

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 06/16/2026
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)		
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, the facility failed to ensure that assessments accurately reflect the resident's status for 1 of 3 residents reviewed related to pressure ulcers (an area of localized damage to the skin and/or underlying tissue that develops as a result of prolonged pressure), Resident ID #2. Findings are as follows: Record review revealed the resident was admitted to the facility in March of 2026 with a diagnosis including, but not limited to, quadriplegia (paralysis that affects all four limbs and the body from the neck down). Record review of a document titled Skin Issues dated 3/5/2026 revealed that the resident had a Stage 2 pressure ulcer (is a partial -thickness loss of the skin where the dermis is exposed, forming a shallow, red or pink wound or blister without visible fat or deeper tissues) on his/her coccyx measuring 3.53 centimeters (cm) by 0.68 cm by 0 cm. Record review of the Minimum Data Set (MDS) assessment dated [DATE] inaccurately coded that the resident did not have a pressure ulcer. During a surveyor interview on 6/15/2026 at 12:53 PM with the MDS Coordinator, she revealed that the MDS dated [DATE] should have been accurately coded to indicate that the resident had a pressure ulcer. During a surveyor interview on 6/15/2026 at approximately 1:15 PM with the Director of Nursing Services she indicated that she would expect the MDS assessment dated [DATE] to indicate that the resident had a stage 2 pressure ulcer, as documented on the skin check from 3/5/2026.		

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record review and staff interview, the facility failed to provide care in accordance with a resident's plan of care for 3 of 3 resident's relative to turning and repositioning, Resident ID #s 1, 2, and 4. Findings are as follows: 1) Record review revealed that Resident ID #1 was readmitted to the facility in March of 2026 with diagnoses including, but not limited to, Parkinson's disease (a progressive neurological disease that primarily affects movement) and adult failure to thrive. Record review of a care plan dated 12/19/2025 revealed in part, .The resident has a pressure ulcer or has the potential for pressure ulcer development. interventions include, but are not limited to, .I require monitoring, reminding, and assistance to turn and reposition at least every 2 hours, more often as needed or requested. Review of the record failed to reveal evidence that the resident was assisted to turn and reposition at least every two hours per the plan of care. 2) Record review revealed that Resident ID #2 was admitted to the facility in March of 2026 with a diagnosis including, but not limited to, quadriplegia (paralysis that affects all four limbs and the body from the neck down). Record review of a care plan dated 3/5/2025 revealed in part, .The resident has a pressure ulcer or has the potential for pressure ulcer development [related to] immobility. Gluteal cleft -unstageable (a full-thickness wound whose true depth and severity cannot be determined because the wound bed is completely covered by dead tissue) [right] buttocks pressure unstageable. Interventions include, but are not limited to, .I require monitoring, reminding, and assistance to turn and reposition at least every 2 hours, more often as needed or requested. Review of the record failed to reveal evidence that the resident was assisted to turn and reposition at least every two hours per the plan of care. 3) Record review revealed that Resident ID #4 was readmitted to the facility in March of 2026 with diagnoses including, but not limited to, aftercare for circulatory system surgery and transient ischemic attack (a temporary blockage of blood flow to the brain). Record review of a care plan dated 11/19/2025 revealed in part, .The resident has a pressure ulcer or has the potential for pressure ulcer development [related to] immobility. Interventions include, but are not limited to, .I require monitoring, reminding, and assistance to turn and reposition at least every 2 hours, more often as needed or requested. Review of the above resident records failed to reveal evidence that the residents were assisted to turn and reposition at least every two hours per their plan of care. During a surveyor interview on 6/16/2026 at approximately 11:45 AM with the Director of Nursing Services and the Regional Director of Clinical Services, they were unable to provide evidence that the above residents were assisted to turn and reposition at least every two hours per their care plans. Cross reference F 686		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, the facility failed to provide necessary treatment and services, consistent with professional standards of practice, to promote wound healing and prevent new ulcers from developing for 1 of 3 residents reviewed for pressure ulcers (an injury to the skin and underlying tissue caused by prolonged pressure on the skin over a bony prominence), Resident ID #2. Specifically, the resident was admitted to the facility without any skin impairments and while at the facility s/he developed a stage III pressure ulcer (an ulcer that has completely broken through the top 2 layers of skin and into the fat layer below) and an unstageable pressure ulcer (an ulcer that occurs when the wound bed is completely covered by dead tissue, slough, or eschar, preventing clinicians from assessing the depth and extent of tissue damage accurately). Findings are as follows: Review of a community reported complaint received by the Department of Health on 6/5/2026 alleged in part that the facility staff left the resident in a single position for entire shifts. Record review of a facility policy titled, Pressure Injuries Overview reveals in part, . ?Avoidable' means that the resident developed a pressure ulcer/injury and that one or more of the following was not completed. Evaluation of the resident's clinical condition and risk factors. Definition or implementation of interventions that are consistent with resident needs, resident goals, and professional standards of practice. monitoring or evaluation of the impact of the interventions. Record review revealed the resident was admitted to the facility in March of 2026 with a diagnosis including, but not limited to, quadriplegia (paralysis that affects all four limbs and the body from the neck down). The resident was discharged from the facility on 3/20/2026. Record review