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	01/14/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to keep residents free from abuse for 1 of 5 residents reviewed, Resident ID # 4.Findings are as follows:Review of a facility reported incident submitted to the Rhode Island Department of Health on 1/10/2026, revealed that at approximately 2:00 PM on 1/10/2026 while sitting in the South Unit Day room, Resident ID #2 was observed touching Resident ID #4's lower private area, both residents were immediately separated, and they were assessed without any injuries. Further review of the report revealed Resident ID #2 was then placed on continuous observation while out of bed, and that s/he will resume his/her 15-minute checks while in bed. Resident ID #4 was also placed on 15-minute checks.Record review revealed Resident ID #4, was admitted to the facility in June of 2016, with a diagnosis including, but not limited to, Alzheimer's disease and major depressive disorder. Review of Resident ID #4's Quarterly MDS assessment dated [DATE], revealed s/he has severe cognitive impairment. During a surveyor interview on 1/13/2026 at 1:41 PM with the Activities Aide, Staff B, he revealed that on 1/10/2026 at 2:00 PM he was walking by the South Unit day room and when he looked in the room, he observed Resident ID #2 in his/her wheel chair sitting on the side of Resident ID #4's chair and observed Resident ID #2 touching Resident ID #4's lower private area. Staff B immediately intervened and removed Resident ID #2 from the room and notified the nurse. Review of Resident ID #2's care plan, initiated on 1/23/2025, revealed a focus area related to a history of sexually inappropriate behavior, and a history of inappropriate touching towards other residents and staff. The care plan indicated that the resident was subsequently involved in further incidents of inappropriately touching other residents on 8/30/2025, 10/14/2025, 12/19/2025 and lastly on 1/10/2026 (with Resident ID #4).Further review of Resident ID #2's care plan revealed an intervention implemented after the 1/10/2026 incident with Resident ID #4 to provide 1:1 observation. Record review indicated that the incident on 1/10/2026 involving Resident ID #2 and Resident ID #4 occurred in the day room on the South Unit. However, the 15-minute observation sheet dated 1/10/2026 documented that at the time of the incident, Resident ID #2 was observed at the nurse's station on the [NAME] Unit.Despite interventions implemented following each inappropriate sexual incident involving other residents including two prior incidents with Resident ID #4 on 8/30/2025 and 10/14/2025, Resident ID #2 continued to engage in inappropriate touching of other residents. During a surveyor interview conducted on 1/13/2026 at approximately 3:00 PM, the Administrator acknowledged that Resident ID #2 had previously inappropriately touched other residents, including three incidents involving Resident ID #4, and that interventions were implemented. However, he was unable to provide evidence that the facility ensured Resident ID #3 and Resident ID #4 were free from abuse by Resident ID #2.

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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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on clinical record review and staff interview, the facility failed to ensure that services provided meet professional standards of quality relative to following physician's orders for medication administration, for 1 of 3 residents reviewed, Resident ID #2. Findings are as follows:Mosby's 4th Edition, Fundamentals of Nursing, page 314 states, The physician is responsible for directing medical treatment. Nurses are obligated to follow physicians' orders unless they believe the orders are in error or would harm the clients.Record review revealed that Resident ID #2 was admitted to the facility in January of 2025 with diagnoses including, but not limited to, dementia with behavioral disturbances and major depressive disorder.Record review revealed a physician's order with a start date of 12/20/2025 for Seroquel (a medication prescribed to treat several types of mental health conditions) 50 milligrams (mg), administer one tablet by mouth twice daily.Record review revealed a physician's order with a start date of 12/19/2025 for Seroquel 25 mg once daily at bedtime.Record review revealed an additional physician's order to re-evaluate the Seroquel orders with the provider on 1/2/2026. Record review of the January 2026 Medication Administration Record (MAR) revealed that on 1/2/2026 the order to re-evaluate the resident's Seroquel medication was signed off as completed by Licensed Practical Nurse (LPN) Staff X, indicating the Seroquel medications were re-evaluated with the provider. Record review of the progress notes failed to reveal evidence that the Seroquel medication was re-evaluated with the provider on 1/2/2026.During a surveyor interview on 1/14/2026 at 3:30 PM with LPN, Staff C, she revealed that she had signed that she re-evaluated the resident's Seroquel order with the provider, but she acknowledged that she had not. Additionally, she revealed that when the Seroquel orders were initially entered into the resident's record, they were entered for only 14 days.Additional review of the January 2026 MAR indicated that the last time the Seroquel order for twice daily was administered on 1/2/2026 at 1:00 PM and that the last time the Seroquel order for bedtime was administered was 1/1/2026 and both medication orders were no longer in place. Further review of the MAR indicated that the same Seroquel order for twice daily administration was ordered again, starting on 1/11/2026 and the same Seroquel order for bedtime administration, was ordered again on 1/10/2026.Review of the January 2026 MAR indicated that the resident failed to receive his/her Seroquel, as ordered, for a total of 8 days. During a surveyor interview on 1/14/2026 at 4:50 PM with the Director of Nursing Services, she acknowledged that the Seroquel orders were initially entered into the resident's record for only 14 days. Additionally, she indicated that when she reviewed the resident's record on 1/10/2026, she realized that the Seroquel orders were no longer in place, and that she had contacted the provider.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observations, clinical record review, and staff interview, the facility failed to maintain medical records on each resident that are complete and accurately documented, for 1 of 2 residents reviewed for falls, Resident ID #7. Findings are as follows: Review of a community reported complaint submitted to the Rhode Island Department of Health on 1/13/2026 revealed in part, the complainant had safety and care practice concerns surrounding the resident's fall on 1/12/2026. Record review revealed the resident was admitted to the facility in April of 2023 with diagnoses including, but not limited to, dementia and neuromuscular dysfunction. Record review of a nursing progress notes indicated that the resident had a witnessed fall in his/her room while care was being provided. The resident was assisted with turning in bed by one staff member; s/he fell out of the bed landing onto the floor. Record review of the Quarterly Minimum Data Set assessment dated [DATE] revealed the resident is dependent with rolling in bed from his/her back, to the left and right side, and returning to his/her back. Record review of the resident's care plan initiated 4/14/2023 with a focus area for activities of daily living (ADL) related to physical limitations due to impaired mobility, revealed the following conflicting interventions for bed mobility: -Date initiated 6/7/2024, I require the assist of 2 staff and a sheet for turning and repositioning. -Date initiated 12/23/2025, I require the assist of 1 staff and a sheet for turning and repositioning. The above care plan failed to indicate a complete and accurate description of what the resident required for assistance when turning and repositioning in bed. During a surveyor interview with the Regional Clinical Director in the presence of the Director of Nursing Services on 1/14/2026 at 4:50 PM, when asked about the above-mentioned care plan with the two different interventions for rolling the resident in bed, she revealed that when the 12/23/2025 intervention was implemented, the 6/7/2024 intervention should have been removed. She was unable to provide evidence the care plan accurately reflected the resident's needs.