

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 01/06/2025
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 0574</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The resident has the right to receive notices in a format and a language he or she understands.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46671</p> <p>Based on record review, staff, resident, and resident representative interviews, it has been determined that the facility failed to ensure that a resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, for 1 of 1 resident reviewed who's primary language is Spanish, Resident ID #1.</p> <p>Findings are as follows:</p> <p>Record review of a community reported complaint submitted to the Rhode Island Department of Health on 1/2/2025 alleged that a staff member had Resident ID #1 sign financial and admission documents, which s/he was not able to read, because the documents were not written in Spanish.</p> <p>Record review of a Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident ID #1's preferred language is not English.</p> <p>Record review revealed a notice of health insurance non-coverage document, which was written in English, that outlines the resident's last day facility services would be covered by his/her insurance and information regarding his/her rights to appeal this decision, was signed by the resident on 7/30/2024.</p> <p>Further record review failed to reveal evidence that s/he received the same document in his/her preferred language, Spanish.</p> <p>Further record review revealed that a 63 page document titled, Admission Packet dated 8/30/2024, which was written in English, was signed by the resident.</p> <p>During a surveyor telephone interview with the resident and his/her representative on 1/2/2025 at 4:57 PM, the representative translated for Resident ID #1, that a staff member told him/her to sign papers or else s/he would have to leave the facility. Additionally, the representative indicated that the person spoke to him/her in Portuguese, not the resident's dominant language of Spanish. Additionally, s/he indicated that was all s/he was told.</p> <p>During a surveyor interview on 1/3/2025 at 10:47 AM, with the Admissions Coordinator, she acknowledged that Resident ID #1's admission documents were signed by the resident despite the documents being written in English and not Spanish, the language s/he understands.</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 0574</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a surveyor interview on 1/3/2025 at 2:59 PM, with the Administrator, she was unable to provide evidence that the resident was provided with the above-mentioned documents in Spanish.</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>46671</p> <p>Based on surveyor observation, record review, staff, resident, and resident representative interviews, it has been determined that the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice, relative to following physician's orders for obtaining a urine sample for 1 of 1 resident reviewed, Resident ID #1 and for 1 of 1 resident reviewed relative to obtaining weights, Resident ID #2.</p> <p>Findings are as follows:</p> <p>According to Mosby's 4th Edition, Fundamentals of Nursing page 314, states in part, The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm the clients.</p> <p>1. Record review of a community reported complaint submitted to the Rhode Island Department of Health on 12/31/2024, alleged in part, that Resident ID #1 had a urine sample collected via a catheter (a flexible tube that is passed into the bladder to remove urine) when s/he could have urinated in a test cup for a urinalysis (when urine is collected and sent to a laboratory where it is tested for abnormalities such as, a urinary tract infection). Additionally, the complaint alleges that the resident does not speak English, and that if it was explained to him/her in the language s/he speaks, Spanish, s/he could have urinated in a test cup.</p> <p>Record review of a progress note dated 11/19/2024 at 5:09 PM, authored by Registered Nurse (RN), Staff A revealed that Staff A received an order from Nurse Practitioner (NP), Staff B, to obtain the resident's urine via a straight catheter.</p> <p>Further record review revealed a physician's order dated 11/19/2024 indicating to obtain a urinalysis for monitoring until 11/19/2024 at 11:59 PM. Further review of the order failed to reveal instructions that the urine sample was to be obtained via a straight catheter.</p> <p>During a surveyor telephone interview with the resident and his/her representative on 1/2/2025 at 4:57 PM, the representative translated for resident that some time ago a staff member, who spoke Spanish, told Resident ID #1 that s/he had to do a urine test exam and that was all that was explained to him/her. S/he then stated a staff member proceeded to hold his/her arms down and another held his/her legs down and s/he was afraid and did not know what they were going to do to him/her, as nothing else was explained to him/her. The representative revealed that after this incident occurred, the resident called several family members, a friend, and his/her representative and was crying because s/he was so upset about what had just happened to him/her.</p> <p>During a surveyor interview on 1/3/2025 at 12:41 PM, with Staff A, she was unable to provide evidence that there was an order for the resident's urine to be collected via a straight catheter on 11/19/2024.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During surveyor interviews on 1/2/2025 at approximately 12:50 PM and 1/3/2025 at 12:39 PM, with NP, Staff B, she stated that she did not give an order for the resident's urine to be collected via a straight catheter on 11/19/2024 and that the resident's dominant language is not English, which would be even more reason not to use a straight catheter with him/her. Additionally, she revealed there was a book that is kept at the nurse's station that contains handwritten physician orders and documented communications between nurses and providers.</p> <p>Record review of the physician's order book in the presence of Staff B, failed to reveal an order for Resident ID #1's urine to be collected via straight catheter on 11/19/2024.</p> <p>During a surveyor interview on 1/6/2025 at 10:01 AM, with the physician, he indicated that a urine analysis is usually obtained by a clean urine catch. Additionally, he indicated that if a straight catheter method is ordered to obtain a urine sample, then it should be reflected in the order.</p> <p>2. Record review of a community reported complaint submitted to the Rhode Island Department of Health on 12/30/2024, alleged in part, that Resident ID #2 had a greater than 20 pound weight loss since his/her admission to the facility.</p> <p>Record review revealed Resident ID #2 was admitted to the facility in October of 2024 with diagnoses including, but not limited to, bacterial infection and chronic pain.</p> <p>Record review revealed physician orders with start dates of 10/25/2024 and 11/1/2024, indicating that Resident ID #2's weight should be obtained on admission, then weekly x 4, then monthly thereafter.</p> <p>Record review of the October, November, and December 2024 Medication Administration Records revealed that the resident's weight was scheduled to be obtained on the following dates:</p> <ul style="list-style-type: none"> - 11/1/2024 - 11/8/2024 - 11/15/2024 - 11/22/2024 - 12/6/2024 <p>Additional record review failed to reveal evidence that the resident's weight was obtained, as ordered on the above-mentioned dates. Furthermore, the record failed to reveal evidence that the physician or provider were notified that the resident's weights were not obtained as ordered on 11/1, 11/8, 11/15, 11/22 or 12/6/2024.</p> <p>During a surveyor interview on 1/6/2025 at 10:01 AM, with the physician, he stated that anything ordered should be obtained and if not, then this should be communicated to the provider.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a surveyor interview on 1/3/2025 at 1:24 PM, with the Director of Nursing Services, she was unable to provide evidence that Resident ID #2's weights were obtained, as ordered. Additionally, she was unable to provide evidence that the physician or provider were notified the resident's weights were not obtained, as ordered.</p> <p>A surveyor interview was unable to be conducted with Resident ID #2 during the survey as s/he had been discharged to the hospital.</p>