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	08/01/2025

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 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. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review, staff and resident interviews, it has been determined that the facility failed to ensure that each resident receives adequate supervision and care to prevent an accident for 2 of 3 residents reviewed who are at risk for falls, Resident ID #s 5 and 6. Findings are as follows:Record review of a United States Food and Drug Administration document titled A Guide to Bed Safety Bed Rails in Hospitals, Nursing Homes and Home Health Care: The Facts states in part, to keep the bed in the lowest position with the wheels locked.1. Review of a community reported complaint submitted to the Rhode Island Department of Health on 7/30/2025 alleges that Resident ID #5 told a social worker at a local hospital that s/he was left unattended at the bedside while receiving care, sustained a fall and was sent to the hospital for an evaluation. Record review revealed Resident ID #5 was admitted to the facility in July of 2025 with a diagnosis that includes, but is not limited to, paraplegia (a type of paralysis that affects the lower half of the body, typically resulting in the loss of movement and/or sensation in both legs and sometimes parts of the lower abdomen).Record review of a Brief Interview for Mental Status (BIMS) completed on 7/31/2025 revealed a score of 13 out of 15, which indicates his/her cognition is intact. Record review of a document titled, Safe Patient Handling Evaluation, dated 7/15/2025 revealed that for bed mobility, the resident is dependent on two staff members using a sheet for turning and repositioning. Record review of the resident's Kardex (a documentation system that enables nurses to write, organize, and easily reference key resident information that shapes their nursing care plan) states in part, monitor for safety and the potential increased risk for fallsDuring a surveyor interview conducted on 7/31/2025 at 1:45 PM, Nursing Assistant Staff A stated that on 7/29/2025, she was the only staff member present in the resident's room while providing care. She reported elevating the bed to approximately waist height to facilitate care and did not return it to the lowest position afterward. Staff A indicated that the resident was positioned on his/her side in preparation for his/her wound treatment when she stepped to the doorway to call for the nurse. While she was at the door, the resident fell from the bed to the floor.Record review revealed that on 7/29/2025 the resident was sent to the emergency room for evaluation and was admitted .During a surveyor interview on 8/1/2025 at 2:15 PM with the Director of Rehabilitation Services, he revealed the resident is a fall risk, has impulsive behaviors, and needs supervision for safety if his/her bed is raised to waist level.During a surveyor interview on 8/1/2025 at 2:45 PM, the Director of Nursing Services (DNS) was unable to provide evidence that the Safe Patient Handling Evaluation dated 7/15/2025 was followed for Resident ID #5. Specifically, the resident was not assisted by two staff members or with the use of a turning/repositioning sheet, as outlined in the evaluation. 2. Record review revealed Resident ID #6 was re-admitted to the facility in March of 2024 with a diagnosis that includes, but is not limited to, spastic quadriplegic (partial or complete paralysis of all four limbs including the torso). Record review revealed a BIMS assessment was dated 4/30/2025 and a score was not able to be obtained due to his/her cognition.Record review of physician's order dated of 7/15/2025 reads in part, .floor mats to bilateral sides of the bed when resident in bed.Record review of a document titled Visual/Bedside Kardex Report states in part, .safety.bed in low position and floor mats.Record review of a care plan last revised on 6/23/2025 revealed that the resident is at risk for falls with an intervention that was implemented on 4/4/2025 to have the bed in a low position and floor mats.During a surveyor observation on 8/1/2025 at 1:40 PM, the resident was in his/her bed and only had one floor mat on the right side of the bed.During a surveyor interview on 8/1/2025 at 1:45 PM, immediately following the above-mentioned observation with a Licensed Practical Nurse, Staff B, she acknowledged a floor mat was not present on the left side of the bed and indicted one should have been.During a surveyor interview on 8/1/2025 at 2:45 PM with the Director of Nursing Services, she was unable to provide evidence that Resident #6 had floor mats to the bilateral sides of his/her bed on 8/1/2025.