

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  06/18/2024
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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>45855</p> <p>Based on record review and staff interview, it has been determined that the facility failed to store medications in accordance with currently accepted professional principles relative to maintaining safe and secure storage of all medications, including limited access and mechanisms to minimize loss or diversion, for 1 of 4 residents reviewed, Resident ID #3.</p> <p>Findings are as follows:</p> <p>Record review of the facility policy titled Controlled Substances dated November 2022 states in part, .The facility complies with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications (listed as Schedule II-V of the Comprehensive Drug Abuse Prevention and Control Act of 1975) .Controlled substances are counted upon delivery. The nurse receiving the medication, along with the person delivering the medication, must count the controlled substances together. Both individuals sign the designated controlled substance record .</p> <p>Record review of a facility reported incident received by the Rhode Island Department of Health on 5/14/2024, alleges that the facility was unable to locate 22 pills of tramadol (a schedule IV pain medication with a potential for abuse and risk of dependence) 25 mg (milligrams).</p> <p>Record review of the resident revealed that s/he was admitted to the facility in December of 2023 with diagnoses including, but not limited to, dementia, anxiety disorder, and right hip pain.</p> <p>Record review revealed that the resident had a physician's order for tramadol 25 mg by mouth two times a day for pain.</p> <p>Record review of a statement written by the Nursing Supervisor, Staff A, dated 5/14/2024 indicates that on 5/14/2024 at approximately 8:15 AM, Staff B, Licensed Practical Nurse (LPN), told her that she needed to call the pharmacy to obtain a refill of Resident ID #3's tramadol 25 mg tablets (tabs). The statement further indicated that at the time she was unaware that the pharmacy had already delivered 60 tabs of tramadol to the facility and the medications had been stored in the Medication Technician medication cart, mixed in with the resident's other medications.</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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a surveyor interview with the Assistant Director of Nursing (ADON), in the presence of the Director of Nursing (DON), and the Regional Director of Clinical Services on 6/18/2024 at 11:28 AM, she presented the following statements from staff interviews for the surveyor to review:</p> <ol style="list-style-type: none"> <li>1. Staff C, LPN signed that she received two medication cards of tramadol 25 mg for a total of 60 pills for Resident ID #3 on 5/13/2024 at approximately 8:00 PM, and gave it to Staff D, Registered Nurse (RN).</li> <li>2. Staff D, RN, denied receiving the 60 pills of tramadol 25 mg from Staff C during their shift from 3:00 PM to 11:00 PM.</li> <li>3. Staff B, LPN, took over for Staff D during the 11:00 PM to 7:00 AM shift, and stated that he was unaware that the tramadol 25 mg tabs had been delivered, as they were not entered into the narcotic log book to be counted.</li> <li>4. Staff A, Nursing Supervisor, found that the 60 tablets of 25 mg tramadol for Resident ID #3 were delivered by the pharmacy the night before, as they were in the medication technician's cart mixed in with Resident ID #3's non-narcotic medication and then notified the ADON of her discovery at 8:15 AM on 5/14/2024.</li> </ol> <p>Immediately following the review of the above statements, the ADON revealed that Nursing Supervisor, Staff A, and herself had figured out that 22 of the 25 mg tramadol tabs went missing, and they were not able to locate them. Additionally, the DON, ADON, and the Regional Director of Clinical Services, were unable to provide evidence that the facility limited access and maintained a mechanism to minimize loss or diversion of a Schedule IV medication, as required.</p> <p>Upon further interview with the DON, she provided evidence of the interventions which were initiated after the missing tramadol tabs were discovered by the facility on 5/14/2024. The following interventions were completed prior to the date of this complaint survey:</p> <ol style="list-style-type: none"> <li>a. A thorough investigation of identified narcotic concerns.</li> <li>b. Reimbursement of the resident who had missing medication.</li> <li>c. Notification of the Pharmacy Representative and the medical director/provider regarding the missing medication.</li> <li>d. Conducted an audit of all the current residents medication storage, to ensure all non-narcotics are stored appropriately and narcotic medications are stored securely in a lock box with an accurate count in Narcotic Book.</li> <li>e. Education was provided to all current licensed nurses on the process in receiving narcotics from pharmacy; immediate storage and narcotic book documentation upon delivery, and immediate notification to the DON if a narcotic count discrepancy is identified.</li> <li>f. DON will conduct random audits of narcotic medication handling and documentation for a minimum of three months or until sufficient compliance is achieved.</li> </ol> <p>(continued on next page)</p>		

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F 0761  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	g. The DON and ADON will be responsible for this process. They will evaluate the audits and report on the process to the Quality Assurance Performance Improvement Committee monthly for review and revisions will be made in process, if warranted, for a period of 3-months.		