STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415039	A. Building B. Wing	08/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Hills Nursing & Rehabilitation Center	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)
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43987 Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to provide treatment and care in accordance with professional standards of practice and failed to follow physician's orders relative to daily wound dressing changes for 1 of 1 resident reviewed, Resident ID #1. Findings are as follows: Record review of a facility document titled Dressings, Dry/Clean states in part; .The purpose of this procedure is to provide guidelines for the application of dry, clean dressing .The following information should be recorded in the resident's medical record, treatment sheet or designated wound form .The date and time the dressing was changed .The name and title (or initials) of the individual changing the dressing . Review of a document titled Competency Assessment Skin Tears-Abrasions and Minor Breaks, Care of states in part: .The purpose of this procedure is to guide the prevention and treatment of .skin tears .Apply the ordered dressing .Label with date and initials to top of the dressing . Record review of a community reported complaint sent to The Rhode Island Department of Health on 8/8/2024 alleges that the facility was not providing adequate care to Resident ID #1. The resident was having hygiene and care issues and that s/he endures long waits without being cleaned. Additionally, it alleged that the resident had developed a severe pressure sore on his/her backside. Record review revealed that Resident ID #1 was admitted to the facility in February of 2024 with diagnoses to include, but not limited to, hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following a stroke and type 2 diabetes. Record review of the resident's Quarterly Minimum Data Set assessment dated [DATE], revealed a Brief Interview for Mental Status score of 15 out of 15, indicating intact cognition. Record review of the resident's order summary report revealed the following physician's order: Cleanse right arm with normal saline, pat dry, apply gauze followed by dry sterile dressing one time a day with a start date of 7/22/2024. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the August 2024 Treatment Administration Record revealed that the above wound dressing treatment was last completed as ordered on 8/14/2024 by Licensed Practical Nurse (LPN), Staff D. During a surveyor interview on 8/15/2024 at approximately 12:00 PM with the resident, s/he revealed that s/he has a wound to his/her right arm but does not remember if the dressing was changed. During a surveyor observation immediately after the above interview, there was a bordered sterile dressing placed on his/her right arm. The dressing was labeled with the initials JS and the date 8/13/24. During surveyor interviews on 8/15/2024 at 1:48 PM and on 8/16/2024 at 8:53 AM with LPN, Staff C, he acknowledged that the wound dressing for the resident's right arm was not changed as ordered on 8/14/2024 and would expect the treatment to be completed daily. During a surveyor interview on 8/15/2024 at 2:10 PM with the Regional Director of Clinical Services, she revealed that she would have expected for staff to change the wound dressing per physician's orders. During a surveyor interview on 8/16/2024 at 10:50 AM with LPN, Staff E, she revealed that she had documented the wound dressing as completed on 8/14/2024. Additionally, she acknowledged that she did not change the dressing for Resident ID #1 on 8/14/2024.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43987 Based on record review and staff interview, it has been determined that the facility failed to provide adequate supervision to prevent accidents for 1 of 1 resident reviewed for falls, Resident ID #1. Findings are as follows: Record review of an agreement between the facility and Rhode Island College School of Nursing revealed in part, .The School of Nursing .referred as the College and [facility name redacted] .referred as the Agency . enters in the following agreement which relates to those portions of the educational program in Nursing of the College which are conducted at the Agency .The Agency's responsibilities .The Agency is responsible for client care .The Agency shall delegate to appropriate members of its staff the responsibility of assisting with the planning and coordination of the learning experiences afforded students of the College . Record review of a community reported complaint sent to The Rhode Island Department of Health on 8/8/2024 alleges that Resident ID #1 fell in the shower while s/he was with a nursing student that was unsupervised by a licensed Nursing Assistant (NA). Additionally, the complainant alleges that the resident sustained injuries/bruising to his/her buttocks. Record review revealed that Resident ID #1 was admitted to the facility in February of 2024 with diagnoses to include, but not limited to, hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following a stroke and type 2 diabetes. Record review of the resident's Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status score of 15 out of 15, indicating intact cognition. Additional review of the MDS revealed that the resident requires substantial/maximal assist (Helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) for showers. Record review of a baseline care plan revealed that the resident was at risk for falls related to deconditioning, weakness, hemiparesis, and poor safety awareness. Interventions include, but are not limited to, assisting or reminding the resident to change positions and to have the resident get up from sitting or laying down slowly. Record review of a facility incident report revealed that on 4/9/2024 at 10:00 AM, the Resident had a fall in the shower room while bathing. Additionally, it revealed that injuries included a bruise to the posterior right thigh and right buttock. Record review revealed written statements from the staff members assigned to care for Resident ID #1 on 4/9/2024; NA, Staff A, and the Licensed Practical Nurse (LPN), Staff B. The statements were collected via phone by the Assistant Director of Nursing (ADNS) on 8/15/2024, as the original statements were unable to be located. