milligrams (mg), Duloxetine (used to treat depression and anxiety) 30 mg, Linezolid (an antibiotic) 600 mg, Oxycontin ER (extended release-a strong narcotic pain medication) 10 mg, Flomax (used to shrink an enlarged prostate) 0.8 mg, and Metoprolol Succinate ER (used to treat high blood pressure) 25 mg.</p> <p>Review of Resident ID #1's physician orders revealed s/he did not have orders for the following medications that were administered to him/her in error:</p> <ul style="list-style-type: none"> -Aspirin 81 mg -Duloxetine 30 mg -Linezolid 600 mg -Oxycontin ER 10 mg <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Metoprolol Succinate ER 25 mg</p> <p>Review of the physician's orders revealed the resident was prescribed Flomax; however, the dosage was 0.4 mg.</p> <p>Record review revealed the following progress notes dated 3/21/2024:</p> <p>- 10:40 AM- .At approximately 10 am this nurse assisted in assessing resident [s/he] was [alert and oriented] to baseline .[complaint of] dizziness with movement [blood pressure] at time was 92/62 [normal blood pressure 120/80] pulse 72 [normal pulse 60-100] .</p> <p>- 12:29 PM-Medication administration reviewed by [Nurse Practitioner] new orders to obtain VS [vital signs] every hour [for] 4 hours then [every 4 hours for 24 hours]. Resident refused lunch stating [s/he] doesn't have an appetite and has abdominal discomfort .</p> <p>- 10:33 PM-Resident was alert and oriented [times 3]. No respiratory distress noted. Resident was able to make .needs known. Resident was not lethargic drowsy. Vital signs were stable. Resident refused vitals after 8 pm check. [S/he] stated [s/he] was tired of having vitals checked and wanted to get some sleep .</p> <p>During a surveyor interview on 4/2/2024 with the NP, she revealed that when she saw the resident s/he was alert and oriented with no signs or symptoms of concern. She stated that a nurse called her later in the day and stated that the resident was very sleepy and in and out. At this point the NP recommended that the resident get sent to the hospital for evaluation due to the narcotic, but she was told that the resident and family wanted him/her to be monitored at the facility. The NP further revealed that when she saw the resident the next day, s/he was alert and oriented.</p> <p>Review of the resident's blood pressure (BP) on 3/21/2024 revealed the following:</p> <p>- 9:20 AM- BP 101/76</p> <p>- 10:00 AM- BP 92/62</p> <p>- 11:00 AM- BP 110/76</p> <p>- 12:00 PM- BP 102/70</p> <p>- 1:00 PM- BP 108/74</p> <p>- 4:59 PM- BP 102/72</p> <p>During a surveyor interview on 4/2/2024 with the Unit Supervisor, Staff A, she revealed that the resident received the wrong medication, it was realized right away, and the NP was contacted. The NP assessed the resident and ordered vital signs every hour. She further revealed that the Nurse who administered the medications stayed with the resident for the rest of the shift as a one on one to monitor him/her.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a surveyor interview on 4/2/2024 with the Director of Nursing Services she revealed that a nurse who was training on medication administration had administered another resident's medication to Resident ID #1. She failed to provide evidence that Resident ID #1 was free of any significant medication errors or that the Administering Medication policy was followed.</p> <p>Upon further interview with the DNS she provided evidence of the interventions which were initiated after the medication error was discovered by the facility on 3/21/2024. The following interventions were completed prior to the date of this complaint survey:</p> <ul style="list-style-type: none"> a) The resident was assessed for any adverse consequences. b) An audit was completed for all resident's rooms to make sure that names and room numbers are posted outside of the door. c) Electronic records were audited to ensure that resident pictures were present. d) All nurses were educated on medication administration along with the responsibility of a preceptor. e) A Quality Assurance and Performance Improvement action plan was put in place and random audits of resident identification measures were conducted. 		