

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  05/09/2024
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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46715</b></p> <p>Based on record review and resident and staff interview, it has been determined that the facility failed to ensure that residents receive adequate supervision to prevent an elopement for 1 of 1 resident reviewed who successfully eloped from the facility, Resident ID #2.</p> <p>Findings are as follows:</p> <p>Review of a facility policy titled, Wandering and Elopement dated March 2019, states in part, The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents .If identified as at risk for wandering, elopement, or other safety issues, the residents care plan will include strategies and interventions to maintain the resident's safety .</p> <p>Record review failed to reveal evidence of a facility policy relative to escorting residents to medical appointments.</p> <p>Review of a community reported complaint dated 5/6/2024 alleged that the resident went to an appointment in the community on 5/3/2024 unaccompanied by facility staff and his/her whereabouts were unknown.</p> <p>Record review revealed that the resident was admitted to the facility in December of 2023 with diagnoses including, but not limited to, mild cognitive impairment, schizoaffective disorder, and unsteadiness on feet.</p> <p>Review of the Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status score of 11 out of 15, indicating moderately impaired cognition.</p> <p>Review of a care plan dated 12/21/2023, revealed I am at actual/potential risk for elopement r/t [related to] attempt to leave the building without informing staff.</p> <p>Record review revealed the following physician's orders:</p> <p>2/27/2024 - resident may go on a leave of absence with a responsible party</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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>3/13/2024 - Wander Bracelet (WanderGuard): Check function of wander bracelet (left ankle) every day, one time a day for elopement risk</p> <p>Review of a Elopement/Wandering Risk Evaluation dated 3/16/2024 revealed s/he is at risk for elopement with an intervention for a wander bracelet.</p> <p>Review of a Neuropsychological Evaluation dated 1/11/2024 revealed that the resident lacks the capacity to make decisions for his/her medical care. Additionally, that his/her cognitive difficulties with functional decline are consistent with a diagnosis of major neurocognitive disorder. Further review revealed recommendations that include, but are not limited to, a surrogate for medical decision making should be activated, s/he requires supervision that would best be achieved through a residential setting such as a nursing facility and the resident is strongly encouraged to abstain from drug use.</p> <p>Record review failed to reveal evidence that interventions were implemented relative to the facility providing a responsible party for the resident during a leave of absence.</p> <p>Review of a progress note dated 2/24/2024 revealed that the resident was found outside of the facility on a main road attempting to catch the bus. Additionally, the progress note indicated the staff were unaware that the resident was not in the building at the time. The resident was then placed on 15-minute checks for 5 days.</p> <p>Review of a community reported allegation dated 5/3/2024 states in part, .[Resident] has noted cognitive deficits, baseline confusion, and incapacity, as well as various other concerns. [Resident] requires walker to ambulate but frequently does not use it .on today's date 5/3/24 .upon arrival, [Resident] was sitting in the waiting area of [Facility] They indicated they had an appointment .[Resident] had attempted to abscond from [Facility] a few months ago and this [Worker] recommended to facility that [Resident] not be transported to appointments at this time .Several hours later .received a phone call that [Resident] never attended their appointment .their current whereabouts are unknown .[Resident] was reportedly spotted at their apartment complex but is not believed to be there presently. At this time, [Residents] whereabouts are unknown .</p> <p>During a surveyor interview on 5/7/2024 at approximately 9:55 AM with the resident s/he revealed that s/he was transported to his/her appointment alone and when s/he arrived at the appointment s/he was informed that it was cancelled. S/he revealed that s/he took three buses to go to his/her home and then went to eat at a restaurant.</p> <p>During a surveyor interview with the Assistant Director of Nursing on 5/7/2024 at 10:40 AM she revealed that prior to the resident leaving for his/her appointment in the community on 5/3/2024 his/her wanderguard was removed in case something happened and s/he was admitted to the hospital, so that the facility would have possession of the device, because wanderguards are expensive.</p> <p>During a surveyor interview on 5/7/2024 at 12:10 PM with the Administrator she acknowledged that the resident was dropped off for an appointment without facility staff accompanying him/her. Additionally, she acknowledged that the resident had previously left the building without staff knowledge and was care planned as an elopement risk.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>During a surveyor interview on 5/8/2024 at 10:26 AM with Social Worker, Staff A, she revealed that she drove to Resident ID #2's apartment on 5/3/2024 and s/he was not there. Additionally, she revealed that she was driving around and found the resident standing on the corner of a highly traveled main road approximately 8 miles from the facility. Staff A indicated that she located the resident at 1:24 PM.</p> <p>During a surveyor interview on 5/7/2024 at 3:05 PM with the Medical Director he revealed that he was unaware that the resident had been dropped off for an appointment alone and was unaware that s/he had been missing for several hours. Additionally, he revealed that he would expect a resident who is care planned as an elopement risk be accompanied by a staff member when leaving the building.</p> <p>During a surveyor interview on 5/7/2024 at approximately 2:00 PM with the Administrator she was unable to provide evidence that Resident ID #2 received appropriate supervision to prevent an elopement.</p> <p>Due to the facility's failure to provide adequate supervision to a cognitively impaired resident who was assessed as an elopement risk resulted in this resident to be unsupervised in the community. The resident left an appointment and took several buses to multiple locations. This resident was found by facility staff standing on the corner of a highly traveled main road approximately 8 miles from the facility which placed the resident at risk for more than minimal harm, impairment, or death.</p> <p>46338</p>		