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Additional record review of the written statements from Staff A and Staff B revealed the following: - Staff A indicated that she was working with a male student nurse providing care to the resident and stepped out to grab something from the linen cart. When she returned to the shower room, the resident was on the floor on his/her bottom. She then told the student nurse to inform the charge nurse. - Staff B indicated that a male nursing student that was working with an NA indicated that the resident had fallen in the shower room out of his/her shower chair while care was being provided. The resident was assessed and was found to have a small cut and a few areas that were starting to bruise. Review of a Falls Risk Assessment completed on 4/9/2024 at 11:41 AM revealed the resident had a score of 16 indicating s/he was at high risk for falls. The assessment indicates the resident is unable to attain balance while standing, sitting and during transitions without physical help. Review of a Head-to-Toe Skin Check and Evaluation completed on 4/9/2024 at 12:02 PM revealed that the following injuries were noted on the resident after the fall: - Bruise to his/her right buttock. - Bruise to his/her right posterior thigh. - A scratch on the right ankle. During a surveyor interview on 8/15/2024 at approximately 2:30 PM with the Regional Director of Clinical Services, she indicated that after speaking with the Director of Nursing Services, she revealed that the nursing student was providing care to the resident with Staff A, but that Staff A had left the resident in the shower room alone with the nursing student. During that time, she indicated that the resident fell out of his/her shower chair. Additionally, she was unable to provide evidence that Resident ID #1 was kept free from accidents.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 43987 Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to maintain appropriate infection control practices to help prevent the transmission of communicable diseases and infections for 1 of 1 resident reviewed for isolation precautions, Resident ID #2. Findings are as follows: Review of a facility document titled Isolation-Categories of Transmission-Based Precautions states in part, Policy Statement Transmission-based precautions are initiated when a resident develops signs and symptoms of an infection: or has a laboratory confirmed infection; and is at risk of transmitting the infection to other residents .Transmission-based precautions are additional measures that protect staff, visitors and other residents from becoming infected .When a resident is placed on transmission based precautions, appropriate notifications is placed on the room entrance door and on the front of the chart so that personnel and visitors are aware of the need for and the type of precaution .The signage informs the staff of the type of CDC [Center of Disease Control and Prevention] precaution(s), instructions for use of PPE [Personal Protective Equipment] . Record review revealed that Resident ID #2 was admitted to the facility in July of 2024. The resident has diagnoses which include, but are not limited to, urinary tract infection, septicemia (infection of the bloodstream), and dementia. The resident is currently positive for COVID-19 and is on isolation precautions. During a surveyor observation on 8/16/2024 at 12:13 PM in the presence of the Assistant Director of Nursing Services (ADNS), Resident ID #2 was heard calling out, Help. You are hurting me. The surveyor walked towards the room in which the calls were coming from and observed Nursing Assistant (NA), Staff E, inside the resident's room, holding soiled linens, wearing an N95 mask (respirator), and gloves. Additional observation revealed Physical Therapy Assistant, Staff F, was already in the room wearing a gown, gloves, and an N95 mask redirecting the resident and explaining that they were changing his/her linens because they were soiled. Further observation of the resident's room revealed signage which indicated that it was an isolation room. The sign also indicated that prior to entering the room, staff and visitors must clean their hands, wear a gown, an N95 mask, use eye protection (goggles or face shield), and wear gloves. During a surveyor interview immediately following the above observation on 8/16/2024 with NA, Staff E, she indicated that she did not know the resident's room required isolation precautions. Additionally, she acknowledged that she was not wearing the appropriate PPE to care for the resident. During a surveyor interview on 8/16/2024 at 12:15 PM with Staff F, she acknowledged she was not wearing the required eye protection while in a COVID-19 positive resident's room. During a surveyor interview on 8/16/2024 at 12:16 PM with the ADNS, she acknowledged that Resident ID #2 was COVID-19 positive and that Staff E and Staff F were not wearing the appropriate PPE while in his/her room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a surveyor interview on 8/16/2024 at 12:27 PM with the Regional Director of Clinical Services, she stated that she would expect for staff to follow infection control practices and wear all required PPE to enter rooms under isolation precautions.