of a document titled Admission/ readmission Screener dated 3/2/2026 revealed a skin assessment indicating that the resident's skin color was normal, the skin was intact and had abnormalities had not been identified. Record review of a skin check dated 3/2/2026 revealed the resident had no skin impairments noted. Record review of a document titled Braden Scale- for Predicting Pressure Ulcer Risk Evaluation dated 3/2/2026 revealed that the resident was confined to a bed, and his/her mobility is very limited, able to make occasional slight changes in body or extremity position, but s/he is unable to make frequent or significant changes independently. Record review of a document titled, .Skin Issues, dated 3/5/2026, revealed a new coccyx wound described as a .stage 2 pressure ulcer/injury: partial-thickness skin loss with exposed dermis. The wound measurements were 3.53 centimeters (cm) by 0.68 cm by 0 cm. Record review revealed a physician's order dated 3/5/2026 to cleanse the wound on the resident's coccyx with wound cleanser, pat dry, to apply medihoney (a treatment to support wound healing) to the open area and cover with a foam dressing daily and as needed. Record review of a care plan initiated on 3/5/2026 revealed a focus area, The resident has a pressure ulcer or has the potential for pressure ulcer development [related to] immobility. Interventions included, but were not limited to, avoid positioning the resident on the area of wound, and to monitor, remind, and assist to turn and reposition at least every 2 hours, or more often as needed or requested. Record review of the Nursing Assistant (NA) Kardex (a resident information system that summarizes a patient's care requirement details for quick reference) revealed that the resident was dependent on 2 staff members and a sheet for turning and repositioning, and that the resident required monitoring, reminding, and assistance to turn and reposition at least every 2 hours. Further Record review revealed the resident was hospitalized from [DATE] until 3/9/2026. Record review of a Minimum Data Set assessment dated [DATE] revealed that at the time of this assessment the resident was at risk of developing pressure ulcers or injuries, and had one actual pressure ulcer, which was a stage 2 pressure ulcer. Record review of a document titled Admission/ readmission Screener, dated 3/10/2026, revealed that a skin assessment was completed upon the resident's return from the hospital and the resident's skin color was normal, the skin was intact and there were no abnormalities. Record review of a skin check dated 3/11/2026 revealed an unstageable pressure ulcer to the gluteal cleft with eschar and slough (types of dead (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	tissue within the wound bed). The wound measured 6 cm by 1.5 cm. Additionally; the facility documented an open wound on the right buttock measuring 3 cm by 2.5 cm. This wound on the right buttock is documented on the skin check as being acquired in house. Record review of a wound care progress note dated 3/11/2026 by the Wound Nurse Practitioner (NP) revealed the following wounds: 1) Right buttock, Stage 3 pressure ulcer, the wound was measured to be 3 cm by 2.5 cm by 0 cm. 2) Gluteal cleft (the groove between the buttocks), unstageable, the wound was measured to be 6 cm by 1.5 cm by 0 cm. The wound contained 50-74% granulation (the formation of new connective tissue typically appears red or pink and moist) 50-74% slough (dead tissue that appears yellow, tan or white which can impede the healing process). Further review of the wound care progress note authored by the Wound NP, dated 3/11/2026 revealed that new wound orders were obtained and under the section titled Assessment /Plan it indicated that the resident should be repositioned every 2 hours. During a surveyor interview on 6/16/2026 at approximately 10:00 AM with NA, Staff A, she revealed that the NAs document resident care including turning and repositioning in the electronic record using an iPad. Record review of the resident's tasks failed to reveal documentation that the NAs were turning and repositioning the resident every 2 hours during his/her time at the facility, as was indicated in the resident's care plan and the wound care progress note. Further review of the resident's record from 3/2/2026 through discharge on [DATE] failed to reveal evidence that the resident was assisted to turn and reposition at least every 2 hours per the care plan. During a surveyor interview on 6/15/2026 at 1:40 PM with the Wound NP, she revealed that she would expect that the resident would be turned and repositioned every two hours to aid in healing the pressure ulcers. During a surveyor interview on 6/15/2026 at 1:13 PM with the Director of Nursing Services, she revealed that at the facility they do not get orders to turn and reposition resident's every 2 hours because that is a standard of practice. She revealed that turning and repositioning would be written in the task section of the NA documentation. However, she could not provide evidence from the resident's record that the resident was turned and repositioned at least every 2 hours per the resident's care plan or the Wound NP assessment. Additionally, she could not provide evidence that the resident was provided with the necessary treatment and services to promote wound healing and prevent new pressure areas from forming. During a surveyor interview on 6/16/2026 at approximately 10:45 AM with the Regional Director of Clinical Services, she acknowledged that the documentation on the Admission/readmission Screener skin checks completed on 3/2/2026 and 3/10/2026, upon the resident's returns from the hospital indicated that the resident's skin was intact with no irregularities, despite documentation from the wound care NP dated 3/11/2026 indicating that the resident had an unstageable pressure wound to the gluteal cleft and a stage 3 pressure wound to the right buttock. Additionally, she acknowledged that she could not provide evidence that the resident was turned and repositioned every 2 hours as per his/her care plan. The facility's failure to ensure the resident was turned and repositioned at least every two hours in accordance with the care plan, wound care recommendations, and the facility's policy resulted in the resident developing multiple facility-acquired pressure injuries, including the progression of a stage 2 pressure ulcer to an unstageable pressure ulcer and the development of a stage 3 pressure ulcer, causing actual harm. Cross reference F 656		